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### Employee Health Screening and Well-Being Assessment to Support Organizational Performance in an Academic Workplace

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#### ABSTRACT

**Introduction:** This community service project was conducted through a collaborative partnership between the nursing program and the UPI Sumedang Campus administration. The activity aimed (1) to assess the health profile and identify risk factors for NCDs among UPI Campus employees in Sumedang, most of whom have sedentary work patterns, and (2) to utilize these findings as a basis for initiating and advocating targeted, evidence-based workplace health promotion and wellness interventions.

**Methods:** Employees were engaged through preliminary informational sessions coordinated with campus representatives to explain the purpose and procedures of the program and to encourage voluntary participation. The methods included comprehensive health screening—comprising measurements of blood pressure, blood glucose, cholesterol levels, body mass index, and body composition—alongside structured lifestyle interviews. The collected data were analyzed to identify health risks and to inform the development of context-specific recommendations for workplace health promotion.

**Results:** Screening of 44 participants revealed a high burden of NCDs risk factors, including pre-hypertension (40.9%), hypertension (25%), overweight (50%), obesity (25%), and high to very high visceral fat (75%). Low skeletal muscle mass was observed in 86.4% of participants, while pre-diabetes and hyperuricemia were identified in 13.6% and 38.6%, respectively, indicating an elevated risk of metabolic syndrome and future cardiovascular disease. Participation reached 73% (44 of 60 invited employees). Lifestyle interviews and feedback sessions identified limited time, and prolonged sedentary work as key barriers to healthy behavior, while discussions generated interest in workplace physical activity initiatives and healthier food options.

**Conclusion:** The conclusion of this activity is the need for continuous promotive and preventive interventions through nutrition education, increased physical activity, and routine health screenings to support employee health and productivity.



## INTRODUCTION

Employee health plays a strategic role in sustaining the continuity and quality of academic and administrative functions within a university environment. The productivity and institutional effectiveness of higher education institutions are closely linked to the physical and metabolic health of lecturers and administrative staff, who carry the core responsibilities of teaching, research, service delivery, and daily operations. Within this context, employee well-being should be understood not merely as an individual clinical concern, but as a shared organizational and social responsibility.

At the Universitas Pendidikan Indonesia (UPI) Sumedang Campus, most employees engage in predominantly sedentary work patterns, characterized by prolonged sitting, extended computer use, and limited opportunities for physical activity during working hours. Such occupational patterns are well established as contributors to non-communicable diseases (NCDs), including hypertension, diabetes mellitus, dyslipidemia, central obesity, and other metabolic disorders. These risks emerge from the interaction between individual lifestyle behaviors and the structural characteristics of the workplace, making them particularly relevant targets for institution-based health initiatives.

Previous studies have shown that a sedentary lifestyle is closely associated with an increased risk of NCDs. Research indicates that sitting for more than five hours per day is linked to a higher risk of cardiovascular disease, respiratory illness, and multimorbidity (Poses-Ferrer et al., 2021). Another study reported that within academic settings, the prevalence of hypertension is 19.6%, diabetes is 17.5%, and heart disease is 12.6% (Khamaiseh & Habashneh, 2024). Additionally, research has found that the prevalence of NCDs among university employees is 10.15%, with hypertension (17%), diabetes (7.2%), and cardiovascular disease (3.2%) being the most common conditions. Major risk factors include obesity, unhealthy waist-to-hip ratios, and a family history of NCDs (Kuruville et al., 2023). While this body of literature clearly documents the magnitude of the problem, fewer studies describe participatory and context-sensitive models for initial engagement, collective awareness-building, and data-driven planning among university employees.

In the context of Indonesian higher education, addressing such multifaceted health challenges aligns closely with the university's Tri Dharma mandate of education, research, and community service. Community service activities provide a strategic platform for translating academic expertise into practical solutions through partnership with communities. In this case, the employee population represents an internal community whose health challenges warrant collaborative engagement rather than purely top-down clinical assessment. A participatory approach that engages employees as active partners in health assessment, reflection, and dialogue has the potential not only to generate relevant health data, but also to foster ownership, advocacy, and readiness for sustainable workplace health interventions.

Based on this perspective, this community service activity was intentionally designed as a participatory, service-oriented initiative that combined health assessment with dialogue and collective reflection. The activity pursued three interconnected aims: (1) a service delivery aim, to conduct a participatory assessment of physical and metabolic health indicators among UPI Sumedang Campus employees and identify key modifiable NCD risk factors; (2) an engagement and empowerment aim, to use the assessment process as a platform for direct health education, shared interpretation of findings, and increased awareness of workplace-related health risks;

and (3) a strategic planning aim, to generate locally relevant, evidence-based data that could support employee and institutional advocacy for targeted and sustainable workplace health promotion initiatives. We posited that engaging employees directly in the process of data generation and interpretation would not only yield meaningful health information, but also build the stakeholder commitment necessary for subsequent intervention and policy development.

## **IMPLEMENTATION METHOD**

### **Participatory Approach and Activity Design**

The methodological approach for this community service project combined a structured health assessment with a participatory engagement framework. The activity designed not only to collect health data but also to initiate a process of discovery, dialogue, and shared reflection on employee well-being. This approach positioned employees as active participants in understanding their health status and contributing to discussions on feasible workplace health improvements.

The activity was conducted on 17 August 2025 at the Universitas Pendidikan Indonesia (UPI) Sumedang Campus and involved both administrative staff and lecturers. All employees present and willing to participate were invited and enrolled voluntarily. The campus setting was intentionally selected to ensure accessibility and to embed the activity within employees' everyday work environment.

### **Health Assessment Procedures**

Health assessments were conducted by a team of lecturers from the Nursing Study Program, supported by undergraduate nursing students under direct supervision. The assessment process followed several sequential stages:

1. Participant registration and verification of employee status.
2. Anthropometric measurements, including body weight (kg), height (cm), body mass index (BMI), body fat percentage, muscle mass, body fat mass, visceral fat level, and resting metabolic rate (RMR).
3. Vital sign assessment, including systolic and diastolic blood pressure and pulse rate.
4. Rapid biochemical screening, including blood glucose, total cholesterol, and uric acid levels.
5. Documentation of individual results using standardized examination forms and compilation of anonymized population-level data.

All examinations were performed using calibrated equipment, including digital sphygmomanometers, glucose–cholesterol–uric acid (GCU) meters, and digital scales with body composition analysis functions. Procedures followed established nursing standard operating protocols to ensure safety, accuracy, and participant comfort.

### **Participatory Feedback and Health Dialogue**

Following completion of the measurements, facilitators (lecturers and supervised nursing students) engaged each participant in a one-on-one counseling session. These sessions were structured to explain individual screening results using accessible, non-technical language; explore participants' own perceptions of their lifestyle behaviors, work-related constraints, and perceived barriers to maintaining health; and collaboratively identify one or two feasible initial health goals tailored to each participant's context.

This dialogical model was intended to transform the delivery of clinical data into an empowering educational interaction, encouraging reflection and shared responsibility for health improvement rather than passive receipt of information.

### **Group Debriefing and Collective Reflection**

Following the individual screenings and counseling sessions, a group debriefing session was conducted. Aggregated and anonymized findings were presented to participants to facilitate collective discussion regarding common risk factors, shared challenges associated with sedentary work patterns, and potential workplace-level strategies to support healthier behaviors. This session served as an initial platform for generating ideas for future campus-based health promotion initiatives.

### **Integration of Service-Learning**

Undergraduate nursing students were integral partners in the implementation of this activity and participated through a structured service-learning model. Under supervision, students were involved in participant communication, conducting health measurements, assisting with counseling sessions, and providing basic health education. In addition, students were encouraged to reflect on the social and occupational determinants of health observed in a university workplace setting. This service-learning integration enabled students to develop clinical and communication competencies while fulfilling civic engagement and professional formation objectives.

### **Data Analysis**

Collected data were analyzed descriptively using frequency distributions and percentages, based on standard health classifications. Body mass index was categorized according to established BMI standards, blood pressure was classified using JNC guidelines, and biochemical parameters were interpreted based on clinical reference values for glucose, cholesterol, and uric acid. Results are presented in tabular form to illustrate the overall health profile of participants.

## **RESULTS AND DISCUSSION**

### **Health Assessment Findings**

The results of this community service activity provide an overview of the health profile of employees at UPI Sumedang Campus, including demographic characteristics, BMI, body composition, as well as biochemical and clinical parameters. The program was attended by 44 participants consisting of lecturers and staff at UPI Sumedang Campus. Based on sex distribution, there were 29 male participants (65.9%) and 15 female participants (34.1%) (Table 1). Meanwhile, the age-group distribution showed that most participants were in the late adulthood category (36–45 years) with 15 individuals (34.1%), followed by early elderly (46–55 years) with 11 individuals (25%), early adulthood (26–35 years) with 10 individuals (22.7%), and late elderly (56–65 years) with 8 individuals (18.2%) (Table 2). These findings indicate that the majority of participants were within the productive to pre-elderly age range, which epidemiologically has a higher risk of metabolic disorders and non-communicable diseases (Song et al., 2018; Xu et al., 2022).

**Table 1**  
**Distribution of Participants by Sex**

Sex	N	%
Male	29	65,9
Female	15	34,1
Total	44	100

Source: Primary Data, 2025

**Table 2**  
**Distribution of Participants by Age**

Age Category (Year)	N	%
Early adulthood (26 to 35)	10	22,7
Late adulthood (36 to 45)	15	34,1
Early elderly (46 to 55)	11	25
Late elderly (56 to 65)	8	18,2
Total	44	100

Source: Primary Data, 2025

Health examination results from 44 employees revealed a notable pattern of non-communicable disease (NCD) risk when analyzed by age group and sex. Overall, the distribution of blood pressure categories showed that the pre-hypertension group was the largest (40.9%), followed by normal blood pressure (34.1%), stage 1 hypertension (15.9%), and stage 2 hypertension (9.1%). When examined by age (Table 3), pre-hypertension was distributed almost evenly across early adulthood (60%), late adulthood (46.7%), early elderly (18.2%), and late elderly (37.5%). By sex (Table 4), males dominated the pre-hypertension category (51.7%) and hypertension (27.5%), whereas females were predominantly in the normal category (60%). Men exhibit a higher prevalence of hypertension than women until the menopausal age, influenced by hormonal factors, lifestyle patterns, and visceral adiposity (Bourdon et al., 2025; Guo et al., 2019; Li et al., 2024). Elevated blood pressure among male participants in this study is likely associated with the combined effects of overweight–obesity, high visceral fat, and lower muscle mass, which were more prevalent among men.

Anthropometric status showed that 75% of employees were classified as overweight or obese, while only 22.7% were in the normal category and 2.3% were underweight. By age group (Table 3), the distribution of overweight–obesity increased in late adulthood (86.7%) and early elderly (81.8%). By sex (Table 4), males had a higher proportion of overweight and obese individuals (79.3%) compared with females (66.7%). The prevalence of obesity among office workers tends to rise with age, driven by decreasing physical activity and changes in body composition (Zabuddin et al., 2022). These findings are consistent with the distribution patterns observed in this assessment. Excess body weight among the majority of employees represents a major risk factor contributing to elevated blood pressure, increased visceral fat levels, and other metabolic disturbances identified in the results.

Body fat composition indicated a more severe risk profile. A total of 75% of employees had very high body fat levels, 20.5% were in the high category, and only 4.5% fell within the normal range. By age group (Table 3), early elderly and late adulthood participants had the highest proportions of very high body fat (90.9% and 80%, respectively). By sex (Table 4), all female participants were classified as having high or very high body fat (100%). Total body fat—particularly abdominal distribution—increases the risk of metabolic syndrome and insulin resistance (Alser et al., 2025; Kwon et al., 2017; Numao et al., 2020). These findings align with the literature and indicate a more severe risk profile among female employees, despite their smaller

representation. This suggests that extreme body fat accumulation among women may be associated with reduced muscle mass, hormonal factors, and low physical activity levels.

Visceral fat levels also demonstrated a high-risk pattern, with 34.1% of participants classified as very high and 40.9% as high. By sex (Table 4), males had more than twice the proportion of very high visceral fat compared with females (41.4% vs. 20%), despite the latter also showing high levels of total body fat. Men tend to store more visceral fat in response to high-energy diets and occupational stress (Mazza et al., 2024; Nauli & Matin, 2019). This pattern is consistent with the examination results. The combination of overweight–obesity and elevated visceral fat likely contribute to the high prevalence of pre-hypertension and pre-diabetes among male participants.

The resting metabolic rate (RMR) profile showed that 65.9% of participants were in the normal category, 20.5% were high, and 13.6% were low. Females had a substantially higher proportion of low RMR (33.3%) compared with males (3.4%) (Table 4). RMR is strongly influenced by muscle mass, age, and hormonal status (Gitsi et al., 2024; Maciejczyk et al., 2023). The examination results also indicated that female participants had lower muscle mass. Individuals with low RMR are at greater risk of weight gain due to reduced energy expenditure, especially when combined with minimal physical activity.

Skeletal muscle mass was found to be low in 86.4% of participants, with the highest distribution observed in late adulthood (93.3%) and among females (80%). These findings are consistent with studies which demonstrated that workers with prolonged sitting time experience reductions in muscle mass due to limited and inconsistent muscle contractions (Kett et al., 2021; Vöröš & Kozinc, 2023). Low muscle mass contributes to a reduced resting metabolic rate (RMR) and facilitates the accumulation of visceral fat—forming a mutually reinforcing pattern of metabolic risk.

Blood glucose examination showed that most employees had normal glucose levels (86.4%), while 13.6% fell into the pre-diabetes category, particularly among early elderly and late adulthood groups (Table 3). Males dominated the pre-diabetes category (17.2%) (Table 4). Pre-diabetes is closely linked to insulin resistance mediated by visceral fat accumulation (Ahmed et al., 2021; Liu et al., 2024; Zhao et al., 2023). Similar trends were observed in this assessment, as high visceral fat levels were predominantly found among male participants. Although the prevalence of pre-diabetes was not high, early intervention is necessary for male employees, considering that the progression to type 2 diabetes can reach 5–10% per year (Bennasar-veny et al., 2020).

Cholesterol levels were relatively good, with 81.8% of participants falling within the normal category. However, females had a higher proportion in the borderline-high category (33.3%) compared with males (6.9%) (Table 4). Pre-menopausal women generally exhibit more favorable lipid profiles, but LDL levels may increase during midlife (Oortmerssen et al., 2025). This aligns with the current findings, particularly among late adulthood and early elderly groups. Despite the high prevalence of obesity, not all employees showed dyslipidemia, possibly due to variations in dietary patterns, genetic factors, or light daily physical activity.

Uric acid levels showed that 38.6% of participants were in the high category, with the largest proportion among males (51.7%) (Table 4). By age group, late adulthood had the highest rate (53.3%) (Table 3). The literature demonstrates that hyperuricemia is strongly associated with obesity, purine intake, and metabolic disturbances (Du et al., 2024; Feng et al., 2022). The examination results were consistent with previous studies, particularly among male participants who dominated

the overweight–obesity and high visceral fat categories. These conditions indicate an elevated risk of gout and insulin resistance in male employees, requiring more intensive health monitoring.

**Table 3**  
**Distribution of Blood Pressure, BMI, Body Fat Level, Visceral Fat, RMR, Skeletal Muscle, Blood Glucose, Cholesterol, and Uric Acid of Participants by Age**

		Age				Total
		Early Adulthood	Late Adulthood	Early Elderly	Late Elderly	
Blood Pressure	Normal	4	4	4	3	15 (34,1%)
	Prehypertension	6	7	2	3	18 (40,9%)
	Stage 1	0	3	3	1	7 (15,9%)
	Stage 2	0	1	2	1	4 (9,1%)
<b>Total</b>		<b>10</b>	<b>15</b>	<b>11</b>	<b>8</b>	<b>44 (100%)</b>
BMI	Underweight	1	0	0	0	1 (2,3%)
	Ideal	4	2	2	2	10 (22,7%)
	Overweight	3	9	5	5	22 (50%)
	Obese	2	4	4	1	11 (25%)
<b>Total</b>		<b>10</b>	<b>15</b>	<b>11</b>	<b>8</b>	<b>44 (100%)</b>
Body fat	Normal	2	0	0	0	2 (4,6%)
	High	3	3	1	2	9 (20,4%)
	Very High	5	12	10	6	33 (75%)
<b>Total</b>		<b>10</b>	<b>15</b>	<b>11</b>	<b>8</b>	<b>44 (100%)</b>
Visceral Fat	Normal	5	3	1	2	11 (25%)
	High	3	7	5	3	18 (40,9%)
	Very High	2	5	5	3	15 (34,1%)
<b>Total</b>		<b>10</b>	<b>15</b>	<b>11</b>	<b>8</b>	<b>44 (100%)</b>
RMR	Low	1	2	2	1	6 (13,7%)
	Normal	7	9	6	7	29 (65,9%)
	High	2	4	3	0	9 (20,4%)
<b>Total</b>		<b>10</b>	<b>15</b>	<b>11</b>	<b>8</b>	<b>44 (100%)</b>
Skeletal Muscle	Low	6	14	11	7	38 (86,3%)
	Normal	4	1	0	1	6 (13,7%)
<b>Total</b>		<b>10</b>	<b>15</b>	<b>11</b>	<b>8</b>	<b>44 (100%)</b>
Blood Glucose	Normal	10	13	8	7	38 (86,3%)
	Prediabetes	0	2	3	1	6 (13,7%)
<b>Total</b>		<b>10</b>	<b>15</b>	<b>11</b>	<b>8</b>	<b>44 (100%)</b>
Cholesterol	Normal	8	13	9	6	36 (81,8%)
	Upper Limit	1	2	2	2	7 (15,9%)
	High	1	0	0	0	1 (2,8%)
<b>Total</b>		<b>10</b>	<b>15</b>	<b>11</b>	<b>8</b>	<b>44 (100%)</b>
Uric Acid	Normal	9	7	6	5	27 (61,4%)
	High	1	8	5	3	17 (38,6%)
<b>Total</b>		<b>10</b>	<b>15</b>	<b>11</b>	<b>8</b>	<b>44 (100%)</b>

Source: Primary Data, 2025

**Table 4**  
**Distribution of Blood Pressure, BMI, Body Fat Level, Visceral Fat, RMR, Skeletal Muscle, Blood Glucose, Cholesterol, and Uric Acid of Participants by Sex**

		Sex		Total
		Male	Female	
Blood Pressure	Normal	6	9	15 (34,1%)
	Prehypertension	15	3	18 (40,9%)
	Stage 1	6	1	7 (15,9%)
	Stage 2	2	2	4 (9,1%)
	Total	29	15	44 (100%)
BMI	Underweight	1	0	1 (2,3%)
	Ideal	5	5	10 (22,7%)
	Overweight	15	7	22 (50%)
	Obese	8	3	11 (25%)
Total	29	15	44 (100%)	
Body Fat	Normal	2	0	2 (4,6%)
	High	9	0	9 (20,4%)
	Very High	18	15	33 (75%)
Total	29	15	44 (100%)	
Visceral fat	Normal	5	6	11 (25%)
	High	12	6	18 (40,9%)
	Very High	12	3	15 (34,1%)
Total	29	15	44 (100%)	
RMR	Low	1	5	6 (13,7%)
	Normal	19	10	29 (65,9%)
	High	9	0	9 (20,4%)
Total	29	15	44 (100%)	
Skeletal Muscle	Low	26	12	38 (86,3%)
	Normal	3	3	6 (13,7%)
Total	29	15	44 (100%)	
Blood Glucose	Normal	24	14	38 (86,3%)
	Prediabetes	5	1	6 (13,7%)
Total	29	15	44 (100%)	
Cholesterol	Normal	26	10	36 (81,8%)
	Borderline high	2	5	7 (15,9%)
	High	1	0	1 (2,8%)
Total	29	15	44 (100%)	
Uric Acid	Normal	14	13	27 (61,4%)
	High	15	2	17 (38,6%)
Total	29	15	44 (100%)	

Source: Primary Data, 2025

Overall, the examination results illustrate a systematically interconnected pattern of metabolic risk. The high proportion of overweight and obese individuals (75%) contributes to the elevated levels of total body fat and visceral fat observed among most participants, while low skeletal muscle mass—identified in 86% of participants—may further exacerbate overall metabolic conditions. The combination of these factors can lead to increased rates of pre-hypertension, early-stage hypertension, and pre-diabetes, collectively forming a risk chain characteristic of metabolic syndrome. This pattern aligns with previous scientific findings indicating that excess body weight, visceral fat accumulation, and low muscle mass in individuals with low physical activity are major determinants of metabolic dysfunction and cardiometabolic disorders in the productive-age population (Kim and Kim, 2020; Damluji et al., 2023; Kim, Shin and Choi, 2024; Shao et al., 2025; Zhu et al., 2025).

Therefore, the risk profile emerging from this assessment underscores the need for sustained promotive–preventive interventions for employees, particularly through lifestyle modification, increased physical activity, dietary regulation, and regular health monitoring as strategic efforts to maintain productivity and prevent chronic diseases within the campus environment.

### Community Service Engagement Findings

Of the employees invited to participate, 44 individuals attended the program, reflecting a high level of engagement for a voluntary campus-based activity. Informal feedback during and after the activity indicated that participants valued the opportunity to receive individualized health information within their workplace setting, particularly when results were explained in a non-judgmental and accessible manner.

Screening results provided a quantitative overview of participants' health status. The distribution of screening outcomes showed that the majority of participants were within normal ranges for key indicators, including blood pressure, blood glucose levels, and uric acid levels. However, a smaller proportion of participants exhibited values above normal thresholds, indicating potential early risk for non-communicable diseases. Specifically, blood pressure (figure 1) screening revealed that while most participants fell into the normal category, several were classified as prehypertensive or hypertensive.

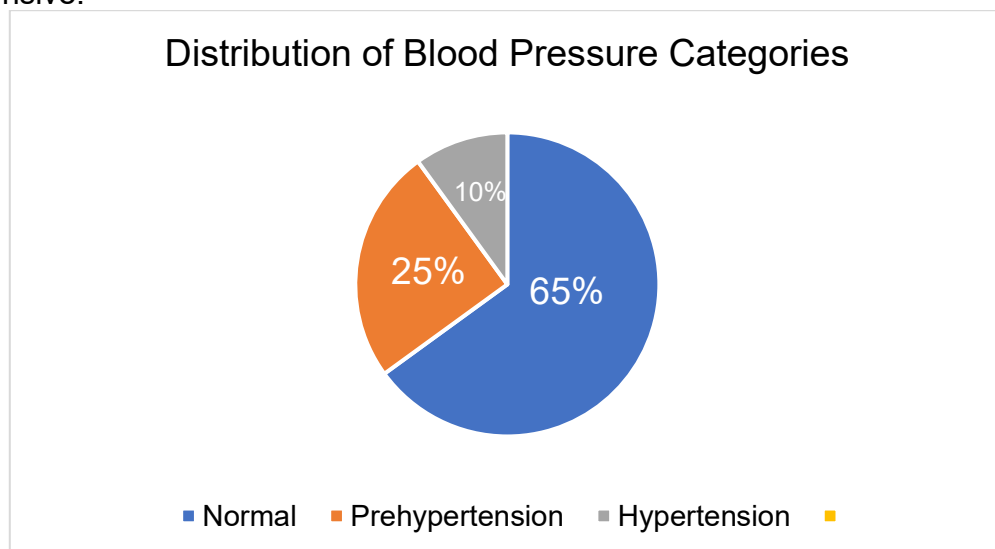


Figure 1. Distribution of Blood Pressure Categories among Participants

Similarly, blood glucose measurements (figure 2) indicated that the majority of participants had normal glucose levels, with a limited number showing elevated values suggestive of impaired glucose regulation.

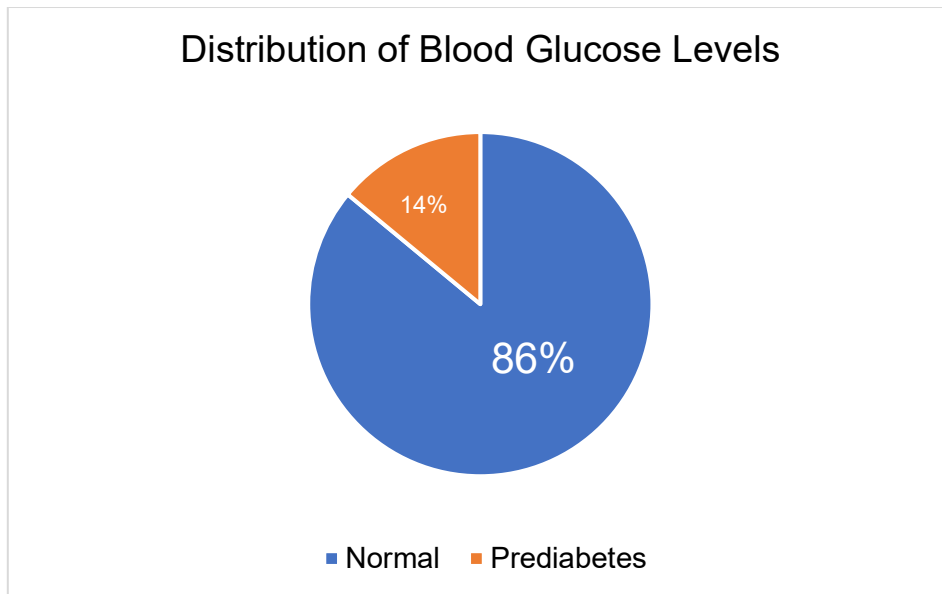


Figure 2. Distribution of Blood Glucose Levels among Participants

Cholesterol screening showed (figure 3) that most participants had cholesterol levels within normal limits, although a subset of participants presented with elevated cholesterol levels, which may increase the risk of cardiovascular disease if not properly managed.

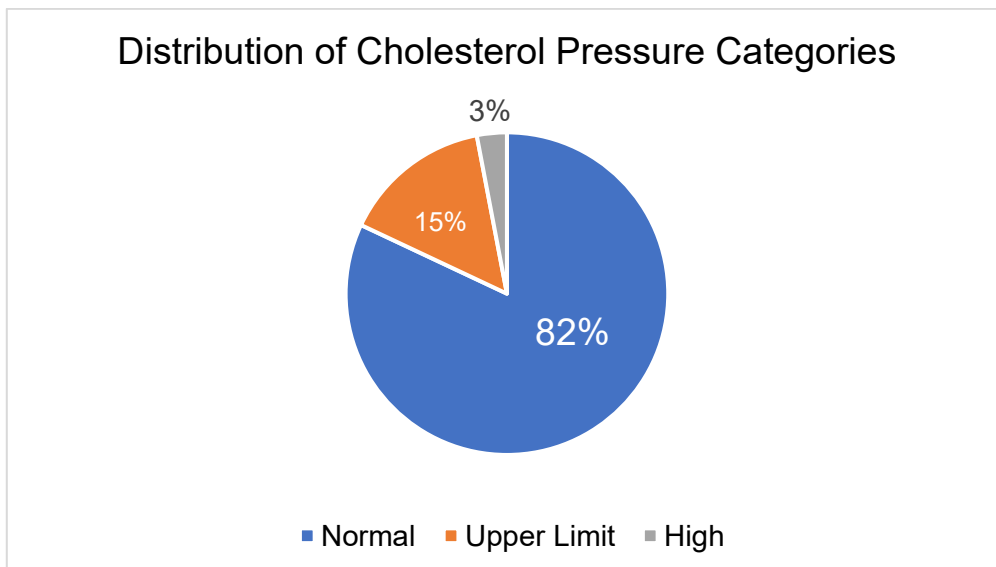


Figure 3. Distribution of Cholesterol Levels among Participants

Uric acid screening (figure 4) also demonstrated that most participants were within normal limits, although a minority presented with increased uric acid levels. These distributions are visually summarized using pie charts to illustrate the proportion of normal and abnormal findings for each parameter, facilitating clearer interpretation of the overall health profile of the participants.

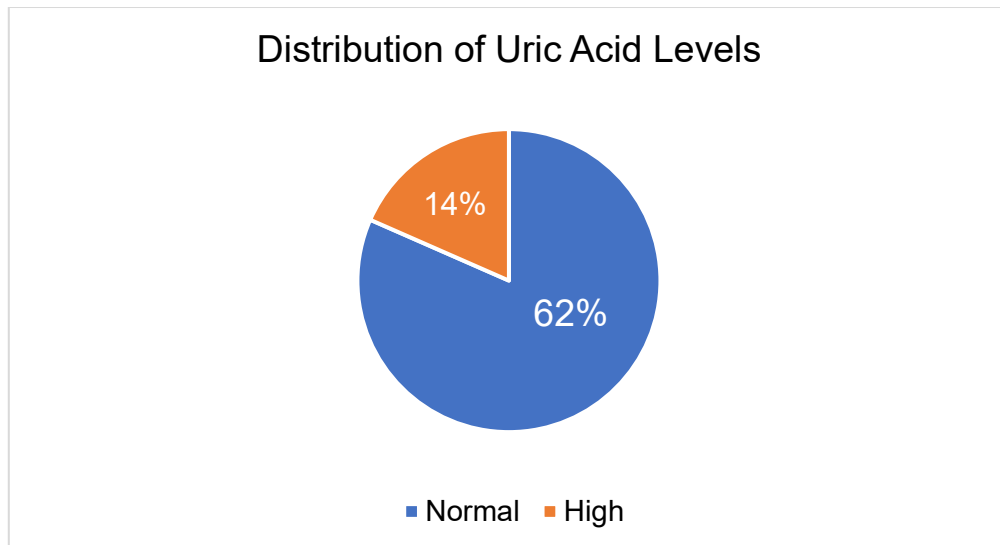


Figure 4. Distribution of Uric Acid Levels among Participants

Insights from one-on-one counseling sessions and group discussions revealed several recurring themes. Participants frequently identified lack of time, prolonged sitting, and limited opportunities for physical activity during working hours as primary barriers to maintaining a healthy lifestyle. Dietary challenges were also noted, including reliance on readily available, calorie-dense campus food options. Many participants expressed surprise upon learning about their visceral fat levels and low muscle mass, indicating gaps between perceived and actual health status.

The participatory feedback process generated concrete, context-specific suggestions from participants, including the need for structured physical activity breaks during working hours, access to healthier food options on campus, and regular follow-up health assessments. As an immediate output of the activity, a summary report of aggregated findings and recommendations was prepared for submission to campus management, serving as an advocacy tool for future workplace health promotion initiatives.

Beyond clinical findings, the participatory screening and dialogue model proved effective in raising awareness and facilitating self-reflection among participants. The individualized counseling sessions enabled employees to contextualize their health results within their daily routines and workplace constraints, fostering a sense of ownership rather than passive receipt of health information. The group debriefing further supported collective awareness and shared problem identification, although time constraints limited deeper discussion for some participants.

The integration of clinical data with participant feedback highlights the need for structural, workplace-level interventions rather than solely individual lifestyle modification. Findings strongly support the implementation of policy-supported physical activity breaks, collaboration with campus food providers to offer healthier options, and institutionalization of regular participatory health screenings. These strategies address both individual behavior and environmental determinants of health.

This project demonstrates that embedding participatory dialogue within a health screening transforms it from a diagnostic exercise into a catalytic community engagement activity. The model illustrates how university-led community service can generate clinical insight, empower internal communities, and build social capital necessary for sustainable health promotion. This approach is replicable in other higher

education institutions and sedentary workplace settings, particularly within resource-constrained contexts.



**Figure 5 Anthropometric, Blood Pressure, Blood Tests Measurements**

## CONCLUSIONS AND SUGGESTIONS

This program provided a comprehensive overview of the health status of employees at UPI Sumedang Campus and revealed that most participants had interrelated metabolic risk factors. The majority of employees were classified as overweight or obese, accompanied by high percentages of total body fat and visceral fat. These findings were further exacerbated by the low skeletal muscle mass observed in most participants, which collectively contributed to the increased prevalence of pre-hypertension, early-stage hypertension, and pre-diabetes. This profile reflects a risk pattern consistent with sedentary workers and indicates the potential development of cardiometabolic disorders if not addressed through early intervention.

Insights gained from participatory counseling and discussions highlighted time constraints for physical activity and limited healthy food options as key barriers. Based on these engagement findings, several targeted recommendations are proposed. At the individual level, employees are encouraged to continue personalized health monitoring and gradual lifestyle modification supported by periodic counseling. At the peer-group level, the formation of simple, peer-supported activities such as walking groups or short collective exercise breaks may help strengthen motivation and adherence. At the institutional level, the results support the adoption of flexible activity

breaks, improved availability of healthy food on campus, and the integration of routine participatory health screenings into workplace wellness policies.

Overall, this community service model demonstrates that participatory health screening can function not only as a diagnostic activity but also as a foundation for sustainable, collaborative health promotion in a university setting.

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