




## Original Article

# A study to evaluate implementation and effectiveness of the program “Fit for Life Initiative”

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## ABSTRACT

**Objectives:** The “Fit for Life Initiative” (FFLI) is a structured health promotion program aimed at addressing lifestyle-related diseases among personnel of the Indian Air Force. The initiative focuses on improving nutrition, increasing awareness, and promoting sustainable behavioral change across the organization. This study was conducted to assess the degree of implementation fidelity, participant engagement, and overall impact on health outcomes.

**Material and Methods:** A convergent parallel mixed-methods design was used to evaluate the reach, implementation fidelity, and impact of the FFLI. Quantitative data were collected through structured knowledge, attitude, and practice questionnaires from 530 personnel selected through random sampling, and the level of implementation from program implementers at 7 different geographically located stations. Objective data were gathered using a checklist during inspection visits, and quantitative data on body mass index (BMI) changes were used to assess health outcomes. The observations were analyzed using descriptive statistics.

**Results:** The study revealed high awareness (96.4%) and positive attitudes toward the FFLI among beneficiaries. Core program activities such as health lectures and visual displays were consistently implemented. However, gaps were identified in practical enforcement, particularly in regulating unhealthy food options in cafeterias. Objective assessments indicated uneven implementation in areas such as nutrition education and sugar-free beverage availability. Importantly, BMI data showed a reduction in obesity levels, with 98.3% of morbidly obese, 87.9% of obese, and 65.2% of overweight individuals moving to healthier categories over 1 year.

**Conclusion:** The FFLI achieved broad implementation and improved health awareness, contributing to reduced obesity rates. Recommendations include stricter cafeteria regulations, supportive supply policies, and ongoing education. Findings offer a strategic basis for future programs, reinforcing long-term wellness and disease prevention within the organization.

**Keywords:** Fit for Life initiative, Program implementation, Mixed methods design, Lifestyle disease, Nutrition

## INTRODUCTION

Lifestyle diseases, including obesity, hypertension, type 2 diabetes, and cardiovascular conditions, have emerged as significant public health concerns worldwide, including within military populations.<sup>[1]</sup> The Indian Air Force (IAF), like many defense organizations, has witnessed a growing prevalence of these conditions among its personnel. Unlike acute illnesses that can be managed through medication, lifestyle-related disorders require sustained behavioral

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modifications, particularly in nutrition and physical activity, for effective prevention and control.

Despite widespread awareness about the benefits of healthy eating, many individuals face challenges in translating this knowledge into practice. Factors such as environmental influences, personal preferences, aggressive marketing of unhealthy foods, and limited access to healthier alternatives often impede the adoption of nutritious dietary habits. The implications of poor nutrition extend beyond physical health, affecting mental well-being, productivity, and overall quality of life, which are critical considerations for operational readiness in military settings.

To address these challenges, the IAF launched the “Fit for Life Initiative (FFLI): The Art of Eating – Eat Right, Eat Light” in February 2024.<sup>[2]</sup> This health promotion campaign was developed as a comprehensive response to the rise in lifestyle-related health issues within its ranks. The initiative aimed to create a culture of wellness through increased awareness, behavioral change, and an enabling environment for healthy living.

The program was implemented in two structured phases. Phase I focused on Information, Education, and Communication (IEC). The objective was to raise awareness among personnel regarding the importance of nutrition and a balanced lifestyle. This included conducting educational campaigns, disseminating materials on meal planning and physical fitness, and using diverse communication platforms to ensure message penetration across all units. Phase II involved targeted interventions to support behavioral change. It included facilitating access to dietitians and nutritionists, introducing healthier food options in cafeterias and canteens, and promoting physical activity. The phase also emphasized community support and incentivized participation to foster sustained engagement.

While the FFLI was well-conceived, the success of such a program depends not only on its design but also on its implementation fidelity, reach, level of engagement, and perceived effectiveness.<sup>[3,4]</sup> One year after its launch, it was imperative to conduct a systematic evaluation to assess how effectively the initiative had been rolled out and whether it had achieved its intended outcomes.

The objectives of this study were (a) to assess the extent to which the program was implemented as planned across both phases; (b) to evaluate its effectiveness in raising awareness and encouraging behavioral change among personnel; (c) to identify barriers and facilitators that influenced the quality of implementation across various geographical areas, and (d) to generate evidence-based recommendations to optimize program delivery, scalability and sustainability.

## MATERIAL AND METHODS

### Study design and study population

A convergent parallel mixed-methods approach was adopted, where both quantitative and qualitative data were collected.<sup>[5,6]</sup> The primary study participants were personnel of the organization, while healthcare providers and administrators involved in the program served as secondary participants. The study was conducted across seven geographically dispersed stations of the IAF, covering a total population of approximately 9000 personnel. A random sampling method was used to ensure equal representation of participants.

### Sample size

Sample size required for knowledge, attitude, and practice (KAP) questionnaire of the target population/beneficiaries of 9564 with 95% confidence interval and 5% margin of error was calculated to be 383. Data were collected from 530 beneficiaries distributed across seven different locations.

### Data collection methods

Structured questionnaires were administered to beneficiaries to evaluate awareness, attitudes, and practices regarding nutrition and healthy lifestyle behaviors. The tools incorporated multiple-choice questions and 5-point Likert scale items. One policy implementer from each station was surveyed using a separate structured questionnaire to gather insights on the challenges and perceptions regarding program implementation. The researchers conducted site visits to seven stations to assess implementation fidelity using a structured checklist. Secondary data were obtained to measure health outcome, which included the change in body mass index (BMI) of personnel pre and post implementation of the FFLI program. Confidentiality and anonymity of responses and health metrics data were maintained.

## RESULTS

The total population of the seven stations examined was 9564. The mean population per station was  $1366 \pm 163$  (standard deviation). The mean age of beneficiaries who provided input on the KAP questionnaire was 34.7 years, with a range of 24–45 years. Participation of the officers in the KAP questionnaire was limited to 15–20% of the officers' strength in each station. Major participation was sought from airmen.

Only one of seven stations had a dietician, and one of the remaining 6 stations had an outsourced dietician as part of the program. Only two of the seven stations claimed to have been using the tele-ahar facility of the organization. The

distribution of posters in various locations of the stations is presented in Figure 1.

Training on healthy recipes, millet-based recipes, and healthy cooking given to Sanginis, cooks, mess boys, catering in-charge (ICs), and catering staff is presented in Figure 2. Education of different target groups, namely, officers, airmen, non-combatants enrolled (NC(E)s), and Sanginis, is presented in Figure 3. Demonstrations, group discussions, conferences, competitions, workshops, and role-plays related to FFLI are presented in Figure 4.

Feedback from program implementers on the implementation of various aspects of “Fit for Life Initiative” is presented in Figure 5.

Feedback on challenges faced by implementers was sought on a questionnaire. Station No. 4 administrators brought out that owing to fixed procurement of ration, change of menu, including millets, better edible oil, and alternative sweetening agent was difficult.

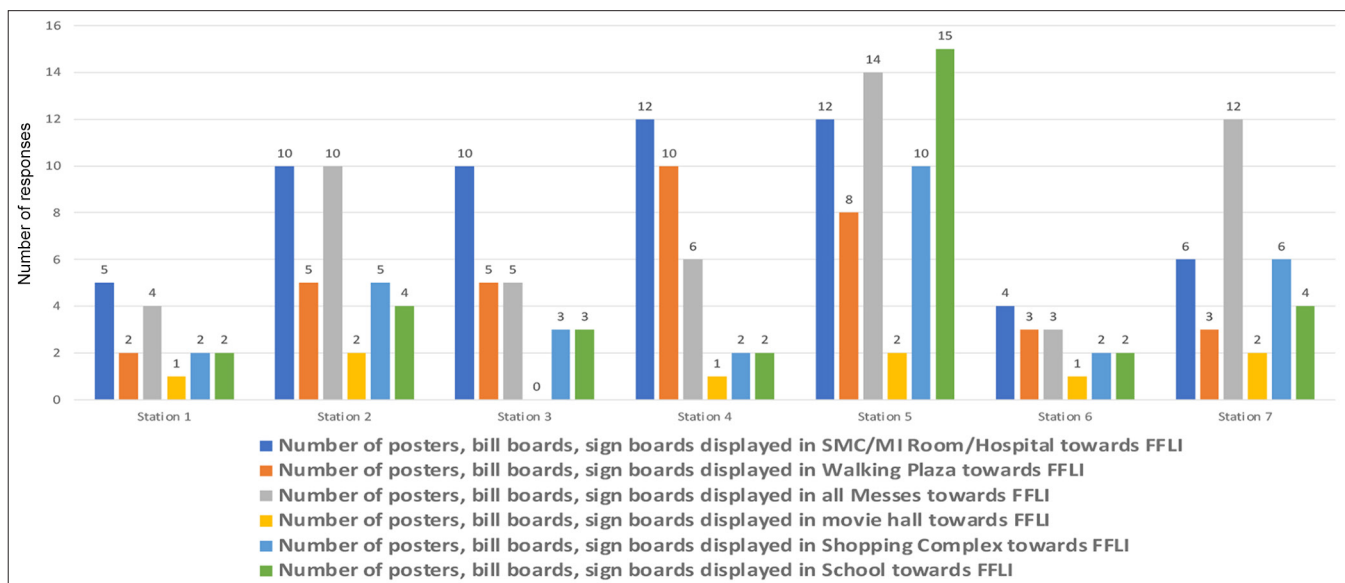
The KAP of beneficiaries toward FFLI obtained through the questionnaire is shown in Figures 6-10.

Out of 530 respondents, 69% identified the main focus of the FFLI as nutritional and related health impacts, while 31% correctly understood it as encompassing all key components. All respondents (100%) were aware that the initiative targets all categories, including officers, airmen, children, and families. The policy was reported to be issued primarily by the medical branch (84%), with fewer attributing it to the administrative branch (16%). Most of the respondents (91%) correctly stated that FFLI-related activities are to be conducted throughout the year, while a small fraction

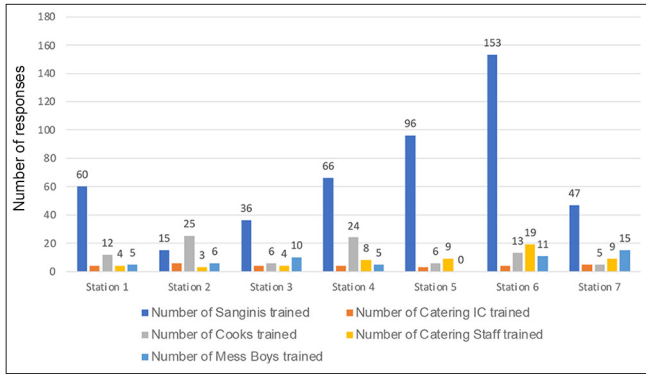
(9%) indicated alternate months. When asked about the venues targeted by FFLI, 39% mentioned comprehensive locations, including messes, playgrounds, cafeterias, schools, and workplaces, whereas others noted partial locations. Regarding implementation responsibility, 100% indicated that all stakeholders, including ground training instructor (GTIs), cooks, gym staff, catering in-charges, and station medicare centre (SMCs,) should be trained.

In terms of cafeteria practices, 97% reported that sugar should be provided separately without adding it to tea/coffee. Fresh juice (54%) and buttermilk (46%) were preferred as healthy drink options, and all respondents (100%) recommended that healthy foods be included in mess menus. On salt practices, 98% supported removing salt from dining tables, while only 2% supported retaining it. Regarding papad and pickle, 90% recommended removal from menus. When questioned about party food, nearly all (98.5%) rejected oily or sugary items, with 99% reporting no advice had been given regarding party food changes. Finally, respondents unanimously agreed (100%) that weekly mess reviews should be conducted by designated officers and that all school-based health promotion activities – healthy lunches, nutritious food policies, IEC material display, and awareness.

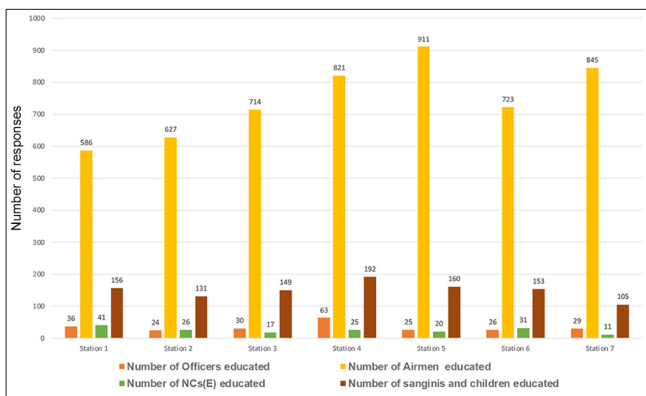
In the feedback from beneficiaries, of the 367 dining in the mess, fried food was reported to be served on most days by 61 respondents (11.6%) and on a few days by 222 (42.2%), while 45 (8.6%) stated it was never served. Regarding the availability of sugar-free desserts, 231 (43.9%) reported they were served on most days, 106 (20.2%) on a few days, and 32 (6.1%) rarely, with 161 (30.6%) not dining in the mess.



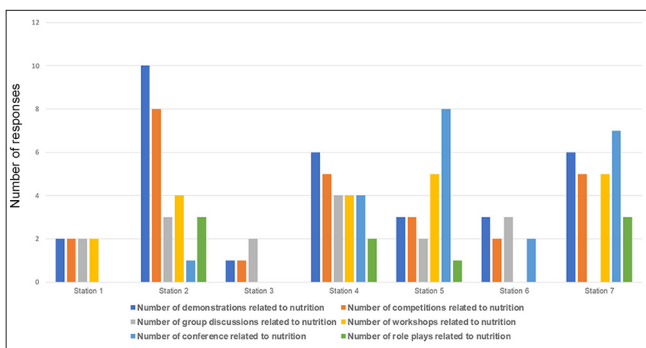
**Figure 1:** Distribution of Fit for Life initiative posters in different places of stations. IC: In-charge, GTI: Ground training instructor, SMC: Station medicare centre, MO: Medical office, IEC: Information, education and communication, CSD: Canteen stores department.



**Figure 2:** Training on healthy recipes, millet-based recipes, healthy cooking given to Sanginis, cooks, mess boys, catering ICs, and catering staff.



**Figure 3:** Education of target groups, namely, officers, airmen, NC(E)s, and Sanginis.



**Figure 4:** Demonstrations, group discussions, conferences, competitions, workshops, and roleplays related to Fit for Life Initiative.

None reported daily availability or complete absence. In terms of perceived effectiveness of the FFLI, 328 respondents (62.4%) rated it as successful, 46 (8.7%) as very successful, and 9 (1.7%) as extremely successful, while 23 (4.4%) felt it was not successful and 38 (7.2%) reported it was not implemented at their station.

Objective assessment of the implementation of FFLI was carried out at the 7 stations using a checklist [Table 1]. The burden of obesity and overweight in the 7 stations before implementation of FFLI is shown in Table 2, and the effects post 1 year implementation of FFLI on these conditions are shown in Figures 11-13.

## DISCUSSION

This study evaluated the implementation and effectiveness of the FFLI a structured health promotion campaign aimed at addressing lifestyle-related diseases across IAF. The findings suggest that the FFLI has significantly improved knowledge related to nutrition and healthy behaviors, catalyzed attitudinal shifts, and fostered observable changes in dietary practices and weight status among participants.

An important component of the initiative was the availability of professional dietary counseling. While one station had an in-house dietician and four others engaged outsourced services, access to nutritional counseling remained underutilized, with only two stations reporting meaningful use of the Tele-Ahar (e-dietician) service. Several factors could have contributed to this underutilization, including a lack of awareness, a preference for direct consultation with medical officers, perceptions that dietitians services are only for individuals with medical conditions, and prevailing stigma around seeking dietary advice.

Visual messaging played a key role in the program, with posters serving as primary informational tools. However, their distribution was inconsistent [Figure 1]. While some stations displayed them prominently in medical facilities, others failed to capitalize on high-visibility public areas such as cafeterias, schools, and recreational zones, indicating a gap between intended and actual outreach.

The FFLI also sought to engage key food service personnel through structured training sessions on healthy cooking and millet-based recipes. Although Sanginis (spouses of air warriors) were trained extensively, which is encouraging given their influence on household dietary choices, training for cooks and mess boys who are critical stakeholders in food preparation and service was found to be inadequate [Figure 2]. This presents a missed opportunity to optimize nutritional quality at the point of food preparation.

Educational activities for the target groups showed similarly mixed results [Figure 3]. Sanginis received strong outreach in several stations, aligning with the family-based approach to behavior change. Airmen, the program's primary beneficiaries, exhibited moderate engagement, with an average of 54.6% receiving direct educational input. In contrast, officers and NCs(E) were underrepresented, highlighting a critical gap in program reach. Given the leadership role of officers and the high-risk profile of NCs(E),

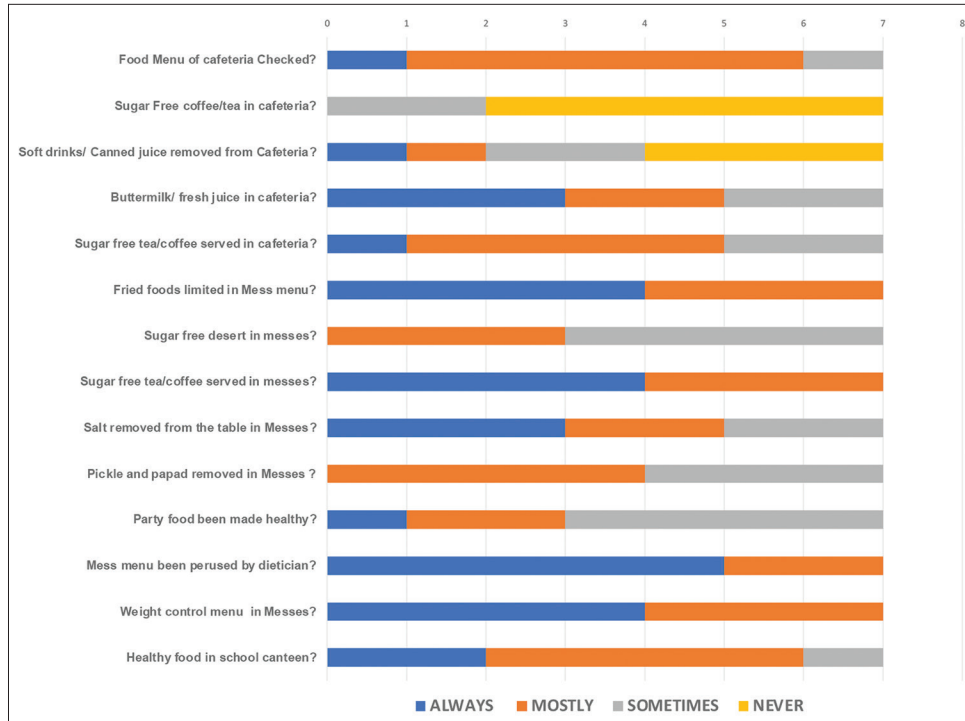


Figure 5: Inputs from program implementers on implementation of “Fit for Life Initiative.”

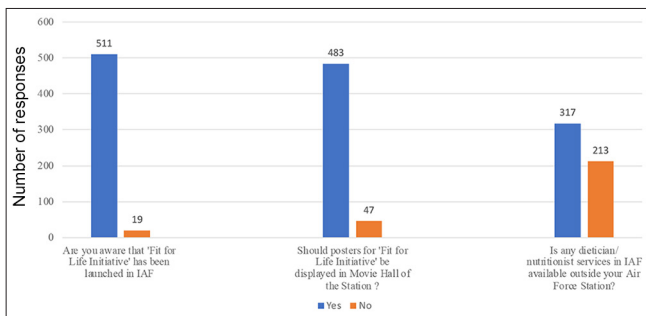


Figure 6: Awareness of beneficiaries on Fit for Life Initiative.

this underrepresentation could undermine the initiative’s long-term effectiveness.

Nutrition-related activities, including workshops, demonstrations, and role-play events, were reported across all stations, although the extent varied. Stations with robust implementation adopted a multi-modal strategy, reinforcing program messages. However, others demonstrated limited activity, suggesting a need for increased administrative support and implementation fidelity [Figure 4].

Feedback on adherence to core program elements indicated partial success. Positive measures included menu reviews by dietitians and the limited introduction of sugar-free beverage options. However, implementation was found lacking in

cafeterias, which were often run by civilian vendors, who are generally resistant to policy changes that could reduce profit margins. In addition, implementers reported challenges in executing the program effectively due to centralized ration procurement policies, which limited their ability to incorporate healthier food options, such as millets, improved edible oils, and alternative sweetening agents into daily menus. This underscores the need for policy-level reforms that support adaptable, health-focused food provisioning in line with the objectives of the initiative.

In this study, the KAP survey highlighted high levels of awareness and acceptance among beneficiaries [Figure 6]. A remarkable 96.4% were aware of the FFLI, and the majority correctly identified its objectives and components. However, only 59.8% were aware of off-site dietitian services, indicating a need for improved communication regarding available health resources. The perception that the program was a medical initiative, rather than an administrative directive, suggests the need for broader ownership across leadership levels to reinforce its multisectoral nature.

Attitudinal responses were overwhelmingly positive [Figure 7]. Nearly all respondents supported the availability of healthy food in organizational spaces, endorsed enforcement of program regulations, and favored full-scale rollout of FFLI activities. This widespread approval signifies a readiness among personnel to engage in behavior change, provided enabling systems are in place.

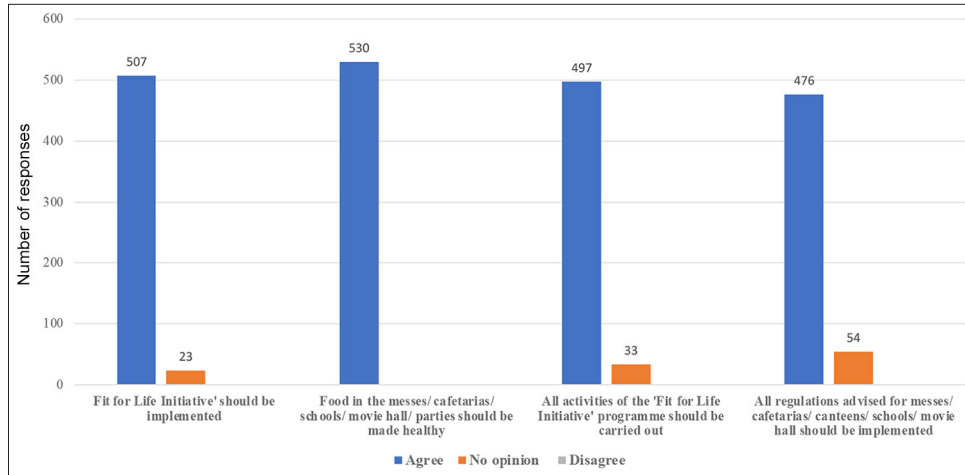


Figure 7: Attitude of beneficiaries toward Fit for Life Initiative.

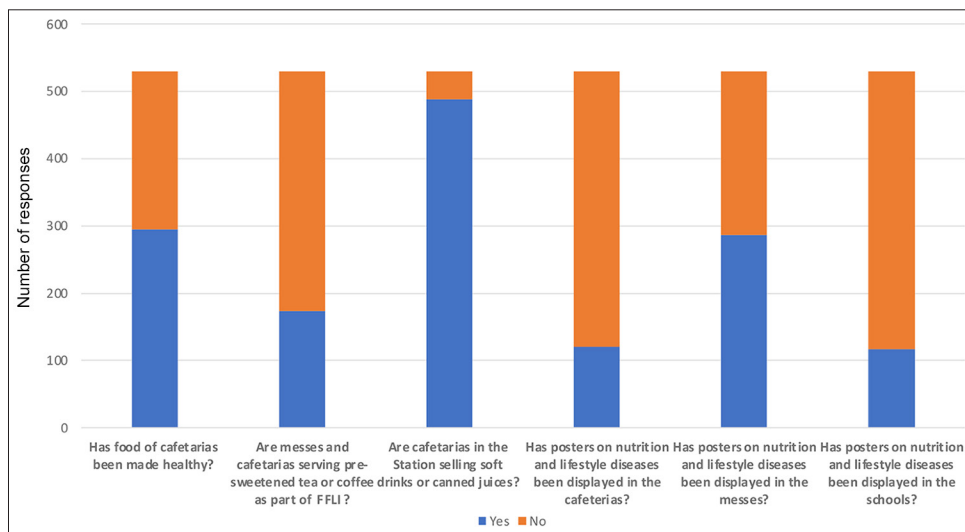


Figure 8: Practice of beneficiaries after implementation of Fit for Life Initiative.

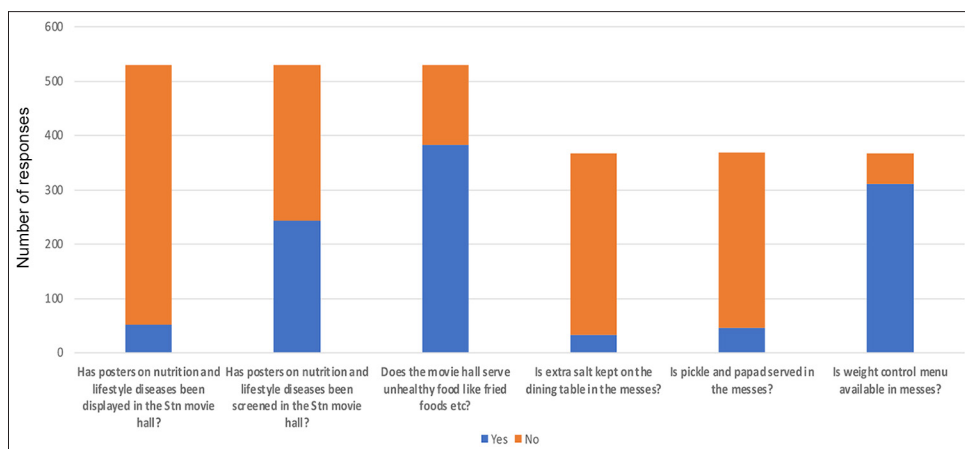
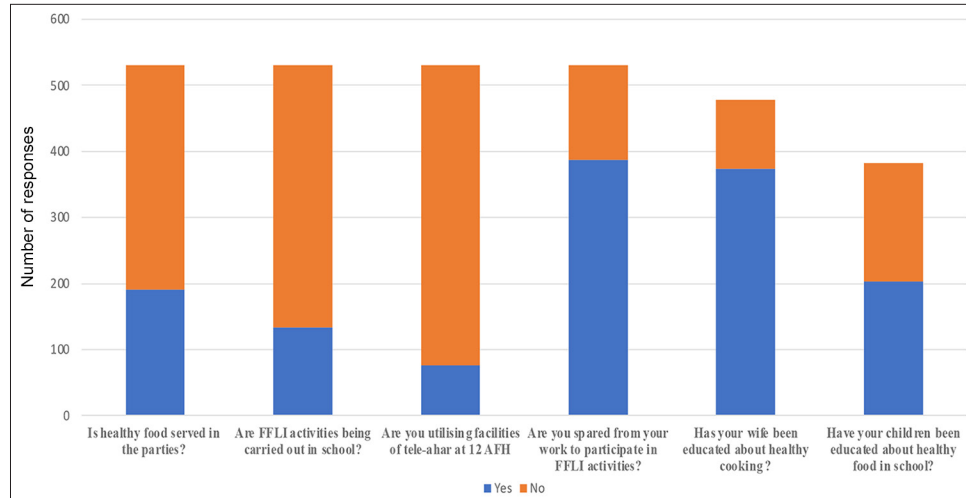


Figure 9: Practice of beneficiaries after implementation of Fit for Life Initiative.



**Figure 10:** Practice of beneficiaries after implementation of Fit for Life Initiative.

**Table 1:** Objective assessment of implementation of fit for life initiative at stations using checklist.

Domain	Indicator	Findings
Awareness activities	Lectures by MOs, Posters, Sub-campaigns, Nutrition Week	Implemented adequately at all stations
Visual media outreach	Posters and billboards display in prominent areas	Partial implementation across stations
Menu and cafeteria interventions	Food menu revision, sugar-free tea/coffee, posters in cafeterias	Not implemented or absent across all stations
Menu and cafeteria interventions	Food menu revision, sugar-free tea/coffee, and posters in cafeterias	Not implemented or absent across all stations
	Sugar-free dessert	Adequate in 4 stations; inadequate in 3
	Soft drinks/canned juice removed	Implemented in 6 stations
	Salt and pickle/papad presence	Salt removed in 3 stations; Pickle/papad removed in 3 Stns
Mess modifications	Limiting fried food, IEC materials, sugar-free coffee	Implemented in all stations
Special diets	Weight Control diet	Provided at all stations
	Party menu change	Not implemented in 4; partially implemented in 3 stations
Personnel training	Training of cooks	Conducted in all stations
Professional support	Dietician services, MO as dietician	MO role implemented; dietician services absent in 5 stations
School and child health	Healthy school canteen, Healthy lunch competitions	Canteen menu adequate; lunch box competitions not conducted anywhere
Wet canteen interventions	IEC in wet canteens	Inadequate across all stations
CSD changes	Switch to healthier food options	Not implemented across all stations

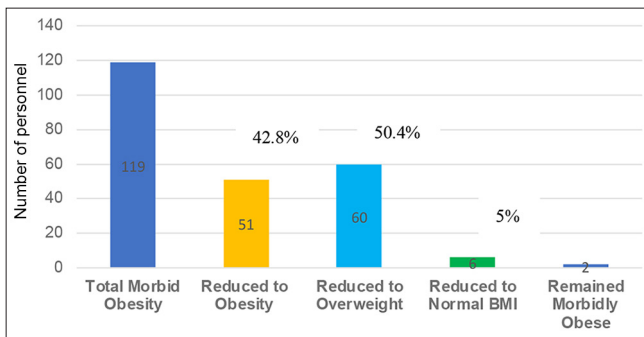
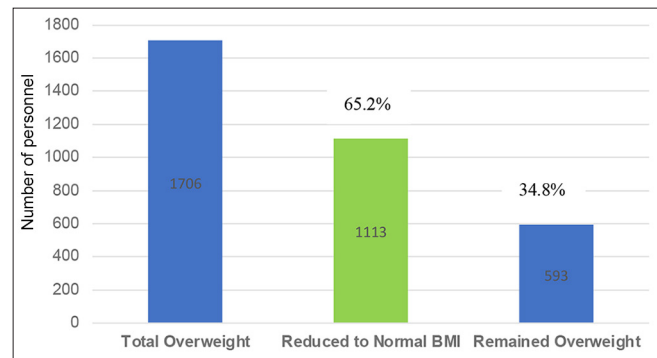
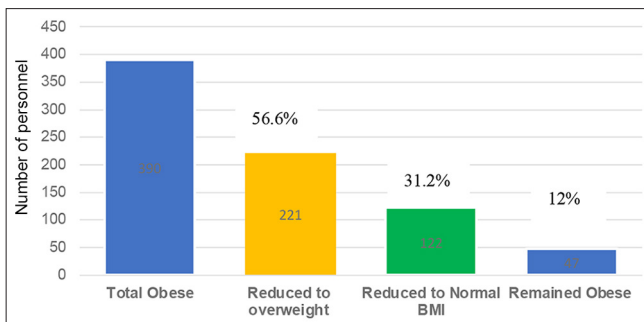
CSD: Canteen stores department

Despite favorable attitudes, actual practices revealed implementation gaps [Figures 8-10]. Most cafeterias continued to stock sugar-laden beverages, and food offerings remained largely unchanged in several facilities. IEC materials were often absent in cafeterias and underutilized in messes and entertainment venues. Nonetheless, improvements were evident in mess practices, including reduced provision

of high-sodium condiments (salt and pickles) and better availability of weight control menus. Positive spillovers were also noted in school canteen menus and household practices, with over 80% confirming that spouses had received training in healthy cooking. However, feedback also indicated unmet needs, such as early lunch timings and greater access to physical activity opportunities.

**Table 2:** Body mass index of morbidly obese, obese, and overweight individuals before implementation of the Fit for Life Initiative.

	Population	Overweight	% Overweight	Obese	% Obese	Morbidly Obese	% Morbidly Obese
Station 1	1395	297	21.3	61	4.4	29	2.1
Station 2	1585	314	19.8	57	3.6	15	0.9
Station 3	1250	255	20.4	55	4.4	14	1.1
Station 4	1500	272	18.1	71	4.7	30	2.0
Station 5	1430	236	16.5	49	3.4	8	0.6
Station 6	1101	156	14.2	50	4.5	12	1.1
Station 7	1303	177	13.6	47	3.6	11	0.8
Total/Average	9564	1706	17.7	390	4.1	119	1.2

**Figure 11:** Effect of Fit for Life Initiative program on morbid obesity.**Figure 13:** Effect of Fit for Life Initiative program on overweight.**Figure 12:** Effect of Fit for Life Initiative program on obesity.

Previous studies evaluating health program implementation have shown that education alone may only partially assist in program implementation.<sup>[7]</sup> A KAP Study on Nutrition and Physical Activity in Healthy Indian Adults (2018) assessed knowledge about nutrition and physical activity in healthy urban Indian adults.<sup>[8]</sup> The study identified significant gaps in knowledge and practice, indicating that knowledge did not always translate to good practices. To bridge such a knowledge-practice gap, interventions must address social, environmental, psychological, and structural factors that influence behavior.<sup>[9]</sup>

Objective evaluation of implementation showed consistent conduct of awareness lectures, Nutrition Week activities,

and training of key personnel in most stations. However, cafeteria reforms, changes in party menus, and the introduction of sugar-free alternatives remained poorly implemented. Stations displayed variability in applying core guidelines, reflecting uneven adherence and perhaps variable administrative support [Table 1].

Most notably, the program demonstrated a measurable impact on health outcomes [Table 2 and Figures 11-13]. Among individuals classified as morbidly obese at baseline, 98.3% (117 out of 119) showed improvement in their BMI category following FFLI implementation. This indicates not only high program penetration among the most at-risk individuals but also affirms the potential of targeted, behavior-based interventions in reducing obesity and related non-communicable disease risk. Similar results were also observed in a group of obese individuals involved in a community-based diet and lifestyle intervention program,<sup>[10]</sup> indicating that behavior change communication plays a critical role in ensuring continuous participant participation. Studies also emphasize that data on adherence to core elements is necessary to interpret why a health intervention succeeds or fails. Differences in fidelity across implementation sites can explain variations in impact and help avoid misattributing failure to the program model rather than to poor adherence.<sup>[11,12]</sup>

## Summary

The evaluation of the FFLI revealed encouraging outcomes alongside notable implementation challenges. Feedback from implementers indicated partial adherence to program guidelines, with moderate success in IEC activities and mess menu changes, but a lack of implementation in cafeterias - largely due to the involvement of civilian vendors. Beneficiary feedback reflected high awareness and strong attitudinal support for the initiative, though practical adherence to healthy practices remained limited, highlighting a gap between knowledge and behavior. Objective assessments confirmed widespread execution of awareness and training activities but revealed inconsistencies in areas such as nutrition education in schools and healthy food availability in cafeterias. Importantly, the program demonstrated measurable impact on health outcomes, with 98.3% of morbidly obese, 87.9% of obese, and 65.2% of overweight individuals showing reductions in BMI, indicating the program's effectiveness in facilitating weight loss and healthier lifestyle changes. These findings underscore the FFLI's potential as a scalable intervention for lifestyle disease prevention, while emphasizing the need for stronger enforcement and sustained institutional support.

## Recommendations

To enhance the impact of the FFLI, key recommendations include enforcing healthy cafeteria practices, revising ration policies to include nutritious options like millets, and improving coordination with Canteen Services Depot for healthier product availability. Strengthening IEC activities through posters, audiovisual messages, and interactive sessions is essential, particularly targeting families and children. Increasing awareness and utilization of dietitian services and tele-ahar can empower personnel to make informed choices, ensuring the initiative's long-term success and sustainability. Further, administrative authorities must actively support implementation through regular reviews.

## Limitations

This study had several limitations. NC(E) personnel were excluded due to literacy constraints, despite their high prevalence of lifestyle diseases. Data from only seven stations limited the use of inferential statistics. The questionnaires, though developed with expert input, were not statistically validated. Scoring-based analysis was not performed. In addition, other concurrent fitness initiatives may have contributed to BMI improvements, limiting attribution solely to the FFLI. Further, rank-wise data have not been disclosed due to security and administrative reasons.

## CONCLUSION

The FFLI has been successfully implemented across multiple geographic locations in the organization, demonstrating broad reach and satisfactory participation among personnel. This study has shown that the program has significantly improved awareness and promoted healthier behaviors, contributing to a measurable reduction in obesity rates. However, certain challenges and limited sustained engagement were identified as barriers. To enhance effectiveness, actionable recommendations include improving cafeteria regulations, revising supply policies to support healthy choices, and reinforcing continuous education. The insights from this evaluation offer a strategic foundation for future health programs, reinforcing the organization's commitment to promoting long-term wellness and disease prevention among its personnel.

**Ethical approval:** The research/study complied with the Helsinki Declaration of 1964.

**Declaration of patient consent:** Patient's consent not required as patients identity is not disclosed or compromised.

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**Use of artificial intelligence (AI)-assisted technology for manuscript preparation:** The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript and no images were manipulated using AI.

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