

Baseline Self-Ratings and Functional Self-Assessments Among Predominantly Female Participants in a 21-Day Digital Corrective Exercise Programme: A Cross-Sectional Study

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ABSTRACT

Background: Brief digital exercise programmes are easy to access, yet relatively little is known about the people who enrol in them or the baseline assessments used to guide programme content. This study described the lifestyle profile, self-ratings, and functional self-assessments of participants entering the PBS+ “21-Day Challenge”.

Methods: Baseline data were analysed for 2,442 self-selected adults (97.7% women; mean age 50.75 years). The online assessment included seven ratings of present state (NOW) and personally attainable desired state (POT), together with six self-administered functional tasks. Missing values were not imputed. Functional results are reported as both total-sample and valid-case percentages. Wilcoxon Signed-Rank Tests were used to describe paired NOW and POT responses, but the main emphasis was placed on the size of the descriptive POT–NOW gaps across domains.

Results: Nearly two thirds of participants reported low-intensity physical activity, and 41.2% spent at least six hours a day using a computer. NOW ratings were the lowest for abdomen and stability ($M = 3.08$) and posture and spine ($M = 3.60$). The largest mean gaps were observed for abdomen and stability (3.15 points), breathing (2.77), and posture and spine (2.70). As expected from the wording of the question, POT ratings were higher than NOW ratings for almost all participants. Among valid functional responses, difficulties were common in deep abdominal activation, foot and ankle mobility, and the breathing task used in the programme.

Conclusion: At programme entry, participants reported the greatest room for improvement in abdominal stability, breathing, and posture. Functional self-assessments also indicated common difficulties in abdominal activation and foot and ankle mobility, together with mixed performance in the breathing task. Because the measures were self-reported and developed for this programme, the findings describe this cohort rather than clinical impairment or programme effectiveness.

Keywords: Digital exercise, functional self-assessment, middle-aged women, sedentary behaviour, trunk stability

1. INTRODUCTION

Insufficient physical activity and prolonged sedentary behaviour remain important public-health concerns because both are associated with poorer physical function and a higher risk of chronic disease. Current guidelines recommend 150–300

minutes of moderate-intensity aerobic activity, or 75–150 minutes of vigorous-intensity activity, each week, together with muscle-strengthening activity. They also emphasise that replacing sedentary time with movement at any intensity can be beneficial



(Piercy et al., 2018; World Health Organization, 2020). Reviews likewise link prolonged sedentary behaviour with unfavourable health and functional outcomes in adults (Saunders et al., 2020). Accessible interventions that can fit into everyday routines are therefore needed.

Digital health and mobile health (mHealth) approaches are increasingly used to provide physical-activity guidance, self-monitoring, feedback, and structured exercise content. Systematic reviews and meta-analyses suggest that these interventions can produce modest improvements in physical activity and physical function, although the effects vary across populations, intervention designs, and outcome measures (Direito et al., 2017; Ferguson et al., 2022; Laranjo et al., 2021; Zangger et al., 2023). Access to a digital platform alone does not ensure engagement. Content must also feel relevant and credible, be easy to use, offer useful feedback, and fit into daily life (Dennison et al., 2013; Jakob et al., 2022; Perski et al., 2017). A clear description of participants at entry can therefore help explain whom a programme reaches and which needs should be addressed first.

Women in middle and later adulthood are particularly relevant to this discussion. Their participation in exercise is shaped not only by health, but also by work and family responsibilities, available resources, social support, and whether an intervention fits into everyday life (McArthur et al., 2014; Wallbank et al., 2022). Tailored digital tools may be acceptable to women in midlife when they offer accessible and context-sensitive support (Arigo et al., 2023). Findings from a predominantly female sample should therefore be interpreted mainly in relation to women rather than generalised to adults as a whole.

Corrective-functional exercise draws attention not only to how much people move, but also to how they experience movement quality, trunk control, segmental mobility, and breathing. Postural and respiratory functions interact within the lumbopelvic system, and trunk-control interventions have been studied in several clinical populations (Hodges et al., 2007; Marchesi et al., 2024). Slow and diaphragmatic breathing practices have also been linked to psychophysiological regulation, although the measures used and the strength of evidence vary considerably (Hopper et al., 2019; Zaccaro et al., 2018). This literature supports the inclusion of tasks related to the abdomen, trunk, and shoulder mobility, foot and ankle mobility, and breathing, but it does not make the tasks used in this programme validated clinical measures.

Self-rated health and body awareness add another perspective on how participants experience their condition. At the population level, self-rated health brings together several aspects of experienced health and is associated with objective health indicators (Wu et al., 2013). Body awareness is also multidimensional and may include attention to posture, breathing, muscle tension, pain, and other bodily signals (Mehling et al., 2011). Ratings collected within an exercise programme can therefore be useful for initial guidance, but they should not be treated as clinical or psychometric measures unless their measurement properties have been established.

In the “21-Day Challenge”, participants rated each of seven domains twice: how they felt at present (NOW) and how they would like their “potential self, within their own possibilities”, to feel (POT). POT therefore referred to a desired but personally attainable state, not to an expected score after 21 days. Since the second question explicitly asked how participants would like to feel, higher POT scores were built into the comparison. The more informative question was how large the gap was in each domain, rather than whether the paired difference reached statistical significance.

The 21-day format should not be taken to imply that stable habits can be formed within three weeks. Lally et al. (2010) found wide individual variation in the time required to approach behavioural automaticity, with a median of approximately 66 days and estimates ranging from 18 to 254 days. A programme of this length is better viewed as an opportunity to begin a routine and support early engagement than as a completed process of habit formation.

Body Technique, developed by Jagodić Rukavina (2019), is a kinesiological approach that combines conscious movement, perceived muscle activation, mobility, posture, and breathing. The method and its online delivery have also been described in a doctoral dissertation involving women with stress urinary incontinence (Jagodić Rukavina, 2024). The PBS+ “21-Day Challenge” (PBS+ is the proprietary name of the application) offers approximately ten minutes of guided daily exercise, educational material, self-ratings, and functional self-assessment tasks. The present article examines only the information collected before the programme began and does not evaluate intervention effectiveness.

The present study aimed to describe the baseline profile of people entering the “21-Day Challenge”, while recognising that the sample was overwhelmingly female. Four questions guided the analysis:

(1) What were the participants' socio-demographic and lifestyle characteristics? (2) Which domains received the lowest NOW ratings, and where were the largest descriptive POT–NOW gaps? (3) How were valid responses distributed across the six functional self-assessment tasks? and (4) Which tasks contained the highest proportions of less favourable response categories?

2. METHODS

Study design

We conducted a quantitative, non-experimental cross-sectional analysis of baseline data collected before participants began the “21-Day Challenge”. The analysis describes who entered the programme and how they assessed their current state and task performance at baseline. Since no post-programme data are examined here, the study cannot address effectiveness or change over time.

Participants

The analysis included 2,442 adults who chose to enrol in the programme and completed the baseline assessment. Because 97.7% were women, the results mainly describe middle-aged and older women who were willing to join this specific digital intervention. The convenience sample does not represent the wider adult population, especially men or people who would not independently enrol in an online exercise programme.

Instruments and variables

Participants completed an online questionnaire embedded in the digital programme. It covered age, sex, education, perceived material circumstances, self-rated health, physical activity level, self-reported body mass and height, body mass index (BMI) as recorded in the programme dataset, and daily computer use. The available physical-activity variable represented the intensity category selected by each participant; information on activity duration was not included in this analysis.

Participants rated seven areas: (1) posture and spine; (2) abdomen and stability; (3) pain and discomfort; (4) health complaints; (5) appearance and physical feeling; (6) breathing; and (7) life habits and lifestyle. For each area, they first answered the present-state question, translated from Croatian as: “How would you generally rate your present self in the domain of [domain]?” They then answered: “How would you like your potential self, within your own possibilities, to feel in relation to

[domain]?” Responses ranged from 1 (*very poor*) to 7 (*excellent*). Present-state ratings are denoted NOW and personally attainable desired-state ratings are denoted POT. POT was not presented as an expected post-programme outcome. Each domain was assessed with a single item developed for reflection and guidance within the programme. The items do not form a previously validated multi-item scale, and information on test–retest reliability, construct validity, and criterion validity is not available.

Participants also completed six functional tasks on their own and selected the description that best matched how they believed they had performed. No trained examiner observed or scored the tasks. The categories covered: (1) lower abdominal strength and coordination, rated as below 60%, 60–80%, or 80–100%; (2) deep abdominal activation, based on perceived muscle activation and coordination with exhalation; (3) forward trunk flexion, based on maintaining a flat back and initiating movement from the pelvis; (4) chest–shoulder mobility, based on the height reached by the hands behind the back without head or trunk compensation; (5) foot and ankle mobility, based on pain or difficulty in three positions defined by the programme; and (6) breathing, based on completing the programme-defined inhalation count of 12 without shoulder elevation. The full response wording is retained in Tables 6–11.

The tasks were developed within the Body Technique programme to support initial screening, participant feedback, and exercise guidance. They were not intended as diagnostic tests, and there is no formal evidence of inter-rater reliability, test–retest reliability, criterion validity, or sensitivity to change. The results are therefore described as functional self-assessments rather than objective clinical or biomechanical measurements.

Procedure

Before the programme began, participants accessed the baseline assessment online. The programme materials provided instructions and response options for each task. Participants completed the questionnaire, performed the tasks independently, and selected the category that they felt best described their performance. Their selections generated tailored feedback within the programme. No researcher or qualified examiner observed, verified, or scored the tasks. This article uses baseline data only; final measurements and predictive analyses are reported separately.

Ethical considerations

The research used data from a voluntary online assessment completed by adults. It did not involve invasive procedures, biological sampling, clinical examinations, researcher-administered physical testing, or experimental treatment. The Kinesiology School of Body Technique [Kineziološko Učilište Body Tehnike] authorised the use of anonymised and aggregated programme-assessment data for research. The institution does not have a formal research ethics committee and does not issue protocol numbers or dated ethics approvals. For that reason, no independent university or external ethics review, approval number, or approval date was available. Participants were informed that anonymised and aggregated responses could be used for research, and participation was voluntary.

Statistical analysis

Data were analysed using IBM SPSS Statistics version 23. Means (*M*), standard deviations (*SD*), minima, and maxima were calculated for numerical variables; frequencies and percentages were calculated for categorical variables. No *a priori* sample-size calculation was performed because all available baseline records from the programme cohort were included. Missing values were not imputed, and numerical analyses used all available valid observations for each variable. For functional self-assessments, missing results are shown as a

proportion of the full sample, while valid percentages for substantive categories were calculated after excluding missing results. The ranges of self-reported body mass, height, and BMI were inspected for obvious inconsistencies. None fell outside a physiologically possible adult range. Because no pre-specified exclusion rules or independent verification were available, all observations were retained. Wilcoxon Signed-Rank Tests described the paired NOW and POT distributions. The mean descriptive discrepancy was calculated as POT *M* minus NOW *M* for each domain. Given the wording of the POT prompt and the large sample, interpretation focused on the size and ordering of these gaps rather than on *p*-values as the primary finding. Statistical significance was evaluated at $p < .05$, and threshold values are reported.

3. RESULTS

Sample characteristics

Data from 2,442 participants were analysed. Valid sample sizes varied slightly for age and self-reported anthropometric variables (Table 1). The mean age was 50.75 years ($SD = 8.60$). Mean BMI was 25.54 kg/m² ($SD = 4.73$). The broad observed ranges, including low and high BMI values, were retained following the plausibility review described in the Methods.

Table 1. Basic sample characteristics

Variable	<i>N</i>	Min	Max	<i>M</i>	<i>SD</i>
Age (years)	2,433	19.00	85.00	50.75	8.60
Body mass (kg)	2,440	35.00	173.00	72.62	14.18
Body height (cm)	2,418	145.00	193.00	168.57	6.26
BMI	2,414	12.70	57.80	25.54	4.73

Table 2 summarises the sample profile. Women made up 97.7% of participants, and 56.3% had university or postgraduate education. Most rated their health as good or very good, yet 65.8% reported

low-intensity physical activity. More than four in ten participants (41.2%) spent at least six hours a day using a computer.

Table 2. **Categorical sample characteristics**

Variable	Category	N	%
Gender	Female	2,387	97.7
	Male	55	2.3
Education	Primary school	7	0.3
	Secondary school	671	27.5
	Higher professional education	388	15.9
	University degree	1,109	45.4
	Postgraduate study	267	10.9
Material circumstances	Very poor	6	0.2
	Poor	70	2.9
	Average	841	34.4
	Good	1,382	56.6
	Very good	143	5.9
Self-rated health	Poor	164	6.7
	Satisfactory	440	18.0
	Good	951	38.9
	Very good	782	32.0
	Excellent	105	4.3
Physical activity level	Low intensity	1,607	65.8
	Moderate intensity	776	31.8
	High intensity	59	2.4
Computer use	Up to 3 hours	893	36.6
	3–6 hours	543	22.2
	6–8 hours	539	22.1
	More than 8 hours	467	19.1

Programme-specific self-rating domains

NOW ratings were the lowest for abdomen and stability and for posture and spine (Table 3). Mean

ratings in the remaining five domains ranged from 3.82 to 4.02 on the seven-point scale.

Table 3. **Descriptive statistics for NOW variables**

Domain	N	Min	Max	M	SD
Posture and spine	2,442	1.0	7.0	3.597	1.2854
Abdomen and stability	2,442	1.0	7.0	3.084	1.4094
Pain and discomfort	2,442	1.0	7.0	3.822	1.4414
Health complaints	2,442	1.0	7.0	3.904	1.3176
Appearance and physical feeling	2,442	1.0	7.0	3.971	1.3106
Breathing	2,442	1.0	7.0	3.837	1.3465
Life habits and lifestyle	2,442	1.0	7.0	4.023	1.1800

POT ratings were close to the upper end of the scale in every domain (Table 4). These scores describe how participants wished to feel within their perceived possibilities; they are not expected post-programme outcomes.

Table 4. Descriptive statistics for POT variables

Domain	N	Min	Max	M	SD
Posture and spine	2,442	1.0	7.0	6.292	0.9935
Abdomen and stability	2,442	1.0	7.0	6.235	0.9818
Pain and discomfort	2,442	1.0	7.0	6.473	0.8411
Health complaints	2,442	1.0	7.0	6.484	0.7917
Appearance and physical feeling	2,442	1.0	7.0	6.478	0.7764
Breathing	2,442	1.0	7.0	6.610	0.7020
Life habits and lifestyle	2,442	1.0	7.0	6.622	0.6852

Descriptive NOW–POT discrepancies and paired comparisons

Table 5 shows the mean POT–NOW gap together with the paired rank results. The gap was the largest for abdomen and stability (3.15 points), followed by breathing (2.77) and posture and spine (2.70). POT ratings exceeded NOW ratings for

94.5–97.1% of participants across the seven domains. Although every Wilcoxon comparison was statistically significant ($p < .01$), this was expected from the desired-state wording and the size of the sample. The test results are therefore not interpreted as an intervention effect or as independent evidence of readiness for change.

Table 5. Descriptive NOW–POT discrepancies and Wilcoxon Signed-Rank Tests

Domain	Mean Gap (POT–NOW)	POT > NOW N (%)	POT < NOW N	Ties N	z	p
Posture and spine	2.695	2,308 (94.5)	21	113	−42.008	<.001
Abdomen and stability	3.151	2,347 (96.1)	15	80	−42.264	<.001
Pain and discomfort	2.651	2,311 (94.6)	22	109	−41.778	<.001
Health complaints	2.580	2,329 (95.4)	10	103	−42.041	<.001
Appearance and physical feeling	2.507	2,341 (95.9)	11	90	−42.195	<.001
Breathing	2.773	2,371 (97.1)	8	63	−42.452	<.001
Life habits and lifestyle	2.599	2,372 (97.1)	6	64	−42.604	<.001

Functional self-assessments

Almost half of the valid responses to the lower abdominal strength and coordination task fell in the

60–80% category (49.3%). Results were missing for 5.7% of the sample (Table 6).

Table 6. Lower abdominal strength and coordination self-assessment

Result Category	N	Total %	Valid %
Missing result	140	5.7	–
<60%	643	26.3	27.9
60–80%	1,135	46.5	49.3
80–100%	524	21.5	22.8
Total	2,442	100.0	100.0

The deep abdominal activation task had the most missing data (19.1%). Among valid responses, the most common category was partial abdominal

drawing-in without a sensation along the spine (49.4%; Table 7).

Table 7. Deep abdominal activation self-assessment

Result Category	N	Total %	Valid %
Missing result	466	19.1	–
Activation of inappropriate muscles (gluteal or chest muscles) and/or short activation of the abdomen without following exhalation	450	18.4	22.8
Abdominal drawing-in without a sensation along the spine	977	40.0	49.4
Abdominal drawing-in with spreading tone along the spinal muscles during exhalation	549	22.5	27.8
Total	2,442	100.0	100.0

In the forward-flexion task, 67.3% of valid responses fell in the most favourable category defined

by the programme. Results were missing for 8.8% of participants (Table 8).

Table 8. Forward trunk flexion self-assessment

Result Category	N	Total %	Valid %
Missing result	214	8.8	–
Movement from the pelvis with a flat back, 10° forward displacement	1,499	61.4	67.3
Unable to maintain a flat back with legs extended	264	10.8	11.8
Trunk upright, without forward displacement	465	19.0	20.9
Total	2,442	100.0	100.0

For chest–shoulder mobility, 57.0% of valid responses fell in the waist-height category. Results

were missing for 12.3% of the sample (Table 9).

Table 9. Chest-shoulder mobility self-assessment

Result Category	N	Total %	Valid %
Missing result	301	12.3	—
Able to barely grasp hands behind the back with minimal distance from the back and compensation of the head and trunk	358	14.7	16.7
Able to raise hands to scapular height without head and trunk movement	563	23.1	26.3
Able to raise hands to waist height without head and trunk movement	1,220	50.0	57.0
Total	2,442	100.0	100.0

Difficulty in the foot and ankle task was common. Only 27.1% of valid responses indicated that all three positions could be performed without difficulty (Table 10).

Table 10. Foot and ankle mobility self-assessment

Result Category	N	Total %	Valid %
Missing result	209	8.6	—
One position is painful or cannot be performed correctly	1,094	44.8	49.0
All three positions are performed without difficulty	605	24.8	27.1
All three positions are painful or difficult to perform	534	21.9	23.9
Total	2,442	100.0	100.0

The two most common valid responses in the breathing task were inability to complete the inhalation count without shoulder movement (41.7%) and completion without difficulty (40.8%). Results were missing for 13.8% of participants (Table 11).

Table 11. Breathing self-assessment

Result Category	N	Total %	Valid %
Missing result	336	13.8	—
Shallow and rapid breathing with shoulder elevation	369	15.1	17.5
Performed without difficulty and without moving the hands on the shoulders	859	35.2	40.8
Unable to complete the inhalation count of 12, although breathing without shoulder movement	878	36.0	41.7
Total	2,442	100.0	100.0

4. DISCUSSION

Most people in the cohort were women in middle or later adulthood: 97.7% were female and the mean age was about 51 years. The findings therefore speak primarily to women who chose to enrol in this particular programme, not to adults in general. Research with women in this age group shows that exercise participation is shaped by health, competing responsibilities, available support, and whether a programme fits daily life (McArthur et al., 2014; Wallbank et al., 2022). The skewed sex distribution may reflect how the programme was designed and promoted, but the present data do not allow conclusions about sex differences in interest in digital exercise.

Most participants rated their health as good or very good, yet almost two thirds reported only low-intensity physical activity and more than four in ten spent at least six hours a day using a computer. These findings are not necessarily contradictory: people may feel generally healthy while still noticing concerns related to movement, posture, or physical function. Digital programmes can make exercise support easier to access, but their usefulness depends on design, feedback, personal relevance, and continued engagement (Direito et al., 2017; Jakob et al., 2022; Perski et al., 2017; Zangger et al., 2023). Baseline information can help shape the first stages of a programme, although it cannot show whether behaviour or function later changes.

The NOW–POT findings are best read descriptively. Participants were asked how they would like their personally attainable ‘potential self’ to feel, so higher POT ratings were expected; with such a large sample, statistical significance was also highly likely. What matters more is the relative size of the gaps. The largest gap concerned abdomen and stability, followed by breathing and posture and spine. These areas were clearly important to participants, but the gaps have not been validated as measures of dissatisfaction, motivation, readiness for change, or expected improvement.

The six functional tasks add another perspective on how participants viewed their abilities, but they do not provide an objective measure of physical function. Participants completed the tasks without an examiner and selected the category they believed best described their performance. Difficulties were often reported in abdominal activation, foot and ankle mobility, and the breathing task. This general pattern is compatible with research on the interaction between postural and respiratory function and

on trunk-control interventions (Hodges et al., 2007; Marchesi et al., 2024), but the present findings cannot establish a physiological mechanism or clinical impairment. The lower NOW ratings for abdomen and stability and for posture and spine also resemble, at a descriptive level, the focus of several trunk-related tasks. Since no correlation or other association analysis was performed, this resemblance should not be treated as an established relationship.

For practice, the findings suggest that the early stages of the programme could place particular emphasis on clear instructions, gradual progression, breathing awareness, trunk-control exercises, and mobility work, with options suited to different abilities. Digital programmes for women in mid-life may also benefit from tailored content, realistic goals, useful feedback, and support that fits everyday demands (Arigo et al., 2023; Sanders et al., 2023; Wallbank et al., 2022). The assessments used here are best treated as a starting point for exercise guidance, not as a basis for diagnosis, exclusion from activity, or claims about clinical status. Anyone reporting pain, marked limitation, or uncertainty should be advised to seek an appropriate professional assessment.

The value of this study lies less in testing an intervention than in documenting, in detail, who entered the programme and how the baseline assessment functioned in practice. The large cohort shows which concerns were common, where responses were often missing, and which parts of the assessment need stronger measurement. It also makes two important limits clear: self-rated task performance cannot substitute for examiner-administered testing, and a gap between present and desired states is not an intervention outcome.

The study has several important limitations. First, the convenience sample was self-selected and almost entirely female, which limits generalisability to men, less educated groups, people with limited digital access, and adults who would not voluntarily enter this programme. Second, body mass, height, physical activity, computer use, health, the seven domain ratings, and all functional categories were self-reported. The six tasks were not observed or scored by a trained examiner, and neither the single-item ratings nor the functional categories have undergone formal external validation. Third, the POT wording made higher scores than NOW structurally likely, so the paired comparison is not a substantive effect. Fourth, functional-task missingness ranged from 5.7% to 19.1%. Available-case analyses were used, but the reasons for nonresponse and

the missing-data mechanism could not be examined. Fifth, unusual self-reported anthropometric values could not be externally verified. Sixth, baseline data alone provide no evidence of programme effectiveness, adherence, safety, or change over time. Finally, institutional permission came from the organisation affiliated with the programme; no independent university or external ethics committee reviewed the study, and the first author developed the method and programme described here. These governance and professional-interest issues are disclosed explicitly.

Future work should use procedures defined in advance, validated outcome measures, and examiner-administered or instrumented functional tests where feasible. Participant identifiers are also needed to link baseline and follow-up data. Studies should record exposure to the digital content, adherence, adverse events, and reasons for missing follow-up assessments. A more balanced and socio-demographically diverse sample would improve external validity. With these improvements, researchers could examine whether baseline concerns predict engagement and whether later changes exceed measurement error and selection effects.

5. CONCLUSIONS

Participants entered the programme with the greatest perceived room for improvement in abdomen and stability, breathing, and posture and spine. Because POT asked how they would like to feel within their own possibilities, these gaps should be understood as priorities expressed at baseline, not as unexpected inferential findings or evidence of readiness for change.

The functional results require the same caution. They describe tasks completed and rated by participants themselves, not objective tests. The responses suggest that difficulties in abdominal activation, foot and ankle mobility, and breathing were common in this cohort, while the missing data also show where the assessment process needs improvement. The findings do not establish clinical impairment or the effectiveness of the 21-day programme.

By documenting a large real-world cohort at programme entry, this study provides a useful starting point for refining both the intervention and its evaluation. Stronger future studies should link participants across time, use validated and examiner-verified outcomes, record programme exposure and adverse events, and include a more diverse sample before drawing conclusions about effectiveness or wider applicability.

Author Contributions: Ana-Marija Jagodić Rukavina: conceptualisation, development of the Body Technique method and the “21-Day Challenge” programme, programme administration, data collection, resources, interpretation of results, and writing review and editing. Luka Pongračić: methodology, formal statistical analysis, interpretation of results, writing – original draft and review and editing. The statistical analysis was conducted independently by the second author, who was not involved in developing or delivering the intervention. Both authors read and approved the final manuscript.

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Informed Consent Statement: All participants were adults who voluntarily accessed and completed the online assessment. They were informed that anonymised and aggregated responses could be used for research and analytical purposes. Completion and submission of the assessment constituted consent to participate and to use anonymised data for the stated purposes.

Ethical Approval: Formal review by an independent institutional review board or university ethics committee was not available. The Kinesiology School of Body Technique [Kineziološko Učilište Body Tehnike] granted institutional permission for anonymised and aggregated programme-assessment data to be used for research. The institution does not operate a formal research ethics committee and does not issue protocol numbers or dated ethics approvals; therefore, no approval number or date exists. The study involved voluntary online questionnaire completion and self-administered functional tasks by adults and did not include invasive procedures, clinical examinations, researcher-administered physical testing, biological sampling, or experimental treatment.

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Conflicts of Interest: Ana-Marija Jagodić Rukavina developed the Body Technique method and the “21-Day Challenge” programme evaluated in this study and is affiliated with the institution that granted permission to use the data. This is disclosed as a potential non-financial professional interest. Luka Pongračić declares no competing interests and independently conducted the statistical analysis; he was not involved in developing or delivering the programme.

Data Availability Statement: The participant-level data are not publicly available because they derive from programme assessments and contain sensitive health- and body-related self-reports. Requests for access may be directed to the corresponding author and will be considered subject to institutional permission, participant privacy, and applicable data-protection requirements.

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methodological descriptions, and scientific interpretations, approved all revisions, and remain fully responsible for the manuscript.

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