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Strengthening Health Cadres' Capacity through a Holistic Care Program for Community-Based Support of Patients with Chronic Diseases in Keramat Village, Martapura

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ABSTRACT

Chronic diseases require continuous community-based support that addresses patients' biological, psychological, social, spiritual, and cultural needs. However, health cadres may have limited capacity to provide comprehensive assistance beyond physical health monitoring. This community service program aimed to strengthen health cadres' capacity to apply a Holistic Care approach in supporting patients with chronic diseases and their families in Keramat Village, Martapura, South Kalimantan. The program involved 10 health cadres and 24 patients with chronic diseases and their families and was implemented through community empowerment, Holistic Care education, interactive training, case simulation, pocketbook-based guidance, digital documentation, and one-month home-based mentoring. Cadres' knowledge was evaluated using a one-group pre-test–post-test design and analyzed descriptively. All cadres demonstrated increased post-test scores, with pre-test scores ranging from 35-80 and post-test scores from 75-100. Individual score increases ranged from 5 to 40 points, with a mean absolute increase of 21.2 points. The evaluation demonstrated an increase in health cadres' knowledge following the program. However, the program did not assess cadres' practical competency or patients' quality of life using validated measures. The program supports continued cadre training, supervision, referral mechanisms, and direct evaluation of patient outcomes in future implementation.

Keywords: chronic diseases, community empowerment, health cadres, holistic care, quality of life

INTRODUCTION

Chronic diseases, including diabetes mellitus, hypertension, cardiovascular disease, and chronic respiratory diseases, represent persistent public health challenges because their long-term course may result in physical limitations, psychological distress, social disruption, and reduced quality of life (M. et al., 2023; Van Wilder et al., 2021). The management of chronic conditions therefore requires continuous care that extends beyond clinical treatment and incorporates promotive, preventive, curative, and rehabilitative approaches. Quality of life in patients with chronic diseases is influenced not only by disease-related symptoms but also by the availability of family support, psychological

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adaptation, social relationships, and spiritual well-being. Consequently, community-based approaches are increasingly important to support patients in maintaining health and functioning within their daily environment (Alsaad et al., 2024; Mbata et al., 2024; Sun et al., 2026).

Health cadres are strategically positioned to support chronic disease management at the community level because they function as an important link between health services and the community (Knowles et al., 2023; Leban et al., 2021). Their roles include delivering health education, monitoring patients' conditions, encouraging healthy behaviors, and facilitating communication between patients, families, and health professionals (Mistry et al., 2021; Sadikin et al., 2024). However, the existing capacity of cadres does not always support comprehensive chronic disease management. In particular, community-based activities may remain predominantly focused on physical health monitoring, while patients' psychological, social, spiritual, and cultural needs receive less systematic attention (Doresha et al., 2024; Zamzami & Jais, 2026). This gap indicates the need to strengthen cadres' knowledge and practical skills so that they can provide more comprehensive and patient-centered assistance to people living with chronic diseases.

The Holistic Care approach provides a conceptual framework for addressing this gap by viewing individuals as integrated beings whose health is shaped by biological, psychological, social, spiritual, and cultural dimensions. In chronic disease management, this perspective is particularly relevant because long-term illness requires patients and families to adapt continuously to changes in physical functioning, emotional well-being, social roles, treatment adherence, and everyday lifestyles (Sa`ari & Chik, 2025; Urfiles, 2026). Previous literature cited in the initial program document indicates that holistic approaches may support treatment adherence, self-management, psychological well-being, and quality of life (Boehmer et al., 2023; Huang et al., 2024). However, translating the holistic care concept into routine community-based assistance requires cadres who are adequately prepared to identify patients' needs, communicate therapeutically, provide appropriate health education, involve families, and recognize the importance of spiritual and cultural factors.

The initial assessment in Keramat Village, Martapura, South Kalimantan, identified a specific community service gap: health cadres had experience in supporting community health but had limited understanding of how to apply a holistic approach when assisting patients with chronic diseases. This condition is important because chronic disease care occurs not only within health facilities but also in patients' homes and communities, where families and cadres may provide continuous support. The gap between the strategic role of cadres and their preparedness to deliver holistic assistance provided the rationale for implementing a community empowerment program that integrated education, practical training, simulation, family involvement, and direct mentoring. The program was therefore designed not merely to transfer knowledge but to strengthen cadres' capacity to apply Holistic Care principles in real community settings.

The expected outcomes of the program can be considered across three levels. At the proximal level, the program was designed to strengthen health cadres' knowledge and prepare them to provide holistic support for patients with chronic diseases. At the intermediate level, strengthened cadre capacity was intended to support more structured community-based assistance through health education, patient monitoring, family involvement, therapeutic communication, documentation, and linkage with health services. At the longer-term level, improved community-based support is intended to contribute to better continuity of care, self-management, and ultimately quality of life among patients with chronic diseases. However, the present program directly evaluated changes in cadre knowledge only. Practical competency, the quality of community-based support, and patients' quality of life were not assessed using validated outcome measures and therefore

should be regarded as intended outcomes rather than demonstrated effects of the present program.

The conceptual framework of the program was therefore based on the assumption that strengthening cadre capacity is an important proximal component of improving community-based chronic disease support. The program combined education on chronic disease and Holistic Care with therapeutic communication, medication adherence, family roles, and spiritual and cultural considerations; practical training through discussion, demonstration, case simulation, and direct practice; the use of a Holistic Care pocketbook as a standardized educational guide; digital documentation through Google Forms; and one month of home-based mentoring for patients and their families. Through these interconnected components, cadres were positioned not as substitutes for professional health workers but as community partners who can provide structured education, motivation, monitoring, and support while strengthening links between patients, families, and health services. The program components were intended to strengthen cadres' immediate capacity and facilitate more structured community-based support, while potential effects on patient-level outcomes, including quality of life, represent longer-term goals that require direct evaluation.

Accordingly, this community service program aimed to strengthen the capacity of health cadres in applying a Holistic Care approach to the assistance of patients with chronic diseases in Keramat Village, Martapura, South Kalimantan. Specifically, the program sought to improve cadres' knowledge and prepare them to provide comprehensive assistance encompassing biological, psychological, social, spiritual, and cultural dimensions, while strengthening family involvement and community-based continuity of care. The activity also sought to establish supporting mechanisms, including the Holistic Care pocketbook and digital documentation, that could facilitate structured and sustainable cadre-led assistance. Patient quality of life was considered a longer-term intended impact of strengthened community-based support rather than a directly evaluated outcome of the present program. The contribution of this program lies in integrating cadre capacity building with direct community mentoring, providing a potentially replicable model for strengthening primary health care and chronic disease support in communities with similar characteristics.

METHOD

Program Design and Participants

This community service program used a community empowerment approach to strengthen the capacity of health cadres in providing holistic support for patients with chronic diseases. The program was implemented in Keramat Village, Martapura, South Kalimantan, in collaboration with the village government, community health center, health cadres, patients with chronic diseases, and their family members. The participants consisted of 10 health cadres and 24 patients with chronic diseases and their families. Health cadres were selected because of their role as community-based partners in providing health education, health monitoring, and patient and family support.

The intervention activities were designed to strengthen cadres' capacity through education, practical training, case simulation, standardized educational guidance, digital documentation, and home-based mentoring. These activities represented the program components, whereas the primary quantitatively evaluated outcome was cadres' knowledge regarding Holistic Care for supporting patients with chronic diseases.

Implementation Sequence

The program was implemented through five sequential stages: (1) coordination and preparation, (2) Holistic Care education, (3) health care training, (4) one-month mentoring of patients and families, and (5) program evaluation. The initial stage involved coordination with the village government, community health center, and health cadres to identify community needs, arrange the activity schedule, and prepare educational materials, evaluation instruments, and implementation tools. The team developed a Holistic Care pocketbook, educational leaflets, and a digital documentation system using Google Forms.

The second stage provided education on the Holistic Care concept, covering biological, psychological, social, spiritual, and cultural dimensions of chronic disease care. The educational content included chronic disease management, principles of long-term care, therapeutic communication, appropriate medication use, treatment adherence, family involvement, and spiritual and cultural considerations in supporting patients.

The third stage consisted of cadre training using interactive lectures, group discussions, demonstrations, case simulations, and direct practice. The Holistic Care pocketbook was used as a practical reference during the training. Cadres were also introduced to the use of Google Forms for documenting patient mentoring activities and monitoring results.

The fourth stage involved one month of mentoring for patients with chronic diseases and their families. Health cadres conducted periodic home visits to provide education, monitor patient conditions, motivate family members, and support patients in applying Holistic Care principles in daily life. During this period, the community service team supervised the cadres to support implementation according to the program objectives.

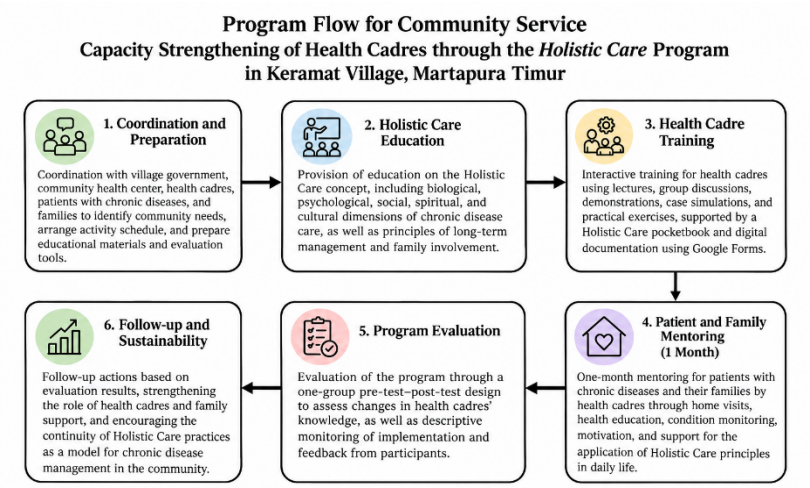


Figure 1. Flow of the holistic care community service program

Educational Materials and Implementation Tools

The materials and tools used during the program included a Holistic Care pocketbook, educational leaflets, a knowledge assessment questionnaire, and Google Forms for digital documentation and monitoring. The Holistic Care pocketbook was developed by the community service team as a practical reference aligned with the educational content delivered during the program. Its content covered the biological, psychological, social, spiritual, and cultural dimensions of chronic disease support, including chronic disease management, long-term care principles, therapeutic communication, medication use and treatment adherence, family involvement, and spiritual and cultural considerations. The pocketbook was used during cadre education, practical training, case simulation, and patient mentoring to provide a standardized reference for the application of Holistic Care

principles. Google Forms was used to support structured documentation of mentoring and patient-monitoring activities.

Evaluation Procedures

The evaluation focused on cadres' knowledge as the primary quantitatively assessed outcome. A one-group pre-test–post-test design was used to assess changes in knowledge before and after the Holistic Care training program. The same knowledge questionnaire was administered to the participating cadres before the educational and training activities and again after completion of the program.

The knowledge assessment was conducted using a structured questionnaire covering the Holistic Care content delivered during the program, including the biological, psychological, social, spiritual, and cultural dimensions of chronic disease support. Each cadre completed the questionnaire individually during the scheduled assessment sessions. Pre-test and post-test scores were compared at the individual level to identify changes in knowledge following program participation. The analysis was descriptive because the available program documentation consisted of individual pre-test and post-test scores and did not include sufficient information for inferential statistical testing.

The practical competency of cadres, patients' quality of life, treatment adherence, self-management, and other patient-level outcomes were not systematically assessed using validated outcome measures in this program. Accordingly, these domains were considered intended or potential longer-term outcomes of the community support model rather than evaluated outcomes of the present activity.

Ethical and Partnership Considerations

The program was implemented in collaboration with the village government and community health center, with active participation from health cadres, patients with chronic diseases, and family members. Participation in the community service activities was voluntary, and the participants were informed about the purpose and activities of the program before participation. Information obtained during the program was used for activity documentation and evaluation purposes.

Participant information and evaluation data were handled confidentially and were not presented using personally identifiable information. Digital documentation through Google Forms was used for program monitoring and was restricted to information necessary for documenting mentoring activities and program evaluation. Data were reported in aggregate form to protect the privacy of cadres, patients, and families.

RESULTS AND DISCUSSION

Respondent Characteristics

The community service program involved 10 health cadres who participated in the Holistic Care capacity-strengthening activities in Keramat Village, Martapura, South Kalimantan. The cadres were involved as the primary community-based participants because of their role in providing health education, monitoring patients, and supporting families in chronic disease management. In addition to the cadres, 24 patients with chronic diseases and their family members were involved in the patient mentoring component of the program.

All 10 health cadres were women (100%). In terms of age, four cadres (40.0%) were aged 30 – 39 years, four (40.0%) were aged 40 – 49 years, and two (20.0%) were aged $\geqslant$ 50 years. Regarding educational attainment, six cadres (60.0%) had completed senior high school, three (30.0%) had completed junior high school, and one (10.0%) had a diploma-

level education. No cadre had a university degree. In terms of cadre experience, five participants (50.0%) had served as cadres for 5–10 years, four (40.0%) for 11–15 years, and one (10.0%) for more than 15 years. None had less than five years of cadre experience.

Table 1. Characteristics of health cadres participating in the Holistic Care program

Characteristic	Frequency (n)	Percentage (%)
Age (years)		
30–39	4	40.0
40–49	4	40.0
≥50	2	20.0
Sex		
Female	10	100.0
Male	0	0.0
Educational attainment		
Junior high school	3	30.0
Senior high school	6	60.0
Diploma	1	10.0
University	0	0.0
Cadre experience (years)		
<5	0	0.0
5–10	5	50.0
11–15	4	40.0
>15	1	10.0

The characteristics indicate that the participating cadres were predominantly women of productive age and had relatively long experience in community health activities. This profile provides an important foundation for capacity strengthening because cadres already possess practical experience in interacting with community members. However, prolonged experience does not necessarily guarantee competence in comprehensive chronic disease management. The need for continuing education is therefore relevant, particularly when cadres are expected to address psychological, social, spiritual, and cultural dimensions in addition to physical health.

This finding is consistent with evidence concerning community health workers (CHWs), which emphasizes that structured training can increase their knowledge and skills and support the transfer of selected health promotion and disease-management tasks to community-based workers. A systematic review of CHW training for cardiometabolic disease prevention and control found that face-to-face lectures, interactive group activities, and blended approaches were commonly used and that training was associated with improvements in CHW knowledge and skills (Seneviratne et al., 2022). Thus, the relatively long experience of the cadres in the present program can be considered an asset, while structured training serves to strengthen and update the competencies required for broader chronic disease support.

Implementation of the Holistic Care Community Service Program

The Holistic Care approach was implemented to broaden health cadres' understanding of chronic disease support beyond physical health by incorporating biological, psychological, social, spiritual, and cultural dimensions of care. These dimensions were introduced through education, group discussion, case simulation, practical exercises, and the use of a Holistic Care pocketbook. The approach was considered relevant to the cadres' community-based roles, particularly in providing health

education, supporting patients and families, and monitoring patients in their home environment.

The observed improvement in cadre knowledge provides direct evidence of the outcome achieved through the educational component of the program. All 10 cadres demonstrated higher post-test scores, with an average absolute increase of 21.2 points. The combination of interactive education, case-based discussion, simulation, and practical activities may have helped cadres connect Holistic Care concepts with situations encountered during community-based patient support. The pocketbook also provided a standardized reference that could reinforce the information delivered during the training and mentoring sessions.

These findings indicate that the program was effective in strengthening cadres' knowledge of the Holistic Care approach. However, the improvement in knowledge should not be interpreted as evidence of improved practical competency because practical performance was not assessed using a standardized competency instrument. Similarly, although the program was designed to support more comprehensive care for patients and families, patient quality of life was not directly assessed using a validated instrument. Therefore, the present findings demonstrate an improvement in cadre knowledge rather than a demonstrated improvement in patient quality of life.

Future community service programs should evaluate whether improvements in cadre knowledge are translated into sustained changes in practical performance and patient-level outcomes. Assessment using standardized competency instruments, patient self-management measures, treatment adherence, and validated quality-of-life instruments, together with longer follow-up, would provide stronger evidence regarding the broader impact of the Holistic Care approach.



Figure 2. Community service team and village health volunteer partners

The multicomponent structure is an important feature of the program. Rather than positioning cadres solely as providers of information, the intervention combined education, practical training, reference materials, digital documentation, home-based mentoring, family involvement, and supervision. Such an approach is consistent with the broader role of community health workers in chronic disease management, where training is most useful when linked to defined community-based tasks and ongoing support. Evidence from CHW training studies also indicates that knowledge and skills can be strengthened when training is accompanied by practical activities rather than relying solely on didactic education (Larasati & Jais, 2026; Lumbantoruan & Nurhidayah, 2023; Schleiff et al., 2021).



Figure 3. Delivery of material and practical activities for the Holistic Care program.

The use of the Holistic Care pocketbook and Google Forms further supported standardization and documentation. The pocketbook provided cadres with a practical reference during patient education, whereas digital documentation created a mechanism for recording mentoring activities and patient monitoring. These components may facilitate continuity of community-based care; however, the present program did not formally evaluate the usability or long-term adoption of these tools.

Changes in Health Cadres' Knowledge

The primary documented outcome was the change in health cadres' knowledge before and after participation in the Holistic Care program. All 10 cadres demonstrated an increase in their post-test scores. Pre-test scores ranged from 35 to 80, while post-test scores ranged from 75 to 100. Individual change scores ranged from 5 to 40 points, with a mean increase of 21.2 ± 10.22 points. The distribution of individual change scores was as follows: two cadres increased by 5 points, two by 20 points, one by 22 points, four by 25 points, and one by 40 points. Thus, all participating cadres demonstrated a positive change in measured knowledge following the program.

Because the available program documentation did not contain the complete individual pre-test and post-test raw scores, the mean and standard deviation of the pre-test and post-test scores could not be reconstructed reliably. Therefore, the analysis was limited to the documented score ranges and the distribution and descriptive statistics of individual change scores. These findings should be interpreted as descriptive evidence of improvement in measured knowledge rather than as definitive evidence of intervention effectiveness.

Table 2. Changes in health cadres' knowledge scores following the Holistic Care intervention

Knowledge indicator	Result
Number of cadres	10
Pre-test score, range	35–80
Post-test score, range	75–100
Change score, range	5–40
Mean change score ± SD	21.2 ± 10.22
Cadres with increased scores	10 (100.0%)

All participating cadres demonstrated an improvement in knowledge following the Holistic Care training. Individual score increases ranged from 5 to 40 points, with a mean absolute increase of 21.2 points. The consistent positive direction of change across all participants indicates an overall improvement in measured knowledge following the training. This finding is broadly consistent with previous evidence indicating that structured training can improve knowledge and skills among community health workers involved in chronic disease management (Abdel-All et al., 2017; Megasari & Suarjana, 2026; Seneviratne et al., 2022).

However, the present result should be interpreted as descriptive evidence of knowledge improvement, rather than definitive evidence of intervention effectiveness. The activity documentation does not report individual raw questionnaire responses, questionnaire validity and reliability statistics, standard deviations for the pre-test and post-test scores, or an inferential statistical test such as a paired t-test or Wilcoxon signed-rank test. Therefore, a statistical significance value cannot be validly reported from the available documentation. Nevertheless, the fact that all cadres demonstrated higher post-test scores provides a consistent implementation-level signal that the training increased measured knowledge.

Interpretation of the Holistic Care Approach

The main conceptual contribution of the program was the integration of multiple dimensions of care into community-based chronic disease support. The cadres were introduced not only to physical disease management but also to psychological, social, spiritual, and cultural aspects of patient care. This approach is particularly relevant to chronic disease because long-term illness can affect multiple domains of patients' lives and often requires continuous adaptation by patients and families.

The Holistic Care approach in this program emphasized the importance of supporting patients with chronic diseases across physical, psychological, social, spiritual, and cultural dimensions. This approach was incorporated into cadre education through structured learning, case simulations, and practical guidance using the Holistic Care pocketbook. The improvement in knowledge scores observed among all participating cadres suggests that the training successfully increased their understanding of the multidimensional aspects of chronic disease support.

The findings are consistent with previous evidence indicating that structured training can improve the knowledge and skills of community health workers involved in chronic disease management (Flanagan et al., 2017; Leach et al., 2019; Morika & Hardisman, 2025). In the context of this program, improved knowledge provides an important foundation for cadres to recognize and address patient needs beyond routine physical monitoring. However, the findings should be interpreted within the scope of the evaluation. The program assessed changes in cadre knowledge only; practical competency, the quality of support provided to patients, and patient quality of life were not measured using validated outcome instruments. Therefore, the observed improvement in knowledge should not be interpreted as direct evidence of improvement in patient quality of life. Further evaluation with competency-based assessments and validated patient outcomes is needed to determine whether increased cadre knowledge translates into improved community-based support and patient outcomes.

Role of Family Mentoring and Community-Based Support

The one-month mentoring component extended the intervention beyond the training room by involving patients and their families through periodic home visits. Cadres provided education, monitored patient conditions, encouraged family involvement, and supported the application of Holistic Care principles in daily activities. This component is

particularly relevant because chronic disease management is largely conducted outside formal health facilities. Patients and families must continuously manage medication, lifestyle, symptoms, appointments, emotional responses, and social consequences of illness. The cadre therefore functions as a community-level connector between patients, families, and formal health services.

The family-oriented approach is also consistent with the broader principle of person-centered and community-based chronic disease care, in which patient support extends beyond biomedical management (Putri et al., 2025). The combination of trained cadres and family involvement may improve continuity because the cadre can reinforce health messages during home visits while family members can provide day-to-day support (Babys et al., 2026). Nevertheless, because the present program did not measure adherence, self-management, family burden, or patient quality of life before and after mentoring, these potential benefits remain an important direction for future evaluation.

Program Contribution and Sustainability

One of the strengths of the program was the combination of capacity building and mechanisms intended to support continuity. The Holistic Care pocketbook provided a standardized educational reference, while Google Forms supported digital recording of mentoring activities. The involvement of village authorities and the community health center also created an institutional context for continuing cadre activities after the community service team completed the intervention.

The sustainability of community-based interventions depends not only on initial training but also on continued supervision, role clarity, access to referral pathways, and opportunities for refresher training. Recent evidence on CHW training emphasizes the importance of structured and standardized capacity building, while also indicating that the evidence linking training directly to patient-level outcomes remains limited and heterogeneous. This supports the need to move from a one-time training model toward a continuing capacity-development model.

For sustainability in Keramat Village, Martapura, South Kalimantan, periodic refresher training, routine review of cadre documentation, regular coordination between cadres and the community health center, and continued use of the Holistic Care pocketbook and digital monitoring system could be implemented. A simple supervision mechanism could also be established to support cadres in referring patients whose needs exceed their role or competence to nurses, physicians, or other appropriate health professionals.

Challenges and Program Limitations

Several limitations should be considered when interpreting the findings. First, the program involved only 10 health cadres in a single village, so the findings cannot be generalized to all community health cadres or other geographical settings. Second, the evaluation used a one-group pre-test and post-test design without a comparison group. Consequently, improvements in knowledge cannot be attributed exclusively to the intervention with the same level of confidence as a controlled study. Third, the available documentation provides score ranges and individual score changes but does not provide sufficient raw data to calculate inferential statistical significance or effect size.

Fourth, the program primarily assessed knowledge, whereas the intervention also aimed to strengthen practical cadre skills and ultimately support patients' quality of life. No standardized competency rubric was documented for assessing practical cadre performance, and no validated quality-of-life instrument was administered to the 24 patients. Therefore, the findings do not establish improvement in cadre competency, patient self-management, treatment adherence, or quality of life.

Fifth, the one-month mentoring period provides an initial opportunity for implementation but is insufficient to determine whether the changes are sustained over the longer term. Future programs should incorporate follow-up assessments at three or six months and evaluate whether cadres continue to use the pocketbook, document mentoring activities, and perform their roles independently.

Recommendations for Future Community Service

Future community service programs should prioritize three areas based on the limitations of the present program. First, longer-term follow-up, preferably at three and six months, is needed to determine whether improvements in cadre knowledge are sustained and translated into continued implementation of Holistic Care practices. Second, future programs should directly assess cadres' practical competency using a standardized competency-based instrument to determine whether knowledge gains are reflected in their ability to provide holistic support. Third, patient-level outcomes should be assessed directly using validated measures of quality of life and, where appropriate, self-management or treatment adherence. These improvements would provide stronger evidence of whether strengthened cadre capacity is sustained over time and contributes to meaningful outcomes for patients with chronic diseases.

CONCLUSION

The Holistic Care community empowerment program was feasible for strengthening community-based support for patients with chronic diseases and was associated with an increase in health cadres' knowledge. However, practical competency of the cadres and patients' quality of life were not directly evaluated using standardized or validated measures. Therefore, the findings should be interpreted as evidence of improved cadre knowledge rather than direct evidence of improved patient outcomes. Longer-term follow-up and direct assessment of cadre competency and patient-level outcomes are recommended to determine the sustained impact of the program.

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