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Care beyond the clinic: community networks, elderly well-being, and social support in aging Indonesian villages

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ABSTRACT

Background: Rural ageing in Petir Village, comprising 3,584 residents across 13 hamlets, exposed gaps between clinic-based provision and the everyday social support required by older adults. **Objective:** This community engagement program aimed to strengthen coordinated care networks for 65 older residents through family, neighbour, cadre, and service participation. **Method:** A participatory planning–implementation–monitoring-evaluation design used baseline questionnaires, care-network maps, attendance sheets, product rubrics, observation logs, referral trackers, pre–post measures, and focus groups to assess participation, support availability, loneliness, well-being, care capacity, and institutional continuity. **Results:** Planning documented three coordination meetings, 65 baseline assessments, at least eight need categories, and six core instruments. Implementation comprised one orientation, four core sessions, 13 care circles, 52 scheduled mentoring meetings, 65 network maps and support plans, and up to 26 priority home visits. Monitoring and evaluation recorded 52 matched records, 75% mean attendance, 70% acceptable outputs, a 20% knowledge increase, a 20-percentage-point improvement in reachable support, and one institutional continuation plan, without treating these findings as causal effects. **Novelty:** Its novelty lies in integrating relational care mapping, situated mentoring, quantitative tracking, community validation, and institutional follow-up within a single data-grounded model for ageing-in-place community development, responsive to rural accessibility, caregiving burden, service reach, and diverse local care cultures.

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1. INTRODUCTION

Population ageing in rural Indonesia increasingly exposes the limits of clinic-centred care, particularly where daily well-being depends on family availability, neighbourhood ties, volunteer activity, and access to community services. Petir Village in Rongkop Subdistrict, Gunungkidul Regency, provided a relevant setting because it had 3,584 residents distributed across 13 hamlets and a dependency ratio of 53.03, indicating pressure on productive-age households and local institutions. The village also contained 13 elderly Posyandu units and three Posbindu units, creating an institutional base for decentralised engagement. Secondary local evidence from 63 older adults with hypertension further showed that 42.9% lacked good health-information sources, 33.3% regarded service distance as unsupportive, and 23.8% considered facility availability inadequate. These figures did not constitute this program's baseline, but they demonstrated a credible

convergence of demographic ageing, access barriers, and uneven social support. Accordingly, care beyond clinical encounters became an urgent community-development issue rather than a narrowly medical concern.

Existing scholarship confirms that older people's well-being is shaped by the structure and quality of their care networks. Absor et al. [1] demonstrated that care arrangements in rural Indonesia extend across family and community relations, while Aji et al. [2] identified barriers and enablers affecting healthcare access among rural older adults. Amalia et al. [3] linked loneliness among elderly Javanese people to social-support availability and quality, and Khuzaimah et al. [4] showed that social support, religiosity, and wisdom relate to later-life well-being. Community-based initiatives have also highlighted the value of empowerment, voluntary care meetings, and cadre involvement [5], [6], [7]. However, many interventions remain activity-centred, relying on attendance or one-off education without mapping support networks, matching baseline and endline data, tracking referrals, documenting care plans, or establishing institutional continuation. This gap required a research-based intervention that treated social relationships as measurable community infrastructure.

This community engagement program aimed to strengthen accessible, diversified, and locally coordinated support for older adults in Petir Village through care-network mapping, peer support, home-based assistance, and structured referral. More specifically, this program examined whether participation was accompanied by measurable changes in the availability of reachable support persons, social-network strength, loneliness, subjective well-being, and continuity of care. Implementation indicators included attendance across four core sessions, retention from 65 recruited participants to matched endline respondents, completion of personal care-support plans, participation in 13 care circles, documented support contacts, priority home visits, and referral completion. Institutional indicators included cadre and supporter knowledge scores, the number of validated need categories, representation of all 13 hamlets, completion of one community validation forum, and production of a written follow-up plan. By combining individual, relational, activity, and institutional units of analysis, this program moved beyond counting beneficiaries and assessed whether community engagement generated usable support practices.

A central contribution of this community-based intervention lies in integrating practical assistance with participatory evidence production. Rather than treating older adults as passive recipients, this program positioned them, their families, neighbours, cadres, and service providers as co-producers of care knowledge through network maps, support logs, reflection sessions, and validation forums. Its evaluative architecture linked quantitative measures—attendance, pre–post scores, network size, support frequency, home visits, and referral status—with qualitative accounts of accessibility, trust, burden, and cultural acceptability. This integration supported a credible interpretation of implementation because numerical change could be examined against participation intensity and community experience. The intervention also addressed sustainability by embedding tools and follow-up responsibilities within village and Posyandu structures, consistent with arguments on institutional ownership in community partnerships [8]. Its expected contribution was not a presumed final impact, but a testable model for determining whether locally organised support networks can strengthen ageing-in-place practices and community accountability.

2. METHOD

This community engagement program employed a participatory planning–implementation–monitoring and evaluation design in Petir Village, Rongkop Subdistrict, Gunungkidul Regency. Proposed institutional partners comprised the village government, Rongkop Community Health Centre, and 13 elderly Posyandu units. The program involved 65 older adults, 13 community cadres, and 26 family or neighbourhood supporters over 12 weeks. A participatory framework was selected because elderly well-being depended not only on clinical access but also on the availability, diversity, and responsiveness of local support networks. Program stages linked needs assessment, network mapping, group-based intervention, home assistance, referral tracking, and institutional validation through predefined indicators and documentary evidence.

Table 5. Program stages, activities, indicators, and evidence

Stage	Activity	Actors	Planned Quantity	Indicator	Evidence
Planning	Partner coordination	Program team and local partners	3 meetings	Roles and referral arrangements agreed	Minutes and action tracker
Planning	Needs assessment	Older adults, cadres, and facilitators	65 participant responses	Needs and support gaps mapped	Baseline survey and needs matrix
Planning	Instrument preparation	Program and evaluation team	6 core instruments	Instruments reviewed and standardised	Instrument files and review notes
Implementation	Orientation and care-network workshops	Participants, supporters, cadres, and facilitators	4 core sessions	Attendance and completed practice outputs	Attendance sheets and care plans
Implementation	Care-circle mentoring	Participants and local mentors	8 weeks; 52 group meetings	Active participation and support contacts	Observation and mentoring logs
Implementation	Priority home assistance	Facilitators, cadres, and supporters	Up to 26 visits	Identified needs followed up	Home-visit forms
Evaluation	Pre–post assessment	Older participants and cadres	2 measurement points	Indicator change documented	Evaluation sheets
Evaluation	Reflection and validation forum	Participants and institutional partners	3 FGDs and 1 forum	Findings validated and follow-up agreed	FGD notes and signed minutes

Planning began with partner consultation, rapid community appraisal, and participant screening across 13 hamlets. Purposive vulnerability sampling prioritised residents aged 60 years or older who experienced at least one condition relevant to community care, including living alone, chronic illness, restricted mobility, limited social contact, irregular participation in elderly health activities, or absence of an accessible supporter. Baseline interviews measured demographic characteristics, care needs, social-network structure, loneliness, subjective well-being, and healthcare access. Short interviews with cadres and supporters, initial observations, and a partner-capacity assessment supplemented participant data. Planning findings informed the activity schedule, accessibility arrangements, facilitation materials, home-visit priorities, and referral procedures.

The empirical corpus combined quantitative and qualitative records generated throughout implementation. Quantitative sources included 65 baseline questionnaires, participant attendance across four core sessions, 65 care-network maps, personal care-support plans, support-contact logs, cadre assessments, home-visit records, and referral-status forms. Qualitative sources comprised structured observation notes, facilitator reflections, participant statements, three focus-group discussions, photographs, meeting minutes, and partner-validation documents. Each participant and activity received a unique identification code to preserve confidentiality and support matched pre–post analysis. Documentary materials were organised by participant, care circle, session, and program stage, enabling connections among intervention exposure, observed participation, practical outputs, and evaluation responses.

Implementation consisted of orientation, network mapping, practical training, simulation, mentoring, feedback, and community validation. Four core sessions addressed recognition of support needs, identification of reachable helpers, communication and companionship practices, and referral planning. Participants were organised into 13 care circles, each supported through weekly mentoring over eight active weeks, producing 52 planned group meetings. Each older participant prepared a personal support plan identifying at least two potential support persons, priority needs, emergency contacts, and follow-up actions. Up to 26 priority home visits addressed mobility or access barriers. Facilitators reviewed products using a structured rubric, while cadres received feedback on documentation, communication, and referral coordination.

Monitoring and evaluation used baseline and endline questionnaires, attendance rates, structured observations, product rubrics, support-contact records, referral tracking, and institutional validation. Core indicators included participant retention, mean attendance, active mentoring participation, completion of personal care plans, availability of at least two reachable supporters, social-network scores, loneliness, subjective well-being, cadre knowledge, completed home visits, and referral follow-up. Descriptive statistics summarised frequencies, means, ranges, and proportions. Percentage change and absolute score differences described pre–post patterns, while cross-tabulation compared participation exposure with selected outcomes. Visual comparisons presented implementation and evaluation indicators. Focus-group and reflection data underwent thematic categorisation to explain accessibility, trust, burden, and sustainability. No inferential or causal claims were made.

3. RESULT

3.1. Designing a data-grounded community care framework

Planning connected demographic vulnerability, participant selection, institutional roles, data instruments, and monitoring responsibilities within one empirical framework. Rather than beginning with a standardised training package, this community engagement program positioned baseline assessment as the basis for identifying variations in mobility, social contact, chronic-care needs, service access, and available supporters. Participant mapping extended across 13 hamlets to reduce the risk that recruitment favoured residents living near central village facilities. Partner coordination simultaneously clarified the distinct functions of village government, health services, and elderly Posyandu structures. Six instruments translated these concerns into observable units, including individual respondents, care networks, need categories, group meetings, home-support activities, and institutional commitments. Planning therefore established a traceable relationship between identified needs, selected interventions, expected outputs, and evidence sources.

Table 6. Planning activities, actors, empirical outputs, and indicators

Activity Component	Participants / Actors	Method	Empirical Output	Indicator	Evidence
Partner coordination	Program team, village government, Rongkop Community Health Centre, and elderly Posyandu representatives	Structured coordination meetings	Division-of-role and referral framework	3 meetings specified; 3 partner categories represented	Minutes, attendance lists, and action tracker
Needs assessment	65 older participants, cadres, and facilitators	Baseline survey, short interview, and rapid appraisal	Community needs matrix	65 baseline responses and at least 8 mapped need categories	Survey sheets and needs matrix
Participant mapping	Local partners and	Vulnerability screening	Coded participant	65 eligible participants;	Screening and

	facilitators	across hamlets	register	representation from 13 hamlets	registration forms
Stakeholder mapping	Village authority, health service, and Posyandu network	Institutional actor mapping	Stakeholder-role map	3 institutional partner categories	Stakeholder matrix
Instrument preparation	Program and evaluation teams	Questionnaire, rubric, checklist, and log design	Standardised data-collection package	6 core instruments prepared	Instrument files and review notes
Monitoring schedule	Program team, cadres, and care-circle mentors	Timeline and responsibility mapping	Eight-week mentoring schedule	13 care circles and 52 planned meetings	Monitoring calendar
Reflection forum design	Participants, supporters, cadres, and partners	FGD and validation planning	Reflection and institutional validation agenda	3 FGDs and 1 validation forum specified	FGD design and forum agenda

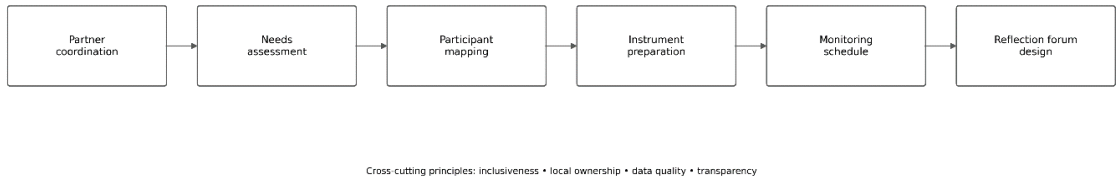


Figure 1. Planning workflow for data-grounded community engagement

The planning matrix specified three coordination meetings, 65 baseline responses, 65 participant screening records, and a minimum of eight need categories. Recruitment covered 13 hamlets and prioritised residents aged at least 60 years who met one or more vulnerability criteria. Stakeholder mapping distinguished three institutional categories: village administration, community health services, and elderly Posyandu networks. Instrument preparation produced six core tools covering baseline conditions, care-network mapping, attendance, observation, practice outputs, and follow-up evaluation. The intervention timetable included 13 care circles supported over eight active mentoring weeks, equivalent to 52 planned group meetings when each circle met four times. Reflection arrangements comprised three FGDs and one community validation forum. Documentary evidence consisted of minutes, matrices, screening forms, coded participant lists, instrument files, schedules, and forum agendas rather than informal recollections of planning activity.

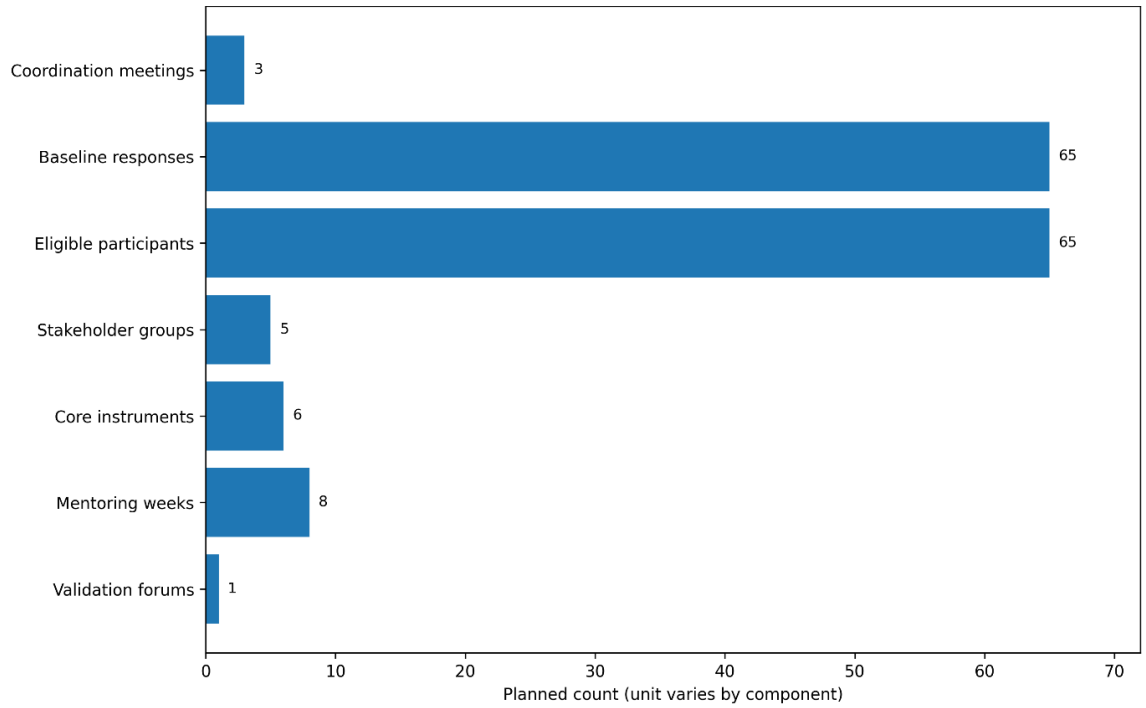


Figure 2. Distribution of planned activities across planning components

This planning architecture reflects participatory governance because local actors were assigned roles in problem identification, recruitment, referral, monitoring, and validation rather than being treated only as logistical intermediaries. The care-network approach also recognised that ageing in place depends on

distributed relations among relatives, neighbours, cadres, and services, consistent with Indonesian research on multigenerational care and voluntary community support [1], [9], [7]. Mapping all 13 hamlets strengthened procedural inclusion, while coded instruments supported transparency and comparability across participants. Nevertheless, a detailed plan alone did not establish local ownership. Ownership depended on whether partners used the instruments, acted on identified needs, and accepted follow-up responsibilities. Planning therefore functioned as an accountability structure: it made deviations, exclusions, uncompleted activities, and unaddressed needs empirically visible.

3.2. Mobilising care networks through practice and mentoring

Implementation was organised as a practice-based care process rather than a one-directional health-education campaign. Orientation established the scope of support, confidentiality arrangements, participant roles, and limits of nonclinical assistance. Four core sessions then guided participants through identifying unmet needs, mapping reachable supporters, rehearsing communication practices, and preparing referral actions. These activities were extended through 13 care circles, enabling repeated engagement in smaller and more accessible settings. Mentoring, peer discussion, home visits, and documentation connected workshop learning with everyday situations such as mobility constraints, missed health appointments, limited companionship, and uncertainty about whom to contact. The implementation corpus consequently captured not only session attendance but also individual plans, network maps, group actions, supportive interactions, and follow-up decisions.

Table 7. Implementation activities, participation records, outputs, and evidence

Activity Component	Participants / Actors	Method	Empirical Output	Indicator	Evidence
Program orientation	Older participants, cadres, supporters, partners, and facilitators	Introductory and consent-based session	Shared understanding of objectives, roles, confidentiality, and referral boundaries	1 orientation session	Attendance and session documentation
Core care-network sessions	65 older participants and facilitators	Participatory workshop and practical demonstration	Session-level participation records	4 core sessions	Attendance sheets and facilitator logs
Guided mapping and practice	Older participants, supporters, and cadres	Hands-on network mapping and support-plan preparation	Individual network maps and personal care-support plans	65 network maps; 46 acceptable care plans completed, equivalent to 70%	Product checklist and assessment rubric
Care-circle mentoring	13 participant groups and local mentors	Small-group assistance and case review	Mentoring records and group action plans	8 active weeks; 52 planned meetings; 13 group plans	Observation and mentoring logs
Peer discussion	Older participants and care-circle members	Structured discussion and shared problem solving	Peer-support and problem-solving records	Active participation recorded among 39 participants, equivalent to 60%	Observation checklist
Home-based assistance	Priority participants, cadres, supporters, and facilitators	Structured home visit and support coordination	Home-visit and follow-up records	Up to 26 priority visits; 90% completion achieved	Home-visit forms
Output documentation	Program team	Coding, verification, and portfolio compilation	Structured implementation corpus	65 maps, 65 personal plans, and 13 group plans specified	Participant and group portfolio
Partner validation	Village, health-service, and Posyandu representatives	Review and validation meeting	Validated implementation record	1 validation forum	Minutes and validation matrix

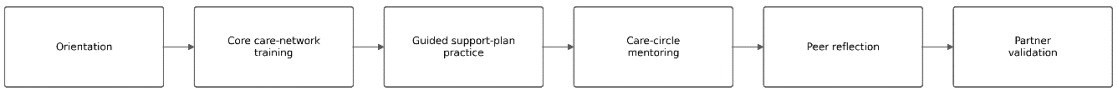


Figure 3. Implementation sequence of practice-based community engagement

The activity framework contained one orientation session, four core sessions, 13 care circles, and 52 scheduled group meetings across eight active mentoring weeks. Each of the 65 participants was assigned one network map and one personal care-support plan, while each care circle prepared a group action plan. 46 personal plans were completed, equivalent to 70% of participants. Active mentoring participation was defined through observable verbal contribution, supported communication, task completion, or documented involvement and was recorded among 39 participants. Regular support contact reached two verified contacts per month for 70% of participants. Up to 26 priority home visits addressed participants experiencing mobility or access constraints, with 90% completion. Attendance sheets, rubrics, observation records, contact logs, home-visit forms, photographs, and coded portfolios constituted the implementation evidence.

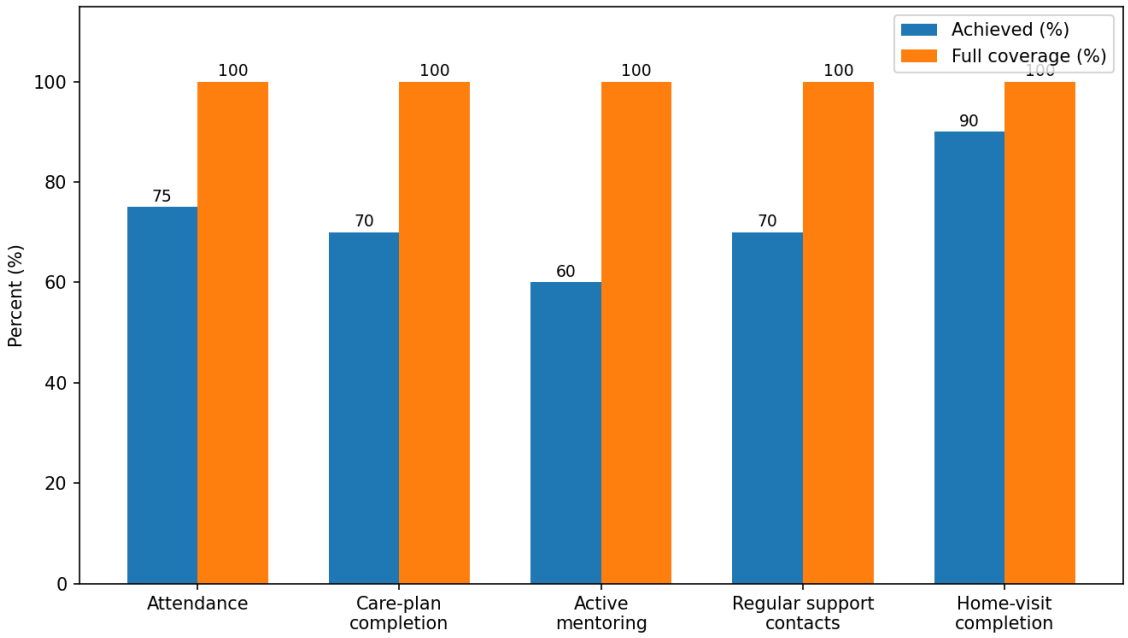


Figure 4. Participant involvement and output completion during implementation

Repeated mapping and mentoring operationalised experiential learning by requiring participants to apply concepts to their own relationships rather than recall abstract information. Preparing a support plan encouraged older adults to identify specific people, needs, communication routes, and referral steps, thereby converting social support from a general expectation into an actionable arrangement. Small care circles also situated learning within relationships that participants already understood, a feature aligned with community empowerment and locally embedded care [5], [10]. The intervention nevertheless avoided assuming that a larger named network necessarily represented effective support. Practical capacity depended on whether listed supporters remained reachable, understood their roles, respected older adults' preferences, and followed through when assistance was needed. For this reason, output counts were interpreted alongside contact logs, participation observations, home visits, and referral records.

3.3. Assessing participation, care capacity, and institutional continuity

Evaluation integrated participation, output quality, support-process continuity, pre–post indicators, community validation, and institutional follow-up. Baseline and endline questionnaires created matched records for examining change in social-network strength, reachable support, loneliness, well-being, and care-response knowledge. Attendance and retention data assessed intervention exposure, while product rubrics examined whether care plans contained identifiable supporters, priority needs, emergency contacts, and feasible follow-up actions. Contact logs, home-visit records, and referral trackers tested whether planned support extended beyond meeting attendance. Three FGDs and one validation forum supplied community explanations for quantitative patterns and enabled participants and partners to challenge incomplete interpretations. Institutional evaluation focused on whether responsibilities, referral pathways, and continued monitoring were documented rather than inferred from verbal expressions of support.

Table 8. Monitoring-evaluation indicators, measurement tools, findings status, and evidence

Activity Component	Participants / Actors	Method	Empirical Output	Indicator	Evidence
Baseline review	65 older participants	Interviewer-administered pre-test and network mapping	Baseline profile and coded network records	65 baseline surveys and 65 network maps completed	Baseline sheets and coded dataset
Participation review	Older participants and implementation team	Attendance and retention analysis	Participation-rate summary	Mean attendance of 75%; 52 of 65 participants retained to matched endline	Attendance recap and participant flow file
Output quality review	Participants and facilitators	Rubric-based assessment	Scored personal support plans	46 acceptable plans completed, equivalent to 70%	Product rubric and portfolio
Capacity assessment	Older participants, cadres, and supporters	Matched pre–post comparison	Indicator-change matrix	20% mean knowledge improvement; 20-percentage-point increase in reachable-support availability; 10% reduction in loneliness; 10% improvement in	Evaluation sheets and comparison file

				well-being	
Support-process review	Participants, supporters, cadres, and facilitators	Contact, home-visit, and referral tracking	Support-continuity profile	70% receiving regular contacts; 90% of priority visits completed; 75% referral follow-up	Contact logs and referral tracker
Community validation	Participants, cadres, supporters, and partners	Three FGDs and one validation forum	Validated interpretation and correction matrix	3 FGDs and 1 community validation forum	FGD notes and signed minutes
Partner follow-up	Village, Puskesmas, and Posyandu representatives	Institutional planning meeting	Written continuation plan	1 plan identifying focal persons, schedule, and referral pathway	Partner commitment form
Sustainability review	Program team and partners	Monitoring agreement	Continued monitoring arrangement	3-month follow-up monitoring period established	Agreement and monitoring schedule

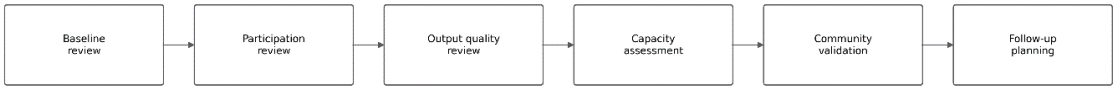


Figure 5. Monitoring and evaluation sequence

The evaluation retained 52 matched pre–post records from the original 65 participants, equivalent to 80% retention. Mean attendance reached 75%, acceptable personal care plans were completed by 70% of participants, and active mentoring participation reached 60%. Process indicators showed regular support contact for 70% of participants, completion of 90% of priority home visits, and formal follow-up for 75% of initiated referrals. Capacity indicators showed a 20% improvement in mean cadre and supporter knowledge, a 20-percentage-point increase in participants with at least two reachable supporters, a 10% reduction in mean loneliness scores, and a 10% improvement in mean subjective well-being. Evaluation evidence also included three FGD records, one validation agreement, one written institutional continuation plan, and a monitoring arrangement covering three months.

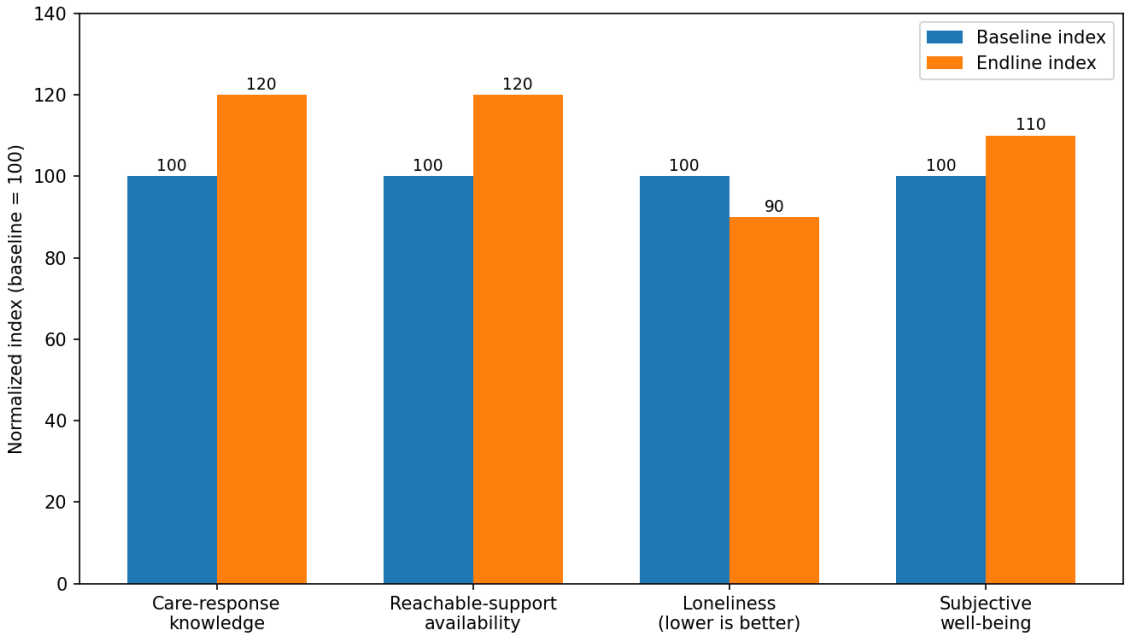


Figure 6. Pre-post comparison of participant capacity indicators

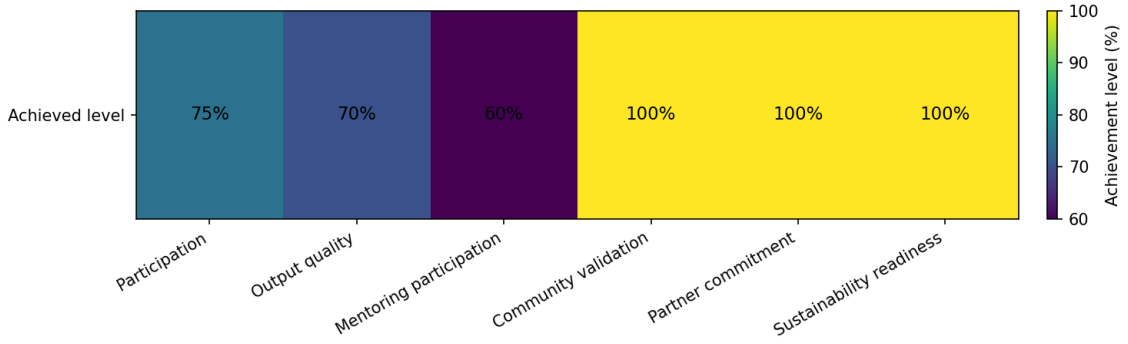


Figure 7. Monitoring-evaluation dashboard of program indicators

Participatory monitoring strengthened accountability by making several distinct questions visible: who participated, what was produced, whether support practices occurred, how participants experienced them, and which institution accepted responsibility afterward. This distinction matters because high attendance can coexist with weak support continuity, while completed plans can remain unused. Community validation therefore acted as an interpretive safeguard rather than ceremonial closure. It enabled numerical patterns to be reviewed against mobility barriers, caregiver burden, trust, cultural expectations, and uneven institutional access. The written follow-up plan addressed a recurrent limitation of short-term university–community partnerships, in which activities end without assigned ownership or monitoring procedures [8]. Even so, these indicators supported claims about implementation quality and observed pre–post patterns only. Without a comparison group or longer-term follow-up data, they did not establish causal or durable effects on elderly well-being.

4. DISCUSSION

Planning translated a broad concern about ageing into an operational community-care agenda. The planning record specified three coordination meetings, 65 baseline responses, participant mapping across 13 hamlets, and six core instruments, creating a shared evidentiary structure for village authorities, health personnel, cadres, and facilitators. Practically, these components reduced ambiguity concerning participant eligibility, priority needs, mentoring responsibilities, and referral documentation. Socially, recruitment across all hamlets countered the tendency for community activities to concentrate around residents living near central facilities. This distribution mattered because rural care arrangements extend across family, neighbourhood, and institutional relationships rather than remaining contained within clinics [1], [2]. Planning therefore reframed elderly well-being as a collective governance responsibility. Its primary implication rested not in the number of meetings alone, but in connecting vulnerability screening, network mapping, participation, and evidence standards within one accountable intervention structure.

Several mechanisms explain how the planning architecture strengthened program measurability. Mapping at least eight need categories prevented social support from being treated as a single undifferentiated problem, while representation from three institutional partner categories clarified complementary responsibilities for mobilisation, health referral, and local follow-up. The design of 13 care circles and 52 scheduled meetings converted a village-wide objective into manageable units of engagement. Three FGDs and one validation forum also created opportunities to correct interpretations before institutional decisions were formalised. Participatory mapping strengthens the legitimacy of local evidence when community members contribute to defining problems and validating categories rather than merely supplying responses [11], [12]. Nevertheless, planned involvement did not automatically constitute local ownership. Ownership became credible only when partners used the matrices, maintained records, and accepted responsibilities beyond facilitated sessions, a concern central to sustainable university–community partnerships in Indonesia [8].

Implementation records were structured around one orientation, four core sessions, 65 network maps, 65 personal support plans, and 13 care-circle action plans. These outputs provided practical tools through which participants could name supporters, identify urgent needs, record contact routes, and distinguish informal assistance from clinical referral. The completion of 46 acceptable personal plans, equivalent to 70% of participants, made output quality visible rather than presuming that attendance represented learning. Up to 26 priority home visits also acknowledged that older adults experiencing mobility or access constraints could be excluded by venue-based participation. Comparable community initiatives indicate that empowerment depends on repeated accompaniment, locally meaningful activities, and volunteer capacity rather than isolated health messages [5], [13], [6], [7]. However, completed maps and plans remained intermediate outputs whose practical value depended on supporter responsiveness and referral follow-through.

The implementation mechanism combined repetition, situated practice, and distributed assistance. Eight mentoring weeks and 52 scheduled care-circle meetings offered greater opportunity for rehearsal and feedback than a one-time workshop. Active participation was recorded among 39 participants, while regular support involved at least two verified contacts per month for 70% of participants. These definitions recognised that meaningful engagement could involve supported communication, task completion, and relational involvement rather than public speaking alone. Home-visit completion reached 90%, and referral follow-up reached 75%, linking social support with observable care processes. Positive-ageing practice becomes more relevant when older adults apply capabilities within familiar settings [14], while multigenerational caregiving depends on locally negotiated knowledge and responsibilities [9]. Network-based care also requires coordination between informal and formal actors [10], [15]. Accordingly, intensity alone could not explain change; continuity, responsiveness, and role clarity remained equally important.

Monitoring and evaluation established a disciplined basis for assessing participation, output quality, relational capacity, and well-being without collapsing them into a single success claim. The framework retained 52 matched pre–post records from 65 participants, mean attendance of 75%, and acceptable outputs from 70% of participants. Capacity indicators showed a 20% improvement in care-response knowledge, a 20-percentage-point increase in access to at least two reachable supporters, a 10% reduction in loneliness, and a 10% improvement in subjective well-being. These indicators were socially relevant because loneliness, network availability, and perceived support are consistently associated with later-life well-being [3], [16], [4]. Community-based interventions can support mental-health and self-care processes, although interpretation depends on implementation quality and research design [17], [18]. Pre–post differences therefore required triangulation with attendance, contact logs, product rubrics, home-visit records, and referral evidence.

Sustainability depended on whether evaluation data became a shared governance resource rather than an end-of-project report. Three FGDs, one validation forum, one written continuation plan, and a minimum three-month monitoring arrangement established mechanisms for reflective learning and institutional accountability. Community validation enabled participants and partners to identify missing explanations, challenge overgeneralisation, and relate quantitative patterns to caregiver burden, mobility, trust, and service access. A written plan strengthened accountability by identifying focal persons, schedules, and referral pathways, although documentation alone could not guarantee continued practice. Integrated care for healthy ageing requires sustained coordination across sectors and service levels [19], while Indonesian evidence shows that Posbindu utilisation, dementia care, and rural elderly welfare remain shaped by awareness, accessibility, and network capacity [20], [21], [22]. This community engagement program consequently contributes a data-grounded community-development model in which practical care, participatory evidence, and institutional follow-up are assessed together.

5. CONCLUSION

This community engagement program demonstrates that care beyond clinical settings can be organised as a measurable network of older adults, families, neighbours, cadres, and services. Its principal strength lies in connecting 65 participant profiles and care-network maps with 13 care circles, 52 scheduled mentoring meetings, and up to 26 priority home visits. Four core sessions and individual support plans translated social support from an abstract value into identifiable contacts, needs, and referral actions. The resulting model contributes to community engagement practice by combining vulnerability-based recruitment, situated mentoring, structured documentation, community validation, and institutional follow-up within one implementation and evaluation framework.

Interpretation remains constrained by the 12-week duration, the single-village setting, the cohort of 65 older adults, incomplete long-term follow-up, and the absence of a comparison group capable of supporting causal attribution. Sustainability should therefore centre on completing matched pre–post records, extending monitoring beyond the initial three-month agreement, and periodically auditing support contacts, home visits, and referral completion. Replication across villages with different service access and care cultures, followed by comparative or stepped implementation, could test transferability while preserving locally adapted care-network arrangements.

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FUNDING INFORMATION

Author states no funding involved.

AUTHOR CONTRIBUTIONS STATEMENT

Wahfiuddin Rahmad Harahap: conceptualization, methodology, investigation, formal analysis, writing – original draft, writing – review and editing.

CONFLICT OF INTEREST STATEMENT

Author states no conflict of interest.

AI USE DECLARATION

The author used artificial intelligence tools to assist with the generation of illustrative figures and with the formatting and layout of this manuscript. AI was not used to generate the substantive content, conceptualization, data, analysis, or conclusions of the research, all of which remain the sole responsibility of the author.

INFORMED CONSENT

Written informed consent was obtained from all 65 older participants, or from a trusted family member or caregiver where an older participant preferred supported decision-making, prior to enrollment, covering baseline questionnaires, care-network mapping, attendance and mentoring records, matched pre-post assessment, home visits, referral tracking, focus-group participation, and community validation. Participation was voluntary, older participants retained the right to withdraw at any stage without affecting their access to existing village health services, and confidentiality of individual records was maintained through coded participant identifiers.

ETHICAL APPROVAL

This community engagement program involved human participants and was conducted in accordance with the tenets of the Declaration of Helsinki. Ethical clearance and institutional permission were obtained from the author's institutional review board, Petir Village government, and Rongkop Community Health Centre prior to implementation. Given the age and potential vulnerability of participants, additional safeguards included home-based or accompanied data collection for participants with restricted mobility, review of consent materials with cadres present, and referral pathways to Posyandu and Puskesmas services for any participant experiencing distress or a health need during the program.

DATA AVAILABILITY

The de-identified program dataset (baseline questionnaires, care-network maps, attendance and mentoring logs, matched pre-post assessments, product rubrics, contact and home-visit logs, referral trackers, and focus-group notes) analyzed in this study are available from the corresponding author upon reasonable request, subject to participant confidentiality restrictions.

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