



The Relationship Between Family Self Efficacy and the Success of Home Care

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Abstract

Background: Family self-efficacy plays an essential role in determining the quality of home care provided to postoperative patients. Low self-efficacy may lead to inadequate care performance and hinder optimal recovery. **Purpose:** To determine the relationship between family self-efficacy and the success of home care among postoperative patients at RSUD Sekarwangi. **Method:** This study used a quantitative approach with a cross-sectional design. A total of 30 family members who provided home care for postoperative patients were included as respondents. The General Self Efficacy Scale (GSES) was used to measure self-efficacy, while the Resident Assessment Instrument Home Care (RAI-HC) assessed home care success. **Analysis technique:** Data were analyzed using the Chi-Square test to examine the relationship between variables. **Results:** Most respondents demonstrated good self efficacy (73.3%) and good home care success (73.3%). The Chi Square test showed a significant relationship between family self-efficacy and home care success ($p = 0.000$; $p < 0.05$). **Conclusion:** There is a significant relationship between family self efficacy and the success of home care among postoperative patients at RSUD Sekarwangi. Enhancing family education and strengthening confidence are recommended to improve home care quality and support optimal patient recovery.

Keywords: self-efficacy; family; home care; postoperative patients.

Introduction

Postoperative recovery continues after hospital discharge, and the quality of care provided at home can influence how safely patients complete wound care, medication use, mobility exercises, nutrition, and symptom monitoring. Family members commonly assume these responsibilities when formal home services are limited. Training for home care has been associated with greater readiness to perform daily care tasks¹. Home care support can also strengthen family independence in managing the needs of a recovering family member². These observations provide a practical basis for

examining caregiver confidence as one component of postoperative continuity of care.

Self efficacy refers to a person's perceived capability to organize and perform actions needed to manage demanding situations. In postoperative and chronic care contexts, higher self efficacy has been associated with better performance of daily activities³, stronger motivation to carry out health related tasks⁴, more consistent wound care behavior⁵, and more active self care after stroke⁶. These findings do not establish that self efficacy alone determines clinical recovery, but they suggest that perceived capability can be relevant when families must translate discharge instructions into repeated care activities at home.

Family caregiving involves more than the presence of relatives. Readiness to provide care can depend on knowledge, confidence, practical skill, communication with health professionals, and the ability to respond to changes in the patient's condition. Family self efficacy has been reported in relation to readiness for caregiving⁷, while family knowledge and support have been associated with self care after stroke⁸. Studies of self management also show that self efficacy is related to the ability to sustain health behaviors over time⁹, including among older adults who require continued family support¹⁰. Therefore, the family caregiver's confidence deserves specific attention when postoperative care shifts from the hospital to the home.

Evidence published in *Healthy Tadulako Journal* also supports the relevance of confidence, structured home care, family capability, and education. Self efficacy has been associated with treatment adherence and quality of life in patients with hypertension¹¹. Pharmacist led home care has been used to support adherence and clinical management outside the hospital¹². Family education and guidance can improve the family's capability to perform care tasks at home¹³, while family psychoeducation can strengthen coping among relatives who face sustained caregiving demands¹⁴. Together, these studies support the importance of evaluating family caregiving capacity while avoiding the assumption that confidence by itself causes a favorable clinical outcome.

At RSUD Sekarwangi, the available study data focused on family caregivers of postoperative patients and recorded family self efficacy together with a dichotomous home care outcome. The research question was whether family self efficacy was associated with home care success among these caregivers. The hypothesis was that the two variables were associated. The objectives were

to describe family self efficacy, describe the recorded home care outcome, and examine the statistical association between both variables. Because the design measured exposure and outcome at one point in time, the study was intended to identify an association rather than a causal effect.

Materials and Methods

Study Design

This study used a quantitative analytic design with a cross sectional approach. Family self efficacy was treated as the independent variable and the study defined home care outcome as the dependent variable. Both variables were measured during the same assessment period, so temporal sequence could not be established. Cross sectional analysis is appropriate for estimating whether variables are associated within an observed sample, but it cannot demonstrate that one variable causes the other¹⁵. The interpretation in this manuscript therefore uses association language consistently.

Sample

The study used purposive sampling and included 30 family members who provided care for postoperative patients connected with RSUD Sekarwangi. The source manuscript identifies these 30 caregivers as respondents who met the study inclusion criteria, but it does not provide the complete sampling frame, detailed inclusion and exclusion criteria, postoperative procedure types, caregiver relationship, time since surgery or discharge, or the exact recruitment dates. These details were not reconstructed because doing so would create information that is not supported by the study records. No prospective effect based sample size calculation was documented. With $n = 30$, a two sided alpha of 0.05, and 80 percent power, a sensitivity calculation indicates that only a very large association of approximately

$\phi = 0.51$ or greater would be detectable¹⁶. The small purposive sample therefore limits precision and generalizability.

The sample was drawn from caregivers who were available in the hospital service network and could participate in the assessment. This recruitment approach may favor caregivers who were more engaged with follow up care and may underrepresent families with limited access, heavier caregiving burden, or lower contact with health services. Because age, educational level, socioeconomic status, relationship to the patient, surgery type, comorbidity, postoperative complications, and formal home care support were not available in the manuscript dataset, these variables could not be assessed as potential confounders.

Data Collection Technique

Primary data were obtained from family caregivers using the instruments named in the original study record. Family self efficacy was assessed with the General Self Efficacy Scale. The standard Generalized Self Efficacy Scale developed by Schwarzer and Jerusalem contains 10 items, uses four response categories per item, and yields a total score from 10 to 40, with higher scores indicating greater perceived self efficacy¹⁷. An Indonesian adaptation of the standard instrument exists. However, the archived study manuscript does not specify the exact language version administered, the item wording used, the cut off that converted the score into the reported good and poor categories, the adaptation procedure, or reliability coefficients for this sample. These missing details are reported transparently rather than reconstructed.

The General Self Efficacy Scale measures a general sense of personal capability. In this study the respondents were family caregivers, so the score is interpreted as the caregiver's perceived self efficacy while providing care, not as a separately validated family system

construct. This distinction is important because a general self efficacy measure does not automatically establish competence for specific postoperative tasks. Future replication should document the exact Indonesian version, scoring rule, category threshold, content validity for caregiving activities, and internal consistency in the study sample.

The home care outcome was described in the source manuscript as being assessed with the Resident Assessment Instrument Home Care. The interRAI Home Care system is designed as a comprehensive assessment framework that can draw on interviews, clinical observation, records, and caregiver information, and its items have demonstrated acceptable reliability when used by trained assessors¹⁸. The source manuscript, however, does not identify the exact RAI HC or interRAI HC edition, the items or scales selected, the respondent or rater, the scoring algorithm, the basis for the binary good and poor classification, or whether the required instrument permission was obtained. Accordingly, the outcome in this article is described as the study specific home care classification recorded by the investigators rather than as a standard interRAI success score.

Data Analysis Technique

Data analysis was performed using the categorical counts reported in the study. Univariate analysis summarized respondent gender, family self efficacy category, and home care category as frequencies and percentages. The displayed margins were checked arithmetically: 22 respondents were classified as having good self efficacy and 8 as poor, while 22 were classified as having a good home care outcome and 8 as poor. The manuscript reports no missing observations in these variables. Because record level raw data were not supplied with the manuscript, independent

verification of individual coding, cut off application, and possible overlap between the two classification procedures was not possible.

For the association analysis, the 2 by 2 table contained complete separation: all 22 respondents in the good self efficacy category were also in the good home care category, and all 8 respondents in the poor self efficacy category were also in the poor home care category. One expected cell count was below 5, so the Pearson Chi Square approximation was not considered appropriate. The table was therefore reanalyzed using a two sided Fisher exact test. Statistical significance was defined as $p < 0.05$. Strength of association was summarized with the phi coefficient. Based on the reported cross tabulation, Fisher exact p was less than 0.001 and phi was 1.00, indicating perfect correspondence in this sample. The conventional odds ratio is infinite because both discordant cells are zero, so it was not reported as a stable effect estimate.

The perfect correspondence required a cautious interpretation. The marginal totals and the cells in Table 2 are internally consistent, but the absence of discordant observations is unusual and can arise from a genuine strong relationship, overlapping operational definitions, duplicated scoring information, or coding error. The record level data and original scoring sheets were not available for an independent audit. Therefore, the analysis confirms the mathematical result for the reported table but does not claim that the underlying classifications have been independently validated.

No adjusted regression model was performed because the available manuscript did not provide individual data on potential confounders such as caregiver age, education, relationship to the patient, type of surgery, time since discharge, comorbidity, wound condition, socioeconomic factors, or professional home care support. Residual confounding must

therefore be considered when interpreting the observed association.

Ethical Consideration

Ethical approval was reported from the Ethics Committee of the Faculty of Health Sciences, Muhammadiyah University of Sukabumi, approval number 086/KET/KE-FKES/I/2025. The submitted manuscript did not describe the informed consent process, confidentiality procedures, data anonymization, or instrument licensing arrangements in sufficient detail. These procedures should be confirmed against the approved study protocol before final publication. No additional participant level information was created during this revision.

Result

The analysis included 30 family caregivers of postoperative patients associated with RSUD Sekarwangi. The source manuscript did not provide the exact recruitment dates or a breakdown by surgical procedure, time since discharge, or caregiver relationship. Results are therefore limited to the characteristics and variables that were actually reported: gender, family self efficacy category, and home care category.

Table 1. Distribution of Respondent Characteristics (n = 30)

Characteristics	Frequency	%
Gender		
Male	16	53.3
Female	14	46.7
Self Efficacy		
Good	22	73.3
Poor	8	26.7
Home Care		
Adherent	22	73.3
Non Adherent	8	26.7

Source: SPSS Data Analysis

Table 1 shows that 16 respondents were male (53.3 percent) and 14 were female (46.7 percent). Family self efficacy was classified as good in 22 respondents (73.3 percent) and poor in 8 respondents (26.7 percent). The

distribution describes the study sample only and does not imply that gender was associated with either self efficacy or home care outcome because no inferential gender analysis was reported.

The study specific home care outcome was classified as good in 22 respondents (73.3 percent) and poor in 8 respondents (26.7 percent). These proportions are identical to the marginal distribution of family self efficacy, which made examination of the joint classification particularly important. The identical marginal totals alone do not establish association; the cell pattern in Table 2 determines whether the classifications correspond within individual respondents.

Table 2. Relationship Between Self Efficacy and Home Care Outcome (n = 30)

Self Efficacy	Home Care Outcome				Total		P Value
	Good		Poor		F	%	
	F	%	F	%			
Good	22	100.0	0	0.0	22	100.0	<0.001
Poor	0	0.0	8	100.0	8	100.0	
Total	22	73.3	8	26.7	30	100.0	

Source: SPSS Data Analysis

Table 2 shows complete separation between the two reported classifications. All 22 respondents with good family self efficacy had a good home care outcome, whereas all 8 respondents with poor family self efficacy had a poor home care outcome. Because the table was small and contained zero cells, Fisher exact test was used. The association was statistically significant ($p < 0.001$), and $\phi = 1.00$ indicated perfect correspondence between the two categories in the observed sample.

The perfect effect size should not be interpreted as proof that self efficacy causes home care success. It describes the reported sample and depends on the validity and independence of the two classification procedures. The aggregate table was internally consistent with the marginal totals, but record

level data, original questionnaires, cut off documentation, and missing data logs were not available for independent verification. The result therefore warrants confirmation in a larger sample using prospectively specified and independently scored measures.

Discussion

The descriptive findings show that caregiving responsibilities were represented by both men and women, with only a small difference in frequency. The study did not test a gender effect, so the distribution should be interpreted descriptively. More relevant to the study question, 73.3 percent of caregivers were classified as having good self efficacy. In postoperative settings, self efficacy has been associated with adherence to mobilization exercises and the ability to persist with recommended activities¹⁹. Family support has likewise been discussed as an important context for maintaining self care in people recovering from disabling conditions²⁰.

Family caregiving competence depends on both confidence and access to clear professional guidance. Clinical and academic supervision models illustrate the broader importance of structured support for care quality²¹. In chronic disease settings, self efficacy and self management have also been linked with quality of life²². These findings are consistent with the conceptual premise that a caregiver who feels capable may be more prepared to carry out repeated care tasks. Nevertheless, the present data do not show whether confidence preceded successful home care or developed as caregivers experienced successful care.

Knowledge is another plausible contributor to caregiver confidence. Family knowledge has been associated with self efficacy in preventing recurrent stroke²³, and postoperative research has described self efficacy in relation to mobilization behavior²⁴.

These studies support the need to distinguish perceived capability from actual technical competence. A caregiver may report high confidence while still requiring instruction on wound care, medication administration, warning signs, nutrition, mobility, and follow up. Future studies should therefore pair self efficacy measurement with objective or clinician rated indicators of care performance.

The clinical relevance of adequate home care is clear because postoperative complications such as surgical site infection can have substantial consequences²⁵. Family support has also been associated with self efficacy in populations requiring ongoing recovery assistance²⁶. However, the present cross sectional study did not directly measure reduction in infection, rehospitalization, or recovery time. The outcome was a dichotomous home care classification, so conclusions should remain limited to the association between the two recorded study variables.

The Fisher exact result was extremely small and phi equaled 1.00 because every observation fell on the diagonal of the 2 by 2 table. Statistically, this is complete separation. Substantively, such a pattern deserves verification rather than stronger causal language. A perfect relationship may occur in a small sample, but it can also appear when the exposure and outcome classifications share content, when identical decision rules are used, or when coding has been copied between variables. The original record level data and scoring forms were not available during manuscript revision, so the independence of the classifications could not be audited.

Measurement interpretation is especially important for the General Self Efficacy Scale. The standard instrument measures a broad personal belief in one's capacity to cope with difficult situations¹⁷. In the present study, respondents were family caregivers, so the score can reasonably describe the caregiver's

perceived general efficacy, but it should not be presented as a validated measure of family system efficacy unless such validation was performed. The unavailable study documentation on the exact language version, category threshold, and reliability prevents a stronger psychometric claim.

The RAI HC related outcome also requires caution. The interRAI Home Care approach is a multidomain assessment system intended to support comprehensive assessment and care planning, with information gathered from several sources and interpreted by trained assessors¹⁸. A single binary classification of good versus poor home care is therefore a study specific operationalization that requires an explicit scoring algorithm. Because the edition, selected items, rater procedure, cut off, and license status were not documented in the submitted manuscript, reproducibility is limited. A future study should predefine a transparent scoring rule or use validated outcome scales and should separate the caregiver self efficacy assessment from the home care outcome assessment.

From a service perspective, the results still identify a useful area for further evaluation. Structured home care and professional education have been associated with better adherence and care related management in community settings¹². Families can develop practical caregiving capability when health professionals provide education and guided care activities¹³, and psychoeducation can support coping under sustained caregiving demands¹⁴. These findings justify prospective evaluation of caregiver education and confidence building, but they should not be used to infer that such interventions will improve postoperative outcomes without direct testing.

Several limitations affect interpretation. The study included only 30 purposively selected caregivers from one hospital service

network, and no prospective effect based sample size calculation was documented. Potential confounders, including caregiver age, education, economic circumstances, relationship to the patient, surgery type, time since discharge, comorbidity, wound status, and access to professional home care, were unavailable for adjusted analysis. The cross sectional design prevents temporal inference. In addition, the exact scoring and psychometric procedures for both variables were incompletely documented, and the perfect separation could not be independently checked against record level data. Larger studies should use transparent scoring protocols, independently measured constructs, adequate sample size planning, repeated home care assessment, and clinically defined postoperative outcomes.

The conceptual distinction between perceived capability and observed care performance also affects interpretation of the perfect table. General self efficacy is intentionally broad and reflects confidence in managing demanding situations¹⁷. Home care performance, in contrast, should ideally represent observable or independently rated behavior. If both variables were categorized using similar subjective judgments from the same respondent, common method variance could increase their apparent agreement. A stronger design would obtain the self efficacy score from the caregiver while assessing home care behavior through a separate checklist, clinician observation, patient record, or independent assessor who is unaware of the caregiver's self efficacy category.

Repeated measurement would also improve the meaning of a home care outcome. Comprehensive interRAI assessments are intended to support assessment and care planning across multiple health and functional domains¹⁸. For postoperative research, an initial assessment soon after discharge could

establish baseline needs, followed by a later assessment to document change in wound status, function, medication management, symptom burden, and service use. Such a design would allow investigators to distinguish baseline caregiving capacity from subsequent outcome and would reduce the ambiguity created by classifying both variables at a single time point.

The practical implication of the current study is therefore not that confidence alone guarantees successful care, but that caregiver capability should be assessed as part of discharge planning. Structured home care delivered with professional input has shown benefits for adherence and clinical management in community care¹². Family members can also acquire specific care skills through health education and guided practice¹³. A postoperative program could combine demonstration of wound care and medication procedures, written instructions, return demonstration, warning sign recognition, and scheduled contact with health professionals. The effect of such a program should be tested directly rather than inferred from this cross sectional association.

Future research should specify the primary outcome before data collection, document the exact instruments and permissions, and use a sample size calculation based on an anticipated effect. Independent scoring procedures should be established before recruitment, and assessors should be trained using written definitions. Potential confounders should be collected prospectively so that adjusted estimates can be reported. If an educational or psychoeducational intervention is evaluated, caregiver confidence, caregiver burden, care performance, and patient outcomes should be measured separately because family focused education may affect several dimensions of caregiving at the same time¹⁴. These steps

would make the observed association more reproducible and clinically interpretable.

Conclusion

Among 30 family caregivers of postoperative patients at RSUD Sekarwangi, family self efficacy was strongly associated with the study specific home care outcome. All 22 caregivers classified as having good self efficacy also had a good home care outcome, while all 8 caregivers with poor self efficacy had a poor outcome. Fisher exact testing produced $p < 0.001$ and $\phi = 1.00$. Because the study was cross sectional, used purposive sampling, had a small sample, and lacked complete documentation of instrument scoring and potential confounders, the result should be interpreted as an observed association rather than a causal effect. Confirmation using independently scored and fully documented measures in a larger prospective sample is required.

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Conflict of Interest Statement

The author(s) declare no commercial, financial, or personal conflicts of interest related to this research. All authors approved the final manuscript and consented to its publication in *Healthy Tadulako Journal*.

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