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Implementation of ILP Through Posyandu: Gap in Life Cycle Group Coverage at Tirtomoyo I Wonogiri Health Center

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Abstract

Integrasi Layanan Primer (ILP), or Primary Health Care Integration, expands Posyandu (integrated community health post) services through a life-course approach; however, expanding the target population does not necessarily ensure equitable service utilization. This study examined ILP implementation through Posyandu in terms of communication, resources, implementers' disposition, and bureaucratic structure, while identifying disparities in service coverage across life-course groups. A mixed-methods sequential explanatory design was employed. Quantitative data on Posyandu ILP visit coverage in 2025 across nine villages and urban wards within the Tirtomoyo I Community Health Center service area, Wonogiri Regency, were analyzed descriptively. Subsequently, in-depth interviews were conducted with eight informants purposively selected from two villages or urban wards. Quantitative and qualitative findings were integrated using the Edwards III policy implementation framework. The results indicated an average visit coverage rate of 61.67%, with the highest coverage among infants and toddlers (97.22%) and the lowest among adolescents (31.67%), representing a disparity of 65.55 percentage points. Qualitative findings suggested that these disparities were associated with limitations in communication, resources, and bureaucratic structure, whereas implementers generally demonstrated positive attitudes toward the program. Overall, ILP implementation through Posyandu had not achieved equitable service coverage across life-course groups. Improving coverage equity requires strengthening resource availability, developing communication strategies tailored to specific target groups, enhancing community health volunteer (kader) competencies, improving intersectoral coordination, and reinforcing organizational structures supporting program implementation.

INTRODUCTION

Primary health care is a fundamental component of achieving universal health coverage (UHC), as it supports the provision of integrated, equitable, and community-based health services. Setiaasih et al., 2025a; I. Fitri et al., 2026) To strengthen primary health care, the Indonesian government introduced the Integrasi Layanan Primer (ILP), or Primary Health Care Integration, policy, which integrates primary health services through a life-course approach (Ministry of Health of the Republic of Indonesia, 2023). This approach organizes health services according to the specific health needs of individuals at different stages of life rather than focusing exclusively on disease categories (WHO & World Bank, 2023).

Under the ILP policy, the service functions of Posyandu (integrated community health posts) have been expanded to encompass all life-course groups, including pregnant women, infants and toddlers, adolescents, working-age adults, and older adults. This transformation

requires Posyandu to extend their traditional maternal and child health services to reach a broader population. In Central Java, ILP is implemented through a network of Puskesmas (community health centers), Puskesmas Pembantu (auxiliary community health centers), and Posyandu. Central Java Governor's Decree No. 441.7/16 of 2024 designated these facilities as implementing institutions for ILP in the province. This policy reflects the government's commitment to transforming primary health care delivery. However, expanding the target population also requires effective translation of policy directives into community-level practices to ensure equitable access across life-course groups (Sambodo et al., 2023). Equitable service coverage is essential because each population group faces distinct health risks that require timely screening, early detection, and appropriate interventions (Ministry of Health of the Republic of Indonesia, 2023; Government of Central Java Province, 2024). Uneven service coverage may limit opportunities for preventive care and early intervention among underserved groups, potentially undermining ILP's objective of providing continuous health services throughout the life course, despite the formal establishment and operational status of Posyandu (Hameed et al., 2024).

Institutionally, Wonogiri Regency has established an extensive network of active Posyandu. The 2025 Wonogiri Regency Health Profile reported that all 2,156 registered Posyandu (100%) were classified as active, including all facilities within the service area of Tirtomoyo I Community Health Center. However, the active status of 86 Posyandu distributed across nine villages and urban wards in this service area did not necessarily translate into equitable service coverage across life-course groups (E. S. Fitri et al., 2024a). Secondary data on ILP visit coverage in 2025 revealed substantial differences among target populations. Coverage was highest among infants and toddlers (97.22%), followed by pregnant women (82.33%), older adults (51.33%), working-age adults (45.89%), and adolescents (31.67%). The difference between the highest and lowest coverage rates was 65.55 percentage points, indicating a substantial disparity between infants and toddlers and adolescents. These findings suggest that the expansion of service targets under ILP has not been accompanied by equally successful outreach and service utilization across all life-course groups. Consequently, understanding these disparities requires examining not only quantitative coverage achievements but also the processes through which ILP policies are interpreted, operationalized, and implemented at the Posyandu level (Wonogiri Regency Health Office, 2025; Tirtomoyo I Community Health Center, 2026).

Previous studies have identified several challenges associated with ILP implementation through Posyandu. Research conducted in Nagari Kasang indicated that program implementation continued to face constraints related to human resource capacity, infrastructure, coordination, and community participation, particularly among population groups beyond the traditional maternal and child health service targets (Putri & Adnan, 2025). Similarly, research examining the readiness of ILP Posyandu community health volunteers (kader) in Yogyakarta emphasized the importance of strengthening volunteer competencies through adequate logistical support, financing, training, and community engagement (Siswati et al., 2025a). Another study focusing on adolescent Posyandu services in Pasuruan identified communication barriers and bureaucratic constraints that hindered effective service implementation, particularly when policy information was inadequately disseminated and

procedural support remained insufficient (Wiyanto & Choiyirah, 2025a). Collectively, these studies indicate that ILP implementation is influenced by community health volunteer readiness and competence, resource availability, institutional support from village governments and community health centers, coordination among stakeholders, and community participation. Nevertheless, previous research has predominantly examined volunteer preparedness or implementation processes within specific settings, with limited attention to how these implementation factors relate to differences in service coverage across life-course groups (González et al., 2025).

These limitations highlight the need for a comprehensive investigation that not only describes disparities in service coverage but also examines the organizational and operational factors underlying ILP implementation at the Posyandu level. The policy implementation framework developed by Edwards III provides a relevant analytical perspective through four interconnected dimensions: communication, resources, implementers' disposition, and bureaucratic structure (Edwards, 1980). These dimensions offer a systematic basis for examining how policy directives are communicated, how resources are allocated, how implementers respond to policy requirements, and how administrative arrangements facilitate or constrain service delivery. Applying this framework to ILP implementation may help explain the organizational conditions associated with variations in visit coverage across life-course groups. Accordingly, the central research question addressed in this study was how communication, resources, implementers' disposition, and bureaucratic structure influenced the implementation of ILP through Posyandu and were associated with disparities in service coverage among target life-course groups within the Tirtomoyo I Community Health Center service area.

To address this research question, the study integrated quantitative evidence on service coverage disparities with qualitative findings concerning policy implementation processes through a mixed-methods approach. Specifically, the study aimed to examine ILP implementation through Posyandu using the four dimensions of Edwards III's policy implementation framework communication, resources, implementers' disposition, and bureaucratic structure and to explain variations in visit coverage across life-course groups within the service area of Tirtomoyo I Community Health Center, Wonogiri Regency. The study was expected to contribute to the theoretical understanding of public policy implementation by identifying how organizational and operational factors were associated with disparities in service coverage. Furthermore, the findings were intended to provide evidence-based recommendations for strengthening institutional coordination, community health volunteer capacity, resource allocation, and targeted outreach strategies to improve the equity and effectiveness of ILP implementation at the community level.

METHOD

This study employed a mixed-methods approach with a sequential explanatory design (Creswell & Creswell, 2018). The research was conducted in the service area of Tirtomoyo I Community Health Center, Wonogiri Regency, Central Java, from May to July 2026. The quantitative phase involved the analysis of secondary data on Posyandu Primary Health Care Integration (ILP) visit coverage in 2025, encompassing five target groups: pregnant women,

infants and toddlers, adolescents, working-age adults, and older adults. Data were obtained from 86 Posyandu across nine villages and urban wards. The qualitative phase involved in-depth interviews with selected informants to explore the policy implementation factors associated with the coverage disparities identified during the quantitative phase.

Eight informants were purposively selected based on their roles, experience, knowledge, and involvement in ILP implementation. They included the head of the community health center, one ILP program coordinator, two village or urban ward midwives, three Posyandu community health volunteers (kader), and one ILP service user. Informants were selected from Banyakprodo Village, which was the first village to implement ILP through Posyandu, and Ngarjosari Urban Ward, which recorded the lowest visit coverage. Data were collected through individual in-depth interviews lasting approximately 15 minutes each. Interviews were audio-recorded after obtaining voluntary informed consent from the participants.

Quantitative data were analyzed descriptively to identify variations in visit coverage across life-course groups and administrative areas. Qualitative interview data were transcribed verbatim and analyzed using the interactive analysis model developed by Miles, Huberman, and Saldaña, comprising data condensation, data display, and conclusion drawing and verification. The findings were organized into coding matrices, thematic categories, and narrative descriptions to identify patterns and relationships among the implementation factors.

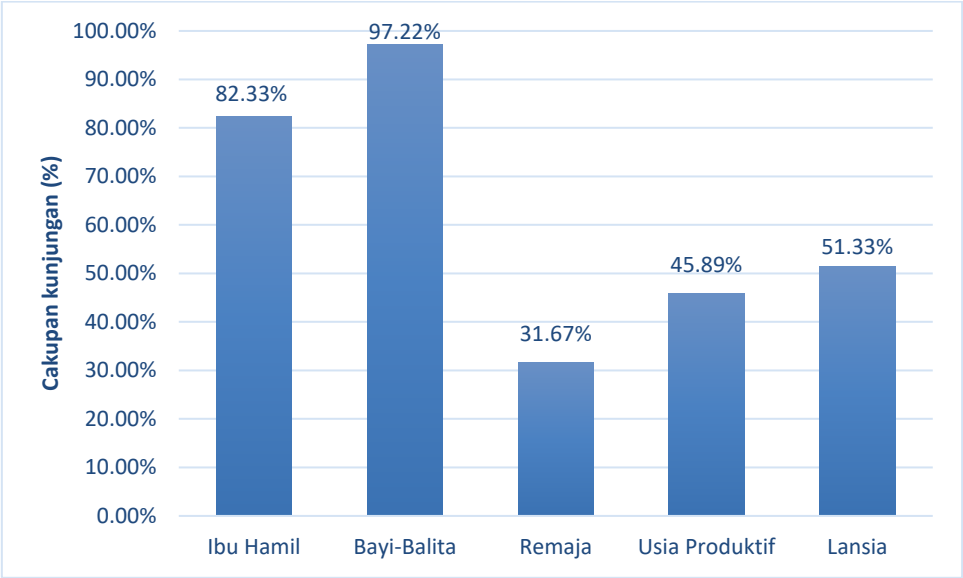
Quantitative and qualitative findings were integrated during the interpretation phase. Quantitative results identified patterns and disparities in visit coverage, while qualitative findings provided contextual explanations of the implementation processes associated with these disparities. The analysis was guided by Edwards III's policy implementation framework, focusing on communication, resources, implementers' disposition, and bureaucratic structure. The trustworthiness of the qualitative findings was strengthened through source triangulation by comparing information obtained from informants with different roles and levels of involvement in ILP implementation, including health center management, program coordinators, midwives, community health volunteers, and service users.

RESULTS AND DISCUSSION

Scope of Primary Service Integration Posyandu Visit

Analysis of secondary data on coverage of Posyandu ILP visits in 2025 in the working area of the Tirtomoyo I Health Center showed the highest coverage in the infant and toddler group (97.22%), followed by pregnant women (82.33%). In contrast, coverage was lowest among adolescents (31.67%), productive age (45.89%), and older people (51.33%). In the infant-toddler group, coverage was relatively even, ranging from 93–99%, while the adolescent group showed greater variation, from 9–65%. The productive age group ranged from 26–76%, while older people ranged from 31–79%. Thus, the difference between the infant and toddler group with the highest achievement and the adolescent group with the lowest achievement was 65.55 percentage points (Diagram 1).

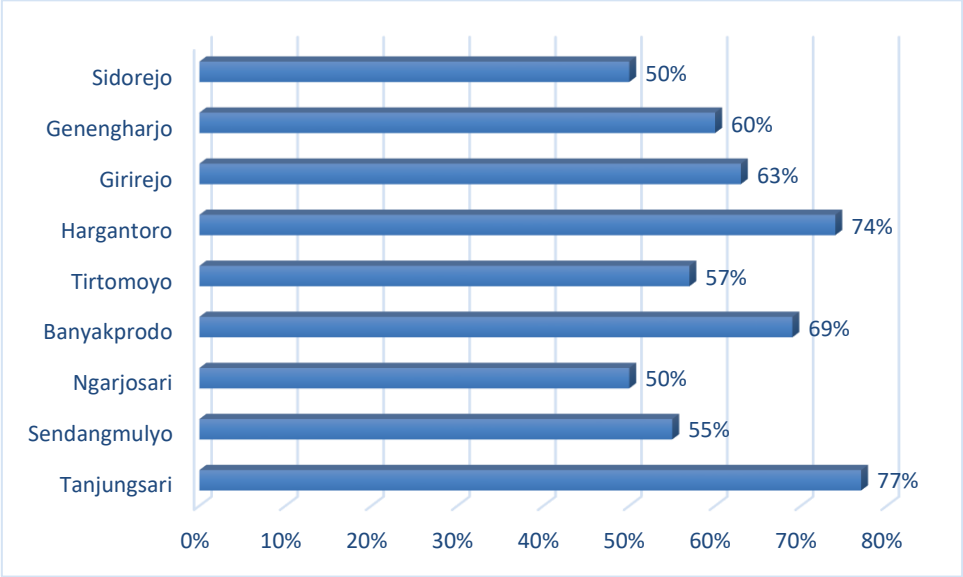
Diagram 1. Scope of ILP Posyandu Visits based on the 2025 life cycle group.



Source: Data from Tirtomoyo I Health Center in 2025.

Achievement also varied across regions. Based on the average achievement of all target groups, Tanjungsari Village showed the highest achievement of 77%, followed by Hargantoro Village at 74% and Banyakprodo Village at 69%. Other regions included Girirejo Village at 63%, Genengharjo Village at 60%, and Tirtomoyo Village at 57%. Meanwhile, Ngarjosari Village and Sidorejo Village had the lowest achievements, at 50% each. (Diagram 2).

Diagram 2. Scope of ILP Posyandu Visits based on village area in 2025.



Source: Data from Tirtomoyo I Health Center in 2025.

The achievement gap is most evident in areas with the lowest average achievements. Ngarjosari has a youth coverage of 11% and a productive age of 30%, while Sidorejo has a prevalence of 19% and 26%, respectively. In contrast, Tanjungsari has youth coverage of 58%

and productive age coverage of 76%. These quantitative findings form the basis for determining the focus of qualitative deepening on adolescent and productive-age groups, as well as the Ngarjosari and Sidorejo areas (Table 1).

Table 1. Scope of targets and achievements of ILP Posyandu visits per village in 2025

Village/Village	Squirt	Baby-News	Teenagers	Productive Age	Elderly
Tanjungsari	83%	97%	58%	76%	73%
Sendangmulyo	82%	99%	9%	43%	43%
Ngarjosari	79%	96%	11%	30%	34%
Banyakprodo	79%	97%	27%	65%	79%
Tirtomoyo	66%	93%	42%	40%	43%
Stuttgart	98%	99%	65%	50%	56%
Girirejo	88%	98%	23%	50%	58%
Genengharjo	90%	98%	31%	33%	45%
Sidorejo	76%	98%	19%	26%	31%

Source: Data from Posyandu ILP Puskesmas Tirtomoyo I in 2025.

Implementation of Primary Service Integration Based on Edwards III Model

The implementation of the ILP posyandu in the Tirtomoyo I Health Center work area includes life cycle-based services for pregnant women, toddlers, adolescents, productive age, and the elderly. Activities involve health workers and cadres through health services, early detection, monitoring, counseling, and recording of service results. Interview results on communication show that the socialization of the ILP policy was carried out in stages, from the Health Office to the Health Center and then to cadres through cadre meetings at the Puskesmas and village levels. Although information delivery has been carried out, understanding of the policy's substance and follow-up have not been completely uniform. Informant 1 said: *"For the follow-up after the ILP posyandu is carried out, I think maybe that is still lacking... So it has only been implemented by the posyandu according to the life cycle, but after that I think the follow-up has not been touched."* (Informant 1). Informant 2 reinforced this, stating: *"For policy, maybe we don't really understand, just more, how to flow in the field."* (Informant 2). In addition to understanding policy, limited socialization to the community is an obstacle. Informant 3 said that public awareness to participate is still lacking: "*Maybe the socialization to the community is also still lacking... public awareness to come to the posyandu is also still lacking*" (Informant 3). In the youth group, communication problems are also related to service time. Informant 4 said: *"For the target... who can come at the same time as the posyandu are not all. One example is teenagers"* (Informant 4).

In addition to communication, the interview results showed that limited resources emerged as a main finding in implementing the ILP. The resources found included health workers, cadres, training, budget, and logistics. These limitations are also related to cadres' demands to serve all life cycle groups. Informant 1 stated: *"Ideally, cadres under five and elderly cadres are different, and youth cadres are also themselves. This is required for everyone to participate... one cadre must finally support all his life cycles.* " (Informant 1). From the aspect of training, Informant 2 said: "*For training, it may still be very lacking, because it is the first time, once, then directly in all clusters within four days. Even though there are five clusters."* (Informant 2). The limitation of assistance for health workers is also reflected in the number of Posyandu that midwives can attend. Informant 3 explained: *"If I*

attend 11 posyandu for one month, it is likely that I can't... at most about 5 or 6 is the maximum." (Informant 3). This condition affects service implementation because some Posyandu activities are carried out only by cadres: *"It still has an impact, because the community wants it to be attended by health workers. But yes... only the cadres." (Informant 3)*. In addition to human resources, budget and logistics limitations were also found. Informant 2 stated: "*Logistics, yes, logistics are still very lacking, because the budget is also very limited."* (Informant 2). Logistical limitations are also evident in the elderly examination form, which causes some service results to be recorded manually rather than in the intended format.

In terms of disposition, health workers and cadres generally accepted the implementation of the ILP. There was no rejection of policies or additional duties. Informant 1 stated: "*If there is no resistance, there is no rejection, from cadres or staff."* (Informant 1). However, this positive attitude occurs amid limited motivational support. Informant 1 explained: *"Incentives in particular, there are none... if the form of reward is specifically in the form of money, it does not exist yet."* (Informant 1). In addition, increasing workload is part of the implementer's experience in running the ILP.

Nevertheless, cadres adapt to these conditions through service arrangements according to available capabilities. The target group also has different perceptions of service needs. Especially for the productive age group, the cadres said: *"Sometimes they feel healthy, so they don't want to come to the posyandu."* (Informant 5). The findings show differences in acceptance and willingness to use services between the target groups. However, conceptually, the disposition aspect in the Edwards III model mainly describes the attitude of policy implementers.

Regarding bureaucratic structure, the SOP for implementing the ILP has been available at the program level. However, the implementation is not completely consistent. Informant 1 explained: *"The SOP is from the programmer... how consistent, as much as possible can be done in accordance with the SOPs, we still implement it. Back to the initial obstacle, with the condition of limited human resources."* (Informant 1). At the village level, access to SOPs or written guidelines is uneven. Informant 3 stated: *"I have not received an SOP from the health center. Or from the health center; there is also no guidance on the SOP of the ILP Posyandu."* (Informant 3). The division of executive tasks is also not ideal because the implementer is still concurrently working on other programs. Informant 1 said: *"Ideally, it is still not possible... ideally, he specifically holds ILP there, continues not to hold other programs, it is also not possible."* (Informant 1). In addition to the division of tasks, limited service time is an obstacle. Informant 2 explained: "One individual takes 5-10 minutes. So, for example, if there are more than 100 people in one area in one day, it cannot be enough for everyone." (Informant 2). The implementation of the counseling table also does not fully align with the ILP concept. Informant 4 stated: *"Counseling is one desk of its own, but there the implementation is not optimal... the form is still the same as before, the form is like joint counseling."* (Informant 4). In terms of cross-sector coordination, the youth group is the weakest. Informant 1 stated: "*The weakest cross-sector coordination... is still the teenagers. If the assistance from the toddler posyandu has gone well, the achievement is already above 90% overall, even 98-99%.* (Informant 1). Support also differed across regions. Hargantoro and Banyakprodo reportedly

have stronger commitment from the village head and apparatus, so ILP achievement is relatively better.

Integration of Quantitative and Qualitative Results

Data integration showed two main patterns: the gap between target groups and the gap between village areas. Qualitative findings based on the four dimensions of Edwards III further explained these patterns. The largest gap was between infants and adolescents: 97.22% versus 31.67%, a difference of 65.55 percentage points. Interview findings showed that service timing was one obstacle to reaching adolescents. The village midwife stated that the Posyandu service was held in the morning, which clashed with adolescents' school schedules. This coincided with limited cadres, who were required to serve all life-cycle groups: *"One cadre finally had to cover all his life cycles*" (Informant 1). In the productive age group, with coverage of 45.89%, the interview findings showed that some targets felt they did not need a Posyandu when they felt healthy. Cadres said: *"Sometimes they feel healthy, so they don't want to come to the posyandu."* (Informant 5). These findings emerged alongside the limitations of KIE media, especially for adolescent and adult groups.

Ngarjosari and Sidorejo have an average achievement of 50%, while Tanjungsari, Hargantoro, and Banyakprodo have averages of 77%, 74%, and 69%, respectively. Other regions include Girirejo Village at 63%, Genengharjo Village at 60%, and Tirtomoyo Village at 57%. Qualitative findings show differences in implementation capacity and institutional support at the village level. In areas with stronger local support, Hargantoro and Banyakprodo showed stronger commitment from village heads and apparatus. In contrast, areas with lower achievements showed limitations in implementation independence and cross-sector coordination. Variations were also seen in the youth group. Coverage for this group ranged from 9–65%, a difference of 56 percentage points. Interview findings showed that cross-sector coordination for adolescent groups remained weakest, while the Family Mobilization Team and RT/RW supported service implementation in several areas.

Discussion of Findings Based on Edwards III Dimensions

The findings show that policies and Posyandu's institutional activity do not automatically guarantee proportional service utilization across all life cycle groups. This gap indicates a disconnect between the universal ILP policy design, which targets the entire life cycle equally, and Posyandu's implementation capacity, which remains oriented toward the old service pattern. This condition is in line with research on the readiness of *health posts* in Indonesia, which shows that the implementation of primary service integration is often constrained by gaps in human resources, facilities, and data synchronization, as well as research on ILP transformation in Jakarta Health Centers, which emphasizes the importance of matching organizational capacity with policy demands. In contrast to the two studies that highlighted readiness at the facility level in general, this study shows how the gap manifests as a disparity in coverage between measurable target groups and explains the mechanism through the four dimensions of Edwards III (Dhynianti et al., 2025).

Coverage gaps by lifecycle group

The pattern of gaps cannot be separated from the Posyandu's institutional history: it was built from the beginning as a maternal and child health service, so the system and cadre orientation are naturally better suited to serving the infant-toddler group than the group newly

added through the ILP policy. Adolescents and productive-age groups, by contrast, have access patterns shaped by school and work routines that do not align with the Posyandu service schedule, as the village midwife informant noted that morning services clash with adolescent school schedules. This pattern aligns with research on access to adolescent health services in Indonesia, which shows that service utilization is influenced by individual, social, and environmental factors, as well as research on Youth Posyandu, which shows inconsistent participation when the service mechanism has not adjusted to adolescents' characteristics. What distinguishes this study is the finding that the gap does not stand alone as a matter of accessibility, but is rooted in four implementation dimensions that reinforce each other, so that the solutions needed are not enough in the form of schedule adjustments, but include systemic improvements in communication, resources, and bureaucratic structures simultaneously (E. S. Fitri et al., 2024b).

Communication as a policy translation mechanism

The multi-level socialization of ILP from the Health Office to cadres shows that the formal transmission of policy information has been underway; however, the gap between the delivery of information and the formation of operational understanding, as seen in the lack of clarity of follow-up after the service delivered by the informant in charge of the ILP, shows that the success of policy communication cannot be measured by the implementation of socialization alone. In Edwards III's view, effective communication requires clear, consistent messages down to field implementers, not just one-way delivery. The lack of KIE media for adolescent and adult groups, as well as the clash of service time with school schedules, shows that ILP communication is still designed uniformly for all target groups, even though the newly involved groups require a different approach from the mothers and toddlers' groups that have long been the main base of Posyandu.

These findings are consistent with Wiyanto and Choiyirah's research on Youth Posyandu in Pasuruan, which also identified weaknesses in communication with adolescents and the absence of formal SOPs as structural barriers. The similarity across these two locations reinforces the suspicion that poor communication with adolescent groups is not just a local problem in Tirtomoyo I. Still, a broader implementation pattern suggests that the national ILP communication design may not adequately accommodate the diverse characteristics of target groups now covered in the lifecycle approach (Wiyanto & Choiyirah, 2025b).

Limited resources as an obstacle to service expansion

The limited resources found, ranging from the ratio of health workers to work areas, dual cadre duties across target groups, to the lack of advanced training, illustrate that the expansion of ILP targets is basically an expansion of workload without being accompanied by a proportional adjustment in the capacity of organizers. This pattern is consistent with Setiaasih et al. (2025), who found that most *health posts* in Indonesia are in the medium-readiness category, with the main obstacles being human resources and facilities. Siswati et al. also emphasize the importance of strengthening logistics and service skills across the life cycle, even though cadres' readiness is generally relatively good. This study enriches the findings by showing the direct consequences for equitable coverage: when one cadre is required to support the entire life-cycle group at once, as the informant said, service priorities will naturally remain skewed towards the group most familiar to that cadre, namely infants and toddlers—so that

resource constraints not only hinder the overall quality of service, but specifically widen the gap between target groups (Setiaasih et al., 2025; Siswati et al., 2025).

Implementing disposition: insufficient strength to overcome system barriers

Implementers' acceptance of the ILP policy without resistance, even amid limited resources and without additional incentives, is a theoretically interesting finding to explore further. In Lipsky's *street-level bureaucracy* framework, frontline officers such as cadres and village midwives often develop adaptive strategies to continue carrying out their duties amid limited resources, rather than openly rejecting the policy. This pattern is evident in this study: cadres adjust services according to available capabilities, rather than stopping or rejecting ILP implementation. However, this adaptive strategy has hidden consequences when resources are limited; implementers tend to follow established service patterns (infants and toddlers) and sacrifice expansion to new groups (adolescents, productive age), which are the main target of ILP policies. Thus, a positive disposition that appears to be policy compliance can indirectly perpetuate coverage gaps rather than reduce them. These findings align with Setiaasih et al., who found cadre enthusiasm and commitment as factors supporting implementation, but still limited by resource and facility barriers (LIPSKY, 1980; Setiaasih et al., 2025).

Bureaucratic structure and the gap between design and practice

The gap between the SOPs available at the program level and their understanding and implementation at the village level shows that formal policy documents are not automatically translated into uniform practices in the field. The division of tasks is not ideal for health workers who concurrently work with other programs, and counseling tables that are not fully in accordance with the concept of ILP show that the organizational structure of the Posyandu has not fully adapted to the complexity of the ILP, which involves more actors than the previous service pattern. Wiyanto and Choiyirah's research in Pasuruan found a similar pattern: the absence of formal SOPs as the main obstacle to consistent implementation of the Youth Posyandu. However, this study shows a more complex problem: existing SOPs are not enough to ensure consistent implementation if distribution, understanding, and capacity at the village level are not strengthened simultaneously. In other words, SOP availability is necessary but not sufficient for successful policy implementation at the Posyandu level (Wiyanto & Choiyirah, 2025b).

Gaps between regions and the importance of local institutional capacity

An interesting pattern found at the regional level is that Ngarjosari and Sidorejo consistently occupy the lowest positions in almost all target groups, not just one specific group. This pattern indicates that the problems in the two villages are likely to be structural at the village institutional level, for example, weak cross-sector coordination or lack of support from village officials, and not just specific problems in one target group. This contrasts with Hargantoro and Banyakprodo, which showed relatively high achievement despite similar resource limitations at the Puskesmas level, suggesting that support from village heads and cadre independence at the local level may offset broader system-level resource constraints. These findings expand on the systematic review by Odhus et al., which emphasized the importance of a combination of factors at various implementation levels. This is supported by empirical evidence showing that village institutional capacity can *buffer* the impact of limited

resources at the Puskesmas level on service achievement at the community level (Odhus et al., 2024).

Edwards III four-dimensional integration

Table 2. Synthesis of qualitative findings of ILP implementation based on Edwards III's four dimensions

Edwards III Dimensions	Key Findings	Implications
Communication	Socialization of policies is tiered, but the understanding of follow-up is not uniform; KIE media is minimal for adolescent and adult groups; service time clashes with the adolescent school schedule.	Communication needs to shift from program-based to target-based characteristics, especially adolescents and productive age.
Resources	Health workers and cadres are limited and concurrently all life cycle groups; minimal training; limited budget and logistics.	Cadre capacity building, cross-lifecycle training, and logistical support are needed before further expansion of the target.
Disposition	Implementers receive the policy without resistance, but without additional incentives; some productive age targets are reluctant to come when they feel healthy.	Positive disposition is an important capital, but it cannot replace the adequacy of resources and service systems.
Bureaucratic Structure	SOPs are available at the program level, but their distribution and understanding at the village level are not evenly distributed; the division of tasks and counseling desks is not ideal; cross-sector coordination for the most vulnerable adolescents.	More detailed SOPs, clear division of tasks, and strengthening cross-sector coordination are needed, especially for youth groups.

Source: Results of research qualitative data analysis, 2026.

The synthesis in Table 3 shows a theoretically important pattern: implementers' positive disposition serves as a temporary buffer that maintains program continuity, but can instead cover and, in the long run, perpetuate structural gaps stemming from communication, resources, and bureaucratic structures that have not been fully strengthened. In other words, because implementers remain compliant and programs continue to run, the coverage gap does not appear to be a surface-level implementation failure. Instead, the root problem lies in the other three dimensions that have received less attention so far. This pattern explains why the coverage gap in this study is more accurately understood as an implementation gap between policy design and organizational capacity, rather than as a low public willingness to utilize Posyandu in line with Zhang et al.'s systematic review and meta-analysis of 119 primary service integration studies, which found that the benefits of structural integration do not consistently translate into perceived improvements in service users. This suggests that ILP success cannot be assessed solely by program sustainability; it must also be measured by equitable coverage among target groups (Zhang et al., 2025).

Implications for ILP implementation

This study implies that strengthening ILP at the Posyandu level should be based on the target group's characteristics. Adolescents need a different strategy than infants and toddlers, especially for determining service times, communication channels, and the involvement of schools and youth organizations. The productive age group also needs a communication

strategy that increases the perception of the benefits of health checks, even when the individual has no complaints.

In terms of resources, cadre training should focus on service competencies across life cycles, not only on the Posyandu's administrative capabilities. Scheduling should also consider health workers' availability, so assistance is not concentrated on only some activities.

In terms of bureaucratic structure, SOPs need a clear division of tasks, cross-sectoral coordination mechanisms, and room to adapt to village conditions. Local adaptation is important, but it must still maintain the core components of ILP services so that there is no gap between program standards and service practices.

This approach aligns with recent research on the readiness of *health posts* in Indonesia, which shows that strengthening human resources, facilities, collaboration, and support systems is needed for sustainable transformation of primary services.(Setiaasih et al., 2025b)

Limitations of the study

This study has several limitations. First, the quantitative data are secondary data from the scope of visits at the ILP Posyandu, so the study cannot explain the characteristics of individuals who do not use the service directly. Second, the quantitative analysis is descriptive, so the causal relationship between the implementation dimension and the scope of the visit cannot be determined. Third, qualitative findings come from one health center, so transferring the results to areas with different geographical, institutional, and resource capacity characteristics must be done carefully. Future research can analyze several areas and combine characteristics of individual users and non-service users to identify factors related to ILP Posyandu utilization in each life cycle group.

CONCLUSION

The implementation of Integrasi Layanan Primer (ILP), or Primary Health Care Integration, through Posyandu (integrated community health posts) in the service area of Tirtomoyo I Community Health Center, Wonogiri Regency, has not yet achieved equitable service coverage across all life-course groups. Based on Edwards III's policy implementation framework, communication, resource availability, and bureaucratic structure remain key areas requiring improvement, whereas implementers' positive disposition has emerged as a supporting factor. The observed disparities in service coverage indicate that successful ILP implementation depends not only on policy availability and the operational status of Posyandu but also on implementer capacity, institutional coordination, and the alignment of service delivery mechanisms with the specific needs and characteristics of each target population.

Future research should include community health centers (Puskesmas) serving areas with more diverse geographical, demographic, and institutional characteristics to assess the transferability of these findings. Further investigations should also directly involve individuals who have not utilized ILP services, rather than relying exclusively on secondary visit coverage data, to identify individual, social, and contextual factors influencing service utilization across life-course groups. Additionally, the potential role of implementers' disposition in mitigating structural and organizational constraints warrants further examination, particularly through the theoretical perspective of street-level bureaucracy. Such investigations could provide a more

comprehensive understanding of policy implementation dynamics and inform strategies to improve equitable access to integrated primary health care services.

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