ORIGINAL ARTICLE
Public Health and Preventive Medicine Archive (PHPMA) 2025, Volume 13, Number 1 : 51 – 61
E-ISSN: 2503-2356

PHPMA
Published by
Department of Public Health and Preventive Medicine, Faculty of Medicine, Udayana University

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Evaluation of the implementation of primary health care integration: A case study of public health center in Denpasar City, Bali Province, Indonesia

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ABSTRACT

Background and purpose: Primary health care integration, as one of the pillars of health system transformation, has been piloted in one of the Public Health Center in Denpasar since 2023. This study aims to evaluate the implementation of primary health care integration in Denpasar.

Methods: This was a qualitative study with a case study design. The study consisted of in-depth interviews with 18 informants whom were recruited purposively. The informants consisted of policymakers from the Denpasar City Health Office, Head of Public Health Center, and Head of one Sub-district, person in charge, nurse, cadres, service recipients from each life cycle. A focus group discussion was also conducted with eight integrated health post cadres. We also conducted document reviews to obtain service coverage data and observation of the supporting infrastructure Data were analyzed using thematic analysis.

Results: Primary health care integration has yet to fully meet the established implementation standards, particularly in home visits coverage. The health service package for cluster three, and service coverage for all life cycles and screening has not reached the target. Inhibiting factors of the implementation were lack of regulations, fundings, increased workload, insufficient cadre inadequate training. While, political support, firm policies, quality infrastructure, and digital technology were significant supporting factors.

Conclusion: Primary health care integration yet to meet completely the established implementation standards. Efforts are required to address inhibiting factors and utilizing the supporting factors.

Keywords: Public health center; primary health care transformation; primary health care integration

INTRODUCTION

Primary health care is one pillar of the health system, which is essential to attain universal health coverage.[1] Universal health coverage by 2025 aims to cover over one billion people worldwide to achieve better health and well-being. The proportion of the population not receiving essential health care decreased from 40% in 2000 to 25% in 2021, but only 2% progress was made after 2015. This decline is uneven across regions that should have experienced increased health service coverage. This indicates that in 2021, about 4.5 billion people did not fully receive essential health services.[2]

WHO has restructured essential health care by recommending a primary service approach through three main strategies. These strategies are integrated primary care and public health functions, empowered people and communities, and multi-sectoral policy and action. These approaches are expected to improve access, quality, and effectiveness of health care and reduce health disparities between and within countries.[2] Indonesia is one of the countries that has yet to achieve the target indicators of the minimum service standards in health. Primary health care services in Indonesia, including Public Health Center *(Puskesmas)*, Integrated Health Post *(Posyandu)*, and Village Health Post *(Poskesdes)*, are the front line in providing quality and affordable health services to the community. However, in 2022, the minimum service standards indicators still needed to reach the optimal 100% target.[3]

To overcome this condition, the Ministry of Health (MoH) adopted transformation to the Indonesian health system, focusing on transforming primary health care by implementing the concept of Primary Health Care (PHC) Integration. PHC integration has a significant change in the approaches that focus more preventive and promotive measures, and providing comprehensive and continuous services.[4] The new paradigm emphasizes three focuses: no longer based on programs but through a life cycle approach, bringing health services closer through networking, and local area monitoring.[5,6]

The MoH has piloted primary health care integration in nine provinces of Indonesia to represent different characteristics of Indonesia's regions, including urban, rural, remote, and very remote areas. The evaluation results of the pilot showed changes in the number of visits before and after the pilot based on health service facilities.[3]

Bali Province has piloted the integration of primary health care. Integration of primary health care in Bali is crucial since some of the health indicators have yet achieve its target, such as the maternal mortality rate in Bali in 2022 was high at 110.4/100,000 live births (target 100/100,000 live births).[7] Meanwhile, the maternal mortality rate in Denpasar City, the capital city of Bali, in 2022 was 103.19/100,000 live births which was twice higher than the target of 56/100,000 live births. At the sub-district level in Denpasar City, the highest maternal mortality rate was in the North Denpasar sub-district as high as 131.7 per 100,000 live births. Other indicators such as health services for pregnant women, toddlers, adults, the elderly, hypertension, mental disorders, and Tuberculosis have not reached 100% targets in the working area of *Puskesmas* I North Denpasar.[8]

The working area of *Puskesmas* I North Denpasar that became a pilot project of primary health care integration is the auxiliary health center *(Puskesmas Pembantu*) Kelurahan Tonja, designated on November 19, 2022, based on the Circular of the Ministry of Health of the Republic of Indonesia Number

YP.01.01/B.VI/1300/2022. Based on a preliminary exploration, the implementation of service integration could have been more optimal; however, an evaluation of primary healthcare integration implementation has never been conducted.

According to the PHC theory of change, strategic and operational driving factors influence the implementation of the integrated health services emphasizing on primary care.[1] Based on these background, the researchers aim to evaluate the implementation of primary health care integration in the working area of *Puskesmas* I North Denpasar.

METHOD

This study used a qualitative design with a case study approach. This approach allows researchers to explore processes related to the selected case.[9,10] This was applied to evaluate the implementation of primary health care integration in the working area of *Puskesmas* I North Denpasar, specifically at the *Puskesmas Pembantu* Kelurahan Tonja, from February to March 2024.

Primary data consists of in-depth interviews, FGDs, and observations. Secondary data consists of documents exploration that includes service coverage based on the life cycle and early disease detection coverage from January to December 2023. It was conducted by collecting documents related to integrated primary health care services, such as Decrees, Standard Operating Procedures, technical guidelines for primary health care integration, and *Posyandu prima* guidebooks. Observations were made on the implementation of indoor activities and the availability of facilities and infrastructure as part of requirement of the PHC integration.

Informants in this study were policymakers, service providers, and service recipients, selected using purposive sampling techniques. Data collection methods were in-depth interviews and Focus Group Discussions (FGD). In total, 18 informants were included in the in-depth interview, including the Head of the Denpasar City Health Office, the Head of *Puskesmas* I North Denpasar, the Head of *Kelurahan* Tonja, the person responsible for the integration of primary health care services at the *Puskesmas*, nurses at the *Puskesmas Pembantu* Kelurahan Tonja, cadres of the *Puskesmas Pembantu*, pregnant patients, mothers of infants, mothers of toddlers, adolescents, adults, and the elderly. Interviews were conducted at agreed-upon locations, lasting for an average of 20-50 minutes, and was audio-recorded. FGD was conducted with eight cadres from each *Posyandu* in the *Kelurahan* Tonja, at the Banjar-hall (*Balai Banjar*) Tegeh Sari, Kelurahan Tonja, lasting for 52 minutes.

The main researcher served as an interviewer who remains unbiased among respondents. The researcher was a master degree student in Public Health at the Faculty of Medicine, Udayana University during the data collection who has studied qualitative research methods. The researcher has eight years of work experience at a *Puskesmas* in Denpasar City, however, she currently works at a Regional General Hospital in Bali Province and has no personal connection or interest in the research location. The researcher used supporting tools such as in-depth interview guides, FGD guides, observation sheets, document analysis sheets, and secondary data extraction forms.

The in-depth interview guide used open-ended questions to explore the research topic deeply from the informant's perspectives. It was tailored to the informant's characteristics, such as background, education, and

experience.[11] The in-depth interview guide was developed based on the PHC Theory of Change and structured according to the research objectives.

The data analysis technique used was thematic analysis, which identifies, understands, and conveys the hidden meanings behind the data or information that emerges from qualitative data.[12] Researchers listened to the recordings repeatedly, then made transcripts of the results of in-depth interviews and FGDs. Data coding was performed using software for developing and managing qualitative data analysis projects by creating codes relevant to the research objectives. Researchers understand these themes so they can tell a logical plot. Theme interpretation used the PHC Theory of Change.

The data collected underwent validity checks to reduce bias and ensure data quality through source and method triangulation approaches. Method triangulation involved collecting data through various methods, such as in-depth interviews, FGD, document studies, and observations. Source triangulation involved testing and confirming the synthesized data originating from policymakers, service providers, and service recipients.

This research received ethical approval from the Research Ethics Committee of the Faculty of Medicine, Udayana University, with number: 0562/UN14.2.2.VII.14/LT/2024, dated February 16, 2024.

RESULT

Characteristics of Informants

Table 1 shows the characteristics of the informants involved in the in-depth interviews consist of three groups, namely policymakers, service providers and service recipients. Most informants had educational backgrounds ranging from a diploma to a master's degree, and predominantly female. The informants' ages range from 17 to 61 years, with occupational backgrounds varying from housewives to civil servant, entrepreneurs and private employees.

Table 1. Characteristics of In-depth Interview Informants

Code	Informant Status	Gender	Age	Education	Occupation
A1	Head of the Denpasar City Health Office	F	57	Master's degree	Civil Servant
A2	Head of Puskesmas I North Denpasar	M	59	Master's degree	Civil Servant
A3	Head of Kelurahan Tonja	M	57	Bachelor degree	Civil Servant
B1	Person in charge of primary health care integration at Puskesmas	F	42	Diploma	Civil Servant
B2	Nurse at Puskesmas Pembantu Kelurahan Tonja	F	55	Diploma	Civil Servant
C1	Cadre placed at Puskesmas Pembantu Kelurahan Tonja	F	45	Senior High School	Housewife
D1	Pregnant woman utilizing the services	F	23	Senior High School	Private Employee

Code	Informant Status	Gender	Age	Education	Occupation
D2	Mother of an infant utilizing the services	F	33	Senior High School	Private Employee
D3	Mother of a toddler utilizing the services	F	36	Elementary School	Housewife
D4	Adolescent utilizing the services	M	17	Junior High School	Student
D5	Adult utilizing the services	M	33	Senior High School	Entrepreneur
D6	Elderly person utilizing the services	F	56	Senior High School	Entrepreneur
E1	Pregnant woman not utilizing the services	F	27	Junior High School	Housewife
E2	Mother of an infant not utilizing the services	F	28	Senior High School	Housewife
E3	Mother of a toddler not utilizing the services	F	29	Bachelor degree	Contract Employee
E4	Adolescent not utilizing the services	F	14	Elementary School	Student
E5	Adult not utilizing the services	F	36	Diploma	Private Employee
E6	Elderly person not utilizing the services	F	61	Bachelor degree	Retired Teacher

Table 2 describes the characteristics of the FGD participants, who are *Posyandu* cadres of eight females aged between 31 and 60. The education levels vary from high school to a bachelor's degree, with most participants working as housewives. The length of time serving as cadres ranges from two to 15 years.

Table 2. Characteristics of FGD Participants

Code	Gender	Age	Education	Occupation	Length of Service as Cadre
K1	F	38	Vocational School	Private Employee	3
K2	F	47	Senior High school	Housewife	4
K3	F	32	Vocational School	Trader	2
K4	F	31	Barhcelor degree	Housewife	2
K5	F	44	Barhcelor degree	Civil Servant	10
K6	F	60	Diploma	Housewife	15
K7	F	45	Senior High school	Housewife	5
K8	F	40	Senior High school	Housewife	15

Implementation of Primary Health Care Integration

Overall, the results of the qualitative data analysis revealed three themes that describe the implementation of primary health care integration in the working area of *Puskesmas* I North Denpasar. The first theme was the conformity of the primary healthcare integration implementation, followed by second theme, the inhibiting factors, and then the supporting factors. The summary of the themes and sub-themes from the study's is presented in Table 3.

Table 3. Summary of Themes and Subthemes

Themes	Sub-themes
Conformity of Primary Health Care Integration Implementation	• In-building health services met the standards • Out-of-building health services was yet met the standards • Cluster two health service packages met the standards • Cluster three health service packages not fully met the standards • Recording and reporting met the standards
Inhibiting Factors	• Lack of regulations for cadre incentive payments • Special funds services are not available • Low community involvement • Increased workload • Insufficient numbers of cadres and inadequate training • Lack of provision for medical needs • Cooperation between the public and private sectors is not sustainable
Supporting Factors	• Strong commitment from policymakers • Availability of adequate infrastructure • Digital technology that works well • Periodic monitoring and evaluation

Theme 1: Conformity of Primary Health Care Integration Implementation

The appropriateness of the implementation of the primary health care integration in the working area of *Puskesmas* I North Denpasar was assessed based on a general overview of the implementation of primary health care integration. This assessment was derived from document reviews and observations of service delivery and is supported by the in-depth interviews. Primary health care integration occurs at the *Posyandu Prima Puskesmas Pembantu* Kelurahan Tonja. In-building health services consist of cluster two which cover health services for pregnant women, maternity, postpartum, babies, toddlers, children and adolescents, and cluster three which is health services for adults and the elderly. The cluster two health service package and documentation and reporting are already compliant with standards. However, out-of-building health services did not meet standards, as home visits have yet to be conducted for all target groups. The cluster three health service package is not fully compliant with standards, as cholesterol and uric acid tests have yet to be performed.

> *"Home visits are rare unless we address specific issues, such as pregnant women, otherwise, they do not occur" (B2).*

Implementation of primary health care integration in service coverage based on life cycles and early disease detection coverage were obtained based on the results of secondary data analysis of the implementation of primary health service integration in 2023 at *Puskesmas Pembantu Kelurahan* Tonja. Adult hypertention screening for high coverage was 48.80% and mental health problem screening for low coverage was 0.14%. Service coverage based on the life cycle and coverage of early disease detection have not yet reached the expected target of 100% minimum service standards achievement in all services.

Theme 2: Inhibiting Factors of the Implementation of Primary Health Care Integration

Lack of regulations for cadre incentive payments

The implementation of primary health care integration at the *Puskesmas Pembantu Kelurahan* Tonja has demonstrated that target objectives have yet to be achieved over the past year. Corresponding policy changes, including the lack of regulations for cadre incentive payments have not supported changes in the integrated primary health care system's work patterns.

"The incentives for cadres cannot be disbursed due to discrepancies with certain regulations. We have not yet found the legal framework for processing these incentives" (A2).

Special funds are not available

There are no funds allocated or available to support the integration of primary health services which could impact their implementation and sustainability.

"As for the funds to support this, there are none, for primary health care integration in particular there are none" (B2).

Low community involvement

Barriers to community involvement, especially their presence because many of them are migrants who have not been well integrated into the community.

"One barrier is that people often do not come to the Posyandu because most are migrants. Migrants often live in rented accommodations monthly. So, they move in and out without us knowing. Naturally, they do not attend" (C1).

Increased workload

Primary health care workers face challenges due to overlapping responsibilities such as screening and documentation, which increase their workload.

"There is certainly an increased workload with screening and documentation. I also manage a dashboard and am involved in medication management. We also handle tasks like sweeping. The problem here is that there is a shortage of human resources. There should be a CS (cleaning staff) and a lack of administrative support. We end up doing multiple jobs" (B2)

Insufficient numbers of cadres and inadequate training

Health cadres play a crucial role in community empowerment, yet there were challenges, including insufficient numbers of cadres and inadequate training.

"There is a need for training. We need to conduct training because, for example, we have seven cadres, but only two are effective, which means the remaining five are very insufficient" (K1).

Lack of provision for medical needs

The inadequacy of medications for infants highlights a shortage in medical supplies, which hinders effective health management.

"We need to increase the supply of medicines. Sometimes when a child has a cough or cold, we find that the medicine is unavailable, so we end up purchasing it ourselves from the pharmacy" (D2).

Cooperation between the public and private sectors is not sustainable

Collaboration between the public and private sectors, such as with PT ASTRA, has been suboptimal due to its non-sustainable nature, lasting only one year.

"Private sector parties like ASTRA are not maximally involved, they act according to their interests. They are only engaged for a maximum of one year. They cannot provide sustained support" (A3).

Theme 3: Supporting Factors of the Implementation of Primary Health Care Integration

Strong commitment from policymakers

Based on in-depth interviews, the supporting factors for implementing primary health care integration include the strong commitment from the Denpasar City Health Office, the Head of *Puskesmas* I North Denpasar, and the Head of Kelurahan Tonja.

"Yes, we at the Puskesmas and the staff are committed to implementing this Primary Health Care Integration. Moreover, the Denpasar City Health Office has designated us as a pilot project to execute this under the existing conditions" (A2).

Availability of adequate infrastructure

Another supporting factor is the availability of necessary infrastructure for effective primary health care service delivery.

"Medical equipment is available… Internet access is present… Restrooms are available" (B2).

Digital technology that works well

Functioning digital technology makes it easier for health workers to enable more efficient and integrated recording in one database.

"Yes, the information system is integrated into e-Pusk. Reports from the community and Posyandu cadres are processed through ASIK, Aplikasi Sehat IndonesiaKu, e-cohort, Siria, etc. We are already using digital tools" (A2).

Periodic monitoring and evaluation

Periodic monitoring and evaluation also support the implementation ensure that health services are of established standards, and evaluate the results to improve the quality of services.

"Yes, the evaluation is conducted from the central level. Since this is also a pilot project from the center. The Ministry of Health from the central level wants to assess the impact of this program on the outcomes" (A1).

DISCUSSION

The implementation of PHC integration in the study area has been operating well which a good achievement of the in-building services but a lower achievement of the out-building activities. Out-of-building health services showed limited number of home visits, that showed improvements for more comprehensive integration was needed.

According to the Technical Guidelines for PHC Integration, health cadres should identify those who have not received health services, were non-compliant with treatment, or exhibit dangerous symptoms during home visits.[6] Cadres become the main human resources to perform out-of-building health services to achieve a more comprehensive service integration. This was align with previous study which illustrates the implementation of comprehensive primary health service integration can only be carried out at the in-building of *puskesmas* due to a lack of human resources.[11,13]

We found the achievement of the clusters three, service for adult and elderly group, service package was not fully up to standard due to the unavailability of cholesterol and uric acid tests for older people. Cholesterol and uric acid laboratory preparations were yet available due to limited funding specifically for integration of primary health services and allocation of financial resources for the procurement of simple laboratory preparations. Previous study also asserted the importance of the scope of service role and health financing mechanism.[14]

PHC integration over the past year has not shown a tendency toward increased visits based on the life cycle. All service coverage areas have yet to reach target goals for PHC indicators and 100% minimum service standards. Several factors hindering minimum service standards implementation include suboptimal regional commitment, limited budget availability, inadequate facilities, and insufficient human resources.[15]

Low service coverage was attributed to the insufficient role of cadres' in-home visits for disseminating information about services. Increasing the number of cadres and their skills through ongoing training is expected to enhance the frequency and quality of home visits. *Posyandu*'s cadres significantly contribute to community health needs, especially in rural areas.[16,17] In health transformation, cadres are required to have 25 basic health skills, one of which is conducting home visits.[6]

Meanwhile, other indicators of early disease detection have yet to meet target goals due to a lack of resources to conduct and interpret screenings effectively. This aligns with a previous finding that comprehensive screening can only be undertaken at the *Puskesmas* due to the lack of human resources at *Posyandu Prima*.[13] Low achievement on screening uptake was partly due to the low frequency and quality of home visits to inform about screening and the limitation of these activities to *Posyandu Prima's* operational

hours. Previous study in Jambi also showed low public knowledge about NCDs, limited screening personnel, insufficient information media, lack of counseling on NCDs, and restricted screening activities to working hours.[18]

Our study reveals several hindering factors for primary health care integration at *Puskesmas* I North Denpasar such as changes in the integrated primary health care system's work patterns without corresponding policy changes, funding, community and stakeholder involvement, and procurement and payment systems. The community plays an active role in shaping and delivering health services that meet their needs, rather than just passively receiving them. This finding is consistent with Shiva Gab-dream (2023), which analyzes the landscape of primary healthcare integration in low- and middle-income countries such as Nigeria, Madagascar, and Nepal. The study highlights factors impeding health integration in developing countries, including shortages of skilled health workers, inadequate financing, insufficient medicine supplies, weak policy oversight, and low community participation.[19,20]

Supporting factors for implementing primary health care integration include solid political commitment and supportive leadership, adequate infrastructure, functioning digital technology, and regular monitoring and evaluation. These factors align with the PHC theory of change emphasizing that integrated health care particularly primary care is influenced by strategic drivers such as political commitment and leadership, and operational drivers such as physical infrastructure, digital technologies for health, and monitoring and evaluation.[1,21]

Our findings can inform policymakers in developing strategies to enhance the implementation of primary healthcare integration through improved regulations and financing, improved number and capacity of human resources, and strengthened collaboration among stakeholders. A limitation of this study is the unavailability of 2022 data before the pilot project, which prevented comparisons of pre- and post-implementation results. This limitation is attributed to difficulties in comprehensive data collection post-COVID-19 pandemic.

CONCLUSION

PHC integration in the working area of *Puskesmas* I North Denpasar specifically at *Puskesmas Pembantu Kelurahan* Tonja, yet to meet the established implementation standards fully. To improve the implementation of PHC integration, it is essential to improve cadre capacity, develop strategy to achieve service coverage targets, adopt strong regulations especially regarding cadre incentives, funding, and increased collaboration between stakeholders.

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