



Utilization of cluster 3 primary care integration services among the elderly

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ABSTRACT

The growing elderly population demands comprehensive and responsive primary healthcare. In Indonesia, the Cluster 3 Primary Care Integration (ILP) Program was developed to address older adults' health needs; however, prior research mostly used quantitative methods focused on accessibility, leaving older adults' subjective experiences unexplored. This study fills that gap by qualitatively examining their utilization experiences—including perceptions, benefits, family support, and barriers—offering a multi-stakeholder perspective combining voices of older adults, families, health workers, PPKBD personnel, and staff. A qualitative phenomenological design was employed, collecting data via interviews, FGDs, observations, and documentation from 30 purposively selected participants, analyzed thematically. Five main themes emerged: utilization experiences, perceived quality, family support, multi-level barriers, and improvement expectations. Findings indicate positive experiences were primarily driven by active family and health worker engagement, whereas physical constraints, lack of caregivers, and limited diagnostic facilities were key barriers. Strong support offset individual barriers, but system limitations constrained potential benefits. The study concludes that Cluster 3 ILP utilization is shaped by interacting individual, family, and system factors, implying the need to strengthen elderly education, caregiver support, diagnostic supplies, and formal integration of community roles into primary care policy.

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1. Introduction

The growing global and national elderly population poses serious challenges to health care systems. Older adults have complex health needs related to chronic diseases, declining physical function, and psychosocial conditions that affect their quality of life (Najafi et al., 2023). These conditions require comprehensive, sustainable, and easily accessible primary health care as the first line of defense. In Indonesia, the Ministry of Health is promoting life-cycle-based Primary Care Integration (ILP) to strengthen access to and the quality of health services, including services for the elderly through community participation and posyandu volunteers (Service & Ilp, 2025).

Nevertheless, older adults' access to health care services still faces physical and operational barriers, such as travel distance, wait times, and financial constraints (Purwito et al., 2025). In addition, limited human resources, suboptimal systems, and insufficient integration of technology also hinder the

effectiveness of primary care services at the community level (Arma et al., 2025). On the other hand, psychosocial factors such as family support, the active role of community health workers, and community-based posyandu support play a crucial role in motivating older adults to utilize health facilities (Arma et al., 2025).

Existing theoretical models fail to fully explain older adults' utilization of Indonesia's Cluster 3 ILP services. The Health Belief Model and Theory of Planned Behavior overlook collectivist family-mediated dynamics, Andersen's Behavioral Model treats operational factors as static without capturing lived experiences, and Social Support Theory rarely incorporates system-level barriers within the new ILP framework. This study addresses this gap by examining the interplay between individual perceptions, family support, and system-level factors.

The significance of this study lies in meeting the basic needs of older adults for inclusive, high-quality primary health care to achieve optimal health. Most previous studies have focused on quantitative approaches to examine the relationship between accessibility and facilities (Purwito et al., 2025). This leaves a research gap, as the subjective interpretations, in-depth perceptions, and dynamics of older adults' experiences in utilizing the ILP particularly Cluster 3 have not been adequately explored (Najafi et al., 2023). These quantitative studies, while valuable for identifying structural associations, are methodologically unable to capture the meaning older adults themselves attach to their experiences or to reveal how individual, family, and system factors interact dynamically in daily life limitations that a qualitative phenomenological design is specifically suited to overcome by centering older adults' lived, first-person accounts (Pyo et al., 2023).

The novelty of this study lies in its integrated conceptual framework, which synthesizes the Health Belief Model, Andersen's Behavioral Model, and Social Support Theory to explain older adults' lived experiences. Specifically, ILP Cluster 3 utilization is conceptualized through three interacting domains: (1) individual benefit and risk perceptions, (2) family and community social support as mediating factors, and (3) predisposing, enabling, and need-based system factors. Empirically grounded in interviews, FGDs, and observations, this study proposes a context-specific utilization model for Indonesia's ILP program, extending theoretical understanding beyond conventional qualitative applications.

Therefore, this study aims to explicitly explore older adults' experiences in utilizing Cluster 3 ILP services using a qualitative phenomenological approach. Specifically, this study seeks to answer three research questions: (1) What are older adults' lived experiences in utilizing Cluster 3 ILP services? (2) What individual, family, and system-level factors influence their utilization of these services? (3) How does family support shape older adults' health-seeking behavior and adherence to ILP services? The study focuses on experiences related to accessibility, perceptions of quality, perceived benefits, barriers encountered, and the role of social support. By articulating an integrated conceptual model linking individual, family, and system factors, this study is expected to make a substantive theoretical and practical contribution to policymakers and healthcare professionals in designing primary healthcare services that are more responsive and oriented toward older adults, while extending the applicability of existing behavioral and support theories to the Indonesian primary care context.

2. Methods

Research Design and Location

This study employs a qualitative approach with a descriptive phenomenological design to explore the lived experiences, perceptions, and interpretations of older adults regarding their use of Cluster 3 Primary Care Integration (ILP) services. This approach was chosen because it is effective in uncovering the essence of phenomena directly experienced by individuals (Oluka, 2026)(Pyo et al., 2023). The study was conducted in the service area of the South Purwokerto Community Health Center, which has implemented the ILP program, from May 24 to June 20, 2026. Specifically, this study adopted Colaizzi's (1978) descriptive phenomenological framework, which was selected over alternative approaches such as Husserl's transcendental phenomenology or Van Manen's hermeneutic phenomenology because its structured, stepwise procedure for extracting significant statements,

formulating meanings, and clustering themes offers a transparent and replicable analytic trail suited to a multi-stakeholder design involving older adults, family members, and health workers.

Participants and Sampling Procedures

Participants were selected using purposive sampling based on the following inclusion criteria: older adults aged ≥ 60 years who had previously utilized elderly health services at ILP Cluster 3. Purposive sampling was combined with maximum variation sampling to capture a range of ages, genders, and levels of physical independence among the older adult participants, as well as differing roles among supporting participants (family caregivers, community health workers/kader, and PPKBD officers), so that the resulting themes would reflect diverse rather than homogeneous experiences. Recruitment began with community health workers and PPKBD officers identifying eligible older adults from the Posyandu Lansia attendance register; the researcher then approached each candidate in person to explain the study, confirm eligibility, and obtain written informed consent before scheduling an interview, while family caregivers were reached through referrals from the older adult participants they accompanied. Supporting participants (health workers/community health volunteers) were also involved to facilitate data triangulation. The sample size was not determined based on statistical calculations but rather on the sufficiency of information until data saturation was achieved (Hennink & Kaiser, 2022). A total of 30 participants were included: 15 older adults for individual in-depth interviews (P01–P15), one focus group discussion of 6 older adults, and 9 supporting participants comprising 2 community health workers, 1 cadre leader, and 6 family members/PPKBD officers a composition consistent with recommendations for reaching meaningful saturation in phenomenological studies of a relatively homogeneous target population (Hennink & Kaiser, 2022). Data collection was halted based on the structure of the interview guide, code saturation, and the absence of new emerging themes (Squire et al., 2024). Specifically, data collection was halted after the 15th individual interview and the focus group discussion, when no new codes or subthemes emerged across the last three consecutive interviews, indicating that code saturation had been reached.

Data Collection and Analysis Procedures

Data collection was conducted systematically through in-depth, semi-structured interviews and a review of documentation of ILP activities. The researcher served as the primary instrument, using an open-ended interview guide to help participants freely express their experiences, benefits, challenges, and expectations (Pyo et al., 2023). Each individual interview lasted approximately 30–45 minutes and was conducted face-to-face at a location chosen by the participant predominantly their home or the Posyandu Lansia post to ensure comfort and privacy, while the focus group discussion, comprising 6 participants, lasted approximately 60 minutes and was held at the community health center. Interviews and the FGD were guided by a semi-structured guide of 10–12 open-ended questions covering participants' experiences, perceived benefits, family support, barriers, and expectations, and were audio-recorded with participants' consent using a digital voice recorder, supplemented by field notes. Audio recordings were transcribed verbatim within 24–48 hours of each interview to preserve contextual accuracy, and transcripts were returned to a subset of participants for member checking prior to analysis.

The data obtained were then processed and analyzed using a systematic and iterative thematic analysis method (Saunders et al., 2023), following Colaizzi's (1978) seven-step procedure: (1) reading each transcript repeatedly to gain a sense of the whole; (2) extracting significant statements directly related to the phenomenon; (3) formulating meanings from each significant statement; (4) clustering formulated meanings into theme clusters; (5) integrating results into an exhaustive description of the phenomenon; (6) condensing the exhaustive description into a fundamental structure; and (7) validating the fundamental structure with participants through member checking. The analysis process began with transcribing the interview recordings word for word (verbatim) and reading the text repeatedly to fully understand the context. Next, the researcher coded relevant units of meaning, grouped similar codes into categories, and synthesized them into main themes that comprehensively describe the phenomenon (Squire et al., 2024). Coding was performed manually and cross-checked

using ATLAS.ti software to organize codes, categories, and themes systematically and to maintain a traceable coding record; a second coder independently coded 20% of the transcripts, and coding discrepancies were resolved through discussion until consensus was reached.

Data Validity and Evaluation

The validity and quality of the research findings were evaluated based on four criteria of qualitative reliability. Credibility was assessed through member checking of the transcripts with participants, as well as data source triangulation and peer debriefing sessions with two senior qualitative researchers from the Faculty of Health Sciences, who reviewed the coding framework and emerging themes to challenge the researcher's interpretations. Transferability was ensured by providing detailed and in-depth descriptions of the research context and participant characteristics. Meanwhile, dependability and confirmability are evaluated by maintaining an audit trail at every stage of coding and analysis to minimize the researcher's subjective bias. Inter-coder agreement for the independently double-coded transcripts reached 85%, calculated using percent agreement, with remaining discrepancies resolved by consensus. The researcher also maintained a reflexive journal throughout data collection and analysis to document personal assumptions, decisions, and potential biases arising from her professional background in community nursing, and revisited this journal during coding to minimize its influence on interpretation. This study has been approved by the Health Research Ethics Committee (KEPK) of Universitas Muhammadiyah Purwokerto with approval number KEPK/UMP/166/IV/2026.

3. Results and Discussion

The results of this study describe older adults' experiences in utilizing integrated primary care services, as well as the perspectives of their families, community health workers, PPKBD staff, and health care providers as stakeholders who support older adults' use of health care services. Data were collected through in-depth interviews and focus group discussions (FGDs) and were subsequently analyzed thematically. Based on the data analysis, five main themes emerged: (1) older adults' experiences using health services, (2) older adults' perceptions of health services, (3) family support in service utilization, (4) barriers to accessing services, and (5) older adults' expectations regarding health services.

Table 1.
Characteristics of Key Respondents

Participant Group	Code	n	Age (years)	Female	Male	Role
In-depth Interview (IDI)	P01-P15	15	60-80	7	8	Older adults
Focus Group Discussion (FGD)	FGD1-FGD6	6	60-67	6	0	Older adults
Supporting Participants	PP1-PP9	9	21-50	7	2	Nurse (2), Elderly family (5), Cadre leader (1), PPKBD (1)
Total	-	30		20	10	

Results

Table 2.
Hierarchical Theme Matrix and Conceptual Structure

Hierarchical Level	Theme / Subtheme Name	Conceptual Mapping / Relationship
Core Theme	Integrated Model of Family-Mediated and System-Constrained Elderly Care Utilization	Represents the overarching phenomenon explaining how older adults' utilization of Cluster 3 ILP services is driven by individual perceptions, mediated by family support, and restricted by system-level barriers.
Theme 1	Older Adults' Experiences	Baseline engagement reflecting routine participation and

Hierarchical Level	Theme / Subtheme Name	Conceptual Mapping / Relationship
Subtheme 1.1	with Health Care Services	initial service touchpoints.
Subtheme 1.2	Experiences with Elderly Health Care Services	Drives regular attendance at Posyandu Lansia and Prolanis for health monitoring.
Subtheme 2.1	Older Adults' Perceptions of Health Care Services	Affective and cognitive evaluations influencing ongoing utilization decisions.
Subtheme 2.2	Healthcare services are perceived as beneficial for maintaining and monitoring health	Perceived utility in early disease detection and habit regulation.
Subtheme 2.2	Healthcare services are perceived as providing high-quality care	Positive appraisal of friendly staff interactions, counterbalanced by facility limits.
Theme 3	Family Support in Utilizing Services	Primary mediating channel bridging individual limitations and service access.
Subtheme 3.1	Forms of Family Support for the Use of Health Services	Tangible, emotional, instrumental, and transportation assistance provided by families
Subtheme 3.2	The Role of the Family in Improving Older Adults' Compliance with Health Services	Family enforcement of schedules, lifestyle modifications, and medication adherence.
Theme 4	Barriers to Accessing Services	Constraints suppressing service utilization potential.
Subtheme 4.1	Barriers Related to Individual and Family Factors	Physical limitations, lack of caregivers, and psychological hesitation/fear.
Subtheme 4.2	Barriers in the Health Care System	Consumable stockouts (test strips) and extended waiting times.
Theme 5	Older Adults' Expectations Regarding Health Care Services	Stakeholder feedback loop for future health system optimization.
Subtheme 5.1	Hopes for Improved Quality of Health Care	Desires for streamlined queuing, dedicated consultations, and continuity of care.
Subtheme 5.2	Expectations for the Development of Elderly Care Programs	Demands for adequate supplies, direct medication, exercise, and rewards.

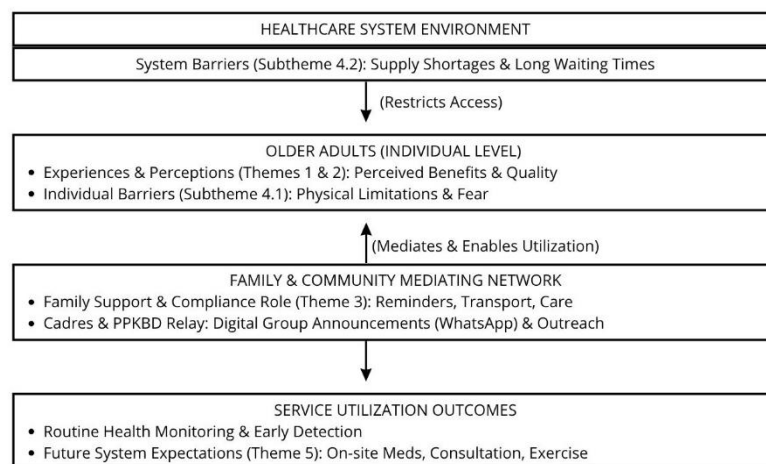


Figure 1. Interaction Model of Older Adults' Utilization of Cluster 3 ILP Services

This model illustrates the interaction process for utilizing Cluster 3 ILP services, in which the family and community volunteer networks serve as the primary drivers that bridge the physical limitations of older adults and systemic barriers to ensure optimal service utilization.

Theme 1. Older Adults' Experiences with Health Services. Subtheme 1. Experiences with Health Services for Older Adults. Data show that routine attendance at Posyandu Lansia and Prolanis serves as a primary health-monitoring routine for older adult participants. Beyond clinical measurement, regular attendance fulfills a psychological need by providing reassurance (*"feeling at ease"*) regarding their physical condition. A cross-group comparative analysis highlights how different stakeholders view this routine attendance: older adults experience emotional reassurance, families manage physical logistics, cadres drive community outreach, and health workers frame visits as population surveillance.

"... If there's a checkup, I go. They check my blood pressure and blood sugar, so I know how my body is doing. If the results are good, I'm happy; if something's high, I'll watch what I eat later..." (P03, Older Adult, 72 years old)

"I spread the word in the group chat, and during the monthly gathering, I also remind them to come in for a health checkup every month so their health can be monitored." (PP8, Cadre Leader)

Subtheme 2. Experiences with Access to Health Care. Participants experienced health care access primarily through point-of-care diagnostic screenings—including blood pressure, blood sugar, cholesterol, uric acid, and weight checks—paired with health education. Older adults and families utilize screening feedback as a practical guide for daily home care and dietary modifications, while cadres and health workers focus on medication adherence instruction.

"...they check my blood pressure, blood sugar, and cholesterol. So I know what the results are... if my blood sugar goes up, I cut back on my food. That way I can keep it under control..." (P09 & P15, Older Adults)

"Usually, they check blood pressure, blood sugar, cholesterol, and uric acid." (PP9, PPKBD)

Theme 2. Older Adults' Perceptions of the Benefits of ILP Services. Subtheme 1. Healthcare services are perceived as beneficial for maintaining and monitoring health. Stakeholders perceive routine ILP services as an essential preventive mechanism. Older adults evaluate benefit through secondary prevention—recognizing that early detection prevents sudden health deterioration. Cadres observe an upward trend in community health awareness, noting that regular monthly tracking allows for consistent health management.

"... They check blood pressure and blood sugar. That way, you know your health status. It's better to know early on than to let the condition get worse later..." (P03, Older Adult, 72 years old)

"Obviously, it's to check your condition. Prevention is better than treatment. So if you know your blood pressure and blood sugar levels, you can adjust your diet accordingly." (PP3, Family Caregiver)

Subtheme 2. Healthcare services are perceived to provide good quality care. Quality of care is predominantly evaluated based on the interpersonal conduct of healthcare personnel. Friendly and communicative staff behaviors generate a comfortable environment that encourages repeat visits. However, while older adults and families express high satisfaction, cadres identify physical supply limitations (test strip shortages) as a constraint on service completeness.

"...the staff are kind and friendly; after the examination, they also explain the results..." (P11, Older Adult, 60 years old)

"Actually, the service is good, but the supply of cholesterol and uric acid test strips is sometimes limited." (PP9, PPKBD)

Theme 3. Family Support in the Use of Health Services for Older Adults. Subtheme 1. Forms of Family Support for the Use of Health Services. Family support manifests across four primary dimensions: instrumental (transportation and accompaniment), informational (schedule reminders), emotional (alleviating fear), and behavioral (encouraging exercise and diet). Cadres emphasize that because many older adults lack smartphones or digital literacy, family mediation is indispensable.

"...if there's information about a Posyandu, I'll say, 'There's an Elderly Posyandu tomorrow; make sure to go.' Then I'm the one who takes her there." (PP5, Family Caregiver)

"Their family members should remind them, 'Come along tomorrow.' After all, not all older adults have cell phones." (PP8, Cadre Leader)

Subtheme 2. The Role of the Family in Improving Older Adults' Compliance with Health Services. Family involvement directly improves older adults' adherence to health checkups and treatments. Information flows through a two-tier channel: digital announcements are posted in community WhatsApp groups received by adult children, who then verbally remind and accompany their elderly parents.

"It's very influential. Because for the health of our parents, older adults need to be monitored." (PP5, Family Caregiver)

"There's a WhatsApp group... From the RT." (FGD Participants)

Theme 4. Barriers to Accessing Health Services for Older Adults. Subtheme 1. Barriers Related to Individual and Family Factors. Utilization barriers at the individual and family level stem from physical mobility limitations, lack of accompanying caregivers, and psychological hesitation (fear of discovering illness or needle phobia).

Table 3.
Cross-Group Comparison of Individual & System Barriers

Subtheme / Barrier Type	Older Adults' Experience	Family Caregivers' Perspective	Cadre & Health Worker Perspective
Physical & Mobility Limits	Difficulty walking or navigating long/narrow alleys (<i>gang</i>).	Physical strain in assisting mobility-impaired parents without transport.	Identification of homebound elderly requiring specialized home visits.
Absence of Caregiver	Reluctance or inability to travel to posts alone.	Conflicts between caregiving duties and daily work schedules.	Primary driver of non-attendance among isolated elderly.
Psychological Hesitation	Fear of needle injections or discovering serious illness.	Difficulty persuading reluctant parents who feel "currently healthy".	Avoidance behavior rooted in medical denial or fear of bad diagnosis.

"My mom sometimes has a hard time getting here. She uses crutches, and the alley is quite a long way in." (PP4, Family Caregiver)

"Afraid their illness will be discovered... Some are afraid of needles; they don't want to get injected." (FGD Participants)

Subtheme 2. Barriers in the Healthcare System, At the health system level, utilization is constrained by consumable shortages (lack of cholesterol/uric acid test strips), extended wait times causing physical fatigue, and the lack of immediate medical consultations and on-site medication dispensation.

"There's often a shortage of cholesterol test strips... If there's a shortage of cholesterol test strips, the same goes for uric acid." (PP8 & PP9, Cadres/PPKBD)

"The worst part is having to wait in line... In my opinion, the healthcare system should be streamlined so that older adults don't have to wait in line for too long." (PP6, Family Caregiver)

Theme 5. Expectations Regarding Health Care for Older Adults. Subtheme 1. Expectations Regarding Improvements in the Quality of Health Care. Participants express a desire for structural improvements in service delivery, specifically requesting streamlined queuing processes to reduce physical fatigue, the integration of dedicated consultation spaces, and broader continuity of care.

"In addition to checkups, there should also be consultations, so older adults can discuss their concerns and know what to do next." (PP3, Family Caregiver)

"The service system should be streamlined so older adults don't have to wait in line for too long." (PP6, Family Caregiver)

Subtheme 2. Expectations for the Development of Elderly Care Programs, Expectations for program development focus on guaranteeing continuous stocks of screening kits, providing immediate

on-site medication dispensation, integrating regular physical exercise sessions, and offering symbolic rewards for consistent attendance.

"If possible, we'd like to have our own equipment to check blood sugar and cholesterol levels... Once we've been checked, the medication should be provided right away." (PP8 & PP9, Cadres/PPKBD)

"We hope there will be exercise sessions every week to keep us in better shape." (FGD Participants)

Discussion

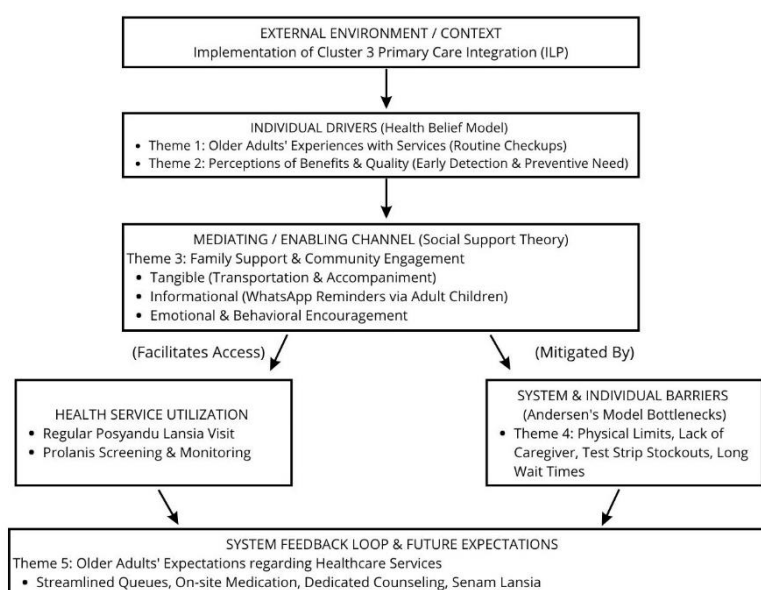


Figure 2. Conceptual Explanatory Model of Family-Mediated and System-Constrained Elderly Healthcare Utilization

This model shows that older adults' use of health services in ILP Cluster 3 is driven by their individual awareness of the benefits of early detection (Themes 1 & 2), but its success is strongly mediated by family support through access to transportation, WhatsApp reminders, and emotional support (Theme 3). Nevertheless, service utilization remains limited by systemic barriers such as physical limitations, shortages of test strips, and long wait times (Theme 4), which ultimately give rise to hopes for service improvements (Theme 5) as feedback for future system optimization.

- Older Adults' Experiences in Utilizing Health Services, Routine attendance at Posyandu Lansia and Prolanis reflects the interaction between evaluated need factors (monitoring health status) and primary care access under Andersen's Model. Engagement is driven by psychological reassurance ("feeling at ease"), transforming clinical checks into dietary self-efficacy. As noted in The Lancet Healthy Longevity, primary care utilization is maximized when services foster personal agency and psychological comfort (Chen et al., 2023). Stakeholders view these visits through distinct functional lenses, ranging from personal tracking to population surveillance.
- Older Adults' Perceptions of the Benefits of ILP Services, In accordance with the Health Belief Model (HBM), *perceived benefits* act as a primary cognitive driver overriding initial reluctance. Early disease detection increases checkup adherence. However, a gap exists between high satisfaction with interpersonal staff conduct and facility limitations. Systemic supply shortages (test strip stockouts) compromise objective quality. *BMC Geriatrics* emphasizes that sustaining high user satisfaction requires combining empathetic communication with reliable supply chains (Najafi et al., 2023).
- Family Support in the Use of Health Services, Under Social Support Theory, family members provide essential instrumental, informational, and emotional support. Filial obligation (*unggah-ungguh*) and digital barriers drive this reliance. As schedules move to digital platforms (WhatsApp), family members serve as "digital-to-relational bridges" for non-literate older adults. Recent

empirical evidence highlights that active family involvement and spousal/child support directly govern healthcare access and treatment adherence among older adults in community settings (Yu et al., 2025). Without active family mediation, structural healthcare access often fails to translate into actual service utilization.

- d. Barriers to Accessing Health Care for Older Adults, Barriers operate across individual and systemic levels: a) Psychological Avoidance: High perceived severity without adequate health literacy triggers fatalistic avoidance mechanisms. Fear of diagnosis (*diagnosis anxiety*) or invasive procedures leads to screening refusal. Empirical findings in geriatric care demonstrate that older adults frequently avoid timely medical consultations and screenings due to emotional factors—including denial, fear of serious diagnoses, and anxiety over potential health outcomes—even when they recognize the severity of their condition (Sengupta et al., 2022); b) Systemic Bottlenecks: Under Andersen's Model, despite strong *need factors*, limited *enabling resources* (test strip shortages, long wait times, lack of on-site medication) force exhausting secondary clinic visits (Purwito et al., 2025). *BMC Geriatrics* highlights that inefficient queuing and resource deficits suppress future care-seeking among frail elderly populations (Pyo et al., 2023).
- e. Expectations Regarding Health Care for Older Adults, Stakeholder expectations for streamlined queuing, dedicated consultation spaces, supply reliability, on-site medication, and group exercise provide a vital feedback loop for system optimization. Aligning with primary care integration frameworks in *Primary Health Care Research & Development*, optimizing Cluster 3 ILP requires three strategic actions (Dodd et al., 2019): a) Supply Reliability: Decentralize procurement to prevent screening kit stockouts at Posyandu; b) Point-of-Care Integration: Provide immediate basic medication and dedicated counseling at local posts to reduce secondary health center visits; c) Age-Friendly Infrastructure: Streamline registration, establish home-visit protocols for homebound elderly, and integrate weekly group exercise (*senam lansia*).

4. Conclusion

This study concludes that older adults' utilization of Cluster 3 Primary Care Integration Services (ILP) is not solely determined by the availability of services, but rather by the interplay between their positive experiences and perceptions regarding the benefits of health checkups, support from family and community health workers, and barriers such as physical limitations, the absence of a companion, and limited service facilities. This is consistent with the findings (Tegalrejo et al., 2024) that knowledge, attitudes, family support, and the quality of service provided by staff influence the regularity of older adults' visits. The contribution of this study lies in its more comprehensive portrayal of the experiences of older adults through a phenomenological approach that incorporates the perspectives of family members, community health workers, PPKBD staff, and healthcare professionals, thereby complementing previous studies, which have generally been quantitative in nature (Wang & Liu, 2021) (Maulida et al., 2026). In practical terms, these findings imply the need to strengthen education for older adults and their families, provide support and assistance to older adults with limited mobility, and develop more comprehensive and responsive services, in line with the principles of integrated care and the importance of equitable access to primary care for older adults (Gao et al., 2022). This study has limitations because the data were collected from a single service area and some of the participants' experiences were retrospective; therefore, future research should expand its scope to include a wider variety of regions and characteristics of older adults, including those with limited mobility or who do not yet use the services on a regular basis.

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