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Implementation of Primary Health Care Integration (ILP) to enhance cadre competence and *posyandu* service standards

Kusuma Estu Werdani[1], Dwi Linna Suswardany[1], Dian Hudiyawati[2], Windi Wulandari[1], Beti Kristinawati[2] Yeni Indriyani[1], Anggi Putri Aria Gita[3]

[1]Department of Public Health, Faculty of Health Science, [2]Department of Nursing, Faculty of Health Science, Universitas Muhammadiyah Surakarta
Jl. Ahmad Yani Tromol Pos I, Pabelan, Kartasura, Sukoharjo, Central Java 57169, Indonesia
[3]Department of Health Administration, Faculty of Public Health, Universitas Kusuma Husada
Jl. Jaya Wijaya No. 11, Kadipiro, Surakarta, Central Java 57136, Indonesia

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ABSTRACT

The Integration of Primary Health Care (ILP) requires posyandu cadres to be competent in delivering life-course–based health services. In Tawang Village, Weru Subdistrict, Sukoharjo Regency, none of the posyandu cadres had received ILP training, so no posyandu in the village was able to operate ILP-standard services. This community service program aimed to improve the knowledge and basic skills of Tawang Village posyandu cadres so that they are prepared to deliver ILP-standard posyandu services. The program involved 37 cadres from five posyandu and was carried out in three stages: ILP education, mentoring of ILP service practice using the five-table system, and evaluation of cadre knowledge and basic skills. The cadres' knowledge was already good before the activity (median 92) and became higher and more uniform afterwards (median 96), with a statistically significant difference ($p = 0.013$). Skill mapping showed that 37.9 percent of cadres reached the "utama" (advanced) category, 29.7 percent "madya" (intermediate), and 32.4 percent "purwa" (novice), revealing skill gaps between posyandu. As an impact, the activity produced a cadre competency map that enables the village midwife and Weru Public Health Center to provide targeted mentoring so that all five posyandu in Tawang Village can meet ILP service standards. Tiered mentoring is recommended, prioritising posyandu with a high proportion of basic-level cadres.

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1. INTRODUCTION

Tawang Village, Weru District, Sukoharjo Regency, has five integrated health posts (*posyandu*), namely Posyandu Anggrek, Mawar, Melati, Teratai, and Kenanga, which have long served as the spearhead of basic healthcare services for the village community. In line with the Primary Health Care Integration (ILP) policy, integrated health posts are required to expand beyond providing immunizations and maternal and child health services to delivering promotional, preventive, basic curative services, and early detection of communicable and non-communicable diseases across all life stages, ranging from

✉ Corresponding Author: **Kusuma Estu Werdani:** Tel. +62 271-717417 | E-mail: kusuma.werdani@ums.ac.id

pregnant women, infants, school-aged children, adolescents, adults, to the elderly (Faza et al., 2022). The success of this service transformation relies heavily on the readiness of *posyandu* cadres as healthcare implementers at the community level (Setiaasih et al., 2025).

The primary challenge faced by the partner is that none of the *posyandu* cadres in Tawang Village have received Primary Health Care Integration (ILP) training. Tawang Village is currently the only village in Weru District where no cadres have been trained in ILP. This condition directly contributes to the absence of operational ILP-standard *posyandu* in Tawang Village, as cadres remain unequipped to deliver comprehensive healthcare services, particularly for adolescent and elderly demographics, as well as for non-communicable disease prevention. Initial identification conducted jointly with the village midwife and the Weru Primary Health Center (*Puskesmas Weru*) revealed that this low level of cadre competency constitutes the root cause of the non-implementation of ILP *posyandu* in the village.

As supporting context, mapping of existing conditions regarding *posyandu* and cadres in Sukoharjo Regency highlights a substantial gap between the current state and Strategic Plan (*Renstra*) targets. Out of 1,206 *posyandu*, only 273 (22.6 percent) have achieved ILP status, while on the cadre side, only 4,246 out of 7,652 cadres (55.5 percent) have undergone training and assessment (Table 1 and Table 2). Specifically, in Weru District, merely 5 out of 69 *posyandu* (7.2 percent) hold ILP status, and only 48 out of 492 cadres (9.7 percent) are trained, placing Weru as the most underdeveloped district in this regard. These specific data reinforce the urgency of conducting community service activities in Tawang Village (Rachmaningsih & Sari, 2025).

Table 1. Existing condition of ILP *posyandu* in Sukoharjo Regency (n = 1206)

District	Existing Condition ILP *Posyandu*	Strategic Plan Target (*Posyandu* in Total)	Gap	Percentage of *Existing* ILP *Posyandu* (%)
Baki	34	116	82	29.3
Bendosari	5	93	88	5.42
Bulu	65	65	0	100
Gatak	26	92	66	28.3
Grogol	19	137	118	13.9
Kartasura	6	96	90	6.33
Mojolaban	1	126	125	0.81
Nguter	86	86	0	100
Tawangsari	6	75	69	8.06
Polokarto	9	128	119	7.04
Sukoharjo	11	123	112	8.97
Weru	5	69	64	7.25

Tabel 2. Data on trained ILP cadres in Sukoharjo Regency (n = 7652)

District	Number of Trained Cadres	Total Number of Cadres	Gap	Percentage of Trained Cadres (%)
Baki	28	463	435	6.05
Bendosari	95	610	515	15.57
Bulu	357	364	7	98.08
Gatak	220	356	136	61.79
Grogol	1023	1149	126	89.03
Kartasura	332	997	665	33.29
Mojolaban	250	818	568	30.56
Nguter	447	447	0	100
Tawangsari	185	368	183	50.27
Polokarto	776	795	19	97.61
Sukoharjo	485	793	308	61.16
Weru	48	492	444	9.75

Beyond skill limitations, *posyandu* cadres are typically volunteers with limited incentives who must balance community duties, household responsibilities, and family economic activities (Cahyani et al., 2022; Rahmawati et al., 2019). Rather than a root cause, this condition represents a sustainability challenge requiring institutional policy support from both the village government and the primary health center to maintain cadre competency gains (Aisah et al., 2024; Isworo et al., 2026).

Training and mentoring offer an effective solution to these partner challenges. Evidence shows that structured education paired with hands-on practice significantly improves cadres' knowledge and operational skills in basic healthcare delivery (Arifah et al., 2023; Irdawati et al., 2023; Kusumawati et al., 2024; Setyoningrum et al., 2025). Previous outreach in Tawang Village targeting early detection of non-communicable disease risk factors similarly yielded marked knowledge improvements (Kusumawati et al., 2024), confirming the local relevance of competency-building initiatives. Consequently, the service team deployed an appropriate technology initiative, namely the "ILP Program," delivering structured education and practical mentoring on the five-table ILP service model to address the existing training gap in Tawang Village.

To address these challenges, this community service initiative specifically aims to enhance the foundational knowledge and practical skills of *posyandu* cadres in Tawang Village, Weru District, through ILP training. The project seeks to elevate operational readiness and service standards across all five village *posyandu* while establishing a cadre competency profile to guide ongoing mentorship by the village midwife and the Weru Primary Health Center.

2. METHODS

Partners, Location, and Target

The activity partners were the *posyandu* cadres of Tawang Village, Weru District, Sukoharjo Regency. The initiative was conducted at the Tawang Village Hall on December 11, 2025, involving 37 cadres across five *posyandu*, specifically Posyandu Anggrek (7 cadres), Mawar (8 cadres), Melati (7 cadres), Teratai (7 cadres), and Kenanga (8 cadres). Partner selection was based on an initial survey conducted jointly with the village midwife and the Weru Primary Health Center, which revealed that none of the cadres in Tawang Village had received ILP training.

The characteristics of the cadres, reflecting the available human resources of the partner, are presented in Table 3. The majority of cadres were aged 36 to 50 years, with a mean age of 46 years. Half of the participants (50 percent) had completed secondary or higher education, most were homemakers (83.9 percent), and nearly half had served as cadres for over 10 years.

Concept and Technology of the ILP Program

The implemented solution is the "ILP Program" as an appropriate technology, consisting of an educational package and practical mentoring on ILP services based on the *Basic Health Skills Handbook for Cadres* issued by the Ministry of Health of the Republic of Indonesia (Kementerian Kesehatan RI, 2023). The program encompasses the mastery of 27 basic cadre skills categorized into five service groups: (1) *Posyandu* management; (2) Infants and toddlers; (3) Pregnant and lactating women; (4) School-aged children and adolescents; and (5) Adults and the elderly. Supporting technologies utilized include PowerPoint presentation slides (45 slides), paper-based knowledge questionnaires (25 multiple-choice questions), and practical *posyandu* service equipment, such as anthropometric tools, mid-upper arm circumference measurement tapes, scales, waist circumference tapes, tensiometers, Maternal and Child Health books, and *Posyandu* Examination Auxiliary Cards.

Table 3. Characteristics of *posyandu* cadres in Tawang Village (n = 37)

Characteristics	Categories	Frequency (n)	Percentage (%)
Age (years)	26–30	1	3.3
	31–35	2	6.4
	36–40	5	16.1
	41–45	6	19.4
	46–50	5	16.1
	51–55	2	6.4
	56–60	4	12.9
	61–65	1	3.3
	Unspecified	5	16.1
	Min. 26; Max 64; Mean 46		
Education Level	Elementary School Graduate	5	16.1
	Junior High School Graduate	7	22.6
	Senior High School Graduate	12	38.7
	Higher Education graduate	4	12.9
	Unspecified	3	9.7
Job	Housewife	26	83.9
	Merchant	2	6.4
	Unspecified	3	9.7
Length of service as a cadre (years)	0–4	3	9.7
	5–9	7	22.6
	10–14	6	19.4
	15–19	4	12.9
	25–29	2	6.4
	40–44	1	3.3
	Unspecified	8	25.7

In brief, the problem-solving framework applied by the team is presented in Figure 1, which illustrates the flow of strengthening cadre competencies ranging from education and practical ILP service delivery using the five-table system to competency assessment.

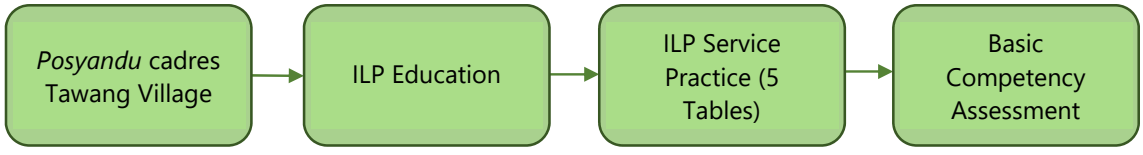


Figure 1. Problem-solving solution framework

Success Indicators

Program implementation success was measured using the following quantitative indicators: (1) Knowledge enhancement, defined as a statistically significant difference between pre-test and post-test scores ($p < 0.05$); (2) Skill advancement, represented by the proportion of cadres reaching intermediate (*madya*) and advanced (*utama*) levels, with a minimum target of having at least one advanced cadre per *posyandu* to serve as a mentor; and (3) Service readiness, indicated by the availability of a cadre competency map for each *posyandu* as a foundation for implementing ILP services.

Implemetation Stages

The activity was conducted in sequential stages, as summarized in Table 4. The structuring of these stages follows the education-practice-evaluation approach commonly utilized in health cadre training programs (Crawford et al., 2025; Setyoningrum et al., 2025).

Table 4. Stages, activities, objectives, implementers, and timeline

Stage	Activity	Objectives	Implementers	Timeline
1	Initial survey & coordination	Identify partner and baseline problems (cadres untrained in ILP)	Community Service Team, Village Midwife, Weru Primary Health Center	Before Dec 11, 2025
2	Pre-test	Measure cadres' baseline knowledge	Community Service Team	Dec 11, 2025
3	ILP Education	Enhance cadres' knowledge regarding ILP	Community Service Team	Dec 11, 2025
4	Post-test	Measure knowledge changes	Community Service Team	Dec 11, 2025
5	ILP Service Practice (5 Tables)	Train ILP service skills	Community Service Team, Village Midwife, Health Promotion & Nutrition Officers	Dec 11, 2025
6	Competency/skill assessment	Map cadre competencies per *posyandu*	Village Midwife & Community Service Team	± one week post-education

Technically, the ILP education was delivered through a lecture format supported by PowerPoint presentations lasting 45 to 60 minutes. The session was preceded by a pre-test and concluded with a post-test administered 15 to 20 minutes following the question-and-answer session, utilizing the same 25-item questionnaire. All cadres participated in the practical ILP service delivery through a five-table simulation, which comprised: (1) Registration; (2) Weighing and measurement; (3) Recording in the Maternal and Child Health (*KIA*) book and Auxiliary Cards; (4) Healthcare services; and (5) Health counseling, with guidance from the village midwife as well as health promotion and nutrition officers from the Weru Primary Health Center. Competency assessments were conducted by the village midwife and the community service team to classify the cadres into three skill categories: (1) Novice (*Purwa*) Cadres, mastering three skill groups comprising two mandatory skills (*posyandu* management and infant/toddler services) plus one elective skill; (2) Intermediate (*Madya*) Cadres, mastering four skill groups comprising the three novice-level skills plus another elective skill; and (3) Advanced (*Utama*) Cadres, mastering all skills across all five service groups.

3. RESULTS AND DISCUSSION

Results

This community service initiative was conducted at the Tawang Village Hall on December 11, 2025. The event was attended by the Head of Tawang Village, the Tawang Village Midwife, the Health Promotion Coordinator of the Weru Primary Health Center, the Weru Primary Health Center Nutrition Officer, and all *posyandu* cadres from Tawang Village. The activities spanned a one-week period, comprising: (1) Opening remarks by the Head of Tawang Village; (2) Pre-test; (3) ILP education; (4) Post-test; (5) Practical ILP service delivery; and (6) Evaluation through cadre skill assessments. A total of 37 *posyandu* cadres attended the program, representing five *posyandu*: Posyandu Anggrek, Posyandu Mawar, Posyandu Melati, Posyandu Teratai, and Posyandu Kenanga. Each *posyandu* was staffed by 6 to 8 cadres.



Figure 2. Opening remarks by the Head of Tawang Village

Pre-test

The pre-test involved administering a questionnaire to the *posyandu* cadres after registration and prior to the educational session. Before the training, cadres completed a paper-based pre-test questionnaire comprising 25 multiple-choice questions that covered details of the 25 basic health cadre skills. Participants were allocated approximately 10 to 15 minutes to complete the test. Educational material was delivered face-to-face via a lecture format supported by PowerPoint presentations. The content detailed all operational steps for ILP services across five skill groups: (1) *Posyandu* management; (2) Infants and toddlers; (3) Pregnant and lactating women; (4) School-aged children and adolescents; and (5) Adults and the elderly. All instructional materials were adapted from the *Basic Health Skills Handbook for Cadres* published by the Ministry of Health of the Republic of Indonesia and condensed into 45 presentation slides. The session lasted 45 to 60 minutes. Following the presentation and a 15-minute interval, cadres completed the same paper-based questionnaire for the post-test evaluation.

ILP education and knowledge assessment

Cadres' baseline knowledge was categorized as good prior to the activity, with a median pre-test score of 92 out of 100. Following the educational session, the median score increased to 96, and the distribution of scores became more uniform, as evidenced by an increase in the minimum score from 52 to 76 (Table 5). Out of 37 cadres, 13 experienced score increases, 2 showed decreases, and 16 maintained unchanged scores. In other words, while the education did not substantially alter the scores of cadres who already possessed high baseline knowledge, it successfully elevated those with lower scores, resulting in a more uniform knowledge level across all cadres.

Table 5. Comparison of knowledge score before and after education (n = 37)

Measurement	Median (Min–Max)	Increased	Decreased	Unchanged	p-value
Pre-test	92 (52–100)	–	–	–	0.013*
Post-test	96 (76–100)	13	2	16	

**Wilcoxon Test Signed Ranks Test; The data are not normally distributed. (Shapiro–Wilk, p < 0,05).*

The Wilcoxon signed-rank test demonstrated a statistically significant difference between the pre-test and post-test scores (p = 0.013). This result indicates that the ILP education was effective in enhancing cadres' knowledge, although the practical increase in the median score was relatively modest due to the high baseline knowledge already possessed by the cadres.




Figure 2. Cadres completing the ILP knowledge pre-test questionnaire
Figure 3. Educational session on ILP

ILP service practice

Upon completing the post-test, all cadres received guidance in practicing ILP service delivery through the five-table system. The meeting room was arranged to mirror an operational five-table *posyandu* layout, comprising: (1) Registration; (2) Weighing and measurement; (3) Recording; (4) Healthcare services; and (5) Health counseling.




Figure 4. Practical session on weighing and measurement techniques
Figure 5. Practical session on data recording in auxiliary books

The practical ILP service session proceeded smoothly. The primary training need identified was the skill of recording data in auxiliary books, which involve extensive entries that vary according to the target groups of the *posyandu*. Each cadre practiced every stage of the process, allowing their competency status to be measured effectively.

Cadre skill evaluation

Skill assessments were conducted approximately one week following the educational session and practical training. Overall, of the 37 cadres, 14 (37.9 percent) achieved the advanced (*utama*) category, 11 (29.7 percent) reached the intermediate (*madya*) category, and 12 (32.4 percent) were classified into the novice (*purwa*) category (Table 6). The proportions of advanced and novice cadres were nearly balanced, indicating that a skill gap among cadres remains.

Disparities in cadre skill levels were also evident across the different *posyandu*. Posyandu Melati demonstrated the highest level of readiness, with 5 of its 7 cadres (71.4 percent) categorized as advanced. Conversely, Posyandu Mawar required the most intensive guidance, as 4 of its 8 cadres (50.0 percent) remained at the novice level. This distribution pattern serves as the foundation for determining priority supervision by the village midwife and the primary health center.

Table 6. Skill mapping of *posyandu* cadres in Tawang Village

***Posyandu* Name**	***Posyandu* Cadre Skill Level Status**						**Total**	
	Purwa		***Madya***		***Utama***		**N**	**%**
	n	**%**	**n**	**%**	**n**	**%**		
Anggrek	2	28.6	3	42.8	2	28.6	7	100
Mawar	4	50	3	37.5	1	12.5	8	100
Melati	1	14.3	1	14.3	5	71.4	7	100
Teratai	3	42.8	1	14.4	3	42.8	7	100
Kenanga	2	25	3	37.5	3	37.5	8	100
Total	12	32.4	11	29.7	14	37.9	37	100

Activity Outputs

The concrete outputs of this activity are: (1) An increase and equal distribution of cadres' knowledge regarding ILP; (2) A cadre skill competency map per *posyandu* (Table 6), which serves as an instrument for the village midwife and Weru Primary Health Center to design targeted mentorship; and (3) The initial readiness of all five *posyandu* in Tawang Village toward delivering ILP-standardized services.

Discussion

The primary objective of this activity was to enhance the competency of cadres in Tawang Village to ensure their readiness to implement ILP services. The results demonstrate that this objective was successfully achieved across two critical dimensions that serve as prerequisites for standardized *posyandu* services: knowledge and practical skills.

In the knowledge dimension, the educational session proved statistically effective ($p = 0.013$). Given that the cadres possessed high baseline knowledge (median score of 92), the primary impact of the education was not reflected in a dramatic increase in average scores, but rather in achieving knowledge equalization. This is evidenced by the rise in the minimum score from 52 to 76, which effectively narrowed the comprehension gap among cadres. Similar findings were reported by Setyoningrum et al. (2025), who noted a mean score increase from 59 to 85.7 following lectures and direct practical sessions, as well as Crawford et al. (2025), who found that structured training significantly enhanced cadres' knowledge and self-efficacy. The educational approach combined with pre-post evaluations in this study aligns with previous community engagement initiatives across various target populations in Sukoharjo and surrounding areas, which consistently demonstrated knowledge improvement. These include training programs for early detection of non-communicable diseases among cadres in Tawang Village (Kusumawati et al., 2024) and community education programs for other populations (Wulandari et al., 2025). Furthermore, demographic characteristics, such as extensive experience and secondary education levels, facilitated the absorption of instructional material (Arifah et al., 2023; Irdawati et al., 2023).

Theoretically, the enhancement of cadres' knowledge through training and guidance is consistent with empirical studies across various regions, demonstrating that structured training and intensive mentorship effectively improve cadre competence in executing ILP and basic healthcare services at *posyandu*. Participatory training and hands-on practice help cadres comprehend core ILP concepts as well as technical skills, such as recording-reporting and basic health screening. In line with Setyoningrum et al. (2025), who observed a significant post-test increase following direct practice and instruction, the

focus of ILP on life-cycle preventive and promotive health services means that competency enhancement elevates not only theoretical knowledge, but also practical skills and motivation for active engagement in community health (Arifah et al., 2023; Irdawati et al., 2023). Nevertheless, competency evaluations indicate that knowledge gains reach optimal effectiveness when supported by follow-up mentorship and monitoring systems from primary health centers. Overall, pre-post evaluation designs serve as a robust method for assessing public health training interventions, including improvements in knowledge and practical skills (Crawford et al., 2025).

Demographically, the largest proportion of cadres belonged to the 41–45 age bracket (19.4 percent). Cadres in this age group typically exhibit strong learning abilities and high intrinsic motivation to serve their communities, enabling them to absorb educational material and field practices effectively. Predominantly senior high school graduates (38.7 percent), this minimum level of formal education facilitated their understanding of ILP concepts and technical procedures. This foundational literacy enabled cadres to follow instructions, comprehend training materials, and apply them in practice, thereby contributing to higher post-test scores. Furthermore, the majority of cadres had 5–9 years of service experience (22.6 percent). Experienced cadres are generally familiar with *posyandu* operational workflows, field challenges, and community needs, allowing them to contextualize theoretical knowledge into practical settings. Additionally, most cadres had previously attended ILP training (74 percent). These characteristics highlight a relatively experienced and educated participant group, which positively influenced their response to the educational intervention.

The skill assessment of *posyandu* cadres in Tawang Village, Weru District, revealed noticeable disparities across different units. Posyandu Melati exhibited the highest concentration of cadres in the advanced (*utama*) category, whereas Posyandu Mawar had the largest proportion in the novice (*purwa*) category. Across most *posyandu*, cadres were predominantly categorized at the intermediate (*madya*) level. These disparities indicate that despite standardized competency criteria, individual capability varies between units. Posyandu with a higher density of advanced cadres can leverage these individuals as mentors for novice cadres and key drivers of operational activities (Santosa et al., 2025). While units dominated by advanced cadres tend to deliver comprehensive, high-quality healthcare services, those with a higher prevalence of novice cadres often remain focused on basic services and require intensive guidance. Consequently, these findings emphasize the necessity of structured, tiered training strategies to harmonize skill levels across all *posyandu*.

4. CONCLUSION AND RECOMMENDATIONS

The educational program and practical ILP mentorship for *posyandu* cadres in Tawang Village successfully enhanced cadre competency, fulfilling a fundamental prerequisite for standardized *posyandu* services. Knowledge-wise, the intervention significantly increased and equalized cadres' comprehension (median score rising from 92 to 96; $p = 0.013$), primarily by elevating the scores of cadres with lower baseline knowledge. Skill-wise, competency mapping revealed that 37.9 percent of cadres achieved the advanced (*utama*) level, 29.7 percent intermediate (*madya*), and 32.4 percent novice (*purwa*), with Posyandu Melati demonstrating the highest readiness (71.4 percent advanced cadres) and Posyandu Mawar requiring the most guidance (50.0 percent novice cadres). Ultimately, this activity yielded a comprehensive cadre competency map, providing an operational foundation for the village midwife and Weru Primary Health Center to advance the readiness of all five *posyandu* in Tawang Village toward ILP-standardized service delivery.

Future programs are recommended to prioritize targeted mentorship for *posyandu* exhibiting higher proportions of novice cadres, accompanied by the development of ILP service modules or Standard Operating Procedures (SOPs), as well as periodic monitoring by the primary health center and village midwife. Furthermore, a peer-mentoring system pairing advanced cadres with novice cadres should be established, backed by local policy support and incentives from the village government to sustain the long-term engagement of volunteer cadres. Finally, longitudinal evaluations assessing the broader impact on the coverage and service quality of ILP *posyandu* should be conducted to guide subsequent program development.

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