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Strengthening Preventive Health Services in Urban Indonesia: A Qualitative Study from Puskesmas Kuta Alam

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ABSTRACT: This study specifically examines how promotive and preventive health strategies are implemented in Puskesmas Kuta Alam, Banda Aceh, Indonesia, to address the challenges of urban health services. This study aims to explore the implementation dynamics of these strategies at Puskesmas Kuta Alam, an urban public health center in Banda Aceh, Indonesia. Using a qualitative descriptive approach, data were collected through interviews, observations, and document analysis, focusing on four themes: communication, resources, staff disposition, and bureaucratic structure. Findings reveal that while health promotion efforts exist, they are constrained by unidirectional communication practices, low community engagement, and a lack of culturally adapted messaging. Human resource limitations, including an absence of trained personnel and insufficient educational infrastructure, further weaken program effectiveness. Staff demonstrated moral commitment to preventive care but lacked formal training and policy literacy, leading to inconsistent implementation of national health regulations. Moreover, the absence of a clearly defined organizational structure for promotive preventive programs resulted in poor coordination and accountability. These insights highlight the systemic challenges faced by Puskesmas in Banda Aceh in translating health policy into practice. The study recommends adopting participatory communication strategies, enhancing training and infrastructure, and establishing a dedicated institutional unit for preventive services. By contributing to the growing body of knowledge on primary health care implementation in LMICs, the study offers evidence based recommendations to strengthen health promotion capacity at the local level.

Keywords: Health Promotion, Preventive Care, Urban Health Systems, Policy Implementation, Primary Health Care, Indonesia, Community Engagement.

INTRODUCTION

The global transition from curative to promotive and preventive health paradigms reflects a fundamental reorientation in public health strategies. Recognizing that health is not merely the absence of disease but a state of holistic well being, international organizations such as the World

Health Organization (WHO) have increasingly emphasized the necessity for disease prevention and health promotion initiatives, especially in the context of the growing burden of non communicable diseases (NCDs) (Fossati, 2016; Holipah et al., 2020). Preventive approaches have demonstrated their efficacy in improving long term health outcomes while simultaneously reducing financial strain on healthcare systems. In this regard, countries with emerging healthcare systems, including Indonesia, are gradually integrating these paradigms into their national policies and community health strategies (Fröberg & Jönsson, 2021).

Indonesia has made substantial strides toward the institutionalization of promotive and preventive health measures, notably through the enactment of Ministry of Health Regulation No. 75/2014 concerning Puskesmas (community health centers) and Regulation No. 46/2015 on Puskesmas Accreditation. These policy instruments are designed to ensure that health centers prioritize community based prevention and health education over merely treating illnesses (Ayu et al., 2022). Through these efforts, the government seeks to reduce healthcare disparities and improve access to basic health services. Despite these policy efforts, implementation gaps remain, particularly in terms of human resources, infrastructure, and community engagement (Efendi et al., 2022; Holipah et al., 2018). This suggests that while policy intent is robust, practical execution at the grassroots level requires significant reinforcement.

Studies have documented that in many Southeast Asian urban health systems, particularly in Indonesia, the integration of preventive care into primary health services remains insufficient (Nazri et al., 2015; Wijayanti & Fadillah, 2019). The challenges include but are not limited to: inadequate budget allocation, lack of specialized training among healthcare workers, poor intersectoral collaboration, and limited public trust in preventive services. Many communities continue to associate health centers exclusively with curative care, rendering health promotion activities less effective. Cultural attitudes towards illness, health seeking behavior, and skepticism toward immunizations or routine health checks further exacerbate the issue (Kuncoro, 2023). Therefore, in Aceh, public health programs must expand beyond biomedical interventions by integrating culturally sensitive and community-tailored strategies

In the Indonesian context, the urgency to strengthen promotive and preventive programs is compounded by the rising prevalence of NCDs such as diabetes, hypertension, and cardiovascular conditions. These diseases are often linked to modifiable lifestyle factors and are thus preventable with appropriate interventions (Alpaslan et al., 2020). However, the persistent curative orientation of health services limits opportunities for early intervention. Furthermore, the economic burden of NCDs on families and the national health insurance system (BPJS Kesehatan) has underscored the need for shifting investments from treatment to prevention (Astuti et al., 2020; Pikoli, 2021). This public health challenge demands an integrative strategy that encompasses medical, behavioral, and structural components.

Government initiatives such as Posyandu (integrated health service posts) and public immunization campaigns are intended to operationalize these preventive goals at the grassroots level. However, in many urban subdistricts, including Kuta Alam in Banda Aceh, community participation remains inconsistent. Data from the Aceh Provincial Health Profile (2023) indicates

that immunization coverage in some kelurahan (urban villages) within Kuta Alam remains below the national target of 80%. Similarly, attendance rates at maternal and child health services are highly variable, often due to low health literacy, limited motivation, and logistical challenges. These data reflect a broader systemic issue: the insufficient integration of community preferences and behaviors into health program design and delivery (Ge et al., 2017; Widiaryanto, 2020).

Public engagement and perception are critical determinants of the success of health promotion programs. Trust in healthcare providers, perceived relevance of services, and ease of access significantly influence public willingness to participate in preventive health efforts. Research in urban Indonesia shows that campaigns tailored to community language and norms are more effective than generic top down messages (Husada et al., 2017). Feedback mechanisms and community dialogues are also vital in ensuring that health services are aligned with the lived experiences and expectations of the people. Without these mechanisms, health centers risk perpetuating top down interventions that lack local resonance and sustainability.

Despite the availability of national guidelines and structured programs, the effectiveness of their implementation varies significantly across regions and facilities. Previous research by Ummiyun (2015) and Noor (2016) emphasized that community health centers often suffer from internal inefficiencies, including vague staff responsibilities, inadequate training, and lack of systematic program evaluation. These challenges result in a disjunction between policy design and real world practice. Additionally, the multiplicity of roles assigned to healthcare workers who often juggle curative and promotive duties without adequate support further dilutes the quality of preventive service delivery.

A focused case study in Puskesmas Kuta Alam, located in the densely populated and socially dynamic urban area of Banda Aceh, presents a valuable opportunity to analyze these implementation challenges. Kuta Alam exhibits the typical urban health profile: high mobility, diverse socio economic backgrounds, and increased exposure to risk factors. Yet, as one of the key health service providers in the area, Puskesmas Kuta Alam is strategically positioned to lead community oriented preventive efforts. The study aims to explore four interrelated components essential to effective program implementation: communication strategies, availability and management of resources, staff disposition toward policy goals, and the coherence of bureaucratic structures supporting program execution.

This study is grounded in implementation theory as articulated by Edward (1980), which posits that successful policy execution is contingent upon communication clarity, resource sufficiency, implementor disposition, and supportive organizational structure. Applying this framework allows for a structured analysis of the institutional dynamics at play in Puskesmas Kuta Alam. Furthermore, this research aligns with the increasing academic interest in health systems strengthening in low and middle income countries, particularly in examining how national health directives are localized within community health infrastructures (Agustino, 2014; Indiahono, 2017).

The objective of this research is to assess the implementation of promotive and preventive programs at Puskesmas Kuta Alam in 2024, identifying key bottlenecks and opportunities for improvement. This study contributes novel insights into the interplay between policy mandates and grassroots execution in an urban Indonesian context. Unlike prior studies that focused predominantly on policy analysis or service outcomes, this research integrates stakeholder perspectives and organizational assessment to provide a holistic understanding of implementation processes. Ultimately, the findings are intended to inform strategic planning and capacity building at the local level, reinforcing the role of puskesmas as frontline actors in achieving national health objectives through community based preventive care.

METHOD

This study employed a qualitative descriptive approach to explore the implementation of promotive and preventive health programs at Puskesmas Kuta Alam, Kecamatan Kuta Alam, Banda Aceh. A qualitative descriptive method was chosen because it is well suited to capture the specific dynamics of health program implementation in Puskesmas Kuta Alam, including staff experiences, community perceptions, and institutional practices. According to Cofie et al. (2014), qualitative descriptive designs allow researchers to maintain close proximity to the data, facilitating straightforward yet richly contextualized descriptions of events and social processes. This approach was considered the most appropriate to understand the dynamic interplay of institutional, cultural, and interpersonal factors influencing policy implementation in a community health center context.

The research was conducted over a two month period from April to May 2024 at Puskesmas Kuta Alam. This site was purposefully selected due to its role in serving an urban population with high mobility and diverse health challenges, yet with programmatic implementation outcomes that have remained suboptimal. The setting provided a relevant and information rich context for investigating how health promotion policies are enacted at the operational level. The purposive selection strategy was also consistent with qualitative traditions that emphasize the importance of selecting sites that best illuminate the research question (Dodd et al., 2019).

The primary data for this study were collected through in depth interviews with a range of informants directly and indirectly involved in the implementation of the health programs. Informants were categorized into three groups. Key informants included the Head of Puskesmas and the coordinator of the promotive and preventive programs. Their insights were crucial for understanding managerial strategies, policy interpretation, and overall leadership disposition. Main informants consisted of health personnel such as midwives, nurses, and health promotion officers who were actively involved in delivering health education and community outreach. Their perspectives shed light on day to day implementation challenges and practices. Supporting informants included community leaders and local residents who were recipients or observers of the services provided. These stakeholders were instrumental in contextualizing the public's reception, perception, and responsiveness to the health initiatives.

In addition to primary data, the research also utilized secondary data sources, which included program documentation, health center profiles, operational guidelines, and relevant regulatory frameworks. The combination of primary and secondary data sources enabled a deeper understanding of the institutional and policy environments in which the health programs were embedded. This method aligns with recommendations from Tzagkarakis & Kritas (2022),who emphasize that comprehensive policy research in public health should draw from diverse sources to enhance analytical robustness.

Data collection employed a triangulated methodology, incorporating three primary techniques. The first was semi structured in depth interviews, which allowed for consistent yet flexible exploration of pre-determined themes while also enabling the discovery of unanticipated insights. These interviews were conducted in Bahasa Indonesia and later transcribed verbatim to ensure accuracy. Interview guides were developed based on themes derived from literature and policy documents, focusing on communication strategies, resource availability, staff readiness, and bureaucratic structure.

The second data collection method was participant observation. Researchers attended health promotion sessions, community meetings, and observed day to day operations within the Puskesmas. This method enabled the documentation of social interactions and implementation practices in real time, providing important contextual information that complemented interview data. Observational notes captured aspects such as the use of visual aids in health education, the quality of interpersonal communication, and the level of community engagement during program activities.

The third technique involved document analysis. Official documents such as reports on health program achievements, implementation plans, monitoring and evaluation records, and Ministry of Health guidelines were reviewed to triangulate and verify information gathered through interviews and observations. According to Wong et al. (2019), the integration of document review in qualitative health research strengthens the validity of findings by anchoring subjective narratives in institutional records and policies.

Data analysis followed the interactive model proposed by Miles and Huberman, which includes three iterative phases: data reduction, data display, and conclusion drawing/verification. During data reduction, interview transcripts, field notes, and document contents were coded to identify patterns, similarities, and deviations. Codes were then grouped into broader themes such as “communication effectiveness,” “resource constraints,” “staff disposition,” and “institutional clarity.” These themes were informed both by literature on policy implementation Edward (1980) and emergent concepts from the data itself. Data display involved organizing coded data into matrices and narrative summaries that allowed researchers to visually inspect interrelationships among themes. Finally, conclusions were drawn by synthesizing these thematic insights and comparing them against theoretical frameworks and regulatory expectations. The verification process involved recursive consultation with the raw data to ensure that interpretations remained grounded in empirical evidence.

Triangulation was a central strategy for ensuring data credibility and analytical rigor. Three types of triangulation were applied: source, method, and temporal. Source triangulation was achieved by interviewing various categories of informants to capture multiple perspectives on the same phenomena, thereby minimizing the bias of single viewpoint analysis. Method triangulation combined interviews, observations, and document analysis to enrich the data corpus and validate findings across techniques. Temporal triangulation involved conducting interviews and observations at different times during the two month research period to assess consistency and detect temporal variations in program implementation. According to Chetty-Makkan et al. (2021), such multifaceted triangulation strategies are essential in community based research where variability in responses and practices is expected.

The study also incorporated techniques to enhance trustworthiness, including member checking and peer debriefing. Selected transcripts and summaries were reviewed by some informants to ensure that the data accurately represented their views. Additionally, regular debriefing sessions were held among the research team to discuss emerging themes and potential biases, fostering reflexivity and analytical transparency. These strategies reflect best practices in qualitative research for improving credibility and dependability (O'Sullivan et al., 2014).

In sum, the methodological framework of this study was designed to comprehensively explore the micro level dynamics of health policy implementation at Puskesmas Kuta Alam. The combination of qualitative descriptive design, purposive sampling, triangulated data collection, and systematic thematic analysis provides a rigorous basis for understanding how promotive and preventive health policies are translated into practice within an urban Indonesian health center. This approach aligns with broader efforts to ground public health research in community realities and contributes to the growing body of knowledge on health systems implementation in low and middle income countries (Sivaprasad et al., 2021).

RESULT AND DISCUSSION

The analysis of interviews, observations, and documents at Puskesmas Kuta Alam revealed four principal themes: communication, resources, disposition, and bureaucratic structure. Direct quotes from informants are presented to illustrate each theme, and a summary table (themes, subthemes, quotes) is added for clarity. These themes reflect key operational dynamics. Communication relates to message delivery and participation, resources to staff and infrastructure, disposition to staff knowledge and attitudes, and bureaucratic structure to organizational clarity. The analysis was informed by Edward's (1980) framework and public health literature.

Communication

Effective communication is essential in ensuring that health promotion messages reach and resonate with the target community. At Puskesmas Kuta Alam, communication efforts were implemented through various channels, including face to face education during Posyandu and antenatal classes, distribution of printed educational materials, and interpersonal communication

between healthcare providers and patients. The findings reveal that while communication is conducted regularly, it is often hampered by community apathy, limited engagement strategies, and insufficient use of culturally adapted media. Informants noted that many community members attend sessions not out of genuine interest, but due to encouragement from local cadres. As supported by Park & Park (2021), communication strategies must be adapted to local sociolinguistic contexts to ensure effectiveness. Cofie et al. (2014) emphasize the importance of participatory approaches where communities are involved in both the planning and delivery of health education.

The use of local figures such as community leaders or health cadres was reported as beneficial but remains underutilized. Yasmin et al. (2022) found that culturally embedded messaging and the integration of trusted local communicators significantly enhance message acceptance. However, Puskesmas Kuta Alam lacks a strategic communication plan that includes diversified and innovative media channels such as social media or audio visual tools tailored to different demographic groups. This shortfall is consistent with Bray et al. (2023), who argue that health messages must be reinforced using culturally relevant imagery and narratives to improve retention and engagement. As noted by informants, timing and notification of community outreach activities are often poorly coordinated, resulting in suboptimal attendance and reduced message penetration.

Resources

The resource capacity at Puskesmas Kuta Alam is characterized by enthusiastic yet overstretched personnel, limited material resources, and a lack of formal training structures. Many health promotion activities are conducted by staff members, such as nurses and midwives, who simultaneously manage curative services. Informants consistently pointed to the absence of designated personnel for health promotion and preventive activities, echoing findings by DeVoe et al. (2014) that show trained staff significantly influence the quality and reach of public health programs.

The infrastructure at the Puskesmas lacks dedicated space for educational sessions, and visual aids such as posters and leaflets are often outdated or self-produced by staff without institutional support. According to Barbosa et al. (2023), physical infrastructure, including information technology and training materials, is crucial for effective health outreach. Moreover, the lack of systematic capacity building initiatives impedes the ability of staff to update their knowledge and engage the community effectively. Schoevers & Jenkins (2015) argue that continuous professional development enhances the credibility and interpersonal skills of health educators, fostering trust and sustained community relationships.

While health workers at Puskesmas Kuta Alam show a strong commitment to service, the absence of structured training leads to inconsistent delivery of health promotion content. This aligns with Pinto et al. (2018), who emphasize that investments in e learning and in service training hubs can bridge skill gaps in under resourced settings. Without sufficient training and resources, health messages may fail to influence behavior change, particularly in complex urban populations with diverse health literacy levels.

Disposition

The disposition of program implementers refers to their understanding, commitment, and attitudes towards the goals of promotive and preventive health. In the context of Puskesmas Kuta Alam, the study reveals considerable variation in policy awareness and program alignment. While the Head of Puskesmas and certain staff members expressed knowledge of Permenkes No. 75/2014, many frontline workers admitted unfamiliarity with its contents. This inconsistency undermines program coherence and continuity, as staff rely on personal experience or directives rather than standardized policy guidelines.

According to Kamanga (2018), higher levels of policy literacy among health workers are correlated with increased commitment to program implementation. Similarly, Kung et al. (2023) demonstrate that when health workers comprehend the rationale and structure of a health policy, their motivation and proactive engagement increase substantially. However, the data from Puskesmas Kuta Alam suggest a lack of formal mechanisms for internal policy dissemination and training.

The reliance on informal knowledge and hierarchical instructions leads to a disjointed execution of health promotion tasks, reflecting a disconnect between policy and practice. Morris et al. (2020) found that frontline health workers who lack exposure to structured training exhibit diminished ability to deliver preventive services effectively. This not only limits their functional capacity but also hampers their confidence in educating the community. Furthermore, the absence of shared policy understanding among team members weakens inter professional coordination and reduces opportunities for collaborative, multi-disciplinary interventions (Habibi et al., 2023).

Bureaucratic Structure

A clear and coherent bureaucratic structure is indispensable for program organization and accountability. At Puskesmas Kuta Alam, Standard Operating Procedures (SOPs) exist for various health services, yet there is no specific organizational framework governing the promotive and preventive health unit. As a result, staff often operate in ambiguity, unsure of their roles and responsibilities within the program. Espinosa-González et al. (2019) argue that organizational clarity enhances operational efficiency and ensures that health interventions are delivered systematically.

The lack of a designated team or unit for health promotion creates structural fragmentation. Staff are assigned tasks on an ad hoc basis, and roles are not formally defined or updated, particularly following staff rotation or reassignment. This results in diminished program ownership and fluctuating service quality. Triplett et al. (2023) note that clearly defined roles within health teams are associated with better task execution, coordination, and accountability.

Moreover, the absence of dedicated leadership for the program weakens decision making and resource allocation. According to Aptriana et al. (2022), role clarity and hierarchical coordination significantly influence the execution of community based health programs. The findings from this study align with those of Maleki et al. (2020), who report that ambiguity in organizational roles leads to inefficiencies and reduced responsiveness to community needs.

While SOPs provide a baseline operational guide, their utility is constrained in the absence of role specific accountability mechanisms and ongoing staff orientation. Hackney et al. (2022) emphasize the importance of integrating SOPs with practical training and supervision to ensure consistent

application. Without this integration, staff may revert to habitual practices or await top down instructions, thereby weakening program sustainability.

In conclusion, the findings underscore critical gaps in communication, resources, disposition, and bureaucratic structure that collectively inhibit the optimal implementation of promotive and preventive programs at Puskesmas Kuta Alam. Despite the presence of regulatory mandates and committed personnel, the lack of strategic communication planning, specialized training, policy internalization, and structural organization constrains the effectiveness of community health promotion. Addressing these issues requires institutional investment, intersectoral collaboration, and a community engaged approach to ensure that promotive and preventive health initiatives are fully integrated into primary care delivery in urban Indonesia.

Discussion

Communication

The findings from Puskesmas Kuta Alam show that existing communication strategies remain limited by one-way delivery, lack of innovation, and minimal community engagement. Theoretically, this supports Edward III's policy implementation model regarding the importance of communication clarity. Practically, it highlights the need for culturally adapted, participatory communication models in Aceh. This study adds novelty by showing how urban community dynamics shape preventive health implementation. A limitation of this study is that it focused only on one urban Puskesmas, so results may not represent all Indonesian contexts.

Evidence from global health literature underscores that the effectiveness of community based health promotion depends heavily on the adaptation of communication strategies to local contexts (Cofie et al., 2014; Dodd et al., 2019). The omission of cultural tailoring in health messages and the underutilization of community leaders as communication agents hinder the resonance of health promotion activities. As Park & Park (2021)argue, localized messaging not only enhances comprehension but also fosters trust in health authorities. Similar observations in studies conducted in Ghana and the Philippines revealed that the involvement of respected local figures, including religious leaders and elders, significantly improved the uptake of health messages (Awoonor-Williams et al., 2019; Elsey et al., 2023).

Further complicating the communication challenge is the reliance on routine health activities, such as Posyandu and immunization, without embedding dedicated, sustained educational interventions. This practice results in the relegation of health promotion to a secondary role, thereby diminishing its visibility and impact. Comparative studies from Tanzania and Kenya indicate that the integration of social media and digital platforms can enhance outreach and engagement, particularly among younger demographics (Hunt et al., 2023). These findings suggest that Puskesmas Kuta Alam must transition from sporadic information sharing to more continuous, interactive, and culturally relevant communication models.

Resources

The resource constraints identified in this study reveal deep structural weaknesses that compromise the sustainability and efficacy of health promotion programs. The dual roles performed by health staff, often responsible for both curative and promotive tasks, echo systemic

inefficiencies observed in other LMICs where workforce shortages are prevalent (Bitton et al., 2016). These limitations reflect not only inadequate human resources but also poor organizational planning that fails to differentiate the roles and responsibilities of health personnel.

Lack of formal training further compounds the problem. As noted by DeVoe et al. (2014) and Veillard et al. (2017), continuing professional development is essential for equipping frontline health workers with the skills needed to execute evidence based and context sensitive health promotion strategies. The findings from Puskesmas Kuta Alam suggest that staff often rely on experience rather than formal guidance, which contributes to variability in message content, delivery, and perceived credibility.

Infrastructure deficiencies such as the absence of dedicated educational spaces and visual communication aids exacerbate these constraints. According to Agustino (2014), effective health program implementation requires supportive physical environments. Moriarty (2019) and Pinto et al. (2018) affirm that investment in educational infrastructure not only facilitates outreach but also legitimizes health promotion as a critical component of primary care. Puskesmas Kuta Alam's reliance on temporary or informal spaces for health education reflects broader system level neglect, where promotional services are deprioritized in favor of curative care.

Disposition

The variation in disposition among health personnel at Puskesmas Kuta Alam represents a fundamental barrier to the institutionalization of preventive services. As Indiahono (2017) notes, the alignment between policy understanding and personal commitment is critical to effective program implementation. In this study, although staff express moral and professional support for prevention initiatives, their limited familiarity with regulatory frameworks like Permenkes No. 75/2014 undermines their ability to implement these policies consistently.

The lack of systematic policy dissemination and internal training mechanisms further diminishes staff's policy literacy. Research by Kamanga (2018) and Hutahaean et al. (2021) confirms that high levels of awareness and perceived organizational support significantly enhance staff engagement in preventive health programs. At Puskesmas Kuta Alam, the absence of such structured reinforcement mechanisms results in ad hoc execution, where staff motivation is not necessarily aligned with institutional expectations.

Nevertheless, the presence of a foundational commitment among some staff members points to a latent potential that could be harnessed through appropriate interventions. As highlighted by Siregar & Ratnawati (2022), targeted policy training and regular supervision can transform passive compliance into proactive implementation. Establishing regular review meetings and participatory forums may facilitate better policy internalization, thus bridging the gap between intention and practice.

Bureaucratic Structure

The bureaucratic deficiencies observed in Puskesmas Kuta Alam mirror structural fragmentation common in decentralized health systems. Despite the availability of SOPs, the absence of a formal organizational structure for promotive preventive services creates ambiguity in role definition and program ownership. Edward (1980) posits that an effective bureaucratic system is one where roles

are clearly defined and embedded within institutional hierarchies. Without these structures, operational efficiency and program accountability are compromised.

Studies by Maleki et al. (2020) and Triplett et al. (2023) demonstrate that clearly delineated team structures improve coordination, reduce redundancy, and enhance service delivery. The failure of Puskesmas Kuta Alam to adapt its organizational chart to reflect changes in staff assignments or program priorities suggests a lack of administrative agility. This rigidity not only impedes internal coordination but also reduces responsiveness to emerging public health needs.

In the absence of structural clarity, decision making becomes highly centralized and reactive, relying on personal discretion rather than institutional protocols. This condition leads to variable program performance, as highlighted by Aptriana et al. (2022), who note that decentralized systems must balance autonomy with standardization to maintain service quality. Institutionalizing promotive and preventive health services as a distinct functional unit, with its own leadership and reporting mechanisms, would address current fragmentation and enhance program resilience.

Implications for Systemic Reform

The findings from Puskesmas Kuta Alam underscore the urgent need for structural and operational reforms grounded in proven international frameworks. The Primary Health Care (PHC) approach provides a relevant model, as it advocates for integrative service delivery, community participation, and cross sectoral collaboration (Bitton et al., 2016). Application of PHC principles would facilitate more cohesive health promotion practices, particularly in urban settings where population mobility and diversity require adaptive program models.

To build sustainable capacity for promotive preventive health services, urban health centers like Puskesmas Kuta Alam must prioritize human resource development, technological integration, and community partnerships. The use of mobile health (mHealth) applications, for example, can supplement traditional training and allow real time access to policy updates, clinical guidelines, and educational materials (Plessis et al., 2022). Moreover, deploying community health workers (CHWs) can strengthen the interface between formal health systems and communities, thereby enhancing outreach and data collection (Perry et al., 2014).

Comparative experiences from the African region, especially in the implementation of Ghana's Community based Health Planning and Services (CHPS) initiative, offer valuable lessons. The success of CHPS lies in its embeddedness within community governance structures, which enhances accountability and relevance (Elsey et al., 2023). Similarly, Haque et al. (2020) emphasize that policy coherence across administrative levels is essential for scaling up preventive health efforts. These insights suggest that iterative feedback mechanisms, continuous learning, and adaptive planning are crucial for sustaining program momentum and relevance.

By situating the challenges faced by Puskesmas Kuta Alam within this broader landscape of global health systems reform, this study provides not only a localized diagnostic but also a conceptual framework for systemic change. The convergence of weak communication, insufficient resources, underdeveloped staff disposition, and fragmented bureaucracy calls for a multi-level response that integrates policy, practice, and community agency. Addressing these intersecting challenges is

critical to repositioning puskesmas as true centers of health promotion within Indonesia's national health architecture.

CONCLUSION

This study examined the implementation of promotive and preventive health programs at Puskesmas Kuta Alam, highlighting critical challenges in communication, resource allocation, staff disposition, and bureaucratic structure. Despite efforts to deliver health education and community outreach, the study found that communication strategies remained largely unidirectional and lacked cultural and contextual adaptation. Human resource limitations, particularly the absence of designated and trained health promotion staff, undermined the effectiveness and sustainability of health initiatives. Staff demonstrated a basic level of commitment, but lacked adequate training and familiarity with relevant policy frameworks, resulting in inconsistent application of national guidelines. Additionally, structural ambiguities in organizational roles and the absence of a dedicated promotive preventive unit further complicated coordination and accountability.

These findings underscore the need for systemic reforms rooted in participatory, community based, and evidence driven approaches. Aligning with international best practices, such as the Primary Health Care (PHC) model, this study advocates for integrating community voices, building professional competencies, and establishing coherent institutional frameworks to support long term public health goals. The research contributes to the growing literature on policy implementation in urban health settings in low and middle income countries (LMICs), offering a case based analysis with transferable lessons. Future research should explore the role of digital health tools, multisectoral governance, and localized policy translation to further enhance preventive care delivery at the community level.

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