

Community Health Centers as Arenas of Public Health Policy Implementation and Social Practice: A Systematic Review

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Abstract

Community Health Centers, known in Indonesia as Puskesmas, hold a strategic position in the national health system as primary health care facilities and local sites of public health policy implementation. However, most studies on Puskesmas have focused on technical, managerial, and service performance aspects, while limited attention has been given to how health policies are interpreted, negotiated, and adapted through everyday social practices. This systematic review aims to analyze the role of Puskesmas as arenas of public health policy implementation and social practice. The review followed the PRISMA guidelines and searched articles published between 2015 and 2025 through Google Scholar, PubMed, and Garuda. Articles were selected based on their relevance to primary health care, policy implementation, and social practice. Six articles met the inclusion criteria and were analyzed using thematic synthesis. The findings show that Puskesmas function as spaces where national health policies are translated into local practice, particularly in the implementation of the National Health Insurance/BPJS and the Healthy Indonesia Program with a Family Approach. Policy implementation is shaped by human resource capacity, infrastructure, intersectoral coordination, health literacy, local culture, and community participation. This review confirms that strengthening Puskesmas requires a contextual, adaptive, participatory, and socially sensitive policy approach that recognizes Indonesia's diverse geographical and sociocultural conditions.

Keywords: Puskesmas; policy implementation; public health; social practice; primary health care

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INTRODUCTION

Community Health Centers, known in Indonesia as Pusat Kesehatan Masyarakat or Puskesmas, are central institutions in the country's primary health care system. As first-level health care facilities, Puskesmas are responsible not only for providing basic curative services, but also for carrying out promotive, preventive, rehabilitative, and community empowerment functions. Their position is strategic because they operate as the closest formal health institution to the community and serve as the main entry point through which national and local health policies are translated into everyday health services. In global health discourse, strengthening primary health care has been widely recognized as a key strategy for achieving Universal Health Coverage and the Sustainable Development Goals, particularly through equitable access, community-based services, and stronger health system responsiveness (World Health Organization, 2018; Kruk et al., 2018).

In the Indonesian context, Puskesmas have a distinctive role because they work within specific administrative territories and social environments. They are not merely health service units, but also local institutions that implement a wide range of public health policies, including the Healthy Indonesia Program with a Family Approach, the National Health Insurance scheme, maternal and child health programs, disease control

programs, immunization, nutrition improvement, environmental health, and other national and regional health priorities. Through these functions, Puskesmas act as a bridge between formal policy design and local community needs. However, this policy translation process does not occur in a simple or linear way. It is shaped by institutional capacity, human resources, leadership, intersectoral coordination, financing, geographical conditions, cultural values, community trust, and public participation.

Health policy literature has increasingly shown that policy implementation cannot be understood only as an administrative process of applying formal guidelines. Policies formulated at the national level often undergo adjustment, reinterpretation, and negotiation when implemented in local primary health care settings. This happens because actors such as Puskesmas managers, health workers, local governments, health cadres, community leaders, and service users play active roles in interpreting and adapting policies to local realities. From this perspective, implementation is shaped by everyday politics, power relations, institutional arrangements, and interactions among formal and informal actors within the health system (Gilson et al., 2018; Erasmus et al., 2019; Topp et al., 2015). Therefore, Puskesmas need to be viewed not only as technical service providers, but also as arenas where policy meanings, institutional practices, and social relations are continuously produced.

Recent studies have begun to place Puskesmas within broader discussions of governance, district-level policy innovation, and primary health care reform. Research on service quality governance, maternal and neonatal mortality reduction, HIV and tuberculosis services, elimination of mother-to-child transmission of HIV, and health information infrastructure shows that Puskesmas function as important sites where national health priorities meet local governance capacity, budgeting mechanisms, workforce arrangements, and community-level service delivery (Kurniasih, 2017; Budiningsari et al., 2017; Apriliani & Khoirunurrofik, 2020; Conti et al., 2025; Zerdo et al., 2022). Other studies also highlight the role of local context, community trust, financing, and institutional capacity in determining whether health policies can be effectively adopted and sustained in primary health care networks, including Puskesmas, Posyandu, and community health worker systems (Hasanbasri et al., 2024; Halimatusa'diyah, 2020; Sutrisni et al., 2023; Cintyamina et al., 2021; Edelman et al., 2025).

Despite this growing body of literature, studies on Puskesmas still tend to emphasize technical and managerial dimensions, such as service quality, patient satisfaction, program performance, facility readiness, compliance with standards, and financial efficiency. These studies are valuable, but they do not fully explain how health policies are enacted in everyday social practice. A narrow focus on service indicators can overlook the social processes behind program achievements, including negotiations between health workers and communities, discretion used by frontline implementers, relationships between Puskesmas and district governments, the role of cadres and community leaders, and the influence of local values on public acceptance of health programs. As a result, there remains a significant knowledge gap regarding how Puskesmas operate as both policy arenas and spaces of social practice.

This gap is important because the success of public health policy is not determined only by the quality of policy design. It also depends on the ability of local institutions to manage social, cultural, and organizational contexts. For example, the implementation of the Healthy Indonesia Program with a Family Approach requires more than family health data collection. It also requires community acceptance, effective communication, adequate health workers, intersectoral coordination, and the ability to respond to household-level realities. Similarly, the implementation of the National Health Insurance scheme at Puskesmas is not only a financing issue. It is also related to health literacy, public perceptions of service quality, availability of personnel, and the capacity of

Puskesmas to adapt services to geographical and socioeconomic conditions. In this sense, Puskesmas function as policy arenas, where formal regulations encounter local realities and are negotiated through everyday institutional and social practices.

The novelty of this systematic review lies in its effort to synthesize existing literature by positioning Puskesmas not merely as primary health care facilities, but as arenas of public health policy and social practice. Unlike studies that focus only on program outputs or the effectiveness of specific services, this review integrates perspectives from health policy implementation, primary health care governance, and social practice. This approach allows a broader understanding of Puskesmas as spaces where actors, resources, values, institutional rules, community expectations, and power relations interact. The scientific contribution of this review is to strengthen conceptual understanding of how public health policies are interpreted, negotiated, and adapted at the Puskesmas level. Its practical contribution is to provide a basis for developing primary health care policies that are more contextual, participatory, adaptive, and responsive to social diversity across Indonesian regions.

Based on this background, this systematic review is guided by three research questions. First, how does the existing scientific literature describe the role of Puskesmas as arenas of public health policy implementation in Indonesia? Second, what forms of social practice emerge in the implementation of health policies at Puskesmas, particularly in relation to actor interaction, community participation, trust, local culture, and the discretion of health workers? Third, what social, institutional, and implementation-related factors support or hinder the effectiveness of health policy implementation at the Puskesmas level?

By formulating these questions, this review seeks not only to map previous findings, but also to connect the existing research gap with a more systematic synthesis of policy implementation and social practice. Therefore, the purpose of this systematic review is to identify, analyze, and synthesize scientific evidence on the role of Puskesmas as arenas of public health policy implementation and social practice. This review also aims to explain how policy design, institutional capacity, actor dynamics, and sociocultural conditions interact in shaping the implementation of public health policies at the local level. The findings are expected to support the strengthening of primary health care policy in Indonesia, particularly by encouraging policy approaches that move beyond administrative compliance and take local social contexts seriously as part of effective health policy implementation.

METHOD

This study employed a *systematic review* design aimed at identifying, examining, and systematically synthesizing scientific evidence related to the role of Community Health Centers (*Puskesmas*) as arenas of public health policy and social practice. The *systematic review* approach was selected because it enables a structured, transparent, and reproducible literature search process, thereby providing a comprehensive overview of the development of knowledge and empirical findings related to the topic under investigation. The review process was conducted in accordance with the *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA) 2020 guidelines as the reporting standard (Page et al., 2021).

The data sources in this study consisted of scientific publications indexed in electronic databases, including PubMed, Google Scholar, and GARUDA. Literature searches were limited to articles published within the last ten years to ensure the relevance and novelty of the findings. The search strategy employed combinations of keywords and Boolean operators, as presented in Table 1.

Table 1. Search keywords used for article collection

Data Sources	Keywords	Year
PubMed	Puskesmas; public health policy; social practice; policy implementation	2015–2025
Google Scholar	Puskesmas; public health policy; social practice; policy implementation	2015–2025
GARUDA	Puskesmas; public health policy; social practice; policy implementation	2015–2025

During the screening stage, the researchers systematically reviewed the titles, abstracts, and conclusions of the articles to identify studies relevant to the research focus. This stage was intended to ensure the preliminary suitability of the studies before conducting further analysis. Subsequently, in the eligibility stage, the selected documents were evaluated more comprehensively based on their substantive relevance and compliance with the predetermined inclusion criteria, as recommended in the *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA) guidelines (Page et al., 2021). Studies that did not meet the specified requirements after full-text assessment were excluded from the *systematic review* process.

This study applied four main selection criteria:

1. Publications were limited to studies published between 2015 and 2025;
2. The documents had to be empirical research articles, while secondary sources such as review articles, books, and conference proceedings were excluded;
3. The articles were written in Bahasa Indonesia; and
4. The publications were indexed in SINTA as an indicator of scientific quality.

All stages of study selection and exclusion in this research followed the *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA) guidelines. The overall selection process was visualized using a PRISMA Flowchart, as presented in Figure 1.

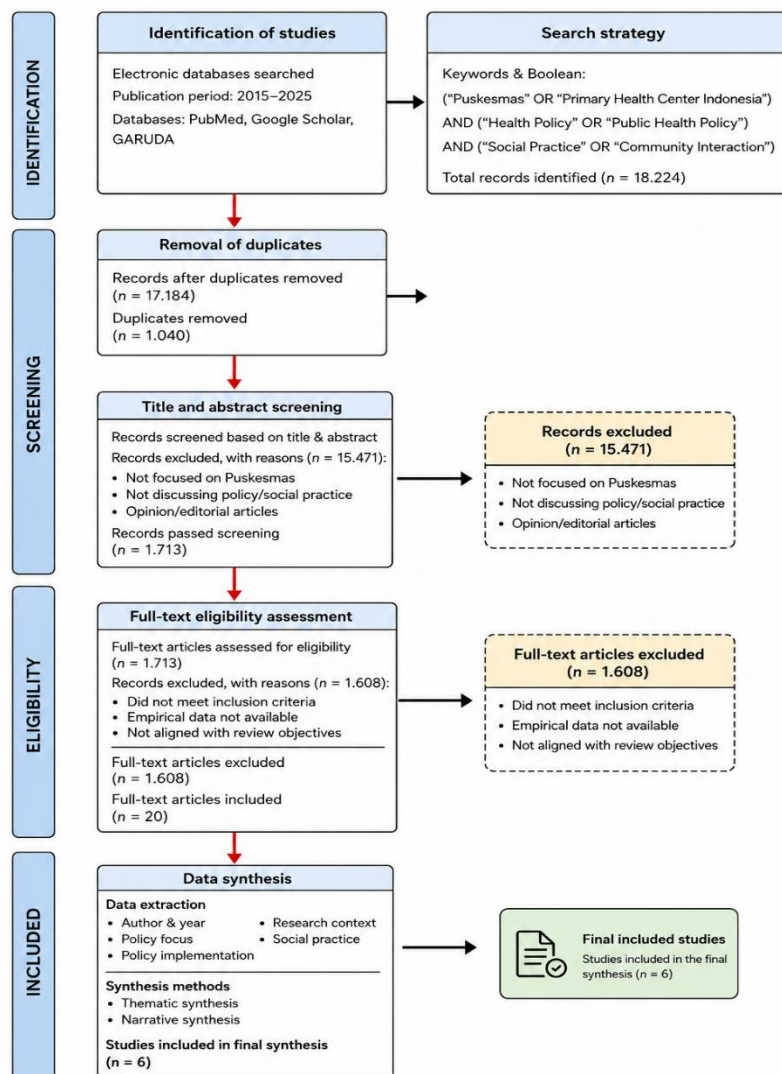


Figure 1. PRISMA Flowchart

RESULTS AND DISCUSSION

Based on the systematic selection process, six articles met the inclusion criteria and were included in the final synthesis. These articles were selected because they were substantively relevant to the focus of this review, namely the role of Puskesmas, or primary health care more broadly, as an arena of public health policy implementation and social practice. The six articles consist of two international studies that provide a conceptual basis for understanding primary health care as a policy arena, and four Indonesia-based studies that directly examine policy implementation in Puskesmas settings. This distinction is important because the international articles are used to strengthen the conceptual interpretation of primary health care implementation, while the Indonesian articles provide the main empirical basis for discussing Puskesmas.

The analysis was guided by the three research questions formulated in the Introduction: first, how does the existing literature describe the role of Puskesmas as an arena of public health policy implementation? Second, what forms of social practice emerge in the implementation of health policies at Puskesmas? Third, what social, institutional, and implementation-related factors support or hinder the effectiveness of health policy implementation at the Puskesmas level? The mapping of the six selected articles is presented in Table 2.

Table 2. Mapping of the Six Selected Articles Based on the Research Questions

No .	Article	Context and method	Findings related to Puskesmas/P HC as a policy arena	Social practices identified	Supporting and inhibiting factors
1	Ramani, Sivakami, & Gilson (2019), <i>How Context Affects Implementation of the Primary Health Care Approach</i>	Primary health care in India; qualitative case study, in-depth interviews, and policy analysis	Primary health care is described as an arena where national policy is translated, interpreted, and adjusted to local contexts. Implementation is not linear, but shaped by institutional capacity, power relations, and the professional values of health workers.	Social practice appears through everyday negotiations among health workers, bureaucratic actors, and communities, particularly in how implementers interpret policy under resource constraints and local pressures.	Implementation is constrained by limited resources, hierarchical authority structures, and tension between formal policy standards and local service realities.
2	Dias de Lima et al. (2025), <i>Between Norms and Practices: Implementation and Regional Repercussions of Changes in Primary Health Care Policies in Brazil</i>	Primary health care in Brazil; policy analysis and field-based implementation study	Primary health care functions as a space where national policy norms interact with regional implementation practices. Policy change produces different effects across regions due to variations in institutional capacity and local governance.	Social practice is reflected in how health workers and local governments adjust national standards to institutional conditions, local needs, and community expectations.	Key factors include regional capacity, readiness of primary health care institutions, and the ability of local actors to interpret and implement policy change.
3	Zamzami & Hayat (2023), <i>Implementation of Health</i>	Masalembu Health Center, Sumenep Regency;	Puskesmas functions as an implementation arena for the	Social practice appears in the interaction	Main barriers include limited human

No .	Article	Context and method	Findings related to Puskesmas/P HC as a policy arena	Social practices identified	Supporting and inhibiting factors
	<i>Service Policy for BPJS Users at Masalembu Health Center</i>	descriptive qualitative study	National Health Insurance/BPJS policy in an island area. National policy meets geographic barriers, limited facilities, human resource constraints, and varied public understanding.	between health workers and BPJS users, including informal adaptation by health workers to keep services running despite limited resources and access.	resources, inadequate facilities, island geography, and low public literacy regarding BPJS service mechanisms.
4	Pujosiswanto , Palutturi, & Ishak (2023), <i>Factors Affecting the Implementation of the Healthy Indonesia Program with a Family Approach (PIS-PK)</i>	Implementation of PIS-PK; mixed-methods study	Puskesmas acts as a mediator between the national PIS-PK policy and household-level health practices. Implementation is not merely administrative, but requires active engagement with families and communities.	Social practice emerges through family data collection, health communication, public acceptance of intervention, and family health behavior.	Supporting factors include local policy support, health worker capacity, and family participation. Barriers occur when community participation is weak, staff are limited, and intersectoral support is insufficient.
5	Rahmawati et al. (2023), <i>Analysis of the Implementation of the Healthy Indonesia Program with a Family Approach at</i>	Pasir Panjang Health Center; qualitative case study	Puskesmas becomes a space of policy adaptation. The national design of PIS-PK must be adjusted to the socioeconomic conditions of the community	Social practice is seen in the way health workers adapt communication strategies, program priorities, and community	Main barriers include limited human resources, high workload, weak intersectoral coordination, and a gap

No .	Article	Context and method	Findings related to Puskesmas/P HC as a policy arena	Social practices identified	Supporting and inhibiting factors
	<i>Pasir Panjang Health Center</i>		and the internal capacity of the Puskesmas.	approaches so that the program can be accepted locally.	between policy design and socioeconomic realities.
6	Trisna (2021), <i>Implementati on of Healthy Indonesian Programs with a Family Approach: Study at Puskesmas Seluma Timur</i>	Seluma Timur Health Center; descriptive qualitative study	Puskesmas functions as a key actor that connects the national PIS-PK policy with local social practice. Policy implementation is shaped by communication, bureaucracy, and local culture.	Social practice is reflected in persuasive and participatory approaches used by health workers, especially when public understanding of the program remains limited.	Supporting factors include policy communication and bureaucratic support. Barriers include low public understanding, limited resources, and the influence of local culture on program acceptance.

The mapping shows that the six articles converge on one central argument: health policy implementation at the primary care level cannot be understood merely as the technical execution of formal guidelines. Rather, policy implementation is shaped by local context, institutional capacity, actor relations, and everyday social practices. The two international articles demonstrate that this issue is not unique to Indonesia. Ramani et al. (2019) show that primary health care in India operates as an arena where national policy is reinterpreted by local implementers. Dias de Lima et al. (2025) similarly demonstrate that changes in primary health care policy in Brazil produce different regional consequences because local institutional capacity and governance vary. These studies provide a conceptual foundation for understanding primary health care as a policy arena rather than a passive administrative unit.

The four Indonesian studies provide more direct evidence on Puskesmas. The case of Masalembu Health Center shows that the implementation of BPJS policy in an island area is strongly shaped by geography, limited resources, service infrastructure, and public literacy. In this setting, health workers are not simply policy executors. They become adaptive actors who negotiate between national policy requirements and local service limitations. The studies on PIS-PK by Pujosiswanto et al. (2023), Rahmawati et al. (2023), and Trisna (2021) also show that Puskesmas operates as a bridge between national family-based health policy and household-level social realities. PIS-PK requires data collection, home visits, health communication, family participation, intersectoral coordination, and community trust. Therefore, its effectiveness depends not only on policy instruments, but also on the quality of social relations established by Puskesmas.

The thematic synthesis identifies three main themes. First, Puskesmas functions as an arena for translating national health policy into local practice. This role is visible in the implementation of BPJS and PIS-PK, where national policy frameworks must be adjusted to local geography, staff capacity, bureaucratic support, and community characteristics. Second, Puskesmas serves as a space of social practice. Policy implementation occurs through communication, negotiation, persuasion, discretion, and trust-building between health workers and communities. Third, the success of implementation is shaped by structural and social factors, including human resources, infrastructure, workload, cross-sector coordination, health literacy, local culture, and support from local government.

The findings answer the first research question by showing that Puskesmas plays a central role as an arena of public health policy implementation. In the Indonesian health system, Puskesmas is not only a provider of basic health services, but also a local institution that translates national priorities into operational programs in specific social and administrative territories. This role is evident in the implementation of BPJS at Masalembu Health Center and PIS-PK in several Puskesmas settings. At the policy level, BPJS and PIS-PK are designed to expand access, improve primary care, and strengthen family-based health intervention. However, when these policies are implemented at the Puskesmas level, they encounter diverse local conditions, including limited human resources, inadequate facilities, geographic isolation, varying levels of public understanding, and uneven local coordination.

The case of Masalembu Health Center provides a concrete example of how national policy is implemented in a challenging local context. As an island area, Masalembu faces geographic constraints that affect access to services, availability of facilities, referral processes, and the ability of Puskesmas to meet the expectations of BPJS users. In such a context, BPJS implementation cannot be understood only as a health financing mechanism. It must also be viewed as a social practice of service delivery that involves public understanding, communication between health workers and patients, and institutional adaptation to local limitations. This finding suggests that national health insurance policy requires implementation strategies that are more sensitive to geography, infrastructure, and local service capacity.

The second research question concerns the forms of social practice that emerge during health policy implementation at Puskesmas. Across the six articles, social practice appears mainly through communication, negotiation, discretion, persuasive approaches, family participation, and trust-building. These practices are especially visible in the implementation of PIS-PK. Because PIS-PK places the family as the main unit of intervention, health workers must do more than collect data or complete administrative forms. They must enter household spaces, explain program objectives, respond to community concerns, overcome resistance, and adapt communication to the socioeconomic and cultural conditions of families.

Rahmawati et al. (2023) show that PIS-PK implementation at Pasir Panjang Health Center has not been optimal due to limited human resources, high workload, and weak intersectoral coordination. This finding is important because it shows that social practice at Puskesmas is closely connected to organizational structure. When health workers are burdened by multiple programs and administrative demands, their ability to engage communities in a participatory way becomes limited. As a result, a policy designed to be family-oriented may become reduced to an administrative reporting exercise. This reflects a common problem in health policy implementation: the gap between policy design and frontline capacity.

Trisna's (2021) study at Seluma Timur Health Center also demonstrates that policy communication and bureaucratic support are crucial for the implementation of PIS-PK. Low public understanding of the program requires health workers to use persuasive and

participatory approaches. In this context, Puskesmas serves as a social mediator between the state and the community. A national policy is not automatically accepted by the public simply because it has regulatory legitimacy. It requires explanation, repeated communication, trust-building, and adaptation to local values. This reinforces the argument that social practice is not an additional element of policy implementation. It is a core component of implementation itself.

The third research question focuses on the social, institutional, and implementation-related factors that support or hinder policy effectiveness. The synthesis shows that supporting factors include local government support, health worker capacity, effective policy communication, community participation, bureaucratic support, and the ability of Puskesmas to adapt policies to local circumstances. In contrast, inhibiting factors include limited human resources, inadequate infrastructure, high workload, weak cross-sector coordination, low health literacy, geographic barriers, and mismatch between policy design and local social realities. These findings indicate that the effectiveness of public health policy at Puskesmas is multidimensional.

The relationship among these findings can be understood through the interaction between policy design, institutional capacity, and social response. National policies such as BPJS and PIS-PK provide formal frameworks, but their effectiveness depends on the ability of Puskesmas to implement them in concrete local settings. This capacity is not limited to the number of staff or the availability of facilities. It also includes leadership, organizational culture, communication skills, data management, coordination with local government, and collaboration with cadres and community actors. When institutional capacity is strong and communities understand the purpose of the program, implementation is more likely to be effective. Conversely, when capacity is limited and community participation is weak, policy implementation risks becoming formalistic and administratively oriented.

The two international studies strengthen this interpretation. Ramani et al. (2019) show that primary health care implementation is influenced by political, institutional, and social contexts. Dias de Lima et al. (2025) show that there is often a gap between policy norms and implementation practices at the local level. Although these studies do not directly examine Puskesmas, they are relevant as conceptual comparisons because they reveal a broader pattern also found in Indonesia: primary health care policy is always reshaped when it meets local realities. Therefore, the findings from Masalembu, Pasir Panjang, and Seluma Timur should not be treated as isolated cases. They represent a wider implementation pattern in which frontline primary care institutions continuously interpret, adjust, and negotiate policy.

The policy implications of these findings are significant. First, national health policy should provide greater room for local adaptation at the Puskesmas level, especially in island, rural, remote, or resource-limited areas. Standardization remains necessary, but rigid implementation requirements can create difficulties when local conditions differ substantially. Second, strengthening Puskesmas should not be limited to adding regulations or program targets. It should include improving the capacity of health workers, reducing excessive administrative burden, strengthening cross-sector coordination, improving infrastructure, and supporting local leadership. Third, community participation should be positioned as a central component of health policy implementation, not merely as a supporting activity. Programs such as PIS-PK can only work effectively when families understand the program, trust health workers, and are willing to participate in health-related decision-making.

Fourth, the review highlights the need for policies that are more responsive to regional variation. Masalembu Health Center requires policy support related to island geography, transportation, facilities, and access to services. Pasir Panjang Health Center

requires stronger human resources, better workload distribution, and more effective intersectoral coordination so that PIS-PK does not stop at data collection. Seluma Timur Health Center requires stronger communication strategies and culturally sensitive approaches to improve public understanding and acceptance of the program. These differences show that one national policy design can generate different implementation needs at the local level. Therefore, evaluation of Puskesmas policy should not rely only on quantitative program achievement, but also examine the social context that explains why a policy succeeds or fails.

Conceptually, this review confirms that Puskesmas should be understood as both a policy arena and a space of social practice. As a policy arena, Puskesmas is the place where national health policies are translated into procedures, programs, and services. As a space of social practice, it is where interactions among health workers, bureaucratic actors, families, cadres, and communities shape the meaning and direction of policy implementation. These two dimensions are inseparable. A well-designed policy may fail if it is not supported by social practices that enable community acceptance. Conversely, strong social practices can help Puskesmas maintain service continuity even under structural constraints.

The six articles analyzed in this review show that health policy implementation at Puskesmas is complex, adaptive, and context-dependent. The main finding of this review is that Puskesmas cannot be adequately understood as a mere technical implementation unit. It is a social and institutional arena where public health policy is interpreted, negotiated, and adapted to local realities. This has important implications for primary health care policy in Indonesia. Strengthening Puskesmas requires a contextual, participatory, and capacity-based approach that recognizes the central role of local actors, community relations, institutional readiness, and regional diversity in achieving effective and sustainable public health policy implementation.

CONCLUSION

Based on the systematic review of the six selected articles, it can be concluded that Puskesmas have a strategic role as arenas of public health policy implementation as well as spaces of social practice at the local level. Puskesmas do not function merely as primary health care units that carry out programs according to administrative guidelines. Rather, they are institutional spaces where health policies are translated, adjusted, and negotiated within the social context of communities. The reviewed articles show that national policies such as the National Health Insurance/BPJS and the Healthy Indonesia Program with a Family Approach cannot always be implemented uniformly across regions, because their implementation is strongly shaped by geographical conditions, human resource capacity, availability of facilities, bureaucratic support, intersectoral coordination, and the social and cultural characteristics of local communities.

This review also shows that social practice is an essential part of health policy implementation at the Puskesmas level. These practices appear in communication between health workers and communities, persuasive approaches to families, the use of discretion by frontline workers, trust-building, and the adjustment of service strategies to local conditions. In the case of Masalembu Health Center, the geographical challenges of an island area and limited resources affected the implementation of BPJS policy. At Pasir Panjang Health Center, the implementation of the Healthy Indonesia Program with a Family Approach faced constraints related to limited personnel, high workload, and weak intersectoral coordination. Meanwhile, at Seluma Timur Health Center, program implementation was strongly influenced by policy communication, bureaucratic support, and community acceptance. These findings confirm that the success of health policy at

Puskesmas is not determined only by policy design, but also by the capacity of local institutions and implementing actors to build supportive social relations.

Therefore, Puskesmas should be understood as dynamic socio-institutional spaces. Within these spaces, public health policies are not only implemented, but also interpreted and adapted to community realities. The main conclusion of this review is that the effectiveness of health policy implementation at Puskesmas depends on the integration of national policy design, local institutional capacity, the quality of interactions among actors, and the level of community participation. Strengthening Puskesmas therefore requires a policy approach that is more contextual, adaptive, participatory, and sensitive to the social and geographical diversity of Indonesian regions.

RECOMMENDATIONS

Based on the findings of this systematic review, strengthening public health policy implementation at Puskesmas requires several strategic directions. First, the government needs to strengthen human resource capacity at Puskesmas, both in terms of the number, competence, and distribution of health workers. Limited personnel and high workloads were shown to be important barriers to policy implementation, especially in programs that require home visits, family data collection, community education, and intersectoral coordination. Therefore, policies aimed at strengthening Puskesmas should not merely add program targets, but should also ensure that frontline implementers have sufficient capacity, time, and organizational support to carry out policies effectively.

Second, primary health care policy needs to provide greater space for local adaptation at the Puskesmas level. National standards remain necessary to maintain service quality and accountability, but implementation should take into account local conditions, especially in island, rural, remote, and underserved areas. The case of Masalembu Health Center shows that the same national policy may face different challenges when implemented in areas with geographical barriers. For this reason, planning, financing, and evaluation mechanisms for health programs should be more flexible and based on local needs, rather than relying solely on uniform administrative indicators.

Third, intersectoral coordination should be strengthened as a core component of policy implementation at Puskesmas. Programs such as the Healthy Indonesia Program with a Family Approach cannot be implemented optimally if they are assigned only to health workers, because family health problems are closely related to education, economic conditions, environmental factors, sanitation, and social behavior. Puskesmas need support from local governments, village or urban ward authorities, health cadres, community leaders, and other relevant sectors. With stronger coordination, health policies can be translated into collective action that is more responsive to community needs.

Fourth, community participation and health literacy should be positioned as central components of Puskesmas policy. Low public understanding of health programs, including BPJS service mechanisms and the objectives of the Healthy Indonesia Program with a Family Approach, can hinder successful implementation. Therefore, Puskesmas need to strengthen public communication strategies, family education, culturally sensitive approaches, and trust-building with communities. Public health policies should not only be formally disseminated, but also communicated in ways that are understandable, relevant to people's lived experiences, and respectful of local values.

Fifth, future research should develop deeper empirical studies on Puskesmas as arenas of policy and social practice. Further studies may use qualitative, mixed-methods, or comparative approaches across regions to explain how actors, power relations, organizational culture, community participation, and institutional capacity influence

health policy implementation. Such research is important so that the development of Puskesmas policy is not based only on quantitative program achievements, but also on a more comprehensive understanding of the social and institutional dynamics that determine policy success at the local level.

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AUTHOR CONTRIBUTIONS

Nurham AA was responsible for the conceptualization of the study, research design, development of the literature search strategy, article selection, data extraction, data analysis, thematic synthesis, and preparation of the initial manuscript draft. S contributed to methodological guidance, validation of the review process, critical review of the analysis, and refinement of the manuscript. R contributed to validating the findings, reviewing the interpretation of results, and improving the final manuscript. All authors read, reviewed, and approved the final version of the manuscript.

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