



Implementation of Free Health Check-up Policy for The Community in Samarinda City

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Abstract

This study analyzes the implementation of the Free Health Examination (PKG) policy in Samarinda City based on the Decree of the Minister of Health Number HK.01.07/MENKES/33/2025 and identifies the factors hindering its implementation. A descriptive qualitative approach was employed using in-depth interviews, observations, and documentation. Sixteen purposively selected informants included officials from the Health Office, heads of health centers, technical staff, community members, and health cadres. Data were analyzed using the Miles and Huberman interactive model and the Van Meter and Van Horn policy implementation framework. The findings indicate that PKG implementation remains suboptimal. Only 45,590 of the 822,962 targeted beneficiaries (5.54%) had received services, with considerable disparities among health centers (0.75–12.64%). Major barriers include inconsistent understanding of policy standards, limited budgets (covering only about 43% of estimated needs), shortages of health personnel, inconsistent adherence to standard operating procedures, weak cross-sector coordination, inadequate public outreach, declining implementation motivation, and the continued dominance of a curative healthcare paradigm. Stronger leadership commitment among health center heads was associated with better performance and appeared to help distinguish higher-performing facilities; however, because target size, staffing, and accessibility also varied across centers, leadership cannot be identified as the sole causal factor. The study recommends developing local technical guidelines, increasing budget allocation, strengthening cross-sector collaboration, and adopting community-based, face-to-face socialization strategies to improve policy implementation.

Keywords : policy implementation, free health check-ups, early detection of diseases,
Samarinda City

Introduction

National health development currently focuses on strengthening quality and productive human resources, as stated in the fourth Asta Cita of the Government of Indonesia which strengthens the development of human resources, including in the health sector. Through Law Number 17 of 2023 concerning Health, the government places promotive and preventive efforts as the main pillars of the transformation of the national health system. The treatment paradigm (curative) seeks to be shifted to disease prevention (preventive) in order to reduce the burden of long-term health financing while improving the quality of life of the community. One of the main strategies taken is early detection of diseases through periodic health checks that can be accessed by all residents without obstacles.

As a manifestation of this commitment, the central government launched the Decree of the Minister of Health Number HK.01.07/MENKES/33/2025 which provides free health checks for the public from infants to the elderly to improve early detection of diseases. The Samarinda City Health Office acts as the main implementer in coordination with First-Level Health Facilities (FKTP), especially health centers, in carrying out Free Health Checks (PKG). This program is designed to encourage people to be more concerned about their health conditions while making personal momentum a trigger for personal health evaluation.

As the provincial capital with the largest population in East Kalimantan, Samarinda City should ideally record a higher utilization of PKG services. However, reality shows that the achievements are not optimal. As of December 31, 2025, the achievement of PKG visits to Samarinda City has only reached 5.54 percent or around 45,590 out of 822,962 targets, placing Samarinda City in third place in East Kalimantan Province, below Kutai Kartanegara Regency (25.44 percent) and Balikpapan City (20.47 percent). The advantages of urban health infrastructure and high population density have not been able to encourage maximum community participation, so the obstacles to implementation are suspected to be more rooted in the aspect of target mobilization than the availability of physical facilities.

At the health center level, the achievement of PKG in Samarinda City shows a very sharp disparity, from 0.75 percent at the Bengkuring Health Center to 12.64 percent at the Trauma Center Health Center. This gap indicates differences in resource capacity, intensity, and community response between work areas. The urgency of this policy is increasingly evident considering the increasing burden of morbidity of infectious and non-communicable diseases. In the period 2023-2025, tuberculosis cases will increase from 3,455 to 5,671 cases, HIV from 509 to 971 cases, hypertension from 45,235 to 89,004 cases, and diabetes from 4,962 to 22,920 cases. This double burden of disease condition emphasizes the need to strengthen promotive and preventive services through PKG as an early detection strategy.

Empirical studies of health policy implementation in various regions show mixed results. Some studies have reported successes, such as the implementation of Universal Health Coverage in Semarang, which is supported by competent resources and effective communication (Nurmantika & Wijayanto, 2024), and stunting prevention in Sukabumi (Wiguna et al., 2022). However, many also conclude that the implementation is not optimal due to limited financial and human resources (Alamsyah et al., 2021; Sahroji et al., 2022; Maulidya & Hakim, 2024), ineffective communication (Kumalasari & Prabawati, 2021; Putri et al., 2022), infrastructure disparities (Pomeo & Winarti, 2024), and implementation understandings that are not yet uniform (Anggraeni et al., 2022). These differences in results prove that the success of the policy depends largely on the specific local situation.

The ideal condition (*das sollen*) is the formation of collective public awareness to carry out early detection voluntarily and routinely. However, the empirical reality (*das sein*) shows the low utilization of services by the majority of the public. This gap indicates that regulatory mandates have not been fully implemented into real health behaviors. Although lifecycle-based personal health screening has so far received limited attention in the Indonesian public administration literature, this study does not rest its contribution on novelty alone. Its central contribution is to explain the low utilization of PKG services by systematically comparing higher- and lower-performing health centers within a single implementation framework, thereby identifying the implementation conditions that distinguish them. Based on this background, this study aims to answer two questions: (1) how to implement PKG policies for the community in Samarinda City; and (2) what are the inhibiting factors in the implementation of the policy.

Method

This study uses a qualitative method with a descriptive approach that aims to provide a systematic and factual picture of the phenomenon of PKG policy implementation in Samarinda City. This approach was chosen to understand the subjective meaning and complex implementation process, rather than simply measure the end result. The location of the research was determined purposively in the city of Samarinda with the consideration that the Samarinda City Health Office is the main implementing agency of the Decree of the Minister of Health Number HK.01.07/MENKES/33/2025 at the city level.

The data source consists of primary data and secondary data. Primary data was obtained through in-depth interviews with 16 informants determined by purposive sampling techniques, divided into key informants (Head of Health Office and Head of Health Services), main informants (heads of health centers and implementing technical staff), and additional informants (target communities and health cadres). The two key informants represented the policy-steering level at the Health Office, while the main and additional informants were drawn from the seven selected health centers so that each case contributed both managerial and frontline perspectives. The interviews were conducted in the period from February to April 2026 at the Health Office and seven selected health centers, including the five health centers with the lowest achievements (Bengkuring, Bukuan, Makroman, Sei Siring, and Sempaja) and the two health centers with the highest achievements (Adolescents and Trauma Centers). These seven facilities were treated as contrasting cases—five lowest- and two highest-performing—to enable a cross-case comparison of implementation conditions across the six Van Meter and Van Horn variables. Secondary data is sourced from regulatory documents, planning and budgeting documents (Strategic Plan and DPA), performance reports, and the Health Profile of Samarinda City.

Data collection was carried out through three techniques, namely in-depth interviews, direct observations, and documentation studies. Data analysis uses the Miles and Huberman interactive model which includes data collection, data reduction through coding, data presentation, and conclusion drawing and verification. Data categorization refers to the six variables of the implementation of the Van Meter and Van Horn (1975) model, namely policy standards and objectives, resources, characteristics of implementing agents, interorganizational communication, implementing disposition, and external environmental conditions. Coding followed the six Van Meter and Van Horn variables, and the coded material for the five lowest- and two highest-performing centers was then compared variable

by variable to identify the conditions that consistently differentiated the two groups. The validity of the data is ensured through source triangulation, technique triangulation, time triangulation, and member checking. The research is carried out by holding ethical principles in the form of research permits, informed consent, confidentiality and anonymity of informants, and the use of data solely for academic purposes.

Results and Discussion

The implementation of the PKG policy in Samarinda City until December 31, 2025 recorded an achievement of 5.54 percent or around 45,590 out of a total of 822,962 targets. There was a very significant disparity in achievement among the 26 health centers, from 0.75 percent at the Bengkuring Health Center to 12.64 percent at the Trauma Center Health Center. This disparity suggests that internal factors of the health center—such as leadership commitment, governance, and socialization strategies—may contribute to performance differences, alongside structural differences in target size, staffing, and accessibility, even though the regulatory framework faced is relatively the same. Table 1 presents the PKG achievements in 26 health centers in Samarinda City.

Table 1. PKG Achievements in 26 Samarinda City Health Centers in 2025

No.	Name of the Health Center	Target 2025	Visit	Reach (%)	Remarks
1	Bengkuring	44.778	335	0,75	Lowest
2	Bukuan	14.987	143	0,95	Lowest
3	Makroman	16.468	241	1,46	Lowest
4	Sei Siring	15.004	241	1,61	Lowest
5	Sempaja	22.341	444	1,99	Lowest
6	Reception	24.502	579	2,36	Medium
7	Pasundan	21.519	546	2,54	Medium
8	Baka Village	30.686	931	3,03	Medium
9	Juanda	34.945	1.138	3,26	Medium
10	Wonorejo	27.907	1.058	3,79	Medium
11	New Hope	36.487	1.392	3,82	Medium
12	Lok Bahu	30.665	1.318	4,30	Medium
13	Sour Coral	28.332	1.367	4,82	Medium
14	Bantuas	4.283	213	4,97	Medium
15	Temindung	61.347	3.315	5,40	Medium
16	Lempake	21.697	1.188	5,48	Medium
17	Water	43.933	2.468	5,62	Medium
18	Mangkupalas	25.998	1.466	5,64	Medium
19	Loa Bakung	34.613	2.215	6,40	Medium
20	Sidomulyo	59.842	3.919	6,55	Medium
21	Stuttgart	61.785	4.622	7,48	Medium
22	Samarinda City	54.416	4.862	8,93	Medium
23	Sei Kapih	15.591	1.456	9,34	Medium
24	Says	32.520	3.245	9,98	Medium
25	Teenagers	33.015	3.689	11,17	Height
26	Trauma Center	25.301	3.199	12,64	Highest
QUANTITY		822.962	45.590	5,54	

Source: Samarinda City Health Office, 2025 (processed by the author)

The implementation analysis was carried out using six variables of the Van Meter and Van Horn (1975) models. The results showed that the six variables experienced interrelated obstacles and collectively affected the low achievement of the program. The Van Meter and Van Horn framework serves as the central analytical lens throughout; other theoretical perspectives are introduced only selectively and illustratively to interpret specific findings within particular variables, rather than as competing frameworks. A description of the findings for each variable is presented below.

Policy Standards and Objectives

Normatively, the Decree of the Minister of Health Number HK.01.07/MENKES/33/2025 has contained very comprehensive service standards, regulating the type of examination for each target age group, the registration mechanism through the SATUSEHAT Mobile application, implementation procedures, recording and reporting flows through the SATUSEHAT and ASIK platforms, and follow-up provisions. Understanding at the leadership level of the Health Office is adequate, but the main challenge lies in the translation of national standards into the operational context of health centers which have high workload characteristics.

At the health center level, the understanding of standards shows striking variations. In low-income health centers, a number of officers still face uncertainty regarding the type of examination for certain age groups, the recording procedure at SATUSEHAT, and the referral mechanism. This condition occurs because there is no local technical guide that translates national standards into operational procedures that are adjusted to the specific conditions of each health center. Instead, the Trauma Center and Adolescent Health Center developed internal operational guidelines in the form of a one-page table that was pasted in each service room, accompanied by short weekly coordination meetings. This finding is in line with the concept of implementation deficit from Pressman and Wildavsky (1984), which is a normatively good policy condition that fails to produce an impact because the process of translating it into real action is ineffective. Anggraeni et al. (2022) found a similar phenomenon in Jember Regency, where differences in technical understanding of officers weakened the effectiveness of implementation.

The national achievement target of 85 percent in five years is perceived by many health center heads as unrealistic for actual capacity. Targets that are perceived to be too far have the potential to create a condition of learned helplessness that actually weakens efforts to achieve, as Tachjan (2016) emphasized that implementation is an arena for testing ideal ideas by the reality of the field.

Resources

Resource barriers are the most dominant and multidimensional, encompassing financial, human, and physical dimensions simultaneously. Based on the Budget Implementation Document (DPA) of the Samarinda City Health Office in 2025, the PKG operational budget for 26 health centers only covers around 43 percent of the ideal needs based on the target cost per capita standard. This budget deficit creates a structural condition where health centers are unable to provide services consistently, including running out of reagent stocks in the middle of the month due to rigid and tiered procurement mechanisms, which in turn lowers public confidence.

The shortage of health workers both in terms of quantity and quality of technical competence is the most consistently complained about. The Bukuan Health Center, for example, only has two general practitioners to serve more than 31,000 people. The addition of PKG's burden on top of regular services that are already crowded creates heavy work pressure. In the perspective of street-level bureaucracy Lipsky (1980), the deficit of human resources not only hinders technical capacity but also provides psychological pressure that encourages field implementers to use discretion towards reducing service intensity as a survival mechanism. Edward III (1980) emphasized that no good program will be realized without the availability of adequate resources on each front.

In terms of facilities, the availability of consumable medical materials and supporting equipment is not evenly distributed. A number of health centers do not have complete equipment according to the Ministry of Health's package, so some examinations must be referred to the Public Health Laboratory (Labkesmas), adding steps and burdens for the community. The instability of the internet connection and device limitations also hinder recording to SATUSEHAT. Interestingly, Trauma Centers and Youth Health Centers are able to manage similar limitations more adaptively, through flexible officer rotation, proactive communication with the Service before stocks run out, and optimization of the role of nurses and midwives. These findings enrich Van Meter and Van Horn's proposition that the quantity of resources and the quality of their management are two different dimensions; The real deficit can be partially compensated by leadership capacity. This pattern of universality of resource barriers is consistent with the findings of Alamsyah et al. (2021), Maulidya and Hakim (2024), Sahroji et al. (2022), and Riley et al. (2016).

Characteristics of Implementing Agents

Structurally, the Samarinda City Health Office already has adequate bureaucratic capacity with the Health Service Sector as the technical coordinator. However, at the operational level, institutional weaknesses were found. Not all health centers have a definitive PKG person in charge of the official Decree; Some are still informal appointments that create a vacuum of accountability. The implementation of SOPs has also not been consistent, especially when the surge of regular patients forces the merging of the PKG flow with the general flow, causing confusion in the community. Supervision from the Office is also not optimal due to the limited capacity of the coaching team to reach 26 health centers evenly.

The low competence in using the SATUSEHAT information system has a direct impact on the quality and accuracy of reporting, with data input per patient that can take 5 to 10 minutes and create an administrative bottleneck. The absence of this orderly bureaucratic element reflects the condition that Scott (1992) called organizational loose coupling, which is that organizational components function separately and are not integrated. Instead, the Trauma Center officially appoints the person in charge, holds weekly coordination meetings, and simplifies the internal reporting system; while the Youth Health Center separated the flow of PKG from public services from the first day. These findings confirm that effective institutional capacity depends more on the quality of internal leadership commitment and clarity of role divisions than on the scale of formal structures.

Communication and Coordination Between Organizations

Vertical communication from the Ministry of Health to the Health Office is going relatively well through official coordination groups, periodic webinars, and written technical

instructions. Distortion begins to occur when information is forwarded from the Office to the health center and from the health center to the community. Some technical instructions are delivered via informal messaging without official documentation, leading to variations in interpretation. This condition is in line with the concept of implementation gap (Hudson et al., 2019) as well as Edward III's (1980) three communication barrier mechanisms: transmission, clarity, and consistency.

The most critical obstacle is socialization to the target community. In most low-income health centers, socialization is limited to banners, leaflets, and social media that are managed as a matter of course, without an active notification mechanism to residents. As a result, many people only know about the program when it comes to other purposes. Village health cadres who are supposed to be opinion leaders (Katz & Lazarsfeld, 1955) have not been involved in a structured manner. On the other hand, the Trauma Center Health Center is actively present in citizen meetings, recitations, and RT/RW meetings, making coordination with the village head and Posyandu cadres a routine agenda, as well as running a pick-up program; while the Youth Health Center relies on the word-of-mouth effect of participant testimonials. In line with Rogers' (2003) theory of innovation diffusion, community trust-based interpersonal communication channels have proven to be much more effective than one-way mass media. These findings add a new dimension to the studies of Kumalasari and Prabawati (2021) and Putri et al. (2022) that not all communication channels have equal effectiveness.

Implementing Disposition

The disposition of the implementers at the leadership level, both the Head of the Service and most of the heads of the health center, is positive and supports policies. The problem of disposition in Samarinda City is not in the form of active resistance, but a phenomenon of progressive erosion of motivation due to an imbalance between the increasing workload and institutional support, incentive systems, and unequal rewards. The implementers substantively agreed on the urgency of the program, but the psychological stress of the multiplied workload without proportional compensation has the potential to create work burnout syndrome. This phenomenon is relevant to Herzberg's two-factor theory, in which the non-fulfillment of hygiene factors gradually erodes motivation, as well as the street-level perspective of bureaucracy Lipsky (1980).

Among the factors observed, the commitment of the health center heads appeared to be one of the more prominent characteristics associated with the difference between higher- and lower-performing health centers, although it co-varied with other conditions and cannot be isolated as the sole cause. At the Trauma Center Health Center, the head of the health center builds meaningful motivation by emphasizing that every resident examined is one life that has the potential to be saved, accompanied by consistent performance appreciation. In low-income health centers, the PKG program tends not to be made a top priority. As Nugroho (2018) emphasized, changing disposition from simply carrying out tasks to full commitment requires inspirational transformational leadership, not just transactional leadership that manages.

External Environment

From the political aspect, there is a strong commitment from the Samarinda City Government; The Mayor asked for PKG to be prioritized and the DPRD declared official support. However, these political commitments have not been fully translated into

proportional budget allocations in the APBD, reflecting practical obstacles at the governance level as warned by Nugroho (2018). From the socio-cultural aspect, the most complex obstacle was found in the form of the dominance of the curative paradigm, namely the tendency of people to visit health facilities only when they have felt symptoms. The stigma that associates visits to health centers with sick conditions, fear of diagnosis, and optimistic bias become mutually reinforcing psychological barriers.

From the economic aspect, even though services are free, there are indirect obstacles in the form of transportation costs and loss of daily income, especially for residents in suburban areas, in line with the findings of Yuan et al. (2019) that services that are nominally free are not necessarily affordable if there are significant indirect costs. Service hours that are limited to regular working hours also disproportionately make it difficult for the productive age group who are the most at risk. These findings are consistent with Okop et al. (2021) in South Africa and Kim et al. (2021) in South Korea regarding the low motivation of preventive screening in people who feel healthy. Within the framework of the transtheoretical model (Prochaska & DiClemente, 1983), most societies are in the precontemplation stage, so a specially designed communication strategy is needed to shift them towards the action stage.

Synthesis of Inhibitory Factors

The factors inhibiting the implementation of PKG are multidimensional and do not operate independently, but rather form a mutually reinforcing negative feedback system. The budget deficit limits the availability of reagents and tools, which reduces the ability of health centers to provide complete services, which undermines public trust. Labor shortages increase workloads that erode motivation and service quality. Ineffective socialization causes low public knowledge so that the demand for services is low. In summary, the six inhibiting factors are: (1) the gap in understanding between levels and the absence of local technical guidance; (2) multidimensional resource deficit; (3) inconsistencies in SOPs, weak supervision, and low information technology competence; (4) non-massive socialization and weak cross-sector coordination; (5) erosion of the motivation of the executors; and (6) the dominance of curative paradigms, social stigma, and accessibility barriers.

Compared to 15 previous studies, this study confirms and expands on the findings in three ways. First, strengthening evidence of the universality of resource barriers in the implementation of preventive health policies in developing countries. Second, adding empirical evidence on the importance of face-to-face community-based socialization strategies as the most determinative factor in driving participation. Third, highlighting the commitment of the head of the health center as an apparent differentiating characteristic between higher- and lower-performing centers—one that warrants further, more controlled investigation alongside structural factors such as resources, target size, and geographical location, rather than being treated as the single decisive cause. The novelty of the research lies in the focus on lifecycle-based personal health screening policies that utilize personal momentum as a trigger for preventive action, a temporal approach that has so far received limited attention in the public administration literature in Indonesia.

Table 2. Cross-case comparison of implementation conditions between lower- and higher-performing health centers

Comparison Dimension	Lower-performing centers (0.75–1.99%)	Higher-performing centers (11.17–12.64%)
Operational guidance / SOP	No local technical guide translating national standards; officers face uncertainty over examination types and SATUSEHAT recording	Internal one-page operational guide posted in each service room, supported by short weekly coordination meetings
Institutional responsibility	PIC often informal or absent, creating an accountability vacuum; SOPs applied inconsistently	Officially appointed PIC; simplified internal reporting; PKG flow separated from general services
Communication & community outreach	Passive socialization via banners, leaflets, and social media; cadres not structurally involved	Active outreach through RT/RW meetings, recitations, and cadres; pick-up program and word-of-mouth testimonials
Implementer disposition / leadership	PKG not treated as a priority; motivation eroded by workload without proportional support	Leaders build meaning-based motivation and give consistent performance appreciation
Resource management	Reactive; reagent stockouts mid-month; limited adaptation to shortages	Adaptive; flexible staff rotation and proactive communication with the Health Office before stocks run out

Conclusion

The implementation of the Free Health Checkup policy for the community in Samarinda City based on the Decree of the Minister of Health Number HK.01.07/MENKES/33/2025 has been implemented but is still not optimal, marked by the achievement of visits of 5.54 percent out of a total of 822,962 targets and a sharp disparity between health centers (0.75 to 12.64 percent). The analysis of the six variables of Van Meter and Van Horn shows that there is a gap in understanding of standards between levels, fundamental resource deficits, inconsistencies in the characteristics of implementing agents, non-massive socialization, risk of erosion of implementation motivation, and external environmental obstacles in the form of a dominant curative paradigm.

The inhibiting factors are systemic and interinteracting, including gaps in understanding and absence of local technical guidance, multidimensional resource deficits, inconsistencies in SOPs and weak supervision, non-massive socialization and weak coordination across sectors, erosion of motivation due to workloads that are not balanced by institutional support, as well as the dominance of curative paradigms and accessibility barriers. The commitment of the health center heads appeared to be an important characteristic distinguishing higher- and

lower-performing health centers; however, because target size, staffing, accessibility, and community networks also differed across centers, the present evidence indicates an association rather than establishing leadership as the sole causal factor.

Based on these conclusions, the study recommends: (1) the issuance of a concise and operational Local Technical Guide for the Implementation of PKG accompanied by standardized training; (2) progressively increasing the PKG budget allocation in the APBD—subject to the city's fiscal capacity and a financial feasibility assessment—toward meeting a substantially larger share of ideal needs (for example, at least 80 percent), together with a more flexible disbursement mechanism; (3) strengthening scheduled internal supervision and the determination of the person in charge of the official PKG in each health center; (4) the transformation of socialization strategies from a passive social media approach to a face-to-face community approach through the involvement of cadres and citizen forums; (5) where authority and funding permit, providing concrete recognition such as performance incentives and capacity building—identifying the responsible institutions and funding sources—to help maintain the motivation of implementers; and (6) redesigning motivation-based PKG communication by utilizing personal momentum as a psychological trigger.

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References

- Agustino, L. (2017). *The basics of public policy*. Bandung: Alfabeta.
- Alamsyah, K., Prastiwi, E. N., & Salamah, U. (2021). Implementation of the policy of implementing the regional health insurance program in Bekasi City. *Policy: Journal of Administrative Sciences*, 12(2).
- Anggraeni, N., Sandra, C., & Khoiri, A. (2022). Implementation of policies to protect and fulfill the health rights of persons with disabilities in Jember Regency. *Journal of Indonesian Health Policy: JKKI*, 11(1).
- Asa, S., Mauritsius, D., & Fall, I. A. T. (2024). The quality of service and patient satisfaction in the implementation of the free health program in Belu Regency. *Indonesian Health Promotion Publication Media (MPPKI)*, 7(5).
- Edward III, G. C. (1980). *Implementing public policy*. Washington, DC: Congressional Quarterly Press.
- Hudson, B., Hunter, D., & Peckham, S. (2019). Policy failure and the policy-implementation gap: Can policy support programs help? *Policy Design and Practice*, 2(1), 1-14.
- Kim, S. Y., Lee, H. S., & Kim, J. H. (2021). Factors affecting the national health screening rate in Korea. *International Journal of Environmental Research and Public Health*, 18(7), 3660.
- Kumalasari, F. M., & Prabawati, I. (2021). Implementation of tuberculosis control policies with the Directly Observed Treatment Short-Course (DOTS) strategy at the Bangsal District Health Center, Mojokerto Regency. *Publishing*, 9(2), 201-214.
- Lipsky, M. (1980). *Street-level bureaucracy: Dilemmas of the individual in public services*. New York: Russell Sage Foundation.

- Maulidya, N., & Hakim, M. L. (2024). Implementation of the Free Healthy Situbondo (SEHATI) policy in 2024. *Journal of Governance and Policy*, 5(2).
- Nugroho, R. (2018). *Public policy: Theory, management, dynamics, analysis, convergence, and policy chemistry* (6th ed.). Jakarta: Elex Media Komputindo.
- Nurmantika, A. K., & Wijayanto. (2024). Analysis of the implementation of the Semarang City Government's policies in the health sector (Case study: Universal Health Coverage Program). *Journal of Political and Government Studies*, 13(3), 759-775.
- Okop, K. J., Cooper, S., Levitt, N. S., & Lambert, E. V. (2021). Perceptions and experiences of screening for cardiometabolic diseases in peri-urban South Africa. *BMC Public Health*, 21(1), 1-13.
- Pomeo, W. R. R., & Winarti, E. (2024). Dynamics of the implementation of health worker placement policies in remote areas: Challenges and realities on the ground. *Tambusai Health Journal*, 5(1).
- Pratama, E. P. P. A., Annajah, K., Adristi, K., & Istanti, N. D. (2023). Analysis of the effectiveness of the implementation of the Universal Health Coverage policy in Indonesia: A review of the availability and quality of health services. *Journal of Husada Medicine*, 3(1).
- Pressman, J. L., & Wildavsky, A. (1984). *Implementation: How great expectations in Washington are dashed in Oakland*. Berkeley: University of California Press.
- Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51(3), 390-395.
- Putri, F. N., Sumaryana, A., & Sukarno, D. (2022). Implementation of HIV/AIDS prevention and control policies in Bogor City. *JANE (Journal of State Administration)*, 14(1), 16-31.
- Riley, R., Coghill, N., Montgomery, A., Feder, G., & Horwood, J. (2016). Barriers and facilitators to the delivery of the NHS Health Check programme: A systematic review. *BMJ Open*, 6(5), e009710.
- Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). New York: Free Press.
- Sahroji, Q. N., Hidayat, R., & Nababan, R. (2022). Implementation of the Health Office's policy in handling stunting in Karawang Regency. *Journal of Government and Politics*, 7(1).
- Scott, W. R. (1992). *Organizations: Rational, natural, and open systems*. Englewood Cliffs, NJ: Prentice Hall.
- Sulistiyani, E., et al. (2022). Implementation of Independent Learning Independent Campus (MBKM) in health and non-health faculties. *Educational: Journal of Educational Sciences*, 4(1), 686-698.
- Tachjan, H. (2016). *Implementation of public policies*. Bandung: AIPI.
- Van Meter, D. S., & Van Horn, C. E. (1975). The policy implementation process: A conceptual framework. *Administration & Society*, 6(4), 445-488.
- Wahab, S. A. (2021). *Policy analysis: From formulation to preparation of public policy implementation models* (Revised Edition). Jakarta: Bumi Aksara.
- Wiguna, A. R., Meigawati, D., & Amirulloh, R. (2022). Implementation of stunting prevention policies by the Health Office in Sukabumi Regency. *Muqoddimah Scientific Journal*, 6(1).
- Winarno, B. (2018). *Public policy: Theory, process and case studies*. Yogyakarta: CAPS.
- Yuan, B., Jian, W., He, L., Wang, B., & Balabanova, D. (2019). Equity in the utilization of the basic public health service project in China: A longitudinal study. *International Journal for Equity in Health*, 18(1), 1-10.

Ministry of Health of the Republic of Indonesia. (2025). Decree of the Minister of Health of the Republic of Indonesia Number HK.01.07/MENKES/33/2025 concerning Technical Guidelines for Free Health Checks for the Public. Jakarta: Ministry of Health of the Republic of Indonesia.