

PREVENTIVE GOVERNANCE IN PREMARITAL HEALTH SCREENING POLICY: A LOCAL GOVERNMENT CASE STUDY IN KOTAWARINGIN BARAT

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ABSTRACT

This study examines the implementation of premarital health screening in West Kotawaringin, Indonesia, from a governance perspective. While the policy is widely promoted as a preventive intervention for maternal and child health, existing studies largely emphasize clinical effectiveness and overlook how governance shapes its outcomes. This creates a gap between preventive health objectives and governance practice at the local level. Using a qualitative case study, data were collected through in-depth interviews with government officials, health workers, and prospective couples, supported by document analysis. The findings show that good governance principles are formally present but operate mainly at a procedural level. Transparency is limited to administrative information rather than health literacy; accountability focuses on reporting outputs rather than health outcomes; and participation is largely compliance-driven. Although coordination between health services and marriage registration improves service coverage, the absence of integrated data systems and longitudinal monitoring constrains preventive impact. This study argues that effective prevention requires a shift from rule-based governance to outcome-oriented governance. It introduces the concept of preventive governance, which integrates health literacy, institutional capacity, cross-sector data integration, and performance-based accountability. This framework extends good governance theory by embedding long-term preventive goals into governance practice, offering a more outcome-driven approach to public health policy.

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INTRODUCTION

Human resource development is increasingly understood as a multidimensional process that relies not only on education and economic growth, but also on health determinants from the earliest stages of the life cycle. The life-course approach in public health emphasizes that health conditions prior to conception have long-term consequences for pregnancy outcomes, birth quality, and child development (Dean et al., 2014; Lassi et al., 2020). Within this framework, preconception health services, including premarital health screening, constitute strategic preventive interventions. These interventions aim to break intergenerational cycles of anemia, non-communicable diseases, reproductive disorders, and sexually transmitted infections that contribute to stunting and maternal and infant mortality. Evidence shows that preconception interventions integrated into primary health care systems contribute to reductions in maternal mortality ratio (MMR) and infant mortality rate (IMR), while strengthening sustainable reproductive health (WHO, 2013, 2022).

Over the past decade, global health development has shifted from a predominantly curative orientation to a promotive-preventive paradigm that emphasizes cross-sector collaboration and adaptive governance (Greer et al., 2015; Kickbusch & Gleicher, 2012). In this context, governance in the health sector is no longer understood merely as formal regulation or hierarchical control. Instead, it refers to institutional capacity to coordinate actors, allocate resources, and align public interests toward equitable health outcomes (World Bank, 2017; Barbazza & Tello, 2014). The effectiveness of preventive policies is therefore closely linked to governance quality, including transparency, accountability, participation, and inter-organizational coordination (Bovens et al., 2014).

However, contemporary governance scholarship cautions against treating good governance as a purely normative checklist. Beyond transparency and accountability as moral standards, governance performance depends on institutional capacity, bureaucratic structures, incentive systems, and organizational culture (Fukuyama, 2013; Painter & Peters, 2018; Andrews et al., 2017). In many decentralized contexts, particularly at the local government level, governance reforms often operate in a compliance-oriented mode, where procedural adherence substitutes for substantive performance outcomes. This condition raises critical questions: Why do normatively ideal governance principles often stagnate at the administrative level? Are global governance standards fully compatible with local institutional realities? To what extent does a gap exist between policy design and implementation capacity in preventive health programs?

These questions are particularly relevant in the Indonesian context. Health checks for prospective brides and grooms have been incorporated into national strategies to accelerate stunting reduction and strengthen family resilience. Promoted by the Ministry of Health and the National Population and Family Planning Agency, this policy forms part of the 1,000 Days of Life (HPK) intervention, which has been expanded to include the preconception phase (BKKBN, 2022; Kemenkes RI, 2020). Given the high prevalence of anemia among women of reproductive age and the risks of chronic energy deficiency, premarital screening represents a long-term health investment with potential intergenerational impact.

Despite its strong normative legitimacy within public health discourse, local-level implementation demonstrates significant variation. International research on preconception care predominantly focuses on clinical effectiveness and nutritional interventions (Lassi et al., 2020; Stephenson et al., 2018). Meanwhile, public policy studies in Indonesia tend to frame premarital examinations either as administrative requirements or as health promotion initiatives. The governance dimensions of implementation how transparency, accountability, participation, effectiveness, and responsiveness are operationalized in practice, remain underexplored. Consequently, a conceptual gap persists between preventive health literature and governance theory in explaining how local governance quality shapes preventive policy effectiveness.

Governance studies emphasize collaborative governance as central to delivering complex public services (Ansell & Gash, 2008; Emerson & Nabatchi, 2015). The integration of health services with marriage registration requires coordination between health institutions, religious authorities, and civil bureaucracy. However, empirical research examining how good governance principles are translated into operational practices in non-metropolitan local governments remains limited. More importantly, there is insufficient analysis of whether governance operates primarily in a compliance mode focused on administrative verification or in a performance mode oriented toward measurable preventive health outcomes.

West Kotawaringin Regency provides a relevant empirical setting because premarital health examinations have been institutionally integrated through cooperation between the Health Office and the Office of Religious Affairs (KUA). This arrangement reflects cross-sector collaboration in family-based public services. Nevertheless, preliminary observations indicate several challenges, including limited public understanding, inconsistent procedural standardization, weak transparency of examination results, workload pressures, and uneven inter-agency coordination. These issues suggest that the central challenge lies not in policy design, but in implementation capacity and governance configuration. Based on this review, the study identifies two major gaps. First, a conceptual gap: the limited integration between preconception care theory and governance theory in explaining preventive policy effectiveness. Second, an empirical gap, the insufficient analysis of how good governance principles is operationalized and constrained within local institutional realities in Indonesia. Addressing these gaps requires moving beyond a purely normative application of good governance toward a more analytical examination of how preventive objectives are embedded within governance structures.

Accordingly, this study asks how are good governance principles operationalized in the implementation of premarital health screening, and to what extent do they produce effective preventive health outcomes at the local level? To bridge these gaps, this study proposes a preventive governance framework. Preventive governance is conceptualized not merely as the application of good governance principles to health policy, but as an analytical extension that integrates prevention-oriented public health goals into institutional capacity, cross-sector coordination, performance-based accountability, and public health literacy. By situating premarital health screening within this framework, the study interrogates the gap between normative governance design and empirical governance practice.

The novelty of this research lies in three aspects: (1) integrating preventive health perspectives with governance theory into a unified analytical framework; (2) operationalizing preventive governance through the core dimensions of good governance while incorporating institutional capacity and performance considerations; and (3) providing empirical evidence from a non-metropolitan local government case. Specifically, this study aims to: (1) analyse the implementation of premarital health testing policies; (2) evaluate how governance principles are operationalized in practice; and (3) formulate a conceptual model of preventive governance to strengthen preventive health policy governance at the regional level.

METHOD

This study employs a qualitative design with an intrinsic case study approach to analyze the implementation of the premarital health test policy from a good governance perspective in West Kotawaringin Regency (Creswell & Creswell, 2018). Case studies enable in-depth exploration of policy implementation within specific institutional and social contexts (Stake, 2010; Yin, 2018), and facilitate analysis of actor interactions and gaps between policy design and practice (George & Bennett, 2005). This research is grounded in a constructivist-interpretive paradigm, which views policy implementation as a socially constructed process shaped by actors, institutional norms, and contextual constraints (Denzin & Lincoln, 2011).

The research location was purposively selected due to the integration of services between the Health Office and the Office of Religious Affairs (KUA), reflecting collaborative governance (Ansell & Gash, 2008; Emerson & Nabatchi, 2015; Sugiyono, 2019). The study was conducted from January to March 2026. Informants consisted of government officials, health workers, and prospective brides and grooms. They were selected purposively based on direct involvement and at least one year of experience (Patton, 2015). A total of 18 informants participated, following the principle of data saturation (Guest et al., 2020).

Table 1. Research Informant Profile

Informant Categories	Kode	Number	Age Range	Years of Experience	Role in Policy
Health Department Officials	ADK1-ADK3	3	35-52 years	5-15 years	Program coordination & monitoring
KUA Officials	AKUA1-AKUA3	3	30-50 years	3-12 years	Administrative verification & socialization
Health Workers (Midwives/ Nurses)	TK1-K6	6	27-45 years	20-18 years	Pre-marital examination & counseling
Prospective Brides and Grooms	CP1-CP6	6	21-30 years	-	Service recipients

Data were collected through semi-structured interviews, non-participant observation, and document analysis. The interview guide was based on UNDP governance indicators, transparency, accountability, participation, effectiveness, and responsiveness (UNDIP, 1997; 2015). Interviews lasted 45-90 minutes, were recorded, and transcribed verbatim (Kvale & Brinkmann, 2015). Observations captured service delivery and coordination dynamics (Angrosino, 2016), while documents such as regulations, SOPs, and reports were analyzed to assess policy-practice alignment (Bowen, 2009). The UNDP indicators were used as heuristic tools rather than fixed benchmarks. This approach allows contextual interpretation, acknowledging that limited participation or administrative compliance may reflect local institutional realities rather than governance failure. Thus, the study focuses on how governance principles are interpreted and operationalized in practice.

Data were analysed thematically using the reduction-display-verification model (Miles et al., 2014). Coding proceeded through open, axial, and selective stages, combining deductive (UNDP indicators) and inductive approaches. Key analytical categories included procedural vs. substantive transparency, administrative vs. outcome accountability, compliance vs. engagement participation, coverage vs. impact effectiveness, and short-term vs. longitudinal responsiveness. Pattern matching was applied to link empirical findings with preventive governance theory (Yin, 2018). Trustworthiness was ensured through credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985; Miles et al., 2014; Nowell et al., 2017). Validation included triangulation, member checking, audit trails, and reflexive journaling. Ethical principles were upheld through informed consent, anonymization, secure data handling, and institutional approval (Israel & Hay, 2016).

RESULT AND DISCUSSION

Implementation of Health Tests for Prospective Brides and Grooms in West Kotawaringin Regency

The implementation of premarital health tests in West Kotawaringin Regency follows a structured administrative and clinical sequence. Prospective couples register at the KUA, obtain a referral letter, and undergo examinations at community health centers (*puskemas*). The services include hemoglobin testing, BMI assessment, tetanus toxoid immunization, general screening, and reproductive counselling. A health certificate is then issued as a requirement for

marriage registration. This design reflects the global preconception care framework that emphasizes preventive intervention prior to pregnancy (Dean et al., 2014; Lassi et al., 2021; Stephenson et al., 2018; WHO, 2013, 2019, 2022). and aligns with national policies on preconception services and stunting reduction (Ministry of Health of the Republic of Indonesia, 2020; National Development Planning Agency, 2021).

At the regulatory level, the policy demonstrates strong alignment with global and national frameworks. Empirically, coordination between the Health Office and KUA operates through referrals and periodic reporting. A Health Office official stated, *“We coordinate with the KUA so that every prospective bride and groom obtains a referral letter for examination before the marriage registration process continues.”* A KUA official added, *“We convey this health test as part of family readiness, not just an administrative requirement.”* These accounts suggest a collaborative orientation. However, the presence of procedures and coordination does not automatically translate into effective preventive outcomes. The findings indicate that governance operates mainly at a procedural level rather than ensuring sustained health impact.

Although coordination is formally established, integration of information systems remains absent. Verification relies on physical documentation, which can delay administrative processes and reinforce a compliance-based orientation. In this configuration, governance ensures requirement fulfillment but does not structurally guarantee long-term health risk management. This limitation becomes evident in the empirical health profile of participants.

Table 2. Clinical Findings of Prospective Brides and Grooms (January-March 2026)

Health Indicators	Total (n=40)	Percentage
Mild anemia (Hb <12 g/dL, females)	4 out of 20 women	20%
Risk of KEK (IMT <18.5)	3	7,5%
Further referral	2	5%
Complete all stages	18	90%

The prevalence of anemia (20%) and nutritional risk (7.5%) indicates that preconception health vulnerabilities remain substantively significant (Temel et al., 2014). A health worker explained, *“Most prospective brides experience mild anemia. We provide iron supplements and nutrition education before marriage.”* While clinical responses are delivered, institutional capacity constraints limit the depth of preventive engagement. During peak wedding seasons, service demand increases. A midwife noted, *“Routine services are already busy. As the wedding season approaches, the number of examinations increases and time becomes limited.”* Consequently, counselling sessions are often shortened. This illustrates how governance capacity constraints compress substantive preventive interaction (Andrews et al., 2017; World Bank, 2017; Fukuyama, 2013). This condition also underscores the need for broader social support, highlighting the importance of synergy among families, peers, and educational institutions to strengthen preventive awareness and, more broadly, to optimally develop individuals’ readiness for future life trajectories, including career readiness (Khasanah et al., 2025).

A more critical limitation appears in the reporting and monitoring stages. Current reporting practices focus on aggregate numbers of examined couples without including outcome indicators such as anemia trends, supplementation adherence, or follow-up status. There is no longitudinal monitoring mechanism for individuals identified as at risk.

Table 3. Identification of Governance Gaps Based on Implementation Stages

Implementation Stage	Key Actors	Empirical Practice	Disparities	Consequences
Socialization	KUA (Office of Religious Affairs)	Verbal information during registration	Low substantive understanding	Administrative compliance
Inspection	Community Health Center	Screening & counseling	High workload	Shortened counseling

Reporting	Community Health Center-Health Office	Manual aggregate reports	No outcome indicators	Administrative evaluation
Monitoring	Health Office	Monthly recap	Not longitudinal	Untracked risk

The absence of longitudinal monitoring constitutes the most significant structural weakness of the policy. Preventive governance requires continuity across time, yet current practice remains episodic. This limitation is evident in the case of CP3 (female, 24 years old, Hb 10.8 g/dL), who received supplementation and counselling prior to marriage without any post-marriage follow-up. Health workers confirmed, *“We can only ensure her health before marriage. After that, there is no specific mechanism to monitor her again.”* This condition reveals a disconnect between integrated primary care and the life-course approach in preventive health (Starfield et al., 2005; WHO, 2019; Halfon & Hochstein, 2002).

Community participation further reflects a compliance-driven pattern. A prospective bride stated, *“At first, we thought it was just a requirement for marriage. After the midwife explained it to us, we realized its importance for the health of the mother and baby.”* A male prospective bride added, *“If it weren't mandatory, we probably wouldn't have taken the test before getting married.”* These findings indicate that participation remains obligation-based rather than awareness-driven (Bovens et al., 2014; Pierson, 2000; Schillemans, 2016). In Arnstein's framework, participation has not yet reached the level of empowered engagement, limiting the transformative potential of preventive policy.

Collaboration between the Health Office and KUA reflects elements of collaborative governance (Ansell & Gash, 2008; Emerson & Nabatchi, 2015; Nabatchi et al., 2017). However, its operational orientation remains predominantly administrative rather than outcome-driven. The absence of integrated digital systems and shared performance indicators indicates that digital-era governance is not yet fully institutionalized (Dunleavy, 2006; Margetts & Dunleavy, 2013; OECD, 2021; Painter & Peters, 2018).

Overall, structured implementation does not automatically produce effective preventive governance. Although regulatory alignment, coordination mechanisms, and service delivery are present, evaluation remains output-based and monitoring is not continuous. This reflects a rule-based governance model, where effectiveness is equated with procedural adherence. However, preventive health policy requires sustained, outcome-oriented governance (World Bank, 2017). Thus, the current system represents administratively coordinated service delivery rather than fully institutionalized preventive governance. Preventive governance requires integration of institutional capacity, cross-sector data continuity, health literacy, and outcome-based accountability. Without these elements, policy implementation remains episodic and limited in generating long-term public health impact.

The Principle of Good Governance in the Implementation of Health Tests for Prospective Brides and Grooms

The premarital health testing policy in West Kotawaringin Regency is formally grounded in the principles of good governance, including transparency, accountability, participation, effectiveness, and responsiveness (UNDP, 2015; World Bank, 1992). In public administration literature, governance quality is a key determinant of policy success, particularly in essential sectors such as health (Bevir, 2011; Painter & Peters, 2018; Rhodes, 1996).

However, empirical findings reveal a more complex reality. While the policy reflects good governance norms at the design level, its implementation remains largely procedural. The gap between normative design and operational practice is evident across key dimensions. Although the policy aligns with preventive public health frameworks and the life-course approach (Halfon & Hochstein, 2002; Shonkoff et al., 2021), a preventive orientation in design does not automatically produce preventive governance in practice.

1. Transparency: Administrative Disclosure Without Deep Risk Literacy

Transparency is formally implemented through SOPs, informational leaflets, and verbal explanations by KUA officials and health workers. In governance theory, transparency is expected to enable citizens to understand procedures and policy purposes (Hood, 2014; Grimmelikhuisen & Meijer, 2014), and in Indonesia it is associated

with institutional trust (Dwiyanto, 2021). Document analysis confirms that SOPs regulate examinations such as Hb testing, BMI measurement, and counselling. However, the content of information remains largely procedural, emphasizing requirements rather than explaining long-term health risks or intergenerational implications.

This procedural orientation is reflected in institutional narratives. A KUA official stated, *“We convey from the outset that there is an obligation to undergo a health test before marriage registration.”* Similarly, health workers noted, *“At the health centre, we explain the types of tests and their purposes.”* These statements indicate that transparency is framed primarily as the delivery of procedural information. In contrast, community experiences reveal limited comprehension. A prospective bride stated, *“We took the test because it was a requirement... we did not fully understand everything.”* Another informant explained, *“We only understood the health implications after consultation.”* These accounts show that although information is provided, it is not fully internalized.

The data indicate a gap between information provision and cognitive uptake. Information is transmitted, but understanding remains partial and often delayed. Transparency, therefore, functions as an administrative instrument that secures compliance rather than as a mechanism that enables informed decision-making. From an analytical perspective, this pattern highlights a limitation in how transparency operates in practice. The assumption that information disclosure leads to empowerment is not fully supported by the data. Instead, the relationship between access to information and meaningful understanding appears mediated by interpretive capacity. When information is presented without sufficient contextualization, it tends to remain procedural and does not translate into preventive awareness.

In public health terms, this condition reflects limited development of risk literacy (Nutbeam, 2008; Sørensen et al., 2012; Meijer et al., 2012). Without the ability to interpret and apply health information, individuals remain passive recipients rather than active decision-makers. Consequently, transparency fails to produce behavioural change, limiting its preventive function. This condition invites a theoretical reconsideration. Rather than viewing transparency as mere openness, the findings suggest the need to conceptualize it as cognitive governance, where the effectiveness of transparency is measured by the extent to which it produces understanding, reflexivity, and informed action. In this sense, transparency is not simply about “what is disclosed,” but about how knowledge is constructed and absorbed within governance processes.

2. Accountability: Reporting Compliance Rather Than Health Outcomes

Accountability mechanisms are structured through medical records, recommendation letters, and periodic reporting. In governance theory, accountability entails not only the provision of information but also the obligation to explain and justify actions (Bovens, 2007). Empirical findings show that accountability is operationalized primarily through documentation practices. At the service level, a midwife stated, *“We record all examination results... and follow up before giving recommendations.”* At the supervisory level, a Health Office official explained, *“We conduct monitoring through monthly reports... regarding the number of examinations and anemia cases.”* These practices indicate that accountability is embedded in routine reporting systems that prioritize administrative completeness.

The KUA reinforces this mechanism through regulatory control. A KUA officer stated, *“We will not proceed with marriage registration if there is no health certificate.”* This requirement creates a formal accountability chain between health services and marriage administration, reflecting inter-agency coordination (O’Donnell et al., 1998). However, closer examination reveals that the object of accountability is narrowly defined. Reporting focuses on quantifiable outputs such as the number of examinations conducted and cases identified, while excluding indicators that capture changes in health conditions. The absence of data on supplementation adherence, behavioral change, or maternal health outcomes indicates that accountability is anchored in procedural verification rather than substantive evaluation.

This pattern suggests that accountability operates within a compliance-oriented measurement framework. Documentation functions as proof that procedures have been followed, rather than as a tool to assess whether the

policy achieves its preventive objectives. In this configuration, certification becomes the endpoint of accountability, not the starting point for outcome evaluation. The limitation becomes more apparent in the temporal dimension of monitoring. Reporting is aggregated on a monthly basis without mechanisms to track individual health trajectories over time. As a result, the system lacks the capacity to connect initial screening results with subsequent health developments. What is absent is not data per se, but continuity of data. This discontinuity constrains the ability to empirically assess whether early detection translates into improved maternal and child health outcomes.

From a critical analytical perspective, these findings reveal a structural gap between answerability and evaluability. While institutions are able to report and justify their activities, they are not equipped to evaluate the long-term effects of those activities. This indicates that accountability is fulfilled in a formal sense but remains limited in its analytical depth. In the context of performance-based governance, accountability is expected to link processes with measurable outcomes (Behn, 2001; Pollitt & Bouckaert, 2017). The empirical evidence here shows that such linkage is not yet established. Instead, accountability is stabilized at the level of administrative reporting, where success is inferred from compliance rather than demonstrated through impact. This condition points to a structural disconnection between administrative answerability and preventive outcomes. It suggests that accountability in preventive policy contexts requires longitudinal tracking and outcome-oriented metrics, so that governance is able not only to report actions, but also to observe and verify their long-term effects.

3. Participation: Obligation-Driven Rather Than Awareness-Based

Participation is reflected in the attendance of prospective couples at health examinations and counselling sessions. In governance theory, participation is expected to position citizens as active agents who engage with and shape policy processes (Fung, 2006). At the implementation level, efforts to facilitate engagement are evident. A health worker stated, *"We try to involve couples in discussions, not just explain laboratory results."* This indicates an attempt to create dialogical interaction rather than one-way communication. In principle, such interaction provides space for clarification and reflection on reproductive health readiness. However, participant responses reveal a different pattern. A prospective bride stated, *"If it weren't mandatory, we probably wouldn't get tested before getting married."* This statement indicates that participation is primarily triggered by regulatory obligation rather than internalized awareness. Attendance is secured through administrative requirement, suggesting that participation is structured externally rather than emerging from individual motivation.

The data point to a distinction between participation as presence and participation as engagement. While individuals attend counselling sessions, this does not necessarily translate into cognitive involvement or behavioural commitment. Participation is thus observable at the procedural level but limited at the level of internalization. In Arnstein, (2025) framework, this corresponds to forms of participation where involvement is regulated and controlled, with limited citizen ownership over policy goals.

This pattern reflects a compliance-oriented participation structure. Institutional arrangements ensure that prospective couples are included in the process, yet the basis of their involvement remains reactive. Participation is activated by requirements rather than by perceived relevance of preventive health. As a result, engagement tends to be situational and contingent on enforcement mechanisms. From a behavioural perspective, sustained preventive practices depend on internal motivation, perceived risk, and personal relevance (Glanz et al., 2015; Sunstein, 2014). The empirical findings indicate that these elements are not yet consistently developed. Although counselling is provided, the persistence of obligation-driven attendance suggests that participation does not fully extend into behavioural transformation. The dominant mechanism remains regulatory compulsion rather than behavioural activation.

Analytically, this condition reveals a limitation in how participation is operationalized. Inclusion is achieved, but depth of engagement remains uneven. Citizens are present within the governance process but are not yet positioned as active co-producers of preventive health outcomes. Participation functions to ensure policy uptake, but not

necessarily to sustain preventive practices beyond the point of compliance. This indicates that participation, in its current form, is procedurally secured but substantively constrained. The findings point to a gap between institutional inclusion and behavioural internalization, suggesting that preventive governance requires participation to extend beyond attendance toward sustained, awareness-based engagement.

4. Effectiveness and Responsiveness: Coordination Without Integration

The increase in premarital examination coverage indicates that coordination between the Health Office and the KUA has produced measurable administrative improvements. Institutional linkage ensures that prospective couples cannot proceed with marriage registration without proof of health examination, thereby expanding service reach. A Health Office official stated, *“Since the collaboration with the KUA, the number of couples getting checked has increased significantly compared to before.”* This suggests that coordination has strengthened compliance and reduced the likelihood of bypassing screening procedures, reflecting administrative effectiveness in expanding coverage (Klijn & Koppenjan, 2016; Rhodes, 1996).

At the service level, responsiveness is visible in the way interventions are adjusted to examination results. A midwife explained, *“If anemia is found, we provide iron supplements and nutrition education. If there are other problems, we refer them for further treatment.”* This indicates that frontline actors respond to individual health conditions rather than merely completing procedural requirements, aligning with adaptive and citizen-centered service delivery (Denhardt & Denhardt, 2015; World Bank, 1992). In this sense, responsiveness is operational at the point of service and has the potential to contribute to improved maternal readiness (Bryson et al., 2014; Moore, 1995).

However, a closer reading of the data suggests that coordination operates at a procedural level rather than as an integrated governance system. The linkage between institutions is based on referral requirements and reporting routines, but does not extend to shared data infrastructures or joint evaluative mechanisms. There is no evidence of integrated digital databases, real-time data exchange, or unified monitoring frameworks. As emphasized in digital-era governance literature, such integration is critical for policy coherence and long-term performance measurement (Dunleavy, 2006; Margetts & Dunleavy, 2013; OECD, 2021; Painter & Peters, 2018). In a different but related context, the existence of social demands and idealized self-presentation on platforms such as Instagram can also constrain individual interaction patterns (Haliza et al., 2025), indicating how structural and normative pressures whether institutional or digital, shape behavior and limit the depth of engagement.

This limitation becomes more apparent in how effectiveness is defined and measured. Current indicators emphasize coverage how many couples undergo screening, while the relationship between early detection and subsequent health outcomes remains unobserved. Data are reported periodically but not longitudinally connected to individual health trajectories. As a result, risk identification at the premarital stage is not systematically followed into later stages such as pregnancy or maternal care. The system produces data, but not continuity of data. The absence of longitudinal monitoring constrains the evaluability of preventive impact. It is not possible to determine whether interventions such as iron supplementation reduce anemia prevalence, whether counselling influences behavioural change, or whether screening contributes to improved maternal and neonatal outcomes. Effectiveness, therefore, is established at the level of administrative throughput rather than verified through sustained health improvement.

At the same time, responsiveness at the frontline level is contingent upon institutional capacity. As examination coverage increases, the ability of health workers to maintain the depth and quality of counselling becomes dependent on available resources. State capacity literature highlights that bureaucratic performance is shaped by organizational stability, human resources, and infrastructural support (Evans & Rauch, 1999; Fukuyama, 2013). In parallel, a more holistic approach that integrates spiritual aspects is needed so that development programs are not only cognitive or technical, but also incorporate character building and mental resilience (Husniah et al., 2025; Syahmidi et al., 2025; A'ini et al., 2025). Without corresponding capacity reinforcement, responsiveness may become increasingly procedural, with reduced time for consultation and limited follow-up.

Across the governance dimensions, a consistent pattern emerges. Coordination expands access, but integration remains limited. Responsiveness is present at the service level, but its sustainability depends on capacity and system design. Effectiveness is demonstrated through increased coverage, yet its preventive outcomes remain empirically unverified. This indicates that effectiveness, in the current configuration, is administratively achieved but analytically constrained. The findings point to a gap between coordinated service delivery and integrated outcome evaluation, suggesting that preventive governance requires not only inter-agency linkage, but also data continuity, system integration, and capacity alignment to capture and sustain long-term health impacts.

CONCLUSION

The implementation of premarital health testing in West Kotawaringin shows that preventive health policy can function within a governance framework, supported by procedural structures, inter-agency coordination, and expanded service coverage. However, empirical findings indicate that governance remains largely compliance-oriented. Transparency operates at an administrative level, accountability focuses on outputs rather than outcomes, and participation is driven by obligation rather than awareness. The absence of longitudinal monitoring further limits the policy's capacity to demonstrate sustained preventive impact.

These findings indicate that the main challenge lies not in regulatory design, but in the limits of procedural governance when applied to preventive policy goals. Prevention requires continuity, behavioural internalization, and outcome-based evaluation, which are not fully captured by existing governance practices. This study concludes that premarital health policy remains administratively effective but substantively constrained. It highlights the need to shift from compliance-based governance toward outcome-oriented preventive governance, where success is measured by sustained health impact rather than procedural fulfilment.

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