

Analysis of Community Health Service Management and Individual Health Efforts at Community Health Centers: A Qualitative Study

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Community Health Centers (Puskesmas), as first-level health care facilities, play a strategic role in providing Community Health Efforts (UKM) and Individual Health Efforts (UKP). The integration and effectiveness of these two efforts are largely determined by the quality of service management. This study aims to analyze the management of UKM and UKP services at Community Health Centers through a qualitative approach. The study was conducted at three community health centers (Puskesmas) in Southwest Sumba Regency in 2025. Data collection techniques included in-depth interviews, participant observation, and document review. Informants included the heads of the community health centers, community-based health unit (UKM) coordinators, community-based health unit (UKP) coordinators, health workers, and community representatives. Data analysis was conducted using thematic analysis through data reduction, categorization, and conclusion drawing. The results indicate that management functions (planning, organizing, implementing, and evaluating) have been implemented, but are not fully based on community needs. Key challenges include limited human resources, administrative burdens, suboptimal cross-program coordination, and suboptimal data utilization. The integration of SMEs and UKPs remains administrative and not yet fully operational. Strengthening managerial capacity, optimizing information systems, and increasing public participation are key strategies for improving service quality.

Keywords: Service management, UKM, UKP, Community Health Center, qualitative study

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1. Introduction

Primary health care is the main foundation of a health system oriented toward achieving optimal community health status. The primary health care approach emphasizes universal access, comprehensive services (promotive, preventive, curative, rehabilitative), community participation, and intersectoral collaboration. In the context of Indonesia, Community Health Centers serve as the frontline for implementing this approach through the delivery of Community Health Efforts (UKM) and Individual Health Efforts (UKP). Conceptually, UKM is population-based, aiming to improve community health through promotive and preventive activities such as health promotion, epidemiological surveillance, community empowerment, and disease prevention. Meanwhile, UKP focuses on individual health services through diagnosis, treatment, medical interventions, and rehabilitation. The integration of UKM and UKP is a crucial prerequisite to ensure the sustainability of primary health care services and their impact on public health indicators.

The latest national health statistics reveal the complex dynamics of health needs among the Indonesian population. According to the 2025 Health Statistics Profile published by the Central Bureau of Statistics (BPS), this publication provides a comprehensive overview of the health status of the Indonesian population based on the 2025 National Socio-Economic Survey (Susenas), including aspects of child health, maternal health, and population characteristics related to access to primary health care services such as Community Health Centers.

In this context, Community Health Centers are expected not only to provide individual clinical services through Individual Health Efforts (UKP), but also to deliver population-based promotive and preventive services through Community Health Efforts (UKM), which include health education, immunization promotion, disease surveillance, early detection, and management of major risk factors such as malnutrition and non-communicable diseases. From a public health perspective, the effectiveness of UKM and UKP service management has broad implications for achieving national population health indicators, such as immunization coverage, reduction of stunting rates, control of non-communicable diseases, and improvement of healthy lifestyle behaviors. Evaluating integrated service management can help explain how the combination of organizational structure, service processes, and actual outcomes contributes to the overall health status of the population.

Based on this background, this study aims to conduct an in-depth analysis of the management of Community Health Efforts (UKM) and Individual Health Efforts (UKP) at Community Health Centers using a multi-site qualitative approach. The analysis is carried out to identify factors that facilitate or hinder the integration of UKM and UKP, as well as to formulate policy implications for strengthening community-based primary health care services. The results of this study are expected to provide theoretical contributions to the development of primary health care service management models, as well as practical contributions for policymakers at both regional and national levels in optimizing the implementation of primary care service transformation.

2. Literature Review and Problem Statement

According to the primary care service transformation policy by the Ministry of Health of the Republic of Indonesia (2022), Community Health Centers are directed to integrate life-cycle-based services, strengthen early disease detection, and enhance the digitalization of the health system. Community Health Efforts (UKM) are promotive and preventive activities aimed at improving the collective health status of the population. UKM includes health promotion, epidemiological surveillance, prevention of communicable and non-communicable diseases, environmental health, and community empowerment. From a public health perspective, UKM has a significant population impact because it focuses on preventing risk factors before they develop into diseases. Recent studies indicate that strengthening promotive-preventive programs at the primary care level is correlated with increased immunization coverage, early detection of hypertension, and control of non-communicable disease risk factors (Yuliani et al., 2025). However, various studies show that the implementation of UKM is often constrained by limited human resources and low integration with clinical services (Amir et al., 2023).

Individual Health Efforts (UKP) are health services directed at individuals, encompassing examination, diagnosis, treatment, rehabilitation, and referral. UKP plays an important role in ensuring access to quality basic medical services. The quality of UKP is often associated with patient satisfaction, waiting time, healthcare worker competence, and the availability of facilities and infrastructure. Permata Sari and Rinaldi (2024) indicate that effective clinical service management contributes to increased patient satisfaction and public trust in Community Health Centers. However, an excessive focus on curative services can reduce attention to promotive-preventive efforts, making the integration of UKM and UKP a significant managerial challenge.

Based on the literature review, it can be concluded that the management of Community Health Efforts (UKM) and Individual Health Efforts (UKP) requires a comprehensive, quality-based approach. Structural issues such as limited human resources and fragmented information systems must be addressed through

managerial reform and digitalization. Meanwhile, strengthening leadership and integrated planning is key to achieving the effective integration of primary health care services.

3. Method

This study employed a qualitative approach with a multi-site case study design to gain an in-depth understanding of the management of Community Health Efforts (UKM) and Individual Health Efforts (UKP) at Community Health Centers from a public health perspective. A qualitative approach was chosen because the study aims to explore the processes, organizational dynamics, and experiences of actors involved in primary health care delivery in a contextual and holistic manner. The research was conducted at three Community Health Centers representing urban, semi-urban, and rural area characteristics. Site selection was purposive, taking into account variations in population size of the service area, service complexity, and achievement of health program indicators. Data collection was conducted from October to December 2025.

Study informants were selected using purposive sampling with the criteria of having a direct role in the management or implementation of Community Health Efforts (UKM) and Individual Health Efforts (UKP) and being willing to participate in the study by signing informed consent. A total of 10 informants were included, consisting of Community Health Centers heads, UKM programme coordinators, medical staff and nurses implementing UKP, as well as patients receiving services. Data were collected through semi-structured in-depth interviews, participatory observation, and document review to ensure data triangulation. Interviews were conducted in a semi-structured format using interview guides developed based on the structure–process–outcome theoretical framework.

Participatory observation was conducted to directly observe patient service flows, the implementation of UKM activities such as health education and screening, as well as internal coordination processes between programs. Field notes were systematically prepared to document interactions, communication patterns, and team work dynamics. In addition, the study also reviewed planning and reporting documents, such as the Health Effort Plan (RUK), program achievement reports, and Community Health Centers performance indicators, to obtain an overview of the alignment between program planning and implementation.

The primary instrument in this study was the researcher as a human instrument, responsible for collecting, interpreting, and analyzing the data. Supporting instruments included semi-structured interview guides, observation sheets, document review checklists, and audio recording devices. The interview guides were pilot-tested on a limited basis to ensure clarity and relevance of the questions to the research objectives. Data analysis was conducted simultaneously with data collection using an interactive analysis model, which includes data reduction, data presentation, and conclusion drawing. Data reduction involved repeatedly reading interview transcripts, performing open coding to identify initial categories and themes, and grouping data according to the analytical framework. The data were then presented in thematic matrices to facilitate identification of patterns and relationships between themes. Conclusions were drawn iteratively, with verification through triangulation of sources and methods.

4. Results and Discussion

This study analyzed the management of Community Health Efforts (UKM) and Individual Health Efforts (UKP) at Community Health Centers using a structure–process–outcome approach. The analysis indicated that the integration of UKM and UKP still faces challenges across structural, process, and outcome dimensions, which are interrelated in a systemic manner.

Structural Dimension: Resource and Information System Inequities

The study results indicate that the limitation and distribution of human resources (HR) are the main determinants of service effectiveness. Informants consistently stated that a high workload leads healthcare workers to prioritize curative services (UKP) over promotive-preventive services (UKM).

A Puskesmas head stated :

"Patients come every day and must be attended to. If staff are limited, we automatically focus on the clinic first. Health education activities are sometimes delayed."

These findings align with the study by Pratama et al. (2023), which reported that uneven distribution of healthcare personnel in primary care facilities leads to the dominance of curative services and weakens promotive-preventive functions. Another study by Amelia and Rahman (2024) indicated that a high administrative burden also reduces direct interaction time between healthcare workers and the community. In addition to human resource limitations, fragmented information systems constitute a significant structural problem. Informants reported duplication in reporting between the UKP system and UKM programs.

A programme coordinator stated :

"We have to enter patient data into the clinic system as well as in the program reports. It takes a lot of time."

This situation supports the findings of Sari et al. (2022), which emphasized that the integration of primary health information systems remains suboptimal in many regions. Data fragmentation leads to work inefficiency and increases the risk of reporting inconsistencies. From the perspective of Donabedian's model (1988), weaknesses in the structural aspects-both human resources and information systems-directly affect the quality of service processes and population health outcomes.

Process Dimension: Cross-Program Coordination and Integrative Implementation

In the process dimension, this study found that formal coordination mechanisms, such as mini-workshops, have been conducted regularly; however, they are more oriented toward reporting rather than integrative strategic planning.

A healthcare worker stated :

"Meetings usually focus on target achievements. Program integration discussions are not yet optimal."

These findings are consistent with the study by Yuliani et al. (2025), which showed that internal coordination forums in Community Health Centers are often administrative in nature and have not been utilized as spaces for integrated service innovation.

Nevertheless, good practices were observed in a rural Community Health Centers that integrated non-communicable disease (NCD) screening in the clinic with group education classes. This approach aligns with the primary care service transformation direction by the Ministry of Health of the Republic of Indonesia (2022), which emphasizes a life-cycle-based approach and early detection.

International research also indicates that integrating promotive and curative services at the primary care level can improve health system efficiency and reduce the burden of chronic diseases (World Health Organization, 2023). Such integration requires transformational leadership capable of promoting cross-professional collaboration (Rahmawati & Nugroho, 2023).

Furthermore, community participation plays a significant role in supporting the success of UKM. In rural areas, health cadres and community leaders actively participate in posyandu activities and health education. This supports public health empowerment theory, which emphasizes the importance of social capital in enhancing the effectiveness of promotive-preventive programs (Lestari et al., 2024).

Outcome Dimension: Service Quality and Health Impact

From the outcome perspective, the majority of patients expressed satisfaction with the friendliness and competence of healthcare workers. However, long waiting times were the main complaint.

A patient stated :

"The service is good, but the queue is long when there are many patients."

These findings are consistent with the study by Handayani et al. (2022), which showed that patient satisfaction in primary care facilities is strongly influenced by waiting time and the efficiency of service flow. Document review showed that urban Community Health Centers achieved higher immunization coverage and NCD screening rates compared to rural areas. However, community participation in UKM activities was higher in rural areas. This indicates that health outcomes are influenced not only by facility availability but also by social and cultural factors.

At the national level, public health challenges in Indonesia remain significant. The Indonesia Nutrition Status Survey (SSGI) 2024 reported a national stunting prevalence of 19.8%, while non-communicable diseases such as hypertension and diabetes continue to rise. This situation underscores the need to strengthen UKM as a long-term preventive strategy.

From a public health perspective, effective integration of UKM and UKP can reduce disease burden and improve health financing efficiency. Global studies show that health systems balancing promotive-preventive and curative services achieve better population outcomes and more controlled healthcare costs (WHO, 2023).

Integrative Analysis

Overall, the study results indicate that the integration of Community Health Efforts (UKM) and Individual Health Efforts (UKP) remains partial and heavily depends on leadership capacity as well as the structural conditions of each Community Health Center. Weaknesses in structural aspects affect coordination and implementation processes, which ultimately influence service outcomes.

These findings reinforce the argument that primary care transformation cannot rely solely on regulations but requires strengthening internal management, digitalizing information systems, redistributing human resources based on workload, and enhancing leadership capacity.

Thus, the contribution of this study lies in strengthening empirical evidence that the management of UKM and UKP services should be viewed as a unified, systemic entity within the public health framework. Effective integration not only improves the quality of clinical services but also contributes to the sustainable achievement of population health indicators.

5. Conclusion

This study demonstrates that the management of Community Health Efforts (UKM) and Individual Health Efforts (UKP) at Community Health Centers still faces challenges in structural, process, and outcome integration. In the structural dimension, limitations and uneven distribution of human resources not based on workload analysis, as well as fragmented health information systems, are the main barriers to delivering

integrated services. These conditions lead to the dominance of curative services (UKP) over promotive-preventive activities (UKM), particularly in Puskesmas with high patient visit volumes. In the process dimension, internal coordination mechanisms such as mini-workshops are conducted regularly, but they have not been fully utilized as forums for cross-program strategic integration. Planning remains largely administrative and focused on reporting indicator achievements. Nevertheless, good practices were observed in several Community Health Centers that have integrated non-communicable disease screening with group education and a life-cycle-based approach, as directed by the primary care service transformation policy of the Ministry of Health of the Republic of Indonesia.

In the outcome dimension, the quality of clinical services is rated positively by patients, especially in terms of communication and healthcare worker attitudes. However, issues such as long waiting times and service flow efficiency remain complaints. Regarding public health outcomes, there are regional variations: urban Puskesmas demonstrate higher clinical indicator achievements, while rural areas show stronger community participation in UKM activities.

From an integrative perspective, this study emphasizes that the success of UKM–UKP integration heavily depends on strengthening organizational structures, optimizing managerial processes, and transformational leadership capable of promoting cross-program collaboration. Effective integration not only improves the quality of individual services but also contributes to the sustainable achievement of population health indicators.

6. References

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