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Strategies of the Palu City Health Office in Achieving a Healthy City

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ABSTRACT

Introduction: This study aimed to analyze the strategies implemented by the Health Office of Palu City in realizing a Healthy City, as part of Indonesia's national movement toward achieving the World Health Organization (WHO) Healthy City framework. The program emphasizes cross-sector collaboration and active community participation, which remain crucial in addressing challenges of urbanization, social inequality, and limited health infrastructure.

Methods: A qualitative case study design guided by Parsons' AGIL functional framework was applied to explore adaptive, integrative, goal-oriented, and latent dimensions of health governance. Data were collected through in-depth interviews, observations, and document reviews involving key stakeholders such as health officials, community leaders, health cadres, and social organizations (e.g., PKK and NGOs). Data were analyzed thematically using NVivo 12 Plus. Ethical clearance was obtained, and all participants provided informed consent.

Results: The findings revealed that the Health Office strategies were categorized into the four AGIL functional dimensions: (1) Adaptation, through fiscal adjustment and program prioritization; (2) Integration, via inter-sectoral coordination and disaster response mechanisms; (3) Goal Attainment, through leadership alignment with municipal health targets; and (4) Latency, through sustained community participation and cadre-led education. These strategies strengthened social structures, communication forums, and community-based initiatives such as GERMAS and open defecation elimination. Despite these efforts, key barriers persisted—namely, limited budget allocation, weak cross-sectoral institutionalization, and uneven citizen engagement across subdistricts.

Conclusion: The study concludes that a socially grounded, AGIL-informed collaborative strategy adopted by the Health Office is effective in promoting the WHO Healthy City initiative within Indonesia's decentralized governance context. These findings contribute theoretically to the discourse on social determinants of health and systems theory, and offer practical implications for strengthening local government capacity, budgeting, and inter-sectoral health policies.

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INTRODUCTION

Urban areas worldwide face persistent challenges in maintaining public health amidst rapid urbanization and socio-environmental transformation (1). Population growth and accelerated development have produced complex health problems—ranging from pollution and social inequality to limited access to healthcare services (2,3). Addressing these multidimensional challenges requires adaptive, integrative, and sustainable strategies aligned with both local governance systems and global health frameworks.

The concept of a WHO Healthy City has gained global recognition as a holistic framework for addressing urban health challenges through intersectoral collaboration. This approach underscores the social determinants of health—including education, income, healthcare accessibility, and civic participation—as fundamental drivers of population well-being (4–7). In Indonesia, the Healthy City (Kota Sehat) initiative operates within the framework of regional autonomy, empowering local governments to innovate in designing contextually appropriate and affordable health strategies (8). Supported by the World Health Organization (WHO), this program aims to cultivate both physical and social ecosystems that promote sustainable urban health and equity (9).

Despite being adopted in Central Sulawesi, the Healthy City initiative in Palu City continues to face implementation gaps across administrative districts (10). As the provincial capital, Palu has committed to building a resilient, safe, and sustainable city through initiatives embedded in the Regional Medium-Term Development Plan (RPJMD). Several achievements—such as reductions in maternal mortality and improved access to safe water—illustrate progress, yet persistent barriers remain: resource limitations, uneven community engagement, and weak inter-sectoral integration (11).

Palu City has developed flagship programs—such as the elimination of open defecation, GERMAS (Healthy Living Community Movement), and Puskesmas accreditation programs—across its eight districts, 46 sub-districts, and 14 community health centers. These initiatives reflect the city's commitment to participatory and cross-sectoral approaches(12). However, the social and institutional mechanisms—such as community forums, local NGOs, and PKK organizations—that underpin these efforts remain empirically underexplored.

This study aims to analyze the strategies of the Palu City Health Office in realizing the Healthy City program, focusing on how local governance integrates policy, intersectoral coordination, and community participation to improve urban health. The research emphasizes the social and organizational dimensions of implementation—particularly the roles of the Health Office, Bappeda, sub-district leadership, and health centers—in operationalizing the Healthy City concept through the AGIL framework of Parsons (Adaptation, Goal Attainment, Integration, and Latency). (13). The findings are expected to provide empirical insights for strengthening collaborative health governance and enhancing the sustainability of Healthy City initiatives in Palu. (14).

METHOD

This study employs a clear, systematic, and ethically grounded approach to ensure the credibility, dependability, and confirmability of its findings. The methodology was designed to reflect both the WHO Healthy City framework and Parsons' AGIL functional model as the analytical lens. The following subsections describe each component in detail:

Research Design

This study employed a qualitative exploratory case-study design, in which the researcher acted as the primary instrument. Multiple data-collection techniques—in-depth interviews, participatory observations, and document analysis—were triangulated within an inductive analytical framework emphasizing meaning, context, and social process rather than statistical generalization(15) . The design was guided by Parsons' AGIL functional framework, enabling systematic interpretation of how adaptation, integration, goal attainment, and latency operate within the Palu Healthy City governance system (16). The study was underpinned by constructivist-interpretivist epistemology, emphasizing cognition through experience, reflection, and reasoning (17).

Study Setting and Duration

The research was conducted at the Palu City Health Office, Central Sulawesi, Indonesia, from January to June 2025. The site was selected for its central role in coordinating planning, implementation, and evaluation of the

WHO Healthy City initiative at the municipal level. The setting also allowed direct observation of cross-sectoral coordination meetings and community-based health campaigns.

Participants and Sampling

A total of six key informants were purposively selected based on predefined inclusion and exclusion criteria. The inclusion criteria were: (1) active involvement in the planning, implementation, or evaluation of the Healthy City program; (2) a minimum of one year of service in the current position; (3) sufficient knowledge of program functions and mechanisms; and (4) willingness to participate. The exclusion criteria included being on leave, inactive status, refusal to participate, or unavailability during data collection. The six informants consisted of the Head of the Palu City Health Office, Chairperson of the Healthy City Working Group (Pokja), Head of the Public Health Division at the Palu City Health Office, Head of the Regional Development Planning Agency (Bappeda), Subdistrict Head of East Palu, and Head of Talise Public Health Center (Puskesmas). All informants participated in in-depth interviews to provide cross-sectoral perspectives on the implementation of the Healthy City program in Palu City.

Data Collection Procedures

Data were obtained through semi-structured in-depth interviews, field observations, and document reviews, complemented by photographic and audio-visual documentation.

The "taxonomic approach" was applied to define, classify, and describe observed phenomena in order to uncover cultural and organizational patterns. Multiple data sources were integrated through an iterative process—linking interview codes, observational notes, and policy documents—to ensure analytical coherence. (18).

Data Analysis

Data were analyzed using a meaning-based thematic analysis supported by NVivo 12 Plus. The analytic workflow consisted of (1) data familiarization and initial open coding; (2) axial merging of codes into categories; (3) selective thematic integration aligned with the AGIL dimensions; and (4) interpretive reporting linking empirical themes to theoretical constructs. Inter-coder reliability was checked through peer debriefing sessions, and coding discrepancies were resolved consensually. Triangulation was implemented across sources (6 informants), methods (interviews, documents, observations), and time (morning, afternoon, evening) to enhance analytic credibility.

Trustworthiness

The study ensured trustworthiness through methodological coherence between research focus, sampling, data collection, analysis, and reporting. Credibility was reinforced through source/method/time triangulation and peer review; dependability through systematic documentation of coding decisions; and confirmability through audit trails and transparent reporting.

RESULTS

Overview of Thematic Findings

Qualitative analysis using NVivo 12 Plus produced a frequency-based word cloud (Figure 1) and coding matrix, illustrating the most recurrent concepts derived from 1,246 coded references. The five dominant terms—strategy, health, participation, community, and collaboration highlight the centrality of collective responsibility and cross-sectoral cooperation in realizing the WHO Healthy City program. These lexical frequencies correspond with four core dimensions of Parsons' AGIL framework identified in subsequent analysis.

A subsequent concept mind map (Figure 2) visually depicts the hierarchical relationship between codes, subthemes, and the four AGIL functions: (1) Adaptation (resource mobilization and coordination), (2) Integration (inter-sectoral collaboration and crisis response), (3) Goal Attainment (leadership and program alignment), and (4) Latency (community trust and value internalization).

Figure 1. Word Cloud of Key Terms Generated through NVivo Analysis

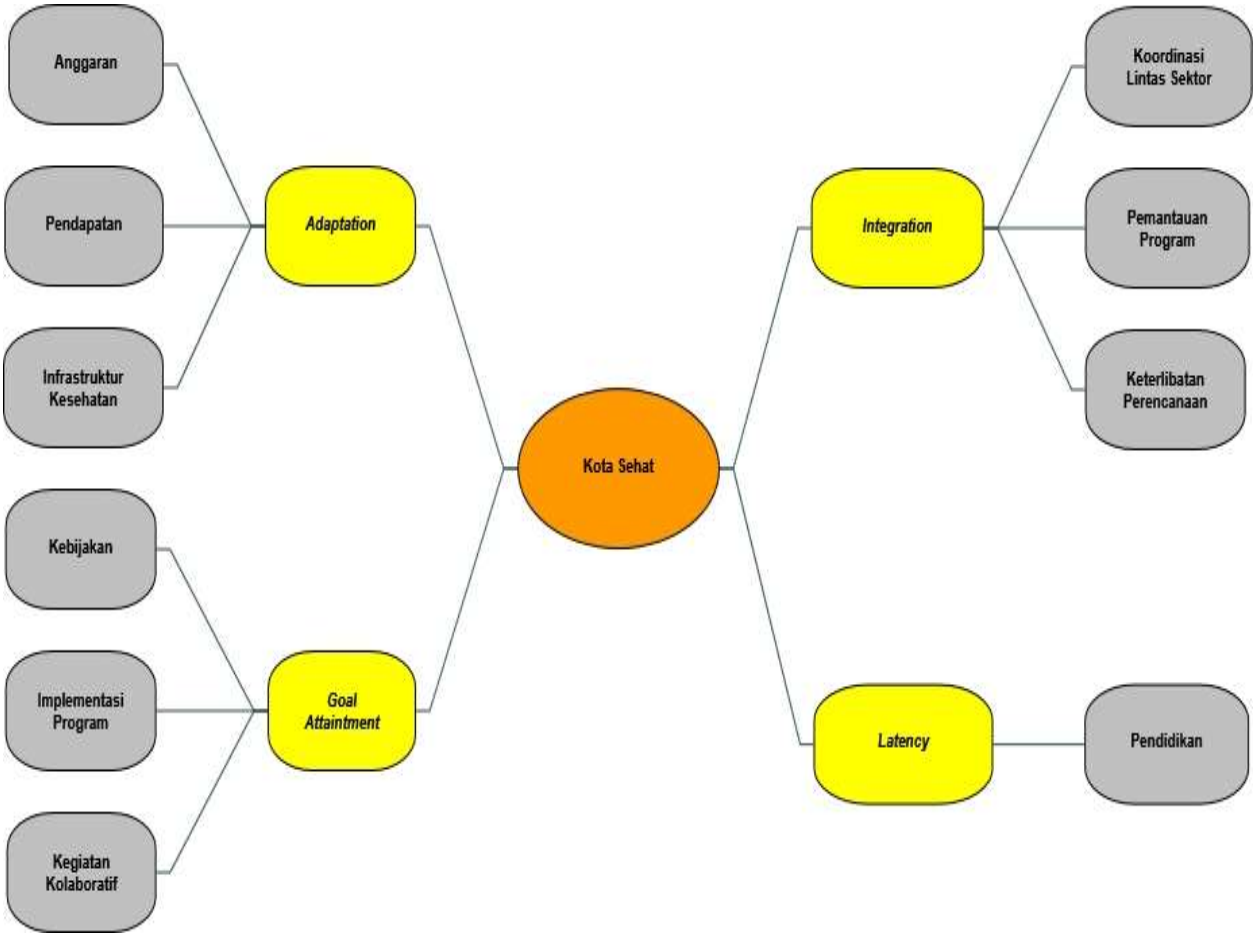

Figure 2. Concept Mind Map of Healthy City Strategies in Palu City

Adaptation

"Coordination with other departments is sometimes weak, and our operational budget is limited." (R1, Head of Health Office)
"The budget is small, so some activities cannot be carried out continuously." (R2, Head of Community Health Section)

These statements illustrate the AGIL function of Adaptation, wherein the system mobilizes and allocates resources to meet external demands. Limited fiscal flexibility and weak departmental coordination constrain program sustainability and responsiveness. To enhance adaptive capacity, the Health Office initiated budget reprioritization, joint funding proposals, and multi-year planning with Bappeda, though fiscal dependence on project-based funding remains a major limitation.

Integration

"When disasters occur, we coordinate quickly with Puskesmas, the Disaster Management Agency, and other related offices to ensure services continue." (R5, Subdistrict Head – Palu Timur)
"We involve community and religious leaders to deliver information faster and prevent panic among residents." (R4, Head of Bappeda)

These excerpts represent the Integration function within AGIL, focusing on cohesion across subsystems. Coordination among health offices, Bappeda, BPBD, and local leaders has improved markedly, enabling rapid response during emergencies. However, integration remains episodic and reactive, rather than embedded within routine governance. Institutionalizing a permanent inter-sectoral coordination forum and shared information system would transform situational cooperation into sustainable systemic integration.

Goal Attainment

"Our programs follow the Mayor's vision. When the leadership supports the Healthy City initiative, progress becomes much faster." (R3, Chair of Healthy City Working Group) "We implement several priority programs—PHBS, STBM, digital data utilization, and Puskesmas accreditation—to meet our city health targets." (R2, Head of Community Health Section)

These findings exemplify Goal Attainment in the AGIL framework, where collective objectives are operationalized through leadership and programmatic coherence. The Health Office effectively translated the mayor's policy vision into six measurable initiatives linked to Healthy City indicators. Nonetheless, program sustainability hinges on leadership continuity, outcome evaluation, and cross-agency accountability systems. Embedding performance-based monitoring and inter-agency evaluation cycles can stabilize goal pursuit beyond political transitions.

Latency

"People respond better when information comes from health cadres or local leaders instead of formal officials." (R6, Head of Talise Health Center)
"Community involvement through cadres and regular health education helps families maintain healthy behaviors." (R1, Head of Health Office)

These insights illustrate Latency, or the maintenance of cultural and normative patterns that sustain collective health values. Health cadres, PKK groups, and religious leaders act as key agents of value transmission, reinforcing health-promoting norms. Ongoing training, religious-based campaigns, and family-centered education maintain the system's latent stability and encourage intergenerational continuity of healthy behaviors.

Barriers to Implementation

> *"The biggest barrier is funding. Programs exist, but without adequate budget allocation, they cannot be continued consistently." (R1, Health Official)*

Budget limitation emerged as the dominant structural constraint, restricting continuity and scalability of community-based initiatives such as PHBS, STBM, and health education. This challenge was compounded by fragmented coordination, overlapping authority, and dependence on short-term project grants. As noted by multiple respondents, inter-agency synergy remained weak, particularly between the Health Office, Bappeda, and environmental units. These constraints collectively undermined the adaptive and integrative functions of the Healthy City system. Strengthening integrated budgeting, institutionalized collaboration mechanisms, and participatory evaluation is therefore critical to achieve fiscal stability and program sustainability in line with AGIL system dynamics.

DISCUSSION

Interpretation of Key Findings

Adaptation

The findings reveal that the adaptive capacity of Palu's Healthy City governance is constrained by financial inflexibility, fragmented coordination, and limited institutional agility. Informants repeatedly emphasized that budget restrictions and irregular inter-departmental collaboration hindered program continuity and responsiveness. Although adaptive innovations—such as mobile posyandu outreach, flexible scheduling, and micro-incentive programs—were introduced, these remain isolated and project-dependent, indicating partial realization of the AGIL "Adaptation" function. From a theoretical standpoint, adaptation within AGIL represents the system's ability to mobilize and allocate resources in response to environmental pressures. In Palu, this process operates effectively at the micro-programmatic level but is underdeveloped institutionally. Building systemic adaptability requires integrated budgeting mechanisms, cross-sector fiscal planning, and long-term resource predictability, ensuring responsiveness and sustainability amid fiscal uncertainty.

Integration

Integration emerged as a notable institutional strength, particularly in disaster preparedness and emergency health response. Informants described functional coordination among the Health Office, Bappeda, Disaster Management Agency (BPBD), and community leaders, which enabled rapid mobilization during crises such as earthquakes, tsunamis, and epidemics. This demonstrates an evolving reflexive governance structure aligned with AGIL's Integration function—maintaining social and institutional cohesion through shared norms and collaborative action.

Nevertheless, integration remains episodic and reactive, largely dependent on individual leadership rather than codified institutional practice. Outside crisis contexts, coordination often diminishes, with the Healthy City Forum functioning as a procedural rather than strategic platform. To consolidate this function, integration should be institutionalized through permanent coordination bodies, shared data repositories, and synchronized monitoring systems. These measures would embed continuous inter-sectoral synergy essential for achieving systemic cohesion in urban health governance.

Goal Attainment

The Goal Attainment function in Palu's Healthy City initiative is driven by strong political leadership and bureaucratic alignment. The Mayor's vision provided a unifying strategic direction, operationalized through six flagship programs—PHBS, STBM, GERMAS, digital health data integration, and accreditation of Puskesmas facilities. This vertical coherence between political leadership and administrative execution demonstrates the system's capacity to translate abstract goals into measurable outputs, consistent with AGIL's "G" function.

However, goal attainment remains leadership-contingent, rendering progress susceptible to political transitions. Monitoring and evaluation frameworks are inconsistently applied, limiting accountability and continuity. To stabilize this function, Palu should institutionalize performance-based governance, periodic outcome reviews, and

cross-sector accountability mechanisms that sustain health gains beyond administrative cycles. Embedding these instruments would align with Parsons' principle that effective systems sustain goal pursuit through stable and recursive feedback loops.

Latency

The Latency function—concerning value maintenance and normative reinforcement—is embodied in Palu's continuous health education campaigns, cadre engagement, and integration of health promotion into schools and religious institutions. Informants consistently reported that citizens respond more positively to messages delivered by trusted local actors such as PKK members, religious leaders, and health cadres.

This dynamic illustrates the normative dimension of AGIL's Latency function, which sustains collective motivation and cultural alignment within the health system. However, participation remains uneven across socio-economic strata, revealing disparities in cultural internalization. To fortify this function, strategies must emphasize contextualized and participatory education, ongoing cadre capacity building, and community-led social reinforcement mechanisms. Such initiatives will foster the institutionalization of health-promoting values, ensuring behavioral continuity across generations.

Barriers to Implementation

Several interrelated barriers constrained the systemic performance of the Palu Healthy City initiative. The most salient obstacle was chronic budget limitation, which undermined continuity and scalability of community-based health initiatives. Weak inter-sectoral coordination further impeded integration across the Health Office, Bappeda, and related agencies, producing redundant activities and inconsistent implementation. Uneven participation across subdistricts also contributed to inequitable outcomes.

These constraints indicate imbalances in the AGIL system, particularly between the Adaptation (resource mobilization) and Integration (coordination) functions. Strengthening these linkages requires transparent, integrated budgeting; institutionalized collaboration forums; participatory monitoring systems; and the strategic use of digital platforms to enhance coordination, accountability, and community engagement. Addressing these issues is essential to transforming Palu's Healthy City into a resilient, equitable, and learning-oriented health governance model.

Comparison with Previous Studies

The strategies observed in Palu align with global and regional evidence emphasizing governance-centered approaches in Healthy City implementation. Coovadia et al. (2009) argue that urban health complexity necessitates integrative, cross-sectoral governance—a finding consistent with Palu's emphasis on coordination between health, development, and disaster agencies. However, our analysis extends these studies by demonstrating, through the AGIL lens, how governance functions interact dynamically—where adaptation and integration determine the sustainability of goal attainment. This integrative interpretation situates Palu's experience within a broader theoretical discourse on systems-based urban health governance.

The study also corroborates literature on the centrality of social determinants of health (Srinivasan et al., 2003; Salgado, 2020) and participatory governance (Saad, 2020; Palutturi, 2017). However, by embedding these determinants within AGIL's structural-functional schema, the study advances prior work by showing that health outcomes in Palu are shaped not only by social conditions but by the systemic coordination of adaptation, integration, and latency functions. Infrastructure disparities—noted by Bedimo-Rung et al. (2005) and Maller et al. (2006)—also resonate with Palu's uneven sanitation and green-space access, underscoring the persistence of structural inequality in resource distribution. The finding aligns with Miharti S et al. (2015), who emphasize that decentralization without fiscal autonomy risks fragmenting urban health systems. Collectively, these comparisons confirm that Palu's challenges reflect a wider developmental paradox in decentralized health governance: institutional autonomy without systemic coherence. (5).

Community participation emerged as another strong theme in this study, aligning with theoretical discussions on the role of citizens in program legitimacy and sustainability. Arnstein's classic ladder of participation highlights that meaningful involvement, rather than tokenistic consultation, ensures stronger ownership of health programs. Suyanto (2015) further stress that purposive inclusion of key stakeholders enhances the depth and quality of

community engagement (19). Our findings echo these frameworks: programs such as GERMAS were most effective when grassroots actors health cadres, PKK, and NGOs mobilized directly within households. This observation is consistent with Palutturi (2017), who argued that Indonesia's Healthy City initiatives thrive when communities are mobilized as agents of change rather than passive beneficiaries (9).

The issue of uneven infrastructure distribution in Palu, particularly in sanitation and safe public spaces, mirrors observations from studies adopting a Healthy Settings approach. Bedimo-Rung et al. (2005) and Maller et al. (2006) argue that environments supporting sanitation, water supply, and green spaces are fundamental to sustaining health improvements (6,7). In Palu, despite achievements such as smoke-free public areas and the declaration of open defecation-free zones, disparities between districts remain evident. These findings mirror earlier reports that structural barriers such as insufficient funding and limited technical capacity undermine urban health progress, especially in developing country contexts. The Palu case therefore confirms the broader evidence that infrastructure gaps perpetuate inequality in health outcomes.

Another important point of comparison lies in the observed budgetary and institutional constraints. Miharti S et al. (2015) highlight that decentralization policies in Indonesia create opportunities for local innovation, but resource limitations often hinder effective implementation (8). Our findings resonate with this observation, as health officials in Palu frequently cited insufficient budgets as a barrier to scaling up otherwise effective initiatives. This finding complements earlier critiques of local health governance, showing that decentralization without adequate resources risks widening disparities rather than closing them (20).

What distinguishes this study is its theoretically integrated and empirically grounded perspective (21). Unlike earlier studies that examined governance, participation, or infrastructure separately, this research demonstrates how these domains intersect through the AGIL functions to sustain a Healthy City system (22,23). The NVivo-generated clustering empirically substantiates this theoretical model, illustrating the interdependence between policy coherence (goal attainment), social mobilization (latency), and adaptive resource management (adaptation) (24). This synthesis extends Palutturi's (2017) conceptual contribution by operationalizing AGIL within Indonesia's urban health governance context (20,25).

Limitations and Cautions

The study acknowledges several methodological limitations. It was conducted within a single-institutional setting, potentially constraining transferability. The reliance on qualitative data limited quantitative validation of outcomes. Restricted access to official reports occasionally constrained policy triangulation. Despite these limitations, methodological rigor was enhanced through triangulation and reflexive validation, and the study contributes to theoretical advancement by applying AGIL empirically to urban health governance. Future research should adopt mixed-method and multi-site designs to strengthen generalizability.

Despite these limitations, the study provides meaningful contributions to understanding the strategies of the Palu City Health Office in realizing a Healthy City. Future research should adopt a mixed-methods design, include multiple case sites, and extend the observation period to strengthen the robustness and generalizability of findings.

Recommendations for Future Research

Future research should employ mixed-method and longitudinal designs to evaluate Healthy City initiatives across varying socio-political contexts. Comparative studies between Indonesian municipalities could elucidate how adaptive and integrative mechanisms evolve under different governance capacities. Moreover, future inquiries should explore the role of digital health platforms, grassroots financing, and inter-sectoral leadership training in reinforcing AGIL functions. These directions will enhance both theoretical understanding and policy relevance of the Healthy City framework in the Global South.

Further research should also examine the role of grassroots organizations and social structures in greater depth, particularly their capacity to reduce disparities in community participation and access to health infrastructure. Exploring innovative financing models, cross-sectoral governance mechanisms, and digital health interventions could generate new strategies for overcoming budgetary and coordination barriers. These efforts would not only advance theoretical understanding of the social determinants of health but also provide practical policy recommendations for local governments in Indonesia and beyond.

CONCLUSION

This study examined the strategies of the Palu City Health Office in realizing a WHO Healthy City and demonstrated that success depends not only on technical and administrative mechanisms but also on systemic collaboration and community-based participation. Improvements in urban health—such as enhanced service access, reduced stunting, and lower maternal and infant mortality—were primarily achieved through grassroots initiatives including GERMAS campaigns, open-defecation elimination, nutrition education, and cadre-led behavioral change programs. These outcomes collectively affirm the AGIL framework's explanatory value, showing that effective Healthy City implementation in Palu emerges from (A) adaptive fiscal and institutional capacity, (G) clear goal alignment under consistent leadership, (I) cross-sector integration through inter-agency coordination, and (L) sustained community engagement that reinforces health norms. Grassroots participation, therefore, functions not only as an operational component but as a latent cultural mechanism sustaining systemic health improvement.

Despite these positive outcomes, systemic challenges persist—notably budgetary constraints, unequal resource distribution, fragmented coordination, and uneven citizen participation. Nevertheless, the findings underscore that socially grounded, AGIL-informed strategies provide a robust foundation for sustainable urban health governance. Going forward, strengthening local institutional capacity, integrating digital health education platforms, and adopting data-driven policy designs tailored to community needs are essential to advance the Healthy City agenda in Palu and other Indonesian municipalities. Theoretically, this study contributes by operationalizing Parsons' AGIL model within a decentralized health governance context, demonstrating its utility for analyzing the interdependence of resources, institutions, leadership, and cultural values in building resilient urban health systems.

AUTHOR'S CONTRIBUTION STATEMENT

All authors have contributed equally to the conception, design, data collection, analysis, interpretation, and preparation of this manuscript. Every author has reviewed and approved the final version and agrees to be accountable for the integrity and accuracy of the work.

CONFLICTS OF INTEREST

The authors declare that there are no conflicts of interest regarding the publication of this article. The authors have no financial, personal, or institutional relationships that could be perceived as influencing the impartiality of this research.

DECLARATION OF GENERATIVE AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

Generative AI tools, specifically ChatGPT (OpenAI), were used to assist in language refinement, structural clarity, and improvement of readability during the preparation of this manuscript. The authors affirm that all intellectual content, interpretation of data, and final conclusions remain their own responsibility.

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BIBLIOGRAPHY

1. Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. The health and health system of South Africa: historical roots of current public health challenges. Lancet. 2009;374(9692):817–34. 10.1016/S0140-6736(09)60951-X
2. Holdaway J, Krafft T, Wang W. Migration and health in China: challenges and responses. IHDP Updat. 2011;2011(1):35–41.
3. Guerra G, Gutiérrez ACQ, Buitrago-Garcia D, Gabrani J, Raguindin PF. The Latin American Call for Young Researcher Editorials: Identifying the Public Health Challenges in One of the Most Unequal Regions in the World. Int J Public Health. 2023;68:1606830. https://doi.org/10.3389/ijph.2023.1606830
4. Srinivasan S, O'fallon LR, Dearry A. Creating healthy communities, healthy homes, healthy people: initiating a research agenda on the built environment and public health. Am J Public Health. 2003;93(9):1446–50. doi: 10.2105/ajph.93.9.1446.
5. Salgado M, Madureira J, Mendes AS, Torres A, Teixeira JP, Oliveira MD. Environmental determinants of population health in urban settings. A systematic review. BMC Public Health. 2020;20(1):853. doi.org/10.1186/s12889-020-08905-0
6. Bedimo-Rung AL, Mowen AJ, Cohen DA. The significance of parks to physical activity and public health: a conceptual model. Am J Prev Med. 2005;28(2):159–68. doi: 10.1016/j.amepre.2004.10.024.
7. Maller C, Townsend M, Pryor A, Brown P, St Leger L. Healthy nature healthy people:'contact with nature'as an upstream health promotion intervention for populations. Health Promot Int. 2006;21(1):45–54. DOI: 10.1093/heapro/dai032
8. Miharti S, Holzhacker RL, Wittek R. Decentralization and primary health care innovations in Indonesia. In: Decentralization and Governance in Indonesia. Springer; 2015. p. 53–78. https://doi.org/10.1007/978-3-319-22434-3_3
9. Palutturi S, Zulkifli A, Syam A. The Key Challenges and Recommendations for Healthy Cities Implementation of North Kolaka, Indonesia. Indian J Public Heal Res Dev. 2017;8(2). DOI:10.5958/0976-5506.2017.00121.8
10. Idrus S Al. Political Change and Urban Growth in a Medium-sized Outer Island Capital in Indonesia: The Case of Palu, Central Sulawesi. 2022;
11. De Leeuw E, Simos J. Healthy cities: the theory, policy, and practice of value-based urban planning. Springer; 2017.
12. Tancred T, Caffrey M, Falkenbach M, Raven J. The pathway to health in all policies through intersectoral collaboration on the health workforce: a scoping review. Health Policy Plan. 2024;39(Suppl 2):i54. doi: 10.1093/heapol/czae046
13. Berglund-Snodgrass L, Fjellfeldt M, Högström E, Markström U. A Healthy City for All? Social Services' Roles in Collaborative Urban Development. Urban Plan. 2022;7(4):113–23. DOI: https://doi.org/10.17645/up.v7i4.5620
14. Lilly K, Kean B, Hallett J, Robinson S, Selvey LA. Factors of the policy process influencing Health in All Policies in local government: a scoping review. Front Public Heal. 2023;11:1010335. DOI: 10.3389/fpubh.2023.1010335
15. Kuantitatif PP. Metode penelitian kunatitatif kualitatif dan R&D. Alf Bandung. 2016;
16. Creswell JW, Creswell JD. Research design: Qualitative, quantitative, and mixed methods approaches. Sage publications; 2017.
17. Saad JM, Prochaska JO. A philosophy of health: life as reality, health as a universal value. Palgrave Commun. 2020;6(1):1–11. 10.1057/s41599-020-0420-9
18. Montenegro C, Green J. Engagement and qualitative sociology in health research: proximal, but incongruent: C. Montenegro, J. Green. Soc Theory Heal. 2025;23(1):12. DOI:10.1057/s41285-025-00231-y
19. Rifqi M, Situmeang MK, Mahmuddin M, Murdani T. THE ROLE OF FORUM BANGUN ACEH (FBA) IN COMMUNITY EMPOWERMENT BASED ON SOCIAL INCLUSION THROUGH THE INGIN MAJU COMMUNITY SELF-HELP GROUP (KSM) IN GAMPONG LUTHU DAYAH KRUENG-ACEH BESAR. J Al-Ijtimaiyyah. 2024;10(1):132–44. 10.22373/al-ijtimaiyyah.v10i1.23975

20. Hidayat MS, Mahmood A, Moss J. Decentralisation in Indonesia: the impact on local health programs. J Kesehat Masy. 2018;12(2):68–77.
21. Nisaid Y, Wijaya AAM, Mayunita S. EVALUASI PROGRAM KOTA SEHAT DI KECAMATAN WOLIO KOTA BAUBAU. J Publicuho. 2024;7(3):1164–74. https://doi.org/10.35817/publicuho.v7i3.474
22. Parsons T. The social system. Routledge; 2013.
23. King A. The structure of social theory. Routledge; 2004. https://doi.org/10.4324/9780203646694
24. Meyer DZ, Avery LM. Excel as a qualitative data analysis tool. Field methods. 2009;21(1):91–112. https://doi.org/10.1177/1525822X08323985
25. Shoesmith D. Decentralised governance in Indonesia's disadvantaged regions: Resource and institutional constraints. Asian J Polit Sci. 2020;28(3):324–41. https://doi.org/10.1177/18681034209631