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# Preventive Governance in Premarital Health Screening: Integrating Guidance and Counseling within Local Public Health Services

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**ABSTRACT**

*Background:* Premarital health screening is widely promoted as a preventive strategy to improve maternal and child health; however, its implementation is often embedded within administrative procedures rather than preventive public health governance. Existing studies predominantly frame premarital screening as either a clinical intervention or a bureaucratic requirement, leaving a conceptual gap between governance practices and the quality of preventive guidance and counselling. This study addresses this gap by examining how premarital health screening operates as preventive guidance and counselling within local public service delivery and by developing a preventive governance model. *Method:* Using a qualitative instrumental case study in West Kotawaringin Regency, Indonesia, the study involved 18 purposively selected informants comprising institutional officials, health workers, and prospective brides and grooms. *Result and Discussions:* Data were collected through semi-structured interviews, non-participant observation, and document review and analyzed thematically. The findings reveal a governance pattern characterized by procedural transparency, administrative accountability, compliance-based participation, capacity-limited responsiveness, and interinstitutional coordination that improves service coverage but remains largely procedural. Although counselling and reproductive education were formally integrated into screening, counselling interactions were predominantly informational rather than dialogical, particularly during periods of high service workload. Participation was frequently motivated by the administrative requirement for marriage registration, while accountability focused on records and reporting rather than longitudinal preventive outcomes. No structured post-screening follow-up mechanism was identified. These findings demonstrate a governance gap in which screening functions procedurally but has not fully evolved into preventive governance that can sustain preventive awareness, reproductive health literacy, and behavioral engagement. The study contributes theoretically by conceptualizing preventive governance as an analytical framework that integrates governance principles, preventive health objectives, and counselling functions within local public services. Practically, it highlights the need for dialogical counselling capacity, outcome-oriented monitoring, stronger preventive health literacy, and integrated follow-up mechanisms to transform administrative compliance into sustainable preventive health behavior.

**Keywords:** Preventive Governance, Premarital Health Screening, Guidance And Counseling, Local Governance, Preventive Health Literacy



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## INTRODUCTION

Human development is increasingly understood as a holistic process shaped not only by education and economic progress but also by health conditions established long before childbirth. Contemporary public health approaches emphasize the preconception phase, recognizing that the health status of prospective parents significantly influences pregnancy outcomes, infant survival, and children's long-term development (Dean et al., 2014; Lassi et al., 2020; Alemu et al., 2021). In this context, premarital health screening has emerged as an important preventive strategy for identifying reproductive and nutritional risks before marriage and pregnancy. However, the preventive value of premarital screening extends beyond the identification of biological risks. For prospective couples, the period before marriage is also a developmental stage in which individuals prepare for new roles, responsibilities, relationships, and decisions associated with family life. Therefore, premarital services can provide an important context for guidance and counselling aimed at strengthening self-awareness, preventive health awareness, decision-making, communication, emotional preparedness, and readiness to seek appropriate support when difficulties arise.

From a Guidance and Counselling perspective, these functions require a distinction between health education, guidance, and counselling. Health education primarily provides information intended to improve knowledge and awareness, whereas guidance

involves structured assistance that helps individuals understand their needs, capacities, choices, and developmental tasks. counselling, in contrast, is a more interactive and professional helping process through which individuals can explore concerns, expectations, values, relationships, decisions, and personal readiness. Thus, counselling should not be reduced to the delivery of reproductive health information. In the context of premarital health screening, counselling can complement clinical assessment by helping prospective couples interpret health information, reflect on their personal and relational circumstances, identify areas requiring further support, and consider appropriate preventive actions **(**Muscat et al., 2021; Richter et al., 2023). This broader understanding is consistent with the preventive orientation of preconception care, which emphasizes preparation for healthy pregnancy and parenthood before conception occurs (WHO, 2013, 2022).

Over the past two decades, global health policy has increasingly shifted from a predominantly curative orientation toward prevention, health promotion, and community empowerment (Greer et al., 2015; Kickbusch & Gleicher, 2012; WHO, 2021). Within this paradigm, counselling and health education are important components of preventive services because they can strengthen health literacy and support individuals in preparing for health-related decisions before marriage and parenthood (Muscat et al., 2021). Nevertheless, the presence of educational information does not necessarily indicate the existence of a meaningful counselling process. A service may provide reproductive health information while offering limited opportunities for individuals or couples to discuss their concerns, expectations, readiness, and personal circumstances. Consequently, the quality of counselling becomes an important consideration in assessing whether premarital health screening functions as a genuinely preventive service rather than merely as a mechanism for information delivery and administrative compliance.

The effectiveness of such counselling-oriented preventive services also depends on the governance arrangements through which they are delivered. Governance quality includes institutional coordination, accountability, participation, responsiveness, transparency, and the capacity of public institutions to translate policy objectives into meaningful social outcomes (Barbazza & Tello, 2014; Bovens et al., 2014; World Bank, 2017). Governance, therefore, should not be understood merely as the existence of regulations, standard operating procedures, or reporting mechanisms. Governance also concerns whether institutional arrangements create the conditions necessary for quality services, meaningful participation, appropriate referral, continuity of support, and responsiveness to the needs of service users.

Governance scholars argue that policy implementation cannot be assessed solely through the presence of regulations and procedures. Governance effectiveness is shaped by institutional capacity, bureaucratic culture, administrative resources, and the ability of organizations to translate policy objectives into meaningful social outcomes (Andrews et al., 2017; Fukuyama, 2013; Painter & Peters, 2018). In decentralized settings, preventive programs may therefore become procedural obligations rather than transformative public services. This tendency is particularly relevant to premarital health screening, where counselling and reproductive education may formally exist but can be interpreted primarily as requirements for marriage registration. When this occurs, the preventive and developmental functions of guidance and counselling risk being overshadowed by clinical examination and administrative completion.

In this study, the distinction between procedural service delivery and counselling-oriented prevention is particularly important. Premarital health screening is expected not only to identify reproductive and nutritional risks but also to create opportunities for prospective couples to understand those risks and consider appropriate preventive actions. From a Guidance and counselling perspective, this process may involve attention to counselling needs, psychological and marital readiness, relational competence, communication, decision-making, emotional management, family-role preparation, and help-seeking skills. These dimensions should not be interpreted as outcomes automatically produced by health screening; rather, they represent developmental and counselling needs that may require systematic assessment, guidance, counselling, referral, and follow-up. The extent to which such functions are incorporated into premarital services therefore becomes an important question for preventive service governance (Javadivala et al., 2021; Yavuzer & Doğanülkü, 2024).

In Indonesia, premarital health screening is integrated into national strategies for family resilience and stunting reduction. The Ministry of Health and the National Population and Family Planning Agency (BKKBN) incorporate preconception services into the First 1,000 Days of Life (HPK) program, emphasizing reproductive readiness before pregnancy occurs (BKKBN, 2022; Kemenkes RI, 2020; Lassi et al., 2021). The program includes health examinations, nutritional assessment, reproductive counselling, and education for prospective brides and grooms. Despite this strategic role, premarital screening is often socially perceived as an administrative requirement linked to marriage registration rather than as a comprehensive preventive service that addresses the informational, developmental, relational, and counselling needs of prospective couples.

Although premarital health screening is widely supported in preventive health discourse, research on its Guidance and Counselling dimension remains limited. International studies primarily discuss preconception care from clinical, nutritional, and public health perspectives (Lassi et al., 2020; Stephenson et al., 2018; Ayele et al., 2021), while Indonesian discussions tend to emphasize premarital screening as a public health program or administrative requirement. Less attention has been given to how guidance and counselling can help prospective couples transform health information into self-awareness, informed decision-making, preventive engagement, and readiness for family life. Similarly, limited attention has been paid to how governance arrangements influence the quality, accessibility, continuity, and responsiveness of counselling-oriented preventive services at the local level.

This situation produces three interconnected research gaps. First, a theoretical gap exists because preventive health, governance, and Guidance and counselling perspectives have rarely been integrated into a single analytical framework. Governance studies generally emphasize institutional coordination, accountability, participation, and service performance, while preventive health studies focus on risk identification, health promotion, and preconception care. Guidance and counselling perspectives, meanwhile, emphasize individual development, interpersonal relationships, decision-making, readiness, and helping processes. The connection among these perspectives remains insufficiently conceptualized in the context of premarital health screening.

Second, a practical gap concerns the way premarital screening is delivered. Although counselling and health education may be incorporated into the service, their implementation can remain predominantly informational and administrative. Such an orientation may limit opportunities for prospective couples to explore their individual and relational needs, clarify concerns, develop preventive decision-making skills, and receive appropriate referral or follow-up. The challenge, therefore, is not simply whether counselling is available, but whether the governance structure provides sufficient time, capacity, coordination, and professional support for counselling to function as an interactive and developmental process (Javadivala et al., 2021).

Third, an empirical gap concerns the limited understanding of how local institutions collaborate to deliver premarital preventive services that respond to the needs of prospective couples. Premarital health screening involves multiple actors, including health offices, community health centres, the Office of Religious Affairs (KUA), health workers, institutional officials, and prospective couples. Collaborative governance literature emphasizes that effective public services require coordination among agencies and frontline providers (Ansell & Gash, 2008; Emerson & Nabatchi, 2015). However, existing discussions often emphasize administrative integration and service coverage while paying less attention to the quality of counselling interactions, user participation, referral mechanisms, and continuity of preventive support.

West Kotawaringin Regency provides a relevant context for examining these issues because premarital health screening has been institutionally integrated into the marriage administration process through collaboration between the Health Office and KUA. Preliminary observations indicate several practical challenges, including uneven public understanding of reproductive health, limited depth of counselling sessions, administrative workload pressures, inconsistent coordination, and the dominance of procedural compliance over preventive awareness. These conditions suggest that the effectiveness of premarital screening depends not only on policy availability or institutional coordination but also on whether governance arrangements support meaningful guidance and counselling processes responsive to the developmental needs of prospective couples.

Conceptually, these gaps require a shift from viewing premarital health screening primarily as a medical and administrative service toward understanding it as a counselling-oriented preventive service. Such a perspective recognizes that preventive governance should encompass more than institutional coordination and accountability. It should also ensure mechanisms for identifying counselling needs, facilitating meaningful counselling interactions, enabling couple participation, maintaining service quality, providing appropriate referrals, and supporting follow-up. In this sense, preventive governance connects the management of preventive public services with the developmental readiness of individuals and couples preparing for family life.

Accordingly, this study conceptualizes preventive governance as a governance orientation that integrates preventive health objectives, guidance and counselling functions, institutional coordination, public participation, service quality, referral mechanisms, and accountability into local service delivery. Through this perspective, premarital health screening is viewed not merely as a technical medical procedure or administrative prerequisite but as a preventive guidance and counselling process designed to strengthen health literacy, self-awareness, preventive engagement, and preparedness for family life. The concept emphasizes that preventive value emerges when governance structures enable information to be transformed into meaningful counselling interaction, informed participation, appropriate support, and continuity of preventive care.

The contribution of this research lies in three areas. First, it bridges preventive health theory, governance studies, and Guidance and counselling perspectives within a single analytical framework. Second, it develops preventive governance as an analytical concept for examining how institutional arrangements influence the delivery and quality of counselling-oriented preventive services. Third, it provides empirical evidence from a non-metropolitan local government setting concerning how premarital screening is implemented through collaboration between health and religious affairs institutions. In doing so, the study positions Guidance and counselling not merely as a supplementary component of health services but as a psychopedagogical mechanism connecting preventive service governance with the developmental and relational readiness of prospective couples.

Accordingly, this study aims to: (1) examine the implementation of premarital health screening as preventive guidance and counselling; (2) analyse how governance principles shape the delivery and quality of counselling-oriented preventive services; and (3) formulate a preventive governance model that strengthens guidance and counselling functions, participation, referral, follow-up, and preventive health outcomes at the local government level.

## METHOD

This study employed a qualitative approach using an instrumental case study design to examine the implementation of premarital health screening as preventive guidance and counselling and to develop a preventive governance model in West Kotawaringin Regency.

An instrumental case study was selected because the case was used to understand the broader relationship between governance arrangements and counselling-oriented preventive services (Stake, 2010; Yin, 2018). The study adopted a constructivist-interpretive perspective, viewing service and governance practices as socially constructed through stakeholder interactions and institutional contexts (Denzin & Lincoln, 2011).

West Kotawaringin Regency was purposively selected because premarital health screening is implemented through collaboration between the District Health Office and the Office of Religious Affairs (KUA). Fieldwork was conducted from January to March 2026. Eighteen informants were purposively selected based on their direct involvement in the service or experience as prospective brides and grooms, comprising institutional officials, health workers, and prospective couples. Data collection continued until thematic adequacy was achieved (Patton, 2015; Guest et al., 2020).

Data were collected through semi-structured interviews, non-participant observation, and document review. Interview and observation protocols covered two domains: (1) governance, including transparency, accountability, participation, responsiveness, coordination, and service implementation; and (2) preventive guidance and counselling, including counselling needs, preventive health understanding, opportunities for dialogue and participation, decision-making, counselling interaction quality, referral, and follow-up. These domains functioned as sensitizing concepts while allowing themes to emerge inductively. Interviews were recorded with consent and transcribed verbatim. Observations focused on counseling interactions and service processes, while SOPs and service reports were reviewed to compare formal procedures with field implementation (Kvale & Brinkmann, 2015; Angrosino, 2016; Bowen, 2009).

Data were analysed thematically through iterative coding, categorization, theme development, and interpretation (Nowell et al., 2017). Governance and counselling dimensions guided the initial analysis but were refined inductively from the data. Data sufficiency was assessed through thematic adequacy, while trustworthiness was strengthened through triangulation, member checking, audit trails, and reflective notes (Guest et al., 2020; Lincoln & Guba, 1985; Miles et al., 2014). Reflexivity was maintained by documenting analytical decisions and researchers' reflections throughout the research process. Ethical procedures included informed consent, participant anonymity, secure data storage, and voluntary participation (Israel & Hay, 2016).

## RESULTS AND DISCUSSION

### Results

### Premarital Health Screening as Preventive Guidance and Counseling

Implementation of premarital health screening in West Kotawaringin Regency shows that preventive counselling is formally incorporated into the screening process through collaboration between the Office of Religious Affairs (KUA) and community health centres. However, the findings indicate that the counselling function remains limited in depth and is strongly influenced by the administrative structure of the screening process. Although participants receive reproductive health information and preventive advice, the interaction does not consistently develop into a dialogical counselling process that allows prospective couples to explore their individual needs, concerns, and readiness for family life.

Referral and reporting mechanisms between the Health Office and KUA ensure that prospective couples complete health examinations before marriage registration. A Health Office official stated, *"Every couple registering for marriage is directed to complete the health examination first."* Similarly, a KUA officer explained, *"We emphasize that the examination is not only administrative, but also related to family health readiness."* These statements demonstrate that preventive intentions are recognized institutionally. Nevertheless, the delivery of these services remains closely connected to the administrative requirement for marriage registration.

The screening process also provides opportunities for preventive action. Clinical screening records from January–March 2026 indicate that several reproductive and nutritional health risks were identified, followed by interventions such as nutritional advice, iron supplementation, and referral for further treatment. As explained by a midwife, *"Women with mild anemia are advised to improve nutrition and take iron tablets before marriage."* These practices demonstrate that health information and preventive advice are provided as part of the screening process. However, the available findings do not indicate that these activities consistently involve an extended counselling process in which participants' personal concerns, expectations, or readiness are explored in depth.

A recurring theme across the interviews concerns the limited time available for counselling during periods of high marriage-registration activity. One health worker explained, *"When the number of couples increases, counselling time becomes shorter because we still have to handle other routine services."* This finding indicates that institutional workload directly affects the quality of counselling interaction. Counselling therefore tends to be informational rather than dialogical, with greater emphasis on explaining examination results, health risks, nutrition, and pregnancy readiness than on facilitating sustained exploration of participants' concerns and individual needs.

The findings also suggest that the current counselling arrangement provides limited opportunities to address broader aspects of preparation for family life, such as communication, decision-making, emotional preparedness, and readiness to assume family roles. However, the data do not support the conclusion that psychological or marital readiness was systematically assessed in the existing service. Rather, the findings indicate a limited counselling space in which such developmental issues could be explored. This distinction is important because the provision of health information alone does not constitute a comprehensive guidance and counselling process.

Participants' accounts further reveal that their initial engagement with screening was frequently motivated by the administrative requirement for marriage registration. One participant stated, *"Initially we thought it was only an administrative requirement, but after counselling we understood its importance."* Another explained, *"If it had not been mandatory, we probably would not have taken the test."* These accounts indicate that counselling can contribute to participants' understanding of the preventive value of screening, but participation initially tends to be compliance-based rather than driven by preventive motivation.

Another important limitation is the absence of structured post-screening follow-up. A health worker stated, *"We can only monitor them before marriage because there is no follow-up mechanism afterward."* This indicates that the preventive process is largely episodic, ending when the premarital screening stage is completed. Although referrals and immediate preventive actions are provided for identified health risks, the existing service does not provide a structured mechanism for continuing counselling or monitoring participants after screening.

Overall, the findings indicate that premarital health screening in West Kotawaringin Regency has established the institutional presence of preventive guidance and counselling, but its substantive counselling function remains limited. The service successfully provides health information, identifies risks, and offers preventive advice; however, counselling interactions are predominantly informational, participation is often compliance-driven, and post-screening continuity is absent. Thus, the central issue is not whether counselling exists, but whether the existing service arrangement enables counselling to become a dialogical, responsive, and continuous process that addresses the needs of prospective couples and supports their preparation for family life. This finding provides an important basis for understanding the transition from procedural screening toward preventive governance.

**Governance Practices in Premarital Health Screening as Preventive Guidance and Counseling**

The findings show that premarital health screening in West Kotawaringin Regency is supported by a procedurally organized governance system involving transparency, accountability, participation, responsiveness, and interinstitutional coordination. However, this governance practices remain primarily oriented toward administrative implementation and have not yet been fully reoriented toward sustaining preventive awareness and counselling outcomes.

Transparency is maintained through SOPs, informational materials, and explanations provided by KUA officers and health workers. A KUA officer stated, *"We explain from the beginning that couples must complete the health examination before marriage registration."* A health worker similarly noted, *"We explain the types of examinations and their relation to pregnancy readiness."* These practices demonstrate that information is systematically provided. However, as reflected in participants' accounts, transparency remains largely procedural because information delivery does not consistently develop into opportunities for dialogue, reflection, and exploration of individual or couple needs.

Accountability is reflected in medical records, recommendation letters, and reporting mechanisms between community health centres and the Health Office. Preventive actions such as nutritional counselling, iron supplementation, and referrals are documented as part of service implementation. A Health Office official explained, *"We monitor the implementation through reports from community health centres."* However, accountability remains primarily documentation-oriented because monitoring is limited to the premarital period. As a health worker stated, *"We can only monitor them before marriage because there is no follow-up mechanism afterward."* Thus, accountability ensures procedural completion but provides limited evidence of longer-term preventive or counselling outcomes.

Participation is characterized by high attendance but substantial reliance on administrative requirements. Participants' accounts indicate that some couples initially regarded screening as mandatory rather than as an opportunity for preventive preparation. This pattern suggests that participation is more accurately characterized as compliance-based participation. From a counselling perspective, the challenge is therefore not only ensuring attendance but also transforming attendance into active engagement, in which couples are encouraged to discuss concerns, understand their health conditions, and participate in preventive decision-making.

Responsiveness is reflected in counselling, nutritional education, and referrals for participants with identified health risks. Nevertheless, institutional workload limits the depth of these interactions. A health worker explained, *"When the number of couples increases, counselling time becomes shorter because we still have to handle other routine services."* This condition limits the ability of service providers to respond to individual needs and contributes to counselling that is predominantly informational rather than dialogical.

Interinstitutional coordination between KUA and the Health Office improves access to screening. As a Health Office official noted, *"Since the collaboration with KUA, more couples have completed the examination."* However, coordination remains largely focused on referral and reporting. The absence of an integrated mechanism for longitudinal reproductive health monitoring limits continuity after the premarital stage. Consequently, institutional coordination improves service coverage but does not automatically ensure continuity or quality of preventive counselling.

Overall, the governance practices demonstrate that the existing system is administratively functional but only partially counselling-oriented. Transparency facilitates information delivery, accountability supports documentation, participation ensures service attendance, responsiveness provides immediate assistance, and coordination expands access. However, these functions have not yet been sufficiently connected to dialogical counselling, individualized needs, active couple engagement, and follow-up. The findings

therefore suggest that preventive governance requires a shift from procedural service management toward governance that deliberately supports counselling quality, meaningful participation, referral, and continuity of preventive support.

**Discussion**

The findings of this study demonstrate that premarital health screening in West Kotawaringin Regency cannot be fully understood through governance or preventive health perspectives alone. Governance principles such as transparency, accountability, participation, responsiveness, and coordination are present in the implementation process, but their preventive value depends on how these principles are translated into meaningful guidance and counselling. From a Guidance and Counselling (GC) perspective, the central issue is therefore not merely whether counselling is provided, but whether it functions as a professional process that enables prospective couples to identify their needs, explore concerns, develop health literacy, participate in decisions, and obtain appropriate referral and follow-up. This interpretation is consistent with the broader literature on shared decision-making, which emphasizes active participation, decision support, health literacy, and communication rather than one-way information delivery (Stacey et al., 2017; Muscat et al., 2021; Richter et al., 2023).

Transparency is institutionally present through SOPs, informational materials, and explanations provided by KUA officers and health workers. Participants receive information about examination procedures, health risks, and pregnancy readiness. However, the findings show that information delivery remains largely procedural. This distinction is important from a GC perspective because health education, guidance, and counselling are not interchangeable. Health education primarily provides information, whereas counselling involves a dialogical process through which individuals can explore their concerns, needs, values, and decisions. Research on health communication similarly demonstrates that communication practices can either facilitate or constrain patient participation in decision-making (Land et al., 2017; Muscat et al., 2021; Richter et al., 2023). In the present case, transparency has not consistently developed into opportunities for dialogue, reflection, and exploration of individual or couple needs. Consequently, information provided during screening may increase understanding, but it does not necessarily produce deeper preventive health literacy or enable couples to reflect on their personal and relational readiness (Nutbeam, 2008; Sørensen et al., 2012; Muscat et al., 2021; Richter et al., 2023).

This distinction is particularly relevant because health literacy involves more than the ability to receive health information. It also involves the capacity to access, understand, appraise, and use information in ways that support health-related decisions. Nutbeam (2008) and Sørensen et al. (2012), already cited in this study, provide a useful foundation for understanding this transition from information acquisition toward functional, interactive, and critical health literacy. More recent evidence also indicates that communication strategies and shared decision-making approaches are important when individuals have varying levels of health literacy (Richter et al., 2023; Waddell et al., 2021). Thus, the limitation identified in this study is not simply insufficient information but the limited transformation of information into interactive understanding and informed participation (Waddell et al., 2021).

The findings on accountability further demonstrate the importance of GC in transforming procedural services into preventive services. Accountability is strongly reflected in medical records, recommendation letters, and reporting mechanisms between community health centers and the Health Office. Preventive actions such as nutritional counselling, iron supplementation, and referral are documented. However, monitoring generally ends at the premarital stage because no structured follow-up mechanism exists. This finding is consistent with the distinction between administrative accountability and outcome-oriented accountability discussed by Bovens (2007), Behn (2001), and Pollitt and Bouckaert (2017). From a GC perspective, the absence of follow-up also represents a limitation in the continuity of support. A counselling-oriented preventive service should provide mechanisms through which identified needs can lead to further guidance, referral, or follow-up rather than ending with completion of the initial screening (Chan et al., 2021; OECD, 2023).

Participation also requires reinterpretation from a GC perspective. Although attendance at screening is relatively high, participants reported that their initial motivation was often the administrative requirement for marriage registration. This pattern can be understood as compliance-based participation. However, compliance should not automatically be interpreted as preventive engagement. Meaningful participation requires individuals to understand relevant information, recognize their own needs, consider alternatives, and participate actively in decisions. Research on shared decision-making shows that decision support and health-literacy interventions can improve knowledge, decision involvement, and patients' capacity to participate in health decisions (Stacey et al., 2017; Hernández-Leal et al., 2021). Therefore, the governance challenge is not simply to increase attendance but to create conditions in which prospective couples can move from externally motivated compliance toward informed and more autonomous preventive participation.

The findings also have implications for the developmental function of premarital counselling. A systematic review of premarital guidance services in Indonesia identifies areas such as mental preparation for marriage, household communication, reproductive health, parenting, and family well-being as important components of premarital guidance. These dimensions broaden the meaning of premarital counselling beyond the transmission of medical information. In the present study, however, the available evidence does not demonstrate that psychological or marital readiness was systematically assessed. Rather, the findings indicate that the existing counselling arrangement provides limited space for these issues to be explored. Therefore, psychological and marital readiness should

be understood as important counselling domains and potential areas for further assessment, rather than as outcomes established by this study.

Responsiveness is particularly important because it connects institutional capacity with counselling quality. The findings show that counselling, nutritional education, and referrals are available, but workload pressures shorten counselling time and reduce opportunities for dialogue. Counselling consequently tends to become informational rather than transformative. This finding is consistent with evidence showing that communication practices can influence the extent to which service users are able to participate in decision-making and express preferences or concerns (Land et al., 2017; Waddell et al., 2021). Recent evidence also suggests that verbal risk communication alone may be insufficient for individuals with limited health literacy, reinforcing the importance of communication strategies that actively support understanding and participation (Richter et al., 2023). Thus, counselling quality depends not only on the availability of counselling but also on sufficient time, provider competence, interactive communication, and responsiveness to individual needs.

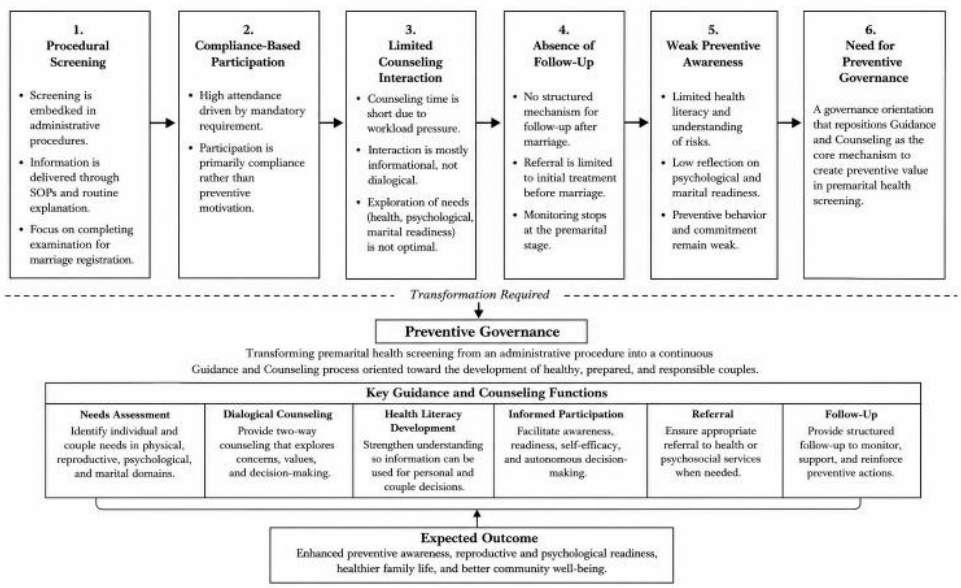
Coordination between KUA and the Health Office has increased access to premarital screening, reflecting collaborative governance (Ansell & Gash, 2008; Emerson & Nabatchi, 2015). However, coordination alone does not guarantee counselling quality or continuity. The current arrangement emphasizes referral and reporting, while longer-term monitoring remains limited. From a GC perspective, interinstitutional coordination should also support needs identification, appropriate referral pathways, continuity between service providers, and follow-up after the initial screening. In this respect, collaborative governance becomes more meaningful when it supports not only service coverage but also continuity and responsiveness to the developmental needs of prospective couples (Duan-Porter et al., 2022; Al-Saadoon et al., 2023).

Taken together, these findings suggest that the central limitation of the current system is not the absence of governance mechanisms or preventive activities, but the weak connection between governance mechanisms and the substantive functions of Guidance and Counselling. Transparency provides information but does not consistently produce interactive health literacy; accountability documents services but does not ensure continuity; participation secures attendance but may remain compliance-based; responsiveness provides counselling but is constrained by limited interaction time; and coordination expands access but does not yet establish integrated referral and follow-up. GC provides the mechanism through which these governance dimensions can be translated into preventive value.

Based on these findings, preventive governance can therefore be understood not simply as good governance applied to preventive health services, but as a governance orientation that deliberately enables professional guidance and counselling functions throughout the preventive service process. Its core elements include needs assessment, dialogical counselling, health literacy development, informed participation, responsiveness to individual and couple needs, referral, and follow-up. This conceptualization is consistent with evidence that decision coaching, patient involvement, and health-literacy-oriented interventions can strengthen participation in health decisions (Stacey et al., 2017), while coordinated care models emphasize continuity and systematic linkage across services (Duan-Porter et al., 2022; Khatri et al., 2023). Within this framework, counselling functions as a psychopedagogical mechanism linking institutional service management with the developmental preparedness of prospective couples.

The study consequently extends the concept of preventive governance by positioning Guidance and Counselling as a substantive mechanism rather than a supplementary service component. The transition from procedural to preventive governance occurs when administrative screening is transformed into a process that enables couples to understand their health conditions, explore relevant concerns, participate meaningfully in decisions, develop preventive awareness, and obtain continued support when needed. The novelty of the Preventive Governance Model therefore lies not simply in adding counselling to governance, but in explaining how governance structures can create the institutional conditions required for counselling to produce preventive value.

**Figure 1.** Thematic Pathway from Procedural Screening to Preventive Governance



The contribution of the Preventive Governance Model is therefore to connect governance dimensions with concrete Guidance and Counselling functions. Transparency can be reoriented toward health literacy; participation toward informed and autonomous engagement; responsiveness toward dialogical counselling; accountability toward outcome-oriented follow-up; and coordination toward continuity of preventive support. In this way, preventive governance becomes a framework through which premarital health screening can move beyond administrative compliance toward a more dialogical, responsive, developmental, and continuous guidance and counselling process.

## CONCLUSION

This study shows that premarital health screening in West Kotawaringin Regency has established a foundation for preventive guidance and counselling through collaboration between health institutions and the Office of Religious Affairs (KUA). The implementation demonstrates transparency, accountability, participation, responsiveness, and interinstitutional coordination through health examination, reproductive health information, nutritional counselling, anemia screening, and referral services.

However, the findings indicate that the service remains predominantly procedural and compliance-oriented. Participation is strongly influenced by the administrative requirement for marriage registration, counselling interactions tend to be informational rather than dialogical, and post-screening follow-up is not systematically established. Consequently, the preventive value of the service remains limited because procedural completion does not necessarily produce sustained preventive awareness, informed participation, or continuity of support.

The study contributes a counselling-oriented preventive governance perspective by positioning Guidance and Counselling as a strategic mechanism for transforming premarital screening into a meaningful preventive service. Preventive governance therefore requires more than institutional coordination and administrative accountability; it requires needs assessment, dialogical counselling, preventive health literacy, informed and autonomous participation, appropriate referral, and follow-up. From this perspective, Guidance and Counselling connects governance arrangements with the developmental and preventive needs of prospective couples.

Practically, the findings highlight the need to strengthen counselling capacity, improve opportunities for dialogue, develop integrated referral and follow-up mechanisms, and orient accountability toward preventive outcomes rather than procedural completion. Future research should examine psychological and marital readiness, counselling quality, and the long-term effects of counselling-oriented premarital services across different regional settings.

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