BKM Public Health & Community Medicine
Berita Kedokteran Masyarakat

Volume 40 **Number** 3, 2024, **Pages** e12250
DOI: 10.22146/bkm.v40i03.12250

Local government implementation of health sector minimum standards policy: a stakeholder analysis

Munib Arrohmah[1]*, Antono Suryoputro[2], Budiyono[2]

Submitted:
February 19th, 2024
Accepted:
March 25th, 2024
Published:
March 30th, 2024

[1]Master of Public Health Program Study, Faculty of Public Health, Diponegoro University, Indonesia

[2]Faculty of Public Health, Diponegoro University, Indonesia

***Correspondence:**
munib.arrohmah@gmail.com

Abstract

Purpose: This study aims to analyze the roles and positions of stakeholders in health-sector minimum service standards policy implementation (HS-MSSPI) in Wonosobo based on stakeholders' interests, authority, attitudes, influence, and involvement. **Methods:** This research is a descriptive qualitative study. The stages in this research are stakeholder identification, data collection through in-depth interviews, data analysis based on the stakeholder classification approach and stakeholder mapping theory. **Results:** The results of stakeholder classification show that decision-makers consist of the Regency Legislative Council, Regency Secretariat, Agency for Regional Development, and Health Office. Providers comprise the Health Office, Public Health Center, and Health Cadres, while Representatives comprise the Sub-District Government, Village Government, and Family Welfare Guidance (PKK) Cadres. Stakeholder mapping results show that there are two types of positions in the decision-maker category: savior and time bomb. In the provider category, there are three positions - savior, friend, and sleeping giant. At the same time, all representatives are in the friend position. **Conclusion:** It appears that stakeholders involved in the implementation of the HS-MSSPI in Wonosobo have not utilized their full authority to provide support and involvement. Perhaps there is room for improvement in terms of stakeholder engagement and collaboration to ensure the program's success.

Keywords: local government; minimum service standards; policy implementation; stakeholder analysis; stakeholder mapping

INTRODUCTION

Indonesia, as the largest archipelagic country in the world, faces challenges and problems with inequitable distribution of health services. The number of islands in Indonesia reaches 17,200, and the total land area is up to 1,890,739 km^2 [1–3]. Indonesian territory is divided into 34 provinces, 416 regencies, 98 cities, 7.266 sub-districts, 8.506 urban villages, and 74.961 villages [4]. The 2022 Indonesian Health Profile shows the ratio of public health services to sub-districts in Indonesia, which shows that not all provinces in Indonesia have at least one public health service (Puskesmas) in each sub-district. The lowest ratios were shown in Papua and West Papua, with ratios of 0.8 and 0.7, which are very low compared to DKI-Jakarta, which reached 7.2. Apart from that, community health centers in several provinces still do not have nine types of required health workers. The provinces with the lowest numbers were Papua (7.6%), West Papua (16.4%), and Maluku (18.9%). The provinces with the highest percentage of health centers without doctors are Papua (38.6%), Maluku (17.6%), and West Papua (14.6%).

To promote fair and equitable social welfare, the government enforces MSS as outlined in Government Regulation Number 2 of 2018. According to Law 23 of

2014 on regional government, health affairs are identified as a compulsory service. Local governments, as implementers of regional autonomy, are mandated to expedite the enhancement of community welfare and develop regional health systems [5, 6].

The MSS is an obligation of the local governments. Implementing the health sector MSS is a top priority for regional budgeting [7]. Despite that, this policy still faces various obstacles ranging from facilities and infrastructure to the competence of health workers, recording and monitoring, and the lack of cross-sectoral support [8–11]. The MSS implementation has not been supported by the formation of a special team and specialized budget allocations [12]. Besides, unclear communication, low employee commitment, and an unoptimized bureaucratic structure were found in HS-MSSPI [13]. The research above indicates that not all district governments are committed to HS-MSSPI. Besides that, the achievement of MSS in the health sector is still low. Only 2 of 35 districts in Central Java achieved 100% of the targets for 12 MSS indicators by 2022. Twenty-five districts achieved less than 50%, and one of these districts was Wonosobo, with 16.67% [14].

The Central Java Province MSS in health sector achievement report shows that in 2022, only two categories of health services in Wonosobo reached the target of 100%. Research about the evaluation of the diabetes mellitus control program in the productive age at one of the community health centers in Wonosobo Regency states that one of the obstacles in the diabetes mellitus control program as one of the program indicators in the HS-MMS was weak cross-sectoral cooperation [15]. Research in the Andalas Community Health Center about the minimum service standards of health at primary education age also stated that one of the barriers to MSS in the health sector is caused by stakeholder factors [16]. A study on stakeholder mapping analysis on the scaling-up nutrition movement during the 1000 days of life between the urban and rural government areas, low stakeholder engagement impacts a lack of funding, inconsistency between policies and programs, and a lack of support and advocacy [17]. These various studies show that one of the obstacles to HS-MSSPI is the stakeholder factor. However, no research has examined the role of each stakeholder and their power, attitudes, and interests in implementing minimum service standards in the health sector.

We conducted this research to analyze the roles, power, attitudes, and interests in implementing minimum service standards in the health sector in Wonosobo. Through their roles, power, attitudes, and interests, this analysis can demonstrate the commitment that stakeholders have already demonstrated as a basis for optimizing policy implementation. This research can also be a reference for all regional governments in Indonesia because these findings will provide a basis for strengthening the commitment of regional stakeholders.

METHODS

Stage 1: Stakeholder Identification

In this stage, researchers identify the stakeholders involved in HS-MSSPI in Wonosobo based on statutory documents: Minister of Home Affairs Regulation Number 59 of 2021 and Minister of Health number 4 of 2019. Furthermore, researchers reconciled the findings with the key informant, the Health Office. Based on the results, researchers identified stakeholders in HS-MSSPI: Regency Legislative Council, Regional Secretariat, Regional Development Planning Agency, Health Office, Community Health Centers (PHC), Sub-district Governments, Village Governments, Village Health Cadres, and Family Welfare Guidance (PKK) Cadres.

Stage 2: In-depth Interview

This research is a descriptive qualitative study. Through this method, researchers gathered comprehensive information on the roles and positions of all stakeholders involved in HS-MSS implementation in Wonosobo. Interviews were conducted with every stakeholder who had been identified. Data collection was carried out from August to December 2023.

Stage 3: Data analysis

All information obtained from the interviews was analyzed based on the stakeholder classification approach and stakeholder mapping theory [18,19]. Stakeholder classification was carried out based on an analysis of the variable interests and authority of each stakeholder. Based on the identification, stakeholders will be classified into three categories: decision maker (DM), provider, and representative. Decision makers are stakeholders who have the authority to formulate policies, manage resources, grant permits, and evaluate programs/policies. Providers are stakeholders directly involved in implementing programs in the field and serve as service providers. Representatives are stakeholders who provide support and investment in the program/policy but are not included in the system [18].

Table 1 shows stakeholder mapping of each stakeholder's attitude, power or influence, and interest in HS-MSSPI in Wonosobo. Positive (+) and negative (-) symbols will represent each stakeholder's opinion. If the stakeholder shows a supportive attitude, a positive symbol (+) will be given, but if the attitude shown is

Table 1. Stakeholder mapping analysis

Attitude	Power	Interest	Label
Support (+)	Strong (+)	Active (+)	Savior
		Passive (-)	Sleeping Giant
	Weak (-)	Active (+)	Friend
		Passive (-)	Acquaintance
Not Support (-)	Strong (+)	Active (+)	Saboteur
		Passive (-)	Time Bomb
	Weak (-)	Active (+)	Irritant
		Passive (-)	Trap Wire

less supportive, a negative symbol (-) will be given. In the influence variable, a positive symbol (+) represents a strong influence, while a negative symbol (-) represents a weak influence. On the interest variable, positive symbols (+) represent active involvement, while negative symbols (-) indicate stakeholder involvement that tends to be passive.

Stakeholders can be categorized into various position based on their influence, involvement, and attitudes. Saviors are highly influential, actively involved, and supportive. Sleeping giants are similarly influential and supportive but remain passively involved. Friends are stakeholders with low influence and high involvement, maintaining a positive attitude. Acquaintances also have positive attitudes and low influence, but are not actively involved. Saboteurs actively oppose the policy with their high influence. Time bombs hold high influence and an unsupportive attitude but are not actively involved. Irritants, with their low influence and unfavorable attitudes, remain actively involved. Lastly, tripwires exhibit low influence, an unsupportive attitude, and minimal involvement [19].

RESULTS

Stakeholder classification

Table 2 presents the roles of stakeholders based on their respective interests and authorities**.** The Regency Legislative Council has the authority to form local regulations, budget, and control so that they are included in the decision-maker category. The Regional Secretariat and Agency for Regional Development have an important position in the minimum service standards in the health sector implementation team, as chairman and deputy who are responsible for preparing action plans, coordinating, monitoring, and evaluating HS-MSSPI, so that they are included as stakeholders in the decision maker category. Stakeholders who are also included in the decision-maker category are the Health Office. This is related to their responsibilities, which include preparing derivative regulations as guidelines for PHC,

Table 2. Stakeholder classification

Classification	Stakeholders
Decision Maker	Regency Legislative Council
	Regency Secretariat
	Agency for Regional Development
	Health Office
Provider	Health Office
	Public Health Center
	Health Cadre
Representatives	Sub-District Government
	Village Government
	Family Welfare Guidance Cadre

fostering, monitoring, evaluating, and reporting on the HS-MSSPI.

There were three stakeholders included in the provider group: the Health Office, Community Health Centers, and Health Cadres. Stakeholders in this category were identified based on in-depth interviews. Stakeholders have roles and responsibilities in HS-MSS in the field. The health office coordinates all types of health services so all target communities can receive them. Public health centers and health cadres are tasked with providing and delivering services under their competencies. Stakeholders in the representative category were identified based on in-depth interviews, which showed that this group is outside the system but supports programs in HS-MSSPI in Wonosobo. This group consists of sub-district governments, village governments, and PKK cadres.

Stakeholder mapping

Table 3 presents stakeholders' category mapping based on attitude, power, and interest, following stakeholders' positions as decision-maker, provider, and representative categories. Two types of positions shown by the decision-maker stakeholder group: time bomb and savior. The Regency Legislative Council is classified as a "time bomb" based on the results of in-depth interviews, where the Regency Legislative Council has a strong influence in the decision-making process related to its functions of legislation, budgeting, and controlling but tends to show low support and involvement. The results of the interviews show that the involvement and support of the Regency Legislative Council is limited to the process of discussing and determining the budget. The absence of a regional regulation in HS-MSSPI indicates low support from the Regency Legislative Council. The Regency Legislative Council also did not actively participate in the policy formulation process or in monitoring the HS-MSSPI.

The Regency Secretariat, Agency for Regional Development, and Health Office are categorized as "savior." These three stakeholders have strong influ-

Table 3. Stakeholders' category mapping based on attitude, power, and interest

Variable	1*	2	3	Category
Decision maker				
• Regency Legislative Council	-	+	-	Time bomb
• Regency Secretariat	+	+	+	Savior
• Agency for Regional Development	+	+	+	Savior
• Health Office	+	+	+	Savior
Provider				
• Health Office	+	+	-	Sleeping giant
• Public Health Center	+	+	+	Savior
• Health Cadre	+	-	+	Friend
Representatives				
• Sub-District Government	+	-	+	Friend
• Village Government	+	-	+	Friend
• Family Welfare Guidance (PKK) Cadre	+	-	+	Friend

* 1 = Attitude, 2 = Power, 3 = Interest

ence, active involvement, and supportive attitudes. The influence, support, and involvement of the Regency Secretariat and Agency for Regional Development are shown in drafting policy plans, preparing budgets, overseeing budget enactment, monitoring, and evaluation. Meanwhile, the Health Office shows its influence, support, and involvement in policy formulation in public health, disease prevention and control, health services, and health resources.

The position of stakeholders in the provider category is divided into three categories: sleeping giant, savior, and friend. The results showed that the Health Office can strongly influence the allocation of resources, a supportive attitude shown by the deployment of resources and derivative policies. Still, its involvement in the field tends to be passive, so it is mapped to the "sleeping giant" position. Public Health Center showed a "savior" position based on the study's results, where PHC has a strong influence, is actively involved, and provides positive attitudinal support. PHC delivers the 12 types of services in the MSS for the health sector, so PHC's actions significantly influence the implementation of this policy. Health cadres are mapped in the "friend" position, and although this group provides active involvement and good attitudinal support, they do not have a strong influence. This is related to the limited resources they have.

The Sub-District Government, Village Government, and PKK Cadres are included in the "friend" position. Although these stakeholders have limited influence, they show active support and involvement. This is shown through their role and involvement in overseeing health programs implemented in the village and sub-district.

DISCUSSION

Decision maker positions

Decision maker (DM) strongly influenced HS-MSS policy in Wonosobo. In line with research about the role of stakeholders in the policy to accelerate the stunting reduction in Banjarnegara, which states that policymakers strongly influence policy implementation and results [20]. Although all DM showed high influence, the stakeholder mapping results showed various stakeholder categories. The Regional Secretariat, Agency for Regional Development, and Health Office are DM with a "savior" position. The Regency Legislative Council, on the other hand, is in a "time bomb" position. The different positions are due to variations in attitude and interests, which are influential factors in policy determination [21].

Research results regarding the participation of education stakeholders in preparing strategic plans for the Pohuwato Regency education service identified factors influencing stakeholder engagement, including coordination and continuous communication [22]. The local government needs to improve coordination and communication to increase the involvement of the Regency Legislative Council. This is crucial because the lack of involvement of decision-making stakeholders in a particular process can lead to a decrease in the involvement of other stakeholder groups [23].

Provider positions

Based on stakeholder mapping theory, providers implement a policy directly [18]. All provider stakeholders are directly involved in implementing the policy but show different positions. A public health center (PHC) is a group of providers in the "savior" position. Health cadres are in the "friend" category, while the Health Office shows an interesting position as a "sleeping giant."

All types of health services in the MSS in the health sector are carried out at PHC, so PHC tried to mobilize their resources. The authority to access resources in HS-MSSPI allows PHC to influence policy implementation. This is in line with research about stakeholder mapping analysis on the scaling-up nutrition movement during the 1000 days of life, which states that providers as technical implementers have greater control to ensure the success of a policy [17]. Health cadres' position as "friends" indicated they do not have a strong influence. This is due to the limited resources they have. Ownership of resources to support a program is very important to fight for the interests of a stakeholder group [24]. In achieving a goal, stakeholders need access to resources: the availability of resources, including human resources, budgets, and technical

infrastructure [25]. The Health Office is identified as a "sleeping giant", because it has a strong influence and supportive attitude but has not been involved in policy implementation. So, they need to increase their role. This is following research about stakeholder analysis in the preparation of the RPJMD in Pidie district, which states that each stakeholder should carry out their roles so that, as a system, policy governance can run optimally. Goals can be achieved [26].

Representative positions

Stakeholder representatives in this study only have the authority to approve program implementation and monitoring according to government direction. They do not have specific tasks and mandates, so they only monitor the program indirectly. The theory of stakeholder identification and salience states that when policymakers have legitimacy attributes but do not have power and pressing interests, then their role is only as recipients of responsibility [27]. Decision-makers need to establish good cooperation and communication so that representatives can continue supporting and contributing to achieving policy targets.

Recommendations

The Regional Secretariat, the Agency for Regional Development, and the Health Office as DM in the "savior" position need to maintain their position and commitment. This is in line with research about the impact of organizational structure on organizational commitment, which states that to increase success in achieving goals, a clear commitment is needed [28]. On the other hand, the Regency Legislative Council, in a "time bomb" position, needs to increase its involvement. The involvement of DM must be active and sustainable because this group holds the authority to influence policy implementation and other stakeholders [29]. It can be facilitated through coordination between all stakeholders in a forum or bilaterally [30].

PHC's position as a "savior" must be considered in the provider category to maintain its alignment. These stakeholders' needs must be considered to make it easier for them to influence other stakeholders. The position of health cadres as friends shows that they can be used as confidants, while the health office as a sleeping giant needs to be encouraged to increase its involvement as the leading sector in the health sector.

In the sub-district government, Village government, and PKK Cadres. Their support and involvement need to be sustained given their role in the empowerment, coordination, and facilitation of health programs organized in the village and sub-district areas, which is an important aspect of health development and achieving MSS targets in the health sector.

CONCLUSION

The decision-maker stakeholder group has not yet fully demonstrated its position as savior, with the Legislative Council showing the mapping results as a "time bomb." Decision makers in the "savior" position are the Regional Secretariat, Planning and Development Agency, and Health Office. The provider stakeholder group showed the most varied positions related to attitude, influence, and involvement: savior, friend, and sleeping giant. PHC has a position as "savior," Health Cadres show a position as "friend," while the Health Office is included in the "sleeping giant" category. On the other hand, all stakeholder representatives have the same position category, "friends." This is because this group shows a supportive attitude and active involvement but has no strong influence. It shows that the strong influence of some stakeholders has not been accompanied by a supportive attitude and active involvement. Increased engagement and collaboration are needed so that all stakeholders can continue to support and contribute to the success of the health sector minimum service standards policy.

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