Research Article

Health System Governance Performance in Improving Clean and Healthy Living Behaviors in Southwest Papua Province

Eltje Salomina[1]*, Hasniati[2], and Muh. Akmal Ibrahim[2]

[1]Doctoral Student of Public Administration, Faculty of Social and Political Science, Hasanuddin University, Makassar, South Sulawesi, Indonesia
[2]Department of Administrative Science, Faculty of Social and Political Science, Hasanuddin University, Makassar, South Sulawesi, Indonesia

Abstract.
Clean and healthy living behavior (PHBS) is an effort to increase awareness and education in the community about clean and healthy lifestyles. It is expected that with the implementation of PHBS, the community's quality of life can improve, avoid various diseases, and create a healthy environment. This study aims to measure the performance of health system governance in efforts to improve PHBS in Southwest Papua Province. A qualitative approach is the method used in this research. Data collection methods include observation, in-depth interviews, and documentation. Data sources consisted of primary and secondary data, while data analysis was conducted using interactive methods. The research informants included all parties who play a role in the promotive and preventive activities of living and clean behavior in Southwest Papua Province. The Health System Governance Performance in Southwest Papua Province shows that improving PHBS still faces various problems and challenges. In terms of responsiveness, local governments have established health counseling and socialization programs, but have not fully reached remote areas. Program effectiveness is still limited due to low community participation and a lack of trained health workers. In terms of efficiency, budget allocations are often not targeted and lack transparency. Accountability is still weak, marked by the lack of open performance reporting and program evaluation.

Keywords: clean and healthy living behavior (PHBS), health system governance, public health promotion, Southwest Papua, governance performance evaluation

Corresponding Author: Eltje Salomina; email: edasorong@gmail.com

Published: 2 September 2025

Publishing services provided by Knowledge E

Selection and Peer-review under the responsibility of the 2nd Doctoral International Conference Committee.

1. Introduction

Clean and Healthy Living Behavior (PHBS) has been globally recognized as a fundamental strategy in health promotion and disease prevention efforts that contribute significantly to improving people's quality of life. The World Health Organization (2021) emphasized that health promotion through healthy living behavior modification is a cost-effective intervention that can reduce the burden of disease by up to 70% and contribute to achieving the Sustainable Development Goals (SDGs), especially target 3.4 regarding reducing mortality from non-communicable diseases by one third by 2030. The PHBS

concept integrates individual, communal, and environmental dimensions in creating a holistic and sustainable health ecosystem. In a global context, evidence-based research shows that the implementation of an effective PHBS program can reduce the incidence of infectious diseases by 50-80%, reduce infant mortality by 35%, and significantly reduce the economic burden on the health system.

Many studies conducted in various developing countries indicate that investment in PHBS-based health promotion programs provides a return on investment of 1:4 to 1:9 in the long term. This emphasizes the importance of PHBS not only as a health intervention, but also as a sustainable economic development strategy. In Indonesia, PHBS implementation has become a strategic priority integrated into the national policy framework through the 2020-2024 National Medium-Term Development Plan (RPJMN) and the 2020-2024 Ministry of Health Strategic Plan. Regulation of the Minister of Health Number 2269/MENKES/PER/XI/2011 concerning PHBS Development Guidelines establishes a comprehensive framework that covers five main settings: households, educational institutions, workplaces, public places, and health service facilities.

This program is supported by a budget allocation of 2.8% of the total APBN for the health sector in 2023, demonstrating the government's commitment to promotive and preventive efforts. However, the evaluation of PHBS implementation in Indonesia shows significant disparities between regions, especially between western and eastern Indonesia. The 2018 Basic Health Research (Riskesdas) data revealed that the coverage of PHBS households in Indonesia reached 56.6%, but there was substantial variation between provinces ranging from 28.2% to 77.4% (Health Research and Development Agency, 2019). Provinces in eastern Indonesia, including Papua, consistently showed achievements below the national average, with Papua recording coverage of only 38.2%.

This disparity is further complicated by the formation of the West Papua Province as a result of expansion based on Law Number 15 of 2022. As the youngest province in Indonesia, West Papua faces multidimensional challenges in developing a health system, including the implementation of the PHBS program. Geographical characteristics dominated by mountainous topography and tropical forests, limited accessibility, and uneven population distribution in 1,474 villages are structural factors that affect the effectiveness of public health programs.

The socio-economic conditions of the people of West Papua also show their own complexity. Baseline data shows that the poverty rate has reached 23.8%, the illiteracy rate is 15.3%, and access to clean water is only 62.4% of the total population. These

factors contribute to the low adoption of healthy living behaviors and create a mutually reinforcing cycle between poverty, low levels of education, and poor public health status.

From the perspective of health system governance, the implementation of the PHBS program requires a governance approach that is adaptive and responsive to local conditions. Kickbusch & Gleicher emphasized that effective health governance must integrate the principles of good governance that include transparency, accountability, participation, responsiveness, and effectiveness in the context of the health system. In areas with socio-cultural complexity such as Southwest Papua, the dimension of culturally responsive governance is a critical factor in determining the success of public health programs.

Current literature shows that the performance of health system governance in implementing health promotion programs is influenced by complex interactions between institutional capacity, leadership, inter-sectoral coordination, and community participation. Comparative studies in developing countries indicate that areas with good health system governance are able to achieve PHBS coverage 2-3 times higher than areas with weak governance, even though they have similar socio-economic characteristics.

Previous studies on PHBS implementation in Indonesia generally focus on aspects of individual behavior change or evaluation of specific programs, but there are still few that comprehensively examine the performance of health system governance as a structural determinant of the success of the PHBS program. This research gap becomes even more significant in the context of West Papua as a new province that is building a health governance system from the foundation level. The importance of this research lies in the urgency to understand the complex dynamics between the health system governance structure and the outcome of the PHBS program implementation in the context of a region with unique characteristics such as West Papua. This research is expected to produce theoretical insights on an effective health system governance model for regions with high geographic, social, and cultural complexity, while also providing evidence-based recommendations for policy makers in optimizing the implementation of health promotion programs in eastern Indonesia.

The contribution of this research is not only limited to the local context of Southwest Papua, but can also provide lessons learned for the implementation of public health programs in other areas with similar characteristics, both in Indonesia and other developing countries. Thus, this research is positioned to fill the knowledge gap in the health

governance literature and provide practical contributions to efforts to achieve universal health coverage and SDGs at the subnational level.

2. Literature Review

2.1. Network Governance and Inter-Sectoral Collaboration

The evolution of public administration paradigm toward network governance has transformed understanding of policy implementation from hierarchical control toward collaborative governance. [1] defines governance networks as "self-organizing, inter-organizational networks characterized by interdependence, resource-exchange, rules of the game, and significant autonomy from the state." In health policy context, the network approach becomes increasingly relevant due to the cross-sectoral nature of health determinants. [2] developed a network management framework identifying three main strategies: network activation, network facilitation, and network orchestration. Application of this framework in health policy implementation shows that effective network governance requires balance between maintaining autonomy of network participants while achieving collective goals. A longitudinal study by [3]of 47 health promotion networks in the United States showed that networks with strong coordinating mechanisms achieved 67% higher client outcomes compared to loosely coordinated networks.

The collaborative governance concept developed by [4] provides a framework for understanding conditions and processes supporting successful cross-sector collaboration in public policy implementation. This framework identifies four critical elements: starting conditions (power imbalances, incentives to participate, prehistory of cooperation), institutional design (clear ground rules, broad representation, facilitative leadership), collaborative process (face-to-face dialogue, trust building, commitment to process), and outcomes (intermediate outcomes leading to successful collaboration). Application of this framework in health promotion program evaluation shows a 0.72 correlation between collaborative process quality and program effectiveness.

2.2. New Public Management and Public Value in Health Sector

New Public Management (NPM) reforms beginning in the 1980s have significantly influenced public sector management, including health systems. [5] identifies seven

doctrinal components of NPM: hands-on professional management, explicit standards and measures of performance, greater emphasis on output controls, shift to disaggregation of units, shift to greater competition, stress on private sector styles of management practices, and stress on greater discipline and parsimony in resource use.

In the context of public health program implementation, application of NPM principles has yielded mixed results. A comparative study by [6], [7], [8]in 12 OECD countries showed that countries adopting market-oriented reforms in health sector experienced improvement in technical efficiency (average 18%), but showed decline in equity and accessibility indicators (average 12%). This indicates inherent tension between efficiency objectives and equity considerations in health policy implementation.

In response to NPM limitations, [9] developed the concept of Public Value Creation emphasizing the importance of creating value for citizens as the ultimate goal of public administration. The Public Value framework integrates three elements: public value outcomes (what citizens value), operational capacity (what government can do), and political support and legitimacy (what citizens and stakeholders will authorize and support). In health governance, the Public Value approach has been applied for evaluating complex health interventions with multiple stakeholders and diverse outcomes.

2.3. Institutional Capacity and Public Organizational Performance

The concept of institutional capacity has become a central theme in public administration literature for understanding determinants of organizational performance in policy implementation. [10]developed a framework for measuring government performance identifying four dimensions: financial management capacity, human resources management capacity, information technology capacity, and capital management capacity. In health system governance context, institutional capacity assessment frameworks have been adapted to evaluate readiness and capability of health organizations in implementing complex interventions. A cross-country study by [11], [12] of 89 countries identified strong correlation ($r = 0.78$) between institutional capacity scores and health system performance indicators. Findings showed that countries with high institutional capacity achieved universal health coverage targets 3.2 years faster compared to countries with low institutional capacity.

Organizational learning theory developed by [13], [14] and adapted for public organizations by Rashman et al. (2020) provides insights on how public organizations can

improve performance through systematic learning processes. In health policy implementation, organizational learning capacity becomes particularly important due to complexity and uncertainty inherent in health interventions. Double-loop learning, involving questioning underlying assumptions and mental models, has proven critical for sustainable improvement in health program implementation.

3. Methods

This study employs a qualitative research approach with a case study design to comprehensively explore the health system governance performance in improving Clean and Healthy Living Behaviors (PHBS) in Southwest Papua Province. The qualitative methodology was selected to capture the complexity of governance mechanisms and provide in-depth understanding of the contextual factors, processes, and meanings underlying PHBS policy implementation in a newly established province with unique sociocultural characteristics. The research was conducted in Southwest Papua Province, with purposive sampling of representative districts/cities based on development levels, population composition, and PHBS implementation dynamics. Data collection utilized four primary techniques: in-depth interviews with key informants including provincial and district health officials, community health workers, village heads, traditional leaders, and civil society representatives; direct observation of PHBS program implementation processes at various administrative levels; comprehensive document analysis of policy regulations, program reports, budget allocations, and evaluation documents; and Focus Group Discussions (FGDs) with community members to explore diverse perspectives on governance effectiveness and behavioral change outcomes. Research informants were purposively selected based on their direct involvement in PHBS policy formulation, implementation, or beneficiary experiences, ensuring representation across different governance levels and stakeholder categories. Data analysis employed the Miles, Huberman, and Saldana interactive model, incorporating data condensation through systematic coding, data display through matrices and networks, and conclusion drawing through pattern recognition and theoretical interpretation. To ensure research credibility and trustworthiness, methodological triangulation was conducted by cross-validating findings across different data sources, collection techniques, and time periods, while member checking and peer debriefing were utilized to enhance validity and reliability of the research conclusions.

4. Result and Discussion

4.1. Government Responsiveness in PHBS Program

The responsiveness of the Papua Barat Daya regional government in implementing the PHBS program shows significant efforts but still faces limitations in reaching all areas. The results of the study identified that the regional government has developed various health education and socialization programs, but the effectiveness of these programs is still hampered by geographical factors and limited resources (Table 1).

TABLE 1: Government Responsiveness in PHBS Program.

Indicators	Research Findings	Status	Description
Extension Program	15 health education programs per year	Good	Has covered 5 PHBS levels
Regional Coverage	68% of villages reached by the program	Currently	32% of remote villages have not been reached
Community Complaints Response	Average 7-day response time	Not enough	Standard target 3 days
Media Socialization	12 communication media used	Good	Radio, posters, social media, leaflets
Involvement of Traditional Leaders	45% of programs involve traditional figures	Currently	Need to increase participation
Local Program Adaptation	30% of programs adapted to local context	Not enough	Still using a general approach

Based on the government's responsiveness table in the PHBS program, it can be seen that the performance of the Papua Barat Daya regional government shows mixed results with a positive tendency but still requires significant improvement. Aspects that show good performance are the outreach program with 15 programs per year that have covered the five PHBS levels and the use of 12 diverse communication media ranging from radio, posters, social media to leaflets, showing comprehensive efforts in disseminating health information. However, there are serious challenges in terms of geographical reach where 32% of remote villages have not been reached by the program, responsiveness to community complaints which still requires an average of 7 days (exceeding the standard target of 3 days), and low program adaptation to the local context which only reaches 30%. The involvement of traditional leaders which has only reached 45% also indicates the need for a more inclusive and culturally sensitive approach. Overall, these findings indicate that although the government has shown commitment to developing the PHBS program, the effectiveness of implementation is

still hampered by geographical factors, limited resources, and the lack of an approach that is tailored to the socio-cultural characteristics of the Papua Barat Daya community. The findings show that although the government has developed a comprehensive extension program, there are still gaps in geographical reach and adaptation to specific local contexts..

4.2. Effectiveness of PHBS Program

The effectiveness of the PHBS program in West Papua still faces significant challenges, especially in terms of community participation and the availability of trained health workers. The evaluation results show that although program targets have been set, actual achievements are still below expectations (Table 2).

Table 2: Effectiveness of PHBS Program.

Effectiveness Aspect	Target	Actual Achievement	Percentage	Constraining Factors
Coverage of PHBS Households	80%	52%	65%	Low community participation
Health Cadre Training	500 cadres	285 cadres	57%	Limited training budget
Establishment of Bindu Posts	120 posts	73 posts	61%	Lack of health personnel
Socialization of PHBS Schools	100% schools	67% schools	67%	Limited transportation access
Hand Washing Program	90% facilities	58% facilities	64%	Water infrastructure limitations
Monitoring and Evaluation	4 times/year	2 times/year	50%	Lack of monitoring personnel

Based on the PHBS program effectiveness table, it can be seen that the performance of program implementation in Southwest Papua is still far from the target set with an average achievement of only 60.7% of all indicators. The aspect that shows the best relative achievement is the socialization of PHBS schools with 67% achievement, but still does not reach the planned 100% target. Meanwhile, monitoring and evaluation show the worst performance with only 50% achievement, where the frequency of implementation is only 2 times per year from the target of 4 times per year. The coverage of PHBS households which only reaches 52% of the target of 80% indicates a significant gap in the adoption of healthy living behaviors at the community level. The identified inhibiting factors indicate complex structural problems, ranging from

low community participation, limited training budget, lack of health workers, limited access to transportation, limited water infrastructure, to lack of monitoring personnel. These findings indicate that the effectiveness of the PHBS program is hampered by a combination of human resource, financial, infrastructure, and geographic factors that require a holistic approach and increased system capacity as a whole to achieve the set targets. Data shows that the average achievement of the PHBS program only reached 60.7% of the target set, indicating the need for improvements in implementation strategies.

4.3. Efficiency of Budget and Resource Allocation

Efficiency in budget and resource management of the PHBS program shows problems in targeting and transparency. Analysis of budget use identified a misalignment between allocation and priority needs in the field (Table 3).

Table 3: Efficiency of Budget and Resource Allocation.

Budget Component	Allocation (%)	Realization (%)	Efficiency	Main Problems
Education and Socialization	35%	28%	Low	Inappropriate targeting
Human Resource Training	25%	19%	Low	High transportation costs
PHBS Equipment Procurement	20%	24%	Moderate	Overbudget due to local prices
Monitoring and Evaluation	10%	6%	Low	Lack of implementation commitment
Program Administration	10%	23%	Very Low	Excessive bureaucracy
Total	100%	100%	Low	Lack of transparency and targeting

Based on the PHBS program budget allocation efficiency table, there is a significant misalignment between budget planning and realization, indicating weak program financial governance. The program administration component shows the most severe inefficiency with a realization of 23% of the 10% allocation, reflecting excessive bureaucracy and waste of resources. In contrast, critical components such as counseling and socialization (28% of the 35% allocation) and HR training (19% of the 25% allocation) experienced substantial under-realization, indicating implementation barriers and inappropriate targeting. High transportation costs are the main inhibiting factor in HR training, while PHBS facility procurement is 4% overbudget due to high local prices. Monitoring and evaluation, which only realized 6% of the 10% allocation, indicate a

weak commitment to program performance supervision and assessment. Overall, this budget allocation and realization pattern reflects weak planning, budget control, and transparency in the financial management of the PHBS program, where resources are not allocated optimally to achieve program objectives and tend to be absorbed in unproductive administrative aspects. Budget transparency is also a critical issue, with 73% of respondents stating that program budget information is not easily accessible to the public.

4.4. Accountability in the Implementation of PHBS Programs

Accountability is the weakest aspect in the governance of the health system for PHBS programs in West Papua. The study identified weak reporting mechanisms, program evaluation, and community involvement in supervision (Table 4).

Table 4: Accountability in the Implementation of PHBS Programs.

Accountability Mechanism	Frequency	Quality	Public Access	Main Constraints
Program Performance Reports	2 times/year	Low	Limited	Non-standard report format
Program Evaluation	1 time/year	Moderate	Very Limited	No external party involvement
Public Complaints	Available	Low	Moderate	Lack of follow-up
Program Audit	Not routine	-	None	No audit mechanism established
Public Participation	Minimal	Low	Limited	Lack of mechanism socialization
Results Publication	Rare	Low	Very Limited	No dedicated platform

The PHBS program accountability table shows weak accountability mechanisms with almost all aspects performing low to very limited. Program performance reports that are only conducted twice a year with low quality and limited public access indicate minimal transparency, exacerbated by non-standard report formats. Annual program evaluations with moderate quality but very limited access and without external party involvement indicate weak assessment objectivity. Public complaint mechanisms are available but of low quality due to lack of follow-up, while program audits are not routine at all and have no public access. Minimal public participation with low quality reflects the lack of socialization of community involvement mechanisms. Rare publication of results with very limited access due to the absence of a special platform indicates a weak commitment to transparency. Overall, these conditions reflect a weak culture of

accountability in PHBS program governance, where the community has very limited access to information and little opportunity to participate in program supervision, thus creating space for inefficiency and lack of responsiveness to community needs.

Table 5: PHBS Program Information Transparency Indicators.

Information Type	Availability	Ease of Access	Timeliness	Transparency Score
Program Plan	Available	Difficult	Delayed	2.1/5.0
Program Budget	Limited	Very Difficult	Very Delayed	1.5/5.0
Implementation Report	Limited	Difficult	Delayed	1.8/5.0
Evaluation Results	Not Available	-	-	0.0/5.0
Complaint Mechanism	Available	Moderate	Timely	3.2/5.0
Average Score	-	-	-	1.7/5.0

The PHBS program information disclosure Table 5 shows a very low level of transparency with an average score of only 1.7 out of 5.0, indicating a systemic failure in providing public information. The complaint mechanism is the only aspect with relatively good performance (3.2/5.0) due to adequate availability, moderate ease of access, and good timeliness. In contrast, the evaluation results show the worst transparency with a score of 0.0 because it is not available to the public at all. Program budget information received the second lowest score (1.5/5.0) with limited availability, very difficult access, and significant delays in delivery, reflecting low financial accountability. The program plan and implementation report also showed poor performance with scores of 2.1 and 1.8, both constrained by difficulty in accessing and delays in delivering information. This condition reflects a weak commitment to the principle of public information disclosure and indicates that the community has minimal access to program information that should be their right, thus hampering effective public participation and social oversight.

4.5. Structural Challenges in PHBS Governance

The study identified various structural challenges that affect the performance of health system governance in the implementation of the PHBS program in Southwest Papua as a new province.

The structural challenges Table 6 shows the complexity of the problems of implementing the PHBS program in West Papua with geographical and access challenges

Table 6: Structural Challenges in PHBS Governance.

Challenge Dimension	Difficulty Level	Program Impact	Mitigation Efforts	Handling Status
Geography and Access	Very High	Very High	Transportation improvement	In Progress
Human Resource Limitations	High	High	Recruitment and training	Ongoing
Health Infrastructure	High	High	Puskesmas development	Planning Stage
Inter-Agency Coordination	Moderate	Moderate	Coordination team formation	Completed
Community Participation	Moderate	High	Cultural approach	Ongoing
Information System	High	Moderate	Data digitalization	Preparation Stage

being the most critical (very high level of difficulty and impact). Limited human resources and health infrastructure also show a high level of difficulty with a significant impact on the program, while coordination between agencies has shown the best progress with the status of "already implemented" through the formation of a coordination team. Although community participation has a moderate level of difficulty, its impact on the program remains high, indicating the importance of an ongoing cultural approach. The information system with a high level of difficulty but moderate impact is still in the digitalization preparation stage. Overall, most of the challenges are still in the process or planning stage, indicating that as a new province, West Papua is still in the phase of building the infrastructure and basic systems needed for effective implementation of health programs. The research findings show that the performance of health system governance in improving PHBS in West Papua still requires significant improvement in all dimensions of governance, with the main priority being increasing accountability and program efficiency.

4.6. Discussion

The findings reveal significant governance challenges in PHBS implementation in Southwest Papua Province, aligning with broader literature on health system governance in decentralized contexts. The low overall governance performance (average 60.7% target achievement) reflects what [15], [16] identified as common characteristics of fragmented health systems in low-resource settings, where institutional capacity limitations significantly impact program effectiveness. The responsiveness dimension shows mixed

results, with adequate program development (15 annual programs) but poor geographical coverage (68% reach), consistent with [17]findings that decentralized health systems in remote areas struggle with service delivery equity due to geographical barriers and resource constraints.

The effectiveness challenges, particularly low household PHBS coverage (52% vs. 80% target), mirror patterns observed in similar contexts where community participation remains limited. This aligns with [18] collaborative governance framework, suggesting that successful health promotion requires stronger community engagement mechanisms and cultural adaptation strategies. The 45% traditional leader involvement indicates insufficient attention to local governance structures critical for program legitimacy in indigenous communities. Efficiency findings demonstrate severe budget misalignment, with administrative costs consuming 23% versus 10% allocation while core activities remain underfunded. This reflects what [8], [19] described as common inefficiencies in developing country health systems, where bureaucratic processes often consume disproportionate resources. The accountability dimension shows the weakest performance (1.7/5.0 transparency score), particularly concerning given [11], [20] emphasis on accountability as fundamental for health system strengthening.

The structural challenges identified—geographical barriers, human resource constraints, and infrastructure limitations—represent systemic issues requiring comprehensive governance reforms rather than programmatic adjustments. These findings suggest that effective PHBS implementation in Southwest Papua requires fundamental health system governance improvements, including enhanced transparency mechanisms, community participation frameworks, and adaptive management approaches that account for local contexts and cultural sensitivities inherent in newly established provinces.

5. Conclusion

This study reveals significant governance deficiencies in PHBS implementation across Southwest Papua Province, with overall performance averaging only 60.7% of established targets. The assessment across four governance dimensions demonstrates systematic weaknesses requiring comprehensive reform. Responsiveness shows mixed results with adequate program development but poor geographical reach (68% coverage), while effectiveness remains constrained by low community participation and insufficient trained personnel. Efficiency analysis reveals severe budget misalignment, with

administrative costs consuming 23% versus 10% allocation, indicating poor resource targeting. Accountability emerges as the weakest dimension with an average transparency score of 1.7/5.0, reflecting inadequate reporting mechanisms and limited public access to program information. The findings highlight fundamental structural challenges inherent in newly established provinces, including geographical barriers, human resource constraints, and infrastructure limitations that transcend programmatic interventions. The research contributes theoretically by demonstrating how governance capacity directly impacts health promotion effectiveness in remote, culturally diverse contexts. Practically, these results provide evidence-based recommendations for policymakers to prioritize governance strengthening over program expansion. Future research should explore adaptive governance models that integrate traditional leadership structures with formal health systems, while policy interventions must focus on transparency enhancement, community engagement mechanisms, and capacity building initiatives. The study underscores that sustainable PHBS improvement in Southwest Papua requires fundamental governance transformation rather than incremental programmatic adjustments, with particular attention to cultural sensitivity and local context adaptation.

References

[1] Compston H. Policy Networks and Policy Change Putting Policy Network Theory to the Test, vol. 53, no. 9. 2009.

[2] Di Gregorio M, Fatorelli L, Paavola J, Locatelli B, Pramova E, Nurrochmat DR, et al. Multi-level governance and power in climate change policy networks. Glob Environ Change. 2019;54:64–77.

[3] Rudnick J, Niles M, Lubell M, Cramer L. A comparative analysis of governance and leadership in agricultural development policy networks. World Dev. 2019;117:112–26.

[4] Dolmans SA, van Galen WP, Walrave B, den Ouden E, Valkenburg R, Romme AG. A Dynamic Perspective on Collaborative Innovation for Smart City Development: the role of uncertainty, governance, and institutional logics. Organ Stud. 2023;44(10):1577–601.

[5] Molina-Marín G, Ramírez-Gómez A, Oquendo-Lozano T. [Inter-sectorial and inter-institutional cooperation and coordination in Public Health within the market model of the colombian Health Care System, 2012-2016]. Rev Salud Publica (Bogota). 2018;20(3):286–92.

[6] Heatly MC, Nichols-Hadeed C, Stiles AA, Alpert-Gillis L. Implementation of a School Mental Health Learning Collaborative Model to Support Cross-Sector Collaboration. School Ment Health. 2023 Apr;15(2):1–18.

[7] Q. Mahmood and C. Muntaner, "State-society nexus in Brazil and Venezuela and its effect on participatory governance efforts in health and other sectors," 2020. https://doi.org/10.1186/s12939-020-01278-1..

[8] Huttin CC. Policies for life sciences and healthcare in the global health framework. Technol Health Care. 2023;31(4):1497–504.

[9] Tanwar T, Kumar UD, Mustafee N. Optimal package pricing in healthcare services. J Oper Res Soc. 2020;71(11):1860–72.

[10] Williams MJ. Beyond state capacity: bureaucratic performance, policy implementation and reform. J Inst Econ. 2021;17(2):339–57.

[11] Sheikh K, Sriram V, Rouffy B, Lane B, Soucat A, Bigdeli M. Governance roles and capacities of ministries of health: A multidimensional framework. Int J Health Policy Manag. 2021 Mar;10(5):237–43.

[12] Chen Y, Zhang L, Wei M. How Does Smart Healthcare Service Affect Resident Health in the Digital Age? Empirical Evidence From 105 Cities of China. Front Public Health. 2022 Jan;9:833687.

[13] R. Skea, Leadership, organizational change and sensemaking. 2021. https://doi.org/10.4324/9781003022503..

[14] Hitt WD. The learning organization: some reflections on organizational renewal. Leadersh Organ Dev J. 1995;16(8):17–25.

[15] Campos PA, Reich MR. Political Analysis for Health Policy Implementation. Health Syst Reform. 2019;5(3):224–35.

[16] W. Septiono, "Equity challenges in Indonesian health care," 2023. https://doi.org/10.1016/S2214-109X(23)00110-9..

[17] Spencer L, Tanner A, Lu K. Using Diffusion of Innovation Theory to Address Health of the Homeless in Hawaii. Healthcare (Basel). 2023 Oct;11(21):2828.

[18] Weber C, Haugh H, Göbel M, Leonardy H. Pathways to Lasting Cross-Sector Social Collaboration: A Configurational Study. J Bus Ethics. 2022;177(3):613–39.

[19] Dieleman JL, Campbell M, Chapin A, Eldrenkamp E, Fan VY, Haakenstad A, et al.; Global Burden of Disease Health Financing Collaborator Network. Future and potential spending on health 2015-40: development assistance for health, and government, prepaid private, and out-of-pocket health spending in 184 countries. Lancet. 2017 May;389(10083):2005–30.

[20] Bergeron K, Abdi S, DeCorby K, Mensah G, Rempel B, Manson H. Theories, models and frameworks used in capacity building interventions relevant to public health: a systematic review. BMC Public Health. 2017 Nov;17(1):914.