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INTER-AGENCY NETWORKS AND COORDINATION IN PUBLIC HEALTH SERVICE DELIVERY: A CASE STUDY OF JENEPONTO REGENCY, INDONESIA

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Abstract: Inter-agency networks represent critical infrastructure for delivering integrated, responsive healthcare services, yet their effectiveness in resource-constrained settings remains poorly understood. This study examines network coordination mechanisms, access expansion strategies, and innovation capacity within a district healthcare system experiencing declining service quality. Through qualitative case study methodology involving in-depth interviews with seven key informants representing health administration, hospital management, and primary care leadership, supplemented by community satisfaction data and policy document analysis, this research investigates how inter-organizational relationships influence healthcare delivery outcomes. Findings reveal significant gaps between formal coordination structures and operational effectiveness across three network dimensions. First, despite extensive coordination frameworks including quarterly cross-sectoral meetings and monthly facility-level forums, coordination functions predominantly as formalistic reporting rather than substantive problem-solving, resulting in fragmented service delivery and information system incompatibilities. Second, although geographic coverage spans 12 community health centers, 45 sub-centers, and 195 integrated health posts, access remains inequitable due to transportation barriers, financial constraints, and cultural exclusion disproportionately affecting remote and vulnerable populations. Third, innovation initiatives remain localized pilots lacking systematic knowledge exchange mechanisms, evaluation frameworks, and scaling pathways that would enable collective learning and adaptive improvement. The documented 4.13-point decline in community satisfaction from 2023 to 2024, with particularly sharp deteriorations in service time and complaint handling, substantiates inadequate translation of coordination efforts into service quality improvements. Strengthening healthcare networks requires fundamental transformation prioritizing relational quality, inclusive engagement mechanisms, collaborative capacity development, and systematic learning infrastructures rather than merely establishing formal coordination structures. These findings contribute empirical evidence on network governance implementation challenges in decentralized health systems, offering insights for policy-makers seeking to enhance inter-organizational collaboration effectiveness.
Keywords: inter-agency networks, healthcare coordination, service integration, collaborative governance, health system strengthening.

INTRODUCTION:

Public health service delivery in the 21st century faces complex challenges that require innovative governance approaches beyond traditional bureaucratic models. The quality of healthcare services has become a critical indicator of government performance, particularly at the local level where citizens directly interact with public institutions (He & Ma, 2021; Lanin & Hermanto 2019). In Indonesia, the decentralization of healthcare services to district governments has created both opportunities and challenges in ensuring equitable, efficient, and responsive health service delivery. Recent studies emphasize that effective public health governance requires moving beyond hierarchical administrative structures toward more collaborative and networked approaches that prioritize citizen needs and experiences (Emerson, 2018; Iedema et al., 2017).

The shift toward more citizen-centric governance models has gained momentum globally, with increasing recognition that traditional top-down approaches often fail to address the complex, interconnected nature of contemporary health challenges. Healthcare systems worldwide are grappling with issues of accessibility, quality, and sustainability, prompting governments to explore innovative governance frameworks that emphasize collaboration, flexibility, and responsiveness (Goniewicz et al, 2025; Abdul et al, 2024). In developing countries, these challenges are often compounded by resource constraints, infrastructure limitations, and fragmented coordination mechanisms among stakeholders (Uddin, 2025; Opdyke, 2017). The Indonesian context presents unique characteristics where local governments must navigate complex inter-organizational relationships while addressing diverse community health needs across geographically dispersed populations (Harsanto & Wahyuningrat, 2024).

Jeneponto Regency in South Sulawesi Province exemplifies these challenges in healthcare service delivery. Despite ongoing efforts to improve public services, healthcare provision in the regency continues to face significant obstacles including limited human resources, inadequate service quality, disparities in access across different areas, and insufficient community involvement in decision-making processes. These persistent issues highlight the urgent need for reformulating public health service models toward approaches that are human-centered, collaborative, and adaptive to community needs (Fischer et al., 2021). The Community Satisfaction Index (IKM) serves as a critical performance indicator reflecting the quality of public service delivery and citizen perceptions of government responsiveness.

Recent IKM data from Jeneponto Regency reveals concerning trends in healthcare service satisfaction. As shown in Table 1, the satisfaction scores have remained stagnant and below the "excellent" category over recent years, with a notable decline observed in 2024. This decline during a transitional government period suggests systemic issues that extend beyond individual service units to encompass broader governance and coordination mechanisms.

Table 1. Community Satisfaction Index (IKM) Trends in Jeneponto Regency (2020-2024)

Year	IKM Score	Service Quality Category	Trend
2020	76.45	Good (B)	-
2021	78.12	Good (B)	↑ +1.67
2022	79.38	Good (B)	↑ +1.26
2023	78.95	Good (B)	↓ -0.43
2024	74.82	Fair (C)	↓ -4.13

Source: Jeneponto Regency Community Satisfaction Survey Report (2024)

Note: IKM scoring categories: 25.00-64.99 (Poor/D), 65.00-76.60 (Fair/C), 76.61-88.30 (Good/B), 88.31-100.00 (Excellent/A)

The decline in satisfaction scores reflects a misalignment between designed service delivery mechanisms and actual community needs, expectations, and experiences. While the scores do not fall into the "poor" category, they indicate significant room for improvement, particularly in service speed, information clarity, and staff attitudes (Van Gestel et al., 2019). The 2024 assessment, based on nine service elements, reveals that citizens perceive healthcare services as failing to meet their fundamental expectations for friendliness, accessibility, affordability, speed, and proximity. This gap between service provision and citizen expectations underscores the necessity for transforming healthcare governance from administrative and bureaucratic orientations toward more relational and participatory approaches.

Breaking down the IKM components reveals specific areas requiring urgent attention. Table 2 presents the disaggregated satisfaction scores across different service dimensions, highlighting particular weaknesses in coordination, service speed, and complaint handling mechanisms.

Table 2. Disaggregated IKM Scores by Service Dimension (2024)

Service Dimension	Score (2024)	Score (2023)	Change	Priority Level
Service Requirements	77.2	80.1	-2.9	Medium
Service Procedures	75.8	79.5	-3.7	High
Service Time	71.5	76.8	-5.3	Critical
Service Costs	78.9	80.2	-1.3	Medium
Service Products	76.1	79.9	-3.8	High
Staff Competence	74.6	78.1	-3.5	High
Staff Behavior	73.8	77.6	-3.8	High
Complaint Handling	69.2	74.5	-5.3	Critical
Infrastructure	76.4	79.8	-3.4	High

Source: Jeneponto Regency Community Satisfaction Survey Report (2024)

The data reveals that service time and complaint handling mechanisms experienced the most significant deterioration, suggesting potential breakdowns in coordination and responsiveness systems. These findings align with broader literature indicating that fragmented inter-organizational relationships and weak coordination mechanisms significantly impair service delivery effectiveness (Musenze & Mayende, 2021). The simultaneous decline across multiple dimensions suggests systemic governance issues rather than isolated operational problems, pointing toward the need for comprehensive reforms in how healthcare services are organized, coordinated, and delivered.

The persistent challenges in Jeneponto's healthcare services reflect broader issues in inter-agency coordination and stakeholder collaboration. Effective healthcare delivery inherently requires synergistic relationships among multiple actors including local government agencies, healthcare professionals, community organizations, and private sector entities (Pereno & Eriksson, 2020). However, evidence suggests that these networks often operate in silos with limited communication, fragmented responsibilities, and unclear coordination mechanisms. The absence of robust collaborative frameworks results in duplicated efforts, gaps in service

coverage, and inefficient resource utilization. Recent research emphasizes that building effective inter-organizational networks requires deliberate effort to establish shared goals, clear communication channels, mutual trust, and appropriate governance structures that facilitate rather than hinder collaboration (Nezami et al, 2023).

Understanding the specific nature of network relationships and coordination mechanisms in Jeneponto's healthcare system is crucial for designing effective interventions. Previous research has explored various aspects of healthcare governance, but significant gaps remain. Studies by Aneta, et al. (2023) examined digital transformation in Indonesian public health services, focusing primarily on technological adoption and e-government implementation at provincial levels, with limited attention to inter-organizational dynamics at the district level. Similarly, research by Sudhipongpracha (2024) investigated community participation in healthcare decision-making in East Java, emphasizing citizen engagement mechanisms but not comprehensively addressing the role of inter-agency networks and coordination structures that enable or constrain such participation.

This study addresses these gaps by specifically examining how inter-agency networks and coordination mechanisms function within Jeneponto Regency's healthcare system. It investigates how collaborative relationships form among stakeholders, identifies challenges impeding effective coordination, and explores strategies for strengthening inter-organizational connections to improve service delivery. By focusing on network dynamics and their impact on service quality as reflected in community satisfaction, this research aims to provide empirical insights into governance reforms necessary for achieving more responsive, efficient, and equitable healthcare services. The study's objective is to analyze the current state of inter-agency networks in healthcare service delivery, assess coordination effectiveness among government agencies, healthcare providers, community organizations, and private sector actors, and identify actionable strategies for enhancing collaborative governance to improve healthcare service quality in Jeneponto Regency.

METHODOLOGY

This study employed a qualitative case study approach to examine inter-agency networks and coordination mechanisms within Jeneponto Regency's healthcare system, focusing specifically on the network principle dimension of human-centered governance. Data collection occurred between October 2024 and January 2025 through in-depth semi-structured interviews with seven key informants purposively selected based on their strategic positions within the healthcare delivery network: the Head of District Health Office, Director of RSUD Lanto Datu Pagala, Director of RS Rumbia, Head of Puskesmas Bululoe, head nurse at RSUD Lanto Datu Pagala, administrative officer at RSUD Lanto Datu Pagala, and legal affairs officer at RSUD Lanto Datu Pagala. Interview protocols contained 62 open-ended questions organized around four thematic domains—relational principles, network structures, interactive engagement, and reflective practices—designed to elicit comprehensive perspectives on stakeholder roles, coordination mechanisms, collaboration challenges, and network strengthening strategies. Each interview lasted 60-90 minutes, was audio-recorded with informed consent, and transcribed verbatim for analysis. Secondary data sources included Community Satisfaction Index (IKM) reports from 2020-2024, regional health policy documents (Perda Jeneponto No. 6/2018 on Health Service Systems), District Medium-Term Development Plans (RPJMD), and health facility operational reports. Data analysis followed thematic analysis procedures involving initial familiarization with transcripts, systematic coding using both deductive codes derived from Bason's (2017) human-centered governance framework and inductive codes emerging from the data, pattern identification across informant accounts, theme development focusing on coordination effectiveness, access expansion, and innovation capacity, and interpretive synthesis contextualizing findings within theoretical frameworks and secondary data evidence. Triangulation occurred through cross-referencing informant perspectives with documentary evidence and IKM performance data, while analytical rigor was enhanced through reflexive memoing, peer debriefing with research team members, and member checking with two key informants to validate interpretive accuracy.

RESULTS AND DISCUSSION

This section presents research findings organized according to three core network dimensions: coordination effectiveness, access expansion, and innovation capacity. Each dimension is analyzed through empirical evidence from Jeneponto Regency's healthcare system, contextualizing results within the human-centered governance framework.

Network Coordination and Service Integration

The coordination dimension examines how inter-organizational networks facilitate integrated healthcare delivery across multiple providers and administrative levels. Research findings reveal a paradoxical situation where extensive formal coordination structures coexist with significant operational fragmentation. The District Health Office, RSUD Lanto Datu Pagala, RS Rumbia, and twelve community health centers (Puskesmas) operate within an established coordination framework centered on quarterly cross-sectoral meetings (Lokmin Lintas Sektor), monthly facility-level coordination sessions, and annual development planning forums

(Musrembang). Despite these mechanisms, service integration remains problematic, as evidenced by the 2024 Community Satisfaction Index decline from 78.95 (2023) to 74.82, marking a 4.13-point decrease.

Analysis of coordination practices reveals three critical deficiencies undermining network effectiveness. First, information system fragmentation prevents seamless data exchange between healthcare facilities, with the Sisrute (referral system) frequently malfunctioning and electronic medical records remaining non-interoperable across institutions. Second, coordination meetings often deteriorate into formalistic reporting exercises rather than substantive problem-solving sessions, with cross-sectoral participants exhibiting minimal engagement with health sector priorities. Third, unclear role delineation generates responsibility ambiguities, particularly at service delivery intersections between Puskesmas and hospitals, and between health facilities and village-level health programs. The disaggregated IKM data substantiates these coordination failures, showing service time satisfaction declining 5.3 points (from 76.8 to 71.5) and complaint handling satisfaction dropping 5.3 points (from 74.5 to 69.2)—both representing critical coordination-dependent dimensions.

The coordination challenges manifest tangibly in referral pathway disruptions and program implementation bottlenecks. Healthcare providers report that patients frequently encounter acceptance delays when Puskesmas initiate referrals, as receiving hospitals fail to promptly confirm availability through the Sisrute application. Recording and reporting complications arise when service recipients originate from outside designated catchment areas, creating accountability confusion and data quality issues. Cross-sectoral coordination proves particularly weak in integrated programs requiring sustained inter-agency collaboration, such as stunting prevention initiatives demanding synchronization across health, social welfare, education, and agricultural sectors. Budget allocation processes further exacerbate coordination problems, with planning cycles across different agencies failing to align, resulting in resource mobilization delays and implementation timing mismatches.

Table 3. Network Coordination Mechanisms and Performance Indicators

Coordination Level	Mechanism	Frequency	Key Stakeholders	Performance Indicators	Current Status
District Policy	Cross-sectoral Lokmin	Quarterly	All OPDs, hospital directors, Puskesmas heads, DPRD Commission IV	Policy alignment, resource allocation decisions, strategic planning	Functional but limited health sector engagement
Service Delivery	Facility-level Lokmin	Monthly	Puskesmas staff, village officials, health cadres, community leaders	Program monitoring, problem identification, service quality review	Variable effectiveness across facilities
Clinical Integration	Inter-facility coordination	Ad-hoc	Doctors, nurses, administrative staff across facilities	Referral completion rates, treatment continuity, information exchange	Frequent disruptions, system failures
Emergency Response	Disaster/outbreak coordination	As needed	Health Office, hospitals, Puskesmas, sub-district offices, security forces	Response time, resource mobilization, communication effectiveness	Generally effective but reactive
Community-Clinical	Community health meetings	Monthly	Health workers, cadres, village health committees	Program participation rates, community feedback, behavior change	Strong in some areas, weak in others

Applying Bason's (2017) human-centered governance framework to these findings reveals fundamental misalignment between network design and operational reality. Bason emphasizes that networked governance must prioritize relational quality over structural formalism, arguing that effective inter-organizational collaboration depends on trust-building, shared accountability, and continuous learning mechanisms rather than merely establishing coordination forums. The Jeneponto case demonstrates that formal network architecture—represented by coordination meetings, stakeholder identification, and policy frameworks—proves insufficient when relationships remain transactional, accountability stays siloed, and learning from implementation

experiences fails to inform practice adjustments. The declining satisfaction scores suggest that coordination deficiencies translate directly into degraded service experiences, contradicting human-centered governance principles that demand service design responsiveness to user needs and organizational adaptability to emerging challenges. Research by Iao-Jörgensen, (2024). demonstrates that successful network governance requires deliberate investment in collaborative capacity-building through joint training, co-design processes, and shared performance measurement systems—interventions conspicuously absent in Jeneponto's current coordination approach.

Network Expansion and Service Access

The access dimension investigates how inter-organizational networks extend healthcare services to underserved populations through multi-sectoral partnerships and community engagement mechanisms. Jeneponto's healthcare network exhibits significant geographic and demographic coverage through 12 Puskesmas, 45 sub-health centers (Pustu), 10 mobile health posts (Posyandu Keliling), and 195 integrated health posts (Posyandu), supplemented by two district hospitals and multiple private clinics. This infrastructure theoretically provides comprehensive population access, yet substantial service utilization gaps persist, particularly affecting remote rural communities, economically disadvantaged populations, and vulnerable demographic groups including pregnant women, infants, and elderly residents with chronic conditions.

Partnership diversity represents a notable strength in Jeneponto's network architecture, encompassing government-community collaborations through health care systems, public-private partnerships for pharmaceutical supply and medical equipment provision, civil society engagement through foundations providing financial assistance to indigent patients, and cross-sectoral initiatives linking health services with education programs, religious institutions, and village governance structures. The health care network constitutes the most extensive community-clinical bridge, with trained volunteers facilitating monthly Posyandu sessions, conducting home visits for health promotion, mobilizing community participation in immunization campaigns, and serving as information conduits between healthcare facilities and households. However, these partnerships operate unevenly across the district, with some Puskesmas demonstrating robust community networks while others struggle with cadre retention, volunteer motivation, and systematic community engagement.

Access barriers persist despite network breadth, revealing structural limitations that coordination improvements alone cannot resolve. Transportation infrastructure deficiencies critically constrain access, with poor road conditions, mountainous terrain, and absent public transportation systems making facility access difficult, particularly for emergency cases and specialty services requiring hospital visits. The RS Rumbia location exemplifies this challenge—while geographically proximate to communities, the facility's mountainous setting and winding roads create substantial access obstacles exacerbated by transportation limitations. Financial barriers compound geographic constraints, as despite universal health coverage through the National Health Insurance (JKN-KIS) program, administrative complications, and coverage gaps for certain services, and indirect costs (transportation, accommodation for accompanying family members) deter service utilization. Cultural factors further impede access, including social hierarchies influencing provider-patient interactions, gender norms affecting women's healthcare decision-making autonomy, and traditional health belief systems creating reluctance toward modern medical interventions.

Table 4. Network Access Expansion and Utilization Patterns

Access Dimension	Coverage Indicators	Partnership Mechanisms	Utilization Barriers	Gap Analysis
Geographic Coverage	12 Puskesmas, 45 Pustu, 195 Posyandu across 11 sub-districts	Village health committees, mobile services, outreach programs	Poor roads, mountainous terrain, no public transport, long distances to facilities	Remote villages underserved, emergency access problematic
Financial Accessibility	JKN-KIS coverage 87% population	BPJS Kesehatan, charitable foundations (Yayasan Kita Bisa), social welfare programs	Coverage verification issues, indirect costs, service exclusions, inactive membership	Economic barriers remain significant despite insurance
Service Availability	Primary care 24/7 at Puskesmas, specialist services at hospitals	Referral networks, telemedicine pilots, visiting specialists	Limited specialist availability, equipment shortages, medicine stockouts	Secondary/tertiary care access constrained
Community Engagement	195 Posyandu, health care network,	Health cadres, village officials,	Low participation some areas, trust	Variable community integration

	community meetings	women's organizations (PKK), religious leaders	deficits, cultural barriers	
Vulnerable Groups	Maternal-child programs, elderly services, disability accommodations	Cross-sectoral programs (education, social welfare), NGO partnerships	Stigma, discrimination, inadequate specialized services	Equity concerns persist

Situated within Bason's (2017) human-centered governance framework, these access findings underscore critical tensions between network scope and service equity. Bason contends that human-centered approaches must prioritize inclusion, ensuring that governance networks actively reach marginalized populations rather than merely providing services accessible to those already well-connected. The Jeneponto network exhibits structural breadth without achieving inclusive reach, as partnership expansion has not systematically addressed root causes of access inequality—transportation deficiencies, financial barriers, and cultural exclusion. The extensive Posyandu network demonstrates community-embedded service delivery potential, yet participation variations across locations suggest that network presence alone does not guarantee utilization, requiring sustained relationship-building, trust cultivation, and cultural adaptation. The public-private partnership gap represents a particularly significant missed opportunity, with limited systematic engagement of private sector resources despite their potential to enhance service capacity, extend geographic reach, and introduce innovative delivery models. Hilliard-Boone et al (2022) argue that network-based governance must intentionally design for equity, implementing targeted outreach strategies, reducing participation barriers, and creating accountability mechanisms ensuring disadvantaged groups receive proportionate attention—interventions that Jeneponto's current network configuration inadequately incorporates.

Network Innovation and Knowledge Exchange

The innovation dimension analyzes how inter-organizational networks facilitate knowledge sharing, practice improvement, and service innovation through collaborative learning and evidence-informed adaptation. Jeneponto's healthcare network demonstrates nascent innovation capacity through several initiatives, including the Integrasi Layanan Premier program consolidating health education, basic services, and community empowerment activities across Puskesmas, Pustu, and Posyandu; the Cess Gammara innovation addressing stunting and wasting through improved complementary feeding practices; electronic medical records implementation at RSUD Lanto Datu Pagala and RS Rumbia with integration to the national health information system; and quality improvement initiatives applying 5S principles (smile, greeting, courtesy, politeness, friendliness) to enhance patient-provider interactions. These innovations reflect predominantly facility-level initiatives rather than network-wide collaborative innovations, with limited evidence of systematic knowledge transfer mechanisms enabling innovation diffusion across the healthcare system.

Technology adoption represents the most visible innovation domain, though implementation remains uneven and challenge-laden. Both district hospitals have deployed electronic medical record systems, with RS Rumbia achieving integration with the Ministry of Health's "Satu Sehat" (One Health) platform, enabling standardized health data exchange nationally. Several Puskesmas have introduced online appointment systems, JKN-KIS membership verification applications, and social media platforms for health promotion and community engagement. The Sisrute referral system provides digital referral coordination infrastructure. However, technological innovation confronts substantial barriers including inconsistent internet connectivity particularly in remote areas, inadequate hardware infrastructure at some facilities, limited digital literacy among both providers and patients, insufficient technical support for troubleshooting and maintenance, and interoperability challenges between different software platforms. These constraints explain why technology-enabled coordination improvements have not materialized despite digital infrastructure investments.

Knowledge exchange mechanisms within the network remain underdeveloped, with minimal systematic learning from implementation experiences, best practice identification, or innovation scaling pathways. Monthly coordination meetings theoretically provide knowledge-sharing venues, yet discussions predominantly focus on performance reporting rather than reflective learning or problem-solving innovation. Professional development opportunities remain largely individual rather than network-based, with healthcare workers attending external training programs but lacking structured forums for translating acquired knowledge into collective practice improvements. The absence of formal communities of practice, peer learning networks, or action research initiatives constrains the network's capacity to generate, validate, and disseminate locally-adapted innovations. Innovation initiatives like Integrasi Layanan Premier and Cess Gammara remain localized pilots without systematic evaluation, documentation, or scale-up strategies, representing missed opportunities for network-wide learning and improvement.

Table 5. Network Innovation Capacity and Knowledge Exchange

Innovation Type	Current Initiatives	Implementation Scope	Knowledge Exchange Mechanisms	Scaling Barriers	Innovation Outcomes
Service Delivery Models	Integrasi Layanan Premier (integrated services), Cess Gammara (stunting prevention)	Pilot at select facilities	Limited documentation, informal sharing, no formal evaluation	Resource constraints, limited evidence base, unclear replication protocols	Localized improvements, no systematic scaling
Digital Health	Electronic medical records, Sisrute referrals, online appointments, JKN-KIS verification apps	Partial implementation across facilities	Technical training, help desk support, user forums (informal)	Connectivity issues, equipment gaps, digital literacy, interoperability	Enhanced data management, improved administrative efficiency where functional
Quality Improvement	5S principles, patient satisfaction surveys, complaint handling systems, service standard protocols	Facility-specific initiatives	Monthly meetings, supervision visits, quality reports	Inconsistent application, weak follow-up, limited methodology training	Variable quality enhancement, unsustained improvements
Community Engagement	Social media health promotion, community forums, participatory planning	Growing adoption, uneven quality	Social media groups, community meetings, health care networks	Digital divide, engagement capacity, cultural barriers	Increased information access, variable behavioral impact
Clinical Protocols	Evidence-based guidelines, treatment standardization, clinical audits	National guidelines adopted, local adaptation limited	Professional meetings, clinical supervision, occasional case conferences	Time constraints, resistance to change, limited research capacity	Improved clinical consistency, gaps in implementation

Examining these innovation findings through Bason's (2017) human-centered governance lens reveals fundamental misalignment between innovation rhetoric and systemic learning capacity. Bason emphasizes that networked governance innovation requires moving beyond isolated pilot projects toward embedded experimentation cultures characterized by rapid prototyping, user feedback integration, failure tolerance, and evidence-informed iteration. The Jeneponto network demonstrates innovation initiation capability—launching pilot programs and adopting new technologies—but lacks the reflexive infrastructure necessary for learning from implementation, adapting approaches based on user experiences, and systematically scaling successful innovations. The limited knowledge exchange mechanisms contradict human-centered principles demanding that service improvements emerge from collective learning rather than top-down mandates, with frontline providers, community members, and service users co-generating solutions through participatory experimentation. The technology adoption pattern—investing in digital systems without adequately addressing implementation prerequisites—reflects a common innovation failure mode where technical solutions are deployed absent the organizational capacity, user readiness, and adaptive management required for effective integration. Chester & Allenby (2019) demonstrate that sustainable public service innovation depends on establishing learning infrastructures including communities of practice, action learning sets, and developmental

evaluation approaches that enable networks to continuously experiment, learn, and adapt—capacities that Jeneponto's healthcare network must systematically cultivate to realize its innovation potential and translate coordination improvements into measurable service quality enhancement.

CONCLUSION

This study examined inter-agency networks and coordination mechanisms in Jeneponto Regency's healthcare system, revealing significant gaps between formal network structures and operational effectiveness. While the district has established comprehensive coordination frameworks involving multiple stakeholders across government, healthcare facilities, professional organizations, and community representatives, network performance remains inadequate as evidenced by declining community satisfaction scores and persistent service quality challenges. Three critical dimensions—coordination effectiveness, access expansion, and innovation capacity—demonstrate fundamental implementation deficiencies that undermine human-centered service delivery. Coordination mechanisms exist extensively yet function predominantly as formalistic reporting exercises rather than genuine collaborative problem-solving forums, resulting in fragmented service delivery, information system incompatibilities, and unclear role delineation that directly undermine patient care continuity. Access expansion efforts, despite extensive geographic coverage through 12 Puskesmas, 45 Pustu, and 195 Posyandu, fail to achieve equitable reach due to persistent transportation barriers, financial constraints, and cultural exclusion factors that disproportionately affect vulnerable populations in remote areas. Innovation initiatives remain localized pilots without systematic knowledge exchange mechanisms, evaluation frameworks, or scaling pathways, limiting the network's collective learning capacity and adaptive improvement potential. The documented 4.13-point decline in the Community Satisfaction Index from 2023 to 2024, with particularly sharp deteriorations in service time (5.3-point drop) and complaint handling (5.3-point drop), substantiates that current network configurations inadequately translate coordination efforts into tangible service quality improvements. Strengthening Jeneponto's healthcare networks requires fundamental transformation beyond structural adjustments, demanding deliberate investment in relational quality through trust-building initiatives, shared accountability frameworks, collaborative capacity development programs, and systematic learning infrastructures that enable continuous experimentation and evidence-informed adaptation. These findings carry implications for district-level healthcare governance across Indonesia, suggesting that achieving human-centered service delivery necessitates prioritizing network relationship quality, inclusive engagement mechanisms, and reflexive learning capacities rather than merely establishing formal coordination structures. Future research should employ longitudinal mixed-methods approaches combining network analysis techniques to map relationship patterns and information flows with quantitative outcome measurements linking network characteristics to specific service quality indicators, enabling more precise identification of which network configurations generate superior healthcare outcomes and under what contextual conditions collaborative governance mechanisms prove most effective in resource-constrained settings.

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