

Development of Local Policy Capacity For Maternal And Child Health Services in Raja Ampat Regency

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Abstract

Introduction: This study aims to analyze the policy capacity of the Raja Ampat Regency Government in delivering maternal and child health (MCH) services and to formulate capacity-building strategies suited to the region's archipelagic characteristics. A qualitative approach with a case study design was employed. Data were gathered through in-depth interviews, observation, documentation, and secondary data analysis. The analysis utilized a policy capacity framework encompassing analytical, operational/managerial, and political capacities at the individual, organizational, and system levels. This framework was expanded to include "geographic-adaptive capacity," as MCH service delivery in Raja Ampat is influenced by inter-island distances, marine transportation, weather conditions, communication, and unequal resource distribution. The findings indicate that Raja Ampat Regency possesses capacity assets for MCH services—including 23 community health centers (Puskesmas), health personnel, MCH programs, referral systems, political support, and a strengthened regional general hospital (RSUD). However, these assets have not been optimally translated into service delivery capacity due to disparities in health workforce distribution, data delays, uneven training, obstacles related to marine transport, weather, and communication, and a lack of institutionalized policy learning. The study reinforces the analysis by Wu, Ramesh, and Howlett—that policy success requires a combination of analytical, operational, and political capacities—and supports the findings of Mukherjee, Coban, and Bali regarding how the interplay between capacity types, design levels, and temporality influences effectiveness. Ultimately, the study proposes a "Geography-Adjusted Maternal and Child Health Policy Capacity" model that integrates analytical, managerial, political, organizational, networking, and geographic-adaptive capacities.

Keywords: policy capacity; maternal and child health; adaptive-geographic capacity.

1 Introduction

Maternal and child health represents a policy arena that demonstrates the direct link between state capacity and the quality of public services. While the government can mandate antenatal care, skilled birth attendance, neonatal services, obstetric referrals, immunization, and nutritional interventions, the success of these programs hinges on the ability to integrate knowledge, organizational structures, resources, stakeholders, infrastructure, data, and political decisions.

The research problem lies not merely in whether Raja Ampat Regency possesses a maternal and child health policy, but in whether the government has the capacity to make that policy function consistently across a fragmented geographical landscape. Wu, Ramesh, and Howlett conceptualize policy capacity as a combination of competencies and resources at the individual, organizational, and systemic levels. Consequently, capacity is not simply a quantitative sum of resources but is qualitative in nature, defined by the ability to adapt policy implementation to complex situations.

Mukherjee, Coban, and Bali (2021) demonstrate that the effectiveness of policy design is influenced by capacity aspects at the system, program, and instrument levels, as well as by the complementarity between different types of capacity. Additional budget allocations or facilities may prove ineffective if unsupported by analytical capacity—particularly in setting priorities—as well as operational capacity to manage implementation and political capacity to sustain support.

Research data indicates that, as of 2025, Raja Ampat Regency has 23 community health centers (*puskesmas*), 38 doctors, 218 nurses, 227 midwives, and 36 pharmacy personnel. However, these aggregate figures are insufficient to determine service capacity, as effective capacity is shaped by factors such as distribution, workforce composition, service continuity, supervision, and facility accessibility. Ministry of Health indicators cited in the research materials reveal that only one community health center meets the standard for a complete staffing mix (comprising 12 types of health personnel), while 18 have yet to meet service quality standards.

The archipelagic nature of the region alters transaction costs, travel times, referral risks, and coordination mechanisms. One informant revealed that during periods of high waves, the challenge extends beyond mere distance to encompass transport safety, particularly for emergency referrals at night. W2 involves a boat journey of approximately three to four hours—a duration that can extend further during inclement weather. Thus, geography acts as a variable shaping implementation capacity.

These findings align with research by Li, Li, and Jiang (2023) in Papua New Guinea, which identified that distance to health facilities, region, place of residence, and other enabling factors significantly influence the utilization of antenatal care (ANC), skilled birth attendance, and postnatal care (PNC). A study in Jayawijaya, Papua, similarly identified bottlenecks regarding workforce distribution, the utilization of obstetric interventions, information, planning, managerial skills, and political commitment.

Strengthening referral facilities is a key component of the health agenda. On May 16, 2025, the Ministry of Health announced the upgrading of the Raja Ampat Regional General Hospital (RSUD) from Class D to Class C to bolster healthcare services in the archipelago region. While this policy demonstrates institutional and political support, its effectiveness ultimately depends on human resources, equipment, referral systems, financing, and functional linkages with community health centers (Puskesmas).

Issues regarding child nutrition also highlight the need to strengthen policy capacity. Research data indicates a stunting prevalence of 31.1% in Raja Ampat (based on the 2022 SSGI) and points to the existence of programs covering mapping, measurement, data publication, the provision of complementary foods, public outreach, and coordination with the regional hospital and the national health insurance agency (BPJS). The challenge lies not merely in the existence of these activities, but in the ability to integrate them effectively to drive meaningful changes in outcomes.

Based on this analysis, the study aims to explain the perspective of policy capacity development for the Raja Ampat Regency Government regarding the delivery of maternal and child health (MCH) services. It covers analytical, managerial, political, organizational, and human resource capacities, as well as data utilization, inter-actor coordination, geographical influences, enabling and inhibiting factors, and capacity development models suitable for archipelagic regions. The study's urgency is underscored by a shift in perspective: moving from viewing capacity merely as a volume of resources to viewing it as a system's ability to transform resources into effective decisions, implementation, learning, and service delivery within the MCH context. This approach is crucial because the mere presence of community health centers (Puskesmas) or health workers does not equate to actual access if transportation, communication, workforce distribution, and referral mechanisms do not function in an integrated manner in Raja Ampat Regency. The research gap lies in the lack of an integrated framework combining literature on policy capacity, maternal health access, health system resilience, and policy learning specifically for Indonesia's archipelagic regions. This study addresses that gap through the concept of "geography-adjusted maternal and child health policy capacity," enabling MCH services in archipelagic areas to achieve optimal performance.

Literature Review

The Concept of Policy Capacity

Policy capacity is understood as the combination of skills and resources that enable a government to perform policy-related work effectively. The framework proposed by Wu, Ramesh, and Howlett distinguishes between analytical, operational/managerial, and political capacities at the individual, organizational, and systemic levels. This framework provides a basis for analyzing not only who possesses these capabilities but also whether the organization and system provide the conditions necessary for those capabilities to be utilized.

Analytical capacity relates to the ability to identify problems, collect and examine data, analyze alternatives, utilize evidence, and forecast policy consequences. In the context of MCH, this capacity is essential for mapping high-risk pregnancies, determining workforce needs, assessing facility capacity, mapping referral patterns, and identifying vulnerable groups. Managerial capacity relates to planning, budgeting, organizing, coordinating, implementation, supervision, monitoring, and evaluation. Political capacity relates to the ability to garner support, build legitimacy, negotiate, manage conflict, and secure resources.

In this study, organizational capacity encompasses structure, human resources, leadership, standard operating procedures (SOPs), budgets, information, facilities, coordination, and a learning culture. This capacity must be viewed across organizations, as Maternal and Child Health (MCH) services involve the Health Office, regional public hospitals (RSUD), community health centers (Puskesmas), district and village governments, community health volunteers, families, regional planning and development agencies (Bapperida), human resource agencies

(BKPSDM), the Transportation Office, the social security agency (BPJS), professional associations, and educational institutions. Policy experiences in developing countries also highlight the importance of coordinative capacity. Saguin, Ramesh, and Howlett (2018), for instance, found that policy work styles in the Philippines are characterized by strong coordination. This finding is relevant to Raja Ampat, as the complexity of MCH services demands collaboration across units and regions.

Archipelagic regions present uncertainties that cannot always be resolved through static planning. Factors such as weather, sea conditions, vessel availability, communication infrastructure, shifting community needs, and workforce shortages can alter implementation capabilities over time. Nair and Howlett (2020) emphasize the importance of adaptability and policy designs that allow for handling uncertainty. Policy learning complements adaptive capacity. Goyal and Howlett (2018) demonstrate that policy learning is a crucial area of study within policy science and can be understood through various forms of learning. Leong and Howlett (2022) note that policy learning must also account for failures, risks, interests, and the reality that governments do not always learn automatically from experience.

In this study, policy learning is conceptualized as a cycle comprising implementation, evaluation, reflection, learning, and policy adjustment. This cycle is vital for MCH services; experiences such as delayed referrals, workforce shortages, data lags, or failed nutrition interventions should drive changes in SOPs, resource allocation, training designs, or coordination mechanisms.

Al Asfoor et al. (2024) demonstrate that health system resilience is linked to the ability to maintain service quality amidst crises and pressures. The attributes discussed include resources, adaptive and transformative capabilities, learning, leadership, networking, integration, and governance. This perspective reinforces the argument that policy capacity for Maternal and Child Health (MCH) in Raja Ampat must incorporate the ability to cope with geographical challenges.

The study draws upon WHO (2023–2024) guidelines regarding the importance of facility data, analysis, visualization, and program reviews—covering maternal, neonatal, child, and adolescent health—to support program planning and improvement. In the Indonesian context, *Permenkes* (Minister of Health Regulation) No. 19/2024 serves as the reference for the operation of Community Health Centers (*Puskesmas*), superseding previous regulations. This regulatory framework underscores the importance of organizational capacity at the primary care level within the health service system, including MCH services.

2. METHOD

This study employs a qualitative approach with a case study design. This design was selected because the research seeks to understand policy capacity within the real-world context of Raja Ampat Regency, including the interrelationships among policies, organizations, actors, data, resources, geography, and service practices. Research sites included the Raja Ampat Regency Government, the Health Office, Raja Ampat Regional General Hospital (RSUD), community health centers (*Puskesmas*), district and village governments, and MCH service users. The primary unit of analysis is local government policy capacity, while supporting units include service organizations and actor networks.

Informants were selected purposively and categorized into groups: Health Office officials, MCH program managers, *Puskesmas* heads, doctors, midwives, nurses, referral coordinators, planning officials, personnel officials, district and village government representatives, community health volunteers (*kader*), and service users. Informants were assigned codes (W1, W2, W3, etc.) to ensure confidentiality. Semi-structured interviews were used to explore policy formulation, implementation, human resources, data, budgeting, referrals, coordination, evaluation, and learning. Documentation reviewed included the Medium-Term Regional Development Plan (RPJMD), Strategic Plans (Renstra), Annual Work Plans (Renja), health profiles, performance reports, data from Statistics Indonesia (BPS) and the Ministry of Health, as well as data on human resources, facilities, Maternal and Child Health (MCH) services, stunting, and policy documents. Observations focused on facilities, service processes, referral mechanisms, data recording, coordination, and service interactions.

Analysis was conducted through data familiarization, coding, categorization, theme development, interpretation, and triangulation. Thematic analysis was employed to identify patterns of meaning within the interview data and documents. Data validity was reinforced through the triangulation of sources, methods, and documents, alongside member checking, researcher discussions, and an audit trail.

3. RESULTS

Profile of MCH Service Capacity

Research materials indicate that Raja Ampat possesses a relatively extensive primary care network. Ministry of Health data lists 23 Community Health Centers (Puskesmas), comprising 20 non-inpatient and 3 inpatient facilities. However, facility capacity cannot be assessed solely based on the number of health centers. Actual capacity is influenced by staffing completeness, staff competence, equipment availability, communication, transportation, and referral capabilities.

Table 01: MCH Service Capacity Profile of Raja Ampat Regency, 2022–2025

Indicator	Data in Research Materials	Policy Implication
Community Health Centers (Puskesmas)	23 (20 non-inpatient; 3 inpatient)	Primary healthcare network is available, but access should be assessed in relation to geographic conditions.
Doctors, 2024	58	Aggregate numbers do not yet reflect the distribution of doctors across service areas.
Nurses, 2024	318	Workforce composition and distribution require further mapping.
Midwives, 2024	227	An important asset for maternal and child health (MCH) services; equitable distribution remains an issue.
Pharmacy Personnel, 2024	46	Indicates available workforce support, but distribution may not be equitable.
Stunting, SSGI 2022	31.1%	Nutritional outcomes remain a significant public health concern.

Source: Raja Ampat Regency Health Office, 2026

Ministry of Health data cited in the research materials also reveals a gap in meeting staffing standards at primary care facilities. This indicates that the capacity issue is not merely an aggregate shortage of personnel, but a mismatch between the specific needs of each facility and the available workforce. Factual data from Raja Ampat Regency shows that the region faces significant challenges in delivering Maternal and Child Health (MCH) services, particularly when trying to improve service delivery across an archipelago characterized by diverse geographical conditions.

Stunting mapping and situational analysis activities indicate that analytical capacity already exists. However, an informant identified as W6 noted, "Reporting is sometimes delayed due to unstable internet connections. Consequently, data arrives late, making it difficult to use for rapid decision-making." This quote highlights a gap between data collection and its application in decision-making. Furthermore, from the perspective of analytical capacity, service providers in Raja Ampat Regency find it very difficult to make decisions. In turn, the service delivery process often encounters technical obstacles, which can hinder the achievement of excellent service targets.

Managerial Capacity and Human Resource Development

Meanwhile, an informant identified as W3 stated, "We need continuous guidance. After training, health workers still require mentoring to ensure the skills they acquired are actually applied in service delivery." These findings demonstrate that training alone is insufficient unless accompanied by mentoring, supervision, and case reviews. Similarly, an informant identified as W4 added, "Training is very helpful in improving staff capabilities, but the issue is equitable access. Not all staff at remote community health centers (Puskesmas) receive regular training opportunities." Thus, human resource development strategies must take into account distance and access to training, rather than focusing solely on the number of activities.

Human resource capacity can be understood through seven elements: quantity, distribution, competence, experience, continuity, motivation, and development opportunities. Therefore, human resource policies need to integrate local recruitment, affirmative education measures, scholarships, mentoring, coaching, supervision, remote-area incentives, housing support, and career pathways. Political Capacity

The upgrading of the Regional General Hospital (RSUD) from Class D to Class C, scheduled to begin in 2025, indicates political and policy support for service strengthening. However, political capacity extends beyond the decision to undertake physical infrastructure development. Such support must translate into operational budgets, personnel, equipment, transportation, referral systems, the strengthening of community health centers (Puskesmas), and oversight mechanisms.

From the perspective of policy capacity, political decisions become effective when they successfully mobilize resources and build cross-organizational legitimacy. Consequently, the Maternal and Child Health (MCH) agenda requires leadership capable of maintaining MCH priorities throughout the regional planning and budgeting processes.

Referral System Capacity

An interview with informant W1 revealed: "When waves are high, the issue isn't just distance. Safe transportation is also a problem, especially when referrals must be made at night." Meanwhile, informant W2 explained: "Some community members have to travel by boat for about three to four hours. If sea conditions are favorable, the referral can be faster, but bad weather can prolong the journey."

These two excerpts demonstrate that geography is not merely a backdrop but a variable that shapes implementation capacity. The MCH referral system must be understood as a chain comprising risk identification, communication, transportation, patient reception, clinical management, and feedback. A failure at any link in this chain can diminish the policy's effectiveness. The following table outlines the taxonomy of issues and the realities of MCH services in Raja Ampat Regency.

Table 02. Identification of Needs for Strengthening the Maternal and Child Health (MCH) Service System in Raja Ampat Regency

Referral Component	Strengthening Needs	Risk Identification
Risk Identification	Mapping of high-risk pregnant women and referral criteria	—
Communication	Emergency contacts, alternative radio/telephone communication, and communication SOPs	—
Transportation	Sea ambulances and backup transportation schemes	—
Reception	RSUD readiness and pre-arrival coordination	—
Management	Availability of healthcare personnel, equipment, and medicines	—
Feedback	Case reviews and improvement of SOPs	—

Source: MCH Services Division, Raja Ampat Regency Health Office, 2025.

The most significant finding is the need for geographic-adaptive capacity. Factors such as distance, the sea, weather, transportation, and communication can alter a policy's effectiveness from one region to another. Consequently, the Maternal and Child Health (MCH) policy in Raja Ampat cannot rely on the same implementation assumptions used for mainland regions.

In this study, the concept of "Adaptive-Geographical Policy Capacity" refers to the government's ability to tailor policy design, resources, Standard Operating Procedures (SOPs), technology, and networks to specific geographic conditions and environmental changes. This concept does not replace the general notion of "policy capacity" but serves as a contextual extension, making capacity metrics more relevant to archipelagic regions. Network constraints highlighted by respondent W6 demonstrate that digitalization should not be viewed merely as the provision of applications. An MCH information system requires infrastructure, devices, connectivity, human resources, interoperability, data governance, analysis, and utilization capabilities. Given Raja Ampat's geography, an "offline-to-online synchronization" system offers a practical approach.

The study proposes an "MCH Policy Intelligence Dashboard" that integrates data on pregnant women, pregnancy risks, locations, healthcare personnel, childbirth, complications, neonatal health, referrals, nutritional status, stunting, and transportation needs. This dashboard must function as a decision-making tool rather than a mere reporting mechanism.

MCH services cannot be managed by the Health Office alone. Key actors form a network comprising the Health Office, Regional General Hospitals (RSUD), Community Health Centers (Puskesmas), districts, villages, health volunteers (kader), and families or the community. Supporting network entities include the Regional Development Planning, Research, and Innovation Agency (Bapperida), the Regional Personnel and Human Resources Development Agency (BKPSDM), the Transportation Agency, the Social Security Agency (BPJS), professional organizations, and educational institutions. Network capacity serves to link policy decisions with conditions on the ground; in this context, Bapperida is crucial for integrating development planning, while BKPSDM handles human resource strategies for implementers, and the Transportation Agency manages logistics. Hospitals handle referrals, Puskesmas provide primary care, and districts and villages ensure community outreach. Addressing Stunting

Research materials indicate the presence of activities such as mapping, measurement, data publication, the provision of complementary foods, public outreach, and coordination with regional public hospitals (RSUD) and the national health insurance agency (BPJS). However, the 31.1% prevalence rate in 2022 reveals that significant challenges regarding outcomes remain. Policy capacity needs to be directed toward the integration of interventions rather than merely increasing the number of activities.

Policy Learning Capacity

Findings from interviews with informant W3 regarding the need for post-training support demonstrate that capacity building must be structured as a learning system. A more appropriate sequence involves the process of training → mentoring → supervision → case review → evaluation → learning → policy adjustment. Through this cycle, field experience becomes a source of knowledge for policy refinement.

Goyal and Howlett (2018) identify policy learning as a crucial area within the policy field, while Leong and Howlett (2022) emphasize the necessity of considering failures, risks, and political factors. In the context of Raja Ampat, learning opportunities can arise from instances of delayed referrals, staffing shortages, network connectivity issues, the distribution of training, and shifting patterns of nutritional problems. These aspects can be concisely summarized in a table outlining the gaps between policy and implementation capacity regarding Maternal and Child Health (MCH) services in Raja Ampat Regency.

Table 03. Gaps Between Policy Intentions and Implementation Capacity

Policy/Agenda	Implementation Capacity Findings
Health Workforce Equity	Workforce distribution and composition remain suboptimal.
Referral System	Referrals are constrained by distance, weather conditions, transportation, and communication barriers.
Digitalization	Connectivity is unstable, and data are not always available in real time.
Training	Training opportunities are not evenly distributed and require continued mentoring.
Data	Reporting activities are in place, but rapid data utilization remains limited.
RSUD Strengthening	Infrastructure improvements need to be accompanied by adequate human resources, equipment, and service networks.
Stunting	Programs are available, but achieving improved outcomes remains challenging.

Source: Raja Ampat Regency Health Office, 2025.

This disparity demonstrates that policy quality cannot be assessed solely based on the existence of a program; evaluations must also examine whether implementation capacity is truly adequate at each location. This aligns with the view that policy capacity is multidimensional and that the relationships between different types of capacity are complementary.

Beyond established capacity, the quality of Maternal and Child Health (MCH) services in Raja Ampat Regency is significantly determined by the quality of both managerial and physical capacities. This factor correlates with various outcomes, particularly regarding the expansion of optimal health service coverage.

The following table summarizes the views of informants, providing an overview of the capacity possessed by the Raja Ampat Regency government to deliver MCH services and perform related functions.

Table 04. Synthesis of the Policy Capacity of the Raja Ampat Regency Government in MCH Services, 2025–2026

Dimension	Findings	Analytical Assessment
Analytical	Data and analytical activities are available, but their utilization remains suboptimal.	Moderate
Managerial	Programs are implemented, but the integration of planning, supervision, and organizational learning needs to be strengthened.	Moderate
Political	Commitment is demonstrated through health agendas and efforts to strengthen the RSUD.	Relatively Strong
Human Resources	Personnel are available in sufficient numbers, but distribution and compliance with staffing standards remain concerns.	Low–Moderate

Organizational	A healthcare service network is available.	Moderate
Digital	High potential exists, but connectivity remains a major constraint.	Low–Moderate
Referral	The RSUD has been strengthened, but geographical conditions remain a major constraint.	Moderate
Networking	Collaboration exists, but integration among stakeholders remains suboptimal.	Moderate
Geographical Adaptability	Geographically adaptive approaches are highly needed but have not yet been institutionalized.	Low–Moderate
Learning	Evaluation activities are conducted but have not yet become a systematic organizational process.	Moderate

Source: Recapitulation of informants' perspectives on the capacity of the Raja Ampat Regency Government in MCH services, 2025.

Discussion

The findings support the framework proposed by Wu, Ramesh, and Howlett (2015), which posits that policy capacity is a combination of skills and resources at the individual, organizational, and systemic levels. However, the context of Raja Ampat demonstrates that the geographical dimension must be treated as a factor shaping capacity requirements.

Analytical capacity requires geographic information; managerial capacity necessitates transport adaptation; political capacity needs to be translated into resource redistribution; and organizational capacity requires support through inter-island networking. In other words, formally identical capacities can yield different implementation capabilities depending on the geographical environment.

Mukherjee et al. (2021) emphasize the complementarity between different types of capacity. The case study of Raja Ampat Regency regarding Maternal and Child Health (MCH) services clarifies that this complementarity also has a spatial dimension: capacity at the regency level must be capable of reaching facilities and communities across different islands.

Based on a synthesis of the findings, this study formulates a "Geography-Adjusted Maternal and Child Health Policy Capacity" model. This model integrates six dimensions: analytical capacity, managerial capacity, political capacity, organizational capacity, network capacity, and adaptive-geographical capacity. These six factors operate through policy knowledge, the policy process, implementation, monitoring, evaluation, and policy learning.

Conceptually, the model's flow can be described as follows: the archipelagic context shapes policy knowledge and enhances analytical capacity, which in turn can boost managerial capacity. Managerial capacity then determines political capacity and influences network capacity. This can subsequently enhance adaptive-geographical capacity, wherein policy learning processes improve the effectiveness of MCH policies—regarding access, quality, continuity, and responsiveness—thereby creating optimal maternal and child health outcomes. Based on these analyses, a proposition can be formulated: the higher the local government's capacity to integrate analytical, managerial, political, organizational, network, and geographical adaptation capabilities, the greater its ability to produce effective, responsive, and equitable MCH policies.

The study's novelty lies in the development of the "Geography-Adjusted Policy Capacity" concept. This concept does not claim that geography constitutes a capacity distinct from all others; rather, it positions geographical characteristics as factors that shape the design of capacity. Consequently, measuring capacity in archipelagic regions requires accounting for travel time, reliance on maritime transport, weather conditions, connectivity, and the ability to mobilize resources across islands.

This model also links policy capacity with health system resilience. Al Asfoor et al. (2024) demonstrate that health system resilience entails the ability to maintain service quality under conditions of stress and crisis. In Raja Ampat, the ability to sustain referral systems and Maternal and Child Health (MCH) services during adverse weather serves as a concrete example of adaptive capacity.

A study by Saguin et al. highlights the importance of coordination in policy work within developing nations. Research findings regarding MCH services in Raja Ampat can be extended to an inter-island coordination perspective, particularly concerning healthcare delivery in archipelagic settings. Meanwhile, a study by Li et al. (2023) underscores the significance of distance and enabling factors in the utilization of maternal health services. The case of Raja Ampat demonstrates that these factors must be translated into policy instruments—such as referral transport—within the MCH service process. Furthermore, while Al Asfoor et al. (2024) indicate that

resilience relies on learning and networking, the Raja Ampat case illustrates that these two elements must be embedded within the policy cycle..

Thus, this study contributes not only by identifying the importance of geography in Maternal and Child Health (MCH) service delivery within archipelagic regions but also by demonstrating how infrastructure and human resource factors can help resolve the complexities of healthcare provision. It elucidates the mechanism by which geography increases transaction costs—thereby intensifying the need for coordination—and highlights that such coordination requires organizational and network capacity. Furthermore, when disruptions recur, the system necessitates adaptive capacity and learning, which in turn can improve outcomes and determine effective access.

Theoretically, policy capacity should be understood as a relational and contextual capacity. It is relational because capacity emerges from interactions between actors, and contextual because capacity sufficient for mainland areas may prove inadequate for archipelagic regions. Ultimately, the concept of "geography-adjusted policy capacity" allows geography to be defined as a contextual modifier influencing the capacity requirements for MCH services.

5. CONCLUSION

The Raja Ampat Regency Government possesses a foundational policy capacity for MCH services, comprising a network of community health centers (Puskesmas), health personnel, various programs, political support, a regional general hospital (RSUD), and community nutrition improvement initiatives. However, these capacities are not yet optimally integrated due to challenges in planning and the management of capabilities and resources. Key bottlenecks lie in the distribution of health personnel, data-driven decision-making systems, disparities in competency development, referral mechanisms, and issues regarding connectivity, coordination, and policy learning.

Research findings indicate that geographical factors—characterized by variables such as distance, sea conditions, weather, transportation, and communication—determine the type of capacity required in the long term. Therefore, policy capacity in the Raja Ampat archipelago must be geographically tailored; it cannot be adequately measured solely by the aggregate of existing resources.

Theoretically, this study reinforces the analytical frameworks of Wu, Ramesh, and Howlett (2015) and Mukherjee et al. (2021), while linking them to health system resilience and policy learning. Its primary contribution is the concept of "Geography-Adjusted Maternal and Child Health Policy Capacity," which positions "adaptive-geographical capacity" as a contextual modifier. In practical terms, the policy priorities include geographically adjusted workforce planning, an island-based maternal referral network, a maternal and child health (MCH) policy intelligence dashboard, continuous professional development, cross-sector governance, policy learning, and geographically adjusted budgeting. These strategies are more fundamental than simply adding new programs, as they directly address capacity bottlenecks.

Limitations

This study is a qualitative case study and is not intended for statistical generalization. Future research could quantitatively test the model by using a capacity index for each community health center (Puskesmas), comparing island-based regencies, and longitudinally linking capacity to maternal and neonatal health indicators. Researchers with a quantitative focus are encouraged to investigate the causal relationships between various capacity determinants, aiming to improve the quality of maternal and child health services through an adaptive-geographical capacity approach.

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