



ORIGINAL RESEARCH

IMPLEMENTATION AND INTERNALIZATION OF HUMAN-CENTRED GOVERNANCE PRINCIPLES IN PUBLIC SERVICES IN THE HEALTH SECTOR IN JENEPONTO REGENCYST. Meriam¹, Sangkala¹, Nurdin Nara¹, Muh Akmal Ibrahim¹, Tahir Haning¹, Hasniati¹¹Public Administration, Hasanuddin University, Makassar, Indonesia**Corresponding author:** ST. Meriam, Public Administration, Hasanuddin University, Makassar, Indonesia
e-mail meriamstunhas@gmail.com*Received: Oct 21, 2024; Accepted: Nov 17, 2025; Published:***ABSTRACT**

Background: The transformation of public service governance towards a human-centered approach is becoming increasingly important in addressing the complexity of health systems in regions with limited institutional capacity. This study aims to analyze the implementation and internalization of four Human-Centred Governance (HCG) principles: relational, network, interactive, and reflective, in health service governance in Jeneponto Regency, Indonesia.

Materials and Methods: A qualitative approach with an exploratory design was used to explore the dynamics of HCG implementation at the institutional and service practice levels. Data were obtained through in-depth interviews with 24 key informants, participant observation in health facilities, and analysis of various policy documents, planning documents, and community satisfaction surveys. Thematic analysis was used to identify patterns of HCG implementation and their interactions within the governance process.

Result: The results indicate that the implementation of HCG principles is not simultaneous and exhibits imbalances between the structural and reflective dimensions. Relational and network principles have received strong normative and institutional support, while interactive and reflective principles remain limited in development, characterized by uneven community participation and low analytical capacity. Although internal discussion forums and feedback mechanisms have emerged as embryonic reflection cycles, these processes have not been systemically integrated. This study contributes by demonstrating the importance of a phased strategy and strengthening institutional capacity in implementing HCG principles to realize adaptive and human-centered health governance.

Keywords: Human-Centred Governance; public services in the health sector; interactive; reflective; public governance

INTRODUCTION

In the past two decades, public governance has undergone a paradigmatic shift from a bureaucratic model to a more collaborative, adaptive, and human-centered model. This shift is driven by the increasing complexity of social issues such as demographic change, the global pandemic, unequal access to healthcare, and a crisis of trust in public institutions¹⁻².

³HCG model offers a conceptual framework to address these challenges through four key principles: relational, networked, interactive, and reflective, oriented toward creating public value through empathetic engagement, multi-stakeholder collaboration, participatory interaction, and a continuous cycle of organizational learning.

Previous studies have shown that implementing HCG principles can improve the responsiveness of public services, strengthen citizen trust, and expand policy innovation, particularly in the health sector⁴⁻⁶. However, most of these studies focused on the context of developed countries with relatively established institutional capacity⁷. In developing countries, implementing HCG principles faces unique challenges, such as capacity disparities across regions, hierarchical bureaucratic cultures, and weak strategic reflection

mechanisms⁸⁻⁹. As a result, many governance innovations remain at the normative level without significantly transforming organizational interactions and learning processes.

Despite the rapid growth of the HCG literature, three key gaps remain. First, most studies emphasize normative aspects and institutional design, while studies on the internalization of HCG principles in local bureaucratic practices are still limited¹⁻¹⁰. Second, the interactive and reflective dimensions of local governance rarely receive in-depth attention, even though they are key elements linking relationships and networks to policy innovation². Third, studies on HCG implementation in regions with limited institutional capacity and unique sociocultural contexts, such as eastern Indonesia, are almost non-existent in the international literature. Thus, there is little empirical evidence on how HCG principles operate in stages, interrelate, and interact within institutional asymmetry. Jeneponto Regency in South Sulawesi, Indonesia, offers a suitable empirical context to fill this gap. The regency already has relatively progressive regional regulations in the health sector, through Regional Regulation No. 6 of 2018, and cross-sectoral networks involving village

governments, educational institutions, and community organizations. However, the 2024 Community Satisfaction Index (IKM) data shows still low scores (75.07 for regional hospitals and 76.08 for community health centers), while digital public reviews indicate weaknesses in empathetic communication and service responsiveness. Meanwhile, various participatory forums and internal evaluation mechanisms are emerging as embryonic interactive and reflective practices. This situation illustrates the gap between normative structures and the internalization of HCG principles, making Jeneponto an important case study for understanding the dynamics of HCG implementation in a local context with limited capacity. The novelty of this research lies in three aspects. First, it shifts the focus from normative adoption to an analysis of the internalization process of HCG principles, specifically how the four principles (relational, network, interactive, and reflective) develop asynchronously and interact with each other within regional bureaucracies. Second, it provides an in-depth analysis of the interactive and reflective dimensions, which remain underexplored in the health governance literature, highlighting the role of internal reflection forums and citizen feedback mechanisms as catalysts for organizational epistemological change^{2,10}. Third, it provides empirical evidence from the local context of eastern Indonesia, which has been underrepresented in international discourse on human-centered governance. Thus, this study not only broadens the empirical base but also makes a theoretical contribution by highlighting the importance of sequencing and institutional capacity in realizing truly human-centered governance^{1,5}.

This study aims to analyze the implementation and internalization of HCG principles in healthcare governance in Jeneponto Regency, focusing on relational, network, interactive, and reflective dynamics. Theoretically, this study extends the transformative governance literature by providing an empirical model of how HCG principles operate in a complex and asymmetrical local governance context. Practically, this study provides strategic insights for local governments in strengthening participation mechanisms, policy reflection, and organizational learning to improve the quality of public healthcare services.

2. MATERIALS AND METHODS

This study uses a qualitative approach with an exploratory design to deeply understand the implementation and internalization of HCG principles in public health service governance in Jeneponto Regency. This approach was chosen because the research focuses not only on identifying the existence of HCG principles in formal policies but also on the dynamics of interactions between actors, organizational learning processes, and socio-cultural factors that shape health governance practices. In public governance studies, an exploratory qualitative approach is

considered relevant for uncovering institutional adaptation processes and relationship patterns that cannot always be captured through quantitative surveys^{2,5}.

The context of this research is Jeneponto Regency, South Sulawesi, Indonesia. Site selection was conducted purposively based on characteristics relevant to the research objectives. Jeneponto has a relatively progressive health regulatory framework through Regional Regulation No. 6 of 2018 and has established cross-sectoral networks involving village governments, educational institutions, and community organizations. However, data from the 2024 Community Satisfaction Index (CSI) shows that public satisfaction with health services remains low, at 75.07 for regional hospitals and 76.08 for community health centers. Digital public reviews also revealed weaknesses in empathetic communication and service responsiveness. This situation highlights a gap between institutional design and user experience, making Jeneponto an appropriate context to explore how HCG principles are internalized under conditions of limited institutional capacity.

Research data was collected through a combination of in-depth interviews, participant observation, and document analysis. Interviews were conducted with 24 key informants consisting of structural officials from the Health Office, leaders and health workers at community health centers, community leaders, and health service users. Semi-structured interviews were chosen to explore actors' experiences and perspectives on the application of relational, network, interactive, and reflective principles in public service practices. In addition, participant observation was conducted at several health facilities, including Lanto Dg. Pasewang Regional General Hospital and several community health centers. Observations focused on interactions between service providers and users, complaint mechanisms, and cross-actor coordination dynamics. Interview and observation data were supplemented by analysis of policy and institutional documents, such as Regional Regulation No. 6/2018, the 2024–2026 Health Office Strategic Plan, the 2024 IKM report, and public feedback through digital platforms. The use of these various data sources provides a comprehensive picture of the normative framework, institutional implementation, and public perception of health services.

The data analysis process was conducted using a thematic analysis approach as developed¹¹. The analysis began with a familiarization process with all the data obtained, followed by initial coding to identify patterns of meaning relevant to the four HCG principles. Next, themes were identified and grouped, reviewed to ensure thematic consistency, conceptually defined themes, and finally, systematically compiled thematic narratives. This approach combines Bason's (2017) theoretical framework with empirical findings through abductive reasoning, so that the analysis not only confirms existing theory but also opens up the possibility of new

contextual findings that enrich theoretical understanding³.

To ensure the validity of the data, this study employed a triangulation strategy of sources and methods. Information from interviews was validated through field observations and institutional documents, while member checking was conducted by re-engaging several key informants to confirm the researcher's interpretation of the data. Furthermore, *peer debriefing* with public health governance experts was conducted to check the consistency of the analysis and enhance the credibility of the findings. This validation approach aligns with high-standard qualitative research practices in public governance studies, which emphasize the importance of researcher reflexivity and traceability of the analysis process⁴.

To clarify the flow of thought and analytical focus of this research, Figure 1 presents an analytical framework that connects the principles of *Human-Centred Governance (HCG)* as proposed by Bason (2017) with the internalization process in the context of health service governance in Jeneponto Regency, as well as the resulting outcomes³. This framework shows how the four HCG principles—relational, networked, interactive, and reflective—serve as the starting point in the process of health service regulation and practice, are then mediated through mechanisms of institutional interaction and reflection, and ultimately contribute to service responsiveness, local policy innovation, and continuous organizational learning. This diagram serves as the primary reference in the thematic analysis process to identify patterns, relationships between principles, and governance dynamics that emerge in the field.

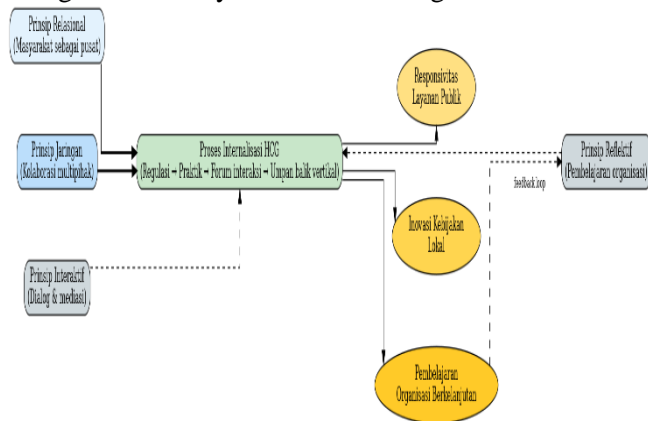


Figure 1. Research analysis framework.

3. RESULTS

This study adopted a qualitative approach to examine the extent to which HCG principles are internalized in health care policies, systems, and practices in Jeneponto Regency. Using thematic analysis¹¹, this study successfully identified and categorized key themes emerging from interviews, observations, and document analysis. The thematic analysis process began with data coding conducted on interview transcripts and observation notes, followed by identifying key themes related to the application of HCG principles in the health care sector. The application of HCG principles in

the health care sector in Jeneponto Regency demonstrates the extent to which relational, interactive, reflective, and networked principles have been internalized in public health care policies, systems, and practices.

Relational principle

The relational principle is one of the main dimensions of HCG As explained by Bason (2017), who emphasized the process of reframing organizational goals around the community, placing user experience at the center of the process, and strengthening multi-stakeholder networks in creating public value³. In the context of Jeneponto Regency, the application of relational principles is evident through the foundation of participatory policies and institutional structures, social interactions at the frontline of service, and community perceptions of health services. However, this research data shows that despite the strong structural foundation, relational implementation at the operational level still faces significant challenges, particularly in aspects of two-way communication, responsiveness, and consistency of user experience.

The relational foundation is reflected in Jeneponto Regency Regulation No. 6 of 2018, which serves as the legal basis for the healthcare system and explicitly regulates the role of the community as an integral part of the system. Informants from the structural level, such as the Head of the Health Office and the Director of the Regional General Hospital, stated that this regulation serves as a foundation for building government-community relations.

"The basis of our services remains Regional Regulation No. 6 of 2018, which is derived from national regulations. Therefore, the relationship between the government and the public in providing services is clearly regulated, including the role of the public." (Head of the Health Office, interview 2025).

This is reinforced by the 2024–2026 Health Office Strategic Plan, which explicitly states that the policy-making process will be conducted through a participatory approach and synchronized planning from the village to the central government, involving various stakeholders. This strategy aligns with the HCG principle of expanding collaborative networks as a means of creating public value.

At the operational level, interviews with health workers, community members, and technical officials revealed that provider-user relations in Jeneponto still face communication challenges and sociocultural sensitivities. Several informants described situations where people come to the service in an emotional state when expressing complaints, while officials do not always possess adequate empathetic communication skills.

"Sometimes people come in emotional, so staff must be able to handle them patiently and communicate effectively. Not all staff can do that." (Health Center Health Worker, interview 2025).

Furthermore, cultural factors and social status, such as

nobility or position, also influence communication patterns and the way services are delivered. The Director of the Regional General Hospital emphasized that communication and interaction must be tailored to the patient's social context to avoid triggering relational tensions. This demonstrates that the relational

dimension is not solely technocratic but also heavily influenced by local social and cultural norms.

To clarify the form and focus of relational interactions found in the field, the following is Table 1 which summarizes the research results related to relational principles:

Table 1. Relational Research Findings in Public Service Governance in the Health Sector in Jeneponto Regency

Relational Indicators	Description of Field Findings	Linkages to IKM 2024	Informant Source
Relations between the government and society	The relationship is regulated in <i>Regional Regulation No. 6/2018</i> which emphasizes the active role of the community; implementation is still limited to formal forums such as Musrenbangkes	Community involvement has not had a significant effect on satisfaction; the IKM decreased (76.10 → 75.07).	Head of Health Service
Relationship Between Service Provider and Patient	Empathetic communication is suboptimal; officers face challenges when handling emotional complaints.	The complaint element (75.00, C) shows the weakness of the two-way interaction mechanism.	Health Center Health Workers
Inter-Sector Relations (Health Sector and Other Sectors)	Synergy with schools and social institutions is ongoing, but is not routine and lacks joint evaluation.	The impact of cross-sector synergy has not been reflected in increased public satisfaction.	Director of Regional General Hospital
Relationships in the Health Team	Collaboration between medical personnel is quite good in internal services, but is still sectoral between health centers and hospitals.	Differences in service standards between facilities affect perceptions of service consistency.	Head of the Community Health Center
Relations with Non-Governmental Organizations (NGOs)	There is collaboration on public health programs (immunization, nutrition, stunting), but it is still project-based, not a long-term partnership.	Short-term impacts are visible, but have not yet had a sustained impact on the satisfaction index.	Health Service Officials
Relations with the Media	Local media plays a role in disseminating health education and issues, but coordination with the Health Office is still reactive (only during crises).	Public opinion management has not yet become an institutional communication strategy.	Public Relations of UPT Lanto Regional Hospital

Source: 2025 Research Processing Data

Table 1 shows that the inter-actor relationship in Jeneponto is not a single entity, but encompasses normative (rules and policies), social (communication and culture), and institutional (multi-stakeholder collaboration) aspects. This aligns with Bason (2017), who emphasized the importance of integrating structural and interactional dimensions in building human-centered governance³.

Another important aspect is the service user experience, which can be quantitatively observed through the 2024 Public Satisfaction Index (IKM) Report. IKM data shows that Lanto Dg. Pasewang Regional Hospital obtained a composite score of 75.07 (category C/Poor), with complaint handling at 75.00 (C). Meanwhile, the Community Health Center recorded an average score of 76.08 (C) with variations between elements: some elements such as politeness and punctuality received a "Good" score, but complaint management and service speed were still "Poor."

Table 2. Jeneponto 2024 IKM Data Related to Relational Aspects

Type of Service	IKM Value (2024)	Category	Relational Description
Lanto Dg. Pasewang Regional Hospital	75.07	C (Poor)	Complaint handling 75.00 (C); shows limitations in feedback mechanisms and two-way interaction
Rumbia Primary Hospital	74.19	C (Poor)	Variations between elements; aspects of complaint handling, Facilities and Infrastructure
Community Health Center	76.08	C (Poor)	Variation between elements; the politeness aspect is quite good but the complaint mechanism and speed of service are still weak; the user experience is not evenly distributed across all units.

Source: Jeneponto IKM Report, 2024

Table 2 shows a gap between policy design and actual user experiences. Although relational principles have been institutionalized, two-way communication mechanisms and user experience design remain limited, particularly in the areas of complaints and responsiveness. This finding reinforces interviews that demonstrated the challenges of interaction in situations of complaints and social differences.

This gap is further reinforced by digital public review data obtained through *Google Reviews*. Figure 6 shows public reviews of Lanto Dg. Pasewang Regional Hospital, with a rating of 2.8 out of 5 based on 153 reviews, reflecting a low level of public satisfaction. These public reviews report complaints about doctors being late, unfriendly service, discrimination against BPJS patients, and slow treatment of critically ill infants. This public testimony reinforces findings from interviews and IKM data, demonstrating a consistent pattern of complaints about communication, responsiveness, and treatment of BPJS users. Within Bason's (2017) framework, this reflects a failure to authentically reframe the provider-user relationship, where public voice has not been fully utilized as a basis for service improvements³.



Figure 2. User Testimonies on Hospital Services
Source: Google Reviews, 2025

The results of this study show that the relational principles in Jeneponto Regency have a strong normative and institutional framework, However, this has not yet been fully realized in the practice of empathetic, equitable, and participatory service delivery. Community involvement in planning and policy forums remains symbolic, the complaints system has not yet functioned as an organizational learning instrument, and communication patterns are still influenced by social hierarchy. To strengthen the application of relational principles within the HCG framework, efforts are needed to develop empathetic communication capacity for health workers, institutionalize cross-sector relational reflection forums, and transform organizational culture from bureaucratic to collaborative. This approach is expected to bridge the gap between regulations and user experience, while strengthening public trust in health care institutions in Jeneponto. Participatory planning and progressive regulations have not been fully accompanied by changes in

interaction patterns and communication mechanisms within health care. Interview data, IKM, and digital public complaints all demonstrate the need to strengthen empathetic communication, a responsive complaints system, and consistent service delivery across units, so that relational principles truly become the driving force of community-centered health governance.

Reflective principle

The reflective principle within the HCG framework (Bason, 2017) serves as a mediator and facilitator of new forms of interaction between public organizations, network actors, and end users. While the relational principle emphasizes empathetic relationships and the network principle builds collaborative structures across actors, the reflective principle demands the concrete operation of both principles through strategic dialogue, co-creation, ongoing two-way communication, and an iterative, empathy-based design process³.

In the context of Jeneponto Regency, the interactive principle is beginning to be seen through community participation mechanisms in health forums, the use of direct feedback channels at health facilities, and interactive activities such as face-to-face outreach and community-based health education. Various health service units, local governments, and community organizations act as facilitators to encourage residents to become active partners in the planning and evaluation of health services. One form of implementation of this principle is community forums and village health deliberations, where the community is involved not only as recipients of information but also as direct input on policies and program priorities. A technical official from the Health Office explained:

" We have a village health forum, where the community attends and provides input on the services they experience. We have several suggestions that we immediately follow up on in the community health center's work plan ." (Head of the Health Office, interview 2025)

Other forms of interaction emerge at the facility level. Some community health centers (Puskesmas) have developed direct feedback mechanisms through regular community meetings or suggestion boxes that are openly followed up. This provides a platform for building transparent, two-way communication between service providers and users. An interactive approach is also evident in health outreach activities, which are dialogical rather than one-way. Health workers report that group discussions with residents, particularly in rural areas, provide a deeper understanding of the barriers and habits of communities accessing services.

To clarify the various forms of interaction found, Table 3 below summarizes the research results related to the application of interactive principles.

Table 3. New Forms of Interaction in the Governance of Health Services in Jeneponto Regency.

Interactive Principle Aspects	Implementation Form	The Perpetrators Involved	Added Value / Impact	Constraint
Collaboration and active participation	Village health forum, planning meeting, community evaluation meeting	Health Service, Community Health Center, community	Users act as partners in program planning and evaluation.	Participation is not evenly distributed across all villages
Empathy and deep understanding	Community group discussions, direct interviews with users in the field	Field health workers, community leaders	Improve understanding of real user needs and barriers	It takes time and adequate human resource capacity.
Open and ongoing dialogue	Quarterly evaluation meetings, public feedback mechanisms (suggestion box, open meetings)	Community health center, community	Service transparency increases, complaints are handled quickly	Follow-up mechanisms are still inconsistent across several units.
Iterative and experimental approach	Improvement of health promotion programs based on user input	Health Service, Community Health Center	Programs become more adaptive and contextual	Documentation and evaluation of changes is still limited

Source: *Processed Research Data, 2025.*

Table 3 shows that interactive principles in Jeneponto Regency emerged through various forms of participatory collaboration and direct feedback, which brought service providers and the community together in a dialogue. However, its implementation still faces several obstacles, such as uneven participation across regions, limited human resources to facilitate in-depth dialogue, and inconsistent feedback follow-up mechanisms.

Conceptually, these findings confirm Bason's (2017) notion that interactivity is an operational prerequisite for relational

and networked governance³. Without concrete interactive mechanisms, empathetic relationships and multi-stakeholder network structures will be ineffective in generating public value. Sustained two-way interaction enables the government to gain a deeper understanding of the social context, strengthen community ownership of health policies, and create service innovations based on real needs.

Reflective Principle

The reflective principle within the *Human-Centred Governance framework* (Bason, 2017) represents an epistemological shift in public service delivery from mere policy implementation to a continuous organizational learning process³. Through this principle, public organizations focus not only on external relationships, networks, and interactions but also on building internal capabilities to systematically learn, evaluate, and adapt. Reflection serves as a means for local governments to ensure that public policies and services are not only contextually relevant but also continuously evolve through a cycle of learning, data-driven decision-making, and critical evaluation of existing assumptions and practices.

In the context of Jeneponto Regency, reflective principles have emerged in routine evaluation mechanisms, the use of community satisfaction survey data, and internal discussions across units to improve health services. Informants from the Health Office emphasized the importance of periodically evaluating program implementation to identify achievements and obstacles, thus providing a basis for developing the following year's activity plan. These evaluations are not merely administrative in nature but are also used to study patterns of program success and failure. For example, in the screening program for productive age and elderly, field performance data showed variations across community health centers (Puskesmas). This information was used to adjust implementation strategies the following year, such as changing outreach patterns and service scheduling.

In addition to program evaluation, community satisfaction survey (CSI) data is also a crucial tool in the reflection process. The Health Office uses CSI results to identify weaknesses in service elements, such as complaint handling and speed of service in several units. This data is then discussed in an internal, cross-sectoral forum to inform the formulation of corrective measures and procedural improvements. This is as stated by the Head of the Health Office's Service Division:

“We don't stop with the IKM survey. We bring the results to an internal meeting and discuss them together, especially those aspects with low scores. From there, we make improvements, such as standard operating procedures (SOPs) for complaints and the division of duties for officers,” (Head of the Health Office, interview 2025).

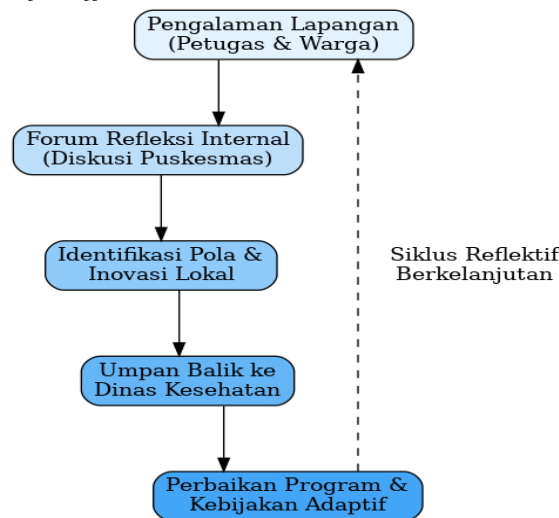


Figure 3. Reflective process in the governance of health services in Jeneponto Regency

The reflective process in healthcare governance in Jeneponto Regency takes place not only through annual evaluation mechanisms or analysis of satisfaction survey data, but also through a systematic organizational learning cycle. Figure 3 shows how field experience serves as the starting point for this process, as health workers interact directly with the community and encounter various obstacles and new patterns in program implementation. These experiences are then incorporated into internal reflection forums at the community health center level, which serve as open discussion spaces for analyzing obstacles and collectively seeking solutions.

Through this process, service units are able to identify contextual local patterns and innovations, such as adjusting outreach strategies or changing service times based on real-world community conditions. These findings and innovations don't stop at the local level, but are instead sent as vertical feedback to the Health Office, which then forms the basis for program evaluation, improving standard operating procedures (SOPs), or adjusting policies at the district level. The final stage of this process is adaptive program and policy improvements, which are then re-implemented in the field. This cycle continues to repeat itself, forming a "continuous reflective cycle," as indicated by the dotted arrow in Figure 3, ensuring that public policies and services remain relevant, adaptive, and based on the real experiences of

users.

Figure 3 not only represents the conceptual framework but also reflects actual practices occurring within the regional health system. This reflective process does not stand alone but is operationalized through various evaluation mechanisms, data-driven decision-making, critical discussion forums, and policy adaptation at various organizational levels. To demonstrate how this reflective principle is systematically implemented, Table 4 below summarizes the key aspects of the reflective principle, its implementation, the actors involved, the objectives achieved, and the challenges encountered. This table demonstrates how the process of learning from experience and using data shapes a reflective culture that underpins the adaptive policy cycle in Jenepono Regency.

Table 4. Reflective Governance Practices in the Public Health Service System of Jenepono Regency

Reflective Principle Aspects	Implementation Form	Actors Involved	Goal / Impact	Constraint
Learning from experience	Annual evaluation of health programs, identification of achievement vs. obstacle patterns	Health Service, Community Health Center	Improve program planning for next year	Evaluation still focuses on quantitative indicators
Data-driven decision making	Utilization of IKM results and program achievement data in evaluation meetings	Department of Health, Service Division	Formulate corrective policies and improve service SOPs	Data analysis capacity is still limited at the community health center level
Policy adaptability	Adjustment of implementation strategy based on evaluation results and field data	Health Service, Community Health Center	Programs become more flexible and responsive to variations in local contexts.	The adaptation process has not been systematically documented.
Critical thinking	Internal discussion forum, hear the experiences of field officers	Health workers, heads of health centers	Innovation emerges from real-world experiences and field perspectives.	The culture of critical discussion is not yet evenly distributed across all units.
Organizational learning culture	An evaluation–planning cycle that repeats annually	Health Service, all areas	Organizational learning is built through an annual cycle of reflection and deliberation.	There is no formal mechanism for documenting learning.

Source: Researcher's Process, 2025

Table 4 shows that reflective processes have begun to take root through regular evaluations, analysis of community satisfaction data, internal focus groups, and local policy adaptations. However, implementing these principles still faces challenges such as a tendency toward quantitative evaluation, uneven data analysis capacity, and the lack of a formal organizational learning documentation system.

Conceptually, these findings confirm Bason's (2017) view that the reflective principle marks an epistemological shift in governance: public organizations are no longer merely policy implementers, but also knowledge producers and active learners³. By leveraging experience, data, and internal dialogue as sources of reflection, healthcare governance in Jenepono has the potential to become more adaptive, innovative, and contextual. This reflection also reinforces the three previous principles—relational, networked, and interactive—by providing systemic feedback that maintains the relevance and sustainability of public policy the local level.

4. DISCUSSION

The application of HCG principles to healthcare governance in Jenepono Regency exhibits unique dynamics compared to Bason's (2017) initial theoretical framework. In Bason's model, the shift toward human-centered governance is assumed to occur simultaneously across relational, network, interactive, and reflective dimensions³. However, field findings indicate an imbalance between the structural and epistemological dimensions, with relational and network principles being more prominent, while

interactive and reflective principles are still developing sporadically. This phenomenon demonstrates that HCG implementation is not linear, but rather relies on different sequencing and institutional capacities¹⁻⁷.

The reflective principle is crucial in this context. As demonstrated by field findings, annual evaluation mechanisms and internal discussion forums have become primary channels for organizational learning. However, these processes generate more episodic learning than continuous learning. ¹⁰Found a similar phenomenon in the context of local government in the

Netherlands: evaluation data is available but used administratively, not as a basis for policy innovation. This situation indicates an evidence-practice gap, which also exists in Jeneponto, where reflection does not fully function as a strategic feedback mechanism for policy adaptation.

Furthermore, policy adaptation patterns remain reactive to problems, rather than proactively addressing changes in the social and technological context.⁶Emphasize that adaptive governance requires a continuous cycle of strategic reflection based on cross-actor learning. However, findings from Jeneponto indicate that policy improvements occur primarily when obstacles arise, rather than through planned reflection on public health trends. This suggests that the reflective principle has not yet functioned as a systemic feedback loop, but rather at the ad hoc stage and through individual initiatives.

The interactive principle also demonstrates a dynamic that strengthens this analysis. Despite the existence of participatory forums, citizen and stakeholder engagement remains fragmented and uneven across service areas. This condition reflects the phenomenon of asymmetric interactivity often found in developing country contexts, where institutional capacity determines the quality of participation^{4,12}. In the Jeneponto case, only units with strong leadership and adequate human resources were able to facilitate meaningful interactions, while other units remained top-down. This finding extends the co-creation literature by demonstrating that substantive participation depends heavily on the local institutional ecosystem, not just procedural design.

Relational and network principles appear more established because they are supported by regional regulations and clear institutional structures. However, as¹³note, the existence of a policy framework does not automatically result in changes in actor behavior. In the Jeneponto context, government-community relations have been facilitated through formal mechanisms, but they remain one-way and normative. Network principles have opened up space for multi-stakeholder collaboration, but have not yet been stably institutionalized. This aligns with¹⁴analysis that collaboration without an institutional foundation tends to be programmatic and momentum-dependent.

The synthesis of these four principles shows that the integration of HCG principles in Jeneponto is still partial and does not fully establish a reflective and adaptive governance cycle. Relational and network principles serve as structural foundations, but interactive and reflective principles are the primary drivers of the organization's epistemological shift². When interactive and reflective principles are weak, feedback and organizational learning processes are limited, making policy innovation difficult to sustain. This finding indicates the need for a sequencing strategy in HCG implementation: strengthening

analytical capacity and a culture of reflection first before expecting comprehensive transformation^{1,5}.

Thus, the main contribution of this analysis is to demonstrate that the implementation of HCG principles at the local level faces not only resource constraints but also epistemological and organizational cultural barriers. The application of relational and network principles without strengthening the reflective dimension will result in governance that is structurally stable but lacking in innovation. Conversely, strengthening reflective principles can create a learning cycle that enables health systems to respond to change adaptively and participatively, as emphasized in the *transformative governance literature*^{4,7}.

Funding

This study confirms that the implementation of Human-Centred Governance (HCG) principles in healthcare governance in Jeneponto Regency is in a transition phase from a normative structure to a more adaptive institutional learning. The four HCG principles—relational, network, interactive, and reflective—have been internalized in various policies and practices, but with varying depth and consistency. The relational and network principles have received strong structural support through regional regulations, multi-stakeholder collaboration mechanisms, and participatory cross-level planning. However, the interactive and reflective principles, which are the primary drivers of the epistemological transformation of public organizations, are still underdeveloped, resulting in the organizational learning process not being fully institutionalized.

This imbalance demonstrates that HCG implementation is not linear. Institutional structures and collaborative networks do not automatically generate meaningful interactions and ongoing policy reflection. Instead, analytical capacity, organizational culture, and strategic feedback mechanisms are key factors in the successful transition to truly human-centered governance. In the Jeneponto context, interactive practices remain asymmetrical—dependent on unit capacity and leadership—while reflective practices tend to be episodic and focused on quantitative indicators rather than substantive learning. This pattern demonstrates the evidence-practice gap and implementation gap that hinder the realization of adaptive and participatory health governance.

This research broadens understanding of the application of HCG principles in the context of local governance in developing countries. Findings indicate that the four principles do not develop simultaneously, but rather require sequencing and strengthening of institutional capacity to build an integrative governance cycle. Relational and network principles serve as structural foundations, while interactive and reflective principles catalyze epistemological change and policy innovation. These findings enrich the literature on transformative governance and co-

creation by demonstrating that the primary barriers to HCG implementation are often epistemological and organizational cultural, rather than simply technical resources.

Furthermore, the results of this study underscore the importance of strengthening mechanisms for reflection and strategic interaction at all levels of health governance. Local governments need to develop more qualitative, data-driven evaluation systems, expand critical discussions across actors, and systematically document organizational learning. With these steps, the HCG principles can serve not only as a normative framework but also as an operational mechanism to ensure public policies and services remain relevant to the dynamic needs of the community.

REFERENCES

1. Chohan, U. W. (2023). Human-centered governance in emerging contexts. *Policy Design and Practice*, 6(3), 335–349. <https://doi.org/10.1080/25741292.2023.2194628>
2. Turnhout, E., Dewulf, A., & Hulme, M. (2023). Rethinking reflexivity in governance. *Policy Sciences*, 56(1), 91–111. <https://doi.org/10.1007/s11077-022-09478-3>
3. Bason, C. (2017). *Leading public design: Human-centered governance*. Policy Press.
4. Meijer, A., Bekkers, V., & Torfing, J. (2021). Reflexivity in public governance: A framework for analysis. *Public Management Review*, 23(10), 1520–1537. <https://doi.org/10.1080/14719037.2020.1775282>
5. Chaffin, B. C., Schultz, L., & Brunner, R. D. (2022). Adaptive governance and complex health systems. *Public Administration Review*, 82(5), 851–863. <https://doi.org/10.1111/puar.13584>
6. Brunner, R. D., Chaffin, B. C., & Schultz, L. (2024). Progress in adaptive governance research. *Discover Sustainability*, 4(1), 15. <https://doi.org/10.1007/s43621-023-00124-4>
7. Sørensen, E., & Torfing, J. (2021). *Transforming governance through networked leadership*. Cambridge University Press.
8. El-Jardali, F., Hemadeh, R., Jaafar, M., & Jamal, D. (2021). Health system governance in low- and middle-income countries: A systematic review. *Health Policy and Planning*, 36(5), 651–663. <https://doi.org/10.1093/heapol/czaa186>
9. Lembani, M., Blaauw, D., & Gilson, L. (2023). Learning in health system governance: Opportunities and barriers. *International Journal of Health Policy and Management*, 12(7), 456–470. <https://doi.org/10.34172/ijhpm.2022.6657>
10. Maris, S., van Buuren, A., & Edelenbos, J. (2023). Understanding evidence–practice gaps in local health governance. *Evidence & Policy*, 19(3), 377–397. <https://doi.org/10.1332/174426423X16765455158813>
11. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
12. Voorberg, W. H., Bekkers, V. J., & Tummers, L. G. (2015). A systematic review of co-creation and co-production: Embarking on the social innovation journey. *Public Management Review*, 17(9), 1333–1357. <https://doi.org/10.1080/14719037.2014.930505>
13. Pressman, J. L., & Wildavsky, A. (2020). *Implementation: How great expectations in Washington are dashed in Oakland*. University of California Press.
14. Emerson, K., & Nabatchi, T. (2015). *Collaborative governance regimes*. Georgetown University Press.