



Collaborative Governance in Strengthening Hospital Environmental Security: The Phenomenon of Overcrowding of Visitors at Kaimana Hospital

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Abstract. *This study analyzes the application of collaborative governance in overcoming the phenomenon of overcrowding of visitors and its impact on environmental security at Kaimana Hospital, West Papua. The background of the research is based on the imbalance in the capacity of hospital infrastructure (serving 65,490 people) with the high number of visits, exacerbated by the habit of the community transporting patients en masse and the massive use of JKN services. The descriptive qualitative method is used with data collection techniques through semi-structured interviews, observations, and visual documentation. The analysis refers to the theory of Ansell and Gash (2008) which includes starting conditions, institutional design, facilitative leadership, collaborative process, and outcome. The results of the study show that efforts such as limiting visiting hours and the construction of halfway houses are not optimal due to less participatory policy design, lack of structured dialogue between stakeholders, and top-down leadership. Overcrowding is triggered by narrow waiting rooms, limited facilities, and the disintegration of the queue system. Despite collaborative initiatives, the results are still partial due to weak cross-sector coordination and low community participation. Strategic suggestions include infrastructure improvement, the development of an integrated digital queuing system, intensive socialization, and the formation of collaborative teams across sectors (RSUD, government, TNI/POLRI, and the community). Conflict management training, periodic evaluation, and participatory leadership approaches are also needed to create sustainable service transformation. This study emphasizes that inclusive and transparent collaboration is the key to overcoming overcrowding and strengthening the safety of the hospital environment.*

Keywords: Collaborative Governance, Overcrowding, Hospital Environmental Safety, Kaimana Hospital.

1. INTRODUCTION

Hospitals are such an important institution in the daily lives of people, moreover the existence of hospitals in Indonesia, precisely in Kaimana Regency, which is so limited, in one district there is only one hospital, namely Kaimana Hospital which operates to serve 65,490 people (BPS Kaimana Data 2023). In contrast to other districts in Manokwari, the number of hospitals is 7 hospitals that serve a total population of 200,785 people in Manokwari Regency (BPS Manokwari Data 2022). Hospitals are the leading agencies of healthcare providers (Dewi et al. 2023), of course, in providing health services, we must provide excellent service for the community, even more so provide inclusive services (Lafrense et al. 2024).

Table 1. Number of General Hospitals, Special Hospitals, Health Centers, Primary Clinics, and Posyandu by District in Kaimana Regency 2023

District	Number of Special Hospitals	Number of General Hospitals	Number of Inpatient Health Centers	Number of Non-Inpatient Health Centers	Number of Primary Clinics	Number of Posyandu
Buruway	–	–	–	2	–	11
Arguni Bay	–	–	1	1	–	19
Lower Arguni Bay	–	–	–	1	–	13
Waitress	1	–	–	2	1	27
Kambrau	–	–	–	1	–	7
Gulf of Etna	–	–	1	–	–	6
Yamor	–	–	–	1	–	8
Waitress	1	–	2	8	1	91
Buruway	–	–	–	2	–	11

Source : Kaimana Regency Health Office.

The condition of health facilities in Kaimana Regency in 2023 shows inequality between sub-districts. Kaimana District is the main service center with the most complete facilities, including 1 special hospital, 2 inpatient health centers, 8 non-inpatient health centers, 1 primary clinic, and 91 posyandu. On the other hand, other sub-districts such as Buruway, Teluk Arguni Tengah, Kambran, and Yamor only rely on non-inpatient health centers and posyandu, without public or special hospitals. Posyandu dominates the spread of health facilities, especially in Kaimana (91 units) and Teluk Arguni (19 units). However, there are data irregularities such as duplication of entries in Kaimana and Buruway Districts, as well as the lack of primary clinics outside Kaimana. Meanwhile, public hospitals are not recorded in all sub-districts, indicating dependence on basic services and unequal access to advanced health facilities. Therefore, in the limited access to health, it is necessary to provide maximum and inclusive services(Lubis et al. 2024).

Service inclusivity is the main key in providing quality of service in the world of health(Ras et al. 2024), the quality of health services is very important for the quality of health. The quality of health services can be known in terms of the form, appearance, performance of a service, and can also be seen in terms of its function and aesthetic aspects (Ahmad Fachrurrozi et al. 2023). As an effort to improve service performance, there is a concept called *Collaborative Governance*.

According to Ansell and Gash *Collaborative Governance* is a governance arrangement in which one or more public institutions directly involve non-government stakeholders in a formal, consensus-oriented, and deliberative decision-making process. This approach is designed to formulate or implement public policy, manage public programs, or manage public

assets. Collaboration is a stage to give birth to a service innovation in the public sector, therefore collaboration in innovation seems endless to always be discussed by the government and other organizations and sectors. (Permini et al. 2023)

In the collaboration process, of course, there needs to be an equalization of the perception that problems will be shared as a form of commitment to jointly achieve the goals that have been set (Andi Lestari 2021). In this case, visitor density is a problem that must be solved, because in the public service sector, the occurrence of cases of an explosion of hospital visitors will cause serious impacts if not resolved properly (Intihan et al. 2023). From ensuring full compliance with regulations to building a strong safety culture, there is still room for improvement and innovation in an effort to create a truly safe and risk-free work environment. (Ernanda 2023)

Density or *Overcrowded* in an emergency installation is a situation or situation that occurs due to increased demand or health visits and is not balanced with the situation and circumstances in the emergency installation (Subandi, A. & Noerjoedianto, D. 2021). If there is an imbalance between the availability in each installation and the number of patient visits, it will have an impact on increasing the waiting time of patients in the emergency room, so that this can cause an accumulation or population density called *Overcrowded* (Subandi and Noerjoedianto 2021).

Table 2. Data on New Patients and Length of Hospitalization at Kaimana Hospital in 2024

No.	MOON	GENDER		SUM	VISITORS		SUM
		MAN	WOMAN		NEW	OLD	
1	JANUARI	129	174	303	98	205	303
2	FEBRUARY	98	172	270	73	197	270
3	MARCH	114	176	290	103	187	290
4	APRIL	145	228	373	125	248	373
5	MAY	137	225	362	96	266	362
6	JUNI	69	62	131	133	222	355
7	JULY	118	195	313	127	186	313
8	AUGUST	118	182	300	95	205	300
9	SEPTEMBER	127	159	286	88	198	286
10	OCTOBER	125	199	324	110	214	324
11	NOVEMBER	99	159	258	58	198	256
12	DECEMBER	148	174	322	97	188	285
SUM		1427	2105	3532	1203	2514	3717

Source: Personal

Based on data from Kaimana Hospital in 2024, it can be seen that inpatients are dominated by women with a total of 2,105 people (59.6%) compared to men (1,427 people), as well as more old patients (2,514) than new patients (1,203). The number of patients per month varied, with April being the busiest month (373 patients) and June being the lowest

month (131 patients). However, there were inconsistencies in the data, such as in June which showed total visitors (355) exceeding the number of patients (131), as well as the annual total difference between patients (3,532) and visitors (3,717). The predominance of female patients and the high proportion of long-term patients indicate a possible pattern of repeat visits or the need for long-term care. In this case, the collaboration process is the right solution in solving the problem that is happening (Sarifah and Nurita 2023).

Collaborative governance is a process that has certain regulations that are implemented together and interact for mutual benefit between the stakeholders involved (R. Feri, et al, 2024). This model was initiated by Ansell and Gash who explained that collaborative governance is a concept that is important in a condition where public actors and private actors (businesses) work together in certain ways and processes that will later produce legal products, rules, and policies that are appropriate for the public or society. (Permini, et al., 2023)

The concept of collaborative governance has become the main approach in addressing complex problems in the public sector, including the hospital environment. According to Ansell and Gash (2008), collaborative governance refers to the collaborative process between the government, the private sector, and civil society to achieve shared decisions through participatory dialogue. In the context of hospitals, this model is relevant to address challenges such as overcrowding of visitors, which impacts environmental safety, service quality, and disease transmission risk (Carayon et al. 2014)

The issue of hospital environmental security does not only include physical aspects, such as spatial planning and facilities, but also risk management due to visitor density. Overcrowding can increase the potential for conflict, theft, and disruption of medical procedures (Rinaldi and Arifin 2024). This emphasizes the importance of integration between hospital policies, community participation, and local government support in creating a safe environment. This overcrowding phenomenon led researchers to assess and see the problems that occurred using the collaborative governance theory approach by Ansell and Gash so that this study aims to find out the process of collaboration between Kaimana Hospital and the government and the community in supporting the order and security of the hospital environment, and aims to find the best solution in overcoming overcrowding of visitors at Kaimana Hospital.

2. METHOD

This study uses a descriptive qualitative approach to analyze the phenomenon *Overcrowding* visitors at Kaimana Hospital in the context of *Collaborative Governance* and the safety of the hospital environment. The research location was focused on the public areas of Kaimana Hospital, West Papua, such as the lobby, waiting room, and emergency room, with a data collection period of one month.

Data was collected through three main techniques: semi-structured interviews, direct observation, and visual documentation. Interviews were conducted with participants consisting of hospital staff, nurses and management as well as visitors/patients. The interview questions are openly designed to explore perceptions, challenges, and experiences related to visitor density, the interview process is recorded with the consent of the participants, then transcribed for in-depth analysis.

Observations are carried out at busy times, such as mornings and weekends, to record visit patterns, interactions between visitors, and the response of officers in managing crowds. The aspects observed included compliance with visiting rules, availability of supporting facilities, and indicators of security disturbances. In addition, visual documentation in the form of photos and videos is used to reinforce observational findings, such as queue conditions or overlapping activities.

Secondary data was obtained from internal documents of Kaimana Hospital, such as annual reports, and security incident archives. This data is complementary to contextualize field findings. The study adheres to ethical principles, including the anonymity of participants (codes: S1, S2 for staff; P1, P2 for visitors) and written permission from Kaimana Hospital. The limitations of the study include the potential for participant bias in conveying subjective experiences as well as the contextual nature of the findings so that they cannot be generalized to other hospitals. However, a descriptive qualitative approach was chosen to provide a holistic picture of the complexity of the phenomenon *Overcrowding* within the framework of collaborative governance.

3. RESEARCH RESULTS

Based on the analysis of interview and observation data at Kaimana Hospital, the application of collaborative governance in overcrowding and environmental security can be described through four main indicators of Ansell and Gash (2008) theory: Starting Conditions, Institutional Design, Facilitative Leadership, Collaborative Process (including face-to-face dialogue, trust building, commitment to process, shared understanding, and intermediate

outcomes), and Outcome. Here's an explanation of each indicator:

Starting Conditions

The initial conditions become the foundation of the collaboration, including the driving factors, the history of the relationship between the parties, and the resources available. Inclusive development will be more ideal if communication between parties continues to be well established (Priyanto and Hentika 2024). At Kaimana Hospital, overcrowding is caused by an imbalance between the hospital's infrastructure capacity (narrow waiting rooms, limited facilities) and the high number of visits (65,490 people served by one hospital). The massive use of JKN services and the habit of people to take sick families en masse exacerbates overcrowding. As stated by the visitor (P1): *"The density occurs because the place is not large... Seats need to be expanded"*. In addition, the lack of specialist doctors and the community's dependence on Kaimana Hospital as the only hospital in the district emphasized the urgency of collaboration.



Figure 1. Queue Conditions for Visitors to Kaimana Hospital

Source: Private

Historically, the relationship between Kaimana Hospital, the local government, and the community has not been built optimally. Although the government has built halfway houses to reduce overcrowding, the distance from the patient care area has led to low community participation. The hospital staff (S2) stated: *"The halfway house has not helped because visitors are more comfortable in the lobby"*. This shows the unpreparedness of physical and social resources as a prerequisite for collaboration. Thus, the starting conditions at Kaimana Hospital are dominated by structural pressures (resource scarcity) and coordination gaps between parties, which require collaborative interventions to achieve sustainable solutions.

Institutional Design

Institutional design refers to the formal structures that govern collaboration, including policies, rules, and coordination mechanisms. Kaimana Hospital has implemented several policies, such as limiting visiting hours and building halfway houses. However, its implementation has not been effective due to a lack of participatory design. For example, the policy of limiting visiting hours is not accompanied by an adequate digital queue system or socialization, so visitors often violate the rules (S1: "Some visitors come outside visiting hours").

Halfway houses as a physical solution are also not designed to meet the needs of urban visitors. As explained by S2: "The halfway house is only for patients from the village, not the families of city visitors". This reflects a lack of integration between policy design and the real needs of the community. In addition, the absence of an official mechanism to involve the TNI/POLRI in the enforcement of discipline shows the weakness of the institutional design. Although the staff stated the need for collaboration with the TNI/POLRI ("They are government partners who are obliged to carry out security duties"), there is no clear operational structure. Thus, existing institutional designs have not been able to create an inclusive and adaptive collaborative framework.

Facilitative Leadership

Facilitative leadership plays a role in directing collaborative processes, ensuring active participation, and resolving conflicts. At Kaimana Hospital, the role of hospital management can be seen in an effort to integrate an online information system for administrative order. However, leadership has not been optimal in building synergy between parties. For example, even though hospitals have coordinated with the government to build halfway houses, the lack of socialization leads to low public understanding (P3: "I never tried halfway houses because I didn't understand"). The limitation of officer training is also an obstacle. S3 revealed: "Conflict management training is needed for staff". This shows that leadership is not yet fully able to empower human resources. In addition, the lack of initiatives to involve communities in policy formulation (e.g. through dialogue forums) reflects a lack of a participatory approach. Thus, the leadership at Kaimana Hospital is still top-down and has not fully facilitated multistakeholder involvement.

Collaborative Process

The collaborative process consists of five key elements:

Face-to-Face Dialogue

Face-to-face dialogue is a means to equalize perceptions and formulate solutions (Sitompul and Indahdewi 2024). At Kaimana Hospital, limited dialogue takes place between hospital staff and visitors, such as in queue arrangements. However, there are no structured forums involving the government or the community. For example, a visitor (P2) complained: "The manual queuing system made us wait a long time", but there is no mechanism to relay these complaints to the policy level. The dialogue that takes place is reactive, not part of a collaborative strategy.

Trust Building

Trust between parties is built through transparency and consistency (Rahmawati et al. 2024). Although Kaimana Hospital has made efforts to improve services (for example with halfway houses), inconsistencies in the enforcement of rules undermine trust. S1 stated: "The effectiveness of the policy is still low because visitors are not compliant". On the other hand, people feel that policies are not responsive to their needs (P1: "Seats should be added"). Lack of transparency in resource allocation (e.g. reasons for long halfway house distances) also reduces trust in institutions.

Commitment to Process

The commitment to the collaboration process can be seen from the efforts of Kaimana Hospital to adopt an online information system and the government to build a halfway house.



Figure 2. Kaimana Hospital Shelter

Source: Private

However, this commitment has not been balanced with consistency. For example, halfway houses are not functioning optimally due to lack of operational budget (S2: "Halfway houses already exist but are not optimal"). In addition, the absence of sanctions for violators of the visit rules shows a weak commitment to policy enforcement.

Shared Understanding

A shared understanding of the problem and the solution is still partial. Hospital staff understand overcrowding as a physical capacity issue (Q1: "Limited waiting space is the main obstacle"),



Figure 3. Condition of Limited Waiting Room at Kaimana Hospital

Source: Private

While visitors emphasize psychological discomfort (P2: "It's very uncomfortable to stand for a long time"). Local governments, on the other hand, focus on infrastructure solutions such as halfway houses without considering community preferences. This difference in perception hinders the creation of holistic solutions.

Intermediate Outcomes

The intermediate results of the collaboration process can be seen in the construction of halfway houses and the implementation of information systems. However, neither has resulted in significant changes. The halfway house does not reduce the density in the lobby due to its remote location, while the information system has not been integrated with patient services. S3 admits: "The online system is only for administration, not yet for queues". Thus, intermediate outcomes are not yet a strong foundation for achieving the final outcome.

Outcome

The outcome is the end result of the collaborative governance process that reflects the effectiveness of collaboration in achieving common goals, such as improving public services, reducing conflicts, and improving conditions that are the focus of collaboration. Based on the results of the analysis of the previous indicators (starting conditions, institutional design, facilitative leadership, and collaborative process), the outcome of the implementation of collaborative governance at Kaimana Hospital is still partial and has not shown optimal results. Efforts such as the construction of shelters and the implementation of online information systems show that there are initiatives towards cross-actor collaboration, but their implementation has not been able to address the root causes of overcrowding and environmental security as a whole. The mismatch between policy design and community needs, weak facilitative leadership, and lack of an inclusive dialogue process have caused the resulting outcomes to not be able to create significant changes. Kaimana Hospital still faces challenges in terms of infrastructure capacity, visitor compliance with rules, and low public participation in policy formulation and implementation. Thus, the results achieved do not represent the success of the collaboration substantively, but only show the initial steps that require design improvement, leadership strengthening, and intensification of participation and trust between stakeholders to create sustainable service transformation.

Supporting and Inhibiting Factors of the Collaborative Governance Process at Kaimana Regional General Hospital.

The legal basis in the form of Law No. 25 of 2009 concerning Public Services provides a legal umbrella for the active involvement of local governments, hospital management, and the community in formulating and implementing security and order policies within Kaimana Hospital. The joint commitment of the management of the hospital and the Regional Government in implementing restrictions on visiting hours and building halfway houses shows a collective awareness to reduce the density of visitors that have the potential to disrupt security. The adoption of a digital information system for administration, which can be developed into an online queuing system, opens up opportunities for data transparency and rapid response to overcrowding situations although the implementation still needs to be refined. In addition, the plan to involve TNI/POLRI officers in the enforcement of discipline adds a more structured security dimension so as to strengthen the legitimacy of collaborative policies. Shared awareness of the health and safety risks of overcrowding, such as potential disease transmission and disruption of medical procedures, encourages all stakeholders to actively participate in

finding common solutions.

Limited physical infrastructure, including cramped waiting rooms and the location of halfway houses far from the care area, hampered the effective redistribution of visitors. The absence of an integrated queue system causes instability and prolonged complaints because adequate digital queuing applications are not yet available. Public participation is relatively low due to the socialization of the visit and halfway house policy that is not comprehensive, so that the public does not understand the alternatives provided. Facilitative leadership, which is still top-down, is characterized by a lack of conflict management training for staff and a lack of multistakeholder dialogue forums that limit the space for inclusive policy formulation. Coordination between institutions has not been formalized, so routine communication between hospitals, local governments, the TNI/POLRI, and the community is not optimal. Inconsistencies in law enforcement, such as violations of visiting hours left unsanctioned, undermine mutual trust and commitment. Finally, limited operational budgets for shelters and limited security and administrative staff further complicate the implementation of sustainable collaborative policies.

4. CONCLUSION

This study analyzes the application of *Collaborative Governance* in overcoming the phenomenon *Overcrowding* visitors and their impact on environmental safety at Kaimana Hospital, West Papua. Based on the findings, it can be concluded that *Overcrowding* at Kaimana Hospital is caused by an imbalance between the hospital's infrastructure capacity (narrow waiting rooms, limited facilities) and the high number of visits, massive use of JKN services, and the habit of the community to transport patients en masse. Mitigation efforts such as limiting visiting hours and building halfway houses have been carried out, but they have not been optimal due to the lack of community participation, the distance of the halfway house far from the treatment area, and the absence of an integrated digital queue system.

Application *Collaborative Governance* at Kaimana Hospital still faces a number of challenges. Overcrowding is triggered by cramped waiting rooms, limited facilities, and incoherence of the queue system (Warsono et al. 2020). From the aspect *Starting conditions*, structural pressures such as resource limitations and coordination gaps between parties are the main obstacles. *Institutional design* less participatory, such as policies limiting visiting hours without a digital queue system, reduce the effectiveness of implementation. Facilitative leadership that is still in nature *top-down* and the lack of structured dialogue between stakeholders also hinders the collaboration process. On the other hand, the commitment of the

local government and hospital management in building halfway houses and adopting online information systems are supporting factors that have the potential to be further developed.

The results of the implementation of *collaborative governance* to date are still partial. Collaborative initiatives such as the construction of shelters and administrative information systems have not been able to address the root causes of *overcrowding* and environmental security holistically. This is due to the misalignment between policy design and the real needs of the community, weak cross-sector coordination, and low public participation in policy formulation.

SUGGESTION

Based on the findings and conclusions of the research, the following strategic suggestions were conveyed to various stakeholders to optimize the implementation of *collaborative governance* in *overcrowding* and strengthen environmental safety at Kaimana Hospital, West Papua:

Local governments and the Health Office must prioritize increasing infrastructure capacity, such as building additional waiting rooms and supporting facilities (toilets, rest areas), as well as revising the location of halfway houses to be closer to treatment areas or providing free transportation for visitors. On the technology side, the development of an integrated digital queuing system including online registration, notifications via SMS/WhatsApp, and real-time information screens needs to be budgeted to reduce confusion and disorder in queues. The management of Kaimana Hospital can also optimize the administrative system by integrating data with health centers and primary clinics to reduce the burden of direct visits.

Community participation must be increased through intensive socialization about visiting hours policy, the benefits of halfway houses, and the importance of discipline. This socialization can be carried out via local media, community leaders, or regular dialogue forums involving visitor representatives, hospital staff, and local governments. Community organizations and NGOs can play an active role in public awareness campaigns about the risks of overcrowding and hospital discipline. In addition, education on the use of non-emergency health services in health centers needs to be intensified to divert pressure from hospitals.

Cross-sector synergy must be strengthened by forming a collaborative team between hospitals, health offices, the TNI/POLRI, and the community. The team can design discipline enforcement protocols, including strict sanctions for rule violators, as well as conduct joint training for security officers and staff in crowd management and conflict resolution. The Ministry of Health also needs to develop national guidelines on adaptive visitor governance,

equipped with incentives for well-performing regions.

Leadership at Kaimana Hospital needs to be directed towards a participatory approach by involving field staff in policy formulation through periodic internal meetings. Conflict management and multistakeholder communication training for staff is also needed to increase response capacity to overcrowding. Local governments must ensure long-term budget commitments for the operation of halfway houses and issue regional regulations regulating inter-agency collaboration mechanisms.

Periodic evaluation and continuous innovation must be carried out. Kaimana Hospital can conduct visitor satisfaction surveys and analysis of visit data to assess the effectiveness of policies. Innovations such as the health service's "pick up the ball" system to remote areas can be developed to reduce queues. Academics and educational institutions can partner with RSUD for follow-up research related to collaborative governance models or community-based health technologies.

With the implementation of the above suggestions, it is hoped that Kaimana Hospital can address the problem *of overcrowding* holistically, improve environmental safety, and become an inspiring model of collaborative governance for other regional hospitals. Inclusive, transparent, and sustainable collaboration between the government, hospitals, the TNI/POLRI, and the community is the main key in realizing a responsive and dignified transformation of health services.

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