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From Policy to Practice: Implementing Special Autonomy–Funded Health Services in South Papua, Indonesia

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Abstract

The equitable distribution of health services in rural South Papua still faces geographical challenges, as well as limitations in health personnel, facilities, and resource distribution, despite support from the Special Autonomy Fund policy. This study aims to analyze the implementation of health service policies through the Special Autonomy Fund in Kurik District, Merauke Regency, focusing on health service programs, resource strengthening, service governance, as well as factors supporting and hindering implementation. This study employs a qualitative descriptive design with informants selected through purposive sampling. Data were collected through in-depth interviews, observations, and documentation, and were then analyzed using the Miles, Huberman, and Saldaña interactive model through data condensation, data presentation, and the drawing and verification of conclusions. Data validity was strengthened through triangulation of sources, techniques, and time. The results of the study indicate that the policy has been implemented through primary health care, maternal and child health services, Posyandu (community health posts), immunization, promotive and preventive activities, outreach services, the provision of medicines and medical equipment, facility strengthening, community empowerment, and monitoring and evaluation. However, implementation has not been fully optimal due to limitations in health personnel, infrastructure, medication distribution, geographic conditions, transportation, communication, budget flexibility, and bureaucratic procedures. Government support, dedicated funding, the commitment of implementers, and community participation serve as factors that strengthen implementation. The study concludes that affirmative funding must be accompanied by the strengthening of local implementation capacity so that health services are more accessible, sustainable, and responsive to the needs of rural communities.

Keywords: Special Autonomy Fund; Policy Implementation; Health Services; Local Implementation Capacity; Rural Health Services

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1. Introduction

Equitable access to health services remains a significant challenge in rural and remote areas, particularly when geographical barriers, shortages of health workers, facilities, medications, and institutional capacity limit community access to services. In the context of South Papua, the Special Autonomy policy provides fiscal support to strengthen basic services, including health care. This framework is reinforced by Law No. 21 of 2001 and Law No. 2 of 2021. At the provincial level, the use of Special Autonomy Funds for the health sector is regulated in more operational terms through South Papua Governor's Regulation No. 103 of 2023 and its amendment via Governor's Regulation No. 19 of 2024. These policies are aimed at delivering health services, strengthening resources, and improving service governance. However, in rural areas, the availability of regulations and funding does not always guarantee equitable service delivery, as implementation is influenced by geographical conditions, the distribution of health workers, and local service capacity (Putri et al., 2022; Asghari et al., 2024).

These conditions are evident in Kurik District, Merauke Regency, South Papua. The service area of the Kurik Community Health Center (UPTD Puskesmas) covers 14 villages and is located approximately 83 kilometers from Merauke City. Health services are delivered through community health centers, auxiliary community health centers, integrated health posts (Posyandu), mobile health clinics, maternal and child health services, immunization, and promotive and preventive activities. However, implementation faces constraints related to healthcare personnel, service facilities, the availability of medicines and medical equipment, as well as transportation barriers. Road conditions in some areas also become more difficult to navigate during the rainy season. These issues indicate that the primary challenge lies not merely in the availability of policies and budgets, but in the capacity to implement them—transforming policy support into health services that are equitably accessible to the community.

Previous studies have shown that health services in rural areas are closely linked to aspects of resources, access, decentralization, and governance. Putri et al. (2022) emphasized the importance of rural area characteristics in Indonesia's health workforce policies, while Wulandari et al. (2022) highlighted disparities in health service utilization between urban and rural areas. In the context of primary care, Fanda et al. (2024) identified challenges regarding the availability of essential medicines at various community health centers (Puskesmas) in Indonesia, while Fanda et al. (2025) highlighted a mismatch between policy and local practices in medicine management within a decentralized health system. From a governance perspective, the effectiveness of primary health care is influenced by coordination, accountability, organizational capacity, and community engagement (Madon & Krishna, 2022; Schulmann et al., 2024; Khatri et al., 2025). Noory et al. (2024) also noted that the decentralization of health services may face constraints related to resources, coordination, and governance capacity at the local level.

Although these studies have addressed rural health care, the distribution of health workers, medications, decentralization, and governance, there remains an area of research that has not been sufficiently explored. Contextually, studies specifically examining the implementation of health care policies at the district level in South Papua are still limited. From a policy perspective, the studies reviewed primarily address health services or the use of the Special Autonomy Fund in general, while the translation of technical regulations governing the use of the Special Autonomy Fund into local service practices has not been analyzed in depth. Analytically, service programs, resource strengthening, and governance also tend to be discussed as separate aspects, even though all three are interrelated in determining the success of policy implementation.

The novelty of this study lies in the use of a regulation-based implementation framework that integrates regulatory substance with a policy implementation perspective. South Papua Governor's Regulation No. 103 of 2023 was used to establish three domains of analysis: the implementation of health service programs, the strengthening of health service resources, and health service governance. These three domains were then analyzed using Edwards III's (1980) perspective through four dimensions of implementation: communication, resources, disposition, and bureaucratic structure. Edwards III's framework was employed as an interpretive lens to explain the factors influencing implementation within each domain, rather than to replace the substance of the regulation. This approach allows the relationship between policy design, local implementation capacity, and rural health services to be analyzed within a single integrated framework.

Based on these phenomena, issues, prior studies, and research gaps, this study aims to analyze the implementation of health care policies through the Special Autonomy Fund in Kurik District, Merauke Regency, South Papua. The analysis focuses on the implementation of health care programs, resource strengthening, service governance, as well as factors supporting and hindering implementation. This study is expected to provide insight into how Special Autonomy-based affirmative policies are translated into health services at the local level and to enrich the discussion on policy implementation, rural health service delivery, health equity, and public service governance in remote areas.

2. Literature Review

2.1 Policy Implementation and the Edwards III Perspective

Policy implementation is the process of translating formal decisions into actions, programs, and services that can be carried out by implementing organizations and experienced by target groups. The success of implementation depends not only on the quality of policy formulation but also on an organization's ability to understand policy objectives, allocate resources, establish coordination, and adapt implementation to local conditions. In the health sector, implementation becomes more complex because it involves various actors, levels of government, funding sources, and differing community needs across regions. Noory et al. (2024) demonstrate that the implementation of health care decentralization can be influenced by the division of authority, coordination, stakeholder engagement, and resource distribution. Therefore, policy implementation must be understood as a process that links policy provisions to the capacity of implementers and the characteristics of the implementation environment.

Edwards III (1980) identified four key factors influencing policy implementation: communication, resources, disposition, and bureaucratic structure. Communication relates to the transmission, clarity, and consistency of policy information; resources encompass the personnel, funding, information, authority, and

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facilities required; disposition refers to the attitudes, commitment, and willingness of implementers; while bureaucratic structure relates to the division of tasks, work procedures, coordination, and administrative mechanisms. These four factors are interrelated in determining how policies are translated into practice. In this study, Edwards III's perspective is used as an interpretive lens to understand the factors that support or hinder the implementation of health service policies, not as a substitute for the substance of the policies being analyzed. This approach aligns with the research design, which positions communication, resources, disposition, and bureaucratic structure as explanatory factors for implementation.

2.2 Special Autonomy and Rural Health Service Delivery

Papua's Special Autonomy is an affirmative policy that grants greater authority and fiscal support to local governments to meet development needs with specific characteristics, including health services. Special Autonomy funds, therefore, serve not only as a source of financing but also as an instrument to strengthen public service capacity at the local level (Bawole, 2021; Mote, 2021; Kossay, 2023; Rumansara, 2023). In South Papua, South Papua Governor's Regulation No. 103 of 2023 governs the use of the Special Autonomy Fund for health initiatives, health human resources, pharmaceutical supplies, medical equipment, community empowerment, health care facilities, and accreditation. For the purposes of this study, these elements are grouped into three main domains: health care programs, strengthening health care resources, and health care governance.

The implementation of health care services in rural and remote areas faces different challenges compared to areas with more adequate access and resources. Distance, transportation conditions, population distribution, the distribution of health workers, and the availability of facilities can all affect the ability of health services to reach communities. Putri et al. (2022) emphasize the importance of rural characteristics in the formulation of health workforce policies in Indonesia, while Wulandari et al. (2022) highlight the relevance of urban–rural disparities in the utilization of health services. From a resource perspective, Fanda et al. (2024) highlight challenges regarding the availability of essential medicines in Indonesia's primary health care centers, while Fanda et al. (2025) point to a mismatch between policy and local practices in medicine management within a decentralized system. This literature indicates that fiscal support will only be effective if accompanied by implementation capacity capable of transforming resources into services that are available and accessible to the public.

2.3 Health Governance and Equity in Rural Health Service Delivery

Health governance pertains to decision-making processes, coordination, accountability, resource management, and the involvement of various actors in the delivery of health services. In primary health care, governance is crucial because local governments, health facilities, health workers, local authorities, and the community must interact to translate policies into services. Madon and Krishna (2022) emphasize the importance of community health governance in strengthening the relationship between the health care system and the community. Schulmann et al. (2024) demonstrate that clarity of roles, coordination, accountability, and institutional capacity play a vital role in the implementation of health systems. In line with this, Khatri et al. (2025) identify policy and planning, resource decentralization, workforce capacity, supply chains, monitoring, accountability, coordination, and community engagement as key elements in the governance of primary health care.

Such governance has implications for the equitable distribution of services, particularly among communities living in rural and remote areas. In this context, health equity is understood as a perspective for assessing whether service capacity and policy implementation can reach communities facing different geographic and resource barriers, rather than as a construct tested in isolation. Windle et al. (2023) demonstrate that local health care organizations play a strategic role in identifying and addressing health inequities, while Asghari et al. (2024) emphasize the importance of collaboration, community engagement, system support, and learning capacity in rural and remote health care. Thus, effective governance is necessary to ensure that policies and resources do not stop at administrative outputs but can support access to services that are more responsive to community conditions and needs.

2.4 Analytical Framework

The analytical framework of this study integrates the substance of South Papua Governor Regulation No. 103 of 2023 with Edwards III's (1980) perspective on policy implementation. The substance of the regulation is used to define three domains of analysis: health service programs, health service resource strengthening, and health service governance. These three domains are analyzed using the four dimensions of Edwards III communication, resources, disposition, and bureaucratic structure to identify factors that support and hinder policy implementation. Thus, the regulation determines what is analyzed, while Edwards III is used to explain the factors influencing implementation at the local level. This analytical framework is presented in Figure 1.

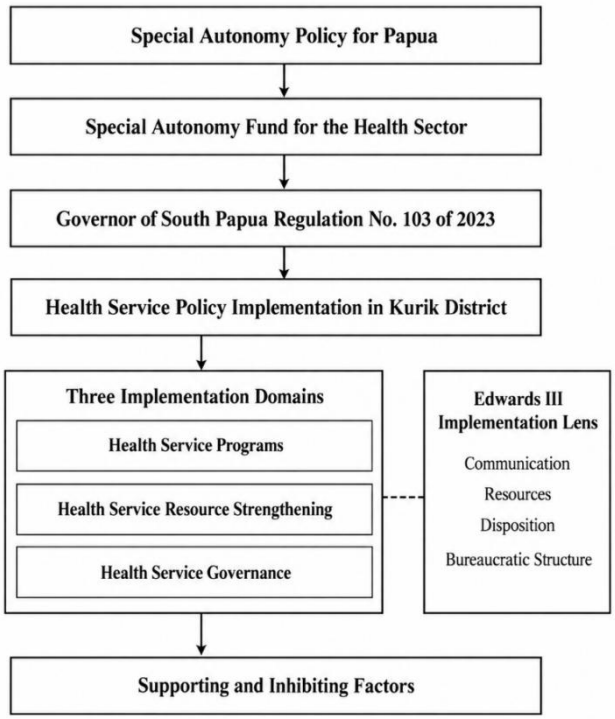

Figure 1. Analytical Framework for Health Policy Implementation

Source: Authors' elaboration based on South Papua Governor Regulation No. 103 of 2023 and Edwards III (1980).

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3. Method

3.1 Research Design and Study Setting

This study employs a qualitative descriptive approach to understand the process of health service policy implementation through the Special Autonomy Fund in Kurik District, Merauke Regency, South Papua. This approach was chosen because it allows researchers to explore policy implementation, the experiences of implementers and service recipients, as well as the factors that support and hinder implementation within the local context. The focus of the analysis covers three main domains: the implementation of health care programs, the strengthening of health care resources, and health care governance.

The research location is Kurik District, Merauke Regency. The service area of the Kurik Community Health Center (UPTD Puskesmas Kurik) covers 14 villages and is located approximately 83 km from Merauke City. Health services are delivered through community health centers (Puskesmas), auxiliary community health centers (Puskesmas Pembantu), integrated health posts (Posyandu), ambulances, health service vehicles, as well as in-house and outreach service activities. Geographical conditions, distances between villages, limited health workforce, and service facilities are key characteristics of the study site.

3.2 Informants and Sampling

Informants were selected using purposive sampling based on their involvement, experience, and knowledge regarding the implementation of health services through the Special Autonomy Fund in Kurik District. Selection criteria included involvement in health services, understanding of the policies under study, experience related to health services at the study site, willingness to provide information, and knowledge of local health service conditions.

The number of informants was determined based on the principle of data saturation, whereby data collection continued until the information obtained was deemed sufficient and no longer yielded new substantive findings. The characteristics, number, and codes of the informants are presented in Table 1. These codes were used consistently in the Results section to identify interview quotes while maintaining the informants' anonymity.

Table 1. Informant Characteristics

Informant Group	Code	Number	Information Provided
Head of the Merauke District Health Office	DHO-1	1	Policy Implementation and Health Program Management
Head of the Kurik Community Health Center	HC-1	1	Local implementation and health service management
Health workers	HW-1–HW-3	3	Service delivery, resources, and operational constraints
Kurik District officials	DO-1–DO-2	2	Local coordination and administrative support
Health service users	SU-1–SU-5	5	Service access, experience, and perceived constraints
Community/village leaders	CL-1–CL-2	2	Community participation and local support
Total		**14**	

Source: Authors' analysis based on data from field informants.

3.3 Data Collection

Data were collected using three methods: in-depth interviews, observation, and documentation. Interviews were used to explore informants' experiences, perceptions, and knowledge regarding program implementation, resource support, governance, and enabling and constraining factors. Observations were conducted on the delivery of health services, the conditions of health workers, medicines and medical equipment, service facilities, promotive and preventive activities, community involvement, and monitoring and evaluation processes. Documentation was used as a secondary data source to supplement the results of interviews and observations. The documents analyzed included South Papua Governor Regulation No. 103 of 2023, South Papua Governor Regulation No. 19 of 2024, health service activity reports, documents on the use of Special Autonomy Funds, and other relevant administrative documents.

3.4 Data Analysis

Data analysis utilized the interactive model proposed by Miles, Huberman, and Saldaña (2014), which includes data condensation, data display, and conclusion drawing/verification. The analysis was conducted simultaneously throughout the data collection process. Relevant data were selected and grouped based on the three research domains, then systematically presented to identify patterns, relationships, and key issues in policy implementation. Findings across the three domains were subsequently interpreted using Edwards III's (1980) framework—namely, communication, resources, disposition, and bureaucratic structure—to explain the factors that support or hinder implementation. Edwards III was used as an interpretive framework, not as a data analysis technique.

3.5 Trustworthiness

Data validity was strengthened through triangulation of sources, techniques, and time. Source triangulation was conducted by comparing information from Health Department officials, Community Health Center (Puskesmas) directors, health workers, district and village officials, and service recipients. Technique triangulation involved comparing results from interviews, observations, and documentation, while time triangulation was conducted by verifying information at different points in time to ensure data consistency.

4. Results

4.1 Health Service Program Implementation

The study results indicate that the implementation of health service programs through the Special Autonomy Fund in Kurik District has taken place through services provided both within and outside the Kurik Community Health Center (UPTD Puskesmas). In-

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facility services include basic examinations and treatment, while out-of-facility services encompass village visits, Posyandu (integrated health posts), mobile health services, immunizations, maternal and child health services, health education, and promotive and preventive activities. Services provided off-site are an important component because the Puskesmas's service area includes villages with varying distances and access conditions.

Support from the Special Autonomy Fund is particularly evident in service activities that directly reach the community. Informant HC-1 stated:

> *"Special Autonomy Funds are very helpful for health service activities, especially those that directly reach the community, such as Posyandu, prenatal checkups, immunizations, and health education."* (HC-1, interview,)

This finding is reinforced by observation results showing the implementation of off-site services through Posyandu, maternal and child health checkups, health worker visits, and health education for the community. Supported programs also include immunization, maternal and child health, stunting prevention, and environmental health.

However, program coverage is not yet fully equitable. Services in a number of villages are still constrained by limited health personnel, distance, access conditions, and the availability of transportation for off-site services. These conditions primarily affect the continuity of services in areas relatively far from the main community health center (Puskesmas). Thus, health service programs have been implemented in various forms, but achieving equitable service coverage still faces operational challenges.

4.2 Health Service Resource Strengthening

Strengthening health service resources encompasses health personnel, medications, medical equipment, service facilities, and operational support. Research findings indicate that basic resources are available at the Kurik Community Health Center (UPTD Puskesmas) and are used to support both basic health services and off-site services. However, the quantity and capacity of available resources do not yet fully meet service needs across the extensive service area. Informant DHO-1 explained the use of Special Autonomy Funds as follows:

> *"The Special Autonomy Fund is used for service operations, the procurement of medicines, and the repair of health facilities."* (DHO-1, interview)

This statement indicates that funding support has been used for several key components of service resources. Nevertheless, limitations still exist, particularly regarding health personnel and the service network at the village level. The number of health workers is not yet fully commensurate with the size of the area and the number of villages that must be served, while staff must also divide their duties between in- s and field services. Limitations were also found in the availability of medications at the auxiliary health centers. One service user stated:

> *"Medications at the village health post are sometimes available, and sometimes they're not complete."* (SU-1, interview)

This experience indicates that the availability of medicines at village-level health facilities is not always consistent. In addition to medicines, some medical equipment and health facilities still require additional supplies, maintenance, or repairs. Overall, efforts to strengthen resources have been made, but there remains a gap between the availability of resources and service needs on the ground.

4.3 Health Service Governance

Health service governance is implemented through community empowerment, monitoring, evaluation, cross-sectoral coordination, and reporting. Community empowerment is carried out by involving community health workers, community leaders, village officials, and families in Posyandu activities, immunizations, maternal and child health services, health education, as well as promotive and preventive activities. Community health workers play a role in helping to convey information and encouraging the community to participate in health services on a regular basis.

Program monitoring is carried out through activity record-keeping, routine reports, monitoring of program achievements, and coordination between the Community Health Center (Puskesmas) and the district government. Informant DO-2 explained:

> *"It is carried out effectively through cross-sectoral activities and performance evaluations conducted every three months."* (DO-2, interview)

This statement indicates that there are mechanisms for cross-sectoral coordination and periodic evaluation in the delivery of health services. Monitoring covers basic health services, Posyandu, immunization, maternal and child health, nutrition services, health education, and mobile health services.

Although governance mechanisms are in place, a number of limitations were still identified in data recording, the completeness of documentation, reporting, and follow-up on evaluation results. In some situations, program staff must provide services while simultaneously performing administrative and reporting tasks, thereby increasing their workload. Program evaluations are also not always supported by complete and timely data, nor are follow-up actions consistently documented. Thus, while governance has clear implementation mechanisms, administrative capacity and the follow-up on monitoring and evaluation results still require strengthening.

4.4 Supporting and Inhibiting Factors

The study identified support from local governments, the Special Autonomy Fund, health workers, community involvement, service facilities, and the existence of health programs as factors supporting implementation. Local government support is evident through guidance, oversight, health programs, and support for community health center (Puskesmas) service needs. Meanwhile, the involvement of community health workers, community leaders, and village officials aids in the delivery of community-based health services.

On the other hand, barriers to implementation include shortages of health workers, limited service facilities, geographical conditions, transportation, medication distribution, budgetary support, communication, and administrative processes. Informant DHO-1 explained:

> *"As for barriers, the most significant ones are the shortage of health workers, geographical conditions, and facilities that are still limited."* (DHO-1, interview)

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This statement is consistent with the finding that the number of health workers is not yet commensurate with the service area, and some facilities still require improvement. Geographical barriers were also highlighted by informant DO-1:

> *"Traveling from some villages to the community health centers is still difficult in some cases, and there is a shortage of health workers at the health posts."* (DO-1, interview)

The findings indicate that resource constraints and geographical characteristics are interrelated in determining the scope of services. Road conditions in some areas are also affected by the weather; during the rainy season, roads can become damaged, muddy, or difficult to traverse, thereby affecting the mobility of both health workers and the community.

In addition to physical and resource constraints, communication and administrative challenges were also identified. Information regarding service schedules, Posyandu, immunizations, and preventive activities is not always received or understood uniformly by the community. Meanwhile, administrative processes—including planning, budgeting, record-keeping, reporting, and accountability—can, under certain conditions, increase the workload of implementers.

Overall, the findings show that all three domains of implementation have been carried out, but the intensity and scope of implementation have not been entirely uniform. The availability of funding, health programs, health workers, and support from local stakeholders enables services to continue, while resource constraints, geographic conditions, transportation, communication, and administrative burdens limit implementation at the local level. Table 2 summarizes the key findings across the three implementation domains, as well as the enabling and constraining factors identified in the field.

Table 2. Summary of Key Findings

Result Domain	Main Findings	Main Implementation Issues
Health Service Programs	Basic health services, maternal and child health services, Posyandu, immunization, health education, and outreach services were implemented	Service coverage remained uneven due to distance, limited personnel, and transportation constraints
Strengthening Health Service Resources	Health personnel, medicines, medical equipment, facilities, and operational support were provided to support service delivery	Shortages of health workers, inconsistent availability of medicines, limited equipment, and inadequate facilities persisted
Health Service Governance	Community participation, monitoring, evaluation, cross-sector coordination, and reporting mechanisms were implemented	Administrative workload, incomplete data, reporting delays, and limited follow-up persisted
Supporting Factors	Government support, the Special Autonomy Fund, the commitment of health workers, community participation, health facilities, and existing health programs	These factors enabled the continuity and expansion of health services
Inhibiting Factors	Shortages of human resources, geographical barriers, transportation constraints, problems with medicine distribution, budget limitations, communication barriers, and bureaucratic procedures	These factors limited the reach, continuity, and effectiveness of service implementation

Source: Authors' elaboration based on field findings.

5. Discussion

5.1 Extending Health Services Beyond Facility-Based Care

The findings indicate that the implementation of health service programs occurs not only through community health center (Puskesmas)-based services but also through off-site services and community-based activities. This indicates that in rural areas, successful implementation is not solely determined by the availability of programs but also by the ability of services to reach communities facing geographical barriers. These findings align with those of Wulandari et al. (2022), who highlighted disparities in health service utilization between urban and rural areas in Indonesia. Putri et al. (2022) also emphasize the importance of rural characteristics in health workforce policies, while Asghari et al. (2024) highlight the importance of community and provider engagement in strengthening health services in rural and remote areas.

From the perspective of Edwards III (1980), these conditions are primarily related to resources and communication. Financial support enables services to be expanded beyond healthcare facilities, while communication through healthcare workers, community health volunteers, and village officials helps communities become aware of and utilize available services. Thus, the policy implication is that the success of the Special Autonomy Fund in the health sector should not be assessed solely by the number of activities, but also by the program's ability to reach hard-to-serve community groups.

5.2 Resource Availability Does Not Necessarily Mean Resource Adequacy

Findings in the resource strengthening domain reveal a distinction between resource availability and resource adequacy. Healthcare workers, medicines, medical equipment, and facilities are available, but their capacity is not yet fully commensurate with service needs and the size of the service area. This finding aligns with Fanda et al. (2024), who demonstrated that the availability of essential medicines at primary healthcare facilities in Indonesia still faces regional disparities. Fanda et al. (2025) also highlight a mismatch between medication management policies and local practices within a decentralized health system. Meanwhile, Putri et al. (2022) emphasize that policies on the distribution of health workers must take into account the characteristics of rural areas.

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Edwards III explains these conditions through the dimension of resources. A shortage of one type of resource can increase pressure on other resources: a shortage of personnel increases the workload; limited village-level facilities increase dependence on the main community health center (Puskesmas); and transportation barriers increase the cost of off-site services. Therefore, implementation resources need to be understood as an interdependent configuration, not as standalone inputs. Consequently, the allocation of Special Autonomy Funds should be increasingly based on the region's actual needs, service workload, geographic reach, and facility capacity at the village level.

5.3 Governance as Coordination and Learning

Service governance has been supported by community empowerment, cross-sectoral coordination, monitoring, evaluation, and reporting. However, these functions have not yet fully evolved into learning mechanisms due to ongoing limitations in data quality, administrative burdens, and follow-up on evaluation results. This finding is consistent with Madon and Krishna (2022), who emphasize the importance of coordination, accountability, and the involvement of local actors in community health governance. Khatri et al. (2025) also demonstrate that governance in primary health care involves interrelated functions, including information, monitoring, coordination, health workers, and accountability. Schulmann et al. (2024) further highlight the importance of governance in linking reform design to its implementation.

From Edwards III's perspective, these issues are primarily related to bureaucratic structure and communication. Reporting structures and mechanisms are in place, but their effectiveness is diminished when record-keeping is suboptimal and health workers must perform both service delivery and administrative functions. Consequently, monitoring and reporting need to shift from an administrative orientation toward learning-oriented governance that is, using field data to set priorities, improve programs, and determine follow-up actions. Simplifying reporting mechanisms is also crucial to ensure that the administrative burden does not undermine the capacity for direct service delivery.

5.4 Understanding the Local Implementation Gap

Overall, this study indicates the existence of a local implementation gap. Regulations, funding, programs, and implementation structures are in place, but their implementation has not yet fully resulted in equitable service delivery because local capacity still faces various limitations. This situation aligns with the findings of Noory et al. (2024), who noted that the implementation of health decentralization can face gaps when local responsibilities are not fully supported by adequate implementation capacity. Fanda et al. (2025) also noted that discrepancies between formal policies and local practices can arise in decentralized health systems.

Edwards' three dimensions provide an integrated explanation for these gaps. Communication determines the clarity and acceptance of information; resources determine the actual capabilities of implementers; disposition relates to the commitment of implementers; and bureaucratic structure determines the smoothness of coordination and implementation procedures. The findings indicate that these dimensions operate interdependently, meaning that the availability of funding alone is insufficient to guarantee effective implementation.

Theoretically, these findings suggest that the implementation of health policies through the Special Autonomy Fund can be understood as a process of transforming fiscal resources into local service capacity. The substance of South Papua Governor Regulation No. 103 of 2023 determines what is implemented, while Edwards III helps explain the conditions that enable or constrain this process. The policy implication is the need for a shift from a focus on fund allocation toward local implementation capacity, so that the success of funding is measured by the actual ability to deliver services that are available, affordable, sustainable, and responsive to local conditions.

6. Conclusion

This study shows that the implementation of health care policies through the Special Autonomy Fund in Kurik District has been carried out in three main domains: health care programs, resource strengthening, and service governance. Basic services, maternal and child health, promotive-preventive activities, and off-site services have been implemented, but equitable implementation remains constrained by the availability of health workers, facilities, medicines, and medical equipment, as well as by geographic conditions, access to transportation, communication, and administrative processes. These findings confirm that the availability of special funding is an important condition, but it is not sufficient; the effectiveness of implementation also depends on local capacity to transform fiscal resources into services that are available, affordable, and sustainable.

The contribution of this study lies in its regulation-based policy implementation approach, which integrates the three substantive domains of the Papua South n Governor's Regulation No. 103 of 2023 with Edwards III's perspective as an interpretive framework. This approach demonstrates that implementation gaps at the local level are related to the interaction between communication, resources, disposition, and bureaucratic structure—not merely to the size of the funding allocation. Studies that specifically analyze this regulation at the district level remain limited. The practical implication is the need to shift the focus from fund allocation toward local implementation capacity, through the strengthening and equitable distribution of health personnel, facilities, and medication; outreach services; cross-sectoral coordination; and more effective monitoring and reporting systems.

The limitation of this study lies in its empirical scope, which focuses on a single district; consequently, the findings are contextual and are not intended to be statistically generalized to the entire South Papua region. Future research could expand the scope to include several districts or regencies and employ comparative, quantitative, or mixed-methods designs to test whether the identified patterns of local implementation gaps also emerge in different contexts. Such an expansion could also help identify variations in implementation capacity across regions and the local factors influencing the success of health service policies funded through the Special Autonomy Fund.

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