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Article

Comparative Analysis of the Implementation of Management Functions in Community Health Centers (Puskesmas) Accredited as *Paripurna* and *Madya* in Kolaka Regency

Failal Ulfi Mauliah[1 2,,a,*], **Asriati**[2,b], **dan Asnia Zainuddin**[2,c]

1 Health Administration, Universitas Sains Islam Al Mawaddah Warrahmah Kolaka, 93511, Indonesia
2 Public Health, Universitas Halu Oleo, 93232, Indonesia

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E-mail: [a*]failalmauliah@gmail.com(Corresponding author), [b] asriatiyusuf@gmail.com, [c]asnia.zainuddin@uho.ac.id,

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A B S T R A C T

This study aims to analyze the differences in the implementation of management functions between community health centers (Puskesmas) accredited as Paripurna and those accredited as Madya in Kolaka Regency. A descriptive qualitative approach was employed using a case study method involving six Puskesmas—three with Paripurna accreditation and three with Madya accreditation. Data were collected through in-depth interviews, participatory observation, and document review. The research focused on three main management functions of Puskesmas: planning (P1), organizing and implementation (P2), and supervision, control, and performance evaluation (P3). The findings show that Paripurna Puskesmas excel in strategic planning that involves cross-sector participation and data-based decision-making. The P2 function is optimally implemented through regular coaching, inter-unit coordination, and the use of information technology. In the P3 aspect, Paripurna Puskesmas demonstrate stronger internal supervision systems and periodic evaluations of service quality. In contrast, Madya Puskesmas still face challenges such as limited human resources, lack of managerial support, and low integration of information systems. The study emphasizes that synergy among human resources, organizational culture, leadership, and local government support is a key factor for effective management function implementation in Puskesmas. The practical implication of these findings highlights the importance of structural interventions and system strengthening to enhance the readiness of Madya Puskesmas toward Paripurna accreditation. This study also contributes to the development of evidence-based primary health care policies at the regional level.

1. Introduction

Community Health Centers (Puskesmas) hold a strategic role as the frontline institutions in Indonesia's primary healthcare system. Their existence is vital in ensuring that communities—particularly those in remote and rural areas—have access to quality, affordable, and equitable healthcare services. To guarantee the quality of care provided, the government, through the Ministry of Health, has established an accreditation system as a mechanism for evaluating healthcare quality and safety standards. Accreditation not only serves to assess the feasibility of healthcare facilities but also acts as a means of continuous improvement for the performance of primary healthcare institutions. Previous studies have shown that accreditation has a positive impact on service reliability, professional competence of healthcare workers, and patient satisfaction (Limato et al., 2019; Misnaniarti & Destari, 2018; Alkhenizan & Shaw, 2011).

The accreditation of Puskesmas has undergone regulatory developments through Minister of Health Regulation No. 34 of 2022, which replaced previous provisions and reaffirmed the government's commitment to improving the quality of primary healthcare facilities. Accreditation is classified into four levels: *Basic*, *Intermediate (Madya)*, *Main (Utama)*, and *Excellent (Paripurna)*—each representing the degree to which a Puskesmas meets national standards. Nationally, in 2022, there were 43 Puskesmas accredited as *Paripurna*, 734 as *Utama*, 3,793 as *Madya*, and 2,195 as *Basic*, while 1,778 Puskesmas remained unaccredited (Mawarni et al., 2022). In Southeast Sulawesi Province, according to LASKESI (2024) data, there are 19 *Paripurna*, 38 *Utama*, and 6 *Madya* Puskesmas.

Kolaka Regency, one of the regions in Southeast Sulawesi, has 14 active Puskesmas consisting of seven accredited as *Paripurna*, three as *Utama*, and four as *Madya* (BPS, 2024; Kolaka District Health Office, 2024). This situation illustrates a variation in service quality achievements at the local level—an important issue to be analyzed further, especially regarding how accreditation correlates with the implementation of management functions in Puskesmas. The core management functions—planning, organizing and implementing, as well as monitoring, controlling, and evaluating performance—are fundamental components in ensuring healthcare service effectiveness and efficiency.

Previous research indicates that Puskesmas with higher accreditation status (*Paripurna*) tend to have stronger management systems than those with *Madya* accreditation. *Paripurna*-accredited Puskesmas are often better prepared to face healthcare service challenges and can perform management functions more optimally (Maghfiroh & Rochmah, 2017; Darmawan & Azni, 2022). This success is supported by consistent internal evaluation, utilization of information technology, capacity building of healthcare personnel, and a quality-oriented work culture. However, higher accreditation status does not automatically guarantee superior management implementation, as other factors—such as human resource readiness, local government support, and infrastructure—also play a role.

The application of information technology in Puskesmas has become a key strategy to enhance management effectiveness. Systems such as SIMPUS, e-Puskesmas, and Electronic Medical Records (EMR) have proven effective in improving data management efficiency and evidence-based decision-making (Adawiyah, 2023; Pratama, 2024). The DeLone and McLean Model is often used to evaluate the success of health information systems. Nonetheless, the effectiveness of these technologies is highly dependent on organizational readiness, infrastructure availability, and adequate staff training (Hakim, 2020; Afiza, 2024).

On the other hand, managerial challenges faced by both *Paripurna* and *Madya*-accredited Puskesmas are strongly influenced by internal factors, such as unequal distribution of health personnel, limited planning capacity, and poor coordination between work units. The quality of human resource management, organizational communication methods, and decision-making mechanisms are critical aspects that need strengthening. Nugraha et al. (2020) found that poor human resource management can lead to workload imbalances and reduced service performance. Therefore, needs-based HR planning and continuous professional development are essential.

Furthermore, effective organizational communication and the use of digital communication media have been shown to

support the implementation of health programs at the Puskesmas level (Febrianty, 2024). Data-driven decision-making using valid and reliable information is a hallmark of professional and efficient management. Accurate data from information systems are crucial in formulating local health policies that are responsive to community needs (Awalludin & Wulandari, 2020; Puspa, 2024).

Within the framework of achieving Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs), Puskesmas must go beyond curative approaches and begin to integrate community-based promotive and preventive health services. Success in this area depends on a strong management system and accreditation that reflects a true commitment to service quality. Therefore, a study analyzing the implementation of management functions based on Puskesmas accreditation levels is crucial to provide a more data-driven and quality-oriented policy foundation.

This study aims to analyze the differences in the implementation of three main management functions—(1) Planning (P1), (2) Organizing and Implementation (P2), and (3) Supervision, Control, and Performance Evaluation (P3)—between *Paripurna* and *Madya*-accredited Puskesmas in Kolaka Regency. Additionally, it seeks to identify the factors influencing these differences. The results are expected to contribute to the development of more effective and evidence-based managerial strategies, particularly in the context of primary healthcare services in resource-limited areas.

The contributions of this study are both academic and practical. For local governments and the Ministry of Health, the findings may serve as a basis for developing policies to enhance Puskesmas management systems and optimize resource allocation. For Puskesmas themselves—whether *Paripurna* or *Madya*—this research offers insights into managerial aspects that need improvement to maintain or elevate accreditation status. For healthcare workers, it provides a deeper understanding of effective management practices and their impact on community health services. Lastly, for researchers and academics, this study represents a scientific contribution to the development of management studies in Indonesia's primary healthcare sector.

2. Research Methodology

2.1 Research Location and Period

This study was conducted in Kolaka Regency, Southeast Sulawesi, with research sites located in six Community Health Centers (*Puskesmas*) selected based on their accreditation levels, namely Kolaka, Kolakasi, Pomalaa, Latambaga, Wundulako, and Tanggetada. The selection of these locations considered the diversity of accreditation levels as a representation of varying quality standards and the implementation of different management functions, thereby allowing for a contextual comparative analysis.

The research was carried out from March to June 2025. The research schedule included the stages of instrument preparation and coordination with Puskesmas officials, data collection in March, and data analysis and report writing from April to June. The research timeline was planned with consideration of weather conditions, data availability, and avoidance of national holidays or other activities that might interfere with respondent participation.

2.2 Research Design

This study employs a descriptive qualitative approach with a case study design. This approach was chosen because it allows for an in-depth exploration of the context, processes, and outcomes of the implementation of management functions in two categories of Puskesmas based on their accreditation levels. The case study method enables the researcher to investigate phenomena contextually within clearly defined units of analysis—namely, each individual Puskesmas.

2.3 Data Sources and Informant Selection Techniques

In qualitative research, the term *sample* is more appropriately referred to as data sources or informants, as data collection is purposive rather than statistically representative. The selection of informants in this study was conducted using purposive sampling, meaning that participants were chosen based on their roles within the Puskesmas management structure and the relevance of their knowledge to the research focus.

Six Puskesmas were selected based on their varying levels of accreditation. The main

informants consisted of: Head of the District Health Office (1 person), Heads of Puskesmas (6 people), Heads of Administration (6 people), Quality Assurance Officers (6 people), Accreditation Assessor (1 person).

The number of informants was determined based on the principle of data saturation, meaning that data collection was concluded once no new or significant information emerged.

2.4 Types and Data Collection Techniques

The data used in this study comprised: Primary Data, obtained directly through interviews, observation, and direct field participation. Secondary Data, including accreditation documents, annual reports of Puskesmas, internal protocols, and other relevant official records.

Three main techniques were employed for data collectio: 1. Open-Ended Interviews – conducted to explore the in-depth understanding of key informants. The procedure included preparing an interview guide, conducting face-to-face interviews, and transcribing the results for analysis. 2. Participant Observation – carried out to understand the actual practices of management function implementation. The researcher directly observed Puskesmas activities using an observation checklist, paying attention to staff interactions, SOP execution, and service patterns. 3. Documentation – involved the collection of data from official documents such as performance reports, accreditation records, and internal policies. This method supported data triangulation and verification of information obtained from interviews and observations.

2.5 Research Instruments

The instruments used in this study included: 1. Open-ended interview guide, containing exploratory questions structured around the core management functions (planning, organizing, implementing, and supervising). 2. Observation checklist, serving as a recording tool during field observations. 3. Puskesmas documents, such as annual reports, standard operating procedures (SOPs), and accreditation audit records, used as secondary data sources. 4. Additional tools included an audio recorder for interviews and field notes to capture findings beyond formal instruments.

2.6 Data Validity Test

The validity of the qualitative data was examined using the credibility approach, which included: 1. Prolonged engagement, involving extended field visits until the collected data reached saturation. 2. Persistent observation, through systematic and in-depth observation of the analysis units. 3. Triangulation of sources and techniques, by comparing data obtained from various sources (interviews, observations, documentation) and across different timeframes. 4. Peer debriefing and member checking, conducted to confirm data interpretations with participants and fellow researchers.

2.7 Data Analysis Technique

Data analysis followed the Miles and Huberman model, consisting of three main stages: 1. Data Reduction – the process of selecting, categorizing, and simplifying field data into key themes based on management function focus. 2. Data Display – presenting findings in the form of descriptive narratives and thematic tables to illustrate similarities and differences between Puskesmas. 3. Conclusion Drawing and Verification – developing a comprehensive understanding of how accreditation impacts the implementation of management functions. 4. The analysis process was conducted simultaneously with data collection, allowing for reflection and refinement of field strategies throughout the course of the research.

3. Results and Discussion

3.1 Differences in the Implementation of the Planning Function (P1)

Based on an analysis of the health profile documents from several Community Health Centers (*Puskesmas*) in Kolaka Regency, all Puskesmas prepared their program plans (P1) systematically, referring to national guidelines and local community needs. In 2024, Latambaga Puskesmas designed two main groups of programs—Essential Health Efforts (*Upaya Kesehatan Wajib*) and Development Health Efforts (*Upaya Kesehatan Pengembangan*)—with a total of 15 programs. Meanwhile, Kolakaasi Puskesmas in 2023 also developed 15 programs following a process of needs identification, priority setting, and work plan formulation. Similarly, Wundulako Puskesmas planned 18 programs in 2024, including 12

development programs covering services such as school dental health (*UKGS*), maternal and child health (*UKGM*), community health care (*Perkesmas*), and non-communicable disease control (*Posbindu PTM*). On the other hand, Pomalaa Puskesmas also formulated up to 18 programs, aligning them with both national and local visions and policies. Tanggetada Puskesmas developed 15 programs consisting of six essential and nine development efforts, providing flexibility for innovative local initiatives.

The document analysis shows that all Puskesmas studied have implemented program planning systematically in accordance with national public health guidelines. Each Puskesmas began the planning process by identifying health problems, mapping community needs, and setting priorities based on the characteristics of their working areas. Generally, all Puskesmas planned at least six essential health efforts and eight to twelve development programs, with a total ranging from 15 to 18 programs annually. This systematic planning approach aligns with health management theory, which emphasizes the importance of data-driven and community-based planning (Ministry of Health of Indonesia, 2020).

In terms of planning, Paripurna-accredited Puskesmas demonstrated data-driven planning, cross-sectoral involvement, and a bottom-up approach. The Head of Wundulako Puskesmas stated that the planning process begins with *mini-workshops* involving all program coordinators to develop proposals based on real field problems. In contrast, Madya-accredited Puskesmas, such as Latambaga, faced challenges including inadequate facilities, regulatory changes, and limited mastery of digital planning tools. The Head of Kolakaasi Puskesmas also emphasized the importance of aligning internal vision and mission with that of local government, as reflected in their work plans.

According to the accreditation assessor, effective planning includes situation analysis, standardized priority setting, cross-sectoral integration, innovation based on local needs, and the use of SMART indicators and objectives. Kolakaasi Puskesmas developed its RUK/RPK (annual and operational work plans) based on previous performance achievements, such as K1 coverage (97%), K4 (70%), and full immunization (91.8%), and conducted participatory planning through cross-sector forums and *mini-workshops*. Meanwhile, Latambaga Puskesmas used similar data (K1 coverage 91–95%, K4 87–89%, and immunization 95%) but still faced issues related to provider network data access, incomplete documentation, and limited community involvement.

The similarity in the types of planned programs—particularly the essential health efforts—indicates that all Puskesmas comply with national regulations, while the variations in the number and types of development programs, such as school health, youth health, and other innovations, reflect flexibility in addressing local community needs. This finding aligns with the participatory and bottom-up planning principles recommended in the Puskesmas management system.

The planning function is a fundamental step in the health management cycle, determining the direction and priorities of Puskesmas programs (Handayani & Hartono, 2019). The findings show that Paripurna-accredited Puskesmas tend to be more advanced in developing data-based plans, engaging cross-sectoral stakeholders, and aligning programs with community needs. The planning process is participatory, involving various actors such as program officers, village heads, and sectoral partners through *mini-workshops* that facilitate shared decision-making.

This condition is consistent with WHO's (2018) recommendation for integrated people-centred health services, which promotes participatory approaches and data-driven decision-making. Setyowati et al. (2020) also emphasized that the success of community-based planning depends on collaboration and the involvement of all stakeholders, from internal staff to the wider community.

In Madya-accredited Puskesmas, although planning remains data-oriented, challenges persist in terms of facility adequacy, data accuracy, and frequent regulatory changes, which make it difficult for staff to adapt to new accreditation standards. As a result, the preparation of RUK/RPK documents tends to be administrative rather than strategic. Putri et al. (2021) found that in Madya-accredited Puskesmas, planning often follows a top-down

model, with limited consideration of program evaluation results or community input, leading to lower innovation and weaker performance indicators.

The use of performance data and risk analysis is a key differentiator. In Paripurna-accredited Puskesmas, data-based decision-making has become part of the organizational culture, supported by the use of health information systems (SIK, SIP, SIKDA) in line with national policy (Kusnanto et al., 2019). In contrast, information systems in Madya-accredited Puskesmas remain underutilized, with decision-making often relying on experience or conventional practices. Staff involvement in formulating vision, mission, and work programs is also more evident in Paripurna-accredited Puskesmas—an important factor contributing to accreditation success as highlighted by Nugroho et al. (2021) and Mubarok et al. (2020).

3.2 Differences in the Implementation of the Functions of Mobilization and Execution (P2)

At the implementation stage (P2), all Community Health Centers (*Puskesmas*) studied demonstrated significant efforts to carry out the programs planned during the previous planning stage (P1). *Puskesmas* accredited as Paripurna, such as Wundulako and Kolakaasi, generally succeeded in implementing all mandatory health programs comprehensively. This success was reflected in high service indicators—such as maternal health coverage (K1 and K4), deliveries by health professionals, child nutrition services, and full immunization—some of which even reached 100% in Wundulako. Beyond the mandatory programs, most development programs—such as school health (UKS), elderly health, dental and oral health, and non-communicable disease prevention (Posbindu PTM)—were also implemented effectively, although some still faced challenges in occupational health (UKK) and traditional medicine services.

Conversely, *Puskesmas* with Madya accreditation, such as Latambaga and Tanggetada, also demonstrated good implementation of all mandatory health programs and most development programs. However, the success of development programs in *Puskesmas Madya* varied more widely and was often constrained by limited resources and community support. Programs such as occupational health and traditional medicine were not fully executed or monitored. The main differences between *Paripurna* and *Madya* centers lie in the proportion of program implementation, human resource stability, and capacity for innovation and adaptation to local needs.

Across all *Puskesmas*, nearly all planned programs were implemented, with six mandatory programs consistently achieved, as shown by key indicators such as maternal and child health coverage, immunization, nutrition, and treatment services. This indicates that basic public health services remain a top priority and are being delivered effectively. The implementation of development programs, however, showed variations depending on resource availability, cross-sector support, and local dynamics. Some programs—such as occupational health (UKK) and traditional medicine (Batra)—were not yet fully optimized due to limited personnel, infrastructure, or external factors such as the post-pandemic recovery period. On average, between 13 and 18 programs were implemented annually in each *Puskesmas*, showing the need for stronger capacity building and policy support to expand development programs.

The mobilization aspect of program implementation was largely determined by internal strategies. In *Paripurna Puskesmas*, regular staff coaching, structured socialization of Standard Operating Procedures (SOP), and consistent application of quality indicators were key. The Quality Assurance Officer at *Puskesmas Kolakaasi* emphasized the importance of continuous internal education and supervision to ensure all staff understand and adhere to service standards. Effective inter-unit coordination was maintained through digital communication channels such as WhatsApp groups, regular meetings, and internal briefings, as noted by the Head of *Puskesmas Latambaga*.

However, *Puskesmas Madya* faced different challenges. Despite efforts to strengthen internal processes, limitations in human resources—especially nurses and midwives—and low community participation in health programs were key constraints. The Head of *Puskesmas Latambaga* reported that community awareness of child health checks

remained low, directly affecting service coverage indicators.

In terms of effectiveness, surveyors highlighted that key success indicators included maternal and child health coverage, immunization rates, nutrition management, service waiting times, and patient satisfaction. *Puskesmas Kolakaasi* stood out, with strong performance in Clean and Healthy Behavior (PHBS) programs (87% of target households reached), consistent *posyandu* activities, and a significant increase in patient visits to 9,802 in 2023. Nutrition, maternal health (KIA), family planning (KB), immunization, and elderly care programs were integrated and supported by continuous cadre training and mentoring. Meanwhile, *Puskesmas Latambaga* implemented similar programs but with more limited coverage—only 35% of households participated in PHBS from a total of 2,840 targets, child health services reached 90%, and active family planning participants were 16.3%. Monitoring and evaluation activities were not conducted regularly, with few active health cadres and uneven training opportunities.

Overall, the mobilization and execution functions were more effective in *Paripurna Puskesmas* compared to *Madya* ones. Key success factors included adequate human resources, strong organizational structures, consistent use of SOPs and quality indicators, and the ability to educate and mobilize the community. *Puskesmas Madya*, meanwhile, need to enhance community engagement, strengthen human resource capacity, and implement continuous monitoring and evaluation systems to achieve better service effectiveness.

In *Paripurna Puskesmas*, mobilization and execution were superior due to: 1. Structured internal education and socialization, 2. Regular staff coaching and mentoring, 3. Continuous monitoring of SOP and service quality indicators, and 4. Strong leadership and a performance-based reward system for outstanding staff. 5. Routine briefings, mini-workshops, and coordination meetings were held to ensure alignment and shared understanding among staff. This aligns with Aulia et al. (2022), who stated that the success of quality management depends heavily on effective internal communication and continuous information dissemination.

Regular staff development programs were conducted not only to address problems but also as part of a structured competency improvement plan through training, mentoring, and coaching led by quality teams and leadership. Susilawati et al. (2022) found that consistent staff coaching strengthens quality management implementation and fosters a positive organizational culture.

Strong leadership played a crucial role. Heads of *Puskesmas* actively provided direction, moral support, and created a supportive work environment. The reward system—including incentives and formal recognition—significantly improved staff motivation, as supported by Tosepu et al. (2022). This system encouraged individual performance and fostered healthy competition and innovation.

These leadership and mobilization strategies significantly enhanced primary healthcare service quality, accelerated achievement of performance indicators, and reinforced a quality-oriented organizational culture. Similar findings were reported in Mahendradhata et al. (2017) and Yuliani et al. (2021), emphasizing that structured leadership, continuous socialization, monitoring, and reward systems are essential in health service reform across developing countries.

Effective mobilization strategies in *Paripurna Puskesmas* improved work motivation, compliance with SOPs, and overall service quality—consistent with Mubarok et al. (2020), who highlighted that effective HR management and reward systems drive quality achievement in primary healthcare. Likewise, Suryoputro et al. (2019) found that regular coaching and supervision from leaders increased staff discipline and service innovation.

Conversely, *Puskesmas Madya* faced major barriers such as limited trained human resources, as reported by Septiawati et al. (2020) and Ningsih & Sudarti (2019). Lack of trained staff hampered adaptation to quality standards and innovation. Financial and infrastructure constraints were also common (Nurhidayat et al., 2022), affecting operational performance, equipment availability, and training.

Low community engagement further weakened program implementation. Studies (e.g., Syah et al., 2019) showed that program success in Indonesia depends heavily on community involvement in planning,

implementation, and supervision. Cultural barriers, such as low health literacy and resistance to preventive health programs, also limited participation (Indriyani et al., 2022).

In conclusion, *Puskesmas Paripurna* demonstrated superior mobilization and execution through strong leadership, staff empowerment, consistent monitoring, and community collaboration. To strengthen *Puskesmas Madya*, integrated interventions are needed—covering continuous staff training, adequate budgeting, community partnerships, and intensive health education to build a sustainable culture of health.

3.3 Differences in the Implementation of the Supervision, Control, and Performance Evaluation (P3) Functions

The stages of supervision, control, and performance evaluation (P3) in the implementation of health programs across the five observed Community Health Centers (Puskesmas) revealed that regular monitoring and evaluation mechanisms are consistently applied. At Latambaga Health Center, P3 activities are reflected in the availability of measurable program achievement data—such as indicator performance percentages, disease case reports, and visualized outcomes presented through graphs and tables. Regular evaluations are conducted on resource utilization, including medicines and medical facilities. Each program is required to produce an annual report containing achievements and recommendations for improvement. These evaluations serve as the foundation for subsequent program planning, thus creating a continuous management cycle.

Similarly, at Kolakaasi Health Center, supervision and evaluation are routinely implemented, evidenced by indicator performance reports, disease case reports, and visual presentations in tables and graphs. Evaluations cover not only program achievements but also the use of medicines, medical equipment, and disease surveillance implementation. The outcomes of monitoring and evaluation activities serve as the basis for improving programs in the following year.

At Wundulako Health Center, monitoring and evaluation are systematically conducted on achievement indicators presented in graphs, tables, and narrative formats. Annual evaluations assess target success and provide recommendations for program improvement. Evaluations also include resource use, disease surveillance, and reporting to the District Health Office. The implementation of integrated management principles—from planning to execution and evaluation—has proven to enhance program and service quality within the center's operational area.

The Pomalaa Health Center also carries out P3 activities regularly through the monitoring and evaluation of all health programs. Each program has measurable performance indicators reported in tables, graphs, or narratives, covering aspects of mortality, morbidity, nutrition status, and basic as well as advanced service coverage. The year-end evaluation focuses on measuring target achievements, identifying obstacles, and preparing recommendations. Evaluation results are used as essential inputs for the next year's planning. Monitoring and evaluation have become integral parts of the management system, significantly contributing to quality improvement.

At Tanggetada Health Center, supervision and evaluation are routinely implemented across all health programs. Reports on performance indicators are presented in tables, graphs, and annual narratives. Evaluations assess targets, identify constraints, and produce recommendations for service enhancement. Fifteen major programs are evaluated regularly, with comprehensive reports especially on mandatory and development programs. The outcomes of monitoring and evaluation serve as the basis for planning and decision-making to improve service quality.

In terms of more advanced supervision and evaluation practices, Paripurna-accredited Puskesmas such as Latambaga conduct regular internal audits by an independent audit team. The Quality Assurance Officer at Latambaga stated that audits are conducted quarterly to assess compliance with hand hygiene, the use of personal protective equipment (PPE), and staff attendance (Interview: June 7, 2025). Meanwhile, at Wundulako, a supervision system integrated with the regional government's *Sikap* application and attendance records is also in place (Interview: Head of Wundulako Health Center, May 29, 2025).

However, Madya-accredited Puskesmas still face significant challenges in terms of physical facilities and staff discipline culture. The Quality Assurance Officer at Latambaga mentioned that physical facilities remain inadequate and resemble a market environment, while staff discipline remains a major barrier to quality management implementation (Interview: June 7, 2025). Regular evaluations are socialized through *mini-workshop* forums, and staff training is facilitated by the District Health Office. The evaluation results are continuously used for quality improvement efforts.

Accreditation assessors emphasized the importance of implementing the PDCA (Plan-Do-Check-Act) quality cycle, annual monitoring, regular internal audits, and follow-up actions as key elements in strengthening quality management (Interview: May 29, 2025). Document analysis shows that at Kolakaasi, program achievement monitoring is carried out monthly and annually, including audits of nutritional status, immunization coverage, and priority disease reports. Audit results are discussed in *mini-workshop* forums and systematically documented in monthly and annual reports (Kolakaasi, pp. 35–37).

Latambaga also monitors key indicators such as maternal mortality (MMR), infant mortality (IMR), tuberculosis recovery, and nutritional status. However, supervision remains reactive, with suboptimal documentation of follow-up actions, and faces constraints due to limited data access and reporting system capacity (Latambaga, Preface, Chapter VI).

This supervision model is highly effective in maintaining service quality consistency and aligns with the concept of Continuous Quality Improvement (CQI) as recommended by the World Health Organization (WHO, 2018) and supported by Kruk et al. (2018). Routine monitoring and evaluation of quality indicators have become an embedded organizational culture. Research by Kusnanto et al. (2019) and Nugroho et al. (2021) also indicates that regular quality audits, managerial supervision, and tiered training are crucial determinants of quality control success in primary healthcare facilities.

Conversely, Madya-accredited Puskesmas face challenges in maintaining consistent supervision practices. Constraints such as inadequate infrastructure, limited staff understanding of quality indicators, and insufficient time for audits hinder optimal control processes (Putri et al., 2021). Attendance systems and performance applications like *Sikap* have been introduced but are not always accompanied by strengthened discipline culture or consistent follow-up actions. Program evaluation and staff training in Madya centers are often reactive—conducted only in response to issues rather than as part of a continuous quality improvement cycle.

Overall, the findings of this study are consistent with previous research emphasizing that achieving Paripurna accreditation success in Puskesmas is largely determined by key factors such as leadership commitment, staff discipline, structured supervision, and continuous evaluation.

4. Conclusion

The comparative analysis of management function implementation in Paripurna- and Madya-accredited community health centers (Puskesmas) in Kolaka Regency reveals substantial differences in managerial capacity, organizational structure, and quality assurance mechanisms. Puskesmas with Paripurna accreditation demonstrate stronger integration across planning, implementation, and supervision functions. They possess more structured work plans aligned with the regional health profile, effective team coordination through functional and cross-sectoral collaboration, and consistent monitoring and evaluation guided by continuous quality improvement principles.

In contrast, Puskesmas with Madya accreditation show limitations in planning comprehensiveness, human resource allocation, and documentation systems. Managerial practices are often reactive rather than preventive, with insufficient coordination in inter-program activities. Supervision and evaluation processes tend to focus on administrative compliance rather than outcome-based performance improvement.

Overall, the findings indicate that higher accreditation status correlates with more mature management functions, particularly in leadership commitment, communication flow, and utilization of health information systems. Strengthening the managerial competence of Madya-level Puskesmas requires systematic

capacity building, consistent monitoring support from local health authorities, and reinforcement of management information systems to ensure equitable service quality across all primary health care units in the region.

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