Research Journal of Medical Sciences 9 (3): 147-153, 2015
ISSN: 1815-9346

Professional Challenges to Strengthen Partnerships in the Implementation of Healthy Cities in Indonesia: A Case Study of Makassar

[1]Sukri Palutturi, [2]Shannon Rutherford, [2]Peter Davey and [2]Cordia Chu
[1]School of Public Health Hasanuddin University, Indonesia
[2]Centre for Environment and Population Health, Griffith University, Australia

Abstract: For successful implementation of the global healthy cities movement, WHO recognizes that working in partnership with different sectors, organizations and background are key ingredients. Current literature has shown various challenges to partnerships, particularly professional challenges. However, little research demonstrates evidence based on real practice example. Before examining the professional challenges for effective partnerships in the implementation of healthy cities, this study explained the activities of the development of Makassar Healthy City (MHC), Indonesia, according to the selected settings and described the organisational structure and working partnerships of healthy city. In-depth interviews of 24 informants from the members of Healthy City Advisory Team (HCAT) and Healthy City Forum (HCF) were conducted. They involved actively in the implementation of healthy city. This research identified several professional factors for effective partnerships including poor understanding and view point, lack of commitment, lack of opportunities for staff development and lack of time. The finding indicates there is a need for stakeholder involvement in strengthening effective partnerships.

Key words: Healthy cities, partnerships, professional challenges, staff development, lack of time

INTRODUCTION

For successful implementation of the global healthy cities movement, WHO recognises that working in partnerships with different sectors, organisations and backgrounds is a key ingredient (WHO, 2000, 2001, 2002, 2004; Palutturi, 2014; Palutturi *et al*., 2013). As the importance of the partnerships, several scholars assessed the challenges and determinants affecting the effectiveness of partnerships such as Wildridge *et al*. (2004), Bauld and Langley (2010), Barton and Tsourou (2000), Roussos and Fawcett (2000), Nelson (2005), McQuaid (2000) and Holtom (2001). Most scholars categorised the challenges and barriers in building effective partnerships into five groups, namely: structural challenges, procedural challenges, financial challenges, professional challenges and status and legitimacy (Bauld and Langley, 2010; Holtom, 2001). However, other scholars view that lack of recognition and acknowledgment for people involved in a partnership is also a barrier to strengthen a partnership (Hudson and Hardy, 2002; Gray, 1989), including partnerships in the implementation of healthy cities.

According to Holtom (2001) professional challenges are one of the crucial issues in fostering effective partnerships. The professional challenges relate to the range of differences in values including culture and roles of people involved. These aspects are the most important elements in the professional challenges. This can be indicated by several authors emphasising these issues, including Barton and Tsourou (2000), Roussos and Fawcett (2000), Hudson and Hardy (2002), Holtom (2001), Bauld and Langley (2010), Israel *et al*. (1998, 2006) and Gray (1989). Nevertheless, there are several aspects influencing the professional challenges in partnership and grouped in these issues. They are different viewpoint; different work culture and values; lack of trust, respect and understanding; lack of skills and capabilities; power distribution and inequitable control; different interest; leadership; lack of awareness; lack of staff, lack of time and morale and energy maintenance. In building effective partnerships such issues need to be identified clearly. Managing the elements relating to the professional factors can help to achieve the organisational goals and to encourage people to involve actively in the program.

Although, WHO recognises that working in partnership is an effective way to achieve the aims of healthy cities, even, this becomes the principle in the implementation of healthy cities, working in partnerships from different sectors and organisations is a huge challenge due to difference in capacity building

Corresponding Author: Sukri Palutturi, School of Public Health Hasanuddin University, Indonesia

(Palutturi *et al*., 2013; Holtom, 2001). Each government department and sector has own planning, capacity building and other program implementation. For example, in the context of Indonesia, the healthy cities program is grouped in the nine settings (themes) stipulated nationally (MOHA and MOH, 2005). They are healthy settlement areas and public facilities, traffic facilities areas and transportation services, healthy mining areas, healthy forestry areas, healthy industry and office areas, healthy tourism areas, food security and nutrition, self-reliant healthy community life and healthy social life. Each setting has a technical department which is responsible for the implementation of the setting. For example the Department of Health is responsible for the implementation of self-reliant healthy community life, including programs relating to capacity building; the Department of Public Works and the Regional Environmental Impacts Control are responsible for the healthy settlement areas and public facilities. These established settings can be chosen by city government according to the capacities and local needs. Selection of these settings is also associated with the healthy city award given by the central government: Swasti Shaba Padapa (basic achievement), Swasti Shaba Wiwerda (middle achievement) and Swasti Shaba Wistara (high achievement) (MOHA and MOH, 2005). In short, working in partnership is essential. It is a more effective way to overcome a specific goal than each partner operating separately and is particularly important in public health where the determinants of health are complex.

Building partnerships requires resources, risks and benefits to be shared by all partner members. Closing the gap of professional challenges for partnerships provides a room for all stakeholders to involve actively in the implementation of healthy cities and to accelerate the achievement of healthy cities in Indonesia, especially in Makassar City: a clean, safe, comfortable and healthy city. This research can be used for policy makers to develop an effective healthy cities program, including strong partnerships.

Study aim: This study explained the activities of the development of Makassar Healthy City (MHC), Indonesia according to the selected settings and described the organisational structure and working partnerships of healthy city. This study also examined the professional challenges to strengthen the effective partnerships in the implementation of healthy cities in Indonesia, especially in Makassar Healthy City (MHC).

MATERIALS AND METHODS

This study used a qualitative approach designing a case study for the implementation of healthy cities in Indonesia. This study was conducted in Makassar City, a largest city outside of Java and Sumatera Islands. The 24 informants from the members of HCAT and HCF were involved in this research. They were from different backgrounds, professions and positions such as the Regional Planning and Development Board, the Department of Health, the Department of Social Affairs, the Department of Tourism, university representatives, NGOs and media. The members of the HCAT and HCF were selected because people who are from these institutions were involved directly in the implementation of MHC as explained in the joint regulations of the Ministry of Home Affairs (MOHA) and the Ministry of Health (MOH). A permission letter from local government of Makassar City to interview them was obtained aimed to all selected departments and sectors. The research guide was designed in unstructured questions for example, about the implementation of healthy city in Makassar and the aspects related to the organisational and procedural determinants for fostering partnerships. This research uses thematic analysis.

Activities of the development of MHC according to the settings: There are several settings programs that have been implemented to achieve a MHC as shown in Table 1. Each setting program has its own aim's, a lead department and supporting sectors.

Organizational structure and working partnerships of healthy city: The policy of the implementation of healthy cities in Indonesia is stipulated by the joint regulations of the MOHA and the MOH. This policy applies to all districts/cities in Indonesia that implement healthy districts/cities, including in Makassar City. For Makassar city, the policy of the implementation of healthy city was stipulated by mayoral decree No. 60/2009. This regulation set up two organisations or institutions in general relating to the implementation of healthy city in Makassar, namely Healthy City Advisory Team (HCAT) (Pembina) and Healthy City Forum (HCF). These organisations have the same aim, as the HCF which is to achieve a clean, safe and comfortable MHC. However, they have different roles and tasks. The membership of HCAT is predominantly from the governmental departments and boards while the members of HCF which are all predominantly from community representatives. This forum is a kind of non-government organization stipulated by the mayor.

The HCAT functions to plan, to implement and to evaluate the healthy cities program according to the settings of healthy cities by respective governmental department and board. This advisory team also provide advice to the HCF. Furthermore, principally, the HCF is a

Table 1: Settings of Makassar Healthy City

Settings of MHC	Aim's	Activities (examples)	Technical agencies	Other sectors
Self-reliant healthy community life	To support the implementation of healthy city from the perspective of the health sector	Dissemination of information via mass media about Healthy Makassar Movement, formation of Healthy Sub-Districts and Working Groups; supervision of Healthy Sub-Districts and Working Groups together with HCF, provision of free health services to the community, assistance to Healthy Schools through IHPP and Healthy Makassar Movement (Gemas); water supply, sports health and immunization programs.	Department of Health	Local Government, Hasanuddin University (UNHAS), NGOs
Healthy tourism areas	To support the realization of a healthy tourist city	Election of Dara and Daeng, art performance at Fort Rotterdam, Bugines Makassarese Art Attraction on the 400th anniversary of Makassar, Traditional Food Festival, Performane of Makassar Arts and Losary Festival	Department of Culture and Tourism	Local Government, Regional Planning and Development Board, Department of Health, Department of Religious Affairs, UNHAS and NGOs
Healthy settlement areas and public facilities	To create a healthy environment and provide an adequate public facilities	Improving the quality of slum areas; improving availability of clean water, increasing availability of urban landscaping, flood control through the provision of an effective drainage system; vehicle emissions testing and improvement of road infrastructure	Department of Public Works	Department of Health, Department of Spatial PlanningandInfrastructure, DepartmentofLandscaping and Hygiene, UNHAS and NGOs
Healthy industrial Areas and offices	To create healthy industrial areas and support to achieve healthy offices	Management and development of traditional markets; increasing trade information network system; improving the physical environmental exhibitions of industry commodities and handicrafts at the local, national and international level.	Department of Industry, Trade and Investment	Department of Health, Department of Labour, UNHAS and NGOs
Healthy traffic and transportation services	To create a friendly environment with adequate transportation infrastructure	Provision of traffic signs and provision and maintenance of road markings, construction of road infrastructure; enhancement of public transport services, improvement of terminal services; education of drivers to improve safety.	Department of Transportation	Department of Health, Department of Public Works, UNHAS and NGOs
Healthy social life	To reduce social problems such as urban poverty, prostitution and victims of narcotic users	Tackling poverty, drug victims, street children, beggars and the homeless and prostitutes; application of local regulation No 2 of 2008 concerning guidance of street children, beggars, homeless and street singers; management of disabled persons, abandoned children and the elderly; provision of social security funds for people with disabilities and elderly and trainings to improve their skills and knowledge	Department of Social Affairs	Department of Health, Department of Religion Affairs, Department of Industry, Trade and Investment), the private sector and communities

place for people to convey their aspirations and to participation. The HCF has a role in determining the direction of healthy city development and formulating proposals, priorities, targets and developing planning which integrates various aspects of development to achieve clean, comfortable, safe and healthy areas. The Forum also functions to coordinate events of the healthy city program conducted by the community, government and non-government elements effectively and efficiently. A member of the HCF stated:

> The task of the forum is only to advocate with all sectors, all departments in order to drive and create a healthy city. How the Department of Transportation, for example, makes activities that always consider its impacts on health (IK-20-M)

Professional challenges for partnerships in Makassar Healthy City

Poor understanding and viewpoint: Understanding of the healthy cities concept varies among the partners. Generally, the partners who are working for the Department of Health Makassar or people from the health education background can define and explain properly the concept of healthy city. However, those who are from other departments do not have adequate knowledge about the concept of healthy cities. They mostly define healthy city according to their working areas. The Department of Education for example, understands the healthy cities concept in relation to school environment. Other informants define healthy cities according to the elements of creating a healthy city. For example, a healthy city has to be clean, green with no pollution or flood and good waste management. For some informants a healthy city is something intangible. Some of them have never heard about healthy cities. A senior member of HCAT stated:

> A healthy city is a way to create, realize and make community willing and able to live a healthy life that is supported by the environment and people's behaviour and supporting infrastructure to be called a healthy

Another member of HCAT commented:

> Healthy city is a city that is Wiyata Mandala (Javanese: Wiyata-teaching or education and Mandala-circle or environment) oriented, able to present a neat, clean and beautiful environment by promoting health factors for community, especially for students in school. The Wiyata Mandala has seven principles: security/leisure, kinship, discipline, shade, hygiene, beauty, order (MD-8-M)

The above quotation shows that not all people involved in the implementation of Makassar Healthy City know about the healthy cities concept. In fact, one key informant who is even working for the government, did not know about the idea of healthy cities. This key informant does not have the same perception regarding the basic concept of a health city. The informant believed that the healthy city program belongs to the Department of Health. He stated:

> I was surprised you wish to ask me about healthy city. Healthy market yes, I know but healthy city in general, I do not know, only heard. I think the healthy city relates to health office so that it is better for you to ask them. From my point of view, for all programs relating to health or 'healthy', the leading sector is the Department of Health (THS-5-M)

Similar statements were also provided by other informant. A member of the HCF stated:

> Many people consider that the HCF is a part of Health Department or belongs to Health Department. Probably this is about paradigm problem. As there is the word 'healthy 'in healthy cities that is why the healthy cities program is identified with a program of the Department of Health (IK-12-M)

Thus, it can be concluded that healthy city is not understood yet comprehensively. There are two conclusions: the first conclusion relates to the concept of a healthy city. The healthy city generally is defined and understood as the aspects that relate to a clean environment. A comfortable and safe city has not been a priority in a healthy cities program. This differs from definition proposed by government as noted in the joint regulations of the MOHA and MOH (2005) in Chapter I General Provision article (WHO, 2000). "A healthy district/city is a clean, comfortable, safe and healthy district/city for the population to live in achieved through the application of integrative settings and activities and agreed by community and local government" (MOHA and MOH, 2005). The second conclusion relates to the lead sector. Some informants still think that the healthy cities program belongs to the Department of Health or that only Department of Health is responsible for achieving the aims of the program.

There are two reasons at least why many people think that the healthy cities program is a part of the Department of Health duties. First, healthy city has the word 'healthy' so they consider that a healthy cities program belongs to the Department of Health. This issue relates to the terminology or nomenclature of healthy cities. Second, the healthy cities award from the central government to the successful cities and districts implementing healthy cities program is handed over when celebrating the National Health Day of Indonesia in November in Jakarta.

Lack of commitment: The implementation of healthy city of Makassar relies heavily on the commitment of the people involved. Commitment relates the willingness of the people involved to achieve the aims of healthy city. Low commitment can be indicated by weak contribution to and engagement activities of the healthy city program. This is seen in poor attendance at meetings and workshops conducted by the HCAT or the HCF. Through, the interview, this study found that some members of the HCAT and HCF did not attend several meetings of their committees. Mostly, they delegated representation to other. Only the main members of the forum usually attended the meetings while others did not. Lack of commitment from some members of the HCAT and the HCF of course, influences the effectiveness of partnership in the implementation of a healthy city program because their participation in the program is inconsistent. Such weak involvement will have impacts in the achievement of healthy city aims. A member of HCF stated:

> Probably, it was about motivation and commitment. Actually the Forum always tried to invite them to attend a meeting but they could say, why do we need to attend it? It does not have any money for transportation. There is a low sense of belonging and healthy cities is not a priority (IK-12-M)

Lack of opportunities for staff development: There is a difference in opinion regarding the opportunities for staff to develop their skills and capabilities. At the HCAT level, individually or group, they often had opportunities to attend conferences, go on study tours, do training or benchmarking, domestic or overseas. For example, some of the members of HCAT and HCF of Makassar attended the healthy cities conference in Australia and also some of them attended the healthy cities short course at Griffith

University, Australia. They are generally 'big bosses'. However, at the staff member level, participants are rarely engaged, though they are spearheading the operational implementation of MHC. A member of the HCF stated:

> Training opportunities were usually only for big bosses for example a short course overseas while staffs at low level were rarely included (Q-22-F)

Imbalance in providing opportunities for staff and related partners can reduce their motivation to be involved in the implementation of healthy city, especially for those who are rarely given opportunities to improve their skills.

Lack of time: Time is very valuable. Time is one of the professional challenges of partnership in the implementation of MHC. According to the informants, the people involved in this program have good capabilities; they are people with high education, especially those on the advisory board of the HCF. They were involved as members of the forum because of their 'big names'. They are prominent people, so they are expected to influence government policy-making, in particular in the implementation of the healthy city program. However, they are also very busy; their time is very limited to attend the various activities of healthy city for example, coordination meetings. This challenge, of course, affects the involvement and coordination among them in the implementation of the program. Even though they have strong capabilities as explained above, they cannot work maximally. For some people, money is not a problem in building partnerships; the biggest problem is shortage of time. A member of the HCF commented:

> They are thinkers, they have competencies yes but they do not have time for the forum (Q-22-F)

In short, this research found professional challenges of partnership in the implementation of MHC. They were weak understanding and viewpoint about healthy cities, low commitment among people involved, lack of clarity and communication, lack of continuity of staff, unfair opportunities for the staff development and lack of time.

RESULTS AND DISCUSSION

Generally, this research aims to examine the professional challenges of partnerships in the implementation of healthy cities in Indonesia, especially for Makassar Healthy City (MHC). This study identified several aspects of professional challenges of partnerships. They are understanding and viewpoint about healthy cities, lack of commitment, lack of opportunities for staff development and lack of time as the main issues influencing an effective partnership for healthy cities. This research differs from the finding of Holtom (2001), Hudson and Hardy (2002) and Bauld and Langley (2010). They do not explain in detail the aspects related to the professional challenges. They only explained the aspects of professional challenges which were range of differences around values and roles.

Human resources and improving capacity building are one of the important components in the development of partnership. Challenge to the implementation of healthy cities is that there is still an understanding and a view point that healthy cities are the business of health sectors or Department of Health. In the development of partnership, viewpoint difference to the healthy cities also had been noted by several scholars such as Barton and Tsourou (2000), Roussos and Fawcett (2000), McQuaid (2000), Israel *et al*. (1998, 2006) and Gray (1989). They argued that different viewpoint will influence the effectiveness of partnership development, including in the implementation of healthy cities. Due to misunderstanding and viewpoint difference of people involved will generate lack of commitment to the organisation (about time, thought and budget allocate). In relation to the implementation of healthy cities in Indonesia, misunderstanding and this viewpoint difference may occur due to: First, healthy cities has a world "Healthy" which is very identical with health or related to health. Second, even though nationally, the implementation of healthy cities has been regulated by the joint regulation between the MOHA and the MOH, the idea and the involvement of the MOH is more dominant than related departments. This involvement also affects to the district/city level. Third, awards of healthy cities given in every 2 years, November, to successful cities are awarded on National Health Day. Forth, awards of healthy cities are usually submitted by the president or vice president of Indonesia. However, when both of them have other agendas, the awards are given by the Ministry of Health on behalf of the Indonesian government. These facts make and support other departments and sectors that healthy cities is the business of health sector. Therefore, misunderstanding to healthy cities needs to be addressed. Some actions may be useful for that for example: First, central government has to strengthen the involvement of the MOHA than the MOH. Second, it seems to be healthy cities has not become a national issue or a government issue; healthy cities only becomes a

department issue. This issue needs to be considered. Third, at city level, to address those problems, the involvement and strong support of Mayors is crucial.

This study also found that opportunities for people involved in the healthy cities to develop their skills were lack. MHC principally has given opportunities for several 'big boss' (heads of government department) to attend conferences and short course of healthy cities for example, in Australia (Griffith University). However, those who attended are big bosses. Opportunities for staff who work operationally and administratively in the healthy cities to develop their skills are limited. Such opportunities should be given to them proportionally to handle a complex issue of healthy cities. Another problem is that the government both central, provincial and city government itself rarely conduct activities that aims to support their skills and knowledge. They usually only attend very common activities such as coordination meetings of healthy cities, annual workshop of healthy cities conducted by city government or by provincial and central government. There are no specific trainings conducted by government on behalf of healthy cities. This may happen as they do not understand appropriately the concept of healthy cities, no budget for that or the HCF or HCAT never conduct a need assessment that relates to trainings and capacity development for them. Such problems had been a concern by previous research conducted by for example, Nelson (2005), Israel *et al*. (2006) and Wildridge *et al*. (2004). They found that lack of skills and capabilities of people in a program and an organisation will affect the effectiveness of partnership development. Therefore, capacity improvement of healthy cities has to run continuously.

CONCLUSION

The implementation of healthy city in Makassar, Indonesia based on the selected settings and the level of expected healthy city award. Each setting has specific aims, activities and departments in charge.

The healthy city is implemented by the healthy city forum and guided and facilitated by the healthy city advisory team. The members of healthy city forum are generally from community level while the members of healthy city advisory team are mostly from the government elements from different departments. They work together and support each other.

However, professional challenges for partnership such as misunderstanding about healthy city, lack of commitment, lack of opportunities for staff development and lack of time are the major issues influencing an effective partnership for healthy city.

REFERENCES

Barton, H. and C. Tsourou, 2000. Healthy urban planning: a WHO guide to planning for people. London: Spon Press for the World Health Organization Regional Office.

Bauld, L. and D. Langley, 2010. Learning from the Partnership Literature: Implications for UK University/National Health Service Relationships and for Research Administrators Supporting Applied Health Research. Photos: Courtesy of US Navy, Dreamstime com, istock com and Fotosearch, Inc. 41 (1): 201049.

Gray, B., 1989. Collaborating: Finding common ground for multiparty problems. San Francisco.

Holtom, M., 2001. The partnership imperative: joint working between social services and health. J. Manage. Med., 15 (6): 430-445.

Hudson, B. and B. Hardy, 2002. What is a 'successful'partnership and how can it be measured. Partnerships, New Labour and the Governance of Welfare, pp: 51-65.

Israel, B.A., A.J. Schulz, E.A. Parker and A.B. Becker, 1998. Review of community-based research: assessing partnership approaches to improve public health. Annual Review of Public Health, 19 (1): 173-202.

Israel, B.A., J. Krieger, D. Vlahov, S. Ciske, M. Foley and P. Fortin *et al*., 2006. Challenges and facilitating factors in sustaining community-based participatory research partnerships: lessons learned from the Detroit, New York City and Seattle Urban Research Centers. J. Urban Health, 83 (6): 1022-1040.

McQuaid, R.W., 2000. The theory of partnership. Public-private partnerships: theory and practice in international perspective, 19: 9.

MOHA and MOH, 2005. The guideline of healthy districts/cities implementation (Peraturan bersama Menteri Dalam Negeri and Menteri Kesehatan) Nomor: 34 Tahun 2005 dan Nomor: 1138/menkes/PB/VIII/2005. Jakarta, Indonesia: Tim Pembina Kabupaten/Kota Sehat Tingkat Pusat.

Nelson, J., 2005. Partnering for success. Geneva: World Economic Forum Global Corporate Citizenship initiatives in cooperation with IBLF the Prince of Wales international Business Leaders Forum, Harvard University and John F. Kennedy, School of Government.

Palutturi, S., 2014. Public Health Leadership. Yogyakarta: Pustaka Pelajar.

Palutturi, S., S. Rutherford, P. Davey and C. Chu, 2013. Healthy Cities Implementation in Indonesia: Challenges and determinants of successful partnership development at local government level. Brisbane, Australia: Griffith University.

Roussos, S.T. and S.B. Fawcett, 2000. A review of collaborative partnerships as a strategy for improving community health. Annual Review of Public Health, 21 (1): 369-402.

WHO, 2000. Regional gudelines for developing a healthy cities project. Philippines: World Health Organization Regional Office for Western Pacific.

WHO, 2002. Healthy Cities initiative: Approaches and experiences in the African region. Brazzaville: World Health Organization.

WHO, 2001. Integrated management of healthy settings at the district Level: Report of an intercountry consultation Gurgaon, India, 7-11 May 2001 India: World World Health Organization Regional Office for South-East Asia New Delhi. http://whqlibdoc.who.int/searo/2002/SEA_HSD_260.pdf.

WHO, 2004. Partnership for health: Collaboration within the United Nations system and with other intergovernmental and nongovernmental organizations. Copenhagen, Denmark: World Health Organization Regional Committee for Europe.

Wildridge, V., S. Childs, L. Cawthra and B. Madge, 2004. How to create successful partnerships: A review of the literature. Health Information and Libraries Journal, 21: 3-19.