Research Article

Gender-inclusive Health Policy Innovation: A Contextual Study of Padang City

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Abstract.
This study explores how gender-inclusive health policy innovation can be developed and institutionalized in a decentralized urban context marked by bureaucratic rigidity and uneven service delivery. While Padang has made progress in expanding health infrastructure and adopting digital tools, existing policies remain largely gender-blind. Drawing on collaborative innovation theory and the diffusion of innovation model, this qualitative case study examines the institutional, socio-political, and technological factors that shape health policymaking. Data were gathered through interviews, document analysis, and participatory observations. Findings reveal that health programs prioritize administrative targets over equity, with limited cross-sectoral collaboration and no structured use of gender-disaggregated data. Promising digital initiatives, such as SMILE and Dokter Warga, lack inclusive design and fail to reach marginalized groups. This study proposes the establishment of a multi-actor gender health innovation taskforce, the enactment of local regulations on gender-responsive governance, and capacity-building for inclusive digital health strategies. This research makes theoretical and practical contributions to ongoing debates on gender equity, digital inclusion, and collaborative governance in health systems.

Keywords: health policy, BPJS gratis, kota Padang, gender innovation

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1. Introduction

Health is universally acknowledged as a fundamental human right and a vital element of sustainable development. The Sustainable Development Goals (SDG 3), established by the United Nations, strive to “ensure healthy lives and promote well-being for all ages.” This goal reflects a global commitment to providing inclusive, equitable, high-quality healthcare. Nonetheless, achieving this objective presents significant challenges, particularly in contexts characterized by decentralized governance. In such environments, local capacity, political dynamics, and institutional cultures play crucial roles in shaping the direction and effectiveness of public health policies.

Indonesia, the world's fourth most populous country, has adopted a decentralized governance model since the early 2000s, granting considerable autonomy to local governments in managing public services, including healthcare. While decentralization is expected to enhance responsiveness and accountability, it also creates disparities in service quality, innovation, and inclusivity across regions. In many urban areas, including Padang City—the capital of West Sumatra—health policies and services often reflect a one-size-fits-all approach, lacking sensitivity to local needs and intersectional vulnerabilities.

In this context, gender becomes a crucial axis of inequality. Health systems worldwide often operate under the assumption of gender neutrality, neglecting the distinct needs, experiences, and structural barriers encountered by women, girls, and gender-diverse populations. Elson [1] argues that the lack of gender analysis in policy formulation leads to "gender-blind" policies that unintentionally reinforce existing inequities. In Padang City, despite significant progress in expanding health insurance coverage through the national BPJS (Badan Penyelenggara Jaminan Sosial) system, disparities in access and quality remain, particularly for women residing in peripheral or underserved areas.

A preliminary assessment of public health services in Padang reveals several critical issues: (1) maternal and child health services are predominantly concentrated in central areas; (2) mechanisms for responding to gender-based violence are limited and often fragmented; (3) older women experience intersectional disadvantages related to age, income, and mobility; and (4) local bureaucracies frequently prioritize quantitative coverage metrics, such as insurance participation rates, over the quality of gender-responsive services. These challenges suggest that while technical and administrative innovations are crucial, they must be complemented by inclusive policy frameworks that take into account gender dynamics, power relations, and the realities at the community level.

The Fourth Industrial Revolution has created new opportunities for transforming public service delivery. Technologies such as artificial intelligence (AI), big data analytics, and digital health platforms can be leveraged to expand access, refine targeting, and enhance the responsiveness of services. However, the mere deployment of technology does not ensure inclusivity. Without intentional policy frameworks that incorporate gender-disaggregated data, facilitate meaningful community engagement, and build institutional capacity, digital health initiatives risk replicating or exacerbating existing inequities [3].

This study occupies a critical space within ongoing debates concerning gender-inclusive health policies. It aims to investigate how local governments, particularly in Padang City, can effectively design and implement gender-inclusive health policy innovations. This exploration focuses on mobilizing collaborative governance, leveraging digital technology, and overcoming bureaucratic obstacles. Drawing on the theoretical frameworks of collaborative innovation [8] and the diffusion of innovation [2], this research highlights the processes and content of innovation. It examines who is involved in these efforts, how innovations are introduced, and whether they effectively address the lived experiences of marginalized groups.

This study's central research question is: "How can gender-inclusive health policy innovation be developed and institutionalized in a decentralized urban context such as Padang City?"

Sub-questions include:

1. What are the institutional, socio-political, and technological factors influencing health policy innovation at the local level?
2. How do actors across sectors (government, civil society, health providers, and communities) collaborate—or fail to cooperate—in shaping gender-responsive health policies?
3. How can digital tools and platforms support inclusive health policy processes?

This study aims to contribute theoretically by providing a synthesized framework for collaborative and gender-responsive innovation and by proposing a context-sensitive model for health policy reform at the city level. The findings are expected to inform local governments in Indonesia and enrich broader discussions on gender equity and innovation within decentralized health governance.

2. Literature Review

2.1. Gender and Health Policy: From Neutrality to Inclusion

Health policy has traditionally been considered gender-neutral, assuming that public services benefit all citizens equally. However, an increasing body of evidence indicates that gender-blind approaches to policy design often reinforce structural inequalities, particularly affecting women and other vulnerable groups [1], [5]. In many situations,

women encounter specific health-related challenges—such as maternal health risks, limited mobility, and insufficient caregiving support—that are not adequately addressed by generalized policy frameworks.

Recent studies highlight the necessity of gender mainstreaming in health policy to achieve inclusive and equitable outcomes. According to George et al. [6], gender-sensitive policy requires disaggregated data, gender-responsive indicators, and the inclusion of women in all stages of policy development. Research in India and Nigeria further demonstrates that policies designed without considering gender differences exacerbate disparities in access to essential health services [7].

Despite some improvements, Indonesia's health policies lack systematic integration of gender perspectives—especially at the local level. This gap is particularly evident in decentralized cities like Padang, where cultural norms, uneven service distribution, and institutional rigidity create significant barriers for gender inclusion.

2.2. Collaborative Innovation in Local Governance

In the era of decentralization and democratic governance, collaborative innovation has emerged as a vital approach for addressing complex public challenges. According to Ansell and Torfing [8], collaborative innovation is a dynamic process that involves multiple stakeholders—including government agencies, civil society, academia, and communities—working together to co-create and implement policy innovations through deliberation, negotiation, and joint learning.

The effectiveness of collaborative innovation depends on several institutional factors, including bureaucratic openness, trust among stakeholders, strong leadership support, and a conducive legal framework. Comparative studies in Denmark, the Netherlands, and the UK have demonstrated that collaborative processes enhance service outcomes and improve policy legitimacy and public ownership [9], [10].

In Indonesia, some progressive cities have begun to explore collaborative health initiatives. Nonetheless, many of these efforts tend to be ad hoc, driven by donors, or confined to limited pilot programs. The lack of institutionalized multi-actor platforms at the municipal level has significantly hindered the scalability and sustainability of these innovations, especially those aimed at promoting gender equity.

2.3. Digital Health and Innovation Diffusion in Developing Contexts

The emergence of digital health technologies, significantly accelerated by the COVID-19 pandemic, has opened new avenues for innovation in public service delivery. Technologies such as telemedicine, electronic health records, health dashboards, and AI-powered diagnostics can enhance efficiency, broaden coverage, and personalize care. However, successfully implementing these tools relies on factors beyond mere technical feasibility. The OECD [3] and WHO [4] studies indicate that socio-cultural acceptance, digital literacy, and infrastructure readiness are key determinants for the adoption of digital health solutions.

Rogers' Diffusion of Innovation theory [2] serves as a valuable framework for understanding how new ideas and technologies are accepted within social systems. This process encompasses the stages of knowledge, persuasion, decision, implementation, and confirmation. Several factors significantly influence the diffusion curve, including relative advantage, compatibility with local values, complexity, trialability, and observability.

In Indonesia, urban regions have rapidly embraced health technology platforms, particularly within the private sector. In contrast, rural and underserved areas lag due to infrastructure and human capacity gaps. Digital innovations risk perpetuating existing inequalities rather than alleviating them without careful integration into policy and service design.

Based on the reviewed literature, three critical gaps emerge:

1. There is limited empirical research on gender-responsive health policy innovation in the Indonesian context, especially at the city level.
2. Studies on collaborative innovation often focus on sectors like education or urban planning, but rarely address the health sector through a gender lens.
3. While digital health tools are gaining attention, their role in shaping inclusive policy processes remains underexplored—especially in decentralized governance systems.

This study addresses these gaps by synthesizing gender studies, collaborative governance, and innovation diffusion into an integrated framework for gender-inclusive health policy in Padang City.

3. Methods

This study employed a qualitative case study approach to explore the dynamics of gender-inclusive health policy innovation within the local governance context of Padang City, Indonesia. The case study design was chosen due to its strength in capturing complex social processes involving multiple stakeholders, institutions, and contextual variables that influence policy innovation [11].

Primary data were collected through 20 semi-structured interviews with representatives from local government agencies, health providers, civil society organizations, and women's organizations. In addition, document analysis was conducted on regional policy plans, health budgeting reports, and legal frameworks, complemented by participatory observation in local health forums. These three sources were triangulated to strengthen the validity and contextual richness of the findings.

The analysis was guided by a synthesized theoretical framework that combines collaborative innovation theory [8], diffusion of innovation [2], and gender mainstreaming principles. Thematic coding was conducted using NVivo, focusing on actor collaboration, institutional constraints, gender representation in policy, and the role of digital tools in these areas. Ethical clearance was obtained from Universitas Andalas, and all participants gave informed consent.

4. Results and Discussion

4.1. Institutional, Socio-Political, and Technological Factors Influencing Health Policy Innovation

4.1.1. Institutional Factors: Fragmented Planning and Budget Prioritization

Padang City, as a regional capital, boasts relatively advanced health infrastructure. By 2025, the city will operate 24 Puskesmas (community health centres), 27 hospitals, 125 clinics, and 933 Posyandu (integrated service posts), distributed across 11 kecamatan (districts) and 104 kelurahan (sub-districts) [19]. However, an institutional analysis reveals that the health sector continues to be dominated by conventional budgeting practices, which limit the potential for policy experimentation and gender-responsive innovations.

Of the 2025 health budget totalling Rp 352 billion, approximately 67% is allocated to salaries (belanja pegawai), while only around 8% is directed toward BPJS subsidies and

inclusive health initiatives. This allocation underscores a bureaucratic focus that prioritizes operational maintenance over strategic transformation. Additionally, the Renstra (Strategic Plan) and the RPJMD Kota Padang 2025–2029 [18] broadly reference health equity and vulnerable groups but fail to offer measurable indicators or operational tools for effective gender mainstreaming.

In terms of regulatory frameworks, although national guidelines mandate gender-responsive planning and budgeting (PPRG), there is no local regulation (Perda/Perwako) in Padang that requires the use of gender-disaggregated health data or the integration of gender perspectives into health service delivery. This regulatory gap contributes to the perception that gender issues are often sidelined rather than integrated into the institutional routines of the health sector.

4.1.2. Socio-Political Factors: Cultural Contradictions and Tokenistic Inclusion

Padang's social and political landscape is significantly influenced by Minangkabau matrilineal culture, which traditionally positions women in key roles related to family and inheritance. However, this cultural potential has not effectively translated into women's institutional empowerment within public policy. The strong presence of Islamic influence, combined with bureaucratic conservatism, paradoxically hampers the development of progressive gender policies.

Field observations and interviews with civil society actors indicate that gender-based health issues—such as maternal mental health, reproductive rights, and access to safe spaces—are rarely prioritized in political discussions or in the Musrenbang (community planning forums). Women's participation often remains limited to ceremonial or advisory capacities, lacking genuine influence on agenda-setting or resource allocation.

Programs such as P2WKSS (Peningkatan Peran Wanita Menuju Keluarga Sehat Sejahtera) and the city's anti-stunting initiative typically depend on women as implementers, particularly through roles like kader Posyandu or PKK. However, these programs seldom engage women as active shapers of policy. This reflects a persistent trend of instrumentalizing women, treating gender merely as a target group rather than recognizing it as a critical lens for institutional transformation.

4.1.3. Technological Factors: Limited Integration and Uneven Access

Technological innovation within Padang's health system has seen selective advancements. A notable example is the SMILE system (Smart Logistics for Vaccines), which was developed with the support of the UNDP and Gavi. This system has effectively streamlined vaccine supply chains by utilizing real-time IoT-based monitoring and dashboards, enhancing cold-chain management and minimizing wastage.

In addition, the "Dokter Warga" program has been established, assigning general practitioners to clusters of 3,000 to 5,000 residents. This initiative has significantly improved the outreach of primary healthcare services in urban neighborhoods. Both programs exemplify institutions' willingness to embrace innovation, especially when such efforts are linked to technical efficiency or supported by external funding.

A notable lack of evidence suggests that digital platforms are not effectively promoting gender inclusivity. For instance, health dashboards often do not provide gender-disaggregated visualizations. Additionally, there is no established digital mechanism to assist survivors of gender-based violence, such as systems for tracking referrals or providing mental health support. Furthermore, the adoption of telemedicine remains low, particularly among older women and informal workers, primarily due to limited digital literacy and a lack of trust in virtual consultation platforms.

Moreover, many technological innovations have not been integrated into local regulations, standard operating procedures (SOPs), or permanent budget allocations. This raises concerns about their sustainability once pilot programs conclude.

TABLE 1: Summary of Key Institutional Constraints and Opportunities.

Sector	Strengths	Weaknesses / Gaps
Budget	Rp 352B annual budget; universal BPJS coverage (99.15%)	67% absorbed by salaries; <10% for innovation/inclusion
Culture	Matrilineal tradition; active women's groups (e.g., Bundo Kanduang)	Limited translation into policy; tokenistic participation in forums
Regulation	National PPRG framework; strategic health documents mention "vulnerability"	No local Perda/Perwako on gender mainstreaming in health
Technology	SMILE, Dokter Warga, digital dashboards	No GESI-based design; limited access in the periphery; not institutionalized

4.2. Inter-Sectoral Collaboration in Gender-Responsive Health Policy

4.2.1. Collaboration Structures and Actor Roles

In Padang City, collaboration among government agencies, civil society, and community groups regarding health policy is conceptually recognized, yet operationally fragmented. The predominant collaboration model tends to be top-down, primarily relegating stakeholders to implementation roles, particularly in gender-related programs. Most health innovation initiatives fail to incorporate inclusive multi-actor design stages.

A noteworthy example of this is the P2WKSS (Peningkatan Peran Wanita Menuju Keluarga Sehat Sejahtera) program, which is coordinated by the Department of Women's Empowerment and Child Protection (DP3AP2KB). A recent Social Network Analysis conducted by Rahayu et al. [12] on the P2WKSS in Padang highlighted a Hexa Helix pattern of collaboration, engaging six sectors: government, business, academia, civil society, media, and traditional leaders (e.g., Bundo Kanduang). However, the structure of this collaboration remains heavily centralized, with DP3AP2KB exhibiting the highest betweenness centrality (27.673). In contrast, civil society and women's groups hold a peripheral position, mainly acting as program executors rather than agenda setters.

Furthermore, collaboration in health policy is seldom cross-cutting. While the Dinas Kesehatan (Health Office) collaborates vertically with BPJS and hospitals, it operates in silos, disconnected from the DP3AP2KB or Social Services. This separation results in gender-based issues, such as domestic violence and elderly care, being addressed across different agencies with minimal integration. Consequently, this fragmentation limits the potential for co-designed and multi-dimensional health responses.

4.2.2. Missed Opportunities in Collaborative Governance

According to Ansell and Torfing [8], collaborative innovation necessitates horizontal interaction, co-production of knowledge, and iterative problem-solving among various actor groups. In Padang, however, this collaborative model remains more aspirational than actualized. For instance, although Musrenbang forums—community consultations—are open to public input, women's participation is often limited or merely symbolic. Observations at Kecamatan-level planning meetings reveal that health concerns raised by women tend to emphasize infrastructure topics, such as renovations of Puskesmas

(community health centers). In contrast, more sensitive issues, such as maternal mental health and reproductive autonomy, are frequently overlooked due to social taboos and a lack of supportive facilitation.

In recent years, Padang has hosted multi-actor training sessions on Gender Equality, Disability, and Social Inclusion (GEDSI) in public services, supported by UCLG-ASPAC and GIZ. While these trainings have increased awareness, they have not yet resulted in institutional platforms for co-creation or joint monitoring of gender-sensitive health indicators. No task force, working group, or joint program is in place to systematize collaboration across sectors for inclusive health innovation.

Furthermore, although religious and adat (customary) leaders hold significant social influence, they are often excluded from the formal formulation of health policy. The cultural concept of Tungku Tigo Sajarangan, which represents the balance between government (pemerintah), religion (ulama), and tradition (ninik mamak), is frequently referenced in discussions but rarely operationalized within policymaking processes.

4.2.3. Policy Implications and Collaborative Gaps

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The lack of integrated collaboration has three key consequences:

1. Service Fragmentation: Programs for maternal care, elderly care, and gender-based violence response are not integrated. For instance, psychological services for domestic violence survivors exist under DP3AP2KB, while health-related follow-ups (e.g., post-abuse screening, trauma healing) are not embedded into Puskesmas protocols.

2. Missed Scaling Opportunities: Innovations like “Dokter Warga” or breastfeeding-friendly spaces—though initiated at the city level—lack institutional partnerships with women’s groups or digital platforms that could scale community outreach.

3. Limited Accountability: Without a structured multi-stakeholder monitoring system, there is no mechanism to evaluate whether health policies and programs meet gender equity goals. Civil society participation remains limited to program evaluation, not policy evaluation.

Table 2: Summary Table of Actor Collaboration.

Sector	Current Role	Missing Role / Gap
Health Department	Service provision, vertical coordination with BPJS	No formal links with gender agencies or CSOs
DP3AP2KB	Coordinates women's programs (e.g., P2WKSS)	Not integrated into health system design or budgeting
CSOs & Women's Orgs	Execute outreach & awareness activities	Rarely included in policy co-creation or monitoring
Religious/Adat	Cultural influencers (Tungku Tigo Sajarangan)	Not involved in gender-health discourse institutionally
Academia	Research and training	Lacks involvement in local innovation platforms

4.3. The Role of Digital Tools and Platforms in Inclusive Health Policy

4.3.1. Emergent Digital Innovations in Padang's Health System

In recent years, Padang has made significant strides in advancing digital health initiatives to enhance healthcare service delivery, transparency, and efficiency. While these innovations hold great promise, they expose critical gaps in inclusive design and gender responsiveness.

One of the most notable initiatives is the SMILE (Smart Vaccine Logistics System), an Internet of Things (IoT)-based platform designed to monitor vaccine supply chains in real-time. Deployed across 24 community health centers (Puskesmas), SMILE has improved transparency and operational efficiency while reducing the rate of vaccine spoilage caused by delayed or inaccurate logistics. By digitizing the vaccine cold chain monitoring process, this system illustrates how local governments can leverage technology to achieve positive public health outcomes.

Another prominent program is Dokter Warga, a community-based initiative that assigns general practitioners to specific neighbourhood clusters comprising approximately 3,000 to 5,000 residents. This approach combines proactive medical outreach with digital scheduling platforms, extending access to basic healthcare services for underserved populations. The initiative reflects a shift toward more decentralized and community-responsive healthcare governance.

Several public hospitals and health centers have also implemented e-health dashboards and QR-based patient registration systems. These tools aim to streamline administrative processes, reduce waiting times, and enhance patient flow management. Adopting such digital solutions signals an institutional commitment to modernizing health systems through evidence-based practices and innovative technologies.

However, despite these promising developments, a critical examination reveals that none of these initiatives explicitly address gendered barriers to access, nor do they include frameworks that ensure inclusive digital user experiences. Women, older people, and individuals with disabilities may still face obstacles in navigating these digital systems due to unequal access to technology, limited digital literacy, or sociocultural constraints. The lack of gender-inclusive design in digital health policies and platforms risks reinforcing existing disparities, even as service delivery becomes more technologically advanced.

This case underscores the necessity for digital health innovation to be integrated within a broader policy framework that prioritizes equity, inclusivity, and intersectional access. It is essential to ensure that the benefits of technological advancements are distributed fairly across all segments of society.

4.3.2. Barriers to Inclusive Digital Adoption

Despite promising developments, the adoption of digital health services remains uneven across social groups, especially among women, older people, and informal-sector workers. According to a recent study on telemedicine use in Padang (2024), only 27% of BPJS participants have used teleconsultation services, with digital literacy, perceived usefulness, and trust in virtual care cited as significant barriers.

From a gender lens, digital exclusion is not merely about internet access—it is shaped by intersecting factors such as:

1. Device ownership: Many women rely on shared family phones, which limits their privacy and continuity of care.
2. Caregiving burden: Women's time poverty reduces their ability to navigate complex digital systems.
3. Cultural barriers: Some communities consider online consultations inappropriate, particularly for discussions related to reproductive health.

Rogers' theory on innovation diffusion explains these challenges through five key attributes: relative advantage, compatibility, complexity, trialability, and observability. In the case of Padang, while the relative advantage of digital health tools is high (in terms of efficiency and convenience), compatibility with social norms and the complexity of use remain obstacles to inclusive diffusion.

4.3.3. Toward Gender-Inclusive Digital Health Design

As of 2025, Padang has yet to institutionalize a gender-equality and social inclusion (GESI) framework within its digital health development initiatives. Key features such as gender-disaggregated service data, multilingual interfaces, low-bandwidth versions for rural users, and confidential channels for survivors of gender-based violence remain largely absent from most platforms. Furthermore, no standard protocol or local regulation, such as a Perwako, mandates the incorporation of inclusive design principles or community co-creation in digital innovation.

Drawing on best practices from around the globe, Padang could greatly benefit from implementing user-centered design workshops that actively involve women and individuals with disabilities. Additionally, targeted training programs to enhance digital health literacy among low-income and vulnerable populations, as well as the adoption of digital inclusion audit tools within local innovation strategies, would contribute significantly to fostering inclusivity in digital health initiatives.

Table 3: Summary Table: Digital Innovation and Inclusivity in Padang.

Digital Tool	Innovation	Inclusivity Challenge
SMILE System	Real-time vaccine stock monitoring	Not linked with user-side services or gender-specific needs
Dokter Warga	Decentralized GP assignment model	No gender-specific outreach or data tracking
Telemedicine Services	Limited BPJS-based consultations	Low uptake by women, older people, and informal workers
Health Dashboards	Operational performance monitoring	No disaggregated indicators or community feedback loop

5. Conclusion and Policy Recommendations

5.1. Conclusion

This study illustrates that while Padang City has made significant progress in expanding healthcare infrastructure and introducing digital innovations, its current policy framework still lacks inclusivity, particularly from a gender perspective. Institutional barriers, including rigid budgeting practices, the absence of gender-disaggregated data, and a lack of supportive local regulations, hinder the effective integration of gender equality into health policymaking. Additionally, the potential benefits derived from the Minangkabau matrilineal traditions have not been fully realized due to existing bureaucratic conservatism and the limited participation of women in governance.

Furthermore, collaboration across sectors remains fragmented. Programs like P2WKSS demonstrate strong government leadership but offer minimal opportunities for civil society involvement. Health initiatives under the BPJS framework prioritize administrative efficiency over equitable outcomes. Similarly, despite their technical promise, digital innovations such as SMILE and Dokter Warga have yet to be tailored to meet the diverse needs of all users, thereby limiting their transformative potential.

The study emphasizes that achieving gender-inclusive health policy innovation in a decentralized urban context necessitates technological advancements and fundamental changes in governance, participation, and institutional accountability.

5.2. Conclusion Policy Recommendations

1. Establish a Gender Health Innovation Taskforce

   Form a multi-actor taskforce at the city level involving Dinas Kesehatan, DP3AP2KB, civil society, academia, women's organizations, and digital developers. This body should coordinate the design, implementation, and monitoring of inclusive health policies.

2. Local Regulation on Gender-Responsive Health Governance

   Develop a Peraturan Walikota (Perwako) mandating gender-disaggregated data, intersectional analysis, inclusive health planning, budgeting, and evaluation indicators.

3. Scale Digital Inclusion and GESI Frameworks

Integrate Gender Equality, Social Inclusion, and Disability (GESI) principles into health technology design. This includes simplified interfaces, privacy protections for sensitive cases (e.g., GBV), and targeted outreach to low-literacy groups.

4. Institutionalize Collaborative Platforms

   Transition from project-based partnerships to sustained institutional mechanisms for collaboration—such as co-budgeting forums, joint performance evaluations, and citizen scorecards for health equity.

5. Build Capacities and Change Organizational Culture

   Provide capacity-building programs for health officials, policymakers, and front-line workers on gender sensitivity, inclusive design, and collaborative innovation. Encourage reflective bureaucratic practices that shift away from administrative formalism toward social responsiveness.

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