Adapted 3C model in health sector collaboration for COVID-19 pandemic response in Surakarta, Central Java, Indonesia

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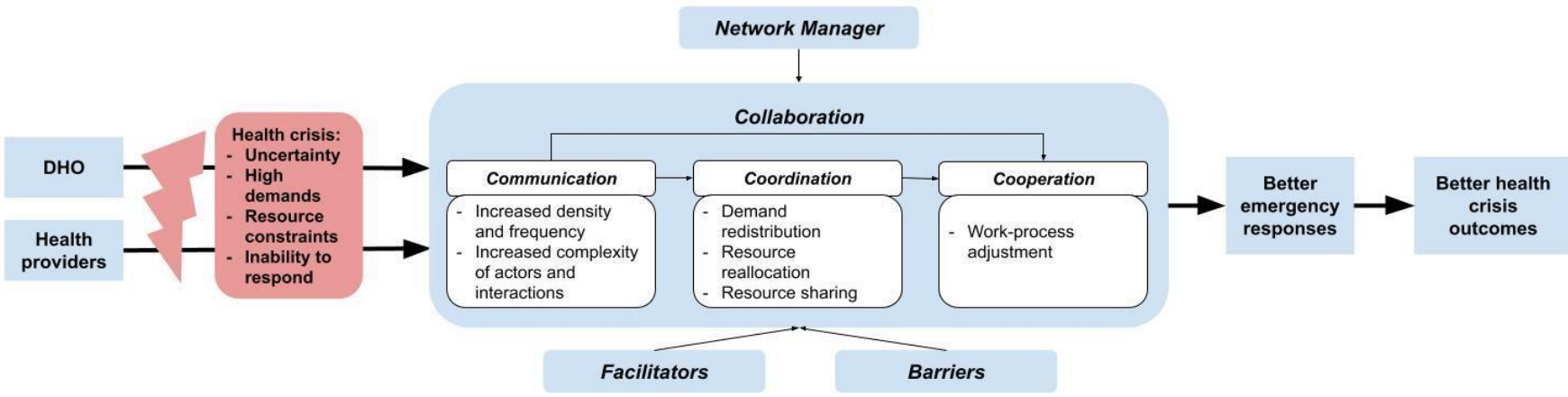
Introduction

Improving stakeholder collaboration is a continuously emerging recommendation to strengthen the health system's response to public health problems. Experiences in tackling the COVID-19 pandemic bring some lessons learned about establishing a collaborative network of health stakeholders under the District Health Office's (DHO) command. This study aims to explore the experiences of local actors in collaboration between DHO and hospitals for coordinated COVID-19 response in Surakarta, Central Java, Indonesia.

Method

Qualitative research design, utilizing the adapted 3C model (Communication-Coordination-Cooperation) in emergency collaboration as the basis of the study. Seventeen informants from DHO and hospitals and 2 key informants were purposefully selected from the COVID-19 Taskforce. Qualitative data collected from December 2022 to March 2023 through in-depth interviews were analyzed using content analysis. Triangulation and member checking were conducted to improve data trustworthiness.

Results



Discussion and Conclusion

Extraordinary approaches in the communication process were utilized to allow rapid responses and decisions. The information shared was used to coordinate resources and activities in different ways from non-crisis settings due to the higher need for resources and the busyness of activities during the pandemic. Communication and coordination affected cooperation in COVID-19 countermeasures which required work process adjustment. Barriers (bureaucratic pathologies, organizational heterogeneity, and lack of preparedness) and facilitators (supporting policies, organizations' motivation, mutual understanding, trust, and leadership) were found to influence the collaboration process. We conclude that the interorganizational relationship between the DHO and hospitals in handling COVID-19 was related to characteristics of crisis situation, i.e. uncertainty, high demand, resource constraints, and the inability to respond individually so that organizations were required to engage in collaboration through processes of 3C with different approaches from the normal situation. Our findings suggest following lessons learned to improve health sector collaboration in public health emergencies: (1) the important role of a capable network manager with adequate crisis governance; (2) strengthening the 3C process, which includes performing effective two-way communication, exercising health crisis preparedness, and building organizations' adaptability; and (3) addressing the identified barriers and optimizing the facilitators.

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References