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Implementation of Health Minimum Service Standards at Tawiri Community Health Center: Workforce Capacity, Digital Readiness, and Service Responsiveness

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ABSTRACT

This study examined the implementation of health Minimum Service Standards (Standar Pelayanan Minimal, SPM) at Tawiri Community Health Center in Teluk Ambon, Indonesia, emphasizing workforce availability and competence, digital information systems, and frontline service behavior. A descriptive qualitative design was employed using interviews, observation, and documentation. The source thesis identified eight purposively selected informants, including one facility manager, three health workers, and four service users. The findings indicated that patients valued professional communication, courtesy, and staff willingness to assist, while staffing gaps in strategic clinical positions and competing administrative duties constrained service readiness. Digital records and role-specific system access were in use, but unstable connectivity, limited workstations, and overlapping reporting demands sometimes delayed registration or referral processing. Morning congestion reflected concentrated arrivals, although some accounts also described occasional staff-readiness problems. Community outreach supported preventive services but required continued follow-up. The study identified operational conditions affecting SPM implementation; it did not independently measure attainment of every statutory SPM indicator. Workforce planning, reliable digital infrastructure, patient-flow monitoring, and sustained community engagement were recommended.

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INTRODUCTION

In Indonesia, Minimum Service Standards (Standar Pelayanan Minimal, SPM) constitute a governmental commitment to deliver specified essential public services. In the health sector, they connect the rights of residents to the obligations of local governments to plan, finance, organize, and assess basic care. Community health centers (Puskesmas) are particularly important because they combine outpatient treatment with preventive activities and community-based outreach. The effectiveness of these arrangements cannot be understood through administrative compliance alone; it also depends on whether a facility can actually deliver timely, competent, and continuous services to the population in its catchment area.

The current regulatory framework gives greater precision to this obligation. Ministry of Health Regulation Number 6 of 2024 establishes the technical standards for fulfilling health minimum service standards and revoked Regulation Number 4 of 2019. Regulation Number 19 of 2024 governs the operation of community health centers and replaced Regulation Number 43 of 2019. Both documents are relevant to examining service organization at Tawiri Community Health Center in 2026. A review

of SPM implementation should therefore distinguish current regulatory expectations from provisions cited in older theses or earlier empirical studies.

It is also necessary to distinguish statutory achievement from service-process effectiveness. A claim that a health center has met one hundred percent of health SPM targets requires identified indicators, denominators, coverage records, and verified performance calculations. Interviews about staff behavior, internet reliability, and patient queues can illuminate implementation conditions but cannot substitute for the official indicator series. This article evaluates the operational mechanisms that facilitate or constrain minimum-service delivery; it does not present a computed facility-wide SPM completion rate.

Public administration research shows that implementation is shaped by authority, resources, and coordination between decision makers and service providers. Arrohmah et al. (2024), in a qualitative stakeholder analysis of health-sector minimum standards in Wonosobo, found that actors had not fully used the authority available to them to support implementation. The implication is that standards are not self-executing; delivery depends on decisions over staffing, training, information flows, community involvement, and cooperation between the health office and primary-care providers.

Human resources represent one crucial dimension. A workforce may have clinical qualifications and a commitment to patient care yet still face difficulty delivering consistent services when critical professional roles are understaffed or when a few employees perform several tasks simultaneously. Limato et al. (2019) described the importance of shared team goals and organizational support for quality improvement in Indonesian primary-care facilities. More recently, Widiastuti et al. (2026) documented continuing workforce and managerial constraints in the implementation of integrated primary healthcare in West Sumbawa. These findings suggest that competence and staffing adequacy should be examined separately.

A second dimension is digital readiness. Electronic records and computerized reporting are expected to improve information access and continuity of care, but the benefits rely on reliable networks, usable equipment, compatible applications, and staff who can maintain the workflow. Aisyah et al. (2025b) described fragmented health information systems and considerable reporting demands across Indonesian Puskesmas. Their complementary national assessment (Aisyah et al., 2025a) documented unequal internet connectivity and supporting infrastructure. These national studies offer context for local findings but do not demonstrate how often the Tawiri system was interrupted.

Service behavior constitutes the third dimension: how professional staff communicate, begin work, manage queues, adapt to unexpected demand, and extend care beyond the health center. Amalina et al. (2025) reported relationships among waiting time, service effectiveness, and patient satisfaction in a quantitative primary-care study. In another Indonesian setting, Ernawati et al. (2025) found that disease-management services encountered personnel, infrastructure, and scheduling constraints despite operating procedures and integrated outreach efforts. The comparison indicates that courteous encounters and organized schedules can coexist with uneven operational capacity.

Tawiri Community Health Center serves coastal communities in Teluk Ambon District, Ambon City, Maluku. Ratnasari Wally's 2026 undergraduate research examined three aspects of implementing health service standards: availability and competence of human resources, the use of technology and information systems, and service behavior. The thesis recorded positive accounts of staff communication alongside concerns about strategic clinical staffing, work overload, digital registration, and variations in waiting time. It also discussed home-based education, auxiliary health facilities, and outreach networks, thereby placing patient-facing services within broader community-health responsibilities.

This article converts that qualitative research into an English-language scholarly manuscript. Its guiding question is how workforce capacity, digital infrastructure, and service responsiveness jointly shape the implementation of health SPM at Tawiri Community Health Center. The article contributes a facility-level account of the distinction between formal service arrangements and their operational reliability, while identifying management actions that are supported by the available evidence. The

interpretation remains bounded by the original thesis and does not generalize its interview findings to all community health centers in Ambon.

RESEARCH METHODS

The study used a descriptive qualitative approach based on the completed undergraduate research of Ratnasari Wally (2026). Its location was Tawiri Community Health Center in Negeri Laha, Teluk Ambon District, Ambon City, Indonesia. The source documents consisted of a preliminary thesis file and a more complete document containing the introduction, theoretical discussion, research methods, interview-based findings, conclusions, and references. No new fieldwork was conducted for the preparation of this article.

Participants in the formal informant table were selected purposively because of their knowledge of and involvement in service provision or use. The table identified one head of the community health center, three health workers, and four community members, totaling eight informants. Some passages in the thesis describe additional coded voices without providing a full reconciled participant register. The stated formal composition is retained here, but no claim is made that the entire set of quotation codes can be matched independently to the eight records in the table.

The research employed observation, in-depth interviews, and documentary review. Interviews addressed perceived staff competence, availability of key personnel, allocation of clinical and reporting work, computerized data entry, internet reliability, timeliness of registration and medical care, communication, and community outreach. The researcher described analysis as an interactive process of data collection, reduction, display, and conclusion drawing or verification. For this manuscript, thesis evidence was reorganized under the three stated dimensions without adding new interview claims or quantitative estimates.

The source included several dated statements from January and June–July 2026, and one passage listed an inconsistent year. Rather than resolve those discrepancies without interview records, this article reports the original study as a 2026 qualitative case and does not infer an exact common fieldwork period. Interview accounts are translated and paraphrased from Indonesian. Where words are quoted in English, the wording is identified as a translation of the source account rather than an independent English transcript.

Triangulation was described in the thesis through comparison of interview material, direct observation, and local documents. However, the supplied files did not include complete de-identified transcripts, a unified interview-code register, an official SPM achievement dashboard, or independently documented ethics approval. The resulting account is a descriptive interpretation of reported practices and experiences, not a causal test, validated satisfaction survey, or formal compliance audit under the 2024 SPM regulation.

Table 1 Composition of Informants in the Source Thesis

Informant category	Number	Evidence role
Head of community health center	1	Management and allocation of institutional resources
Health workers	3	Clinical practice and digital reporting
Community members / patients	4	Experienced timeliness and interpersonal care
Total	8	Purposively selected informants

Source: Table 1.2 of the Ratnasari Wally thesis (2026).

RESULTS AND DISCUSSION

Organizational context and the formal capacity profile

Tawiri Community Health Center is an Ambon municipal primary-care facility located on Jalan Nuntati, Air Manis, Negeri Laha, in Teluk Ambon District. The thesis describes a coastal service area encompassing Laha, Tawiri, and Hative Besar. In addition to clinical outpatient functions, the center carries responsibility for maternal and child health, immunization, disease prevention, nutrition counseling, sanitation-related activities, and referral support. Service capacity therefore includes both work inside the facility and field activities coordinated through the community service network.

The source personnel recap recorded 42 employees, including six men and 36 women. The professional listing identified one general practitioner, 12 university-qualified nurses, 11 diploma-qualified midwives, five diploma-qualified nurses, three public-health graduates, three nutrition diploma holders, three applied-science midwives, two pharmacy graduates, and several other technical roles. The table used dashes against some professional categories. These dashes are preserved as "not separately listed," rather than interpreted automatically as a verified count of zero staff or definitive absence of a service.

The same source described two auxiliary health centers, two village maternity posts, one village health post, nine integrated community health posts, and one mobile health-center unit. These data indicate an extended network across the catchment area. They do not establish how frequently each outreach point operated, whether all were staffed to required standards, or the number of eligible residents who received every SPM service. Accordingly, the network counts provide organizational context rather than an outcome score.

Table 2 Selected Workforce and Service-Network Characteristics

Recorded characteristic	Value	Interpretation
Total employees	42	Administrative headcount in the thesis
Female / male personnel	36 / 6	Staff composition, not workload ratio
General practitioners	1	Listed in the profession table
Professional nurses (S1) / diploma nurses	12 / 5	Reported qualification categories
Diploma midwives / applied-science midwives	11 / 3	Reported qualification categories
Auxiliary health centers / integrated posts	2 / 9	Network units described in the facility profile
Village maternity posts / village health post	2 / 1	Additional community-service units

Source: Personnel, qualifications, and service-network tables in the source thesis. Numbers describe entries reported in the supplied files.

Workforce availability and competence: interpersonal quality amid workload constraints

Interview material described health workers as generally capable of explaining illnesses, providing treatment information, and responding with courtesy. Several patient accounts valued the patience with which staff answered questions about medicines or self-care. One service user said that a nurse not only treated a child with fever but also explained how care could continue at home. Such material provides qualitative evidence of accessible communication and empathy; it is not a standardized measurement of clinical competence or patient satisfaction.

The manager, however, distinguished workforce competence from workforce completeness. In an interview reported as occurring on 30 June 2026, the head of the health center explained that when required professional qualifications were not available or staff retired, the center submitted a letter to the Health Office requesting replacement or additional personnel. This route shows that staffing decisions involve an administrative relationship beyond the facility, rather than being fully controlled by the Puskesmas manager. The thesis did not attach copies of the staffing requests or provide evidence about the timeliness of the response.

At the frontline, personnel described a willingness to maintain safety under pressure. A nurse reported following procedures while facing limited colleagues; another worker spoke about managing multiple patients alongside daily reporting. An emergency-service account emphasized quick and safe treatment but noted that staffing and space were sometimes inadequate. These statements suggest that professional effort helped sustain routine care even when organizational slack was limited. They do not prove that minimum staffing ratios were or were not met, because official workload analysis was not presented.

The personnel table reinforces the need for more detailed workforce assessment. A nominal headcount of 42 employees says little about whether every service unit had the correct professional coverage during shifts. Some staff held qualifications in nursing, midwifery, nutrition, or pharmacy, while the report drew attention to strategic gaps in resident medical and technology-related expertise. The appropriate policy question is not simply whether the total number of employees is large, but which roles are available at the point and time that patients need them.

The thesis also reveals variation between patient accounts. One respondent reported that clinical personnel were knowledgeable but that treatment could require waiting when staff were covering other tasks. Another described attentive explanations and frequent checks during care. These are not contradictory observations: the quality of interpersonal interaction and the predictability of access to a specific professional are different dimensions of service effectiveness. Using patient courtesy as proof of adequate staffing would overlook the resource issue, while using workforce gaps as evidence of poor staff attitudes would misrepresent the favorable accounts.

Comparative studies place these observations in a wider context. Widiastuti et al. (2026) found that primary-care integration in West Sumbawa was constrained by shortages of doctors, medical technologists, and other personnel, alongside management and financing difficulties. Limato et al. (2019) showed how support and team organization influence quality-improvement activity within Indonesian health centers. The Tawiri case is consistent with the proposition that trained and motivated personnel require organizational support; its data cannot establish the statistical magnitude of a workforce effect.

For monitoring purposes, the center should distinguish authorized posts, staffed posts, actual shift coverage, and service demand. A register of the number of daily visits, professional time allocated to outreach, emergency assignments, and time spent on duplicate reporting would be more informative than an undifferentiated employee total. Such indicators are recommended prospective management measures, not data collected in the current study.

Digital health records: clear responsibilities, uneven infrastructure

The thesis described computerized service records and unit-specific account access as a feature of the facility's operational arrangements. Staff had responsibility for entering data in line with their service roles, including general care, maternal health, emergency services, and immunization. Managers and health workers spoke of helping one another when patient numbers increased or internet connectivity was disrupted. The existence of role-based access indicates some organizational structure supporting digital use, although the study did not inspect access logs or security configurations.

Evidence about hardware sufficiency was not uniform. One management account characterized the availability of digital devices and applications as sufficient and emphasized clear task allocation. Other staff and patient accounts pointed to too few working computers at busy service points, slow validation, and unstable connections. Rather than select one statement as definitive, the analysis interprets this difference as an issue of distribution, performance, or timing: equipment judged sufficient at an organizational level may not be accessible when several units need it simultaneously.

One midwifery account illustrated how a requirement for rapid data processing can collide with unplanned clinical activity. Emergency deliveries may occur at night or on holidays, while reporting tasks still require timely input. Workers described sharing duties or covering more than one shift when information systems were slow. Such measures can maintain continuity in the short term but may increase fatigue or divert attention from direct care if they become routine. The thesis did not quantify overtime or document system-downtime frequency.

Patients also connected digital operations with waiting. One account described delayed data validation when computers were slow during early-week or busy periods. Another described prompt emergency treatment but a referral document that could take approximately half an hour to process, depending on internet conditions. These accounts show an important distinction between clinical response and administrative completion: treating an emergency swiftly does not guarantee an equally prompt referral record. The half-hour estimate is a particular interview report, not a facility-wide average.

National evidence offers a useful comparison. Aisyah et al. (2025b) mapped health information systems across Indonesian Puskesmas and reported system fragmentation, reporting burdens, and variability in training. In another national assessment, Aisyah et al. (2025a) documented infrastructure disparities and internet-access gaps across facilities. Siswati et al. (2025) evaluated electronic medical-record implementation in Padang and identified shortcomings in system and information quality as well

as training and infrastructure. These studies substantiate the plausibility of digital bottlenecks, without establishing identical prevalence at Tawiri.

Information-system improvements should begin with observation of the complete patient-data path. The facility can record elapsed time at registration, the number of simultaneous users per workstation, frequency and duration of network disruption, workarounds used during outages, and time to finalize referral documents. If some units experience delays while others do not, the problem may concern device placement or scheduling rather than the total number of computers. If all units slow down during interruptions, network resilience and offline continuity procedures become more important.

A further implication is to reduce duplicate administrative effort. Data entry that must be performed both electronically and manually may be understandable during an outage, but repeating the same content across incompatible systems can absorb clinical time. Introducing a new digital queue, as the thesis recommends for morning congestion, should therefore be evaluated against the readiness of computers, staff, and connectivity; otherwise the new application risks creating another reporting demand rather than reducing waiting.

Table 3 Digital-Service Findings and Evidence Limits

Process	Reported evidence	What was not measured
Role-based access	Accounts allocated by work function	Actual user-log compliance or security audit
Computer availability	Management and users reported different experiences	Usable workstations by service unit and hour
Connectivity	Intermittent slow connections or errors described	Duration and frequency of downtime
Referral processing	One account described around 30 minutes	Mean or median referral turnaround time
Workarounds	Cross-cover, extra shifts, and repeated reporting	Number of overtime hours or duplicate transactions

Source: Qualitative interview accounts in the source thesis. The right-hand column describes information not supplied; it is not a finding of noncompliance.

Service behavior, arrival patterns, and the meaning of punctuality

The behavioral-service dimension captured respectful communication, adherence to opening hours, handling of queues, and action outside the facility. The study described operating hours of approximately 08:00–14:00 local time, with some accounts indicating that registration opened at about 07:45. Several patients perceived staff as ready when the service began, and one patient recalled arriving before 08:00 and receiving examination shortly after the official opening. Such details suggest visible staff effort to begin services promptly.

At the same time, patient arrival was concentrated in the morning. One respondent said that although staff were at the counter around eight o’clock, the queue could last nearly half an hour when many people arrived together. Another contrasted the long early queue with quicker service later in the day. The thesis summarized early waiting as varying between about ten and thirty minutes in selected observations. These are descriptive reports, not a measured sample distribution with defined start and end points.

Other accounts qualified the picture of punctuality. The manager acknowledged occasional difficulty around Mondays, poor weather, and staff assignments in outlying areas. A patient described an occasion when a health worker was not yet ready because the person had only just arrived. Another described waiting for a doctor or nurse to become available. Therefore it would be too strong to attribute every delay exclusively to simultaneous patient arrivals; the available evidence suggests several possible causes, including demand peaks, professional coverage, and occasional readiness issues.

This distinction is particularly relevant to public-service accountability. Staff attendance and patient waiting time are not interchangeable. A punctual clerk can still face a long registration line, while a clinic that opens on time may have limited room for examination or few clinicians available at that hour. Amalina et al. (2025) found that waiting time and service-process attributes were related to perceived effectiveness and patient satisfaction. In Tawiri, the available interviews identify plausible pressure points but do not estimate their relative contribution.

If queues rise at predictable times, operational adjustments should be based on direct measurements. A temporary assignment of additional registration support, staggered appointments for routine visits, or better explanation of service sequences may reduce uncertainty. However, those options should be tested against daily case mix, emergency demand, and workload capacity. A digital booking interface without supporting clinical coverage may redistribute but not resolve the bottleneck.

The qualitative reports also suggest that responsiveness includes the way staff communicate during unavoidable delays. Patients valued being told what illness they were being treated for, how medicines should be taken, and what action could be continued at home. These interactions may mitigate frustration but should not become a substitute for improving administrative efficiency. A patient who praises a nurse's courtesy can still experience delayed document validation or difficulty accessing a practitioner.

Outreach, institutional relationships, and preventive continuity

The original research discussed outreach services as part of the center's minimum-service responsibilities. The facility network included auxiliary health centers and Posyandu, and the manager emphasized that village-based nurses and midwives should be able to work independently within their professional procedures. One community member recalled observing a nutrition worker conduct household education about healthy food. This is evidence of at least some proactive community-facing activity, though the source does not quantify coverage or subsequent changes in behavior.

The study also identified difficulty maintaining the effects of education after outreach events. Accounts suggested that some people sought care only after symptoms had become serious and that household or community follow-up was inconsistent. These observations should not be generalized as a measured level of health literacy across the catchment area. They do, however, point to an implementation problem: a one-time health message may not be sufficient to sustain preventive practice without repeated contact and supportive community networks.

At a system level, SPM implementation depends on multiple institutions. The head of the Puskesmas can organize shifts, supervise staff, and coordinate local outreach, whereas authorization of key staffing positions, certain training programs, and major equipment investments may involve the Ambon City Health Office and other governmental actors. Arrohmah et al. (2024) demonstrate why stakeholder engagement and authority matter in minimum-service implementation. This division of responsibility means that an improvement plan should distinguish what the center can deliver immediately from what requires action by the municipal administration.

For digital services, the recommended action is a joint review of device distribution, connectivity, and training schedules rather than purchasing hardware without operational diagnosis. For personnel, the center can document workload and shift gaps, while the relevant health office evaluates redistribution or recruitment. For outreach, staff can collaborate with village officials, community cadres, and integrated health posts to repeat key health messages and follow up with households. These actions are derived recommendations, not interventions reported as having been completed in the study.

Integrating the findings: SPM effectiveness as operational capability

The three dimensions can be understood as mutually dependent capabilities. Qualified staff are necessary for safe care, but the value of their expertise decreases if scheduling does not match demand. Digital systems can improve reporting, but slow networks and competing data demands can delay patient flow. Courteous and punctual behavior improves the experience of service, but it does not compensate for missing clinical coverage or unreliable referral documentation. The Tawiri case therefore cautions against judging health SPM implementation by any one dimension in isolation.

A practical assessment framework would pair three operational measures with formal SPM outcomes. The workforce component could track professional coverage by service and shift, the digital component could monitor downtime and completion time for records and referrals, and the behavioral component could record arrival-to-service intervals and patient feedback. These indicators should then be compared with the legally specified service population and achieved service outputs under Regulation Number 6 of 2024. This integrated framework would allow managers to ask whether a

service shortfall arose from inadequate coverage, workflow barriers, or difficulty reaching the eligible population.

The current thesis does not include the complete SPM indicator table or the annual target population denominators for Tawiri. As a result, the study supports conclusions about observed and reported strengths and limitations, but not the assertion that the center achieved or failed a numerical 100% statutory standard. It also cannot establish causal relationships between computer limitations, patient satisfaction, and health outcomes. An expanded evaluation would require formal facility records, repeated observations across shifts, and additional interviews with health-office representatives.

Finally, reported inconsistencies matter to interpretation. The source contains some differing descriptions of computer sufficiency, occasional patient experiences that do not align with blanket claims of punctuality, and at least one location reference in the discussion that appears unrelated to Ambon. This article preserves the different perspectives and excludes the out-of-jurisdiction statement from Tawiri-specific attribution. The objective is to produce an honest qualitative synthesis, not to convert an incomplete record into false precision.

Table 4 Synthesized Implementation Dimensions and Practical Responses

Dimension	Observed strength	Reported constraint	Suggested management response
Workforce	Courtesy, clinical explanations, staff cooperation	Strategic profession gaps and multiple duties	Map posts, shifts, workload, and competency needs
Digital systems	Role-based access and computerized records	Slow internet, workstation bottlenecks, duplicate data	Log outages and referral processing; review equipment allocation
Service behavior	Mostly punctual starts; responsive communication	Morning congestion; some readiness variation	Track each service-stage delay and adjust patient flow
Community outreach	Posyandu and household education activities	Limited continuity after education	Schedule repeated follow-up with local cadres

Source: Thematic synthesis of the supplied thesis. Suggested responses are recommendations, not documented outcomes.

Implications for measurement, learning, and local accountability

An important distinction for the next cycle of SPM assessment is the difference between inputs, processes, outputs, and coverage. The workforce headcount and facility-network inventory in this study are input descriptions. Registration flow, functioning computerized records, staff attendance, and the continuity of community education describe processes. Completed consultations, administered immunizations, and documented screening services would be outputs if systematically recorded. Statutory health SPM achievement additionally requires comparison between those eligible for each service and those who received care meeting the relevant technical requirements. Without the final comparison, no defensible total-coverage percentage can be calculated.

The practical consequence is that a service may appear effective at one level and inadequate at another. A patient may receive friendly care while a referral document is delayed; a facility can have trained midwives while facing a staffing gap during a particular shift; and a nutrition campaign can be delivered even when household follow-up is irregular. Research on patient-experience measurement highlights this complexity. Quyen et al. (2021) examined how patient satisfaction differs across health-service settings, while Sirajuddin et al. (2026) studied the relationships between perceived reliability, responsiveness, empathy, and satisfaction at an Indonesian health center. Their measures cannot be transferred to Tawiri, but they show why evidence should be collected across distinct service dimensions rather than collapsed into a single favorable judgment.

A first improvement priority is a shared operational dashboard between the health center and the Ambon City Health Office. A practical workforce sheet might record required qualifications by unit, filled positions, daily attendance, deployment to the village network, and unmet shift coverage. This would document where shortages are located and whether they result from vacancies, allocation decisions, or unusual demand. Lewis et al. (2023) suggested that management and engagement help distinguish stronger-performing health facilities. For Tawiri, an operational dashboard would not itself create new staff, but it could support more specific requests and evaluate whether municipal responses match the stated problem.

A second priority is to measure delays as a sequence of events, rather than asking patients to estimate a single waiting period. Registration start and finish, arrival at the consultation room, time of clinical examination, and completion of pharmacy or referral procedures can each be recorded with simple time stamps. It would then be possible to examine whether the largest delay occurs at the digital checkpoint, while patients wait for a particular clinician, or during the morning arrival surge. Zhang et al. (2023) investigated relationships between outpatient waiting time and satisfaction, and Hapsari et al. (2026) examined waiting, perceived competence, and loyalty in an Indonesian setting. These studies strengthen the rationale for measurement but cannot supply the missing time statistics for Tawiri.

Third, improvements should not assume that digitalization is equivalent to a more effective service. The source interviews show that electronic records and role-based access were already present, yet the experience of using computers varied among workers and patients. Comparing the number of installed devices with the number of service points that can use them at the same time would clarify why some participants perceived the equipment as adequate while others encountered shortages. Staff would also benefit from documented procedures for network failures and referral processing, supported by periodic drills and training. Such practical assessment is consistent with the digital-readiness issues described by Aisyah et al. (2025a) and Siswati et al. (2025).

Fourth, service standards should link care inside the health center with the continuity of community activities. A home education visit is valuable, but the relevant managerial question is whether the identified resident subsequently receives preventive or follow-up services when indicated. It would be appropriate to document household visits, agreed follow-up activities, the responsible cadre or staff member, and the status of completion. Ernawati et al. (2025) reported that insufficient equipment, scheduling conflicts, and resource constraints hindered preventive-service efforts despite existing programs. The Tawiri findings point toward similar categories of risk, while their frequency and reach remain unmeasured.

Finally, accountability should be allocated to the actor able to respond. The community health center can revise work allocation, communication routines, complaint handling, and selected scheduling practices. The municipal health office is better positioned to address formal staffing authorization, training support, and some infrastructure investments. Local village institutions and community cadres can support follow-up for preventive services. Law Number 25 of 2009 establishes a wider public-service responsibility, while Regulations Number 6 and 19 of 2024 define the relevant contemporary health-service context. Keeping these levels distinct helps prevent facility workers from being held solely responsible for shortages that require decisions above them, while preserving accountability for actions they can directly control.

Fanda et al. (2024) found that essential-medicine availability varies across Indonesian primary care facilities. Although this study emphasized workforce and digital processes rather than medicine stocks, the comparison illustrates that operational standards are interdependent. A delayed clinician consultation, a data-system interruption, or an unavailable medicine can each prevent timely completion of a patient journey. Tracking a small number of interconnected measures may therefore reveal more than an isolated appraisal of staff courtesy or digital adoption. The facility should review which constraints it can address directly and which require municipal procurement or interfacility referral support.

Further research should follow the same service processes repeatedly over several weeks, cover both busy and quiet periods, and include management, clinical, technical, and patient perspectives with a reconciled informant register. Documentary evidence should include digital incident records, staffing requests, a verified service population, and formal SPM indicator reports. If service improvements are introduced, their effects should be evaluated using before-and-after observations without assuming causality from simple temporal association. These additions would allow the qualitative explanation in this article to be connected with quantitative compliance information and with patients' experience of actual service continuity.

CONCLUSION

The study found that the implementation of health Minimum Service Standards at Tawiri Community Health Center was supported by skilled and courteous frontline staff, defined digital reporting responsibilities, generally observed opening routines, and selected community outreach activities. At the same time, the thesis documented difficulties in providing consistent professional coverage, distributing clinical and administrative workload, maintaining reliable information-system performance, and managing concentrated morning demand. Reports about the adequacy of digital equipment and the causes of waiting differed across informants, indicating the need for direct operational measurement rather than a single categorical judgment. These findings describe conditions shaping SPM delivery but cannot establish a numerical SPM compliance rate. Priority actions include competency-sensitive workforce planning with the Ambon City Health Office, more reliable information-system infrastructure, monitoring of service-stage waiting time, and repeated preventive outreach through local community networks. Future work should incorporate the official indicators, denominators, and coverage records required to assess statutory SPM achievement.

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