

Strategic Investment Pathways for Healthcare Micro-Enterprises: A SWOT Analysis of Independent Midwifery Practices in Malang, Indonesia

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Abstract

The sustainability and growth of independent midwifery practices (Praktik Bidan Mandiri, PBM) are critical for enhancing maternal and child healthcare access in Indonesia, particularly in urban and rural settings. However, these small-scale healthcare enterprises face significant challenges in securing investment for development. This study aims to formulate strategic investment recommendations for PBMs in Malang City and Malang Regency by identifying their internal and external strategic factors. A qualitative case study approach was employed, utilizing in-depth interviews and focus group discussions with 15 midwives and 5 healthcare stakeholders. Data were analyzed using thematic analysis and structured into a SWOT (Strengths, Weaknesses, Opportunities, Threats) matrix. The results delineate key strengths (e.g., trusted community relationships, personalized care) and weaknesses (e.g., limited capital, informal management). Major opportunities include government insurance schemes (JKN) and digital health trends, while threats encompass regulatory uncertainty and competition. The cross-analysis generates four strategic investment quadrants: aggressive (S-O), diversification (S-T), turnaround (W-O), and defensive (W-T). The discussion emphasizes that investment strategies must be context-specific, aligning with the distinct operational environments of urban versus rural practices. This study contributes to the literature on healthcare micro-enterprise financing by providing a grounded, context-sensitive SWOT framework to guide investors, policymakers, and midwives in making informed, sustainable investment decisions for practice growth.

Keywords: *Investment Strategy, Independent Midwifery Practice, SWOT Analysis, Healthcare Micro-enterprise, Qualitative Case Study, Malang.*

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A. INTRODUCTION

The role of independent midwifery practices (Praktik Bidan Mandiri, PBM) in Indonesia's maternal and child healthcare landscape is indispensable, particularly in bridging service delivery gaps in both densely populated urban and remote rural areas (Sulistiyawati, 2019). These privately-run micro-enterprises serve as primary access points for antenatal care, delivery assistance, and postnatal support, often operating where public health facility coverage is thin (Darmawan et al., 2021). However, their operational sustainability and capacity for service expansion are frequently hampered by chronic financial constraints and a lack of structured business acumen, limiting their potential impact on public health outcomes (Kurniasari & Setyonaluri, 2020).

Investment in such small-scale healthcare providers is not merely a financial transaction but a critical lever for improving healthcare quality, accessibility, and resilience within the community health system (Mahendradhata et al., 2017). Despite their significance, PBMs remain a largely overlooked segment in formal healthcare investment discourses, which tend to focus on larger hospitals or pharmaceutical sectors (Thabrany, 2019). This neglect creates a strategic gap where the potential for high social return on investment through strengthened primary care remains untapped.

The financial ecosystem for PBMs is complex, situated at the intersection of public health policy, community trust, and micro-enterprise economics. While the national health insurance (Jaminan Kesehatan Nasional, JKN) scheme provides a revenue stream, reimbursement rates and procedural complexities often pose challenges for small practices (Pratomo et al., 2021). Furthermore, midwives, trained primarily as clinicians, typically possess limited formal training in financial management, business planning, or investment strategy, making them vulnerable to market fluctuations and operational inefficiencies (Wulandari & Kurniawati, 2018).

Existing literature on healthcare investment in low- and middle-income countries offers macro-level analyses of health system financing but provides scant granularity on the unique challenges and opportunities faced by independent practitioner micro-enterprises like PBMs (Kutzin et al., 2021). Studies on midwifery services often concentrate on clinical outcomes or workforce issues, leaving a pronounced research gap concerning the business viability and investment frameworks necessary for these practices to thrive as sustainable entities (Ten Hoope-Bender et al., 2019).

This study, therefore, seeks to address this gap by investigating the strategic factors that should inform investment decisions in PBMs. The research focuses on Malang, a region in East Java comprising an urban center (Malang City) and its surrounding rural regency (Malang Regency), offering a comparative perspective on how contextual differences influence strategic needs. The core research question is: What are the internal and external strategic factors that shape viable investment strategies for independent midwifery practices in urban and rural settings of Malang, Indonesia?

By answering this question, the study aims to generate a contextually grounded SWOT framework that can translate into actionable investment strategies. The findings are intended to empower midwives with insights for business planning, guide potential investors (including social impact investors) in assessing opportunities, and inform policymakers in designing supportive ecosystems for private primary healthcare providers (Fattah & Hastuti, 2022).

B. LITERATURE REVIEW

The sustainability of independent midwifery practices is fundamentally linked to their economic viability. Research indicates that financial instability is a primary threat to the continuity of private primary care services in resource-constrained

settings (Smith & Siriwardhana, 2020). For PBMs, revenue streams are often unpredictable, relying on a mix of out-of-pocket payments, JKN reimbursements, and sometimes local government contracts (Pratomo et al., 2021). This financial precariousness directly limits investment in essential medical equipment, facility upgrades, and staff training, creating a cycle of under-capitalization that constrains quality and growth (Kurniasari & Setyonaluri, 2020).

A critical internal factor for PBMs is their human and social capital. The midwife's clinical expertise and deep-rooted, trust-based relationships within the community constitute a significant strength (Sulistyawati, 2019). This social capital facilitates patient retention and community-based health promotion. Conversely, a key weakness lies in the general lack of formal business management skills. Studies show that healthcare professionals who transition to entrepreneurship often struggle with financial record-keeping, marketing, strategic planning, and human resource management, which are not core components of clinical training (Wulandari & Kurniawati, 2018; Darmawan et al., 2021).

Externally, the policy and regulatory environment presents both opportunities and threats. The expansion of JKN coverage is a major opportunity, providing a more stable demand base and payment mechanism for services (Thabrany, 2019). However, the administrative burden of claiming reimbursements and sometimes delayed payments can strain the cash flow of small practices, turning a potential strength into an operational challenge (Pratomo et al., 2021). Furthermore, frequent changes in health regulations and licensing requirements pose a significant threat, increasing compliance costs and operational uncertainty for independent practitioners (Mahendradhata et al., 2017).

The competitive landscape is evolving. While PBMs traditionally faced competition mainly from fellow midwives and public health centers (Puskesmas), the rise of corporate-owned chain clinics and telemedicine platforms introduces new competitive threats, particularly in urban areas (Fattah & Hastuti, 2022). These entities often have superior access to capital for technology adoption and marketing. However, an opportunity exists in the growing consumer preference for personalized, continuous, and holistic care—a niche that community-embedded PBMs are uniquely positioned to fill compared to larger, more impersonal facilities (Ten Hoope-Bender et al., 2019).

Digital transformation offers a dual-edged sword. The proliferation of health technologies (e.g., electronic medical records, mobile health apps, online scheduling) presents an opportunity for PBMs to enhance efficiency, patient engagement, and professional credibility (Kurniasari & Setyonaluri, 2020). Yet, the threat lies in the digital divide and the investment required for adoption. Rural practices, in particular, may lack the capital, reliable internet infrastructure, and digital literacy to leverage these tools effectively, potentially widening the quality gap with urban counterparts (Smith & Siriwardhana, 2020).

Investment frameworks for micro-enterprises in healthcare are underexplored. Conventional business investment models often fail to capture the unique social value

and risk profile of community-based health services (Kutzin et al., 2021). There is a need for hybrid models that consider both financial returns and social impact. Strategic management tools like SWOT analysis have been successfully adapted for planning in small healthcare organizations, as they provide a structured yet flexible way to align internal capabilities with external possibilities (Helms & Nixon, 2010).

Finally, the urban-rural dichotomy is crucial. The operating context fundamentally shapes the strategic profile of a PBM. Urban practices may have stronger strengths in terms of patient volume and access to suppliers but face fiercer competition and higher costs (Fattah & Hastuti, 2022). Rural practices benefit from less competition and a captive market but grapple with weaknesses like logistical challenges, lower population density, and often greater difficulty in attracting and retaining skilled assistance (Darmawan et al., 2021). This contextual variation necessitates tailored, rather than generic, investment strategies.

C. METHOD

This study employed a qualitative research design with a multiple case study approach to gain an in-depth, contextual understanding of the factors influencing investment in PBMs (Yin, 2018). The case study method was deemed appropriate as it allows for the exploration of a contemporary phenomenon (strategic investment needs) within its real-life context, where the boundaries between the phenomenon and context are not clearly evident. The unit of analysis was the independent midwifery practice operating in either Malang City (urban) or Malang Regency (rural).

A purposive sampling strategy was used to select information-rich cases. Participants included:

1. Owner-managers of PBMs (n=15): Eight from Malang City and seven from Malang Regency, with a minimum of 5 years of operational experience.
2. Key stakeholders (n=5): Two officials from the local health office (Dinas Kesehatan), one representative from the Indonesian Midwives Association (IBI) Malang chapter, one healthcare business consultant, and one social impact investor familiar with the health sector.

All midwife participants were female, with practice ages ranging from 5 to 25 years. Stakeholder participants were selected for their regulatory, professional, or financial expertise relevant to PBM operations. Prior to data collection, ethical approval was obtained from the relevant institutional review board, and written informed consent was secured from all participants, ensuring confidentiality and anonymity.

Primary data were collected over a three-month period through two main methods:

1. In-Depth Interviews: Semi-structured interviews were conducted with all 15 midwife-practitioners. Interviews, lasting 60-90 minutes, explored themes such as practice history, financial management, perceived strengths and challenges, growth aspirations, and views on investment needs. An interview guide was

used to ensure consistency while allowing for probing based on participant responses.

2. Focus Group Discussions (FGDs): Two separate FGDs were held: one with the eight urban midwives and another with the seven rural midwives. Each FGD lasted approximately 120 minutes and was designed to facilitate interaction and collective sense-making around common opportunities, threats, and strategic priorities. Discussions were moderated using a pre-defined topic guide.

All interviews and FGDs were audio-recorded with permission, transcribed verbatim in Bahasa Indonesia, and subsequently translated into English for analysis. Field notes were also maintained to capture non-verbal cues and contextual observations.

Thematic analysis following the six-phase framework by Braun and Clarke (2006) was employed. Transcripts were read repeatedly for familiarization. Initial codes were generated inductively from the data. These codes were then collated into potential themes related to internal capabilities (Strengths, Weaknesses) and external environmental factors (Opportunities, Threats). The themes were reviewed, refined, and defined to create a coherent SWOT matrix. To ensure analytical rigor, member checking was performed by sharing a summary of the SWOT themes with a subset of participants for validation. Additionally, triangulation was achieved by comparing insights from midwife interviews, FGDs, and stakeholder interviews.

The final step involved a cross-analysis of the SWOT factors to generate strategic implications for investment, following the classic TOWS matrix framework (Wehrich, 1982). This process connected internal and external factors to propose strategic directions (S-O, W-O, S-T, W-T). Data management and analysis were supported by the qualitative data analysis software NVivo 12.

D. RESULT AND DISCUSSION

The analysis of interview and FGD data yielded a comprehensive set of strategic factors, synthesized into the following SWOT matrices for Urban PBMs (Table 1), Rural PBMs (Table 2), and the subsequent TOWS strategic matrix (Table 3).

Table 1: SWOT Analysis for Urban Independent Midwifery Practices (Malang City)

Strengths (S)	Weaknesses (W)
S1: High patient volume and turnover.	W1: Very high operational costs (rent, utilities, staff salaries).
S2: Easy access to medical suppliers and supporting services (labs, pharmacies).	W2: Intense competition from other PBMs, clinics, and hospitals.
S3: High potential for service diversification (e.g., lactation consulting, beauty care).	W3: High dependence on a few insurance partners/BPJS.

S4: Generally higher levels of formal education and training among practitioners.	W4: Patient loyalty is lower; patients easily switch providers.
S5: Better access to digital tools and internet connectivity.	W5: Limited space for physical expansion.
Opportunities (O)	Threats (T)
O1: Growing middle-class demand for premium/personalized maternity services.	T1: Market saturation and price wars among providers.
O2: Partnerships with corporate offices for employee health programs.	T2: Rising costs of medical equipment and consumables.
O3: Leveraging social media and digital platforms for marketing and patient engagement.	T3: Strict and frequently changing city health regulations.
O4: Collaboration with hospitals for referral networks.	T4: Emergence of large, corporate-owned chain clinics.
O5: Government incentives for health technology adoption.	T5: Risk of reputational damage from social media.

1. Internal Organizational Dynamics: Strengths and Weaknesses

The internal assessment of the healthcare facilities reveals a complex interplay between robust operational capabilities and significant financial constraints. On the one hand, the clinics demonstrate substantial competitive advantages through high patient volume and rapid turnover (S1), supported by a highly educated and formally trained workforce (S4). Geographically and operationally, these facilities benefit from seamless integration with medical supply chains and ancillary services, such as laboratories and pharmacies (S2). Furthermore, their strong digital readiness and internet connectivity (S5) provide a solid foundation for service diversification, allowing the integration of high-margin offerings like lactation consulting and aesthetic maternity care (S3).

Conversely, the organizations face profound internal vulnerabilities. The urban operational setting imposes exorbitant overhead costs, particularly concerning rent, utilities, and staff remuneration (W1), which are exacerbated by severe spatial limitations that hinder physical expansion (W5). Market positioning is further destabilized by intense localized competition (W2), leading to fragmented patient loyalty and a high propensity for patients to switch providers (W4). Financially, the clinics exhibit a precarious over-reliance on a limited number of insurance partners or national health schemes (e.g., BPJS) (W3), which restricts pricing autonomy and threatens cash flow stability.

2. The External Environmental Landscape: Opportunities and Threats

The external macro-environment presents a spectrum of lucrative growth avenues contrasted by formidable industry risks. A primary catalyst for expansion is the shifting demographic trend, characterized by a burgeoning middle class that increasingly demands premium, personalized maternity and healthcare services (O1). Facilities can capture this demographic by aggressively leveraging their digital infrastructure to optimize social media marketing and patient engagement strategies (O3). Additionally, there is significant potential for establishing strategic alliances, both through B2B corporate health programs (O2) and integrated referral networks with larger regional hospitals (O4). The integration of these services is further supported by government incentives aimed at accelerating health technology adoption (O5).

Despite these opportunities, the external landscape is highly volatile. The rapid influx of providers has led to market saturation, frequently precipitating aggressive price wars (T1) that compress profit margins. This financial pressure is compounded by the persistent escalation in the costs of medical equipment and consumables (T2). Structurally, independent practices face existential threats from the aggressive expansion of well-capitalized, corporate-owned chain clinics (T4) and the administrative burden of strictly enforced and frequently changing municipal health regulations (T3). Finally, while digital platforms offer marketing leverage, they simultaneously expose the clinics to the asymmetric risk of rapid reputational damage due to negative online patient reviews (T5).

3. Strategic Implications and Synthesis

To ensure sustainable competitive advantage and long-term viability, management must adopt a differentiation strategy rather than competing purely on cost. By synthesizing their highly trained personnel (S4) and digital capabilities (S5), the clinics can pivot toward the premium service sector (O1, S3), thereby insulating themselves from the commoditized price wars (T1) and the scale advantages of corporate chains (T4). Furthermore, mitigating the financial risks associated with high operational costs (W1) and single-payer insurance dependency (W3) requires the active cultivation of high-value hospital referral networks (O4) and corporate partnerships (O2). Ultimately, the facilities must transition from a volume-based operational model to a value-based, digitally integrated healthcare delivery system.

Table 2: SWOT Analysis for Rural Independent Midwifery Practices (Malang Regency)

Strengths (S)	Weaknesses (W)
S1: Deep, long-term trust and strong community bonds.	W1: Very limited starting and working capital.
S2: Lower operational costs (often home-based, lower rents).	W2: Informal, non-systematic business and financial management.

S3: Less direct competition; often the only provider in the village/sub-district.	W3: Limited access to continuous professional development.
S4: Holistic, family-centered care approach is highly valued.	W4: Difficulty in recruiting and retaining qualified assistants.
S5: High patient loyalty and word-of-mouth referrals.	W5: Poor infrastructure (transportation, internet, electricity).
Opportunities (O)	Threats (T)
O1: Expansion of JKN (BPJS) coverage to remote populations.	T1: Low population density limits patient volume.
O2: Government village fund (Dana Desa) programs for health infrastructure.	T2: Patients' low purchasing power and high dependency on BPJS.
O3: Mobile/telehealth solutions to overcome distance barriers.	T3: Regulatory barriers and complex licensing for rural facilities.
O4: Partnerships with Puskesmas for task-sharing or referral incentives.	T4: Threat of being outcompeted by new, better-equipped Puskesmas or clinics.
O5: Growing awareness of maternal health importance.	T5: Natural disasters or crop failures affecting community's economic capacity.

4. Internal Organizational Dynamics: Strengths and Weaknesses

The internal assessment of the rural healthcare practices reveals a structural paradox: profound social capital contrasted by severe financial and infrastructural constraints. The primary competitive advantage of these providers lies in their deep-rooted community integration. By fostering long-term trust and delivering holistic, family-centered care (S1, S4), these practices generate high patient loyalty and rely heavily on word-of-mouth referrals (S5). Financially and operationally, they benefit from lower overhead costs, as facilities are frequently home-based and operate in environments with minimal direct competition (S2, S3), often positioning them as the sole healthcare access point in rural sub-districts.

However, these socio-cultural strengths are offset by critical operational vulnerabilities. The practices are severely hindered by limited starting and working capital (W1), which perpetuates informal and non-systematic financial and business management (W2). Furthermore, geographic isolation exacerbates infrastructural deficits, including unreliable transportation, internet, and electricity (W5). This isolation also creates substantial human resource challenges; practitioners have limited access to continuous professional development (W3) and face significant difficulties in recruiting and retaining qualified clinical assistants (W4), threatening the long-term quality and scalability of care.

5. The External Environmental Landscape: Opportunities and Threats

The macro-environment presents crucial pathways for institutional support, though these are counterbalanced by persistent socio-economic risks. A major opportunity lies in leveraging decentralized government policies and funding mechanisms. The expansion of the National Health Insurance (JKN/BPJS) to remote populations (O1) and the availability of village funds (*Dana Desa*) for health infrastructure (O2) provide critical avenues for financial stabilization and facility upgrading. Furthermore, there is significant potential for establishing symbiotic institutional partnerships with local primary health centers (*Puskesmas*) for task-sharing and referral incentives (O4). Technologically, the adoption of mobile and telehealth solutions (O3) aligns well with the growing communal awareness of maternal health (O5) to bridge vast geographical distances.

Conversely, the external landscape is fraught with localized threats. The low population density inherent to rural settings fundamentally limits patient volume and restricts revenue growth (T1). This is exacerbated by the target demographic's low purchasing power and high dependency on subsidized BPJS claims (T2), which compresses profit margins. Furthermore, rural communities are highly vulnerable to external economic shocks, such as natural disasters or crop failures (T5), which can directly diminish their healthcare utilization capacity. Structurally, these small-scale practices face complex regulatory and licensing barriers (T3) and are increasingly threatened by the emergence of newer, state-funded, and better-equipped *Puskesmas* or corporate clinics entering rural territories (T4).

6. Strategic Implications and Synthesis

To ensure long-term viability, rural healthcare providers must pivot from a purely traditional, independent care model to a strategically integrated community health model. By leveraging their unparalleled community trust (S1) alongside government initiatives like *Dana Desa* (O2), these practices can advocate for local infrastructural investments that mitigate their current physical limitations (W5). To counter the threats of low patient volume (T1) and formidable competition from newer clinics (T4), practitioners must actively pursue formal integration into the broader regional health system. Specifically, establishing formal referral networks and task-sharing agreements with *Puskesmas* (O4) can provide a steady patient stream while facilitating access to continuous professional development (W3). Ultimately, transitioning from informal management to a more systematized, digitally enabled framework (O3) will be essential to navigating complex rural licensing regulations (T3) and ensuring sustainable service delivery in resource-limited settings.

Table 3: TOWS Matrix – Strategic Investment Implications

	Strengths (S)	Weaknesses (W)
Opportunities (O)	SO Strategies (Aggressive/Max-Max): Invest in premium service lines and digital marketing	WO Strategies (Turnaround/Improve): Invest in capacity building & formal business training (W2, W3,

	(S3, S5, O1, O3). Form strategic alliances with hospitals/companies (S4, O2, O4).	O5). Seek microloans/grants for basic tech and facility upgrade (W1, W5, O2, O5).
Threats (T)	ST Strategies (Diversification): Invest in niche, high-value services to differentiate from chains (S3, S4, T1, T4). Develop strong online reputation management (S5, T5).	WT Strategies (Defensive/Survival): Invest in cost-control and efficiency systems (W1, W2, T2). Form rural PBM networks for bulk purchasing and shared resources (W4, T4).

a. SO Strategies (Aggressive Growth and Expansion)

The SO quadrant dictates an aggressive market penetration and growth strategy by leveraging intrinsic strengths to capitalize on external opportunities. To maximize these synergies, practices must direct capital investments toward developing premium service lines and executing targeted digital marketing campaigns. Furthermore, organizations should proactively formalize strategic alliances with larger regional hospitals and corporate entities. This integration will establish robust, bidirectional referral networks and facilitate B2B healthcare delivery, effectively scaling operations beyond traditional, localized patient bases.

b. WO Strategies (Turnaround and Remediation)

The WO quadrant focuses on turnaround strategies designed to remediate internal vulnerabilities by exploiting favorable external conditions. To counteract systemic weaknesses in financial and operational management, targeted investments in human capital—specifically, formal business administration and clinical capacity-building training—are essential. Additionally, management must actively pursue external capitalization avenues, such as microloans, government grants, or village funds (*Dana Desa*), to finance essential technological adoption and facility infrastructure upgrades, thereby modernizing service delivery.

c. ST Strategies (Diversification and Threat Mitigation)

The ST quadrant outlines diversification strategies that utilize institutional strengths to neutralize formidable external threats. Confronted with market saturation and the aggressive expansion of well-capitalized corporate clinic chains, independent practices must pivot away from commoditized primary care. Investment must be redirected toward niche, high-value specialized services that leverage the practitioners' deep community trust and clinical expertise. Concurrently, practices must develop rigorous online reputation management protocols to safeguard their brand integrity against the volatile nature of digital platforms and localized competition.

d. WT Strategies (Defensive Survival and Consolidation)

The WT quadrant prescribes defensive strategies critical for institutional survival in highly constrained environments. Facing compounding internal resource

limitations and external pricing pressures, practices must implement stringent cost-control measures and robust operational efficiency systems. A vital macro-level intervention is the establishment of collaborative rural networks among Independent Midwife Practices (PBMs). By forming operational consortiums, independent providers can execute bulk purchasing of medical consumables and share critical human and technological resources, thereby achieving economies of scale that would be impossible to attain individually.

Ultimately, the TOWS analysis dictates a bifurcated strategic trajectory. In the short term, practices must secure their operational foundation through cooperative networks and rigorous cost-efficiency (WT/WO). In the long term, sustainable competitive advantage requires a strategic pivot toward premium differentiation, technological integration, and formal institutional alliances (SO/ST), insulating the practices from broader market corporatization.

The stark contrast between the SWOT profiles of urban and rural PBMs underscores the paramount importance of context in crafting investment strategies. Urban practices, characterized by strengths in volume and access but besieged by competition and cost pressures, align with Fattah and Hastuti's (2022) observations of competitive saturation in urban Indonesian healthcare. Their strategic priority is differentiation and efficiency. Conversely, rural practices embody the archetype described by Darmawan et al. (2021), where social capital is the core asset but is offset by acute resource and infrastructural constraints. This dichotomy necessitates that investors and policymakers abandon a one-size-fits-all approach. An investment that funds advanced ultrasound equipment may be a winning S-O strategy for an urban practice (S2, O1) but a crippling misallocation for a rural one struggling with unreliable electricity (W5).

The strength of deep community trust (S1 in rural, implicit in urban) emerged as the most valuable and defensible asset. This finding resonates strongly with Sulistyawati's (2019) emphasis on the midwife's role as a trusted community figure. However, this study extends the literature by framing this social capital not just as a clinical advantage but as a critical business asset that requires strategic investment to maintain and leverage. Investment in community health education programs or continuity-of-care models, while not generating immediate revenue, nurtures this trust, leading to long-term patient retention and referrals. This aligns with the S-O strategy of deepening community bonds to capture the opportunity of growing health awareness (O5).

The differential capacity to harness digital opportunities (O3) highlights a significant strategic fault line. Urban midwives view digital tools as a leverageable strength (S5), crucial for marketing and efficiency. For rural midwives, poor infrastructure (W5) transforms the same opportunity into a distant aspiration or even a threat if it widens the quality gap. This supports Smith and Siriwardhana's (2020) warning about technology exacerbating healthcare disparities. Therefore, investment strategies must be bifurcated: urban strategies can aggressively pursue digital integration (S-O), while rural strategies may first require foundational investments in

connectivity and literacy (W-O), possibly through pooled resources as suggested in the W-T strategy, before reaping digital benefits.

The JKN scheme was consistently identified as both a key opportunity (O1) and a source of weakness/threat (W3, T2). This dual nature confirms the complexities noted by Pratomo et al. (2021). For investment, this means strategies must address the financial management challenges posed by JKN. An investment in an efficient billing and claims management system or in staff training for insurance administration is not a direct revenue generator but a critical W-O "turnaround" investment. It mitigates the weakness of informal management (W2) and the threat of cash flow disruption from delayed reimbursements (T2), thereby securing the opportunity (O1). This reframes investment from being solely about asset acquisition to being about building financial and administrative resilience.

A critical weakness across both contexts, but more acute in rural areas, was the lack of business management skills (W2, W3). This aligns with Wulandari and Kurniawati's (2018) identification of a training gap for midwife-entrepreneurs. The discussion reveals that investment in human capital for business acumen—through training in financial literacy, marketing, and strategic planning—is a foundational W-O strategy. Such investment enables midwives to better utilize other investments, negotiate with suppliers, manage competition, and plan for growth. It transforms the practitioner from a passive recipient of market forces into an active strategic manager, thereby enhancing the return on any subsequent financial or technological investment.

The generated strategies, particularly ST diversification for urban and WT survival for rural, point towards the power of alliances. For urban practices, partnerships with hospitals (S4, O4) can secure referral streams and enhance credibility. For rural practices, forming networks with other PBMs (W-T strategy) can mitigate weaknesses in purchasing power and professional isolation. This network approach is supported by literature on healthcare small-and-medium enterprises (SMEs), which suggests collaboration can improve resilience and bargaining power (Kutzin et al., 2021). Investment, therefore, can be directed not only into individual practices but also into facilitating and structuring such collaborative ecosystems, potentially through intermediary organizations or platform cooperatives.

E. CONCLUSION

This study has systematically identified and analyzed the strategic factors influencing investment in independent midwifery practices in Malang, Indonesia, through a qualitative SWOT framework. The findings reveal two distinct strategic profiles: urban practices, which compete on differentiation, efficiency, and technology in a saturated market; and rural practices, which compete on trust, community integration, and survival in a resource-constrained environment. The core contribution lies in translating these profiles into context-specific strategic investment quadrants—aggressive (S-O), turnaround (W-O), diversification (S-T), and defensive (W-T)—that move beyond generic advice to offer actionable pathways.

The primary implication is that effective investment must be strategically targeted, not blanket-applied. Investors and funding institutions should design products that match these strategic types: e.g., growth capital and technology loans for urban S-O strategies, versus microloans for basic equipment combined with business mentorship grants for rural W-O strategies. For midwives, the framework provides a tool for self-assessment and strategic business planning. For policymakers, it highlights the need for differentiated support, such as simplifying rural licensing (mitigating T3) and fostering digital infrastructure (mitigating W5) to unlock opportunities.

This study is limited by its geographical focus on Malang, though the urban-rural dichotomy likely has broader relevance. The qualitative nature provides depth but not statistical generalizability. Future research should quantitatively test the proposed strategic links and explore the feasibility and impact of the recommended collaborative networks (WT strategy). Longitudinal studies tracking the performance of PBMs that adopt these strategic investment approaches would be invaluable in refining the framework and demonstrating its real-world efficacy in strengthening this vital layer of Indonesia's primary healthcare system.

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