An Explanatory Study of Health Policy Agenda Setting in Indonesian Immunisation Policy for Religious Anti-vaccination

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Declaration

I, Tetrawindu Hidayatullah, declare that at the best of my knowledge this dissertation does not contain any materials previously published or written by another person except where due reference is made in the text or footnotes. And this dissertation does not incorporate without any acknowledgement any materials previously submitted for a degree or diploma in any university.

Date: 10 January 2016

Dedication

"…to those who struggle to make health policy better in Indonesia"

Abstract

Indonesia, as one of the biggest moslem country, had been facing with religious opposition to vaccination. What had been in public dispute, it is around halal/haram status of vaccines. This study explains health policy making for religious opposition to vaccination in Indonesia. In heuristic linearized policy cycle, this study accentuates in the first stage, the agenda setting or priority setting. With very limited scholarly knowledge on agenda setting about health policy derived from developing country, this study may fill this knowledge gap by elucidating the case in developing suitable immunisation policy.

Grounding on Kingdon's agenda setting theory, this case study analysed the failure of opening policy window to change the national immunisation policy. Despite acknowledging the lucid analysis through Kingdon's theory, two important peculiar accounts are identified. First, the operation of populist logic in the competitive course for winning policy agenda. In this study, populist logic could be the understood as gaining mass-based appeal, as a *vox populi*, striking on behalf of the majority society, the 'un-halal' vaccines. And second, considering with political patronage culture as macro context of the functioning power behaviour in the general agenda setting course. Those two accounts may arguably play as political expediency in the endeavour of agenda setting and subsequently explain the failure in opening policy window to change immunisation policy, that no entrepreneurs could counter the populism of un-halal vaccine in the way of benefiting health policy, and changing immunisation policy.

The study suggests acknowledging on national political culture and its associated power behaviour to provide a strategic knowledge for public health policy entrepreneurs in agenda setting from developing country setting. Populist logic, as an incentive structure for policy entrepreneurships, may arguably expedite or hamper the agenda setting trail to open policy window.

Keywords: agenda setting, immunisation policy, Indonesia, religious anti-vaccination, populist logic, health politics

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Glossary and List of Abbreviations

Anak buah : the followers
AS : Agenda setting
Bapak : ideal father figure
Bappeda : Local Planning and Development Body
BIAS : in-school immunisation program
BPJS : Indonesian National Health Care Cover
BTL : Bantul District, Jogjakarta Province
BYH : Boyolali District, Central Java Province
CHO : Central Health Office
Depkes : health department
Darurah : emergency situation
DHO : District Health Office
Dirjen KIA : Director General of Mother-child Health
DPR : House of Representative
EBPH : Evidence Based Public Health
Fatwa : Islamic legal verdict
GAIN : Gerakan Akselerasi Imunisasi Nasional (National Immunisation Acceleration Movement)
Gotong royong: burden sharing with volunteerism
Hadith : one of various reports describing the words, action, or habits of the Islamic Prophet Muhammad, as an Islamic jurisprudence tool after Holy Qoran
Halal : religiously permissible under Islamic law
Haram : religiously forbidden under Islamic law
Kadinkes : Head of health department (district/province)
Kabid : Head of a unit in health department under Kadinkes
Kasubdit : Head of a sub-unit in health department under Kabid
Kekeluargaan: family life, collectivity.
KRH *:* Karanganyar District, Central Java Province
KT : Knowledge Transfer
K2A : Knowledge to Action
LMIC : Low Middle Income Country
LP POM : Food and Drug Authority
Mbalelo/durhaka: rebellious, commit a sin
MoH : Ministry of Health
MoHA : Ministry of Home Affairs
MoR : Ministry of Religion
MoE : Ministry of Education
MUI : Indonesian Ulema Council
Musyawarah : building consensus
NIK : National Identity Number
NSPK : Norm, Standard, Procedure, Guideline in public government
Pancasila : five pillar of Indonesian fundamental ideology
PHO : Provincial Health Office
P2PL : Disease Control and Environmental Health
Qawaid : purpose principle

Rukun	: willingness to compromise to achieve conformity, peace, and harmony
SBREC	: Social Behavioural Research Ethics Committee
SKH	: Sukoharjo District, Central Java Province
SKPD	: Working Unit in province/district government
SL	: Sleman District, Jogjakarta Province
SPM	: Minimum standard of services
SWOT	: Strength Weakness Opportunity Threats
Ulema	: arbitrator of Islamic law/sharia
UCI	: universal childhood immunisation

An explanatory study of agenda setting in Indonesian immunisation policy for religious anti-vaccination

Executive Summary

Introduction

Indonesia, as developing country, had been recently challenged with anti-vaccination on the basis of religion (Islam). With the fact of Indonesia's huge amount of Moslem adherents, this religious anti-vaccination could become a significant public health problem as potential of epidemics threat to the community. Eventually, it also became a policy significance in the way health policy actually generated in addressing the problem. The Indonesian immunisation policy appeared to remain un-updated, that the policy always focused in implausibly imposing high target of coverage for all region and unclear in the way of addressing those religious refusals. This study had tried to explain the way of Indonesian health department developing their policy to address the religious refusals. A huge research gap exists in this arena that enable to explain the health policy making with the specific character resonate the actual country setting and to explain *about what happened rather than described what happened*. This study could explain to fulfil the gap by elucidating the case of anti-vaccination for developing immunisation policy. From the four standard heuristic stage of policy making, this study emphasized with the initial stage of policy process, or the agenda setting stage.

Methodology and methods

This study was designed as instrumental qualitative case study, with variety of data collection mainly, but not limited to, semi-structured interview to answer the research question of 'what and how the understanding of the health policy makers about developing immunisation policy for the religious anti-vaccinations and how did the actual policy address them'. The data sampling employed with purposive network sampling comprised of three different tiers of Indonesian health departments and interviewing with elite health bureaucrats from five districts, two provinces and central health office. Kingdon's theory had been selected as an overall framework in answering the research questions for viewing and explaining the reality of agenda setting with the consideration that the theory enables to accommodate the influence of state ideological value in health policy making. Kingdon's theory highlighted the way of opportunity for policy change happened when the notion of problem, policies, and favourable political streams are merged at a particular time by policy entrepreneurs. In analysing the case, multiple findings were employed to develop the global understanding on the course of agenda setting that led to certain outcomes. There were no *a priori* knowledge before data collection to the extent in which agenda setting had been developed by the government nor the policy outputs that may have undertaken. Thus, there were no certain pre-set up variables in the outset apart from Kingdon's principles for understanding the process and forces that accelerate or hamper the agenda setting for this particular case. Data analysis of this case study was performed

by explanation building, or sequentially data-driven and theory-driven (inductive-deductive) to avoid in the exclusion or pre-sorted meaningful findings. The former was not aimed to generate a conclusive end but to withdraw categories of themes grounded from the data. The latter was aimed to allocate the inductive themes framed with Kingdon's theory to build the overall explanation.

Findings

The findings describe the themes involved with several categories of inductive themes that covered around the character of Indonesian immunisation policy, the nature of Indonesian decentralization and bureaucracy disincentives, the profile of regional anti-vaccination, the national cultural background, the significance value of popularity factor for proposing policy, the actual problem understandings, the ideas and alternatives, and some overriding internal restraints.

Discussion and Analysis

The use of Kingdon's principles demonstrate the difficulty of agenda setting in immunisation policy to explain the religious refusals. Despite the problem of religious anti-vaccination being prioritised in MoH agenda, it failed to push the action in opening a policy window to change the national immunisation policy. The problem streams are underdeveloped because the statistical indicators unable to mark that the problem exists along with other inherent obstacles. Despite the policy streams provides a variety of policy alternatives, the unsolidity of problem stream and unfavourable politics stream has made the policy stream thriveless. Politics stream mainly consists of the predatory interest of elite Islamic politic actors manoeuvring as client politics to the MoH, problematizing the porcine-trypsin enzyme by adjudicating the un-halal status of the vaccines. The policy output by MoH seemed to be a 'non-decision making', leaving silent the political theatre while also not changing the national immunisation policy. The three streams had failed to grow and join to open policy windows in the benefit of changing immunisation policy, and no explicit policy entrepreneurship exists to enable growing and joining the streams.

While remaining broadly within Kingdon's framework, the analysis of results suggests features of the domestic policy community in which political culture and democratization affect the way agendas are set and developed., contributing to problems in agenda setting. Drawing on contemporary Indonesian politics, the case suggests that national cultural values (paternalism) and populism may have contributions to shape the agenda setting process. Despite the decades of post-Suharto's authoritarian leadership, Indonesia's overall political culture landscape plausibly explains the difficulty of a non-established figure (or policy entrepreneur) to appear and participate in the general agenda setting process. Substantial policy proposals are difficult to get on the agenda without the approval, endorsement, or tolerance of substantial patronage powers. To emerge in the policy agenda, populist logic is arguably an important factor. This style of politics of populism invokes with *vox populi* (the voice of the people) as a strategy of political power

competition. In this case, a reverse path prevailed that the elite politics actors had successfully utilized populist logic by problematizing un-halal vaccines in order to propose the importance of halal certification for vaccines. The un-halal vaccines has successfully reached its populist logic and open the political agenda. None of entrepreneurships exists enable to counter this populist logic in the benefit facilitating a surfaced policy proposal to change the existing immunisation policy. With the lack of populist logic, none patronage political support could vehicle the policy proposals in the agenda. As a result, a non-decision making is the deliberate choice.

Conclusion

This study provides contextual and culturally relevant analysis of the influence of populist logic and political culture as the way of opening policy window. This modifies to some extent Kingdon's agenda setting theory by contextualizing it for contemporary Indonesian politics. This study suggests observing at higher context in its national level where the operation of political culture and its associated power behaviour dominates, which arguably may provide a greater knowledge in the analysis of agenda setting process. Populist logic and favourable patronage politics carrier may both accelerate or impede the endeavour of agenda setting to open policy window. Some limits are also observed in the degree to which this case may not be replicable. For the discipline of public health, this study may assist in understanding the crux of political culture in stepping the analysis of health policy making process, especially from an industrializing country. Correspondingly, the analysis of this study might be benefited for the health bureaucrats partaking the role of health policy entrepreneurs.

An Explanatory Study of health policy agenda setting in INDONESIAN Immunisation policy for religious anti-vaccination

Chapter 1 Introduction

1.1. The background

The growing anti-vaccination 'movement' in the industrialized countries has been explored and elucidated by many scholars (Streefland, Chowdhury, & Ramos-Jimenez, 1999), including their derivative laws (Sanzo, 1991) as well as their exemption policies (Silverman & May, 2001). The related literature encompasses mainly the dispute around individual rights, in the form of philosophical or religious freedom versus public's health.

Limited research, however, has been done on the same arena in developing countries. Indonesia, as a developing country in Southeast Asia, initially revealed vaccination resistance in the media (Faisal, 2011). This first anti-vaccination behaviour mainly related to the Islamic religious claim of halal/haram (religiously allowable/forbidden) status of the vaccines (Suwarni, 2010). In the context of contemporary Indonesia, the concept of halal or haram within Islamic jurisprudence appears to have been translated and traversed beyond the value of edible matter, reaching to any affairs that interact with human body. As the Indonesian nation did not adopt secularism, practising religion is never a private affair but by and large a public matter of public and one of governance. This made difficult to isolate which affairs were actually value-free; that is not violating any religious value or vice versa. In the case of this research, it was found that religious values intersected with the health policy area.

Most of the religious "propaganda" about "un-halal" vaccines are promoted through social media, internet websites, public oration and by publishing books. A clear example, the religious groups argued that vaccine is processed

from prohibited religious material ('haram') (Ahmad, 2011). To support their religious reasoning for 'haram' vaccines, the groups usually provide claims from the western anti-vaccination movement of overwhelming side effects (Salamah, 2012). It is important to note that from inside the Indonesian medical profession there is support for anti-vaccination. Some medical professionals propose replacing vaccination with natural breastfeeding, alleging the chemical adjuvant in the vaccine preparation is dangerous (Zainal, 2011).

The consequences of the anti-vaccination movement are prominent in some part of the country. For example, from media reports, Central and East Java province has had diphtheria endemics of more than 300 cases and 11 deaths due to religious barrier to immunisation (Faisal, 2011).

1.2. Problem Statement

This study explains and analyses the creation of immunisation policy, addressing the Islamic anti-vaccination issue at different bureaucratic levels within the Indonesian health department. It includes analysing the way in which the actual policy exists or does not exist as a means to address the issue. This study is not intended to explain and question the way in which Islamic religious ethics confront public health policy. Rather it aims to use the issue as a case study for explaining the agenda setting or priority setting of public health policy in the new Indonesian democratic sphere after the fall of Soeharto authoritarian regime since 1998. The Islamic anti-vaccination movement itself serves as 'the case' to explain the terms needed for an open window for immunisation policy (i.e. the time when opportunity surfaced to seriously make or change the Indonesian immunisation policy either nationally or regionally).

With the fact that Indonesia comprised of the biggest population in the world affiliated with Islam (estimated around 204 million) (PewResearch, 2013), religious-anti vaccination could become a barrier for the existing immunisation policy, creating pockets of the population which are not immunized either partially or totally. That there is a threat of pocket of partially/totally un-immunized people is exampled in 2013, national immunisation coverage reached 58.8% of the total population, with 32.1% still incomplete and 8.7%

unimmunized (MoH, 2013). In 2010, however, the average cover was 69.2% with high drop-out rate of 45.3% (Depkes, 2011). It indicates threat of slowly growing pocket areas.

Due to the prevailing decentralised Indonesian health system, this research is targeted at the way in which different levels of the health department (central, provincial and district) create immunisation policy, dealing with religious anti-vaccination. In Indonesia, the health department remains the key player in terms of position power and capacity to draft law (Trisnantoro, 2009).

1.3. Motivation of undertaking the research

The health policy process in low-middle income countries (LMIC) has rarely been paid significant attention by scholars. Very few studies overtly examine the challenges of explaining health policy process in LMIC setting (Walt et al., 2008). Moreover, health policy analysis in LMIC shows immaturity because it is limited in explaining how the health policy process can be actually understood. The main LMIC studies are usually posed around describing '*what happened*' rather than "**explaining** *what happened'*. The analysis involving and relating to power as a central element of policy change process appears to be minimum (Gilson & Raphaely, 2008). Very little hint and direction exists in *how* actually to do health policy analysis in LMIC setting. However, transferring concepts or theories of policy analysis from high income countries to LMIC settings needs to be undertaken cautiously. It is necessary that policy analysis resonate with the actual LMIC setting, where local specific characteristics affect and differentiate with others, especially in the health environment (Walt et al., 2008).

This study could help fill the scholarly gap in understanding policy process by explaining the case of immunisation policy in relation to religious anti-vaccination in Indonesia, particularly in the agenda setting stage. The issue of Islamic religion may be useful in explaining the Indonesian context since the state ideological foundation has not been secularly separated from religion. Thus it may further explain the power context in health policy making. And few of the health policy researchers in Indonesia focus on such unstable influential

variables (i.e. religion, politics, and culture) when accounting for policy making or articulate their possible links. Meanwhile, there are limited theoretical frameworks in health policy research, usually applied in developing countries to explain the analysis (Gilson & Raphaely, 2008).

1.4. Research Questions, Aims, Objectives

This research seeks to answer the overall question of: 'what and how of understanding the perspective of health policy makers in developing immunisation policy about the religious (Islamic) anti-vaccination. In particular it asks: How did the actual policy deal with that issue? Since the policy makers are not homogeneous as mentioned before, this study approaches different levels of authority to get a better understanding of the phenomena under study.

In a more detail, this study elaborates the following aims and objectives:

1. To explore the perspective and insights of health policy makers experienced with immunisation policy about whether, and how claims about religion influences government policy in relation to immunisation
    a. To investigate how and to what extent the religious issue is perceived as a problem by the policy makers
    b. To understand how religion is positioned as a determinant variable in the existing policy
2. To investigate how policy makers respond to any influences from claims about religion and what their accounts reveal about the policy models being used.
    a. To understand to what extent the content of existing immunisation policy elaborates the issue at a central and district level
    b. To explore the alternatives/choices proposed by the policy makers when dealing with the religious anti-vaccination issue
    c. To understand the barriers and means to facilitate such alternatives.
3. To compare whether/how religion influences immunisation policy both at central and district level.

a. To investigate the determinant factors and general contexts which are in favour or not in favour of the policy process contributing into a policy window in response to the religious issue
b. To analyse the differences in the policy window at a central or regional level, in respond to the religious issue.
c. To analyse the presence or absence of key actors who have role in changing the policy window, including how and whether or not it works.
d. To analyse the political window and its likelihood in shaping and influencing policy making, dealing with the religious anti-vaccination issue.

4. To generate a context-appropriate policy window and model in ways that account for any previous aims.

1.5. Outcome and Significances

There are not many studies exploring how health policy is developed in LMIC setting, especially on religious opposition to immunisation policy.

The outcome of this study, therefore may reveal some unexplored peculiar features and variables that could contribute and further explain former theories or frameworks on health policy making, in particular around agenda setting, in relation to developing countries.

1.6. Thesis structure

Chapter 2 of this the thesis reviews the literature on the subjects to providing the necessary background to answering the research questions. It comprises two sections. The first deals with the nature of Indonesian and culture, and its civic philosophy, followed by a review of Indonesian anti-vaccination, including an account of the Islamic religious ‘anti’-vaccination. The second section provides a brief introduction of public and health policy. To understand contemporary immunisation policy in Indonesia, an analysis of a MoH (Ministry of Health) provision in immunisation is described as an example to provide

background in national immunisation policy consonant with research based evidence. It is followed by a review of agenda setting theories and the rationale of taking a particular theoretical framework.

Chapter 3 comprises the methodology, study design, data collection and data analysis. The overall study design is an instrumental case study: the case performed is an instrument or device to emphasise the consideration of cultural or state context in the process of making health policy.

Chapter 4 describes the findings and the narrative of the inductive themes. The themes are not exclusive ends in themselves but more directed towards data-driven analysis that is drawn into categories to provide a big picture of the answer to research questions.

Chapter 5 refers to the discussion and analysis. To understand the answer to the research question, the themes generated previously are allocated and framed with a theoretical lens to build the whole explanation. The first section of this chapter addresses theme allocation and categorization. The subsequent section covers the theoretical analysis of the themes, including the way the previous themes either defend or revise the theory.

Chapter 6 mainly describes the research transfer and conclusion. It informs the proper stage of research transfer for this study type and illuminates the way for suitable transfer from certain knowledge transfer frameworks. This chapter also describes some limitations and potential future research consistent with this study. It is followed by the final conclusion in answering the research questions

Chapter 2 Literature Review

2.1. Introduction

The purpose of the literature review is to provide the background resource for the research question: ‘what and how are the understanding or perspective of the health policy makers in developing immunisation policy about the religious (Islamic) anti-vaccination and how did the actual policy deal with that issue? The area of study raised from the research question is involved with immunisation policy, religion (Islam), anti-vaccination and its related terms, Indonesia and other developing countries. Furthermore, this study will use Kingdon's multiple stream theory to frame the answer to the research question in its policy process analysis of the agenda setting stage. Thus, despite the study being involved with variety areas, the focus is the policy process and its initial stages, particularly, the agenda setting stage. In other words, this study utilises the Islamic opposition to vaccination as a case object to examine and analyse the health policy process in respect of immunisation in Indonesia’s health department.

There are very few scholarly articles which analyse the health policy process conducted from developing countries. Reviews of health policy in low-middle income countries are still in an immature state: there is too much superficial of analysis, which is mostly descriptive, with less attention drawn to understanding the process of policy change (Gilson & Raphaely, 2008). To better grasp the health policy process in developing countries, studies should draw the attention to the importance for incorporating politics, process and power. In supporting the understanding of power and politics, in analysing health policy for low-middle income countries, it is important for researchers to involve an analysis of their own institutional power and position rather than assume an ‘objective and independent’ account. Including an analysis of the researchers own institutional power could be achieved by drawing attention to the importance of greater reflectivity of the researcher (Walt et al., 2008).

In order to provide support for gaining a deeper understanding and analysis,

this literature review is divided into two sections, within which of the first section briefly describes the national ideology and culture in Indonesia. This brief description of ideology and culture might provide a better grasp and background for understanding Indonesian power and politics. The second section starts with the history of immunisation in Indonesia, including rise of the anti-vaccination and religious anti-vaccination movements and their debates in respect of immunisation policy. Section two consists of an analysis of Indonesian immunisation policy. And since the accentuation of this study was mainly in agenda setting, the second section also reviews policy and agenda setting theory. The method employed in the literature review search is a 'simple' search strategy rather than a robust procedure, in order to prioritise the relevancy of materials, involving the researcher's conscientious reflectivity to accommodate the 'authorial voice'. Accommodating the 'authorial voice' will plausibly correlate with the analysis chapter to comprehensively build the argument.

Section 1

2.2. The National Ideology and Culture in Indonesia.

The crucial point to recognize about the fundamental ideology of Indonesia (or the *Pancasila*) in this study is, firstly, that the historical discourse of ideology is immersed with the value of religion (especially Islam, despite its historical rewording of the phrase 'Belief in a single God' in the first clause of the *Pancasila*). And the second point is that domestic culture operates within this country. The culture of ideological and religious immersion may contribute, but not absolutely, to the way in which power is exercised such that could affect the health policy process (Walt, 1994b).

The *Pancasila*, established in mid-1940s by state founding fathers, consisted of five pillars of Indonesian ideology which are: belief in a single God, humanitarianism with a just civilization, national unity, a people's democracy led by wisdom to build consensus, and social justice (Ramage, 1995). One of the historical messages brought by the *Pancasila* is about ideology of tolerance in particular relation to religious matters to make sure that Islam

would not over prioritize other religions. Although the *Pancasila* demands the Indonesian state ideology is based on religious grounds, it does not validate only one specific faith (Islam). The Pancasila demands that the government respect religious diversity (Mubarak, 2004).

In macro political context, the national Indonesian political culture could only be precisely defined by the term of *'what it is not': not theocratic but not secularist, not liberal democratic but also not totalitarian, not capitalist but not socialist'(Liddle, 1996)*. In addition to the notion of indecisiveness inferred from the that of *'what is not'* account, the other theme brought by the *Pancasila's* values is the *subordination of the individual interest* to the state: state interest should transcend private/individual interest to establish the common good (*'kepentingan bersama'*) This subordination of individual human rights and obligations to the state arguably explains and could be used to justify the specific Indonesian interpretation in *'invalidating'* the statement of universal basic human right of human dignity (Niels, 1994). This paradoxical notion referred from the *Pancasila's* implicit message was not without intention: The main intention of submersing individual rights was the quest for societal harmony and political equilibrium among other values in Indonesia.

Moreover, in taking up societal harmony, the inferred message of the Indonesian ideology may be reflected in an inequality of power rather than a more egalitarian principle. The actual key to comprehending the human rights and political culture of the *Pancasila* at no point rests on a sense of equality but on the *kekeluargaan* (family life). Within the function of family, the principle is to live in *rukun* (the willingness to compromise to achieve conformity, peace, and harmony). With Indonesian ideology resting on *kekeluargaan* (family life), *gotong royong* (sharing burden) and *musyawarah* (building consensus) are the basic principles of the Indonesian nation. Thus, the nation was seen as a big family, *'guided by the principles of family life*". The common good (*kepentingan bersama*) outweigh individual/private interest with the assumption that when the common good is achieved, all individual interests will also be achieved. The reasoning here was *not* to divide *res privata and res publica* (Niels, 1994).

Within this cultural context, the concept of political leadership is the notion of the ideal father (or '*bapak'*) who is expected to be a reliable patron to guide and protect society and who should be obeyed and according to '*natural quasi-religious'*, moral obligation and hierarchy. Any disagreements, discordances, or criticism towards the 'father'/leader should not be expressed openly, otherwise, it will be regarded as 'rebellious' (*mbalelo/durhaka*) because it shows that people are not in conformity and harmony (*rukun*) as they should be. It is then better for people to avoid disagreement or conflict by withdrawing from making an opinion, not involving themselves and remaining indifferent (Niels, 1994).

In overall, the outlook of Indonesian state resembles with secularism but in operational governance and political structure, religion (especially Islam) is inseparable account for considerations of policy making.

2.3. 'Anti'-vaccination in Indonesia

In Indonesia, the 'anti'-vaccination movement tends to not be organized in a formal association or union but appears to be a formless movement mostly voiced through social media. In addition, there is no published and peer-reviewed research data on them. The term 'anti' here might more precisely to refer to 'resistance', 'reluctance' or 'reticence'. In Indonesian history, the resistance to vaccination had identified during the Dutch colonialism in the early decades of the 19th century(Boomgaard, 2003). The resistance were mainly based upon traditional beliefs, such as a 'magical mark' into Indonesian children to influence them for willingly join the Dutch army after they become adults, or a powerful tool of the Dutch to make them 'weak and cowardly'. Financial rivalry was also one of the resistance. The Dutch government made immunisation free which threated for indigenous vaccinaters who expected to be paid (Boomgaard, 2003). Religious based resistance for vaccination also surfaced during the Dutch era among a variety of groups, including Hindus, Christians, and Moslems, with similar reasoning: that smallpox was due to a lack of faith in God, and prevention for it is immoral, or smallpox was caused by a demon having a negative effect on spiritual wellbeing. The Dutch had a

strategy to deal with it, both using Moslem leaders, local noble people, village heads, to espouse the positive effects of vaccination and employing Moslem leader as vaccinators (Boomgaard, 2003).

Over a century and half later, a similar strategy was adopted by the Indonesian Government in their vaccination campaign of 1971. The government at that time usually consulted a local Ulema to release a fatwa (islamic legal verdict) in favour of vaccination (Neelakantan, 2010). For example, in vaccination program during fasting month (Ramadhan), the Indonesian government released an interpretation of Ulema (arbitrator of Islamic law/sharia) by a Bukhari Moslem (one of the leading Sunni Islamic leader) from the Prophet Hadith that vaccination was not forbidden during the fasting month (Ramadhan) because the route through which the vaccination is taken is not the mouth-intestinal tract. The technical policy to overcome this resistance would rest in gaining support from local religious leader embodied with quasi-religio-educational campaign. There are important exogenous social factor imbued with their cultural context, causing a community to obey the local leader. Local leaders had been a significant role in motivating or instructing the community for performing immunisation despite they were not in charge for delivering a precise immunisation knowledge (Kim & Singarimbun, 1988).

2.3.1. Recent religious anti-vaccination in Indonesia

Very few reliable data showed the statistical data of anti-vaccination in Indonesia. The latest MoH survey (MoH, 2013) may offered some reason from the cause of 'forbidden by the family' (family restriction') as the second to top reason at 26.3%. Chart 2.1. depicts the composition of reticence for immunisation. Despite its limitation on survey details, this survey added into another dimension: that the family variable was one of the dominant social factor in determining vaccine uptake. The family variable in opposition to vaccination may indicate that *religion* could be one of the determining factors within the family for refuse immunisation. During ground working period in MoH offices and DHO (District Health Ofices), the information reveals that the family restriction was related and following to their immediate community or family religious leaders.

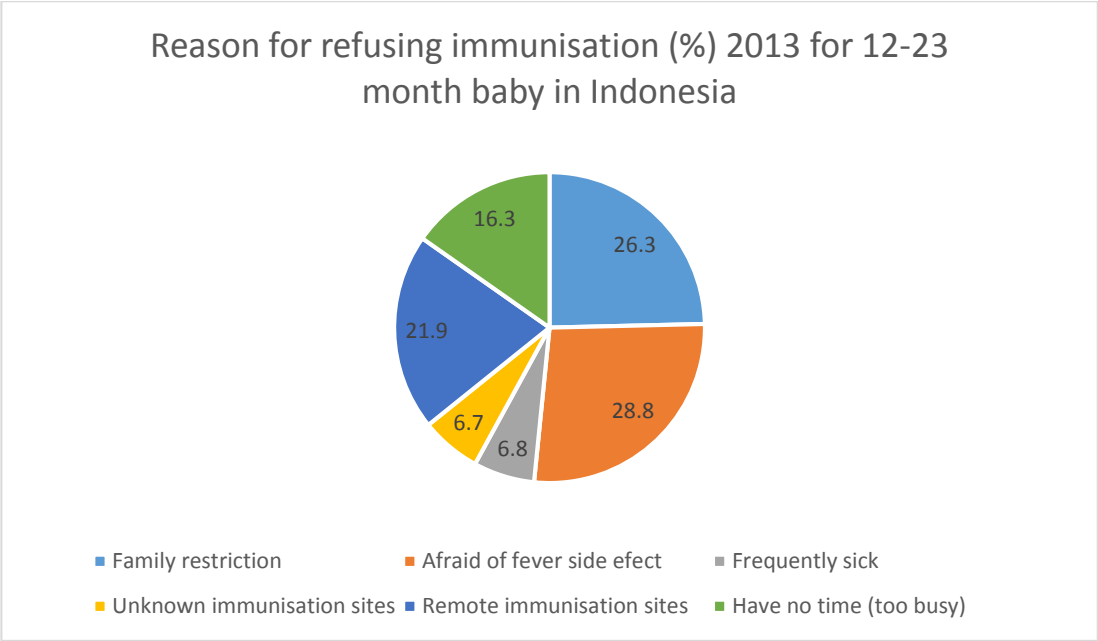

Chart 2.1. Riskesdas 2013, tabulates the reasons for not taking immunization. The threat of fever is the most common reason at 28.8%, followed by 'forbidden by the family" (family restriction) at 26.3% and long distance from immunisation service as the third reason at 21.9%. (MoH, 2013):p 235).

One such study offering supporting evidence for family variable and religious restriction for immunisation in Indonesia comes from a 'grey literature' of a small local qualitative study by Wulandari (2010). In a district area of Central Java province, Wulandari's study describes that mothers of families have religious consideration for avoiding vaccination due to unclear haram/halal status of the vaccine, which as a result they viewing immunisation as unsafe. They argued that diseases could be prevented not only by vaccination but by following a natural healthy life in accordance with their religious belief (Wulandari, 2010).

The general line was similar here that the vaccine uptake resulted from mainly external recommendation and/or exogenous 'social pressure' in form of encouragement or discouragement from a community or religious leader or other significant people. Following mother's religious instruction in the above study, which including generally following leaders' instruction, can be termed

as passive acceptance behaviour, is supported by the results from the Riskesdas MoH survey of 'forbidden by the family' as a 'social pressure' discouraging vaccination (MoH, 2013).

2.3.2. Recent Immunisation Profile in Indonesia

The MoH's Riskesdas surveys from 2007-2013 showed an increasing trend for completed immunisation and decreasing trend for incomplete groups. The completed groups had risen from 41.6 to 59.2 while the incomplete group had declined from 49.2 to 32.1 during the same period of time. On the other hand, the total un-immunized group seemed to be ups and down with a decreasing trend ranging from 12.7 in 2010 to 8.7 in 2013. Chart 2.2 below describe the immunisation profile in three consecutive year surveys by MoH from 2007 to 2013.

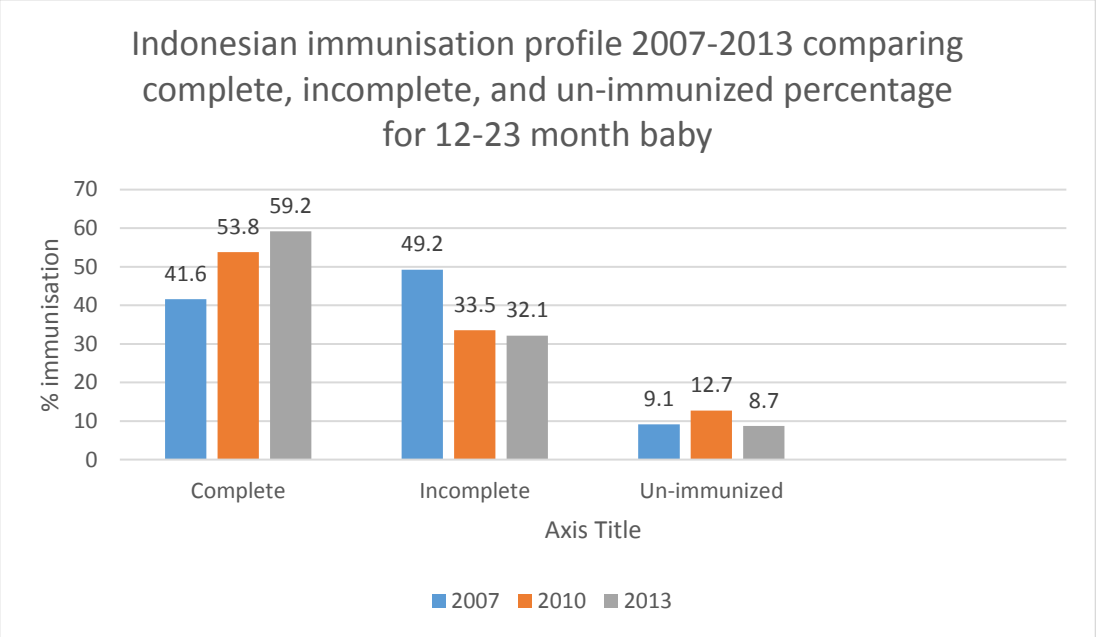

Chart 2.2. Immunisation profile by MoH for three consecutive periods, 2007-2013, depicting complete immunisation, incomplete immunisation and un-immunized (MoH, 2013):p 230).

Despite having a good representation of immunisation achievements, the MoH's surveys suggested caution in the minimum infrastructure of recording system in Indonesia. Data was collected based on memory recall of mothers,

which could generate recall bias, as one of drawback of the MoH cross-sectional surveys (MoH, 2013).

2.4. Brief Review in Islamic position to vaccination

In general, the religious barrier to immunisation covers not only Islam, but also other beliefs such as Orthodox Catholic, other Christian congregations and the Amish. For Islamic belief, one study in Pakistan for example, espoused Islamic anti-vaccination, claiming the vaccine contained a pork substance and served as a plot against Muslims violating the Hadiths and God's will (Murakami et al., 2014). On the other hand, Nigeria succumbed to long term polio vaccination boycotts, mostly driven by political and historical discourses rather than the theological reasoning. The historical and political tension in Nigeria, during the political change from the authoritarian military regime to democracy may contributed to the vaccination boycott (Jegede, 2007; Kaufmann, 2009). The safety of the polio vaccine become a dispute provided that the underlying between political and religious power during the shift to democracy rather than purely distrust of vaccine safety (Clements, Greenough, & Shull, 2006). Grabenstein and Grabenstein (2013) provides a comprehensive account among different religions in which "*theological reasoning per se*" does not ground refusal for immunisation but rather personal belief in society around a faith community. Wong and Sam (2010) study suggested that, in Asian communities, religious issues are ultimate factor which determine vaccine uptake. The halal status of vaccine was the main element in deciding to have the vaccine for Malays group while for the Chinese and Indian participants vaccine safety influenced their decision to be vaccinated. Their study indicate that religio-ethnic variables influence the decision to vaccinate.

Turning to the role of Islam in relation to vaccination, what had been in concern and debatable for Islamic bioethics for the halal status of vaccine, it was the use of porcine gelatine in vaccines (Aasim I. Padela, Furber, Kholwadia, & Moosa, 2013).

Haram status become permissible when it meets with dire or emergency situation (*darurah*). Due to the nature of vaccination as preventive, taken in

healthy non-dire situation, where to locate the emergency, or *darurah* to allow it to be permissible become confusing. The *darurah* account in vaccination, according to A. I. Padela (2010), was best not seen in advance or as soon just as in the counterpart of emergency or real life-threatening condition. He offers some explanations within Islamic jurisprudence in which porcine-vaccine become permissible. These include redefining the concept of 'necessity' within an epidemiological context, and defining the chemical transformation of porcine products in vaccine production. The input of epidemiologists may help to define the concept of necessity, at a population level versus individual level. By using a robust algorithm the risk of mortality in a population versus individual risk, could be used to calculates a threshold number to mandate that public vaccination is necessary.

A situation eliciting public threat affecting a critical proportion of the populace, may change the haram status to become permissible, or halal (A. I. Padela, 2010; Aasim I. Padela et al., 2013). Kasule (2007), a professor in Islamic biomedicine in Brunei Darussalam University, also supports vaccination by using the *qawaid* or purpose principle. It states that vaccination is necessary when the benefits outweigh the risk of the burden of infection by diseases. The IOMS (Islamic Organization for Medical Science), an Islamic council consisting of transnational Islamic jurist and biomedical expert in bioethics, uses the transformation of porcine products during the production of vaccines to ground their argument to allow porcine based derivate in medication (Aasim I. Padela et al., 2013). However, the argument within Islamic ethico-legal deliberation depends on the level and degree of Islamic jurist-consultants in every country who may have different views. These differing views may provide a gap in which an influx of other interests, such as politics could influence their verdicts or fatwas.

Overall, religious opposition to vaccination is not a unique. The public health arena, does not stand alone as an exclusive domain, but is influenced by the intertwining of significant political, cultural and religious discourses (Clemens, Holmgren, Kaufmann, & Mantovani, 2010).

Section 2

2.5. Policy, Public Policy, and Health Policy

Many definitions were attempted to identify the concept of policy. Policy is not a static entity, but a dynamic process changing over time, which changes how it is to be defined. What's more, most policies do not enter an empty space but rather a crowded space, in which various pre-existing policies impact upon and influence each other. Therefore, policy implies several rather than single decisions. And these decisions may include both actions and inactions. Indeed, the study of policy could be seen to be the study of *'action without decision*' (M. Hill, 2014). For example, the outcome of policy might involve non-decision as a reference of inaction, while some political activity could emanate within status quo, obviating any challenge to established values. Policy can also be in the form of both explicit (written) or implicit (unwritten) objectives to produce activity (Buse, 2012b). Despite the format, policy might also occur through a variety of interconnected activities, having either close or distance consequences, rather than an exact decision to achieve precise goals (Walt, 1994b). Health policy might cover both public government and private non-government institutions, either as action or inactions which influence the health sector and health care system (Buse, 2012b). That health policy influences the health care sector and system means that policies from the outer arena of health care system, for example the environment, politics and socio-economic could also have an effect on health (Walt, 1994b).

Policy makers or policy elites, include several communities or groups of people, organizations, who have a highly strategic and privileged position as decision makers both in the public and private sector, in any level from central to regional, national to local.

Articulating the *public* policy, it had its claim on the primacy of the 'state' over other policies. The State, is defined as a legal superordinate institution with legitimate territory, consisting of the legislative, executive and judicial bodies in a range of levels from national to regional. Beyond the state, there are international agencies, termed '*supra-states'*, for example the United Nations,

the World Bank, International Monetary Fund, which can challenge their policies (M. Hill, 2014). These complex institutions interact in a multifaceted process that deliver policies, either as actions or inactions. Given the complexity, policy, narrowly defined might be termed as programmes. These programmes, may consist of actions or decisions which may or may not be formally defined or written in a policy document or statement (Buse, 2012b). Wheter they are formally defined or written, programmes articulate policy actions, for example school immunisations (Buse, 2012b).

2.6. Immunisation Policy in Indonesia

2.6.1. Different policy approach for vaccination refusal

Based upon the different historical discourses of religious or moral values and the prevailing cultural account between the developing and developed countries, it seems difficult to apply and generalise the policy discourse from western-developed countries to address religion and immunisation in developing countries.

The Indonesian historical anti-vaccination path and setting differs from the historic-political anti-vaccination path in England, during 19th century. During the 19th century, western society was transformed by the industrial revolution, while Southeast Asia (including Indonesia) at the same time, did not pass through a similar course.

Henceforth, during the 19th century, as England was already a democratic state, the policy was focused between individual rights and public health. And from that time, it has occurred the same through the western policy (Bayer, 2007). On the other hand, Indonesian national ideology and civic philosophy, appears to discount individual rights, overweighing the state interests, as ascribed in section 2.2. And occasionally, in contrast to democratic state, the Indonesian state in Suharto's authoritarian style enforces standard practice by sweeping the village houses even if they have already vaccinated (Fenner et al., 1988). Even more, the WHO epidemiologists during the end of smallpox eradication program in Southeast Asia in the 1970s applied a *'to make an omelette, the egg must be broken*' policy. This policy was directed a

‘containment’ by sweeping out refusals (Clements et al., 2006; Greenough, 1995). A similar approach also prevailed in Indonesia at the same time during the authoritarian Soeharto regime, obtaining a free smallpox award from WHO in 1974. What's more the sweeping policy used by the Soeharto regime, and typical in Southeast Asia, is still being adopted by the MoH in the recent 482/2010 immunisation policy. While the successful achievement of immunisation coverage in Southeast Asia to eradicate smallpox was in part achieved by sacrifice the rights of individual, the western policy counterpart respected that right for the last century by guaranteed exemption for the conscientious objector (Durbach, 2002; Salmon & Siegel, 2001). The historical policy discourse between the two worlds articulates the gaping differences in immunisation policy addressing religious exemption.

Given the fact of the key role of cultural, social and religious values as well as other socio-demographic factors (age, education, socio economic level) as predictors for motivating vaccination up take, Serquina-Ramiro et al. (2001) suggest immunisation policy should involve some strategies to muster the community and religious leaders: delivering education suitable with their cultural language, identifying the specific facilitator and constraint factors among different villages, and thus re-structure the immunisation service. While this strategy offers an ideal approach, it seems difficult to implement in a developing country setting, in particular Indonesia, where blanket mass vaccination program prevail and other difficulties might arise for taking into account specific socio-cultural influences, such as infrastructure, human resources, bureaucracy and monetary issues.

2.6.2. EBPH Framework for immunisation policy analysis

No immunisation policy in written format explicitly, exists in Indonesia. Rather the policy is mostly issued in the form of decrees, regulations and/or guidelines from the Indonesian government. The most important regulations related to in Indonesian immunisation is related to higher government institutions, that is the MoH (Ministry of Health) decrees.

From the MoH websites, in the collection of MoH decrees, regulations, and

instructions (http://www.hukor.depkes.go.id/), the specific policy for only addressing religious anti-vaccination does not appear to exist. -(Although that policy might embedded in the other higher policy goal.) Given a specific religious anti-vaccination policy does not appear to exist, the MoH decree No. 482/2010 (GAIN UCI; *Gerakan Akselerasi Imunisasi Nasional* Universal Childhood Immunisation/ National Acceleration Movement on Immunisation UCI) was chosen from 11 other immunisation decrees. This decree was chosen for analysis with the consideration that its content, aims and description serve a more comprehensive deliberation and contemporary analysis (e.g. by SWOT analysis) to achieve the goals. The main intention of the MoH policy 482/2010 was to achieve 100% UCI (Universal Childhood Immunisation) by the end of 2014 in order to fulfil the MDGs (Millenium Development Goals), while other immunisation decrees mostly served as bureaucratic formality and hierarchical procedures within government structure.

This section analyses MoH decree 482/2010 for immunisation. Rather than doing a contemporary policy analysis to address and solve particular problem of choice, I analyse this policy by using the EBPH (Evidence Based Public Health) approach into policy/practice. This analysis will offer a supporting argument for chapter 5 and 6 consecutively.

The definition of evidence based public health by Brownson, Baker, Leet, Gillespie, and True (2010); Brownson, Gurney, and Land (1999) is: "*The development, implementation, and evaluation of effective programs and policies in public health through application of principles of scientific reasoning, including systematic use of data and information systems and appropriate use of program planning models*". In public health arena, evidence is type of information which cover both quantitative (epidemiologic, public health surveys and surveillances) data, and qualitative data (media, word of mouth, personal experience). Both types of data are included within the scientific literature, in journal articles or in a systematic reviews which hold different range of subjectivity and objectivity level (Brownson, Fielding, & Maylahn, 2009). However, policy makers usually use evidence, based on scientific reasoning

in their deliberation, as much as the political sense: that is there is a significant influence of political judgement in shaping the application of principles of scientific reasoning). The EBPH (evidence based public health) framework is arguably able to understand and track *the shift* in the way political logic has penetrated the decision making of a policy. This section will identify that shift in government immunisation policy by using Brownson et al. (1999) sequential framework *vis a vis Satterfield et al. (2009)*. It will be followed by a relevant critique in the 'numbness' of research evidence for policy making in developing country, explaining its disappearance from consideration in particular policy decision making.

Brownson et al. (1999) and their companion article (Brownson et al., 2010) explain sequential framework as putting EBPH in practice through a step by step process via the use of evidence in every day policy decision making. This sequential framework was designed to promote and enhance the use of EBPH in policy decision making by identifying the path of decision making in taking up the evidence of interest. Despite its appearance of a linear or sequential process, the steps might include circular loops, and help to identifying the broken line or shift to political logic further explaining the disappearance of the EBPH in policy process. The first Brownson step is to establish initial interest of the issue (i.e. for immunisation policy, MoH decree 482/2010, it is the under-achievement and unequal immunisation coverage among regional areas in relation to health decentralization). The second step is to elucidate the relevant evidence from scientific literature and manage the information; in this second part, the MoH uses the relevant data mostly on their own epidemiology, surveys and immunisation records. Given the MoH uses its own data, it might contain bias or redundancy, but no policy, or scientific articles involve a systematic review. And rather, this policy is usually referred for jurisdictional judgement from other laws and decrees. The third Brownson step is to calculate the initial problem of interest using the sources of information. In this way, the policy applies a SWOT analysis to weigh the problem of interest. However, without underlying specific research-based arguments, most of the SWOT analysis appeared to be based upon *self-organizational experiences*

and preference, which *then lead to subjectification* and *the prevailing potential of political influx*. The result of which is reflected in the fourth step of Brownson's framework: the consequences in policy formulation of planning and prioritizing the options to determine the policy direction and strategy. Most of the policy strategies outlined and listed in MoH decree 482/2010 are non-specific in answering the initial problem: by the section 'general advisory planning' is filled with words like '*improving or stabilizing*' but minimal in actual strategies to address the fundamental problem of its interest (overcoming under achievement and unequal coverage in relation to health decentralization). Thus, despite its higher policy product, it seems to be less operational and implementable in the downstream path. The straight critique question for this policy is: In what way does this intended MoH immunisation policy actually allow 100% UCI to be achieved by the end of 2014 among regional area within decentralised health system framework? The fifth step of the Brownson framework which is to evaluate the intended policy outcome of achieving 100% UCI in 2014, allow this question to be answered However, based the latest 2013 basic health survey of 59.2% UCI coverage, it would be unrealistic and take an incredibly high effort to obtain the intended goal of 100% UCI in a very short time. Hence, the MoH 482/2010 immunisation policy tends to serve a short term approach rather than long term strategy, And although the previous progress had been significant, but not spectacular in increasing the complete immunisation nationally from 41.6% to 53.8% in three years period (2007-2010) the goal has been tantalizingly elusive, It might indicate effect of transnational forces through the MDGs message in the deliberation of the immunisation policy rather than the MoH's original intention to set up a more rational long-term strategy for gaining high coverage immunisation, for example by starting with the real problem as way to address health decentralisation rather than how immunisation should be done. It might be plausibly inferred that the MDG's immunisation policy deliberation serves international attention, about the government's seriousness to address foreign donor funding, and is less about policy content to actually overcome its basic problem statement

Moreover, the use of limited research evidence by MoH is also a plausible explanation for the MoH short term strategies since, as Indonesia is a developing country, the MoH might themselves face limited availability of relevant supporting research data, which is published, and the available relevant reviews might be less implemented in a poor resource setting, allowing multi-sectoral influences to become significant in policy decision making (McMichael, Waters, & Volmink, 2005). This multiple sector influence in policy decision making might in turn be explained with the Satterfield et al. (2009) model, which revises the three-circle model in evidence based practice (EBP). According to Satterfield et al. Research based evidence should compete with other contestants in policy decision making. Although, as mentioned above there is research resource evidence done by government institutions, the institutions are likely be bounded to a rigid bureaucratic and hierarchical procedure that might not in favour challenging the *status quo* within the organization itself thereby indicating the need for independent research. With rigid bureaucratic procedure, it is often difficult to take-up significant research evidence into policy/practice. A supporting organizational culture and climate is important to make such innovations and change (Simpson, 2002). Hence, research evidence itself is such only one among other important variables and factors that are influencing policy decision making (Satterfield et al., 2009).

The factors which intervene in evidence based decision making, include the values and preferences characterising a population, and the practitioner's preferences. Satterfield offers a transdisciplinary model to show the way evidence based decision is intervened in by individuals or groups framed in a broader cultural context within organizational and environmental spaces.

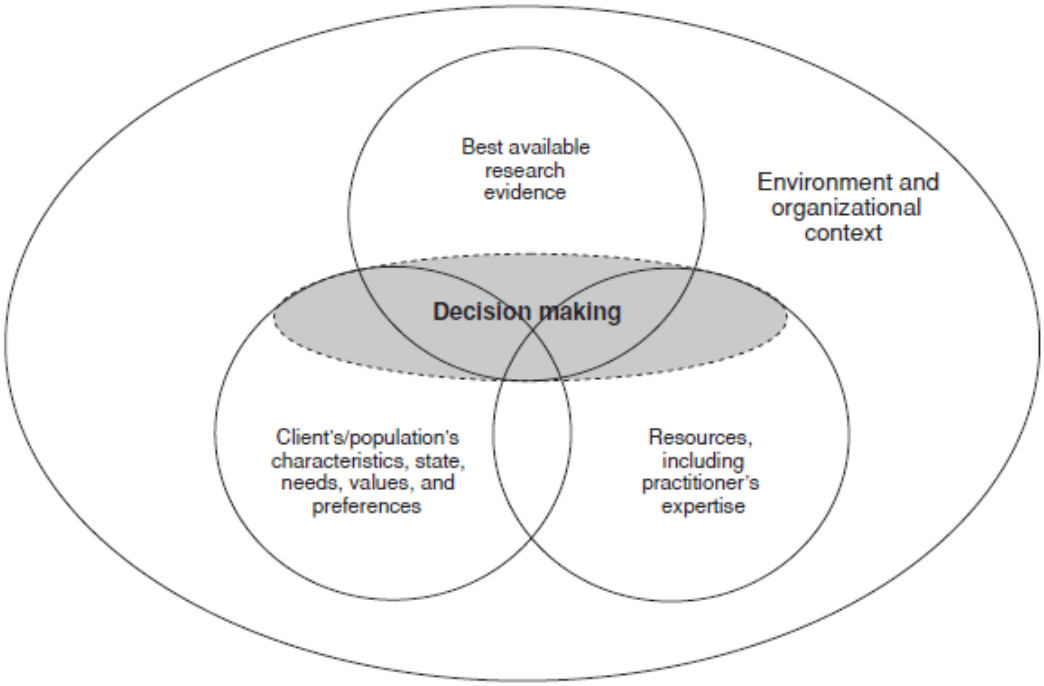

Figure 2.1. A transdisciplinary model depicting the position of evidence based practice in policy decision making by Satterfield et al. (2009)p: 382).

As indicated by Satterfield's model (Figure 2.1), 'decision making' is located in the central framework. In essence the decisional process is a combinatorial process incorporating the available evidence with community characteristics or state values and practitioners' expertise, framed within their broader organizational and cultural context. This model offers the means to figure out the difficulties and obstacles in the process of evidence based policy decision making.

In particular, it offers an adjunct explanation to the previous Brownson's template analysis on the MoH immunisation policy that with minimum research evidence at hand, its policy deliberation could be influenced by other spheres. Resonating with Satterfield work, as mentioned these sphere include health policy maker's expertise, Indonesian state and ideological values of the state framed within the broader MoH organizational and environmental context within which the Indonesian government operates. Satterfield's particular model is arguably useful to explain and guide in an inter-disciplinary and real-world setting the way in which the cultural and political dimensions of authority

could distil and become an influential variable in policy decision making *vis a vis* personal elite health bureaucrat's experience and interest. As part of this analysis, it will also arguably be able to locate and analyse in which 'sphere' the dominant powers could shape the policy process.

As outline by Waters and Doyle (2002), along with the value of evidence, "politics and timeliness" are summoned into public health decision making: Highly qualified research evidence does not speak on its own and is an inadequate tool to persuade policy makers to make or change a policy. Hence, the policy deliverables might evolve in such a way that was difficult to adjust to an ideal sterile research environment. Meanwhile, the policy itself may be made in a very short time, and ultimately decided upon by other considerations and demand from other stakeholders (Choi et al., 2005). For example, the MoH, as a public health agency, might face opposition from other stakeholders, while the health minister, as well as other top elite bureaucrats have to argue and defend their positional rank/echelon with their own political capital (Brownson, Royer, Ewing, & McBride, 2006). In this way, the decisional process reflects a 'winner or loser' battle which can be an odds in EBPH discourse (Abney, 1988).

Overall, recent immunisation policy in Indonesia is crafted towards the fulfilment of the UCI (Universal Childhood Immunisation) achievement, As the ultimate goal of the MoH, it is assumed to be followed by the regional health offices, enabling them to overcome every obstacle to deliver the immunisation program. Despite the goal of 100% immunisation, there is no clear regulation or policy addressing religious refusals of immunisation in Indonesia.

2.7. Agenda setting and policy process; Theoretical background to focus the study.

As noted in the previous section due to the unclear articulation of immunisation policy addressing religious refusals, it is reasonable to overview the policy making cycle process to facilitate in what way the punctuation of this study should be emphasized. A more streamlined policy process, describes sequential stages by discriminating between agenda-setting, policy

formulation, decision making, implementation and evaluation (Wegrich, 2007). Despite many critiques of the natural difficulty in separating the chronological stages of actual world of policy making, this linear heuristic rational stage model is still important to explain and systemize research in public policy from the real-complex policy process (Walt & Gilson, 2014; Wegrich, 2007). One of the other reasons for its longevity is its applicability to assessing the normative ideal-type inherent within evidence based policy making. The linear rational stage-type policy process also allows the significance of the stage domain or its policy process sub-system to be highlighted. However, academic research in policy studies rarely uses the whole cycle or stages as an analytical tool to guide the research questions and focus. Policy studies usually originate from only particular stage rather than the whole cycle process (Wegrich, 2007).

2.7.1. How do I locate this particular study within policy process?

Observing the previous analysis of the MoH immunisation policy lack of clear accentuation of religious anti-vaccination, (Islam), in particular with the policy stage cycle framework guides this study to analyse the policy the starting stage when the issue had, (or had not) been recognized as a problem. In other words, it is appropriate and plausible that the study emphasizes within the agenda setting arena, as the initial policy stage rather than the subsequent policy process stages. Specifically, since the religious anti-vaccination had raise media and public attention (or the first-two parts within agenda setting architecture (Rogers, Dearing, & Bregman, 1993)), this study may supplement within the third part, or the rise of the issue within the groups of health policy making. In this way, the understanding for the dimension of health policy agenda setting can be well comprehended.

It is obvious that many problems arise and some issues successfully obtain attention and others fade from the view. Despite a problem being identified, is debatable how some issues become noticeable for policy makers, such that they decide to act on some issues but not on others. Agenda setting is a selection process among a variety of problems and issues because not all matters are perceived with the same attention level in an already crowded policy space. In basic form, policy agenda can be described as a concrete list,

of legislation agenda, or in the form of beliefs of abstracted problems and how the problems should be addressed by the government or other institutions (Birkland, 2007). In this form, agenda setting is therefore defined as the process in which some issues successfully compete over others to enter the policy agenda via substantial consideration by policy makers (Buse, 2012a).

Problem recognition and agenda setting are inherent to the political process in where political actors persistently influence the process and shape the agenda by exaggerating a problem or accentuating a problem definition (Wegrich, 2007). However, the series of issues that usually become the policy agenda are those the government assumes they are able to address (Buse, 2012a). However, this activity might not been controlled by a single actor. In fact, it might depend on the democratisation and political climate in a particular country by articulating the level of participation in decision making, advancing the agenda setting (Buse, 2012a; Walt, 1994a).

The initial research on agenda setting started in response to a context of pluralism in the United States. The many variables (ideas, actors, interests, organisations and others) which interact together in highly contingent condition implies that rational choice is far from relevant in agenda setting. The ‘attention cycle’ and the unpredictability of the problem perception may shift the agenda and develop the policy rebutting previous research based evidence (Wegrich, 2007).

In examining and exploring the specific frameworks on agenda setting particularly in the health arena, Buse (2012a) acknowledges some scholars namely Hall, Shiffman and Smith, and Kingdon. Briefly, Hall et al. theorise that an issue could be successfully up taken in government agenda with the consideration of *legitimacy, feasibility* and *support*. The logic at play with Hall et al.'s model is the likelihood of an issue moving into the government's agenda when the issue falls into these three high continuum considerations. This model provides the simplest tool for analysing agenda setting (Buse, 2012a). However, Jeremy Shiffman and Smith (2007) offer a more prescriptive framework. Their examination of agenda setting derives from their study in

reducing maternal mortality among countries identified by global Safe Motherhood Initiative's lack of attention. Shifman and Smith framework consists of four elements, in analysing the priority setting of an issue: the power of actors, the strength of ideas to understand and interpret the issue, the political environment within which the actors operate supports or inhibits the issue, and lastly the feature behind the issue itself (Jeremy Shiffman & Smith, 2007; Walt & Gilson, 2014). Shiffman and Smith's priority setting model rationalizes that the fulfilment of these four determinants become the likely way to take policy agenda towards action.

2.7.2 Why Kingdon's Model suit for this study?

Both of the last models above (Hall and Shiffman) might best fit with the 'rational' approach to interpreting how policy agenda *should* happen and be prescribed in the real world setting. Contemporary research evidence based policy might aspire to this rationalism model in how to secure the 'best policy solution' unspoiled by politics. However, both models of the 'ideal type' might miss the realistic way in which actual policy processes happen. The 'incrementalism' model offers a counter analysis (M. J. Hill, 2009). Lindblom proposes "incrementalism" as the way policy is actually set. Instead of taking rational comprehensive methods, the policy makers set the policy by '*successive limited comparisons*' of policies or prescriptively '*muddle through*' to the extent to which some policies will achieve the closest goals. In this way, a serious mistake by unavoidable events can be prevented when the incremental policy performs changes. However, this incrementalism may best answer 'the ordinary policy question' or policy-as-usual, while it might less be suited the operation of ideology or philosophy glued, in a particular population play a role. To address the ideological or philosophical notion, it is important to emphasize Kingdon's model of agenda setting. Both the former models seem still to be 'too rational' and unable to explain the failure the agenda to occur. Kingdon appears to be important in analysing further than the narrow attentiveness of rationalism incrementalism (M. J. Hill, 2009).

As exemplified elsewhere, for example by Gilson and Raphaely (2008) the LMIC (Low-Middle Income Country) setting is usually 'descriptive in nature',

and less comprehensive of the operation of ideological power in the policy change process, it is imperative to deepen the analysis of this study by drawing on a precise tool for such complex ideological related approach. Kingdon's model may best explain the notion of Indonesian ideology in agenda setting discourse, for this study. Moreover, the model might also explain in more detail a policy silence, when failure prevail from the opening policy agenda. It may explain the way in which the influx of related political influences operates, by not seeing a dichotomy of politics and policy making, contextualized in recent Indonesia political setting.

2.7.3. A Brief Review Kingdon's Model

Kingdon (2002) has conceptualized a more complex model. According to Kingdon's model the policy process runs within a 'primeval soup-like environment' mimicking 'biological evolution', where policy changes surface by free 'genetic combination' with only some of them surviving. There are three streams in the soup-like environment: the problem, policy and political. Kingdon argues that despite rational policy being designed to solve problems there are times when the policies actually have to search for the problem to solve rather than already existing problems and waiting to be solved. According to M. J. Hill (2009), problems are socially, politically constructed and the key actors eager to solve them for their own justifications rather than assume a problem already exist waiting to be solved. Kingdon introduces the notion of 'policy entrepreneurs'. Policy entrepreneurs are like 'surfers waiting for the big waves' (Kingdon, 2002). The notion of an ever-changing environment is reflected in the attention cycle of the political course, leading to either the opening or closing of a 'window of opportunity'. The window opens when the three independent streams merged together (Buse, 2012a).

The '*problem stream'* connotes the issues perceived as a public problem requisite for government policy to address. The problems are exercised from program feedbacks and indicators, such as statistical records. However, the evidence seldom 'speak by themselves' to produce policy: the policy actors attempt to interpret the evidence to shape the policy agenda. The '*policy stream*' comprises the ideas proposed as possible solutions available for the

problem stream, along with the debates around them. To survive, the ideas should meet certain criteria, such as technical feasibility, have ideological coherence with the dominant values of the society, be resilient with ongoing impending constraints and tolerable to politicians. The '*politics stream*' runs in a rather separable path from the two previous streams, and reflects socio-political qualities, such as national mood and governmental changes (Buse, 2012a).

As mentioned above, the three streams run independently and join at a suitable time of the opening policy window, i.e. the suitable time when the opportunity emerges to take the issue seriously to be considered for action (figure 2.2). At this time, the issue is transferred on to the agenda by policy makers. However, it's transfer to the agenda does not offer an absolute warranty for policy change to happen. The window of opportunity is opened by specific circumstance or events in the politic stream, and the duration may be either short or long, depending on the particular subject and political atmosphere. Once the opportunity is available, it is possible for them to be joined by the policy entrepreneurs. The policy entrepreneurs comprise of individuals, groups or institutions who are able to read when the window of opportunity is open and examine the potential it offers to initiate their proposals (Kingdon, 2002). Thus, the policy path is not a linear logical staging such that the joining of the streams could be artificially engineered or anticipated by the participants before the problem was identified. The window of opportunity does not pre-exist to be joined by the solution to problem (Buse, 2012a).

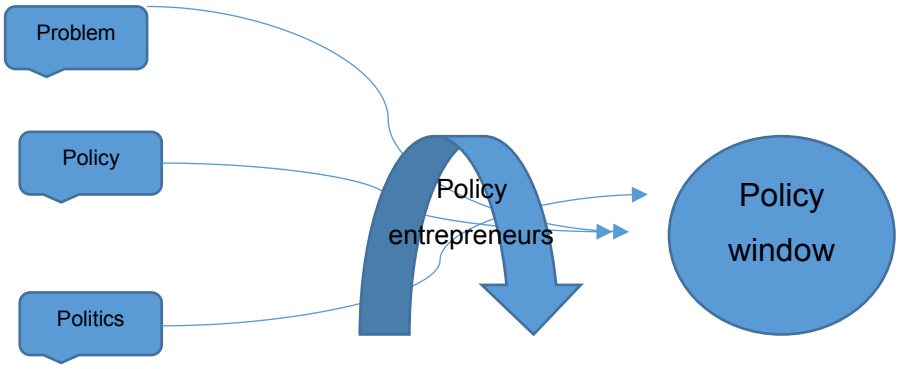

Figure 2.2. Illustrative diagram of Kingdon's stream model of agenda setting. Adapted from Kingdon (2002).

Kingdon categorizes the policy community affecting the three streams into visible and invisible clusters. Visible participants usually consist of the top executive position of the government, for example presidents, prime ministers and governors, who have power (hence being 'visible') to impose their will. The invisible cluster of participants are usually civil servants, researchers and academics , who as specialists in their sectors deal with the possible solutions in the policy stream (Buse, 2012a; Kingdon, 2002).

2.7.4. The use of Kingdon in Indonesian context from other study

Kingdon is inherent with American ethnocentrism: his theory derives only from the US, or at closest analogy the federalist government system. However, his principles are not 'dogmatic and he has posited them away from the traditional American positivist political arena, viewing matters as 'universal testable propositions'. Reasonably, his principles can be used as 'toolkit' to analyse agenda setting elsewhere (M. J. Hill, 2009).

Very limited research has been published in peer-reviewed journals that explain agenda setting in Indonesia, particularly in the health sector. Jeremy Shiffman (2003), for example, cited above, has elaborated Kingdon's approach

retrospectively, in explaining the Safe Motherhood policy in Indonesia, during Soeharto's authoritarian regime. Applying Kingdon to account for the development of this policy during the regime, Shiffman suggest that a policy entrepreneur, from the invisible cluster, in this case a civil servant successfully joined the three streams to offer a policy solution to become the Safe Motherhood policy. His study found that four factors highlighted the chance of putting an issue into the national agenda: indicators to ignite the attention that the problem exists; the policy entrepreneurs able to penetrate the single power circle at that time; supportive focusing events that stimulate wide-concern of an issue; the presence of suitable alternatives that appetizing to political actor such that they address the problem with the proposed policy. However, Shiffman was aware of the Soeharto regime's authoritarian political system, indicating caution when generalising the four factors.

It is expected that Kingdon's framework could provide the answer for this study research question. His theory may reasonably offer a means to understand how policy makers attention is rationed to address the issue of religious anti-vaccination. How for example, do they obtain policies or solutions? How they select them from others? And how do the influences of other streams create the bias and affecting the preparation of a decision. It may also further explain comparatively Kingdon's analysis from the previous Jeremy Shiffman (2003) study. Henceforth, it could serve as a framework to provide thick substantial answer to the line of inquiry, posed by the research question.

2.8. Concluding Remarks of the Literature Review

This chapter served a range of explanations which focusing on the Indonesian context, cover agenda setting in immunisation policy. Indonesian immunisation policy itself is not clear in how address religious anti-vaccination, while its main goals are to achieve the UCI target to meet the MDGs. In conclusion, very limited literature and data exists that explains religious anti-vaccination in Indonesia.

Kingdon's framework appears to serve in explaining agenda setting, in the way policy makers address the issue on religious anti-vaccination. It may also

explain some silences about anti-vaccination, the way of silence in policy process, how the problem understood, the available choices and the political obstacle for opening the policy window.

Chapter 3 Research Methodology

3.1. Research Approach

The overall decision for the selection of a research approach involves the nature of the issue being researched, the researcher's philosophical assumptions and their experiences, the target of the audience, and the design and method of the research (Creswell, 2014).

As illuminated in the previous literature review, the issue under study could be potentially complex and traversed with different disciplines. For example, the case, i.e. agenda setting in relation religious opposition to vaccination, could possibly deal with the national ideology or culture, Indonesian decentralization or democratization problems, or other unidentified accounts. Therefore, the qualitative research method is applicable to this study; it allows the research problem to be posed and answered when the subject of interest has never been explored before, and the important significant variables are unknown, and hence, the existing theory might not be applicable (Morse & Field, 1996). In other words, the method of choice is as a 'tool' but not one which is used according to a set of predetermined rules to obtain the aim of the study. While quantitative research is usually applied as an approach to test the hypothesis by examining the relationship among variables (Creswell, 2014), qualitative research starts with assumptions and theoretical constructs assigned to social inquiry or human experiences that inform the research problem under study. The data analysis of qualitative research includes both inductive and deductive strategies to establish patterns or themes. The presentation reports have a flexibility to cover the participant's understandings, the researcher's reflectivity, detailed problem interpretation, and its influence on the theory's development or modification (Creswell, 2007).

In terms of philosophical assumptions, to support answering the research question, focusing on the understanding of health policy makers (the 'what and how' question), this study adopts an iterative mixed epistemology between interpretivist and constructivist assumptions or, generally speaking, mixed

inductive-deductive. Being interpretivist, one interprets in a particular way to find meaning or to understand what the respondents are saying or doing (Schwandt, 2000). To serve the interpretivist notion, as mentioned in the literature review, this study starts with a theoretical underpinning which is Kingdon's agenda setting, to collect data that appears to either support, refute or refine the theory. Doing so, it is not to attest the theory towards a single truth, such as a hypothetical testing, to prove or disprove it by calculating the correlation among variables through its validity. Rather the theory is used to provide an overall framework for viewing reality at the particular time of the research. It seems once we acknowledge the tenets of different social meanings derived from literature reviews, we unconsciously move to look for the theoretical issues that could explain the phenomenon of interest. Consequently, answering the research question through the applied methodologies will inevitably be theoretically informed. In the case of qualitative research, the theory provides guide the interview questions which act as a floating buoy rather than a static anchor: flexibility is important to understand the meanings which may emerge from the respondents because providing a boundary of understanding to a particular theoretical account might lose the actual important message delivered by the participants. Using a theoretical guide rather than a fixed theoretical frame means that the theory is unable to be disproved. Rather, it means knowing whether it stands as being useful or less useful, to view and understand the reality or phenomenon. Hence, the theory is able to be developed and modified (D. Silverman, 2013). Being able to develop or modify the theory benefits by incorporating interdisciplinary lenses. Or, being interpretivist-constructionist, inductively building up the pattern of meanings grounded from the data, while acknowledging and comprehending the specific historical and cultural settings in developing the interpretations.

This iterative mixed epistemology approach is arguably the most suited to explain the problem and posit it within the political, social and cultural context under study, along with the interpretative nature and reflexivity of the researchers, in response to the emerging evidence.

The target audience for this particular study is the health policy and politics arena, particularly scholars enthusiastic about qualitative study (non-positivist epistemology) in an Asian context or at least developing country setting. Kingdon's agenda setting theory highlights that a window of opportunity for policy change open when the three independent streams of problem, policy, and politics are joined together by policy entrepreneurs capable of assessing their access, capacity, mode, and the size (Zahariadis, 1999).

This chapter consists of the research design, data sampling and collections, data analysis, and ethical considerations followed by research limitations and concluding remarks.

3.2. Research design

Following the qualitative inquiry and holding its particular epistemology, the importance of taking a particular study design over others is how to emphasize the outcome to be accomplished (Creswell, 2007). As already stated, this study intends to answer the research question and thus conceivably explain the posed research problem, which is the agenda setting of immunisation policy on haram vaccination in Indonesia. And taking a qualitative methodological approach does not either aim to generate a substantive grand theory or study of individuals. Hence, the case study is the design of choice to administer this research.

Moreover, the other reason in opting for the case study design comes from Yin (2003). Yin stresses the empirical enquiry of a case study is to investigate a current phenomenon in a real-life context, appreciating that the border between phenomenon and context is not clear. As explored in the literature review, the ambiguity among tenets prevails so that the boundaries between contexts are not clearly demarcated. In this case, the problem (the perceived haram vaccination) might involve and transcend many aspects of politics, ideology, religion, culture, and health policy.

It is essential to define the 'case study'. To do so, I adopt Punch (2014). Punch states that "*the basic idea is that one case (or small number of cases) will be*

studied in detail using whatever methods and data seem appropriate. While there will be specific purposes and research question, the general objective is to develop full understanding of this case as possible". A case study intends to understand the case holistically to explaining the case under study (the agenda setting for immunisation policy regarding Islamic anti-vaccination in Indonesia). Stake (1995) emphasizes that a case study is a 'bounded system' that restrains consideration to such aspects that are pertinent to the research following at the time, focusing the conformity and the comprehensiveness of the system.

Hence, back to this study. In answering and demarcating the case, the basic question then is: 'W*hat is the case"*? The suitable definition of the case under study is: "*the agenda setting for immunisation policy addresing religious refusal for vaccination in Indonesia*". This definition emphasises that the case is in the immunisation policy making itself. In this way, the predetermined unit analysis will ground enquiry about the agenda setting in immunisation policy. And to identify and describe clearly the boundary of the case I confine the case, according to a specific setting and time period. In accord with the central emphasis of immunisation policy, the specific setting of the case rests on the health policy makers in the immunisation arena; resting on the health policy makers means that the *locus of the study* is *inside* of the Indonesian health department responsible for the immunisation program which is held mainly under the P2PL (Disease Control and Environmental Health) directorate. The places or locations of study will be identified in the next section.

The specific time of the study is confined to the emergence of the Islamic religious anti-vaccination campaign. The precise time the religious anti-vaccination campaign emerge is difficult to determine due to the lack of valid scholarly information. Therefore, media reports have been referred (Hapsari, 2010; JakartaPost, 2010; Suwarni, 2010); hence drawing on media reports the timing period was bracketed from 2010 to 2013. This time frame and specified setting will support the strategy of data collection, particularly in how to derive the inclusion or exclusion criteria of the participants or object of the research. However, as a qualitative research approach, the specified time and setting

criteria will not be enforced rigidly: to do so risks sacrificing the possibility of obtaining valuable information.

As Stake (1995) describes a case study is distinguished into several types, such as intrinsic, instrumental and collective. This case study falls under the *instrumental* type. The instrumental type of case is one which is examined to provide insight into an issue, and although investigated in depth, the main focus is something else, for example, to refine a theory (D. Silverman, 2013). Hence, the case study serves as a device or instrument to emphasis another consideration, rather than merely examine the case. Here, the case study design will provide insight *into Kingdon's the theory of agenda setting.* Moreover, it may also update the theory or framework or develop a concept having a broader resonance as a result. A qualitative case study might provide a "*lesson learned",* a note on "analytical generalizability" as a counterpart to the "statistical generalizability" of a quantitative study (Yin, 2003). The 'lesson learned', 'working hypothesis' or other similar principle of analytical generalization from a case study is still applicable replicating a variety of real situations and not just the abstraction of theory building. The analytical generalization is built upon either supporting, refining, refusing the theoretical proposition referred in the case study design, or developing a new concept derived from the conclusion in the case study. The analytical generalization of a case study also supports its *external validity* (Yin, 2003).

It is well known that statistical generalizability attached to quantitative research is obtained from its calculated statistical sampling process. Subsequently, the generalizability is related to the representativeness of the sampling number able to make inference to the whole populace (Sturgis, 2008). Qualitative research is usually inconceivable to perform large representative samples and thereby impedes the intensive in-depth analysis attached to qualitative research (Mason, 2002). However, it is still possible to make inferences from relatively small samples if it is drawn randomly and has a known sampling distribution (Sturgis, 2008). For the purpose of this study, it is implausible to do a precise random sampling from the whole populace, which are all health officers in all provinces in Indonesia. What's more reliable and convincing data

confirming the sites or localities facing the Islamic religious anti-vaccination issue is very limited, and has already stated is mostly grounded from media reports. And also considering the accessibility issue in each regional health offices because religiously motivated vaccination may be a sensitive problem, the random sampling is difficult to employ and thus may miss the opportunity and ability to obtain valuable information. Consequently, the sample representativeness of this study is *not* best fitted as representative of the population, but representative of the phenomenon under study.

3.3. Data sampling and data collection

With the above reasoning, I employ a *purposive network sampling* or synonymy as *theoretical sampling (D. Silverman, 2013)*. The sampling is applied purposively based on relevance with the theoretical proposition being used to explain or developing an answer the research question (Mason, 2002). A theoretical sample means that the 'sample-able' units are purposively defined by the available network based on the theoretical account relevant to explain the research question. Hence, in essence, the sampling does not apply random style sampling as its quantitative counterparts. D. Silverman (2013) clarifies theoretical sampling as the choice related to three points, the settings, the research focus and additional generalization.

The first sampling point related to the setting issues (the administrative location of the study; I explained previously that this case study is bound to the health department where the immunisation program situated, and that the settings are not representative of the population demographically as in quantitative research, but *of the phenomenon* of interest (Hammersley, 1989) which in this case study is the areas are in which the immunisation department is facing the haram vaccination issues. I will explain about the sampling area/location shortly. In the outset of this study, I also had elucidated about health decentralization. The decentralization of the health department has made deciding the precise level of government for sampling (e.g. central, provincial or district health department) ambiguous.

With such ambiguity due to the decentralization of the health department, I

take all three levels together, from central to district. The reason for this decision is because taking only a single government level would make the analysis incomprehensive, in respect of answering the research question. By default, decentralization brought autonomy to the district level for the immunisation program. In this situation, the health district, one end of the decentralised continuum, might plausibly develop their own immunisation regulation apart from the central office at the other end of the continuum which may have no discretion to develop such regulations. However, the generic structure of the health department appears to remain centrally controlled, indicating that central health office could exercise power over national immunisation policy, while at the same time the decentralization prevails. The more disguised level, in assessing the health department's respective powers would be the middle level, of the provincial government, for example. Positioned both as representative of the central government authority over the districts, and provider of consulting services for the district regions, it is difficult to withdraw its authority precisely over the district health offices

The second point related to the research focus could help to determine the population sampling. As discussed, this research focuses primarily on immunisation policy as a way of addressing the issue of agenda setting. Consequently, the sampling is targeted to the level or position of those who have the experience to make immunisation policy. Those that have the experience to make policy may be incumbent persons or those who have experiences previously sat in that position, or have retired, or persons potentially and highly recommended by insider (networking) groups in the health department office due to their competency, accountability and capacity. Regardless, all should be acquainted with the Islamic religious anti-vaccination movement. The structure in the health department the level or position correspond with the immunisation would be within mainly the directorate of P2PL (diseases control and environmental health) either in district, province or central health offices. However, targeting the P2PL is not done so according to strict criteria, sacrifice the potential for relevant information to be collected.

The third sampling point deals with additional generalizations. While a single

sampling site could be efficient to provide ample information to develop a generalization about the study issue, it is be necessary to have '*structural bent*' to broaden the sampling (D. Silverman, 2013). I prefer a 'cross sectional' approach, encompassing several places rather than studying in single site, with two plausible expectations: firstly, to obtain more samples from near or adjacent sites and secondly, to analyse samples in a range of the chosen area. Importantly, all samples are not random but purposively driven.

With very limited information, as mentioned above, the decision of taking sampling locations from particular regional districts was mostly guided from media reports (Faisal, 2011), grey literature of a previous small study (Wulandari, 2010) presented in the literature review, and clarified with personal information (medical alumni of Gadjah Mada University networking communications). From this simple triangulation of resources, it is clear that the East, Central Java and Jogjakarta special provinces appear to be facing Islamic religious anti-vaccination. Although, it appears that these three provinces are facing religious anti-vaccination, is not simply exclude other provinces around Indonesia that could be facing a similar situation which has not be publicized.

As a student researcher with limited time, funding and resources to explore many districts, I decided to select the regional sampling from *Central Java province* and its neighbourhood provinces, *Jogjakarta Special Provinces.* And obviously I included *the central health department* based in Jakarta, the capital city of Indonesia.

Despite facing the anti-vaccination issue, the profile of immunisation coverage was different between the two provinces. The data displayed below includes two national surveys about complete and incomplete immunisations done in 2010 and 2013 in Central Java and Jogjakarta. The data presented in chart below was obtained from the basic health survey held by the central health office (Riskesdas) as part of the three-year health surveys (Depkes, 2011). The reason for using Riskesdas' data among other data is that it serves as a more valid and 'trustworthy' method than other local district or provincial data

because it's performed independently by the national health department through the research and development division of the central health office ("*Balitbangkes*").

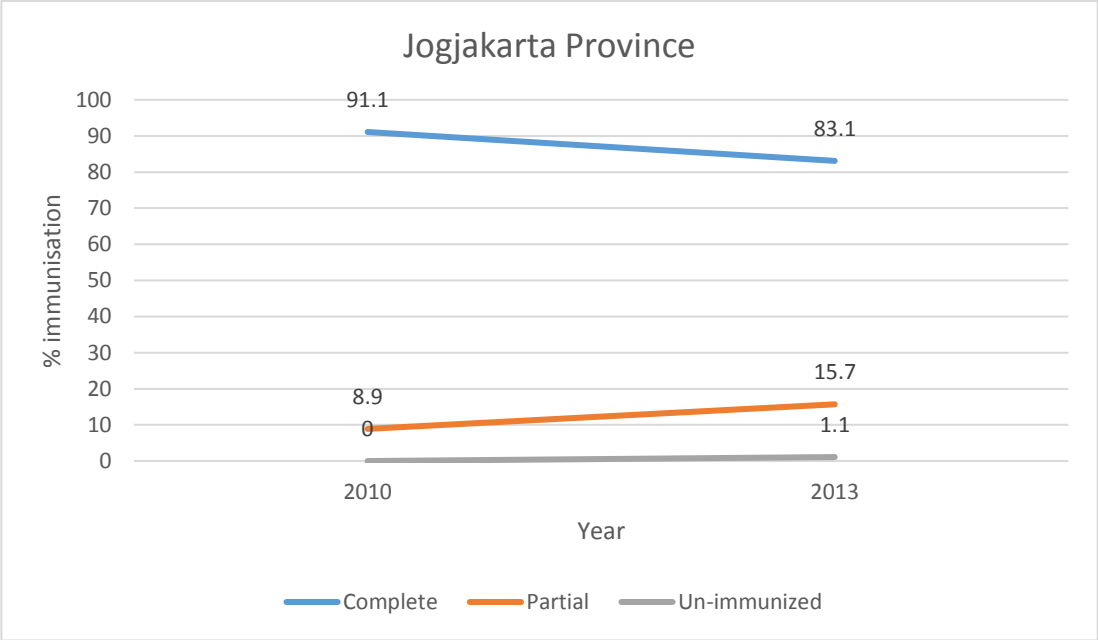

Chart 3.1. Profile of Jogjakarta province's immunisation status during 2010 and 2013. The trend was one of slight decline in complete vaccination status but it still had high coverage at over 80% and a slightly increasing trend of partial and un-immunized babies (Depkes, 2011; MoH, 2013): p 116 and 233, respectively.

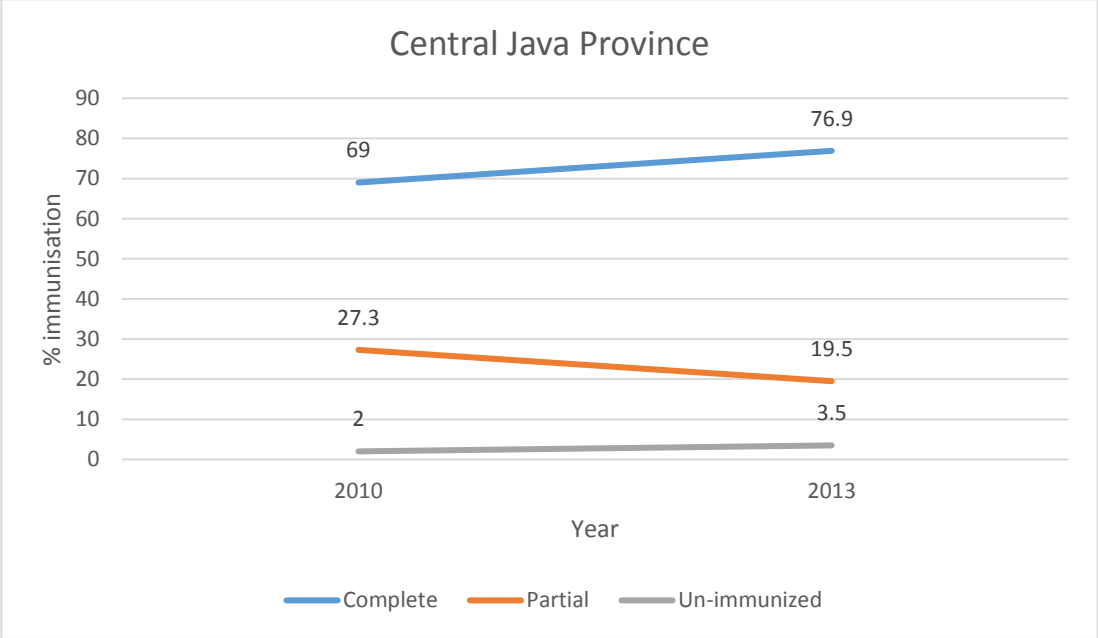

Chart 3.2. Profile of Central Java Province's immunisation status in 2010 and 2013. Complete immunisation increased as did as the un-immunized group, but the partially immunized group dropped. hence the rise in complete immunisation may partially explain the drop in those partially immunized undermined the un-immunized group (Depkes, 2011; MoH, 2013): p 116 and 233, respectively

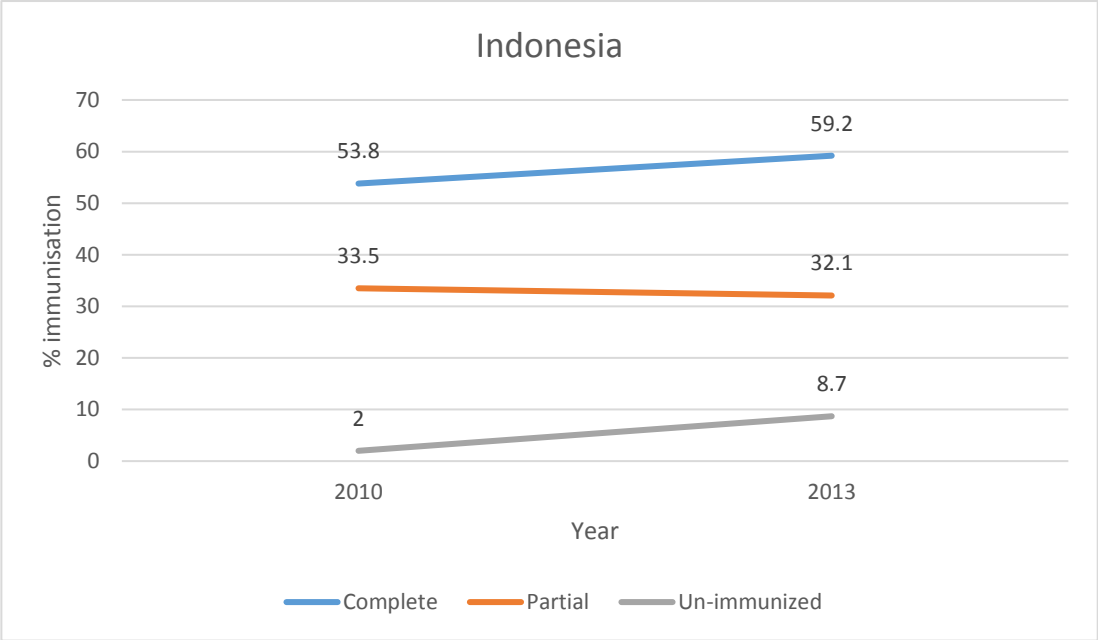

Chart 3.3. General profile of immunisation nationally in Indonesia in 2010 and 2013. Complete immunisation was trending to increase close to 60% but as did the un-immunized group of babies arising to 8.7%. The increase of complete immunisation could be supported in part from the drop of the partially immunized group (Depkes, 2011; MoH, 2013): p 116 and 233 respectively).

In Jogjakarta Province, there appears a tendency towards declining immunisation coverage, despite the percentage of those covered being still top among those provinces with high coverage. In contrast, neighbouring Central Java Province experienced an increase of immunisation coverage in the same time period. In overall, those data may not represent exactly that the un-immunized groups belong to the religious refusal for vaccination, and, with regard to those data, the statistical indicator for un-immunized group remains to be trivial.

The health district offices within these two provinces is purposively selected

for those facing most the problems in their working area. Given minimum information from the scholarly literature, media and public government data about the location of issue, *the alumni networking* was used to determine the district for sampling in each province. The term alumni networking, in this study, refers to the alumni of medical doctor who graduated from the same local university (Gadjah Mada) as researchers, they have spread and been working as health officers around the selected provinces. Although it would not be scientifically justifiable in collecting samples, with a limited time and funding resources as student researcher, this strategy offered a hint to select the most appropriate sample in data collection and subsequently also support to access, approval and develop rapport with the health offices.

In this way, narrowing down within Central Java Province, three districts prominently facing the religious anti-vaccination over consecutive years (see below) were selected for sample: Karanganyar (KRH), Sukoharjo (SKH), and Boyolali (BYH). In Jogjakarta Special province's counterparts, Sleman (SL) and Bantul (BTL) districts were also identified as currently experiencing the issue and were also selected. In addition to the selection criteria being based upon ongoing experience with the issue of religious anti-vaccination, the location of the district adjacent and accessible by land-transportation was also used.

However, not all of the districts or provinces under study provided data or records of religious anti-vaccination issues or a geographic map of un-immunized regions. Only two districts in Central Java Province, SKH and KRH, provided archival records of vaccination refusals. In addition, much of the data obtained was only from the short previous 2-3 years. Therefore, it was only possible to get a short or cross sectional time-frame rather than a longer time-frame of religious refusal fluctuations. Looking from the few year span that showed an increasing trend of the number of religious vaccine refusals, it was plausible that the number beyond the recorded would be higher than expected.

This study was not aimed to measure the number beyond the available data but to analyse how the drawbacks of the data limitation are articulated and

responded in the agenda setting discourse, reflected in the interview as qualitative findings.

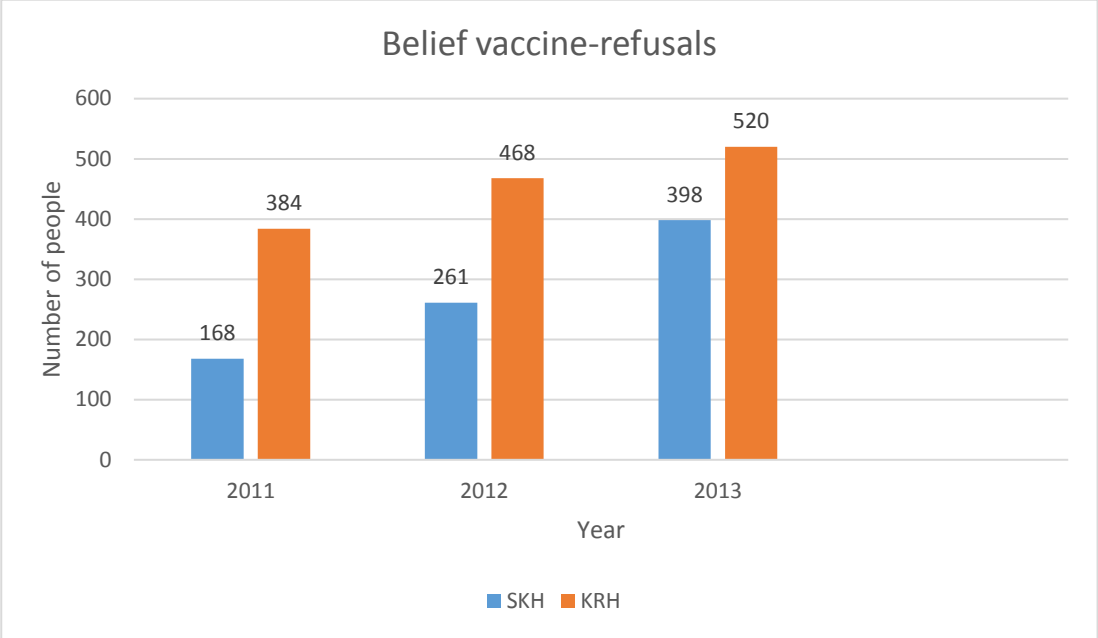

Chart 3.4. Example of vaccine religious refusal in two districts (SKH and KRH) of Central Java province. Both have a similar escalating trend annually, with KRH having a higher profile than SKH. The original data usually categorizes Islamic religious refusal as 'belief' refusals to avoid a judgement position of particular religion position towards vaccination. The data was available for the total amount of refusals (data obtained from SKH and KRH district health office).

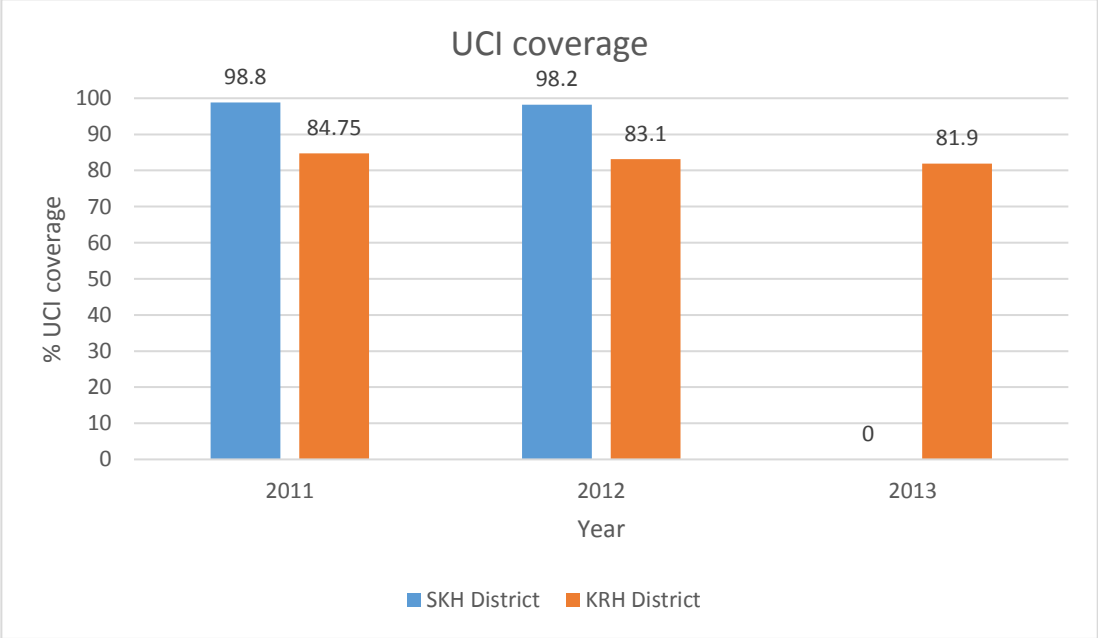

Chart 3.5. A comparison between two districts facing religious anti-

vaccination (SKH and KRH) in Central Java province about UCI's achievement in the same three years as the previous chart (3.4). There was a slightly decreasing trend in UCI coverage in both districts but was still high at above 80%. The SKH district did not provide data for 2013. In general, looking at the UCI data, it does not strike any particular strong correspondence with the religious refusals of vaccination data in chart 3.4. (Data obtained locally from SKH and KRH district health office)

The maps below (figure 3.1, 3.2, 3.3) describe the localities of the sites in Central Java and Jogjakarta provinces in this study where the issue of Islamic anti-vaccination surfaced.

Figure 3.1. Map of Java island. The red arrows indicate that The study was performed in Central Java, Special Province of Yogyakarta, and the capital Jakarta.

Figure 3.2. Map of Central Java Province showing the three districts studied Karanganyar, Sukoharjo, and Boyolali. As indicated by the red arrows, Karanganyar and Sukoharjo are nearby each other.

Figure 3.3. Map of Special Province of Jogjakarta, showing the districts of Bantul and Sleman, addressed this study (pointed in red arrows).

The overall fieldwork was undertaken from January to March 2014. The alumni networking really supported opening access to the health department offices, obtaining a rapport with the health department officers to gain approval for performing the research. As it is the head of national health department in Indonesia the last sequence of data collection ended in Jakarta.

3.3.1. Data collection

As previously ascribed, population number is an approximation from the unit of health policy makers for immunisation. Guided by the structure of the national health department and the P2PL (Diseases Control and Environmental Health) sub-department where the immunisation program exist according to their websites (http://www.depkes.go.id/article/view/13010100002/kemkes-struktur-organisasi-2014.html and http://pppl.depkes.go.id/berita?id=1275), the

approximate total population for the two provinces (five district in total) is around 20 people. Within the government structure, all the policy makers in this study were long term career civil servant in different levels or positions of government bureaucracy. Despite that no minimum number required for qualitative research, data saturation was expected from sampling half of the population of around 10-15 participants, or whenever data reached saturation; that is when no novel information can be obtained by the researcher.

The data collection was performed in a mainly 'bottom up' fashion, starting from the district level and ending in the central health office. This direction of sampling was taken due to the decentralization policy with the assumption that the district level would have more authority for implementing the immunisation program as they were closer to the community who may refuse immunisation. It was expected that the district would have more understanding towards the religious based vaccine refusal and how to develop policy to address it. However, some preliminary consideration was also taken in which the partial dominancy of the central office could prevail at some point during data collection and the direction from district to central office was not a strict rule.

Most of the district health offices have very tight bureaucratic procedures in respect of granting permission to do research about the highly sensitivity of the religious based anti-vaccination, which points to them, making flexibility in the work field difficult. Rather than create tension in implementing the strict protocol of this study sacrifice the rapport with them, this difficulty was worked out *by identifying and assessing the appropriate potential respondents who had experience with the issue of religious based anti-vaccination, and who had a policy making role either they are incumbent, retired or moved to other department*. Information was gathered verbally, to start developing a rapport with the administrators of the district health offices. As part of these discussions, administrators were also asked who they knew in a potential position to participate in this study to gather the required participants. During the waiting the time for the research permits from the regional governments, the verbal information collected was triangulated and re-confirmed with local medical colleagues through alumni networking either from inside or from local

university academics). The final clues of who to speak to usually pointed to *the head of the health district office* (“Kadinkes”) and/or the head of disease control (“Kabid P2PL”), and the head of immunisation program (“Kasubdit imunisasi”). The same strategy applied also to the central health office in Jakarta, pointing to the director general and the head of immunisation program (“Kasubdit imunisasi”). As mentioned above, some targeted respondents had moved to other government departments or had retired from their position.

The role of the ‘Kadinkes’ at the district level is parallel to the extension of the ‘executive arms’ in regional offices, as they are part of the SKPD (*Satuan Kerja Perangkat Daerah*/ Work Unit Area) which perform the executive function under a mayor of districts or governor of provinces. At a district level, their role is pertinent in managing the policy. However, as described in the literature review, the district health officers (Kadinkes) are not in a fully independent position, despite the decentralization and regional autonomy policy, due to maintaining the form of a unitary state in Indonesia.

The directorate general position in the central health office is the top bureaucrat just under the minister of health. Drawing on Kingdon’s categorization of policy community, in this study, the respondents includes the invisible cluster or the health bureaucrats.

A total of 12 key respondents were willing to participate and be interviewed ranging from the district level to the central health office, including a variety of key positions related to the immunisation policy. These key positions included the head of the head of health district offices (the *Kadinkes*), the head of diseases control (*Kasi P2PL*), the head of immunisation program (‘*Kasubdit imunisasi’*) and the director general of mother child health and nutrition (Dirjen KIA). To serve for the need for anonymity, the name of the position as well as the name of respondents in this study is anonymous by coding them according to their government position level and the initial of their location. Two respondents from Central Java Province office and one respondent from the central health office did not respond to participate in this study, despite a vigorous effort to encourage them The table below (table 3.1) summarizes the

study participants from the five districts health offices, to the central health office.

Table 3.1. Summary of the key respondent from 5 district of two provinces and the central health office

The terms ‘top’, and ‘middle' level in either district, or provincial health office refers to the position of “Kadinkes” (Head of Health District Office), and “Kabid P2PL or Kasubdit Imunisasi” (Head of Diseases Control or Head of Immunisation) respectively. The term of ‘top' level, and ‘middle' level’ in the Central health office refer to the position of Direktur Jenderal (Directorate General), and Kasubdit Imunisasi (Deputi of Immunisation) respectively. With the nature of Indonesian bureaucracy system usually rotational position is prominently frequent, the years that the officers have been in these position is not a strict criteria for inclusion research participant. Purposive network sampling with carefully triangulated judgement of information from the insiders recommended by respondents, and confirmed by alumni networking was employed as a useful tool for selecting the potential respondent who had experience, knowledge and insight in their professional job role in the immunisation.

Government Level	**Position**	**Location interview**	**Interview duration**	**Time Interview**	**Code**
District	Top level in health district office	SL District Health Office	± 1 hr	Feb’14	DHOJG-SL1
District	Top level in health district office	Bappeda Head office	± 1 hr	Feb’14	DHOJG-SL2
District	Middle-level in health district office	BTL Health office	± 1 hr	Feb’14	DHOJG-BTL1
District:	Middle-level in health district office	Café at Jogja City	± 2 hr	Feb’14	DHOJG-BTL2
District:	Top-level in district health office	KRH District Health Office	± 2 hrs	Feb’14	DHO-KRH
District:	Middle-level in district health office	SKH District Health Office	±1 hrs	Feb’14	DHO-SKH
District:	Retired-Top Level in district health office	Private Clinic, Boyolali	± 2 hrs	March’14	DHO-BYH
Province	Middle-level in health province office	Province Health Office	± 1 hr	Feb’14	PHO-JG1
Province	Middle-level in health province office	Province Health Office	± 1 hr	Feb’14	PHO-JG2
Central Health Office	Retired-middle level in central health office	Jakarta Central Health Office	± 3 hrs	March’14	CHO-ENIH
Central Health Office, Jakarta	Middle-level in central health office	A Private Hospital, in Jakarta	± 3 hrs	March’14	CHO-DI
Central Health Office, Jakarta	Top-level in central health office	A University Building in Semarang city	± 1 hrs	March’14	CHO-DG

The benefit from taking this group of career health bureaucrats rather than political appointees was that they had experienced in facing a variety types of

political appointees. And that they usually know more of the context, content and process of a policy rather than the "*come and go*" of the top political appointees because they had long term career jobs as professionals medical doctors inside the health department (Kingdon, 2002). In the Indonesian context, despite power of health policy decision rests with the minister, policy formulation is generally delegated to the bureaucrats underneath (e.g. director generals and its proponents) who are the '*key decision shapers*' of a policy at a ministerial level. These bureaucrats are usually the most senior in Indonesian civil service. Thus, by default, they are the people who were more "*likely to draw on knowledge in advising the ministers to shape ministerial priorities"* (Datta, Jones, Harris, Wild, & Young, 2011). However, the disadvantages of taking this type of cluster of the policy community is that they may be likely to answer narrowly or very normatively (i.e. formally such that the actual message is implicit) to save their career position. Hence, 'smart' interviewing was an important way of not asking direct questions which may signal an implicit threat. Indirect conversation and turning the conversation to other topics before going back to the main conversation was a useful way to obtain information.

In a simplified public policy process, there are four heuristic stages which have been sequenced above,: agenda setting, formulation, implementation and evaluation (Sabatier, 1991; J Shiffman, 2010). As already mentioned, this study, the focus is on the first stage of the policy process, agenda setting. Agenda setting is the first stage during which the issue of religious opposition to vaccination comes into the attention of policy makers.

As explained in the literature review, the core of scholars on agenda setting, in particular Kingdon's multiple stream theory, investigate how such an issue could emerge or submerge in the policy agenda of the government officials (Kingdon, 2002). The other consideration to use Kingdon's multiple stream theory, as already mentioned, is that it does not strictly follow a sequential stream of policy making. Rather, it follows an independent account in which the streams may join when the window of opportunity for policy change is open (J Shiffman, 2010). Hence the focus of collecting the data in this study is how the issue emerges as a government agenda and how the attention of

policy makers is obtained with less on the formulation, implementation and evaluation of policy -although, the latter will act as either part of the agenda setting process or evidence of policy choices. Drawing on his multiple stream theory, Kingdon's theoretical proposition provides a "blueprint" for this case study, and a guide for the data collection and a strategy for data analysis. Hence, Kingdon's theory delivers *external* validity of a case study research (Denzin & Lincoln, 2005; Yin, 2003).

In order to obtain the evidence for the case study, some multiple 'hybrid' data collection is employed, consisting mainly of interviews, documentation, archival records and 'casual' observation. The interviews are an important part of the study because as Yin (2003) notes, they supply one of the important points of evidence in a case study design. The interviews were discretely design with the question structured from Kingdon's framework. Using Kingdon's framework to design and structure the interview acted a 'protocol' to follow the line of inquiry. However, the interviews were not performed in a formal rigid structure of queries, which would risk missing important message and information from the participants, and sacrificing bonding between participant and the researcher. Rather, the interview followed a 'guided conversation' in an unbiased manner, allowing the participants to make a native response from the question thereby following their actual information.

When a normative answer, as defined above, prevailed, probe questions were applied to obtain factual rather than normative information.

The question guiding the interviews are listed in the table below (table 3.2).

Table 3.2. Interview question guided (rather than dictated by) Kingdon's multiple stream theory. Each question derives from policy and politics streams.

Problem Stream
2. In your opinion, does the religious Islamic anti-vaccination movement constitute or identy as a problem? How do you define it as or not a problem and what are the indicators? (data/figures/time of crises/focusing events/feedback)? How do you interpret the indicators?
3. Have there been much change, during the last year in respect of the problem? IIf yes, how/why?

4. Why do you think the problem is or not the receiving attention? How did it come to be, or not, the hot issue? Why/how did the problem fade? 5. What sort of data/research needs to support defining the problem? 6. How does the burden size of the issue compare to other problems? 7. How should the issue's severity be measured and its progress monitored? 8. To what extent do you agree on the definition of the cause and solution of the problem? Can you explain each of them?
Policy/Solution/Alternatives 9. In your opinion, what are the proposal solution/initiatives for this issue? 10. What about the program, what's on the front line for addressing the issue? Have you listed them? Has there any much changes? If yes, why? 11. Why do you think those particular initiatives are being seriously considered? How did they come to being the hot proposal? 12. What sort of data needs research to support a solution? 13. To what extent are the proposed solutions/initiatives cost effective, backed by scientific evidence, simple to implement? Could you explain more about each of them? 14. Do you think that the initiatives will last say for two to five years? 15. What are the anticipated future constraints?
Politics stream 16. How do you characterize the *political climate/national mood* in favour/against the issue? 17. Do you consider the way the *turnover of key persons* may affect/change the priorities and push new agenda? 18. What about the *jurisdictions boundaries*? What is the turf battle affecting the agenda? 19. Do you think that there are persons/groups are able to unite the policy community and be strong champion for this issue? 20. What about the institution/organisations/stakeholder/interest groups: Do you think that any of them effectively take the initiative? 21. Can you explain the extent to which norms and institutions operate to provide a platform for effective collective action? 22. Do you think that there are some conditions or events that align favourably for this issue, presenting opportunities for advocates to influence decision makers?

During the interview, some threads in the participants responses which were created by the influence of researcher's perspective (reflexivity) (Yin, 2003). To minimize this, I applied a 'bracketing' approach as in phenomenology: that is deliberately putting aside one's own perception about the case study under research, or an account already known beforehand (Chan, Fung, & Chien, 2013). Bracketing is also a strategy I used to construct the validity of the data collection and analysis (Ahern, 1999). However, a bracketing strategy is difficult to implement due to unconsciousness course of reflexivity. As a means to minimize unconsciousness reflectivity, I decided to confine the literature

review before data collection, particularly on agenda setting theory. I contained the knowledge I obtained from literature because it may unconsciously influence the preconception of study topic and carry over to interviews, tailoring and affecting the participant's response, and decreasing curiosity during the data collection process. By limiting thorough knowledge of the literature before data collection, it was expected that I may obtain some important new natural cues to follow (Chan et al., 2013). Hence, before data collection I limited my knowledge of agenda setting to Kingdon's multiple stream framework.

Documentation is in the form of government letters, or other relevant administrative documents that relates to Islamic religious anti-vaccination. The important point about selecting documentation is to corroborate information from other sources, especially the interview, and to make inference from the document as a clues for further investigation. Assessments were carried out identifying the target audience of the documents and in what circumstance the document were made for a particular purpose (Yin, 2003).

Archival records, in this case study, include statistical data on immunisation, particularly on refusal data, immunisation coverage, maps or sites of the district or other relevant records. However, as with assessing the documentation I was aware of the accuracy and purposes of particular records.

According to Yin (2003) direct observation may support obtaining evidence in case study design when the phenomenon under study does not attach to only retrospective cases. In this case study, I did casual observation during fieldwork; that is, I did less formal observation such as sidewalk conversations with office staff, observing scenes in the work space to collect behaviour which may indicate something about the culture of the health department, for example the policy makers having an implicit sense of privilege when surrounded by their co-workers in their department.

Triangulation

With some arrays of evidence, it was important to do triangulation. Triangulation refers to crossing among different reference points to precisely

analyse "*the development of converging lines of inquiry*" (Yin, 2003). Using triangulation allows different sources of information to be developed into a convincing and accurate conclusion.

There are four ways of doing triangulation, namely data, investigator, theory, and methodological triangulation (Yin, 2003). In this study, the triangulations carried out were data and theory. The triangulation of data refers to the different sources of evidence (e.g. interview, government documents, archival records, casual observation) which are not analysed separately to produce a comparison of conclusion. Rather they are analysed convergently so that they follow the same line of inquiry to the conclusion. Theory triangulation provides analysis of the same data set evaluated from different theoretical perspectives (Yin, 2003). In this case study, the theoretical triangulation was corroborated to gain perspective on the findings of the inductive themes in chapter 4, and part of the theoretical analysis in chapter 5, in which Kingdon's framework is evaluated.

The transcripts were written from the tape recordings and translated to English by the researcher. With one of the co-supervisors originating from a local university in Indonesia allowed the meanings and codings from the translated transcript were checked for balance and validity Moreover, the key participants also offered to review the transcript to avoid misinterpretation of the analysis in the interview data. Triangulation gave the construct the validity of a case study (Yin, 2003).

3.4. Data Analysis

Case study analysis is challenging because there have no definite procedures, despite its effort to 'play' with the data to find the patterns, concepts, insights 'for what to analyse and why' (Yin, 2003). In this case study, my main consideration in data analysis is that the approach of analysis should be able to answer the research question. The 'what and how' of the question posed in the research was guided but not confined, by the theoretical *a priori* of Kingdon's agenda setting framework in the interview structure. However, the naturally occurring data may not conform to the predetermined theoretical

assumption. Applying the structured interview questions as the codes to filter the data might lose the nuance and message delivered by the participants which actually answer the research questions. Therefore, two approaches are used: the inductive-deductive data analysis, otherwise known as the data and theoretical driven approaches.

This general analytical approach was chosen as it may offer an 'in-between' strategy, between the initial theoretical proposition and the 'ground up' approach. The technique mimics 'explanation building' (Yin, 2003), in which the observed themes, codes, that develop naturally are compared for the extent to which they match the *a priori* theory being used, in this case Kingdon's multiple stream theory. Explanation building also allows a way to analyse how inductive findings may explain the differences. In addition, it may offer a way to build them up to revise the Kingdon's *a priori* theory or change it with other frameworks to explain the case as a whole. This approach will also corroborate the instrumental case study type: the case as an instrument to explain or revisit the theoretical orientation being used. Hence, the aim of the line of inquiry is to analyse the case as a whole. Each district/location site or government level (district to central health office) is not treated as separate single and cumulative multiple case studies. Rather, the collected evidence from each site/location/government level is used to build the explanation and substantiate it into a whole explanation of the case.

In practical terms, the sequential analysis steps were initially started with the inductive approach (data-driven) and followed by the deductive approach (theory-driven). The former was not aimed at developing a conclusive-end separate from the analysis but to generate categories of themes grounded from the data. The subsequent analysis was then done in non-linear fashion mostly in an 'iterative mode' repeatedly comparing the themes with Kingdon's theoretical proposition to analyse how the findings may be built in either accordance with, or revise the theory being used. Hence, it was understood that this gradual analysis might not produce a decisive orientation at the beginning.

This method of analysis is equivalent to Fereday and Muir-Cochrane (2008) qualitative thematic analysis combining the inductive-deductive approach. The difference to their approach is that in this study starts initially with inductive themes which are then screened by the deductive angle (figure 3.4). This sequence is organized in a way that minimizes the likelihood of pre-sorted themes to be *pushy categorized* in the deductive coding (Morse, 2003). Their message may be lost, although they might carry important clues to revisiting or re-examining to what extent, Kingdon's theory actually explains the data findings.

The findings chapter will explain the inductive themes in narrative form. Subsequently, the themes are referred and compared to the theoretical propositions, allocating the differences that could build or revise the theoretical framework and be developed into the whole explanation.

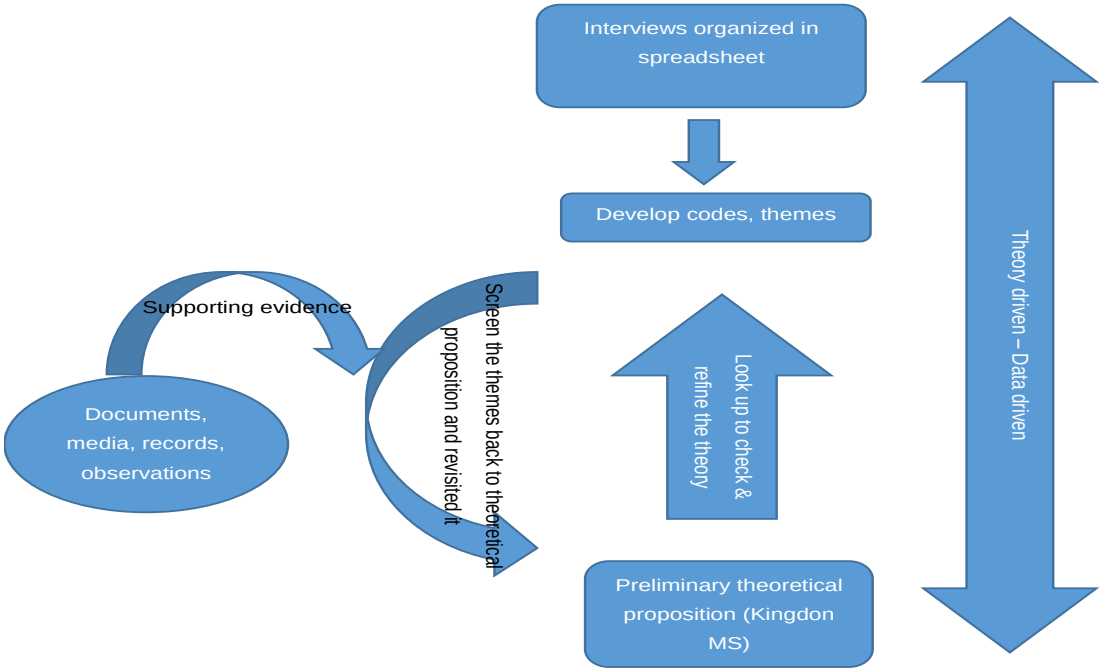

Figure 3.4. Diagrammatic scheme of the analysis process, involving the inductive-deductive approach. The data corpus of interview script triangulated with other evidence were inductively defined into themes (data driven). The themes were subsequently screened and categorized

with Kingdon's agenda setting theory, allowing the possibility to build up or revised the theoretical proposition.

The interviews were recorded and transcribed into word files and develop the codes and theme. Moreover, to build a converge line of inquiry rather than a separate fragmented conclusion, the non-interview evidence (e.g. casual observation, media reports, government documents, and archival records) was collected and *weaved* into the main interview evidence to support building the explanation rather than separately analysed.

In the inductive approach, the codes were derived and guided by the research questions rather than Kingdon's theory. The codes were guided by the research questions because as accentuated in previous page, the predetermined codes might influence and pre-sort the data producing an overly narrow analysis (Morse, 2003). Alternatively, they might push the data categorization excessively and lose the key message from the evidence which may be valuable for answering the research question as well as revising the theoretical orientation. In this way, the scheduled interview questions are not the code for categorizations because, as mentioned above, the nature of the interview is open ended and conversational, following the responses of the participants. And the natural occurring responses may not simply conform and follow the structured questions. The interview was performed in a flexible manner, collecting the evidence in a way to potentiality answer the research questions. The inductive process was employed with open coding, crafting the categories through abstraction. The unit analysis in this open coding is directed by consideration of how to answer the research question. And it can be either words, sentences, or paragraphs sufficient to be a context for meaning, both manifest and latent (Elo & Kyngäs, 2008). Hence, the precise codes and themes were defined posteriori, in accordance with the responses of the respondent. Thee codes and themes were defined posteriori because it may be that the inductive form of analysis come from the natural data with minimum pre-filling of theoretical presumption.

The categories were developed and grouped into higher order headings with abstraction as far as reasonable and possible. Each category is labelled with the name reflecting the characteristic of the themes. This process was not static but involved continuing reflective revision and refinement by the researcher to interpret and understand the phenomenon (Thomas, 2006).

In the deductive process, the defining category was structured with a template based upon Kingdon's theory. The themes generated inductively were allocated accordingly to the theory-driven category. As mentioned above, Kingdon's theoretical concept can be formatted into several broad categories: the problem, policy, politics streams, and the entrepreneurs and policy windows. Each element of these category is elaborated via the iterative interpretative phase, such that the clustered themes are connected into an explainable frameworks consistent with the context in and among each category (Fereday & Muir-Cochrane, 2008). In this case study, overlapping clusters among categories is unavoidable because strict demarcation is difficult without eliminating the interconnection among categories.

To facilitate and guide the allocation of categories from the inductive themes (data-driven) to theory driven themes is based upon the direction of Kingdon's theory corroborating the answer to the research question as follows:

Category	Deductive process (theory-driven) allocation of themes
Problem stream	The inductive themes indicate and provide the explanation of the way religious anti-vaccination is defined and reflected to be a situation that needs to be overcome and addressed by government
Policy stream - Primeval Soup	The inductive themes provide explanation about the available policies, ideas and alternatives around immunisation policy and the workings of the typical natural environment policy community system.
Politics stream	The inductive themes denote the circumstance associated with the 'what and how' the conflict among parties to achieve power in pursuing the problem/policy of interests.
Policy window	The inductive themes indicate the opportunity to put the problem into the government agenda, and of joining with the favourable policy and politics streams, allowing the chance to change the policy.
Entrepreneurs	The inductive themes designate the subjects who have

	significant capacity to bring the policy proposals into the policy community to match the streams together and take greater risks to change the policy.

Table 3.3. General guidance in the process of categorization from the inductive themes into Kingdon's theory-driven deductive analysis.

The above categorization (table 3.3) process is iterative, flexible, reflective, multi-disciplinary, dynamic, and mutually contingent to respond to the evidence or findings, rather than a fixed procedure, carrying the risk of missing important relevant accounts. The subsequent process of deductive discussion involved interpretation deliberately to "*go beyond the primary study or transform the data*" (Barnett-Page & Thomas, 2009). This deductive process might appear to be similar with critical interpretive synthesis (Dixon-Woods et al., 2006). However, I would rather term it a critical interpretive approach. The reason for espousing this approach is because, firstly, it seeks to push beyond the original data to a fresh interpretation and orientation of the phenomena under study, problematizing the framework (Barnett-Page & Thomas, 2009). And secondly, it allows the '*authorial voice*' to be accommodated given that the author is required to be critical and reflective of the production of a theoretically sound account grounded in the evidence. With a critical interpretive approach, the aim of this study is '*to be critical'* (Dixon-Woods et al., 2006) problematizing the framework over the existing evidence.

3.4.1. The limitations of data analysis

The limitation of this approach which plausibly applies for all other studies, is that the natural process of a doctoral study, the coding and theme categorization are developed by one person and the subsequent analysis discussed with supervisors. This approach, despite sufficient enough to be consistent, might be insufficient in time and resources to accommodate a different perspective from variety of research expertise (Fereday & Muir-Cochrane, 2008). Thus, the interpretations will not value-free as in quantitative research as the construction will be influenced by the value of the researcher. A more detail description of limitations is available in section 3.7.

3.5. Ethical consideration

There were many general principles of the ethical boundaries for research across disciplines. The most eminent feature was non-compulsory participation, giving the participant the right to withdraw, examining the potential risk and benefit for the participant, informed consent approval, and avoiding harm (D. Silverman, 2013).

Importantly, as most of the respondent have substantial positions on government departments, confidentially of the information and anonymity of the respondent become essential. To meet with these criteria, the recorded interviews were transcribed into password protected files without the name of the respondent which was replaced with a code and stored in the Flinders University server. Only the researcher and supervisors know about the code. However, there was no absolute guarantee respondent's anonymity due to their specific job position in a governmental office or the interview's location. However, the comment would not be directly linked to the particular respondent. Hence, that anonymity could not be guaranteed was explained in the information sheet and informed consent form.

Moreover, the information sheet also explained to the respondent the risk and benefit of involvement in this research. The benefit for the respondent included sharing of knowledge, reflection, experience and difficulties about immunisation policy and religious anti-vaccination. The risk or discomfort for the respondent involved the possibility of feeling insecure when giving 'the real' answer even it was very unlikely endangering their reputation and position. I negotiated the risk in a way that would make the respondent feel confident and overtly answer the interview questions, for example, by asking the convenient time and location for the interview and following their non-verbal signs.

The ethical clearances were obtained both from the SBREC (Social Behavioural Research Ethics Committee) Flinders University and from, Mataram University, Indonesia where I was working. As this study involved more than one province, a national research permit was obtained through the Indonesian Ministry of Internal Affairs, in Jakarta.

3.6. Research limitations and impediments

Despite the above limitations in data analysis, I will elaborate the limitation and impediments of this study in three general scopes: the pertinent political evolution in Indonesia, the positional standpoint of the researcher's role, and the specialized participants under study.

The first scope is the ongoing path of *political transition* towards democratization in the *Reformasi* era of Indonesia post Suharto from1998 - to the time of writing this thesis which may result in shifting the discourse within the policy and politics stream. In particular, the time of this study was performed during the last year term of the incumbency of President Susilo Bambang Yudhono (2014). The change to the subsequent president Joko Widodo could affect policy change and therefore might discount to some extent, some part of the result/analysis of this study.

The second scope of limitations and impediments is related to the insider/outsider role of the researcher which to extent could shape the objectivity of the analysis. It has been commonly assumed that the insider role has the advantages that the outsider's lack, such as easy access, the ability to ask more important questions, and provide an ultimate understanding about the context and content under study. On the other hand, the outsider has the other kinds of advantage such as curiosity to unfamiliar cues, attaining non-bias explanation or getting more balanced information without involving the researcher's preliminary assumption. However, the dichotomy of the researcher's membership in qualitative research might not fall instantly into such a simple category, in shaping the objectivity of the analysis. Hence, I use three 'themes' from Merriam et al. (2001) in explaining the limitations and impediment of this study relevant to frame the researcher's membership role: positionality, power and representation.

The first theme, 'positionality', indicates what my insider/outsider position depended on at different levels and/or different times. By having Indonesian nationality and a job position as Indonesian civil servant as well as Islamic religion affiliation, I am a high level of insider to the site and subject of religious

anti-vaccination in Indonesia. Having a high level insider status brought a sense of having already some *a priori* knowledge and presumption, to some extents. However, at different levels, at the same time, my role became an 'outsider'. Because my position as government employer rests in the national education department rather than in the health department, I am outside the area which makes health policy. Although there is different subculture within different organisations, at some stages, there is some presumption of generalities among government organization that I understood could influence the data analysis and become an implicit target of subjective perspective and reflection despite rigorous bracketing. Furthermore, as Merriam argues, the 'positionality' account could shift and be determined by 'relation to the other' and thus making some variations possible. In my case, I was neither a totally 'indigenous insider' (not employed by Indonesian health department) or totally 'indigenous outsider' (being Indonesian with its value and norms). The term 'external-insider' seems to be more appropriate in this context (Merriam et al., 2001) given my lay position in the internal population but outside the place that I studied.

The second theme of limitations and impediments deals with 'power'. In this regard, the research activity framed in power dynamics presents the unequal relationship between the researcher and the researched (Merriam et al., 2001). The power dynamics of the interview process was something that was negotiated by the respondent and the interviewer within the culturally embedded context. For Asian culture, it was subject to seniority, educational degree, age, authority, dignity and respectability that structure Indonesian society. The Indonesian health policy makers interviewed might explicitly or implicitly express their disbelief or enjoyment at the interview questions. And with the sensitive topic of religion, to some extent, they could resist and reject the interview questions that imposed a 'threat or insecurity' to their position and privacy. This could become reluctance to be involved in the answering the questions at some points, and therefore a limitation to the research. Hence, I was aware of this power relation. As an 'outsider', it was important to manage and negotiate it in a way to make the respondent comfortable and safe within

their territory.

The third theme is ‘representation’. Each qualitative researcher tries to accurately represent the interpretation of the respondent’s perspective. A different language and culture might complicate an accurate translation into English because some local dialects, idioms, or specific cultural and religious nuances could be translated clumsily and need further explanation.

The third scope of the limitations is related to both the specialized subject (immunisation) and the specialized participants (cluster of health bureaucrats in the immunisation arena) rather than a broad heterogeneous cluster of participants. This was because the immunisation subject itself carried a specialized scope and the role of the health department was still central for policy making in immunisation. The territory of explanation is also limited to the expected assumptions from a the wide-range of readers.

3.7. Concluding remarks of the methodology chapter

In these remarks, I will make a concise review of the methodology and effort to obtaining quality research. This study employs a qualitative inquiry to explain agenda setting of immunisation policy for religious anti-vaccination. In this case, I applied Kingdon’s multiple stream theory as a theoretical proposition because it serves the contextual ambiguity of the developing agenda setting for immunisation policy. Kingdon's theory also provides the independent variables of the streams, the problem, policy and the politics to be emphasized.

The case study design was adopted because it offers flexibility of methods to explain the study case of immunisation policy for religious refusal of vaccination in Indonesia. Moreover, the case study design is applicable because any demarcation of the phenomenon from the context is absurd. The context transcends into a variety of phenomenon, for example Islamic religious values, politics, immunisation policy, and culture and ideology. The instrumental type of case study is applicable for this study because the case serves as a tool to examine other considerations, not merely the case. In this study, the case provides an insight to examine agenda setting for immunisation

policy in Indonesia. To establish boundary for the case, I confined the setting to the Indonesian health department, in which the department for immunisation programs exist, and limited time period to an estimation of when the issue surfaced between 2010 - 2013.

Data collection performed by purposive network sampling was done to obtain the correct respondents to talk to due to the sensitive nature of religious opposition to vaccination. The qualitative inquiry did not call for random sampling from the population as in quantitative study but is employed to be representative of the subject of interest, which are the suitable health policy makers facing religious opposition to vaccination. The health policy makers, in this study, were in the three of government levels from the district to central health office within the immunisation arena, and all were long term career civil servants. With minimum information, the selection of the site or location of districts was guided by the media, grey literature, and alumni networking information. Some districts within Central Java provinces and Jogjakarta provinces were selected, which had experienced with the religious opposition to vaccination. Data collection involved several methods but mainly employed the interview, casual observation, documentation and archival records. The interview structure was guided, but not confined by, Kingdon's theory of agenda setting. The interview questions were posed in an open ended conversational manner rather than strictly scheduled.

As a case study, the data analysis applied the inductive-deductive method, starting from a data driven elaboration of the themes followed by iteratively, using Kingdon's theory to categorize the them and build the explanation. Hence, the case study is a single unit of analysis which is holistic rather than multiple.

In order to obtain the quality of this qualitative inquiry, several efforts were involved: to obtain construct validity (applying correct tools for the concept under study), the data collection involved multiple formats that encourage developing a convergent line of inquiry. And the data and triangulation theory was applied to support the construct validity.

Internal validity (i.e. distinguishing from false relationship of causal link between variables in explanatory case study) was related to the problem of inference in which it is usually difficult to explain the consideration of possibilities directly. To deal with them, explanation building was used to develop a holistic explanation and the evidence analysed to corroborate or refine the initial theoretical proposition of Kingdon's multiple stream theory.

External validity, which corresponds with generalizability, was addressed with analytical generalizability. Analytical generalizability was developed by refusing, refining or supporting the theoretical proposition to assess whether the analysis is applicable to other situations (Yin, 2003).

The next chapter addresses how the findings obtained from the data collection through interviews, documents, and observations were produced into the inductive themes, along with an explanation for each. The way the themes build the explanation of the case is discussed in chapter 5.

Chapter 4 The Findings

4.1. Introduction

This chapter will describe the inductive themes in a narrative way. As outlined in the previous chapter, this inductive approach is not aimed at a separate conclusive-end type analysis; the purpose is to generate categories of themes grounded from the data (data–driven). Some theoretical triangulations are also corroborated from scholarly references to gain perspective on the data findings. In this way, the naturally occurring data will be able to be matched and contrasted in detail with Kingdon's underpinning theory.

The inductive themes were not segregated into levels of government or positions but compiled together among data sets to abstract the latent meanings from the overall data. The sequence of themes is not ordered according to their level of importance, but merely show the categorizations with their own key characteristics, scopes and distinctions (Thomas, 2006).

In this case study, rather than compiling the outcome categories into very small numbers of key summary themes, I prefer to develop them into varieties to capture the rich detailed nuanced of the overall data, and to provide a more serious apprehension of the latent meaning, enabling a more vibrant discussion and analysis.

The themes cover a variety of descriptions drawn into categories to provide a big picture of understanding of those health bureaucrats who were interview in this study to the answer of research questions. In chronological order, these themes comprise the characteristics of immunisation policy, the decentralizations and bureaucratic disincentives, the elite Islamic politics and regional politics, the cultural factors, the problem debates, the ideas and alternatives, and the overriding constraints.

4.2. The Themes

Characteristics of Indonesian immunisation policy

It is a manifest type theme that describes the scope of queries in the explicitly

understanding the existing characteristic of immunisation policy in Indonesia. It provides the obvious background in comprehending the key characteristic of outdated immunisation policy.

The immunisation policy has been characterised as being old and obsolete policy without any change since the beginning of Soeharto's authoritarian presidency in the 1960s. There were some sub-themes characteristics, providing the features of the outdated immunisation policy. These sub-themes are: centralised policy, commanding and obligatory policy, one-sided regulation, and inherited policy. All features denoted the continuing policy character from the previous authoritarian Suharto's president legacy. The narrative of obsolete immunisation policy stems from centralised policy.

Centralised policy

The term centralised in this context, highlights the role of the central political elite bureaucrats essential to the understanding of the Indonesian state and its mode of authority. The term has the connotation of a unitary state system of control and policy development. The authority is centralized in the hand of elite actors to deliver uniformity along the region to conform to a unitary state model. The Indonesian unitary state has best characterized as a 'bureaucratic state'. In the most extreme analogy, the bureaucratic state of Indonesia has been featured as 'bureaucratic polity' in which all important decisions are made within elite bureaucratic machines. These bureaucratic machines include the elite civil bureaucrats, but have a minimum of participants from the general society, mass organizations, or the periphery of the state power structure (Barker & Van Klinken, 2009).

The regional offices, district branches are the 'extended hand' of the central state authority. With this centralised character, the regional health offices, both provincial and district health have only been given the space to be implementer of policy: they have authority to manoeuvre *technical and tactical* policy for the operational stage of the immunisation programs developed by the central health office. For example, as stated by a respondent in BTL district: "*the policy we have in the district is only about technical policy*" (Interview DHOJG-BTL2)

Thus, in reality, the prevailing health decentralization did not change the core of the immunisation policy which remains centrally performed.

Commanding and compulsory policy

The centralised policy also implies an authoritative and commanding message from the central health office, ordering the regional office and the subordinate levels to compulsorily perform the immunisation program as to obtain a certain amount of immunisation coverage in their area. The district health offices have to be able to achieve more than 95% coverage, in order to gain herd immunity. The achievement of target coverage is accentuated under a centralised policy to become the key point. As a derivative of centralised policy, the national immunisation policy is, by default, target oriented. As illustrated by the respondents both from the district and central office:

"So the district just implements what the central said as in their written guidelines. They give targets to us to achieve a certain percentage of immunisation." (Interview DHOJG-SL2)

"In management language … it (immunisation policy) is output based, 'principally, our target should be achieved, 80%, 90% reached […] But then they (regional offices) don't take the meaning of health investment. Because of it being output based, the orientation is as long as it takes for their target to be achieved; 90% achieved, full-stop. And forget the other aspect." (Interview CHODG)

This finding corroborates with the triangulation data analysis of immunisation policy document (the MoH decree 482/2010) outlined in chapter 2, the Literature Review. The decree assigned the regional offices to place primary emphasis on achieving an 'unrealistically high target' of immunisation coverage in a short time, but with only a generic indication of likelihood that these targets can be actually achieved. Despite the MoH decree recommending by having done a SWOT analysis that the underachieving regions adopt the successful provinces strategy to achieve their immunisation target, there is very little explanation of how the feasibility model could be generalized to other regions.

One-sided regulation

One-sided regulation in the centralised immunisation policy gives means unbalanced regulation because the implementation of policies appears not to be part of the central office authority, while the regional health offices usually *demand a clear instructional central policy* for certain problems. Thus, the regional health offices usually have unclearly regulated policy for any religious exemptions or other individual objections to immunisation. The regulation for compulsory immunisation rests in the state obligation to provide and deliver the immunisation program for the public. However, the regulations for the refusals are not clearly developed in the implementation stage. In the Indonesian philosophical context, health rights appear not to be self-reliant or individual initiative based, as in the Western. Rather, it is the state's duty to carry the health of the public. For example, as confessed by province level respondent:

"It's compulsory (the vaccination program), the problem is that regulation is for the service provider. So for the government it is compulsory to provide services (i.e. immunisation program). But the one that is not regulated is the receiver" (Interview PHOJG2)

The regulation of the religious refusal of vaccination (on the receiver's side) remains one-sided as the state is obligated to provide immunisation services. However, this one side regulation is not sufficiently addressed by the health officers. In turn, make more burden for the front-line health officers actually delivering the immunisation program, they have to work out by themselves how to address the refusals. For example, as confirmed by the central office respondent:

"No, no, as far as I know, no (no penalty for the refusals) … just as it is, 'a program' (slogan), that's all, so the burden is on the health officers to deliver it is a program about public protection" (Interview CHODG)

'Inherited' policy

The immunisation policy itself, despite being outdated centralised policy and having a rigid state order message, is also understood as a policy passed

down over generations of policy makers in the central health office. The policy seems to be stagnant, never revisited and just handed down over generations while there is no constructive feedback from the regional offices due to the 'dictatorial' nature of the central office. Thus, both sides play the situation stalling and stagnating policy development. In each tier of government, the overwhelming accentuation was, again, emphasized coverage number to be achieved:

*"And in the central office, we are here; we look at this level which also already a **given** (policy) …[…] So, in the field level, the health workers only talk about coverage, in the meso-local policy level, they only talk about coverage, so nobody talks about the impact to those people". (interview CHODG)*

Perplexing decentralization, undeveloped district empowerments

Decentralization is not a new or exclusive subject because this feature has also been a tough issue in the 'Reformasi' (post-Suharto) era, affecting health sectors as well as other many sectors of governance.

The prominent manifest effect is in the discordancy bureaucratic machine, accommodating both the centralised bureaucratic state (to conform to unitary state value) and the already delegated power of the decentralization policy. For example, the provincial health office in Jogjakarta argued that the province health office was not in authority of the district health office but only provided a '*consultation and advisory role*' while the authority rested in the district offices. The province office is posited as the 'extended hand' of the central government but autonomy is tied to the district level. Thus, there is a sense of 'recentralization' in the province office while the district office remains autonomous. This situation reflects the anomaly of decentralization. Some other scholars have also supported and corroborated the above accounts. For example Trisnantoro (2009) has viewed the anomaly of Indonesian health decentralization as 'half-hearted'.

Moreover, there is a tendency for prematurity in delegation of function and authority downward to the district level because of the lack of resources available in the lower district. For example, this condition had been admitted by KRH district respondent in their difficulty of having only few competent staffs

for policy making. Many of the local office, human resources are from pragmatic backgrounds such as medical clinicians. Eventually, the burden of policy making levels up towards the head of the health district office (‘Kadinkes’) to become the discretional decision maker. At the same time, the head of the health district also has to be able to advocate and build the capacity of the staff rather than directly obtain the right person in the right place. Quoted from the interview with KRH district:

“They (staffs) don’t want to be complicated, their (staff's) character, what I observed, is: “tell me what to do, I do it”,. […] they are health service people, who have concern in the health service scope. For example, medical doctors who have the character for providing health service, don’t ask them for a meeting to make health policy, that won’t work, they just tell what they feel and make complaints (to me). But the ones who have an analytical character, they then should bring him up here.[…] I have to process/prepare them, the human resources, process their mindsets” (DHO-KRH).

The inconsistency among laws and regulations, lack of detail about functional and operational responsibilities, governing the decentralized health system results in confusion and blame-shifting between local tiers of government. This condition has been cited as one of the prominent factors for abstinence of local policy making, in addressing religious anti-vaccination at district levels.

There appears a mixed but not a blend of, the philosophical value systems for maintaining a unitary state concept (providing single conformity and uniformity) and performing decentralization (or broadly speaking acting as federalism but at a district level). Subsequently, decentralization appears to be semi-federalist. In practice, the system has tried to preserve the unitary centralised concept while at the same time, simulating federalist behaviour. In addition, the budgeting system and the officialdom has already been decentralized into regional offices (Crouch, 2010).

With decentralization, the district health offices were practically more entangled with the district government (i.e. the mayor’s office) rather than serving the intention and policy of the central health office. In other words, there was a limitation of central health office power to intervene and interfere

with the local health authorities.

In the real setting, the purchase of the vaccines is still subsidized and freely provided by the central health office. However, the budget authority and the implementation of the immunisation program rests with the local authorities. Consequently, as explicated by a central office respondent, despite the central health office having established 'NSPK' policy (health service standards, norms, procedure, guidelines) for the regional health offices, the interpretation and implementation of those delegated functions might be different and not fully performed by the regional authorities. Quoted from the interview with CHO-ENIH:

"With regional autonomy, no longer top-down order (centralized order), the central government of the day only provides the norms, standards, guidelines, procedures, trainings, but the execution is at the district level"

Hence, the control by central authority of the regional offices became weakened and loosen. In other words, the MoH authority was not followed by or not in line with the flow of money (funding), responsibility and reporting (in this case the immunisation records from the districts). In practice, the coordination among agencies was poorly performed. As such, this might explain why only a few of the districts health offices (SKH and KRH districts) from two provinces under study deliberately made the official report for Islamic anti-vaccination. Moreover, the absence of a clear and unambiguous penalty that could be applied to the district health offices who failed to conform to the national policies hindered the province health office's effective advocacy roles.

There are some sub-theme features contributing to the elements of general policy making with this decentralization anomaly that built the explanation. They are the emerging of local power bringing local campaign menu, the pragmatics of popularity, the penetrating pollicisation, declining trust among tiers of government, structural organization factors, ineffective inter-agency coordination and bounded rationality.

Local power in regional offices

In the post-Suharto autonomy era, not all of the districts were willing to perform the instructions of central office policy. The central health office had complained that the regions did not seriously take into account the health sector, including immunisation programs, despite the fact that vaccines were free available to them. The central office also acknowledged that they were more powerless in handling the interest of the local elites. The local elites might be able to organize themselves more cohesively at the local level because their interests were more homogeneous and the costs were lower than national ones. Triangulating from the political articles, after the fall of Suharto in 1997, the situation was reflected by the distributed power from Suharto's centralized power into the born out of local elites power that controlled regional governments (Aspinall & Fealy, 2003).

Moreover, there are no clear mechanisms to require the regional governments to develop explicit plans linking to health analysis, including immunisation, before Jakarta's fund transferred regionally. This prevented the central health office in judging the conformity and securing commitments from the regional governments.

Regional commitments are in turn, often defined and focused towards fulfilling the target proposed by their campaign wishes to gain public popularity in order to maintain electoral votes, while at the same time ignoring other policy. In practice, the regional offices find it difficult to do the commitment with central office because they were elected by direct regional popular vote, bringing political interest among regional political parties which might not be in conjunction with the central health office interests. Quoted from the interview with CHO-ENIH:

"…up to the mayor, he wanted to make an airport, for example, health is not necessary, with limited resources, his actual priority was when his political campaign, he promised to make roads, they make roads, immunisation go to hell…"(Interview CHO-ENIH)

This political interest became the strong reason for the central health office's

unwillingness to decentralize immunisation policy to the lower tiers as they were concerned it may jeopardize immunisation coverage nationally. The immunisation policy was forced and pushed to be a centralised policy, despite the fact that there was discordance in the line of power, authority and money.

Pragmatic Popularity as a political capital

With authority devolved into the district level, the district respondents usually admitted that the local level district leader had generally more pragmatic thinking in putting in or leaving out a particular subject of their policy agenda. The main consideration is to maintain local electoral votes at a high level. Hence, the subjects which are popular typically became prominent political assets district leaders to maintain their electability. In turn, the religious anti-vaccination issue escaped from their attention, or inversely, the issue is only taken up to gain pubic recognition and popular sentiment, or for gathering public justification.

"I mean they (the mayors) don't know if this issue is serious. We assume he reads them (the immunisation reports). He should know that there are schools over there that refuse immunisation, but he is not from health arena. He thinks "oh, the UCI coverage is good, I don't have warning from the governor" that's number one. The second is perhaps "oh, there is no KLB (epidemics)". The policy makers at that level, they 'think simple'" (Interview DHOJG-BTL2)

Intense politicization

The nuance of political atmosphere reflected by the central office respondents was that the outside political stream had entered the health offices both in the central and regional levels, influencing them. It appears to be difficult to differentiate who is against what or vice versa. Either the subject or object was blurred towards politicization. The interferences from any side has been reflected to be dominantly carrying political interest, making suspiciousness and threat on each side. Quoted from the interview:

"If we want to identify who is the stakeholder, or the shareholders, number one is politics, number two is politics, number three is politics, number four is politics, number five is politics. We should be aware and alert that everything wants to be taken into the politics arena. One or two person can say they are on behalf of the public" (Interview CHODI)

The health officers were trying to avoid the political stream rather than be involved in it. Hence, policy is generated towards any regulation that avoids the need to change or modification by the parliamentary process. Bad experiences from previous failure in proposing regulations through the parliament also carry reluctances that affect non-decision making in the SKH district. Quoted from the interview:

"This (political) condition we have today, just follow the stream. Moreover, with our present national constitutional condition, we, the ones who are on track (doing the right thing), the truth can be twisted back to us as trouble makers. Why? Because, that's the majority community present at moment. They can twist the truth because they have networking. These conditions, even in the immunisation arena are the same" (Interview DHO-KRH)

Decline of trust between central and regional offices

With devolving power to the regional district level and the 'mixed but not blended' concept of unitary and federalist value, the trust between the central and regional may easily erode. One of the problems originated from where the flow of authority was not aligned with the flow of money and information. The central office had seen regional health offices being incompetent to manage themselves. On the other hand, the regional health office argued that the central bureaucrats did not have local level understanding and experience of local circumstances. Thus, the top down policy appears to be in discordance condition with the local interests. For example, the sense of that feeling had been explicitly expressed by the respondent:

"Now, the problem, our friends in the central office need colleagues who understand the real local field situation; the staff component in the central health office are raised in only the scope of policy environment, they have never been given opportunity to know the real/factual situation. Policy product sometimes is not implementable. This becomes a problem; we, who are in the local field, have trouble to implement… they should know our circumstance, they should know from the policy level until the policy implementation. What does the policy mean if it can't be implemented?"(Interview DHO-KRH)

The heavy and vulnerable organizational structure

Despite the prevailing health decentralization, by default, the MoH itself is a

super-heavy-structure organization with biased internal functions; it is direct manager of the health care providers (hospitals), while at the same time being a regulator, supervisor, service provider (public hospital) as well as taking a quality assurance and accreditation/licensing role. And the structural organization of the regional health offices are still a 'microcosm' of the MoH. Hence, corroborate by Trisnantoro (2009) the effectiveness of policy planning, development, regulation, implementation and evaluation appears to be compromised, uncoordinated and sluggish. The same applies to the province and district health offices' organizational structures. The immunisation policy, including with other health policies, has been faced with *this structural barrier of how the MoH exercises and deliver the policy within the framework of a decentralized statutory structure*. And, in turn, the offices are vulnerable to political invasion. The local political influx has caused individual defences by the head of the regional health offices (the 'Kadinkes') to protecting immunisation from political motives. For example, in BYH district, the Kadinkes has admitted his effort to shape the mayor's political motive in order to keep the immunisation program from Islamic anti-vaccination political drive.

Ineffective interagency coordination

In conjunction with the decentralization anomaly, the four inter departmental agencies from different ministries related to the immunisation program, the MoH, the MoHA (Ministry of Home Affairs), the MoR (Ministry of Religion), and the MoE (Ministry of Education), appear to be uncoordinated. This situation has a downward affect to the implementation level by the district offices running the immunisation program. It is not an arguable discussion by most of the district respondents that the coordination and detailed function description appears to be unclear and lack an operational concept, which it makes it difficult for each to exercise authority over others.

Bounded rationality

Bounded rationality implies the limitations of addressing all problems at the same time due to the natural cognitive capacity. The problems should be able to pass through the bottleneck of attention which means that only one layer of a multi-layer of problem is able take up the attention of policy makers (Simon,

1991). The discordance, in meeting both centralised strong uniformity with federalist-decentralized structured health offices has made bottleneck tension within the structure of the organization. This had numbed the creative manoeuvres and innovative capacity of staff. This numbed activity, in turn, might explain the stagnancy of obsolete centralised immunisation policy with little lines of communication, consideration for feedback and further reconsideration. Without eliciting any changes in the policy concept, very little consideration is able to be discussed about actually how to achieve the immunisation target. Without a clear answer to elicit changes a realistic notion of integrated planning is really not operational. And this, in turn, influences the target orientation and implementation among the regional offices. While spending most of the time focusing on the target number achieved, areas where policy concept reform is necessary are neglected, even when the central government actually does have the capacity to act. This is acknowledged by the central office respondent:

"So, if we want to be honest, we have to change, conceptually… But, in the other hand, our mental model is still like that, actually; it should not always be termed centralised, but the mental model is never able to develop ideas." (Interview CHODG)

Bureaucracies Disincentives

The disincentives mentioned above mean that some prominent impediments still exist, despite varying in intensity, such as a patrimonial bureaucracy, one directional centralised features, the importance of showing a neat, good and complacent reports to superiors. These features are still part of the doctrine style of policy prevailing in the Indonesian civil service. Thus, this bureaucratic condition could also support explaining the discordance of information among tiers and channels of bureaucracy. And it is not uncommon that most of the districts showed high coverage of UCI and only two districts (KRH and SKH) provided actual data on anti-vaccination in a more reliable manner. As exemplified by a district respondent:

"…if you know working with civil servants like us, recording is very bad,

because we always oversimplify the database … We look complacent (in reporting) because the UCI indicator, always shows above target. Perhaps the (central) government perception is 'Oh the (immunisation) program has run well.'(Interview DHOJG-BTL2)

The overlapping highly hierarchical organizational structure within the health department could also support bureaucratic disincentive, backing the patrimonial and superior in the work place. Because of this situation, efficiency and consistent coordination appears to be difficult to manage. Most of the respondents also acknowledge the circumstance of overlapping functions of these directorates. In organizational terms, the health department appears to have succumbed to long lines of procedural internal communication and thus may sacrificed the original intentions of the communication. The district health offices have the same situation as a miniature of the central health office.

The bureaucratic disincentives may also explain the vulnerability of intense political interest (politicisation) penetrating the offices from two factors: The low reliability of data recording and the highly hierarchic patronage organizational structure. These conditions could imply that decision and policy making will give less consideration to the use data as a ground for policy reasoning. Instead, the ill-favoured work environment for civil servants and the non-collegial hierarchical organizational structure may allow decisions to be made by levelling the discretion of the head of the health offices (the 'Kadinkes'). Hence, policy decision making might become personalized decision.

Despite anecdotally, during casual observations and informal talks, most of the 'Kadinkes' (the head of the district health offices) were appointed by the discretion of the mayor of the district, rather than through merit based appointment. Some of the Kadinkes felt and complained that the rotational position was based on political interest, to play with defining and assessing their competency, despite being justified by existing regulations. Moreover, the civic data itself was not well organized in the regional offices making it difficult to track or compile accurately the input data. This condition may make it difficult to analyse and derive the policy alternatives to address the anti-vaccination movement. The lack of a reliable coordinated national identification system for citizens is usually the reason given for their inability for developing a

comprehensive civic record for immunisation. This unreliable administrative capacity within the regional offices has been acknowledged by the central office. As accentuated by the central health office respondent:

"As long as we don't have a NIK (national identity number) for all Indonesians, there is no possibility for it to be changed; it's difficult, if we don't have a NIK and finger print; it's difficult ..."(Interview CHODI)

A contaminated vaccine manufacturing process

The key reason behind the debate of un-halal vaccines was sourced from the use of the porcine derived trypsin enzyme, which is religiously forbidden according to some tenets of Islamic school of thought (see chapter 2), during the vaccine manufacturing process. Despite the final vaccine product not containing any porcine produce, the MUI[1], as the national fatwa maker, defined that, during the production process must not touched by haram substances. According to this posed halal criteria, the porcine derived trypsin enzyme is allegedly the source of haram contaminants, during the vaccine production, despite the fact that in the final product there is no such religiously prohibited element. The MUI did not accept the explanation that the laboratory process rigorously removes the trypsin enzyme from the final product. They insisted that everything in a halal vaccine should be made also from halal sources. Quoted from the interview with central health office:

"They (MUI) constantly said that "everything which is good should be performed in good ways", well that's true, everybody knows it; there are no good things performed in bad ways, isn't that right? That thing is overly expressed, so we have checked mate." (interview CHODI)

It was a difficult alternative because the use of non-porcine enzyme alternative

[1] Essentially, the MUI is a national Islamic organization from a variety of Islamic streams in Indonesia established by the late president Soeharto to unite the Islamic voice for serving government interest. After the fall of the Soeharto regime, the MUI restructured themselves into a more conservative stream and collecting support for their interest and voices. This turning point can been seen from their fatwa (Islamic ethico-legal assessment) and statements that are more 'strictly literalist' address social, political and economic issues including influencing the health sector. This 'conservative turn' of MUI may be best termed as 'puritanical moderate' for Indonesian version (Ichwan & Bruinessen, 2013).

would fail to achieve mass production on an industrial scale, and would only be able to supply a small laboratory scale. On the other hand, using enzyme from different animal types, for example cattle, might provoke refusal from other religion in Indonesia, such as Hindu's. As stressed by a central office respondent:

"…without (porcine) trypsin, the harvest is not much, we can't get mass production, only on the research scale. We have tried cow (enzyme), but then the Hindu's said no, we use tofu. It's promising, but it's too little, just on an experimental scale, not an industrial scale." (Interview CHODI).

The pressure of the MUI on the MoH to satisfy their interest in providing the 'truly halal' vaccine has made the Indonesia lay public, which are dominantly Moslem, indecisive, and undermined the vaccination program because it is perceived as not meeting religious merit. Eventually the pressure from MUI could jeopardize achievement of 100% immunisation coverage because the public more disinclined take up immunisation. As stressed by the central office respondent:

"Well, in the MUI pushing the government to do that…, it makes the public which has a half-understanding/awareness become unsure … indecisive (about taking up immunisation)" (Interview CHODI).

Political charge for vaccine halal certification

On a national scale, the central health office acknowledged an intense political pressure from the MUI (*Majelis Ulama Indonesia*; Indonesian Islamic Council) through problematizing the porcine derived trypsin enzyme.

Through their Islamic food and drug council (LP-POM MUI), the MUI pushes the MoH to obtain the right to assess the "halal-ness" of all vaccine production in Indonesia. During the time in which this fieldwork was performed, the MUI became the sole legal institution, providing halal certification nationally in Indonesia. The discussion and debate always came to gridlock between the two, the MoH and the LP POM MUI. Explanation about health and the importance of immunisation by the MoH was useless in convincing the MUI. At

the same time, however, the provision in assessing halal/haram of vaccines was not put on the public scheme cost and it may eventually be overburdening the public sector. This notion resembles towards rent-seeking behaviour[2]. The language of politics behind the discussion is this, as per Kingdon (2002): *"you (the MoH) give me (the MUI) my provision (assessing halal criteria for vaccine) and I'll give you yours (halal label for vaccines)",* rather than "*let me (the MoH) convince you (the MUI) of the virtue of my provision*". There was an intense sense of trade and exchange of interest for obtaining halal fatwa and halal certification in return for business ventures with halal certification. Quoting from the interview:

"To do that, it's not cheap …. to produce their fatwa is not cheap….[…]no, for the FEE… each member …ONE sitting (in a meeting), it may not be a quorum … how many times (to get quorum) can you imagine?…. Can you understand? The main thing is that their cost is very expensive" (interview CHODI)

The MoH had a sense that giving the MUI a concession by submitting the vaccines to be assessed by them, it would eventually be committed to 'long-life entitlements' that are difficult to withdraw, vegetating into outstanding oligarchic group. In turn, it could shift the basic public immunisation scheme to be a private scheme.

The above MoH reasoning is plausible when withdrawing from the MoH's experience with MUI that granting halal vaccine for particular meningitis vaccines for hajj pilgrim while other vaccine is haram (MUI, 2010). This experience had raised a significant cost factor to the MoH. Eventually, this political controversy had made the MoH considered that the regular vaccines may also be in target for business venture. Quoting from the interview with central office:

"Now, it's like this … meningitis vaccine is considered halal (by MUI) for how many years, do you know? Only 2 YEARS … the precedent is (to make MoH)

[2] Rent seeking behaviour as political economy motive includes variety of ways attempting to make profit as a result of favourable public policy decision at the expense of the taxpayer or other groups and most common when the rent seeker also the monopoly and/or have sufficient political power. See Rowley, Tollison, and Tullock (2013)

close to the "cash cow", business matter… whereas, vaccine itself, the characteristic is very rarely to change once they are made …."(CHODI)

Halal Warranty Product Bill

In concert with macro political context, during the time in which this fieldwork performed, Halal Warranty Product Bill had been in process for passing the parliament. This Bill may affect health sector because the Bill included the pharmaceutical products for legally halal assessment. What had been behind the move, it is the interest of elite politics groups to take part in the lucrative halal certification market that still, during that time, monopolized by the MUI as the sole proprietor of halal certification in Indonesia. Quoting from an interview:

"That's a business matter, not substance matter ... Now, the one who wants to make that (halal) certificate, they overstate the story overstate, or distort the real information. There are some interests over there as long as we have an institution that can professionally work … then done, now we haven't that and MUI, for many opinions, some said no, others yes, and it is debatable for long time in Indonesia."(Interview CHODG)

When there was no support from the Islamic religious groups could make made it more difficult for the MoH to implement their health service program including the immunisation. The issue of 'un-halal' vaccines could bolster the Indonesian lay public who have a majority Islamic affiliation, which without halal labelling, creates the image that the vaccines are *not religiously legal*[3].

To corroborate with the interview findings, some of the media had also reported the dispute of the uncompromising stand between the MUI and the health minister. For example, national newspapers had released the standpoint of the MUI by alleging the incumbent health minister as '*anti-Islam'* because she wanted to halt the Halal Warranty Bill in the parliament. The MUI claimed that the MoH did not recognize the need for Islamic public consumer protection for

[3] The MUI had refused to be interviewed during the fieldwork and long after the fieldwork, in the final period of Yudhoyono's presidency (October 2014), the Indonesian parliament had finally passed "Halal Warranty Product Act" that included drugs and vaccines to be assessed their halal status (Right, 2014). It may eventually put MoH in consequent challenge for ongoing political tension. Subsequent case study would be crucial to analyse the succeeding MoH policy and its political manoeuvre in health sector.

halal products. The MoH argued that health minister had never been involved in the drafting of the bill from the beginning and was concerned about the difficulty of halal assessment for pharmaceutical products as the process of deliberating halal status would also be complicated, which in turn would have a significant effect on the pharmaceutical industries (Margareth S. Aritonang, 2014; Parlina, 2014). In respect of the collective support of the house of representativse (DPR) to pass the Bill, what had been contested is the demonopolized authority of halal certification and decommercialised halal labelling from the MUI (Anwar, 2014; Nurhayati, 2008).

Health minister[4] and president leadership

The incumbent health minister during the time this data collection, Dr Nafsiah Mboi, a senior paediatrician, was characterised as a strong, hard-liner leadership. She had been known to be a blatant speaking, and decisive character, not using implicit message including when opposing the Halal warranty bill by the Islamic groups in and out of the presidential cabinet. Her character had been understood by the health bureaucrats as bringing a new vision to their department, encouraging their professional work rather than call forwarding their personal beliefs into their work. As accentuated by a central health office respondent:

"She doesn't want to be taken into politics and back to remain objective. So it means, there is a new colour brought by our present health minister. For example, in a public forum she said bravely: "Even it is a pig, we can use it if it is for the health of the people and we have no other choices". This has never been said by the previous leader. il looks simple, but only some small group of elite people are willing to speak on behalf of the public." (Interview CHODI)

In the other hand, the presidential leadership during the data collection, Mr. Susilo Bambang Yudhono, had been referred by many political scholars as

[4] The Indonesian health minister and its organizational structure had long standing been occupied by mostly senior medical professional background rather than outsider political actor enable to provide robust internal communication control among internal stakeholders (Sasongko, 2014). Despite its high potency for strong internal dominion, the external political capacity may be less in handling and facing outer political charge even within the coalition cabinet. Datta et al. (2011) had argued that the 'visible' ministry with high external dominance is held by ministry of finance and trade, ministry of public work, and the central bank.

having a high power distance, and indecisive figure to balance and satisfy the competing vested interest within his own cabinet (Fealy, 2011; Tomsa, 2010). The health minister, with her strong leadership style, seemed to struggle in her own to face the political charge against the MoH territory, that in this case, around the battle of halal vaccine certification.

Regional anti-vaccination, a fragmented and unnoticed practice

It was difficult to assess the direct causal link between the Islamic anti-vaccination movement in regional communities in the districts under study with the MUI's elite manoeuvres with the MoH because the local community usually relied on their local religious leader rather than to the MUI in their daily life. Moreover, despite the MUI having many local branches at the regional level, and having many representatives from a variety of Islamic streams, the MUI does not have any specific mass-based following at the grass-root level like other prominent Islamic organizations in Indonesia.

The anti-vaccination campaign usually performed not in open and organized manner but through local informal religious preaching and sermons. Thus, it became difficult to define which streams explicitly brought the anti-vaccination campaign because of the many fragmented networks within the community without visible organizations. With that difficulty, the respondents mostly did not indicate which dominations or streams were responsible for promoting anti-vaccination.

The anti-vaccination movement was usually discovered during the BIAS program) a routinely scheduled immunisation program done by the district offices. The refusal of vaccination typically came from the traditional Islamic boarding schools (*pondok pesantren*) or their associated compounds when the immunisation team tried to provide regular immunisation services within the schools. There were tendencies of blame shifting between the school foundations and the parents. The school did not want to be blamed as the source of the immunisation refusal and fell back onto the parents as the ones refusing immunisation. Other regular immunisation services, such as '*pos yandu'* (remote health services), usually could not identify the refusal of

vaccinations because parents came intentionally to immunize their babies. However, vaccination refusals could also be identified when the vaccination program was done incidentally and impromptu when attached to other local health programs run by the district offices, such as breastfeeding or supplemental nutrition. Those incidental condition support the difficulty of recording data about those anti-vaccinationists in a reliable manner in conjunction with the pre-existing bureaucracy disincentives features

Regional respondent accentuated the local community issue being surrounded and influenced by the local Islamic groups living in traditional boarding school camps ('*pondok pesantren*'). Because of the difficulty to persuade and approach these groups, the context of the anti-vaccination movement was interpreted and perceived as *regional politics* which could not be handled by the local district health office. As stressed by a district respondent:

"In the beginning, yes (fa aith/belief issue), but, now it's not about that; there are many reasons now […] faith is not the number one reason; the issue is developing (politically). As I said, Kesbangpol (National Political and Social Unity Department) entered here as one team, and the National Defence Force are also involved. (Interview DHO-KRH)

A similar tendency in interpreting and perceiving the issue as political agenda of the Islamic movement was raised by the SKH district. Because the government seemed too strongly pressure the local Islamic radical groups, in turns they responded by refusing the government immunisation program.

A focusing event

A local seminar held by a public Islamic university in Jogjakarta about the halal-ness of vaccination raised the attention of the public and the health office in provincial Jogjakarta attention. Since it was held by a University, the Jogjakarta health province office had significant concern about the event because it would be able to elicit a negative sceptical message to the public that the vaccines are not religiously acceptable. Consequently, the public would be in more doubt about having the vaccination due to religious concern jeopardizing

immunisation coverage. Quoted from the interview with Jogjakarta Province

"We have attended the seminar on behalf of the community or people that have not yet agreed with the immunisation program. And there are questions about the 'halal-ness', of the vaccine ingredients, used in the government immunisation program. When we attended the seminar, the sponsors came from NGOs, and being held in UIN (Public Islamic University) […], we have some concerns that the seminar will effect public understanding in Jogja, particularly that they will doubt the importance of immunisation.".(Interview PHOJG1)

The impact of the message was not clearly assessed for what extent it affected immunisation coverage. Hence, the seminar was as a vigilant focusing event to the successful of immunisation program.

Insider refusals

On the other hand, the health department itself is not sterile of influence of religious opposition to vaccination. As claimed by the respondents either both the central and regional offices, they had acknowledged that there are supporters of religious anti-vaccination in their organization. The insider refusals that come from medical professional in particular backlash onto the health department because they are seen as the representative of the health department. The way of managing them was usually by job reposition, to avoiding them being directly in contact with the lay public, and by threatening them with administrative sanction such as repealing their professional licenses. As illustrated by a regional office respondent:

"Oh yes, even some midwives, they don't want to promote for immunisation. We make approach, the IDI (Indonesian Doctor Association), local professional organisations, and local health office, if they don't want to promote immunisation, instructing them not provoke the public to refuse immunisation. If not, we can withdraw their license (PHOJG2)"

Cultural background in the society *vis a vis* the organization in the power behaviour

This theme has been named this way because it indicates the way power has been exercised in accordance with cultural tenets of Indonesia. Both the regional and central health offices acknowledged that the existing cultural background in Indonesia has a significant influence in bolstering the spread of

Islamic anti-vaccination. There exists a sense of a blend of religious belief and cultural factors: belief is exercised in accordance with cultural grip. From most of the respondent's views, fundamentally, general Indonesian civil society is not either a clearly secular or deistic society, and *paternalism is its cultural foundation*. This paternalistic culture has become the source of the people behaviours.

In a paternalistic culture, the society typically believes in particular superior figure(s) or patron(s), which are the local religious leaders they trust and can give their loyalty rather than relying on individual assessment of the risks vs benefits of vaccination based on scientific explanation. The loyalty and sense of dependency towards a superior person such as religious leaders is imbalanced against their own personal judgement, and developing into leader-follower model. For example, in the interview with a district respondent:

"This is because mostly those people with such belief adopt the role model. Our people are still paternalistic people, following the figure/leader person." (Interview DHO-KRH).

The paternalism model appears to be web-like and fragmented according to their doctrines or schools of thoughts. Thus the tenet differences within and among them is prominent and it is difficult to unite their vision. As such, usually a small subject becomes highly debatable and divisive among different school of thoughts because their justification of a problem is always different and irreconcilable. Moreover, the ultimate sacrifice made by adherents to a particular position to defend their thoughts can be justified by their willingness to die. This commitment to sacrifice themselves has made it difficult for the health office to influence them, as stressed by a district respondent:

"No, for belief stuff, no one can unite them. Who can unite them? They have their own spiritual quotients: it is in their blood. . Belief has fused with their flesh and blood. For example, they are willing to die rather than be injected with haram stuff, have you heard that?" (Interview DHO-BYH)

The importance of a dual figure role in the campaign for immunisation

In campaigning for immunisation by clarifying the haram status of vaccination,

the district office respondents claimed that the difficulty was that the local community would not simply believe the explanation from the district officers: The ideal figure usually has a dual capacity as a highly devout religious person and as a proven scientific expert on the subject. Finding a suitable person meeting this criterion became an obstacle in the technical delivering immunisation policy. For example, a respondent in BTL district of Jogjakarta province said: a:

"… but Professor A directly goes there, speaks over there; it may be that he has famous name as a senior paediatrician, and he show good Moslem faith, something like that approach" (Interview DHOJG-BTL2).

This campaign strategy corroborates with a study by Kim and Singarimbun (1988). In their study, the village hamlet became the person motivating or instructing about immunisation. This type of situation still remains the important exogenous social factor because substantial awareness about immunisation originates *not* from their own individual assessment of risk and benefit, but from the patron they should believe and obey.

Paternalistic rationality in organizational practice

The origin of Indonesian paternalism is understood as emanating from Javanese culture as the dominating culture in Indonesia. This paternalism has created the patronage model in which the subordinate people are the loyalists of patrons or superiors. This phenomenon might blur the power practice of an organization. The organization's power appears to attach to the respected figures within it, while, institutionally, the organization's capacity remains weak. The capacity of an organization dependent upon a figure of power is prominent in conjunction with the hierarchical structure of the government organization, and the unreliability of the available data recordings/archives for use in policy decision making. Thus, the power of decisions would likely culminate in the hand of the figures or patrons who have significant influence and social capital within the organization. In other words, the power practice and discretions in an organizations appear to be very personalized rather than having genuine checks and balances. As in the old enduring Javanese culture, strong patrons

appear to have their own informal followers or loyalists in and out the organizations to secure their interests. This personalized power appears to fragment between organizational and patronage network power. Quoted from the interview with central office respondent:

"In the structure of our religious culture, a figure becomes the key: the figure is a very important variable, so our people follow the figures ("ndherek kyai" in Javanese .. The figures (patrons) voice will be followed wherever they are. Either the figures reside in government positions, or in the ulema council, or outside; everywhere, they have their own followers. This (phenomena) is very…. entrenched in my experience. I said this about Indonesian culture, but you know may be in America it is different. They (the Americans) have different rationality; our rationality is paternalistic. This explains why something (policy making) could function well in a place (organization), but not function the same in other places, just because the figures are different… […] Someone (figure) sit in an organization, always being representative of the organization's voice […] so, the representativeness of a figure (patron) in organization become problematized." (Interview CHODG)

Inner power rather than outsider/marginal power to change policy

To successfully accommodate the voicing of a proposal, there should be attention *from within the inner patronage circle*, rather than germinate voices directly at the more marginalized levels or outside the key actors of the patronage circles. There has been a reflection of unequally hierarchical power in the policy community, rather than horizontal power indicating that internal power is owned by the patrons.

From a paternalism lens, there is substantial dependency of the subordinates towards a respected figures' power, when pushing a policy window open for proposals. The patrons have the power to take the risks of making decision rather than the subordinates. The power resides within the prominent figures rather than the units within the institution or the periphery of groups who are unable to step over the hierarchical power to propose a policy change without the approval, endorsement or at least toleration from the patronage groups or their associates. As accentuated by the respondent:

"… (just) as it is, a program (immunisation), that's all, so the burden is on the health officer to deliver it is a program about public protection… <u>because the</u>

figures (patrons) do not talk much about that. […](Interview CHODG)

Decisions designed from mostly within the elites of the highest echelons of organisations are made by the prominent patrons. This account could be reflected in the variant condition of bureaucratic polity, a form of governance where there is no significant organized participation from the people or organizational-driven influence (Jackson, 1978). Some variants of participation exist but it only involves the implementation level (downstream rather than upstream). This is true for immunisation policy where the district health offices are involved only in the technical policy of implementation rather than deciding the policy concept at the national level. The figure elites have captured and controlled agenda setting, limiting policy change in general. In addition, the highly hierarchical organizational structure bolsters the situation of elite power. Quoted from interview with central office respondent:

"It should be like that (turning over the key leaders influence on policy making), but, factually it's not. As I said, the figures are very prominent, in Indonesia, besides structure which has become distinctive challenge".(CHODG)

The importance of Popularity to push the proposal on the policy agenda

Both of the central and regional health offices have the same shared understanding and reflectivity around the account of popularity in policy making in post authoritarian Suharto era. Firstly, it serves to attract attention from the society and policy communities for justifying wide-concern, social capital for gaining collective support. Secondly, the popularity could make the particular groups be recognized within and around the policy community. The goal is to be able to cultivate mass-based support from within the society. Popularity has been used to deliver the agenda by tapping into community sentiments. In essence, a single negative issue combined with religious dogma, to which most Indonesian Moslem adhere, could be managed to obtain significant public legitimacy, and subsequently open policy agenda. There are exertions to persuade (or manipulate) some, if not the majority of the society, to comply with popularized goals and agendas. For example, as illuminated by

the central office respondent:

"…. every politician tries to find followers. If not, they can't become politicians. I don't know who started it: the point is that they look for popularity and followers." CHODI

In this case study, immunisation policy lacks of popularity due to its obsolete policy concept, in addition to the influence of the haram vaccines campaign. It would need an extraordinary effort to reverse the crisis into an opportunity.

The power of popularity, for example, has proven useful to gain attention in opening policy window for a health program in tuberculosis, in Jogjakarta province. Once tuberculosis reached a certain level of popularity among the local policy community, it appeared to easily gather whole support, as a perceived problem to which a specific policy must be necessarily attached. In this example popularity is a tool for gaining political capital that in turn pushes the agenda into successful policy output. Quoting from a district respondent,

"… previously, tuberculosis is very popular issue. And then, after the province successfully made it a popular program, they advocated to the province governor and parliament to make a province regulation…[…]… Look, if we can make similar things (have high popularity) for immunisation, I would be very happy -not necessarily at the national level, just in province level. (DHOJG-BTL2)

The problem debates, a disconcerting characterization of the problem

This theme covers the way Islamic opposition to vaccination is defined as a problem by the health department. In most circumstances at any tier of government level, there is sound disagreement among the respondents, about the way to interpret the issue *as a problem* that needs to be addressed by them. Islamic opposition to vaccination carries diverse meaning to the respondents in the way they defined it as a problem. There were some prominent sub-themes that came from explaining this theme: the disputes in halal assessment, halal labelling issue, problems of ownership, and the indicator of vaccination records as well as geographical considerations.

The dispute in halal definition and haram exceptionality

There were unsettling arguments that originated around what substance are halal and religious exceptionality from taking not-halal substances. For both matters, most of those debates were due to the different points of justification by a variety of Islamic school of thoughts. Because of this reason, the respondents argued that the public carries a variety understanding in scope and scale about halal covering only foodstuffs or being diversified onto non-foodstuff, such as e.g. cosmetics, drugs, vaccines, etc. The problematization of halal coverage is around the unequal shift in thinking about what things should or should not be assessed for halal. Quoted from the interview with province office respondent:

"Everything that enters our body, in their opinion, should be halal. Not only foodstuff. But the funny things is that they only problematize vaccines, and other drugs. When they get sick in hospital and are being injected, they never ask whether the injection contains halal/haram. "What injection do you give to me? Does it contain halal/haram stuff?" They never ask about that. Do any patients problematize that? None. (Interview PHOJG2)

What's more, MUI's used in halal assessment also claim to be unclear by the regional offices, and it appears to have more political ground rather than purely religious judgement. Hence, it carries more difficulties for policy alternatives to be determined exactly to fit with the MUI's interest about the vaccine's halal status.

Since the MUI had given halal certification to particular foreign meningitis vaccine in 2010 for the hajj pilgrim, while the other vaccines had not, the decision of MUI fatwa itself had been a public controversy. The MUI seemed to be biased in the judgement of halal assessment such that its actual motive behind giving the halal assessments could be questions. This in turn posed a question about providing the explanation for halal status of the government vaccines to the lay public, for the local policy level of the immunisation program. The question appears to directed to the MUI's motives for defining halal/haram fatwa. For example, as accentuated in the interview by province health office respondent:

"Actually the (central) government should also aware, for example, about the meningitis vaccine, for the hajj vaccines, why did they become halal labelled? If our regular vaccines are produced locally by biopharma, but don't have a halal label why is a meningitis vaccine from a foreign company being halal labelled, even when we didn't see their making process? That's number one. Number two, the meningitis vaccine that we bought, is new product, but our regular vaccine for babies has been produced for a long time. These new vaccine products have been sought to be halal labelled, but why doesn't the government want to try to seek to make the old vaccine halal?" (Interview PHOJG2)

The demarcation of exceptionality for taking haram substance is also debatable for the use of vaccines. The Islamic criteria carrying religious concession to consume haram elements is usually when a person faced with an 'emergency' condition, such as a life threatening circumstance. Vaccinations, however, are a preventive measure, taken when a person is healthy, not in a life threatening emergency. This incoherent criterion allows for the tension and debates in the assessment of alternatives that could be derived. Moreover, vaccination always required a collective effort to achieve herd immunity. In this respect, vaccine is different to drugs for treating individual life-threatening diseases. Hence, it has the opposite prerequisite in the context of assessing the emergency situation within religious criteria allowing the alleged haram substances to be taken to vaccines. This difference between drug and vaccine is a prominent theme in the interviews with respondents at all levels of the health system. For example, a central office respondent said:

"But what if about immunisation? For drugs people may have choices; the nature is different. If you look at these drugs for example … for example, these are some drugs, a pig symbol, pig' touching, is attached and this one has no symbol, that's an illustration, okay? If the drugs contain pig, there's no other choice; if you want you take it, take it if not, you don't take it, that's your right. But immunisation is different in nature … it's a prevention. It can protect all the Indonesian public IF, and it is an IF CLAUSE, the coverage is more than 95% ... herd immunity. … is that right?" (interview CHODI)

Halal certification for vaccine become a problem for the districts

Halal certification became a source of conflict and argument at the district

policy level, because the absence of halal certification has been emphasized to be the problem for their duty to immunise the local people. The local community has become confused with the status of vaccines because other products have been halal labelled, including some other vaccines, while other vaccines were not. The regional health offices emphasize that the absence of halal labelling of vaccine vials is one of the underlying reason for indecisiveness about immunisation in the community. For example, as explained by the district office respondents:

"They (the public) are in doubt about whether the biopharma vaccine is halal or not. If it is halal, the label should be put on each vial, not only just being spoken (by central office). As with other products in the shop, if there is halal, in the package, there is a halal label. That's it". (Interview DHOJG-SL1)

"If there is no halal label, do you think that this (vaccine) is haram? That is the understanding. It has been twisted by those anti-vaccine people to create the sentiment that it 'must' be haram." (Interview DHOJG-BTL2)

With that unsettling account, the situation developed towards blame shifting at the government level. There were two themes emerged explaining the unsettling way the issue was defined as a problem. The first deals with who owns the problem; the second deals with the indicators they use to define the problem.

Unclear Problem ownership

The theme of unclear ownership relates to the decentralization anomaly. There appears to be an unclear distribution of responsibility in the regional offices, especially between provinces and districts. In practice, the determination of responsibilities between the central and regional offices gives the impression that it is be based upon administrative/bureaucratic boundaries and not based on the policy context. Hence, there are conflicting interpretations of the ownership roles. There is no solid agreement to whom the issue of religious opposition to vaccination belongs, and the regional health office appears to be forced into taking the responsibility (escaping the central health office). The argument behind the escape is that the central health office is too far up bureaucratic ladder to reach for the affected people who belongs to the local

district.

Responsibilities became the authority of the central health office when the issue spans and crosses the provincial territories. Equally, when the issue crosses two or more districts, it becomes the provincial authority. However, contextually some problems which occupy only the central office are not identified by the regional office. In this case, the central office argues that it is not a problem for them to address immunisation nationally. And the central office is inclined to categorise anti-vaccination people at a low policy level and therefore a regional rather than a central office problem. Due to the bureaucratic ladder, UCI achievement is done by regional offices. The implicit language is that it is *the problem of the policy executor* and *not* the problem of the policy maker. Supported by the health decentralization policy, the burdens seem to shift to the regional offices, positing the central office in a 'save' position. As argued by central office respondents:

"So if the question is: "Is it a problem?" Then the problem is from which side. Sometime there are national problems but not in a region or vice versa. In the region the problem maybe severe, but nationally it is unidentified […] It means, if we talk immunisation itself, actually, there is no problem […] but in a local scope, the unit analysis is the district. It is a problem in the context of coverage because it is prominent for the UCI" (Interview CHODG).

"Because the immunisation service is in the regional office, we here (in the central office) are just coordinators only; the one who has problem is the regional health office. If they are not successful in immunisation, if they got "KLB" ("extra ordinary events", or epidemics), the region will get effected That's true, isn't it? Whose people are there? That's their main (local) people. We also feel (about their problem), but we are far (from them), the stage is so far".(Interview CHODI)

In contrast, the district health office argued that the issue of Islamic anti-vaccination should be allocated to the central office. The districts usually cited halal certification of vaccines as the problem and the issue with the MUI came to the central office. The halal certification at national level became an asset for the regional office to escape responsibility. For example, in the interview with district respondent:

"[…] it has to be solved first, the substance of the issue should be solved from up there (the central office) at first, and matched, from my view, the substance of the issue is over there (in the central office), the implementation issue is

here (the district). So, the vaccine issue is up there, in the central office The vaccine refusal claim is about the halal-ness of the vaccine. So, this is the role of the central health office." (DHO-KRH)

With using the 'halal labelling/certification' as the core of the issue, the 'ball' become 'a political stake' hurting the central office but helping the regional health office escape from responsibility for the issue. In other words, they attempted to define the problem in a way that moved and adjusted the burden to somewhere else. This could mean that neither sides were actually willing to take the responsibility. Contriving the reason that it was about executing the immunisation policy, the regional office *kicked back* the problem to the central office, asking them to put the halal stamp on the vaccine vials. As accentuated by district office respondent:

"So finally what we expect from the central government is … that they able to put the halal stamp on all of the vaccine vials. The halal stamp from MUI, so that the public truly believe it is really halal" (Interview DHOJG-SL1)

The 'ball' of the issue seemed to further evolve and belong to a conflict of between elites of the MoH and the MUI, as the Islamic institution for the discretion of issuing halal certificate in Indonesia. The problem *at stake* was between the MUI and the central health office and the regional health office not wanting the responsibility. As emphasized by respondents in district offices,

"Just talk and discuss between MUI and MoH. If it is for our people's need, that's the essence. Why do they have to argue each other (about halal labelling)? Look, we just implement in the field, even if we make policy, our policy is just operational, technical policy in the field. But if it is about halal or not halal, it's not about operational policy, it's substantial policy. That's an issue for up there (in the central health office) […] like I said, it is not our role, it is central office's role. It is a substantial issue, not an implementation issue or execution issue here".(DHO-KRH)

Indicator and geographical profile play an important role as fading factor

One of the main reasons of central office argument, was there was no problem with the immunisation program nationally with regard to the emerging Islamic anti-vaccination movement, which appeared to be justified from the UCI and BIAS indicator for immunisation coverage. On the other hand, as explained in theme: Bureaucratic Disincentives, the central office admitted the low reliability

of the recording system among districts.

The immunisation indicators became the main driver for the health policy makers to decide to take Islamic opposition to vaccination as a problem that needs their attention. It became of interest to policy makers only *when it had the potential to affect the immunisation coverage number*. For example, a respondent in central health office stated that:

"If it causes a decrease in immunisation coverage … of course it becomes a problem that need to be addressed" (Interview CHO-ENIH).

The same applied to the regional office respondent:

" If the coverage report, for example the BIAS, for school children's monthly immunisation of children in class 1,2,3, is supposed to achieve 100% immunisation, we can look from there, at the analysis of the coverage report based on each unit target" (PHOJG1)

Bureaucratic effect and the emerging diseases (epidemics) became the other valuable sign and indicator for the local district offices to oversee the issue as a problem because both affect their way of getting a bad assessment for their work performance. Thus, the idea went back to the obsolete centralised immunisation policy that strives for percentage number of coverage carried out by the regional offices. While the epidemic threat seemed to be minimum, the accentuation was more on whether there was failure or success, in obtaining the immunisation target. As stated by a district respondent,

"If it is about the tendency of developing KLB (epidemics), the issue is not serious … if the burden is looked at from the success of the (government) program the issue is very serious." (Interview DHOJG-BTL2).

Meanwhile, the regional immunisation coverage usually and constantly showed a high record of attainment and they claimed the proportion of Islamic religious refusal of vaccination comprised only a small number. Moreover, the

small number did not support with specific event, such as epidemic disease. Thus, *there was no significant crisis event that was visible to the policy makers, in any level at that time*.

Geographical profile became the other fading factor in the problem to be defined. Due to the scattered distribution profile of unimmunized religious groups, appearing in pockets, surrounded by herd immunity, may prevent the emerged of full-blown epidemics.

Tension in preserving national values

As already mentioned in chapter 2, the other core Indonesian values relate to the 'five core pillars' of the state (the *Pancasila*) which accommodate religion as the first pillar ("*Ketuhanan Yang Maha Esa*"/Believe in One God). The state is not secular, dividing religion from governance and political institution. Religion, (Islam in this case) is *always* part of the political commodity. Changing the national core values appears to be impossible and could emanate from more complex spheres drawn from the beginning of Indonesian history. As highlighted by a central office respondent:

"No, impossible, for Indonesia, it's impossible. It's (the Pancasila) has already been chosen by our founding fathers, and the challenges will be very heavy…[..] well, there will be still, some groups that from the beginning didn't want collegiality, and they will surface" (Interview CHODG)

The ideas and alternatives; MoH indecisiveness and the district's burdens

There were many arguments about how to address and solve the Islamic religious anti-vaccination issue, despite no solids agreements about in *what context* the proposed alternatives should emphasize. Some prevailing themes emerged, however. For example, the penalty model, which involves withdrawing other benefits or rights of the anti-vaccination at people either in the health insurance, social or education sector. Restructuring public education also emerged as a long term development policy. And lastly, the idea of reforming the concept for immunisation policy also emerged.

Most of the respondents had the same shared understanding about the difficulty of addressing those religious communities which opposed

vaccination. This same shared understanding was that belief or other religious factors such as willingness to sacrifice their life at the utmost loyalty to the God, etc, usually contradicted whatever rationality offered. In the subsequent paragraphs, the policy alternatives will be described.

Non decision making

In the central health office, as a national level policy, the MoH's deliberate decision was *not to make a decision*. The MoH's indecisiveness was in part to calm down the lay public, and try to confine it, to inner circles, rather than intensify the debate. The MoH efforts toward the MUI was *not* to make a concession for them (by submitting to the halal certification for vaccines). Rather it was to try to make them just publicly support compulsory immunisation. As exemplified by the central office respondent:

"We try to approach the MUI (Indonesian Ulema Council), to make the immunisation "Okay" […} in principle … what we want of MUI is to write that: "immunisation is compulsory".(Interview CHODI)

The MoH reasoned that the lay Indonesian public, which is majority Islam, will have in their mind that such vaccines will be categorized haram when they fail the MUI halal assessment. And in turn, the failure will create the possibility that most of the public will be more indecisive about immunisation, which will result in decrease the herd immunity.

Reform the concept of immunisation policy adopting operant selection contingency

The central health respondent envisioned that religious anti-vaccination could be addressed, by targeting the cultural and behavioural change. This change in behaviour can be explained by the operant contingency model. Education became the meta-contingency and an increase in quality immunisation service became the operant conditioning. Meta-contingency is the recurring interrelated and interlocked operant lineage contingencies of multiple individuals, having an aggregated product with functional consequences based on the nature of the product (behaviour changes in accepting immunisation)(Malott & Glenn, 2006).

The education system is seen as the meta-contingency because it allowed building individual capacity able to diminish paternalism. Diminishing paternalism in turn elicit individual rationality, fading the culture of paternalistic influence.

The improvement of immunisation service quality has been seen as the operant condition because it would be expected to potentially elicit respect and trust of the government, who are usually perceived as delivering low quality of services. In doing the improvement of services, the delivery of the immunisation program should be changed to more individualized service rather than the existing collective and mass-based services. Individualized service of immunisation would be able to properly deliver the message which would accentuate transparency. This transparency would develop mutual trust and build social capital for the government's immunisation program. This expression is prominent with the background that the existing immunisation service is delivered with a minimum of quality service control and unclear minimum health service standards (or SPM, *Standard Pelayanan Minimum*) in every regional office. Quoted from respondent in central office,

"…. Yes, with the quality of service and (transparency of) information, (religious) followers become rational, and there will be respect for the government. In my opinion, this will be the strongest behaviour change… as I said, at an operational level, the most important thing is transparency. Whatever we do, in the language of medicine language, it's informed consent." (CHODI)

In essence, both of those alternatives was more likely to mimic an ideal, rational and heuristic policy choice rather than offering an incremental change of immunisation policy actually started by addressing their own organisational problem internally.

Unsuitability of imposing judicial penalty

In addition to the above central office's vision in immunisation policy reform, the respondents in regional health offices, as the policy executors, mostly shared the same understanding, of the difficulties of imposing a regulation for adopting penalties or legal sentences for religious refusals of immunisation. The argument was that for religious grounds, imposing a penalty would not be

able to make those with entrenched belief change their mind to complying with immunisation. Most of the respondents also had the shared understanding that religious grounds made the anti-vaccination people not afraid to face death due to disease. Any other penalties models, such as halting their entitlements in education or government health insurance, became highly questionable its applicability to those groups. For example, highlighted by district office respondent,

"It won't work in here applying like that (penalty), their (mind) system is different. …[…] To force something with different condition, that's difficult.(DHO-BTL1)

District's Manoeuvres in the technical policy

The regional health offices had their efforts to address those refusals by delivering a variety of technical and tactical policies. However, none of these approaches seemed to be significantly successful. This section describe some manoeuvre performed by the regional offices.

Using the Sultan and local MUI letter

Jogjakarta province health office made an effort to use recommendation letter from the Sultan and local MUI to encourage immunisation. They considered that those two bodies would have a significant influence on the Islamic anti-vaccination movement in their regions. Their reason was that the Sultan embodies a charismatic king from the ancient monarchy of Jogjakarta whose voice would be obeyed and instructions carried out by the Jogjakarta's people. The respondents stated that the MUI of Jogja was willing to give support to the provincal health offices. Nevertheless, none of the wording highlighted the halal/haram status of vaccination. In reality, this letter was not able to change the minds of those religious refusals to accept immunisation. Due to paternalistic culture of the local people they usually only followed the local *Ulema* they trusted rather than the Sultanate or the MUI. A copy of the letter from the MUI is attached in the appendix.

Approaching local Ulema and finding a precise insider

In central java province, the head of the health province office approached the

local MUI leaders to discuss immunisation with them. The same discussion emerged that the local Ulema had debated the pig derived enzyme being used in the process of vaccine productions. Opinion had polarized among the Ulema, in examining the vaccines. The capacity of the regional offices to lobby the local Ulema was very crucial. It was important not to oppose their opinion but follow their line of discussion line and provide certain detailed information about immunisation. Despite the conclusion of discussion might not be in line with the health office's intention, the important message about immunisation could be delivered to their community.

In most of district health offices, the similar finding from their approach to the local Ulema was that they were *indecisive* about vaccination. This indecisiveness had made the local community in doubt about being immunised. The indecisiveness is related to, the paternalistic cultural background, as previously described that relied on a figure's opinion to make a personal decision. As exemplified by a district respondent:

"Yes, but it's not easy to influence them. On some occasion we attend to their religious leader. If they indicate that they actually don't agree with us, they just say: "I leave it to my follower whether they want it or not". Automatically, the follower becomes confused, unless they said: "Come on, let's get vaccinated" That's a clear message. But it looks they are ambigious, not clear. Behind them, but we don't know what actually the leader said. Maybe they said: "don't get vaccinated".(Interview DHOJG-BTL1)

In KRH district, the respondents had an understanding that the key to changing the behaviour of those refusing to accept vaccination was by approaching the considerable significant '*Aamir*' (religious leader for that particular community) who was willing to internally lobby to the Ulema groups to shaping their view about immunisation. It seemed difficult to find a dual role figure, representing both the ulema's and the health department's interests. However, having an Aamir lobby could be promising, to some extent, because the message originated *from within* their own l people, who would have considerable attention of their ulema groups, rather than an outsider. The district office made an effort to find a precise person from within their own community whom they

could make an inside campaigner.

"We would like to find someone, a community figure, whom we can "fill" in. But the process to find this figure is very hard, especially for those groups; it is not easy to get the "Aamir" (religious head man). It is the problem. We have tried to find a cadre, whatever the name, there is a mediator, sourced from their own community, and then we make him campaign inside their community. This is our policy here." (DHO-KRH)

Difficulty applying individual informed consent

Jogjakarta Health Province had made another manoeuvre in the implementation policy, by using individualized informed consent for immunisation during the in-school immunisation of children ('BIAS' program). The BIAS program had usually been performed with collective informed consent. The children at the primary school in the first to the third year classes were been given the informed consent letter for their parents with the consideration that after they read the immunisation letter, they would be willing to sign the consent form, allowing their children to be vaccinated in the school by the district health officer. This was supported by the Javanese culture in which usually the local people are reluctance to avoid an offer from other people, in this case, the government immunisation program.

However, the responses were totally opposite. As claimed by the district office respondent, the letter that they sent had been used as a legal tool by the religious parents to avoid immunisation. This opposite response was a backlash at the district office for applying individual informed consent to address immunisation refusals.

"The hope is like this … if the informed consent is given and they write "no" and what their reason is, they will be reluctant to say no. That's the hope … factually, they are not, it did not happen!!! It became boomerang; they are given informed consent, but this becomes their justification to say "no". that's last year, so this year, an informed consent form will not be given again. Actually, according to the procedure, there is no informed consent." (Interview DHO-BTL2)

Community engagement and mother's empowerment

The restriction for immunisation usually had been understood to be came from

the head of the house, the husband (father), the wives having to obey him. The respondent comprehended that the mother did not always agreed with the husband, and looked for vaccination furtively from their husband. The district tried to make the health officers understand this as a chance, and to make them and the community ready to do secret immunisations for mothers, carrying their babies hidden from their father's surveillance. Quoted from the interview in KRH districts:

"But this is good signal, that the mothers (wives) don't want to be like this; but their husband is in dominant role; the wife should obey the husband. Some play I hide and seek with their husband. We are trying to find a strategy and a way that if for example, we should play like that we can develop a community that is also prepared to "play hide and seek". (Interview DHO-KRH)

Strengthening inter-ministerial coordination.

The district health offices suggested that the Islamic anti-vaccination issue would not be solved only by the regional government. The issue itself carries national leverage, such that it should not be ranked on an administrative ladder scale. The non-alignment of a hierarchical government institutional structure in a decentralized system, affecting an incongruent flow of money, authority and information, could make considerable effort to manoeuvre technical policy to solve the issue. Inter-ministerial coordination among the Ministry of Health, Ministry of Education, Ministry of Home Affair and Ministry of Religion is mandatory to deliver an agreement on technical policy, including Islamic school. Without such higher institutional arrangement, the regional office is considerably limited in addressing the issue.

The overriding internal constraint

This internal constraint reflects some internal factors supporting the failure of a change to government health policy in general, including but not limited to immunisation policy.

Pre-allocated national budgeting

The budget is an old and ongoing issue. In this study, the budgeting structure refers to the fund that have already been pre-allocated by the National

Indonesian Constitution (amended 1945) which gave limited space for budget lobbying or manoeuvring. Constitutionally, 20% of the budget should be allocated to the education sector, leaving the other sectors, including the health less than 10%. Because of this law, the central health office has argued that the national budgeting constitution has made it difficult to accommodate flexible debate flexibility and provide space for other sector's needs, including health.

The message is that the national budgeting model constricts for changing immunisation policy. This preallocated budgeting model accounts for one of the important variables contributing to the policy silence, i.e. discussed in earlier section, the central office is reluctant to push for changes to the immunisation policy, due to restrictive constitutional style of budgeting. Quoted from the interview with central office respondents:

"… Whoever is the president, in the context of the budgeting structure, policy won't change, because planning and budgeting policy hasn't changed … education budget 20%, health 5%,, wage 50%, what can I say? … the budget has been already divided like that… so whoever the president, they should allocate 20% for education" (Interview CHODG).

This budget predisposition might also explain the deliberate non-decision making of the MoH towards the MUI's interest to submit the vaccines for halal certification, which could consume and disrupt the budgeting of the health department.

MoH's lacking of political capable staff

A central health office respondent admitted and understood that the health department did not have human strong political Islamic figures capacity respected both by the Islamic council and as health professionals. The expectation of having such strong Islamic figures, is that the voice from health department could be trusted by both Islamic groups and the medical profession. In this way, the MoH would have the political capacity to address Islamic group interests at a national level.

However, the structure in Indonesian health minister is still dominantly originated from the group of senior doctors in order to be able to hear the voices within the medical associations, of health professional, hospitals pharmaceutical groups. Hence, the position of the health minister usually has strong internal political credentials, but lacks external political capacity, in this case, in response to the Islamic council.

Concern for international agreements

The central health office respondents acknowledged the importance of international agreements, which in this case, is the Millennium Development Goals (MDGs). Acknowledging the importance of the MDGs created a sense of international political obligation for completing and achieving the target of immunisation coverage set for Indonesia. With this international obligation background, it is plausible that the central government is reluctant to give the districts authority to create their own immunisation targets, and isolates them to implementing technical policy. Giving a more authority for immunisation to the regional offices might risk incompletion of immunisation program nationally. As accentuated by a central office respondent:

"No, it can't. The districts have authority, but it's technical authority. If we have signed the MDGs which binds 187 countries, the government should say: "I have signed it". We live in the world, not at an individual level. Individual choices can be made, for those choices, but at the national level, we can't."(Interview CHODG)

Concluding remarks

This chapter has described the inductive themes in a basic narrative of the respondent understandings. Indonesia immunisation policy has been understood to be outdated with dictatorial characteristics from the central health office. This has made it difficult for the regional health offices as the policy executors, particularly when decentralization policy exists and religious opposition to vaccination prevails. The regional offices only have room implementing technical policy, and the core of the policy is to achieve the required target of herd immunity. Moreover, the bureaucratic disincentives and

decentralization anomaly exert discordance among the flow of authority, information and funding. This discordance has made it difficult to plan, regulate, and evaluate immunisation policy as central elements through a comprehensive system of management and control.

At the national level, Islamic political manoeuvres, of the political religious elites, especially the MUI requesting halal fatwa and certification for vaccines have been comprehended as a way of making rent seeking behaviour with the MoH. In this game of politically manoeuvrings, the trypsin enzyme is the ball in play. At the regional level, the religious opposition to vaccination is also understood as motivated by the regional radical Islamic movements.

The culture of Javanese paternalism has been understood as the crucial factor in nurturing local religious leaders to inform communities about considering immunisation. Some insider refusals of immunisation also exist in the health departments. The paternalism of the Javanese culture has also been understood as a contributing factor power within government organisations. The organizational power within government reflects the practice of patronage in which a loyalist has informal followers. Both the highly hierarchical government structure and these cultural variables prevail as impediments within the system to delivering policy proposals. And the hierarchical organizational structure has made less effort in checking the balances of power and authority within the health department, such that it could become the bottleneck to policy proposals. Moreover, limited reliable indicators from data recordings also supports the difficulty in framing and categorizing the problem of religious opposition to vaccination in terms of a definite policy response. Putting a problem into the similar category would make the subsequent policy response erroneous. This had been proven by the inconsistency of the policy alternatives offered.

The existing policy for addressing religious opposition to vaccination has surfaced in two segments. The lower segment, which is the regional offices, has dealt with technical policies, while the upper segment which is the central office, has remained silent or non-decisive and failed to change the basic

foundation of the policy.

Political popularity was found to be the main tool for gaining social capital to attract the attention of the policy community about the importance of Islamic opposition to immunisation despite not stipulating a clear position. The national value debates, national fixed budgeting policy, and international agreements were found to be the prominent constriction factors in changing the health policy, including immunisation policy. The absence of figures representing both the Islamic community and the health profession within the MoH, in conjunction with the already inflexible national budgeting was found to be a barrier to the MoH having the capacity for political manoeuvre supporting health policy.

This data was understood in the context of the invisible cluster of the policy community, according to Kingdon's criteria, comprising of the health bureaucrats in three levels of governance. These bureaucrats experienced the 'come and go' of political appointees made by the elites. This finding has offered a reflection of the visible clusters, comprised of political elites, correlating with the theoretical perspective of the Indonesian political literature.

The next chapter will discuss the deductive process, moving beyond the data findings to explain them with Kingdon's theoretical framework which will expound a more robust analysis.

Chapter 5 Discussion and Analysis

5.1. Introduction

As explained previously in chapter 3, the Methodology, this chapter covers the deductive process of building an explanation from the inductive themes using Kingdon's theory of agenda setting.

The chapter will be divided into two parts, the first part (section 5.2) will explain the inductive themes according to the Kingdon's categorization as ascribed in table 5.1. The second part (section 5.3) will analyse more deeply in 'how to explain actually what happened' about developing health policy that respond to Islamic anti-vaccination, by critically and reflectively interpreting some peculiar themes commensurate with the contemporary Indonesian political setting.

The analysis of data may not be generalizable widely but the use of theory may lead to some transferability in other similar country settings with some observed limitations. This analytical approach, as mentioned in chapter 3, does not propose a well-defined highly technically procedure that can be used by other researcher. Rather it is a result of the author's reflectivity and use of theory and supporting scholarly materials, applied to the data (Dixon-Woods et al., 2006).

5.2. The Themes categorized using Kingdon's theory.

The table below (table 5.1) categorizes inductive theme or sub-themes into Kingdon's categories. Either the sub-themes or themes are categorized to the problems, policy, politics, policy window and the entrepreneurs. Some of them overlap into several categories because it is difficult to demarcate each category.

Kingdons' derived category	Inductive theme/sub-themes
Problem streams	The problem debates. A disconcerting characterization of the problem Regional anti-vaccination. A fragmented and unnoticed practice Bureaucracies Disincentives
Policy streams- the primeval soup	Characteristics of Indonesian immunisation policy. The ideas and alternatives. MoH indecisiveness and district's burdens Perplexing decentralization, undeveloped district empowerments The overriding internal constrains Tension in preserving national values
Politics streams	Political charge for vaccine halal certification
Policy window- Entrepreneurs	Health Minister and President Leadership The importance of a dual figure role in the campaign for immunisation The importance of popularity to push the proposal onto the policy agenda Paternalistic rationality in organizational practice Inner power rather than outsider/marginal power to change policy Pragmatic popularity as a political capital

Table 5.1. categorization of inductive themes into categories derived from Kingdon's. The policy window and entrepreneurs were merged because Kingdon also includes the entrepreneurs within the context of policy window

and the data did not indicate a clear separation of the two.

5.2.1. Problem stream

Problem definition is basically a "*perceptual entity, interpretive element*" (Kingdon, 2002). From the three main themes allocated in the problem stream, there were two types of problems between the national and regional level. However, it was difficult to draw a causal relation between the two. At the national level, the problem was around the politics of halal certification for the vaccines proposed and brought by the MUI. The political streams eventually become *the* actual basis of problem streams. However, at the regional level, the problem appeared to be blurred. It was difficult to define between the political stream and the problem behind the religious opposition to vaccination. The uncertified halal vaccines appeared to be a supporting account of the regional Islamic radical community to oppose vaccination rather than the original cause, rooted from the allegedly religious 'dirty' vaccine processing using porcine-derived trypsin.

Bureaucratic disincentive supports the ambiguity of the problems streams at both the national and regional levels to be seen as vanishing rather than solidify developing. The first fading factor, the indicator numbers (UCI and BIAS statistical records) did not show a 'strong push' for retaining the attention of the policy makers. These weak indicators could be related to the bureaucratic disincentive factors evidenced by unreliable recording system. Not all of the districts provide anti-vaccination records, in addition to the difficulty of detecting the refusals. Only during BIAS program, the districts usually identified those vaccine-refusals people. In general, from the two provinces, the immunisation reports usually appeared to record good immunisation coverage.

The second vanishing factor is related with the problem of ownership due to the decentralization anomaly. Decentralization has made that the responsibility of whom should take the problem into account remain obscure. This decentralization factor also might support the incomplete recording and data archives attributable to incoherence in the line of authority, information and

money. The immunisation policy is centralized while it is implemented in a decentralized health system.

The third vanishing factor is related to the difficulty of categorising the problem into a settled classification. From the three tiers of government, the problems seemed to be difficult to define whether it was social community, political, one of policy implementation problems, a religious/philosophical problems or other category of problem. In general, the respondents tried to categorize the problem of religious opposition to vaccination by not making their own authoritative territory being responsible for the anti-vaccination issue. The analysis of the respondents' attempts to categorise the issue of anti-vaccination showed shifting across the tiers of government. However, none of the categorization came into a settled category. This failure to address the categorization of the problem religious opposition to vaccination supported it diminishing from the attention of health bureaucrats.

The fourth vanishing factor, is that there were a minimum of epidemics to support the problem gaining attention. Epidemics surveillance became the DHOs (District Health Offices) '*real-time indicator'* to traditionally define the problem of religious opposition to vaccination. When none or very few vaccine-preventable diseases surfaced in the community, it was assumed that the immunisation coverage had reached the herd immunity, protecting the unvaccinated cluster. When a single case emerged, especially close to the territory of traditional Islamic villages or compounds, it was assumed that those opposing vaccination had risen to a level that the situation became attentive problem.

Thus, without a reliable indicator at hand, there was simply no tool to measure the burden of opposition to vaccination on the policy makers. Rather, their consideration was only made by *monitoring the field situation* directly and other informal evidence when the epidemics were identified.

Epidemics must develop in an incremental fashion, disseminated from patient to patient and built up to a proportion to become a crisis that requires attention. This would eventually take time and not all cases were detected quickly at a

single time. Hence, an actual potential agenda issue can fail to hold the government's attention due to the absence of epidemics that could push them into the agenda at an earlier time (Kingdon, 2002).

Henceforth, the Islamic opposition to vaccination was mostly excluded from being an agenda priority in all three level of governance. The CHO (Central Health Office) respondent admitted the issue was put in their policy agenda but in respect to the 'political problem' between the MoH and MUI. This political point will be described in detail in the politics stream below.

5.2.2. Politics Stream

The politics stream involves MUI's politicization of the religious concern with vaccine un-halal status, that charges the MoH providing porcine derived trypsin vaccine. As previously described in chapter 4, the political charges were not derived from purely religious reasoning but involved the logic of money politics. The blockage between the MoH and MUI happened because the discussion between them was practically constructed upon reaching a political consensus rather than classical persuasion of the MUI by the MoH. The MUI tried to impose the cost of vaccine halal labelling through private enterprise rather than a public scheme, a single religious organization collects the contributions and the MoH that foots the bills. The practising political play to press the MoH for rent-seeking practice by proposing ongoing halal vaccine certification, may be seen as the new emerging oligarch to capture power sharing as a new interest group in post-authoritarian Suharto Indonesia when defining oligarchy as politics of wealth defends[5]. The remaining question then, if it is an oligarch, is the MUI an organized political forces? In this study, it would be too premature to define it as such, because, firstly, at the regional level, the way of MUI behaves, according to the PHO (Province Health Office) and CHO (Central Health Office) respondents, is ambiguous and indecisive. The MUI still supported the health departments to deliver the immunisation program despite there being no explicit halal wording in the MUI statements, instead,

[5] Oligarch is a set in a larger structural framework of a structural political economy (Winters, 2013). Oligarchy in this study is understood in the context of capitalist development, exhibited in late developing countries.

by giving the decision to immunisation back to the community. Secondly, a calculation of support and opposition was not assessed as part of this case study. However, the fact that the decision makers finally come and arrive in an assumption indicating that the power balance does not exist. The imbalance is because of the dominance of moslem adherents in Indonesia is at the stake, jeopardizing the national immunisation coverage. This threat was emphasized by the CHO respondents as opening a Pandora box because it would offer religious validity to opposition to vacination.

The third reason why it is immature to define the MUI as organized political forces come from the higher context of Indonesia political institution, i.e. there is no permanent opposition chambers. The coalition and opposition parties in parliament could shift their alliance map against the president and the cabinet (Crouch, 2010). Thus, the inexistence of formal oppositional chamber might be an obstacle to define a stable and visible organized political forces, including from the religious based opponents. Moreover, at the time of this study, the indecisive leadership style held by Susilo Bambang Yudhoyono (SBY) presidency has arguably contributed to the MoH's recalculation of choice and alternatives to the MUI (Fealy, 2011). The SBY leadership was recognized as very cautious, sensitive, and hesitant in relation to crucial decision making. He was most likely avoid conflict with major political forces and not go against the wave of public interests, being keen to keep step in the populist policy and unwilling to make unpopular decisions. Hence, substantive issue rarely invoked in the cabinet meeting (Fealy, 2011; Tomsa, 2010).

5.2.3. Policy stream, the primeval soup

Kingdon (2002) explains the soup of alternatives and ideas as the natural environment of the policy community in which the alternative of policy is germinated similarly to biological natural selection. Some ideas float to the top of the soup and are able to survive, while some others sink.

According to Kingdon's idea of primeval soup, the inductive themes can be included into two main policy accounts: non-decision making and low survival of suitable alternatives. Despite suitable alternative for changing national

immunisation policy in regard to religious opposition to vaccination, the decision at hand appears not to change the existing policy, reflecting indecisiveness.

5.2.3.1. Indecisiveness.

The issue of non-decision making can be addressed at two different problem levels: indecisive towards MUI's political raid of the MoH and indecisive with regional in response to religious opposition to vaccination. The MoH appeared to choose *inaction* towards the MUI's political bargain and at the same time by also not proposing any change to the existing national immunisation policy, specifically addressing the regional opposition to vaccination. This choice not to act, or policy silencing, in turn, affected the lower implementation policy level in the DHOs struggling by developing their own variety of technical and tactical policy, as described in chapter 4.

There were other potential explanations for inaction being a deliberate choice. Firstly, the indecisiveness might relate to the fading factors come from the weak statistical indicators described previously in the problem stream. With unjustified indicators, the regional anti-vaccination movement seems to have faded from the attention of elite bureaucrats and therefore unable to reach a solid stable stream. Secondly, with the unclear way to define the problem stream, in turn, a realistic notion of the policy stream was really difficult to conceptualize. What policy type should be developed and operationalized when problem category is obscure? Thirdly, the inaction can be related to the account of internal constraints, particularly the MoH's lack politically capable staffs, in conjunction with the pre-allocated measures of inflexible budgeting law.

5.2.3.2. The low survivability of ideas

Looking back to Kingdon's framework, an alternative has to be able to survive in order to get a neat and firm position in the policy stream. The alternatives should be technically feasible and valued as acceptable to avoid fading (Kingdon, 2002).

As explained previously in chapter 4, generally the best policy alternative is for

the national immunisation policy to be changed to accommodate more individualized immunisation, rather than the existing collective oriented sweeping-catchment based service. However, this policy alternative appears to be difficult to meet technical feasibility and value acceptability. The decentralization factors arguably contribute to hinder feasibility because, obviously, not all of the regional offices have an equal interest in applying a more individualized immunisation service. The significant feasibility question is to what extent the CHO could grip the DHOs commitment to change the immunisation policy in a decentralized system of funding and authority. The most plausible approach in answering this question is the way in which decentralized fiscal or budgeting could be tailored in 'conditional clause' to accommodate the CHO's policy interest. Bureaucratic disincentives are arguably another impediment to policy change given the typical ineffective civil servant working culture. Eventually, it arguably takes an enormous effort of inter-agency coordination between the MoH and other ministries, such as the ministry of religion, education, and interior. The other technical feasibility impediments are due to the internal MoH organizational structure in which civil servant lack political competency having dual or multiple roles which would otherwise give them not only internal power, but also external lobbying skills acceptable to outside stakeholders.

As mentioned above, the survivability of a policy proposal also demands acceptability in terms of socio-cultural value. In regards to Indonesian values, as mentioned in literature review, *Pancasila* (national philosophy) does not partitioning religion from the government and political arena, as is the case in secular state (Ramage, 1995). The CHO respondents acknowledged this reality and it appeared very difficult to accommodate and balance religious interests with secular interest because every policy alternative touching religious issue could escalate the political stream.

Another consideration in the survival of alternatives is equity (Kingdon, 2002) among minority religious groups in Indonesia. The choice of eliminating non-porcine enzyme in vaccine production does not guarantee that it is acceptable for other religious groups, hence it did not have the same equity among other

minor religious adherents. For example, cattle, rather than porcine derived enzyme, might invoke protest from the Hindu groups. This policy effect is admitted by respondent in central office and preventing them from taking such a policy into consideration.

The unmet feasibility and value acceptance means no solution is offered to the case making it difficult for the policy stream to move on in agenda setting. For example, even if the issue ignites attention, there may still no viable proposal attached to it. The likelihood of a problem to achieve a decision agenda is increased if it has a viable solution. However, in this case, no viable solution exists explaining why the issue remain on the agenda but does not get more attention (Kingdon, 2002).

With the prevailing difficult dispositions, the workable policy alternatives are not new strategies (e.g. comprehensive immunisation policy reform) but mostly cover local technical policy manoeuvre through non-coercive measures by the DHOs. Much of the DHOs strategies for immunisation programs as elaborated in chapter 4 were keen *to test the water of public religious attitudes* towards immunisation. Hence, workable immunisation policy alternatives are more directed towards practice applied through intuitive experience and tacit knowledge by the local policy makers in each regional office.

5.2.4. Policy window-Entrepreneurs

5.2.4.1. Policy window:

In this study, the policy window, or the opportunity to launch their pet immunisation policy to change or to drive attention to immunisation policy with regard to religious opposition to vaccination, seemed mostly to be closed. Kingdon (2002) accentuates that the policy window opens usually due to a change in the politics stream (for example, a people shift in officialdom). Among the three stream, According to Kingdon, the political stream more prominently affects the other two streams (Kingdon, 2002). However, in this case, it appeared difficult for the nature of problem and policy stream to make a solid and clear articulation. The problem stream appeared to fade and the criteria of survivable and equitable solutions dealing with religion usually

became very fragile, fragmented and cumbersome as a result. Thus, the efforts would arguably be difficult to change the national collective centralized catchment based immunisation policy into the best alternative of a one-to-one service.

When the amount of problems and alternatives flowing overwhelmingly in the agenda funnel, the agenda become heavy and vexing for the policy makers, and thus seized by '*its own weight'.* If the subject appear to be too serious in the mind of the policy community, Kingdon tells us, supervision during the agenda process may be deficient and the risk would be uncontrollable, hence the window may be deliberately closed down in the outset (Kingdon, 2002). As a result, in this case, the resultants of the closed policy window became no policy change and eventually over burdening the regional health offices, particularly the regional office's efforts in the form of experimentally manoeuvring technical policies. Although some manoeuvres in technical policy are done by the regional offices, it is not a policy change, and they are still done as part of the same centralized immunisation policy. While the problem of Islamic opposition to vaccination has successfully pushed into the government agenda at the CHO level, it has failed to result in policy change.

5.2.4.1. The Entrepreneurs

According to Kingdon the policy entrepreneurs should be the ones who are willing to invest their time, energy, resources and political capital to change immunisation policy to address religious refusal of vaccination. An entrepreneur should define the problem and be able to tailor policy to a particular territory despite it will hurt the other side. However, no explicit potential entrepreneurs surfaced during this study. There are some explanations which explains why no entrepreneurs surfaced.

When looking back at the feature in each streams, all three streams appear highly unfavourable for couplings and therefore the policy window closed. Thus, to change each stream to become favourable for opening policy windows is tremendously difficult. The leadership of the MoH at that time is the key for the coupling of the stream and opening the policy window. At that time,

the minister of health herself, Dr. Nafsiah Mboi, despite showing a strong iron style leadership preferred to choose a non-decision making. Moreover, the lack political capacity in the MoH organization because it is mainly staffed by medical professional, arguably explain its inability to bridge and buffer the religious groups.

Overall, available policy space is only in at the lower level, within implementation policy level, through fragmented efforts of regional health offices. They implement scattered technical policy manoeuvres by practising their own tacit knowledge rather than comprehensive national policy reform.

In order to grasp the better understanding of the inexistence of policy entrepreneurships and the closed policy window, the evidence indicates the importance of considering political culture that operate in policy community ascribed below.

5.3. Agenda setting and the influence of paternalism and populism.

While the above Kingdon's guided-analysis may rationally explain *what happens* in the failure of the agenda setting process, such as the inexistence of policy entrepreneurships, and the closed down policy window, the evidence also suggests the analysis to acknowledge the 'primeval soup' of the domestic policy community where the agenda setting process actually takes place. In essence, agenda setting relates to national political culture and the operation of *power*. This further analysis may further explain *how* those failures happened to change immunisation policy in this study with respect of native characteristic of policy community. Specifically, three inductive themes, the paternalism, inner power, and popularity, might provide a further precise clues for deepening the analysis and reflection from the Kingdon's theory in the area of the *policy entrepreneurs, policy window and the coupling of the streams*. Table 5.2 below provides the succinct assumptions underpinning the value reflection between the Kingdon's and those of peculiar inductive themes.

Kingdon's theory	Data inductive themes

The entrepreneur's qualities: *The suitable categories of entrepreneurships contributed to succeed the policy agenda is the one who claim that their voices could be heard* (Kingdon, 2002 p. 180-181) Coupling of streams: "*These proposals are constantly in the policy streams, but then suddenly they became elevated in the government agenda because they can be seen as solution for a pressing problems or politicians find their sponsorship expedient*" (Kingdon, 2002, p. 172) Policy window-entrepreneurs "*Basically, windows open because of change in the political stream*" (Kingdon, 2002, p. 168)	Inner power rather than outsider/marginal power to change the policy Paternalistic rationality in organizational practice Pragmatic popularity as a political capital

Table 5.2. The value reflection from Kingdon's account of entrepreneurships, and policy window (coupling of the streams) in inductive themes.

As discussed in the literature review, the political culture and ideology differs among countries and influences the participation in public policy making. Each country has different democratic and political systems affecting the public policy making (Walt, 1994a). In this case, reflection on contemporary Indonesian politics and democracy background is an important variable for explaining the three inductive themes. The reflection may explain and give *a more accurate assessment and understanding of the stipulation of the actual possibility for coupling of the streams and opening the policy window*.

Because Kingdon's work on agenda setting was developed only in the United States and in practice is drawn from that federalist government system, Kingdon's theory is contextualised within a modern western liberal democracy setting where power is more distributed. Therefore, individual actors may find it difficult to dominate the agenda setting process. Despite his work not

intending to apply seamlessly outside the US, it has been applied to developing countries (Gilson & Raphaely, 2008; M. J. Hill, 2009). However, adoption of Kingdon's theory without considering the actual power structure and its associated cultural characteristic of the particular setting in which it is applied, may miss the precise analysis of agenda setting. And eventually, the adopted theory may imprecisely explain the real situation to different power characteristics from the context in which Kingdon's theory was developed, influencing the agenda setting process. Culture has influence on power because essentially policy making related to power and power is often culturally bound (Buse, May, & Walt, 2012; Torelli & Shavitt, 2010).

5.3.1. Indonesian paternalistic culture and the patronage network as the primeval soup of the policy community

The findings from this study suggest, as illustrated in table 5.2., that the Indonesian paternalistic cultural landscape may plausibly explain the difficulty of non-established figure operating the agenda setting process. The characteristic of paternalistic power within the 'primeval soup' of the policy community arguably influence and affect policy entrepreneurships.

To illustrate the need to take specific power into account when applying Kingdon's theory, the Indonesian paternalism dimension had been specifically created and structured according to the binding family system of father-ism or '*bapak*'-ism derived from Javanese culture (Antlöv, 2005; Niels, 1994; Pye & Pye, 1985). The Javanese are the dominant culture politically and inseparable with the Indonesian state history. The psychological relationship was mirrored with family ties, where father ('*bapak*'), as a patron, taken care of their clients ('*anak buah*' or children). The unbreakable bonds initiated with patrons, who are in favoured positions, are constantly surrounded by people who craving for protection and declare loyalty to the patrons. The patrons cultivate the loyalties from the sub-ordinates ('*anak buah'* or the staff followers), while the *anak buah* often force the patrons to undertake risks in decision making to gain more power and influence that in turn the *anak buah* also get benefit from them. Patronage relation is basically denoted a particularistic dyadic ties between patron and clients forming a pyramidal structures comprised of *informal*

promised relations between patron and clients. (Eisenstadt & Roniger, 1980).

In Indonesian context, this paternalistic landscape had become the main source of patronage network practices within Indonesian government (Blunt, Turner, & Lindroth, 2012). The informal structure of pyramidal bonds is emulated in its formal organizational structure, with the head of departments running the staff from membership of both systems. When power is personalized, authority becomes privately owned. This kind of vertical solidarity pattern provide a *"pyramid of informal but enduring"* vertical cohesion (Pye & Pye, 1985). The effect is to reinforce loyalty to the individual patron rather than to the organization or institution. Religion and paternalism 'push from behind' the landscape of governance feature and managerial so called as 'patronage democracy' (Blunt et al., 2012). The structure of the paternalistic power is best pictured as a web with branched of encompassed and encompassing hierarchical power configuration and rays of power and influence spreading out from the central figures (Errington, 2012). Compared conceptually with Hofstede's framework, Indonesian paternalism is consistent with the value of high power distance, collectivism, and uncertainty avoidance (Hofstede, 2001). These three values are in concert with the acknowledgement of paternalism arguably resonate with and explain subsequently the inductive theme of 'inner power' as the centre of entrepreneurships in table 5.1.

5.3.1.2. The entrepreneurships and coupling of the streams, the inner power from the patrons

To explain the relation of policy entrepreneurships to the Indonesian cultural context, it is important to recognize the broader macro political context post-authoritarian Suharto era in which the domestic Indonesian policy community operates. In authoritarian power structure, the agenda setting may obviously be operated with and controlled by the access, mode, and capacity of policy entrepreneurs to penetrate its single central power. Safe motherhood policy is one of the best case study example for this scenario, in where a domestic civil servant could run as a successful policy entrepreneurships during authoritarian president Suharto in charge (Jeremy Shiffman, 2003). However, with the fall of authoritarian power, the establishment of liberal-egalitarian power may not

automatically replace the existing political power institution. The internal character of power structure may not automatically accommodate the development and transformation into egalitarian power infrastructure. The hierarchical paternalistic structure may explain the difficulty of non-establishment figure to find their ways to the mainstream power. Despite the replacement of authoritarian power landscape is enable for accommodating new participants in policy making, but it is in the form of 'elites capture' in where their power boundaries are blurred. This reorganized and disenfranchised power structures have been reflected on and interpreted by political theorists such as the neo-Marxist camps in term of a patronage-driven oligarchy power paradigm (V. R. Hadiz & Robison, 2013). The power of patronage-driven oligarchy groups is so strong that substantial policy proposals may be difficult to convey without the approval, endorsement, or at least being tolerated by those of the oligarchic patronage power structure and their associates. This neo-Marxist school of thought implies that the policy proposal should be sponsored by and from patronage elites or their proxies to climb high in agenda setting. Any demands from the individuals or outside patronage-web power institution can only be *'piecemeal'* (V. Hadiz & Robison, 2005)[6].

In contemporary Indonesian political culture landscape, the play of power struggle is not to replace or co-opt or to establish formal visible opposition chamber but "*to sneak from inside, participate and influence from within the power system and struggle within it"* (Mietzner, 2012). General civil society may actively participate to promote their causes not from the margins of society as visible outside or separated groups but by "*using patronage-driven system* or *approaching from within the power centre of political institution".* By entering mainstream patronage power, the policy entrepreneurs could not only lobby *for* policy proposals but also *against* the existing policy. (Mietzner, 2012).

[6] As an additional information, the contemporary patronage politics of Indonesia is eminent in the way of political party established upon a sponsor of a rising figure rather than build by a shared ideological basis. For example, the rise of personalized political party by the former president Susilo Bambang Yudhoyono with his Democratic Party. In macro political context, the Indonesian political parties are reflected with weak bonding of shared ideological platform and it had made less loyalty toward political party ideology as a robust institution and grown into 'intra-party' loyalist group and the rise of new local patron elites (Ufen, 2008).

Consistent with the inner power inductive theme, the key message when understanding the paternalistic behaviour in respect of agenda setting is that, policy entrepreneurs from outside of the patronage networks should be able to visibly incorporated and performed *within* the power of mainstream patronage structure rather than from the margins of the power.

Policy entrepreneurships may involve multitude actors and who are able to select which suitable and appropriate vehicles of patronage machinery or oligarchic power to put their preferred pet policy on the agenda. In relation to immunisation policy, the variety of alternatives in immunisation policy which emerged to address the religious opposition to vaccination, while entrepreneurs may gain access to 'inner power', but none succeeded in making policy change for immunisation. Much of all of this strategy is arguably correlated with *popularity* as the basis of political capital.

5.3.2. Popularity as a political capital.

The evidence indicates, as ascribed in table 5.1, that popularity play its role in agenda setting. This case study guides on the importance of populist logic to be attach to a policy proposal in the journey of agenda setting in concert with Indonesian political context.

Popularity, or populist logic in this context, may be considered as a social agency to *reflect higher interest on behalf of the whole society interests, that in this case, such as using publicity of 'un-halal' vaccines.* This type politics of populism arguably invoke as a *vox populi* (the general will/voice of the people), an appealing factor to obtaining popular legitimacy and mass-based support. Politics of populism has been utilised by many political actors word widely and epitomized from four general characteristics: stressing as the representative of the whole populace, castigating the ruler, assuming people as a uniform-homogenous object, and declaring a state of crisis (Rooduijn, 2014). The case of un-halal vaccine has arguably fulfilled the four criteria because the elite religious political actors has successfully claimed their existence as the emissary of the majority Indonesian moslem people, condemning the MoH in distributing un-halal vaccines, pretending that the whole Indonesian moslem is

a homogenous entity against un-halal vaccine, and stating a critical situation in the need of halal labelling and certification for vaccines.

In respect of being the representation of the whole populace, populism is a vague and latent agency in the relationship between the 'elite' and the 'people', but fail to explain the actual heterogeneity of the people, even within moslem people themselves. The ambit of populism is not appeal to the 'actual people' (or the whole moslem people, in this study) but demands from a such cumulative dissatisfactory degree rose to that of demands of 'logic of equivalence' dominates (Stanley, 2008). The vaccines must meet with equivalence demand of moslem people, having certified halal vaccines, to provide social protection for the majority Indonesian moslem people. Despite the unsatisfied demands may conceivably bears only with 'individuals' or few elites, the elite political groups engage in collective-solidaristic expression sufficient the populist logic to occurs, attempts to mobilise 'the people'. This phenomenon postulates populism become a 'thin'-centred ideology, having an elusive and ambivalence entity (Stanley, 2008). The 'thin' means that populism is incompetent to independently act as a practical political ideology at the play, i.e. having incapacity to answer the societies' political question in a coherent solution. As an fluctuated and elusive ideology, populism is lack of intellectual validity and easily coalesce and converted with many other full ideology spectrum, for example conservatism, nationalism, socialism, liberalism (Stanley, 2008). Stressing that politics should be a manifestation of the *vox populi*, populism is neither characterizable as left-wing nor right-wing spectrum of ideology but may be used by both wings (Kaltwasser, 2012; March, 2007). With its chameleonic character, populist logic is also be understood as catch-all pragmatism, proposing and promising striking achievement, on behalf of the *"vox populi"* (Kaltwasser, 2012). In this case, the mode of populist logic, as an ambivalence ideology, arguably cohabit with other 'full' ideology in similarity with socialism, or a leftish-populism because halal vaccines offers a diverse social benefit for the whole Indonesian moslem society. Moreover, for some Marxist writers, socialism is arguably as 'the highest form of populism', Leftist is inherent with populist. In this regard, Left-populism stressed in 'moral people'

as its central ideology, and espousing their social rights from their constituent people. (March, 2007). The majority of Indonesian people bearing with Islamic belief may automatically reinforce the legitimacy of elite political actors lay their claims as genuine representative of the *vox populi,* reflecting the popular will in favour for a particular policy, that is halal certification by MUI.

In macro Indonesia political context, popularity is considered as an important force factor to channel the policy outcomes because populist logic provides the way to the mainstream power dominated by the patronage elites (Aspinall, 2013). Populist logic is the '*porous hole'* in the mainstream political power institution that the outsider power may be able to traverse. Popularity had been a new incentive structure of social agency responded by the power figures in return for their political investment. Traditional populist type policy usually come into a policy with 'decorative, ambitious and generous' social programs regardless being minimal in their operational concept (Aspinall, 2013). Once a subject successfully reaches high populism level, it may attract a self-promotion and may accelerate the agenda setting journey, collecting and cementing coalition of power from the many fragmented competing interests, enable to strongly push the opening policy window.

Arguably, the foremost evidence for the successful leftish-populist policies is the establishment of Indonesian universal health care (the '*BPJS'*) and education in Indonesia. The leftish populist logic, appealing for 'pro-people' logic, with generous universal benefits, irrespective of its quality, capacity and expansion coverage, then the 'pro-people' platform became a 'modular policy strategy' adopted in 'viral mode' across the regional and national level (Aspinall, 2014). Despite its tantalizing populist content policy, it is not on the verge of shifting to a health system offering better high quality health care, in respect of the remaining poor health care infrastructure, data system, and services.

Or in other words, appealing and crafting with leftish populism in a problem or policy stream is given as a false impression and performed as an agent to mobilize and obtain legitimizing interest from the variety fragmented power

networks to make higher probability in agenda setting. Gaining mass based popularity became the justification in fostering and buffering to make a proposal legitimate in the policy community.

By reflecting and reasoning in this way, a successful policy entrepreneur should be able to find a pet policy bearing with a strong left-populist content policy (despite the policy may lack operational concept) and joined into the suitable and acceptable patronage power network and make use of the advantage of them.

Leftish populist logic and suitable patronage political vehicles, as policy entrepreneurships, are politically important to catalyst the journey of agenda setting and the likelihood of success for opening policy window. The failure of policy growing in popularity and lacking political patronage can lead to the stalls within the policy system that eventually may result in non-decision making, incrementalism or 'muddle through' policy making, i.e. leading to no significant policy change. Populist logic could be more important than the logic of strong indicators, focusing events in traditionally constructing the problem, and shaping the policy proposal behind the endeavour of agenda setting journey, as how Kingdon's theory conventionally suggests.

Mirroring the above reasoning, in this study, the discourse of agenda setting actually appeared to run in a *reverse direction* to that which would benefit of immunisation policy. *The tool of populist logic and patronage power had been utilised by elite religious political actor to entrepreneur themselves in proposing and popularising the un-halal status of vaccines, by problematizing the porcine trypsin enzyme.* Eventually, the subject of un-halal vaccines in the problem streams is understandable rising high in its popularity, bearing with simplified slogans, appealing to 'gut feeling' rising the Islamic people's consciousness, enabling for appealing the policy streams to grow and push halal labelling policy for vaccines, that is in the form of successfully passed Halal Warranty Product Act by Indonesian parliament. Thus, at the stake of Indonesian moslem populace is the leftish-populist logic of the Islamic religious issue. Ultimately, populist logic may plausibly have contagious effect and

consternation on national and regional stability. Surprisingly, despite utilising leftish populism, the substance at play actually confers with the opposite spectrum of ideology, that is in return for money politics. Hence, dual ideology spectrum, both the leftish and the rightist appears to operate at the same time.

In effect, this case study comes with the prima facie of the 'leftist' looks alike of a wish-list for socialist platform sentiment espousing collective social rights for their Islamic proletarians behind 'un-halal' vaccines, by proposing halal certification and labelling, while, at the same time, the secondary facie of the 'rightist' asserts with the logic of pro-capitalism with lucrative halal labelling politics elide externally. A mixed but not blended dichotomy of two ideology spectrum using populist logic. As previously expounded, populism is an oscillating amorphous ideology, neither firmly to left or right (March, 2007). The net results, in this case, may appear with populism as the 'shadow' of the leftist as its core component ideology despite only as strategical or stylistic measures.

In effect, the immunisation policy became a more *unpopular* subject and thereby, even in a more popular situation, could be difficult to reverse. In this case study, there are no strong enough ideas or populist policy proposals (opposing the already popular existing 'haram' vaccine status). No policy entrepreneur could take the risk to *counter* religious opposition to vaccination becoming a popular agency, neither conforming a proposal to the 'leftist' nor to the 'rightist' populism, for changing national immunisation policy. Losing its populist factor may cause difficulty in obtaining suitable patronage politics to sustain the concern about religious opposition to vaccination in agenda setting endeavours. Subsequently, the final agenda setting process involved deliberate inaction or non-decision making of the MoH.

Since the case involved politics as an inherent element of Kingdon's agenda setting, Oliver offers a framework to understand the politics streams in which public health politics framework usually operate. In brief, Oliver categorized the politics of public health policy into a four square category based on the diffuse vs concentrated cost and benefit platform (i.e. 'Client politics',

‘Majoritarian politics’ for diffused costs but concentrated and diffuse benefits respectively and ‘Interest group politics’ and ‘Entrepreneurial politics’ for both concentrated cost but with concentrated and diffuse benefit respectively) (Oliver, 2006).

In this study, populist logic as a political stream may be difficult to be inferred with the logic of distribution cost and benefit. The perspective of the policy game using Oliver logical political design could be puzzling because the operational basis of populist logic is arguably similar with the ‘majoritarian politics’ overtones (i.e. leftist populism) where both the cost and benefit are diffuse rather than concentrated but in practice serving with client politics (concentrated capital benefit with distributed cost from the public). To explain how this dual model happens in the same time may go beyond this case study area, but by acknowledging the status of Indonesia’s post-authoritarianism may be useful clues inherent in the overall state development and democratization process. Populism usually arise in response to the instability of existing political legitimacy (March, 2007), propitious to the Indonesian patronage-driven political environment.

Populist logic may contradict and challenge the rationalist camps of policy making that assume the process starts linearly from the problem definition with striking statistical indicators, or focusing events, the existing feasible policy alternatives, and a favourable political climate. Incrementalism may assume that policy making occurs by piecemeal policy change with some approximations to avoid considerable mistakes (M. J. Hill, 2009). On the other hand, populist logic engaged with mass-based appeal irrespective of conventional rationality, by invoking the *vox populi*, attaining wide spectrum of political capital in succeeding for opening policy window and policy change.

In conclusion, the case indicates the need of considering carefully agenda setting theory about the interplay of patronage political culture and populist logic in shaping the trail of an issue into policy agenda. The ‘un-halal’ vaccine may had been successfully emphasized as the *vox populi* followed by its successfully launch Halal Warranty Act which includes vaccines for halal

assessments. This study may also fill the scarcity of understudied works in policy entrepreneurships from developing country's agenda setting. Kingdon was derived from modern western democracy, in particular federalist system in the US where its modern cultural politics environment makes it difficult to for any groups or individual actor to govern the process. In contrast, developing countries may have contradictory rule in that the patronage power network is less clear in power boundary. The *vox populi* logic arguably provides a tool to unite the fragmented patronage power interests.

The account of populism and patronage behaviour may *not sufficient to revise or modify* the Kingdon's theory or advance towards a new variance of Kingdon's theory but the analysis may *provide a more accurate assessment* in elaborating *the influence of populist logic and patronage practice* in the endeavour of policy entrepreneurships and trajectory to open policy window. An accurate assessment is important because there are not many scholarly arguments explaining power in terms of specific cultural reference and how it shapes the political culture affecting agenda setting especially health policy. The argument about the way paternalism in Indonesia guides the contemporary political culture complements the reasoning about opening policy window rather than treating culture as merely an underneath forces which is difficult to incorporate and justify with rational scientific thinking. Observing culture accentuated as in terms of its specific differences rather than general principles helps clarify some peculiar aspect that are missed from the general analysis using only a Kingdon's theory in agenda setting (Atkinson, 2002).

5.4. Concluding remark in Chapter 5, implication for theory

This last subsection (5.3) answers the 'how understanding of the policy makers in developing health policy for religious anti-vaccination' research question where the primary concern became the challenge of crossing level of analysis, taking a cultural account of Indonesia into Kingdon's framework. Agenda setting is all about power struggle, and the operation of power is culture bound. On a macro conceptual level, the different state development and cultural

background may not simply contradict or refute Kingdon, despite his theory being American in origins, Kingdon theory may still be explainable but may miss analysis of different cultural power behaviour, which could actually explain the silence or success of opening the policy window. Taking into account different cultural power values offers a better general understanding of agenda setting.

Looking at previous study, for example Taras, Kirkman, and Steel (2010), the predictive power of the cultural dimension was less significant, in when coming down cultural value dimension from a national to individual level and groups level. Thus, health policy system analysis, including the agenda setting, should not be overstressed and confined with examination and analysis from domestic health department as the dominant variable in influencing the agenda setting for health policy making. By looking at higher context national level where the operation of cultural value provides a greater knowledge of analysis.

In this case study, reflecting on national-wide level, along with the post-positivist interpretivist paradigm, the main variances of the political paternalistic consequences which come from within the mainstream patronage network to Kingdon's theory is arguably one of a way of the three streams are joined favouring the opening of policy window in the decades of post-authoritarian era. Populist logic, appears in the form of leftish-populism by stressing with the vox populi reasoning, became the entrepreneurship agency, as a catalyst and leverage factor, by cementing the fragmented vested interest within the patronage networks. To lead in the agenda setting journey, leftish populism logic attached to the problem and policy stream may accelerate the agenda setting process to open policy window. This leftish-populism acts as blanket tactics, despite the actual substance could accommodating the opposites, or in this case in the form of rent-seeking behaviour or client politics. Reflecting from this study, Indonesia is arguably transforming from the mode of state-led into market-led mechanism with an appearance of left-populist platform as a shadow by involving religion, cultural power, and politics influencing health policy. The logic behind this dual phenomenon might be understood as a natural discourse of post-authoritarian period of state

development propitious with the fragile and deinstitutionalized patronage-based political power institution.

When avoiding the role of political cultural, there can be consequences of inability or mismatch for explaining the inconsistency in empirical findings to fit with a social theory (Kingdon's theory). The explanation of analysis may be considered inaccuracy due to missed or failure to attend the specific culture characteristic that actually play important role. And, incorporating the consideration of political culture into policy making might demonstrate the critical role played by informal cultural power systems which actually operate and control behind it. Consideration of the operation of political culture behind policy making is important because health policy researcher usually avoid taking into account the cultural domain for withdrawing from a more complex exploration of the health policy making (Atkinson, 2002).

In conclusion, this case study analysis suggests the importance of acknowledging the state development process, along with its political culture and its associated power behaviour, in agenda setting journey for an industrializing country background. Indonesia state development arguably provides a unique social laboratory of mixed but not blended phenomenon between the two ideology continuum, i.e. socialism-conservatism outlook, or the leftish (sectarian, pro-moslem, exclusive), and the liberal-capitalism, or the rightish (secularized, liberal, nationalist-pluralism). In the declining of Marxists era in Indonesia, this type of religious-flavoured of leftist-populism possibly may become an intrinsic feature of contemporary 'left-wing' politics plays in larger part of Indonesian political spectrum (Zenzie, 1999).

Chapter 6 Knowledge Transfer & Conclusion

6.1. Introduction

In regard to the knowledge transfer (KT), or research utilization, this study domain is about the agenda setting (AS) or, thinking in linear sequence, at the very beginning of policy making. The main objective of this section is to elaborate the ways in which this AS-based study can inform policy making within KT process as they seem to be an integral part of KT platforms. This section will therefore discuss the relationship between agenda setting with KT. The subject addressed in this study, agenda setting for immunisation policy, addressing Islamic opposition to vaccination, may only example part of the larger enterprise involving KT. The relationship between KT and AS is explained by the way in which this AS study is situated within the KT map and will be elucidated using the Knowledge to Action (K2A) framework (Wilson, Brady, & Lesesne, 2011).

This chapter will cover the research dissemination or knowledge transfer which includes the relationship with agenda setting (AS), plausible prescriptive solutions, followed by study limitations and promising future research. It will be concluded with an overall conclusion in answering the research questions, and aims/objectives.

6.2. Knowledge Transfer (KT)

Arguably, health researchers should recognize the need to evaluate and assess the extent to which their research evidences are effectively implementable in their intended settings. Barriers and facilitators should be identified to design strategies to improve the chances of successful policy transfer (Whitty & Kinn, 2011). Identification of those parameters may be able to support in elucidating the successful integration of evidence into KT processes, ensuring their utilizability.

KT is defined as "*a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically sound application of knowledge,*

through sustainable partnerships to improve the health of citizens, provide more effective health services and products and strengthen the health care system" (Graham et al., 2006).

For this discussion, the K2A framework has been chosen because it is not a causal but a sequential phase model so that it would be in line with the subject of AS at hand. The K2A framework has been created to provide a more common language of understanding and conceptualization from various disciplines and areas to stimulate collaboration, communication and translation of research into policy and practice. Moreover, it was also constructed for wide applicability to address many factors concerning policy and practice and recognize the vital crossing elements within its structure (Wilson et al., 2011).

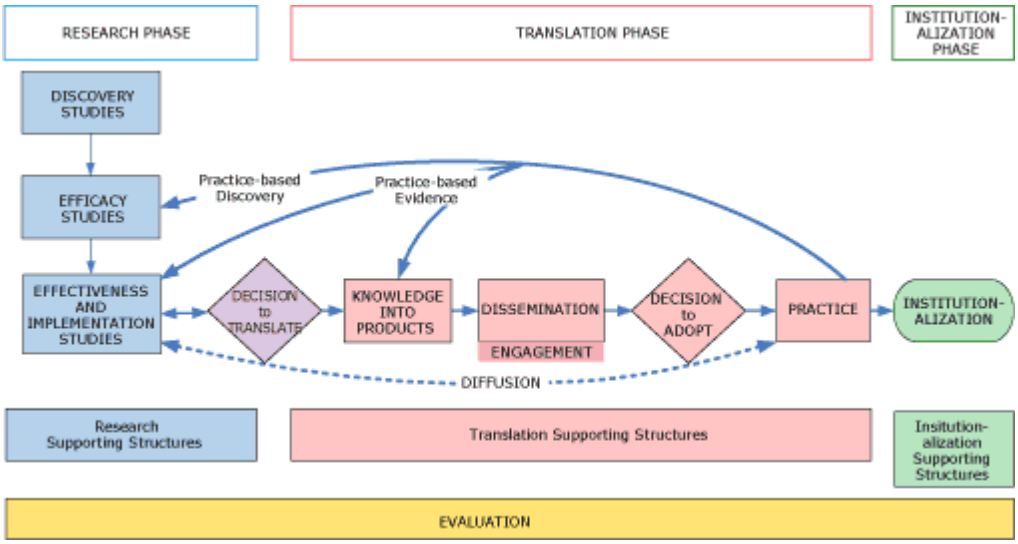

Figure 6.1. Schematic diagram of K2A framework for public health (Wilson et al., 2011) p: 2).

In brief, the K2A consists of three phases: the research phase, translation phase, and institutionalization phase (figure 6.1). The research phase covers the research process which includes efficacy studies, and effectivity and implementation studies. The translation phase involves the process of dissemination from making a decision to uptake the research findings, professional engagements with potential policy makers and deciding to utilize the evidence in policy product and practices. This step to utilize evidence might depend on the policy community, organizations, and policy makers having

sufficient support and resources. The institutionalization phase involves the sustainability of using evidence in the policy, program or practices within the community or society based work (Wilson et al., 2011).

6.2.1. The relationship of this study AS research within K2A platform.

Agenda Setting (AS) is part of policy process in which the variety of problems and solutions vie for the attention of policy makers at any given time. The agenda term is a list of problems, solutions, or other issues that demand attention to the government officials (Birkland, 2007). The process of agenda setting involves the recognition of an issue as a problem defined in a certain way and moves the problem in government policy agenda for serious consideration. Although problems may make their ways into policy agenda, not all policy agenda move into decision agenda (Buse, 2012a).

In referring to the above K2A platform, this study may be located within the transitional demarcation between the research and translation phase where AS is beginning of policy making process. There are many factors influencing the translation phase in which decisions are developed by considering the research evidence instead of other factors and how they compete for agenda consideration in final time. This study analysis may support process of agenda consideration. This study has implied and accentuated that the cultural climate operating within the policy system, is paternal, and the dominant tool in opening policy window towards policy change is popular agency. And that it is necessary to consider these two aspects for the successful translation phase of KT.

In paternal type policy community, where hierarchical cultural power structure exists, the deployment of policy proposals attached to research evidence, would have a high likelihood of success when endorsed or at least tolerated by the elite patrons or their associates. By attaching policy proposal to research evidence, populism becomes a catalyst to resolve competing interests in the policy environment resulting in a successful research transfer. Without populist logic attached to policy proposals based on research evidence receptivity in the translation phase might be hampered. In the public

health arena, this study analysis might assist in understanding the core political culture assessing the health policy making process in Indonesia, or at least in low-middle income countries. Koon, Rao, Tran, and Ghaffar (2013) study might help and support these accounts in elucidating several factors influencing the way in which evidence comes into decision making in low-middle income countries. Koon et al (2013) study involves four parameters: reputation, quality and quantity of connection to decision makers, and capacity (figure 6.2).

Reputation means "*the perception that an organization produces quality outputs for other within its domain*" (Koon et al., 2013). Reputation correlates with the degree of reliability of the organization. However, reputability of an organization may only happen in selected section or domains. This partiality correlates with the other dimensions, such as organization capacity. The higher the capacity of an organization the more likely it will take up a more accurate evidence when policy decision making (Koon et al., 2013). The quality and quantity of connections refers to the degree to which organizations can interlink with several decision makers and the strength of relations with other centrally powerful and highly influential decision makers. The stronger both dimension are, the more likelihood that organisations take up research evidence in policy decision making.

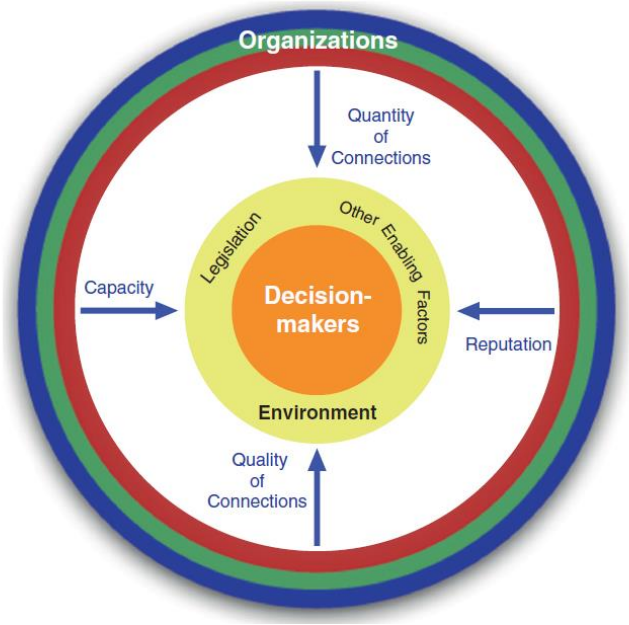

Figure 6.2. the four influential domain close to the decision makers (Koon, Rao, Tran, & Ghaffar, 2013): p 7).

From this study analysis, as elaborated in chapter 5.3, the contextualized Kingdon's analysis contextualised with paternalism and populism can be understood with Koon et.al (2013) model of four influential domains mentioned above which explain the successful penetration of research evidence into translation phase. The reputational factor may be related with the sufficient degree of reliability of the patrons power and their proxy organizations. As mentioned above, the more reliable their organizations, the more chance to adopt the research evidence in policy making. Capacity, in this case, may be inferred by the amount of power owned by the elite patron groups to successfully impose their interests among competing others. The quantity and quality of connections may be explained by the number of relationships of a patronage network and their associates in connection to the other networks of patron power and resources and the extent of the strength of connection owned.

Populism may serve to be the 'other enabling factor' to logically taking on interests on behalf of the whole populace and cementing the various elite power. Thus, the research evidence should be able to be attach to and reflect fabricated popular ideas, having an outstanding interest factor. Having an outstanding interest factors enables the direction of policy decision making to be directed by the intended research evidence. Popular ideas may be involved by the ability to portray and understand the issue at hand and direct the extent to which the agreement can be achieved to take the research evidence into the policy decision making process.

The benefit of understanding Agenda Setting (AS) research on a KT platform is that its enables acknowledging, identifying, and comprehending the way in which research evidence may be successfully adopted by policy makers. And it may also explain the failure of adoption of research findings into policy.

6.2.2. This study translation based on a K2A framework and Koon et. al's model.

As elaborated in chapter 5.3 engagement into the ‘inner power’ circle of patrons is important. Supported by Koon et al’s four dimension of penetrating decision making for evidence based policy making, the suitable way of doing research translation for policy advocacy and prescription is by making long-term professional engagements sensing the way elite patronage power is mapped within the national health department as a whole, and the elite patron's receptivity or acceptability towards any idea or policy proposals. Two plausible starting points could be creating a joint publication with suitable respondents in the health department and publishing it in a reputable journal and creating a continuous collaborative research platform. A joint publication may become research evidence which can be used to incite the attention of a broad audience of policy makers which can snowball into the inner power circle. Alumni networking from Indonesian medical universities may be used to support these broad audience and inner circle engagements. Joint publication may be more effective and soft engagements rather than one shot exposure through seminar presentation, or workshops because religious opposition to vaccination is a sensitive issue as it relates to personal religious beliefs that may create feeling of keeping the distance from it. Therefore, the context of national culture and religion should be taken into consideration. In turn, the content of policy advocacy and prescription should not be about the debate on Islamic or religious jurisprudence, but crafted from the context of organizational advocacy for the Indonesian health department.

Continuous collaborative research platforms, involving suitable inner elite health bureaucrats as research team member may become the subsequent method of translation. Collaborative research platforms may be able to identify mutual interests between health researcher and policy makers building up the trust and interest to learn to work together. It is vital to continuously engage with various stakeholders and build the capacity of collaborative team consisting of health researchers and multi-level health policy makers. The subsequent section will describe the concrete policy advocacy for this case study

6.2.3. Concrete Policy Advocacy for KT using Laris and MacDougall (2012) model for two target: the national politics level and securing agenda setting in regional level

This section on policy advocacy is not intended to directly find the way to change the national immunisation policy by tailoring the agenda setting process. It is intended to address the difficulty in national politics bombarding the health arena, in relation to immunisation, and the strategy for reducing bureaucratic bias among regional health offices, within the complexity of health organization and decentralization. In addition, to make successful KT, it is important to keep in mind the feasibility of implementing policy prescription to avoid unrealistic practices. To serve this intention, Laris and MacDougall (2012) provide a prescriptive trilogy model of custodial role, civic philosophy and civic organizer which may suit guiding policy such that it has KT.

The model had been proposed by Laris and MacDougall's to support the development of an organizations to advance healthy public policy, drawing on Milio's (1987) of healthy public policy as 'ecological in perspective, multisector in scope, and participatory in strategy'. The authors argue that it is necessary to work and balance the three element of civic philosophy, civic organiser, and custodial role taking into account the three values, in administration, and intersectoral action to advance a healthy public policy.

In brief, civic philosophy underpins the importance of changing the wider social and political culture. Civic philosophy can play guide and the custodial role of organizations in an ever-changing political, economic and social environment. The custodial role of an organisation embraces the responsibility to deliver the expectations of the stakeholders expressed through their civic philosophy, either implicitly or explicitly. Custodial activity conforming to civic philosophical values might minimise the risk of misunderstanding by the stakeholders and partners (Laris & MacDougall, 2012).

Within the civic organisational element, the capacity for organising an organization rests in the partnerships with other groups, agencies, or funding partners. In other words, to advance healthy public policy, the organisation must develop 'external focus', both effectively performing as organiser and as

partner. In order to achieve partnerships, some features are important. Transparency in the process and structure is important to obtain understanding, respect and trust between the collaborators. Readiness to change and negotiate with the participants is also significant, and as part of the readiness, competency for conflict resolution is important because each partner might have different agendas. Having a "buffering" capability is therefore also important to manage conflict and generate organisational change (Laris & MacDougall, 2012).

What is the relation of the trilogy model to the policy advocacy for this case study?

Laris and MacDougall's trilogy model has been developed to sense and balance the highly advance neoliberal strategic planning, which is reshaping organisations to provide a comparative advantage in the open market. Their model has been developed from continuing acknowledgement about the 'hostile' environment of market-based countries which making it difficult to attain public health policy.

In respect of the hostility of market based arrangements, Indonesia, as a developing country, appears to be emerging towards market-led countries leaving state-led countries. Robison (1986) viewed that the Indonesia started its capitalist formation through the authoritarian state. Subsequently, Aspinall (2013) has argued that during post-authoritarian Suharto era Indonesia had evolved from the 'Rise of Capital' to the 'Triumph of Capital'. During these years, Indonesia has dramatically changed not only in democratisation but also in its 'primeval'-capitalist platform, the business relations are still reflected with clientelist platform. The indication from the data findings has revealed that that religious based issue has become a business client in the health sector rather than merely a basic social belief.

The trilogy model could also benefit policy advocacy by sensing new ways to develop better public health public policy in the emerging neo-liberal capitalist market-oriented policy agenda in Indonesia. By strengthening intersectoral consideration among civic philosophy interdependently with the two other aspect of the model, the custodial role and civic organiser of the health

department will allow the problem of outsider capitalist political attacks on health department in general. To response to neo-liberal economics, the effort will need to accentuate the custodial role and civic organiser of the health department while managing to conform with civic philosophical value.

Strengthening the custodial role by restructuring the health department from a hierarchical into collegial platform

The highly hierarchical structure of the health department and the national paternalistic culture may corroborate each other, forming incapacity through limiting innovation and ideas by penalizing the noncompliance behaviour at the subordinate levels. Both the hierarchical and paternalistic environment, arguably, may imply an impediment in the decision making process of agenda setting given power is owned by elite patrons and their associates, within the highly hierarchical bureaucracy, there is more imbalance in power. Both cultural patterns and structural organizational arrangement may plausibly silence the alternatives for immunisation policy and its related policy that actually deserve better attention. The unequal paternal power may become and act as a filter of attention in an actual rich policy alternative environment. From an organisational context, the organization's structure broadly shapes the goals and interests that are considered to be relevant policy alternatives (Jr, 2012). And the organization's structure may fashion the information networks for the process of agenda setting (Egeberg, 2012). At the same time, not all the problems and alternatives can be addressed simultaneously (bounded rationality) (Simon, 1991). Thus, the structure of organisation and culture seems to be never be of a neutral tone; it may reflect an indigenous bias in agenda setting. In parallel, the culturally nurtured paternal behaviour may guide the selection process of who should take responsibility for the variety of alternatives. With unbalanced power, only ones who are able to penetrate the patronage network and their associates with suitable and acceptable policy alternatives, are able to tap into the agenda setting process. The people inside the organizations may feel a moral obligation to obey and comply with cultural behaviour within organization and adopt role expectations and code of conducts (Alvesson, 2002).

The Health department structure in which the immunisation program is located and the overall department structure appears to have a highly vertical specialization within and among sub units. This hierarchical arrangements affects the coordination of responsibility moving it to the higher echelons according to the ladder of bureaucracy (Egeberg, 2012). In turn, hierarchical arrangements may affect the policy agenda setting to be more shaped, filtered and personalized decision making. In addition, those in the lower level units may narrowly consider problem, policy and their consequences, rather than wide national concerns (Egeberg, 2012). Thus, through the funnel of bureaucracy the policy process may be lengthy and tend to be vulnerable to silence or negligence. The culture of paternalism may plausibly explain this situation through the superior levels imposing punishment and penalty for deterrence or non-compliance. Thinking in this way, the paternal factor could bolster the filtering or silencing factor for unavailability of both data and policy alternatives rather than function as a supporting factor.

In this case study, the best arrangement to consolidate internal organisational coherence for immunisation, would be to restructure the health department into a more collegial structure, lessening the cultural influences and hierarchical filter. Restructuring might increase the chances of accommodating policy alternatives by debating, bargaining, and arguing about the immunisation problem and possible policy streams. In the Indonesian health department, it would be difficult to achieve collegiality only within the immunisation unit because of the interdependency among the sub-departments. And the collegial arrangement would suit the higher level of the central office rather than lower district levels provided that the political tension usually only insulated and experienced by the central agencies rather than lower level health department. The decision process of agenda setting through collegial arrangement may arguably increase the likelihood of checks and balances of power and policy alternatives while at the same time, examining and assessing political process. Through collegial arrangements, Kingdon’s three streams could run in a more equal structure and system. In a collegial structure, the Minister of Health's power and decision making, could be more officially checked and balanced by

their elite echelons through arguing, debating, and voting rather than through personalised command. Thus, as part of equal checks and balance of power, there may be increased debate and argument rather than accentuating patronage power. The goal is that the organizational unit would arguably have a much stronger institutional base and less dependence on a few strong persons within it.

Strengthening civic organiser by establishing advisory board within MoH elite structure

Within a collegial organizational structure, it may also become easier to establish an advisory board or executive steering committee in the top MoH organizational structure. By taking the MUI members and other stakeholder groups onto the advisory board, might offer a better scenario for strengthening the MoH's political power as civic organiser. This board is to buffer the lobbying and confine the political debate within the advisory board, providing more collective political power (despite not absolute) to the MoH, and thereby more chance of winning any political bargains with the MUI or other outside political charges. The advisory board may be flexibly comprised of members, including panel experts, pharmacy groups, affected parties, public figures who could support the minister of health in areas of wide political concern not only those concerning the MUI. A more flexible advisory board along with collegial organisational structure may accommodate and support political control over MoH policy in, not only immunisation, but also other health affected areas. And it also may be more effective for the MoH to sit in a group rather than singly confront the MUI on a regular by demand-meeting basis. In other words, an advisory board or executive steering committee may balance emerging political interests in health and resolve conflicting interests and disputes concurrently. The board may become an arena of political battle for expressions of interest in a confined territory and thus provide more autonomy for the lower agencies level to accomplish their tasks. The aim of having the board to bring all interested parties to a single table to ‘craft package deals’ which may enhance the success over the MoH by generating many possible trade-offs around the halal/haram vaccine issues. The board may resolve the

political negotiations comprehensively, reducing the number of hurdles when policy is taken outside the board individually (Jr, 2012). It may also minimize the political effect in the general society about the issue of halal/haram vaccination.

6.3. Final Conclusion, the answer to research questions

From the outset of this study, the research questions were to explain the "what and how" understanding of the health policy makers, when developing immunisation policy about Islamic opposition to vaccination in Indonesia. It also asked: How did the policy actually address those religious anti-vaccinationists? The answer to the research questions are framed using Kingdon's agenda setting theory. By taking policy deliberation into account, his theory enables and explanation about government policy agenda setting about immunisation, addressing Islamic opposition to vaccination. Located in heuristic cycle of policy process, the accent dominantly on the early stage, or the agenda setting phase of health policy development, despite the fact that actual demarcation in each phase is difficult to establish (Wegrich, 2007).

6.3.1. Answering the first research questions: "the what and how" understanding of the health policy makers in developing immunisation policy about Islamic anti-vaccination)

There are several key accounts that offer fundamental explanations to the first two related questions framed with Kingdon's model of how the three streams of problem, policy and politics operate within the policy community. The problem stream allows for the conclusion that those oppositions to vaccination are difficult to categorize into a certain and robust problem category. Moreover, the Indonesian bureaucracy culture might make the problem of categorization worse due to the unreliability of data recording. Highly hierarchic organizational structure and the paternal Indonesian cultural background may also reinforce the personalized power practice of the patrons rather than the capacity to build upon the organizations. With the unstable and unclear problem stream reaching a solid account, this, in turn, might also negatively influence the policy streams. The policy proposal appears to be blurred, indistinct and elusive because of unclear problem categorization and definition. Basically, the policy

streams reflect that Indonesian immunisation policy remains unchanged as obsolete centralised policy unsuitable to address religious opposition to vaccination. The obligatory, authoritarian policy orders from the Central Office to the Regional offices, characteristic of the old centralised immunisation policy, to achieve high immunisation coverage doesn't acknowledge the realistic conditions at the implementation level. The perplexing, decentralization of the health system appears to one of the major hindrances. Decentralisation basically implies an environment of discordancy among authority, money (budget), and information. This discordance makes it difficult for the Central Health Office to reach the regional offices to impose their intended centralised immunisation policy, including addressing religious opposition to vaccination. The discordance might also create blame shifting among different government level. In other words, the policy streams subsequently failed to attenuate the problem streams. Thus, both the problem and policy stream experienced shortfall and therefore difficult to effectively expand and impossible to join. The politics stream also appeared unconducive to the joining of other two streams. The MUI's politic scenario dressed by halal certification for vaccines incited the doubt in society towards vaccination, which appeared to be a hard political card to play for the MoH.

Continuing to answering the first two related "how" and "what" research questions while remaining with Kingdon's principles, there are two accounts from the data which might explain the failure to open the policy window for joining the problem, policy, and politics streams. These two accounts both of which reflect contemporary Indonesian politics and democratization.are: the culturally entrenched Indonesia patronage landscape and the need for political popularity. These two accounts can also be broadly considered as influencing factors within the discourse of agenda setting in wider aspect rather than limited to health sectors.

This two typical account, patronage and political popularity might shape the way policy entrepreneurship should take into account when proposing a policy. Within the paternal Indonesia policy community, the way policy entrepreneurships are performed is from within a suitably strong patronage

network or their associates. The cultural landscape seems difficult to provide entrepreneurships for non-establishment figures. In doing entrepreneurships, popularity attached to the policy proposal appears as an important agency to provide political capital to cementing the fragmented patronage interests. The logic of traditional populism is the catalyst during the process of agenda setting in the form of policies offering generous, universal benefits to the society, despite these benefits being questionable in operational principles to implement. Failure to craft or articulate the subject into popular policy proposals might be insufficient to cement the patrons power.

Taking the above cultural perspective into the analysis, in this case study, neither the logic of popularity and patronage entrepreneurships attached to the immunisation policy. Rather, both but ran in the reverse direction. The perceived un-halal vaccine was problematized by elite political actors through the trypsin enzyme. This problematization of the trypsin enzyme was used as a tool of popular agency as a political ploy by elite actors to entrepreneur their interest in rent-seeking behaviour withdrawing the state resources through justificatory lucrative halal labelling for vaccines. The failure to alter the national Indonesian immunisation policy might also arguably be explained due to the inexistence of policy entrepreneurs able to reverse the already highly popularized topics or the failure to craft an inversed popularity (taking the advantage of ‘haram’ vaccines as an asset rather than a negative credit) as a proposal to change the national immunisation policy. By lacking of popularity, the agenda will arguably fail to reaching the strong patronage power network or their proxies. Other classically internal constraints, for example budgeting policy, and decentralization, seem to support this failure. Hence, it is unrealistic to suggest that the cultural factors are the only cause of the failure to join the three streams.

In conclusion, the value offered here is in answering the research questions by contextualizing Kingdon's in Indonesia both in terms of paternalism and populism.

6.3.2. Answering the second research question: how did the policy actually address religious opposition to vaccination)

The overall response of health department appears to arise in two ways, both through Central and Regional Office levels. In the Central Health Office, it is reflected in the policy stream, influenced heavily by the political stream, indicating non-decision making by the MoH. This approach had been taken to respond to the MUI's political move. However, at the same time, this silent approach could not answer the grass-roots religious anti-vaccinationist people faced by the regional offices because the core concept of the national immunisation policy remained unchanged. The MUI themselves, assembled by many Islamic dominations in Indonesia, appeared to have fragmented voices at the regional level. Consequently, the burden to address the religious anti-vaccinationists became concentrated downstream at the provincial and district offices. The provincial and district health offices provided their local policy response by tailoring the implementation level, and manoeuvring technical and tactical policy among the regional health offices. However, the policy responses among the five districts in two provinces appeared to be varied and inconsistent. Such a tactical policy example from Jogjakarta province was to use the Jogjakarta Sultanate Pamphlets to entice people to trust vaccination, despite many claims of its ineffectiveness.

Taken together from previous explanations, the summary of the answer of research questions are listed in the table below (table 6.1).

Table 6.1. Summary of the explanation in the answer of research questions

Research questions	The answer explained by Kingdon's theory
The "what and how" of understanding the health policy makers response to developing immunisation policy about Islamic opposition to vaccination in Indonesia	Islamic opposition to vaccination in Indonesia is unclearly defined as a concrete problem, and the national immunisation policy remains unchanged and unsuitable to accommodate the problem. The Islamic opposition to vaccination made a clear political move political move by using unclear halal status, developing as business interest by claiming for halal labelling. Both of the unsettling problems and political streams made a significant influence in the deliberation of the policy streams. The Indonesian cultural account might explain the failure to address a new policy

	proposal for immunisation due to the unavailability of entrepreneurs enables in popularizing a change to the national immunisation policy and their involvement with a suitable patronage network. Decentralization, government bureaucracy, budgeting issues, function as classical hindrances, reinforcing the other obstacles to expanding the three streams so they are able to join.
How did the policy actually address those religious anti-vaccinationists?	The policy deliberation occurred at two level. The Central Office used a non-decision making to respond to the political move. The regional office used various inconsistent efforts through their own technical or tactical policies.

6.4. Study Limitation and Future Research

Continuing from the limitation section in Chapter 1, this section complements the limitation of this study. In terms of drawing generalisations or general applicability as acknowledges in section 5.1, this study may be of limited. There are degrees of limitations when seeking replicability of this study. Firstly, the period when the data collection was performed was during the end of the decade-long rule of 'regal' president Susilo Bambang Yudhoyono. He has been acknowledged as an indecisive leader, serving to establish 'balance' among competing socio-political forces. In this way, he allowed distributing culturally entrenched patronage practice to withdraw state resources. Yudhoyono's indecisiveness might also explain the overwhelming infiltration of patronage-driven forces towards state authority, in this case through the MoH immunisation program. Secondly, ongoing Indonesian democratization appears to be naturally fluctuating, creating room for debate between pluralist theorists and patronage-driven oligarchy theorists about power struggles in Indonesia. This study finding about the role of patronage power might be illuminated with the latter rather than the former. The camps of pluralists, who during the writing of this thesis, argued that the dominance of patronage power started dissipating and the scope of traditional populism, offering irrational benefit on behalf of the people voice, has lessened. In its place, populism mirroring the innovative political atmosphere brought by the new Indonesian elected president, Joko Widodo (October 2014), has become wider (Mietzner,

2015). Thirdly, in spite of their cultural constraints, the values of the Indonesian national ideology appear to be always in volatile interpretation (neither leftish nor rightist between that two spectrum) when drawn on for any downstream operational policy principles. This buoyant ideological paradigm may be the *raison d'etre* of the quandary in health policy analysis, in which continuum the logic should be predominantly stressed. Fourthly, foreign funding donors appear to be hitherto supporting Indonesia's health program. Thus, the religious opposition to vaccination may not simply be the *sine qua non* of changing national immunisation policy.

Complementary future research in fulfilling the limitations of this study fruitfully expand into wider participants, for example covering top political appointees or the parliaments. Wider participants may balance and further validate this study analysis and elaborate in more detail the fluctuating phenomenon of power struggle debated by the pluralist and oligarchy theorists, which affects agenda setting of health policy. Hence, future research subject may not only embrace immunisation, addressing the religious -opposition to vaccination, but research themes, accommodating health policy, politics, power ideology and culture. It will help fill the huge research gap about health policy making and analysis in developing country settings.

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Appendix

Ethical Clearance from SBREC (Social Behavioural Research Ethics Committee) Flinders University.

FINAL APPROVAL NOTICE

Project No.:	**6361**
Project Title:	An explanatory study of health policy about immunisation related with religious (islamic) anti-vaccination movement in Indonesia
Principal Researcher:	Mr Tetrawindu Hidayatullah
Email:	hida0011@flinders.edu.au
Approval Date:	10 February 2014
Ethics Approval Expiry Date:	**1 November 2015**

The above proposed project has been **approved** on the basis of the information contained in the application, its attachments and the information subsequently provided with the addition of the following comment:

Additional information required following commencement of research:

1. Please ensure that dot point 4, point 5 is removed from the consent form (Attachment: Consent Form)

RESPONSIBILITIES OF RESEARCHERS AND SUPERVISORS

1. Participant Documentation

Please note that it is the responsibility of researchers and supervisors, in the case of student projects, to ensure that:

- all participant documents are checked for spelling, grammatical, numbering and formatting errors. The Committee does not accept any responsibility for the above mentioned errors.
- the Flinders University logo is included on all participant documentation (e.g., letters of Introduction, information Sheets, consent forms, debriefing information and questionnaires – with the exception of purchased research tools) and the current Flinders University letterhead is included in the header of all letters of introduction. The Flinders University international logo/letterhead should be used and documentation should contain international dialling codes for all telephone and fax numbers listed for all research to be conducted overseas.
- the SBREC contact details, listed below, are included in the footer of all letters of introduction and information sheets.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 'INSERT PROJECT No. here following approval'). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au.

2. Annual Progress / Final Reports

In order to comply with the monitoring requirements of the *National Statement on Ethical Conduct in Human Research (March 2007)* an annual progress report must be submitted each year on the **10 February** (approval anniversary date) for the duration of the ethics approval using the annual / final report pro forma available from Annual / Final Reports SBREC web page. *Please retain this notice for reference when completing annual progress or final reports.*

If the project is completed *before* ethics approval has expired please ensure a final report is submitted immediately. If ethics approval for your project expires please submit either (1) a final report; or (2) an extension of time request and an annual report.

Student Projects

The SBREC recommends that current ethics approval is maintained until a student's thesis has been submitted, reviewed and approved. This is to protect the student in the event that reviewers recommend some changes that may include the collection of additional participant data.

Your first report is due on **10 February 2015** or on completion of the project, whichever is the earliest.

3. Modifications to Project

Modifications to the project must not proceed until approval has been obtained from the Ethics Committee. Such matters include:

- proposed changes to the research protocol;
- proposed changes to participant recruitment methods;
- amendments to participant documentation and/or research tools;
- change of project title;
- extension of ethics approval expiry date; and
- changes to the research team (addition, removals, supervisor changes).

To notify the Committee of any proposed modifications to the project please submit a Modification Request Form to the Executive Officer. Download the form from the website every time a new modification request is submitted to ensure that the most recent form is used. Please note that extension of time requests should be submitted prior to the Ethics Approval Expiry Date listed on this notice.

Change of Contact Details

Please ensure that you notify the Committee if either your mailing or email address changes to ensure that correspondence relating to this project can be sent to you. A modification request is not required to change your contact details.

4. Adverse Events and/or Complaints

Researchers should advise the Executive Officer of the Ethics Committee on 08 8201-3116 or human.researchethics@flinders.edu.au immediately if:

- any complaints regarding the research are received;
- a serious or unexpected adverse event occurs that effects participants;
- an unforseen event occurs that may affect the ethical acceptability of the project.

Ethical Clearance from Research Ethics Committee Medical Faculty, Mataram University

Formulir Keputusan Panitia Etik

Komisi Etik Penelitian Kesehatan Universitas Mataram	Keputusan Penelaahan	No: 83/UN18.8/ETIK/2014

Judul Penelitian:
Studi Eksplorasi Kebijakan Kesehatan tentang Imunisasi dan Gerakan Anti-vaksinasi Berdasarkan Agama (Islam) di Indonesia

Peneliti Utama:
Tetrawindu Hidayatullah

Peneliti:

Tanggal Penelitian:

Kesimpulan:

☑Disetujui ☐Ditolak ☐Perlu diperbaiki ☐Belum dapat dibahas

Butir alasan, perbaikan/perubahan/keterangan tambahan yang diperlukan:

- Penelitian dapat dilaksanakan, tidak ada potensi pelanggaran etika.

Ketua Panitia Komisi Etik Penelitian Kesehatan Universitas Mataram **Tanggal**

dr. Yusita Silvana, M.Sc., PhD 11 Januari 2014

Catatan :

1. Mohon menyerahkan hasil penelitian selambat lambatnya 1 (satu) bulan setelah selesai penelitian kepada Komisi Etik Penelitian Kesehatan Fakultas Kedokteran Unram, sebagai bahan evaluasi.
2. Apabila pelaksanaan penelitian tidak sesuai dengan usulan kegiatan, Komisi Etik tidak bertanggung jawab terhadap kelayakan etik penelitian tersebut.
3. Apabila ada perubahan prosedur/kegiatan penelitian, mohon agar mengusulkan kembali proposal kelayakan etik.

Research permit from Directorate General of National Unity and Politics, Ministry of Internal Affair, Republic of Indonesia

KEMENTERIAN DALAM NEGERI
REPUBLIK INDONESIA
DIREKTORAT JENDERAL KESATUAN BANGSA DAN POLITIK
Jl. Medan Merdeka Utara No. 7 Telp. (021) 3450038, Fax (021) 3454270, Jakarta 10110

Jakarta, 21 Januari 2014

Kepada

Nomor : 070/0247/D.I
Lampiran : 1 (satu) berkas
Perihal : Rekomendasi Penelitian

Yth. Gubernur Jawa Tengah, D.I. Yogyakarta dan DKI Jakarta.
u.p. Kepala Badan Kesbangpol dan Linmas

Dalam rangka memperlancar pelaksanaan kegiatan penelitian bersama ini terlampir disampaikan Rekomendasi Penelitian Nomor 440/0157. D.I Tanggal 17 Januari 2014 atas nama Tetrawindu Agustiono Hidayatullah dengan judul proposal Studi Eksplorasi Kebijakan Kesehatan Mengenai Imunisasi yang Berkaitan Dengan Gerakan Anti-Vaksinasi Berdasarkan Agama (islam) di Indonesia di Provinsi Jawa Tengah, D.I Yogyakarta dan DKI Jakarta, untuk dapat ditindaklanjuti.

Demikian untuk menjadi maklum dan terima kasih.

a.n. DIREKTUR JENDERAL
KESATUAN BANGSA DAN POLITIK
SEKRETARIS DITJEN,

TAUFIK BASKORO
Pembina Utama Madya (IV/d)
NIP. 19600925 198503 1 001

Tembusan :
Yth. Bapak Dirjen Kesbangpol, sebagai laporan.

Consent Form

Flinders
UNIVERSITY

CONSENT FORM FOR PARTICIPATION IN RESEARCH
(by interview)

An explanatory study of health policy about immunisation related with religious (islamic) anti-vaccination movement in Indonesia

I .....

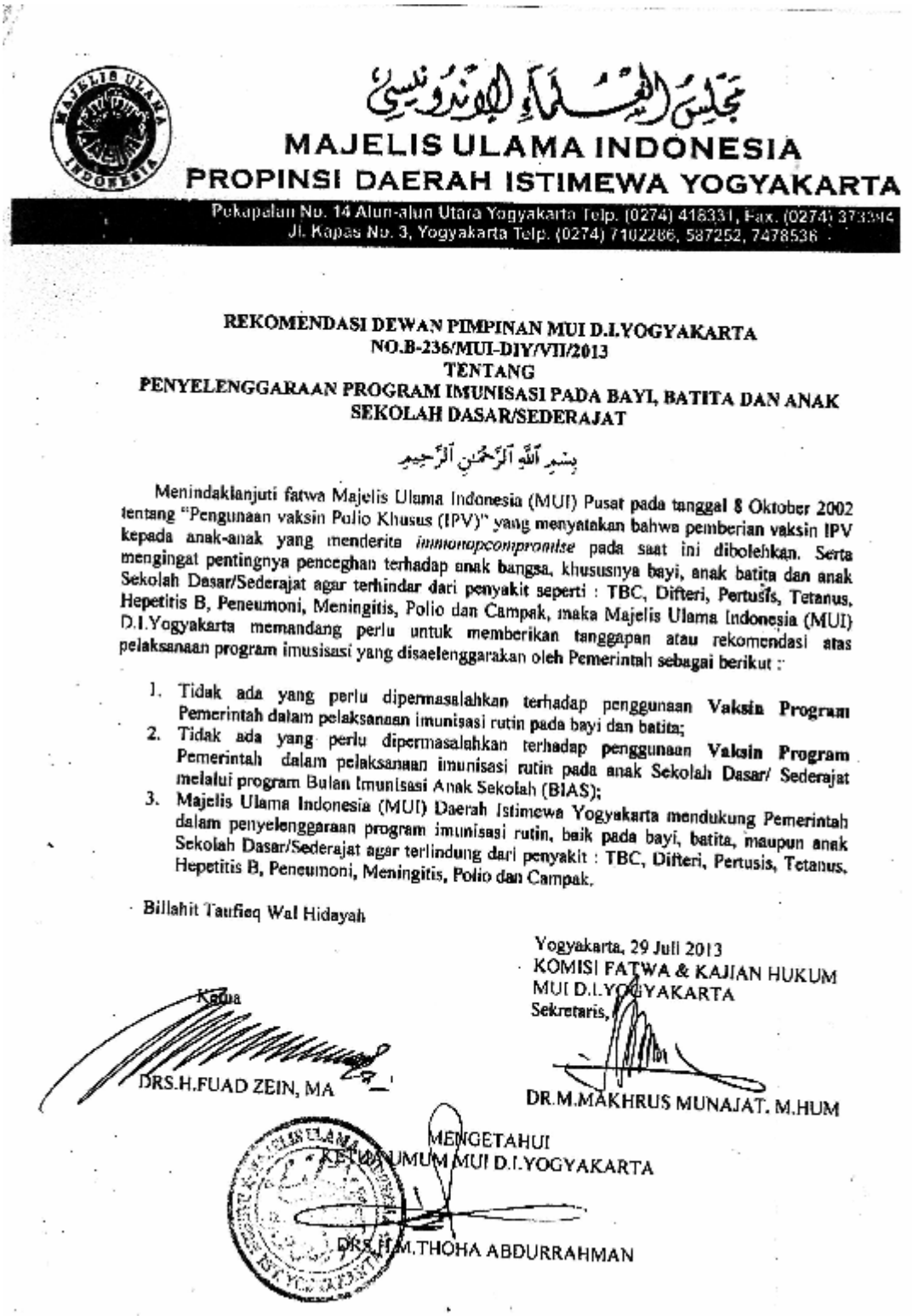
being over the age of 18 years hereby consent to participate as requested in the Information Sheet and Letter of Introduction for the research project on "An explanatory study of health policy about immunisation related with religious (islamic) anti-vaccination movement in Indonesia"

1. I have read the information provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to audio recording of my information and participation.
4. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.
5. I understand that:
   - I may not directly benefit from taking part in this research.
   - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
   - While the information gained in this study will be published as explained, absolute anonymity may not be fully guaranted.
   - Whether I participate or not, or withdraw after participating, will have no effect on any treatment or service that is being provided to me.
   - I may ask that the recording/observation be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.
6. I agree/do not agree* to the tape/transcript* being made available to other researchers who are not members of this research team, but who are judged by the research team to be doing related research, on condition that my identity is not revealed.
7. I, the participant whose signature appears below, have read the researcher's report and agree to the publication of my information as reported.

Participant's signature.....Date.....

12

MUI's Jogjakarta province letter recommendation for immunisation program despite without 'halal' wording



مجلس العلماء الإندونيسي

MAJELIS ULAMA INDONESIA
PROPINSI DAERAH ISTIMEWA YOGYAKARTA

Pekapalan No. 14 Alun-alun Utara Yogyakarta Telp. (0274) 418331, Fax. (0274) 373344
Jl. Kapas No. 3, Yogyakarta Telp. (0274) 7102286, 587252, 7478536

REKOMENDASI DEWAN PIMPINAN MUI D.I.YOGYAKARTA
NO.B-236/MUI-DIY/VII/2013
TENTANG
PENYELENGGARAAN PROGRAM IMUNISASI PADA BAYI, BATITA DAN ANAK SEKOLAH DASAR/SEDERAJAT

بِسْمِ ٱللَّهِ ٱلرَّحْمَٰنِ ٱلرَّحِيمِ

Menindaklanjuti fatwa Majelis Ulama Indonesia (MUI) Pusat pada tanggal 8 Oktober 2002 tentang "Pengunaan vaksin Polio Khusus (IPV)" yang menyatakan bahwa pemberian vaksin IPV kepada anak-anak yang menderita *immunapcompromise* pada saat ini dibolehkan. Serta mengingat pentingnya pencegahan terhadap anak bangsa, khususnya bayi, anak batita dan anak Sekolah Dasar/Sederajat agar terhindar dari penyakit seperti : TBC, Difteri, Pertusis, Tetanus, Hepetitis B, Peneumoni, Meningitis, Polio dan Campak, maka Majelis Ulama Indonesia (MUI) D.I.Yogyakarta memandang perlu untuk memberikan tanggapan atau rekomendasi atas pelaksanaan program imusisasi yang disaelenggarakan oleh Pemerintah sebagai berikut :

1. Tidak ada yang perlu dipermasalahkan terhadap penggunaan **Vaksin Program** Pemerintah dalam pelaksanaan imunisasi rutin pada bayi dan batita;
2. Tidak ada yang perlu dipermasalahkan terhadap penggunaan **Vaksin Program** Pemerintah dalam pelaksanaan imunisasi rutin pada anak Sekolah Dasar/ Sederajat melalui program Bulan Imunisasi Anak Sekolah (BIAS);
3. Majelis Ulama Indonesia (MUI) Daerah Istimewa Yogyakarta mendukung Pemerintah dalam penyelenggaraan program imunisasi rutin, baik pada bayi, batita, maupun anak Sekolah Dasar/Sederajat agar terlindung dari penyakit : TBC, Difteri, Pertusis, Tetanus, Hepetitis B, Peneumoni, Meningitis, Polio dan Campak.

Billahit Taufieq Wal Hidayah

Yogyakarta, 29 Juli 2013
KOMISI FATWA & KAJIAN HUKUM
MUI D.I.YOGYAKARTA
Sekretaris,

Ketua

DRS.H.FUAD ZEIN, MA

DR.M.MAKHRUS MUNAJAT. M.HUM

MENGETAHUI
KETUA UMUM MUI D.I.YOGYAKARTA

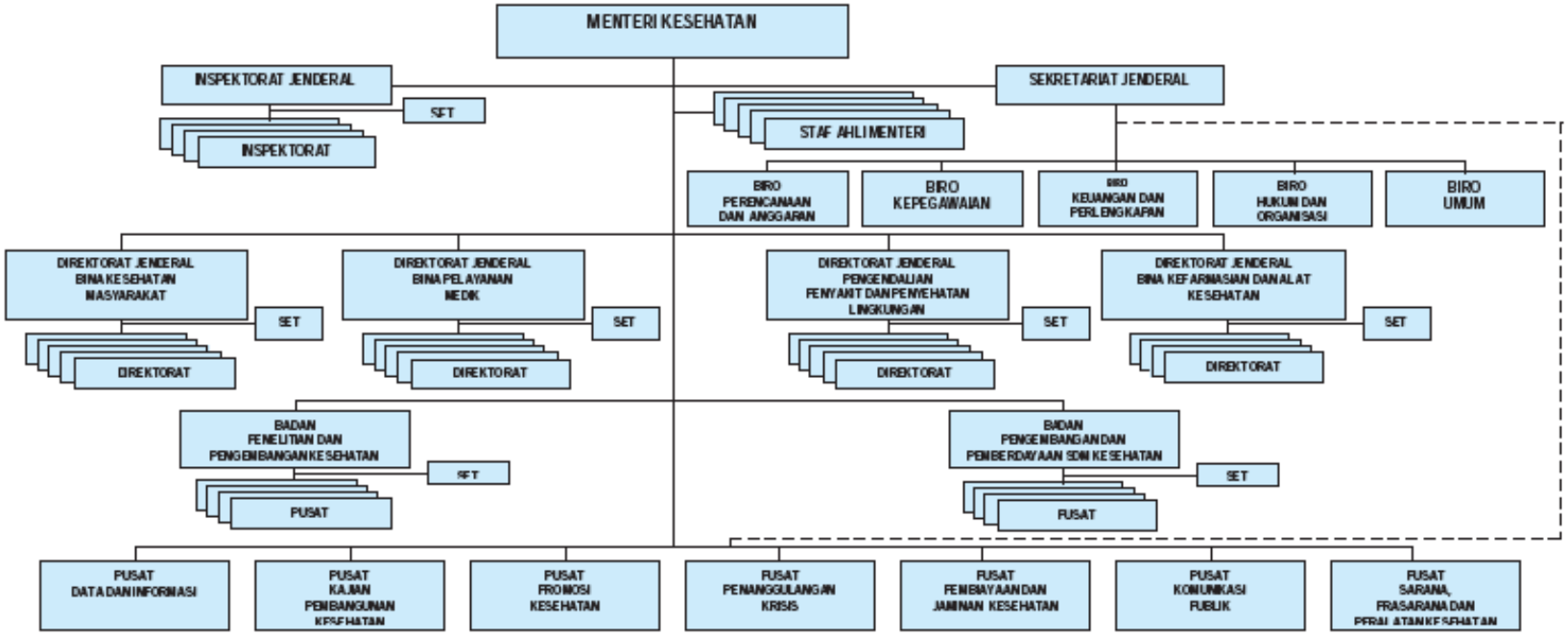
DRS.H.M.THOHA ABDURRAHMAN

Organizational structure of the MoH with hierarchical and internal vertical specialization

MENTERI KESEHATAN
REPUBLIK INDONESIA

LAMPIRAN PERATURAN MENTERI KESEHATAN
NOMOR : 1575/Menkes/SK/XI/2005
TANGGAL : 16 November 2005

STRUKTUR ORGANISASI DEPARTEMEN KESEHATAN



Turnitin Originality Report

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