

# The Right to Health in Evidence-based Policymaking: The Case of Indonesia, 2009-2017

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## Abstract

The right to health is included in United Nations (UN) Sustainable Development Goals (SDG) number 3, “Good health and well-being”. This goal aims to ensure healthy life and to promote well-being for all, at all ages. The SDGs, which build on the Millennial Development Goals (MDGs), provide a significant expansion to the development agenda. Inclusive development is part and parcel of the SDGs. Evidence-based policymaking studies provide explanations of normative and legitimate expectations for policymakers, namely, to use scientific evidence and specific indicators in their policymaking process. The right to health, as constructed, in evidence-based policymaking discourse is in contention. This paper addresses the various types of meaning Indonesian policymakers attach to the right to health through their discourses in norms of health policy. This study provides an analysis of discourses, regulatory analysis, and historical narratives (based on analysis of health regulations and newspaper articles) pertaining to evidence-informed policy in the health sector in Indonesia from 2009-2017. Our findings elucidate how the right to health manifests in the processes of evidence-based policymaking. We do so by way of a two-pronged analysis, i) discourse analysis at the macro level in Indonesia about the right to health as a norm and ii) health policymaking at the micro level, in the Indonesian district of Gunungkidul, within the region of Yogyakarta.

Keywords: *The Right to Health, Indonesia, Evidence-Based Policymaking, Health Policy*

## I. INTRODUCTION

The paper examines the meaning that policymakers in Indonesia attach to the right to health in their discourses concerning health policy norms and evidence-based policy-making. Indonesia is an interesting case study as changes in its health system are often accompanied by regulatory and policy changes as well. In 2004, the central government introduced social security laws, such as Law No. 40, Year 2004.

Jamkesmas (*Jaminan kesehatan masyarakat*/National Health Security) was implemented in 2008. Jamkesmas provides social assistance to access health services for poor and disadvantaged people. Contributions for the poorest Indonesians are paid by the Government of Indonesia. Jamkesmas is managed by the Ministry of Health. The BPJS (*Badan Penyelenggara Jaminan Sosial*), which is the ‘Social Security Administering Body’ related law, attempting to ensure social security related rights are fulfilled, was passed in 2011.<sup>1</sup> The BPJS and Jamkesmas work towards ensuring Universal Health Coverage in Indonesia.

In 2010, Indonesia’s central government launched various programmes in the health sector.<sup>2</sup> One leading initiative was the National Health Insurance (JKN/*Jaminan Kesehatan Nasional*) programme. This initiative was one of the administration’s priority approaches to establishing mainstream universal health coverage. By way of implementing the BPJS Programme, the state, i.e. the central government, subsidises health insurance premiums for the 92.4 million Indonesians who need them the most. All other Indonesians make contributions to the scheme.

In 2017, there was an issue with a national budget deficit amounting to 645,624,104 USD (9 trillion IDR). In order to overcome the financial deficit there was a discussion amongst officials within the BPJS about whether co-sharing of funds with participants for eight diseases (heart disease, cancer, kidney failure, stroke, thalassemia, cirrhosis hepatitis, leukaemia, and haemophilia) was feasible.<sup>3</sup> Also in 2017, a proposal was made by the Central government to involve district-level local governments to co-finance the overall health budget at a national level.<sup>4</sup> The district or city governments’ minimum contribution to the BPJS health services budget was in the spotlight as there was no co-sharing from either the district and city governments beforehand.

The International Covenant on Economic, Social and Cultural Rights (ICESCR), an international human rights instrument developed by the UN, provides an inclusive stipulation about the right to health in Articles 7, 11 and 12. The United Nations (UN) Sustainable Development Goals (SDGs) contain 17 goals, which are an urgent call for action by all countries, both developed and developing, in a global partnership.<sup>5</sup> These countries recognise that ending poverty and other deprivations must go hand-in-hand with strategies that advance health and education, reduce inequality, and promote economic growth – all while tackling climate change and working to preserve oceans and forests.<sup>6</sup> The right to health is included in UN SDGs 3: “good health and well-being”. The SDGs, building on Millennium Development

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1 The-Jakarta-Post, “Govt devises policy to mitigate BPJS Kesehatan’s financial deficit”, *Jkt Post* (10 November 2017), online: <<http://www.thejakartapost.com/adv/2017/11/10/govt-devises-policy-to-mitigate-bpjs-kesehatans-financial-deficit.html>>.

2 The-Jakarta-Post, “Govt to accelerate programs to overcome stunting among Indonesians”, *Jkt Post* (9 November 2017).

3 *Ibid.*

4 The-Jakarta-Post, *supra* note 1.

5 United-Nations, “Sustainable Development Goals”, (2018), online: <<https://sustainabledevelopment.un.org/?menu=1300>>.

6 *Ibid.*

Goals (MDGs), provide a significant expansion of the global development agenda. Inclusive development is a core focus of the SDGs.

This paper's principal question is: what kind of meaning do policymakers prescribe to the right to health in their discourses regarding norms in health policy? Evidence-based policymaking studies provides explanations for normative and legitimate expectations regarding policymaking as informed by scientific evidence, including indicators. However, the ways in which the right to health is constructed in the evidence-based policy-making discourse remains contentious. This paper provides an analysis of discourses, regulatory analysis, and historical narratives (based on analysis of health regulations and newspaper articles) pertaining to evidence-informed policy in the health sector of Indonesia from 2009-2017. Discourses explain discursive events that underpin policy processes and narratives. It also considers qualitative evidence gathered from Indonesian policymakers from different levels of governance. Our study finds that the right to health was rarely explicitly referenced, via normative terms, within the currently-existing laws on health care and health services in Indonesia that were produced through evidence-based policymaking processes. These rights are recognised, however, in the discourse of policymakers in reference to SDGs and other development-oriented goals. Budgeting practices in the healthcare sector, both at the district level and nation-state level (the Ministry of Health), still neglect considerations of the right to health. Rather the focus remains on bureaucratic practices during funding allocations. Moreover, we see a plurality of norms regarding the right to health. One norm may follow development goals, while another follows customs enforced by family and kinship ties encased in the belief system, as shown in our case study of one Indonesian district: Gunungkidul.<sup>7</sup> In part 2 of this paper we consider the right to health as a norm. In part 3 we consider evidence-based policymaking in Indonesia. In part 4 we discuss our methods and data analysis. In part 5 we discuss our research findings, including through a case study of Gunungkidul District, before proceeding to our conclusion in part 6.

## II. THE RIGHT TO HEALTH AS A NORM

What are the ways in which the right to health as a norm operates in evidence-based policymaking?<sup>9</sup> This section explores the ways in which a norm manifests in a policymaking setting. Norms, socially constructed expectations about appropriate behaviour, are the basis upon which normative order functions. Twining calls for normative ordering that reflects all levels of human relations in the various global, international, regional, transnational, intercommunal, territorial state, sub-state and non-state local sites.<sup>8</sup> One line of study, the Kelsenian approach, focuses on the hierarchy of norms. Kelsen argued that the law is a higher order norm as it wields a

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7 Gunungkidul is chosen as a case study as it is often overlooked due to the poverty, malnutrition, education, and the quality of soil of the district, which is in stark comparison with the region of Yogyakarta where Gunungkidul is located. The region of Yogyakarta was ranked at number two in Indonesia's Human Development Index in 2014.

8 W Twining, *Globalisation & Legal Theory* (London, UK: Butterworths, 2000).

coercive force to require human behaviour to comply with rules.<sup>9</sup> Another approach focuses on the ‘transplant’ of a norm from the global or international level to the nation-state level. This strand is visible in legal theories that identify the international drivers behind law reform.<sup>10</sup>

Understanding norms and how they operate in evidence-based decision-making in health is important. The ways in which new global norms for inclusion in, and exclusion from, established health interventions are based on varying visions of how disease, health and socio-economic ecologies globally intertwine.<sup>11</sup> Indonesia is a party to international treaties and protocols regulating health, including social determinants of health, through norms and standards governed, inter alia, by the UN and the World Health Organization (WHO). WHO creates norms by way of treaties, protocols and global codes.

There are several characteristics of a norm viewed from a sociological perspective which enables an understanding of how it may shape social interaction. For example, reciprocity is a norming trait, as pointed out by Gouldner,<sup>12</sup> that is universal in form and can be found in all value systems. The norm of reciprocity makes two interrelated minimal demands<sup>13</sup>: ‘First, people should help those who helped them and, second, people should not injure those who have helped them’. This example of a norm is of particular relevance to the right to health.

What are the pertinent functions of norm? Norms serve a stabilising function<sup>14</sup> and assist in starting social interactions within groups, functioning prior to the development of a distinct and customary set of status obligations.<sup>15</sup> Ullmann-Margalit (2015) argues that there are three types of norms. The prisoner’s dilemma (PD) is a norm that entices one to cooperate rather than defect in a particular situation assuming the objective form of a PD game. The partiality norm arises in situations to motivate players to stick to an original status quo, even if unequal. The coordination norm emerges in coordinated conditions to contribute to the motivation of all concerned to follow an established convention. In Ullmann-Margalit’s view, ‘convention’ should turn into a norm.<sup>16</sup> Whilst Gouldner’s ideas of reciprocity are derived from functional ideas of society, Ullmann-Margalit’s conception of norms hinges on rationality and game theoretic models. Within this second conceptualisation of norm, an important element is vacant: actors’ internal

9 Hans Kelsen, “On the Pure Theory of Law.” (1966) 1:1 *Isr Law Rev* 1–8.

10 W Twining, *Globalisation & Legal Theory* (London, UK: Butterworths, 2000).

11 Matthew Sparke, “Unpacking Economism and Remapping the Terrain of Global Health” in Adrian Kay & Owain David Williams, eds, *Global Health Governance: Crisis, Institutions and Political Economy* (London: Palgrave Macmillan UK, 2009) 131.

12 Alvin W Gouldner, “The Norm of Reciprocity: A Preliminary Statement” 25:2 *Am Sociol Rev* 161–178.

13 *Ibid.*

14 The norm of reciprocity plays a stabilising role in two ways; i.e. in the absence of a well-developed system of specific status obligations it has a stabilising role. Notwithstanding these obligations, it adds social stability even when the obligations are firmly established and present (Gouldner, *supra* note 12, 175).

15 Gouldner, *supra* note 12.

16 Edna Ullmann-Margalit, *The Emergence of Norms* (Oxford, UK: Oxford University Press, 2015).

predispositions and historical processes. Amitai Etzioni<sup>17</sup> adds, with regard to social norms, human behaviour is formed and shaped by processes of internalisation and persuasion, and that the norms themselves make up parts of rational choice and a reflection of historical processes. Thus, engaging the study of norms, in this context the norm of the right to health, through policymakers' discourses will bring to light the meaning-making process and how the norm is 'activated' in a jurisdiction.

There is a debate around tension in the promotion of norms between different legal orders or of the hierarchy in the international legal order.<sup>18</sup> It is also essential to shift from the contention that the promotion of human rights may insist on an adherence to certain values, despite the fact that the practice of international organisations remains pluralistic.<sup>19</sup> It is timely to move beyond this debate. In fact, it is more valuable to review the ways in which the norm of the right to health as a human right operates in domestic settings.

Discourses explain discursive events that underpin policy processes. The policy-making process is not as simplistic as integrating evidence and inserting science into the process. Technically, 'discourse' refers to a study of spoken or written-language use, the analysis of which reflects on social practices.<sup>20</sup> There are four perspectives encapsulated in terms of analysing discourses: persuasive, critical, analytic, and the sociology of knowledge approach.<sup>21</sup> Persuasive discourse is derived from literature of political science and organisation theory, wherein ideas, information and political persuasion all play an important role in analysis. In critical discourse, it is held that rational analysis should not be viewed as merely an instrumental activity, but a practice in reasoned and critical reflections concerning political values as well as policy assumptions. Analytic discourse consists of endeavours by the traditional community of policy analysts to integrate the concerns of critics into the practice of analysis.<sup>22</sup> Another approach is that of the sociology of knowledge, which explores the social realities that exist in the policy sector. It is an approach that combines considerations of the element of power, in a Foucauldian sense, in analysing discourses as 'practices of power/knowledge' and meaning production<sup>23</sup> and another element of social construction, such as the symbolic interactionist tradition of analysing public discourses and the social construction of collective action/problems.<sup>24</sup>

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17 Read Amitai Etzioni, "Social Norms: Internationalization, Persuasion and History" (2000) 34:1 *Law Soc Rev* 157-158.

18 Martti Koskenniemi & Päivi Leino, "Fragmentation of International Law? Postmodern Anxieties" (2002) 15 *Leiden J Int Law* 553-579.

19 Gerry Simpson, *Great Powers and Outlaw States. Unequal Sovereigns in the International Legal Order* (Cambridge University Press, 2009).

20 Norman Fairclough, "Critical discourse analysis and the marketization of public discourse: the universities" (1993) 42:2 *Discourse Soc* 133-168; Norman Fairclough, Guiseppina Cortese & Patrizia Ardizzone, *Discourse and Contemporary Social Change*, 1st ed (Bern: Peter Lang AG, Internationaler Verlag der Wissenschaften., 2007).

21 Louise G White, "Policy Analysis as Discourse" (1994) 13:3 *J Policy Anal Manage* 506-525; Reiner Keller, "Analysing Discourse. An Approach from the Sociology of Knowledge" (2005) 6:3 *Forum Qual Sozialforschung Forum Qual Soc Res*.

22 White, *supra* note 21.

23 Keller, *supra* note 21.

24 *Ibid.*

Access to health resources is a widely-protected right in international treaties and through soft law instruments. This right is prescribed in several related international law instruments, such as Article 25 of the Universal Declaration of Human Rights (UDHR), which was hailed by Jack Donnelly<sup>25</sup> as the most important statement of norms of the International Human Rights regime. In addition, ICESCR also provided quite an inclusive stipulation of the right to health in Articles 7, 11 and, most prominently, Article 12. The Committee on Economic, Social and Cultural Rights interprets the right to health in General Comment No. 14, Year 2000, as ‘an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health. These include access to safe and potable water and adequate sanitation; an adequate supply of safe food, nutrition, and housing; healthy occupational and environmental conditions; and access to health-related education and information, including on sexual and reproductive health. Further, the population retains the right to participation in all health-related decision-making at the community, national, and international levels’.<sup>26</sup>

The Committee of Social, Economic and Cultural Rights (the Committee) outlines the domestic implementation of the ICESCR in General Comments No.9. Section A. states that ‘the Covenant norms must be recognised in appropriate ways within the domestic legal order; appropriate means of redress, or remedies, must be available to any aggrieved individual or group; and appropriate means of ensuring governmental accountability must be put in place’.<sup>27</sup> Though the ICESCR does not specifically point out the means for the norms to be implemented in the national legal order, the ability to claim social-economic rights, including the right to health, in the state party of the ICESCR, remains vital. The Committee itself emphasises the importance of judicial remedies for violations. The General Comments No. 9 further states that ‘the adoption of a rigid classification of economic, social and cultural rights which puts them, by definition, beyond the reach of the courts, would thus be arbitrary and incompatible with the principle that the two sets of human rights are indivisible and interdependent’.<sup>28</sup> The justiciability, or the ability to claim socio-economic rights in the national court, is essential in ensuring the full enjoyment of human rights for the individual in the ICESCR signatory nation. The right to health imposes several obligations for immediate effect, such as non-discrimination and the prerequisite that a state is required to prepare a national plan for health care and protection.<sup>29</sup> This socio-economic right also calls for the establishment of indicators and benchmarks to be used to monitor progressive realisation.<sup>30</sup>

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25 Jack Donnelly, “International Human Rights. A Regime Analysis” (1986) 40:3 Int Organ 599–642.

26 CESCR, “E/C.12/2000/4 General Comment No. 14”, (2000), online: <<https://digitallibrary.un.org/record/425041?ln=en#record-files-collapse-header>>.

27 CESCR, “E/C12/1998/24 General Comments No 9”, (1998) of the Committee on Economic, Social and Cultural Rights (CESCR), *The Committee on Economic, Social and Cultural Rights (CESCR)- United Nations*.

28 CESCR, *supra* note 26.

29 Gunilla Backman et al, “Health systems and the right to health: an assessment of 194 countries” (2008) 372:9655 *The Lancet* 2047–2085.

30 *Ibid.*

The right to health, as it falls under the category of economic, social and cultural rights, may require considerable budgetary resources because it is associated with the provision of health care services. In its implementation or enforcement, it is also involves various actors, including state apparatuses, non-governmental organisations, and private providers of health care and pharmaceutical companies. The right to health overlaps with other rights, such as rights to food and water.

Domestic courts may adjudicate any claim to the right to health which may be brought by an injured party or through public interest litigation. According to Siri Gloppen,<sup>31</sup> public interest litigation aims to improve the situation of marginalised people at individual and community levels. Further she argues that the ultimate goal of public interest litigation is social transformation.<sup>32</sup> In upholding human rights, the national court may adopt one of several stances. Bahdi's study reveals that judges invoke international law for five interdependent yet discrete reasons. These are (1) as a concern for the rule of law, (2) as a desire to promote universal values, (3) due to a reliance on international law to help uncover values inherent within the domestic regimes, (4) as a willingness to invoke the logic of judges in other jurisdictions, and (5) out of concern for receiving a negative assessment from the international community.<sup>33</sup> Ann Marie Slaughter has pointed to the trend of transjudicialism in order to illustrate the ways in which courts communicate throughout the world, often increasingly referencing each other through national and transnational courts, and tribunals.<sup>34</sup>

In addition to court-based public-interest litigation, the right to health may be advanced by means of advocacy-related activities. Advocacy of the strategic movements of non-government organisations (NGO) and other civil society actors in pressing for reforms.<sup>35</sup> One relevant example of effective, education-related activity and advocacy is the Treatment Action Campaign (TAC), which was launched in South Africa on the 10<sup>th</sup> of December 1998 (International Human Rights Day) by a small group of political activists. The group's consensus statement stated that equitable access to health care, particularly HIV medicines, is a human right.<sup>36</sup> Treatment literacy is a TAC health education and communications programme that strives to educate HIV-vulnerable and impoverished people about the science of HIV, health, and the benefits of treatment.<sup>37</sup> After becoming equipped with proper knowledge about HIV, persons with HIV can become their own personally- and socially-empowered advocates.<sup>38</sup>

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31 Siri Gloppen, *Public Interest Litigation, Social Rights and Social Policy* (2005).

32 *Ibid.*

33 Reem Bahdi, "Globalization of Judgment: Transjudicialism and the Five Faces of International Law in Domestic Courts" (2002) 34:555 *George Wash Int Law Rev* 1-72.

34 Anne-Marie Slaughter, "A Typology of Transjudicial Communication" (1994) 29:1 *Univ Richmond Law Rev* 99.

35 Stephanie Doris Short, "The Human Right to Health (Book Review)" (2016) 22:2 *Aust J Prim Health* 174.

36 Mark Heywood, "South Africa's Treatment Action Campaign: Combining Law and Social Mobilization to Realize the Right to Health" (2009) 1:1 *J Hum Rights Pract* 14-36.

37 *Ibid.*

38 *Ibid.*

Networks of NGOs, which may sometimes involve the government, are essential in the effort to promote the right to health. Several network theories gauge the trends of networking among non-state actors and the state, especially in the trend of litigating the right to health. The ‘transnational advocacy network’ or ‘principled-issue’ theory captures how actors working internationally on a particular issue are bound together by shared values, a common language of discourse, and deep exchanges of information and services.<sup>39</sup> In summation, the right to health has been discussed in terms of international human rights instruments, both in international treaties and through soft law instruments. By focusing on a domestic setting, the right to health may be advanced by means of advocacy-related activities, by public interest litigation, as well as in discourses in policymaking. This particular right calls for considerable budgetary resources as it is related to health care and health services. Having explained the various ways in which a norm is conceptualised in a policymaking setting in the right to health context, as well as how discourses explain discursive events that underpin policy processes in understanding a norm, this section provides the ground for the study of this paper. The next section examines how evidence-based policymaking incorporates the right to health in health interventions and policy.

### III. EVIDENCE-BASED POLICYMAKING IN INDONESIA: HEALTH INTERVENTIONS & POLICY

In this study we primarily focus on health interventions and policy regarding nutritional health. Health interventions, specifically those that focus on nutrition, are needed in Indonesia given the history of nutritional deficiencies in poor communities within the country due to insufficient food intake.<sup>40</sup> Moreover, in the early 2000s, about 50% of Indonesian citizens – over 100 million people – suffered from various forms of nutritional deficiencies, which precipitated other major public health problems. These included intra-uterine growth retardation, protein energy malnutrition, iodine deficiency disorders, vitamin A deficiency, iron-deficiency anaemia, obesity, folate deficiency, zinc deficiency, calcium deficiency and osteoporosis, amongst others.<sup>41</sup>

The Government of Indonesia has launched various programmes emphasising the importance of nutritional health interventions. These include the rescue programme Social Safety Net in Health (*Jaringan Pengaman Sosial Bidang Kesehatan*) and Healthy Indonesia 2010 (*Indonesia Sehat, 2010*).<sup>42</sup> The former dealt

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39 Thomas Risse & Kathryn Sikkink, “The socialization of international human rights norms into domestic practices: introduction” in Thomas Risse, Stephen C Ropp & Kathryn Sikkink, eds, *Power Hum Rights Int Norms Domest Change* (Cambridge, UK: Cambridge University Press, 2009) 1.

40 Atmarita, *Nutrition Problems in Indonesia* (Yogyakarta, 2005).

41 *Ibid.*

42 *Maternal Behaviour in Child Rearing and Its Relation with the Child’s Health and Nutritional Status in the Rural area of East Lombok (Perilaku Ibu dalam Mengasuh Anak dan Hubungannya dengan Status Gizi dan Kesehatan Anak Balita di Pedesaan Lombok Timur)*, by Sauqi Ahmad & Ridwan (Lombok, Mataram, 2002).



with the problem of nutrition and community health and the impacts of the 1998 monetary crisis, and the latter established a health reform programme. These programmes were managed by the central government. The central government recognised that the intervention programmes required the support of the provincial (*Provinsi*) and district (*Kabupaten*) governments, especially in light of the health decentralisation era, which began in 1999 with the passing of Law Number 32 Year 2004 and Government Regulation Number 25 Year 2000 (*PP No. 25 Tahun 2000*). This period of time, i.e. from 1999 to 2004, allowed the introduction and implementation of provincial and district government programmes designed to improve maternal and child nutritional status in their constituent regions.

An example of one such health intervention was the Vitamin A capsule supplementation campaign. The Vitamin A capsule supplementation programme in Indonesia was praised as being quite effective between 1983-2008 in decreasing the frequency of severe vitamin A deficiency.<sup>43</sup> This intervention was then evaluated using the Nutritional and Health Surveillance System (NSS) – a project carried out by Helen Keller International in Indonesia which focused on the nutritional status of the population in South Kalimantan, South Sulawesi, East Java, and Central Java during the post-economic crisis era.<sup>44</sup> The NSS involves gathering household information on nutritional and health indicators. This information is then analysed for its significance or for indications of public health problems. The results of this analysis are then used to determine policy decisions, programmes and services designed to address the identified health problems.<sup>45</sup> By using the NSS, Berger<sup>46</sup> demonstrated how the Vitamin A capsule supplementation programme was not reaching the children at highest risk of malnutrition and infectious disease morbidity in urban Indonesia. Thus the surveillance system was efficacious in detecting the weaknesses of nutritional interventions. Berger has argued that NSS, in line with the health decentralisation policy in Indonesia, needs to be integrated with the local and provincial government decision-making, policy-making and resource-allocation processes.<sup>47</sup> As shown by the Vitamin A capsule supplementation, NSS, in conjunction with the decentralisation in health policy has developed a new dimension in allowing local governments to decisively intervene in population health issues.<sup>48</sup>

The ability of a household to finance food expenditures involves a complex interaction between food intake needs, access to safe water and sanitation, nutritional knowledge of caretakers, and access to care and medical services.<sup>49</sup> The usage of

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43 Sarah G Berger et al, “Malnutrition and morbidity among children not reached by the national vitamin A capsule programme in urban slum areas of Indonesia” (2008) 122 *Public Health* 371–378.

44 *Nutrition and health-related issues resulting from Indonesia’s crisis. Summary and recommendations*, by M Bloem et al (Jakarta, Indonesia, 1998).

45 Martin W Bloem, Regina Moench-Pfanner & Dora Panagides, *Health & Nutritional Surveillance for Development* (Helen Keller International Asia Pacific Regional Office, 2003).

46 Berger et al, *supra* note 43.

47 *Ibid.*

48 Farah Purwaningrum & Stephanie Doris Short, “Epistemic layers in development planning: A case study of the health sector in the Gunungkidul District, Indonesia” (2018) 33:4 *Int J Health Plann Manage* e1200–e1210.

49 Berger et al, *supra* note 43.

income as one of the chief determinants of nutritional status was been critiqued by several scholars. Wolfe and Behrman<sup>50</sup> argued that income is overrated as a nutritional determinant within the literature. Furthermore, Skoufias<sup>51</sup> found that increases in income are likely to widen the gender gap in malnutrition in rural areas, but diminish it in urban areas. In his study Skoufias<sup>52</sup> also pointed out that mothers with an education up to the junior or secondary level would be likely to have healthier children than would mothers with who had completed fewer years of schooling. For girls, the positive effect of a mother's education on health appears only if the mother has been educated to levels above that of senior high school.<sup>53</sup> Skoufias<sup>54</sup> demonstrated that gender discrepancies may be reconstituted through income generation. It has become increasingly apparent that the using maternal education as the sole indicator of socio-economic status would no longer suffice.<sup>55</sup> Several studies<sup>56</sup> have demonstrated that maternal education has the magnitude and significance to exceed the income effect. So far, we have explained nutritional interventions and programmes in the Indonesian context. The ensuing paragraphs will focus on evidence-based policymaking.

There are several key requirements of evidence-based decision-making within the discourse of public health. They are as follows: 1) intervention approaches are based on the best possible science; 2) problem-solving is multidisciplinary; 3) theory and systematic programme planning approaches are used; 4) sound evaluation principles are followed; and 5) results are disseminated to others who require the information.<sup>57</sup> An example of this evidence-based decision-making is the utilisation of the NSS to enable the District Government to gather information regarding health and nutrition in their working area; to monitor changes in health and the nutritional

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50 Behrman JR & Wolfe BL, "More evidence on nutrition demand. Income seems overrated and women's schooling underemphasized" (1984) 14 *J Devel Econ* 105-128.

51 Emmanuel Skoufias, "Parental Education and child Nutrition in Indonesia" (2006) 35:1 *Bull Indones Econ Stud* 99-119.

52 *Ibid.*

53 *Ibid.*

54 *Ibid.*

55 Barbara A Reed, Jean-Pierre Habicht & Cyrille Niameogo, "The effects of maternal education on child nutritional status depend on socio-environmental conditions" (1996) 25:3 *Int J Epidemiol* 585-592.

56 *Child Survival Nutritional Status and Household Characteristics: Evidence from Brazil*, by Duncan Thomas, John Strauss & Maria Helena Henriques, Center Discussion Paper (Yale, New Haven: Yale University: Economic Growth Center, 1987); *The Role of Maternal Schooling and its Interaction with Public Health Programs in Child Health Production*, by A Barrera, Center Discussion Paper (Yale, New Haven: Yale University: Economic Growth Center, 1988); Marie T Ruel et al, "The mediating effect of maternal nutrition knowledge on the association between maternal schooling and child nutritional status in Lesotho" (1992) 135:8 *Am J Epidemiol* 904-914.

57 R Brownson, J Gurney & G Land, "Evidence-based decision making in public health" (1999) 5:5 *J Public Health Manag Pract*, online: <<http://www.uic.edu/sph/prepare/courses/chsc400/resources/evidencebasedpublichealth.pdf>>; R Brownson et al, *Evidence Based Public Health* (Oxford University Press, 2003).

status of their constituent population over time; and to assess and monitor ongoing health and nutrition-related programmes.<sup>58</sup>

‘Evidence-based policymaking’ is held to be ‘the development, implementation, and evaluation of effective programmes and policies in public health through the application of principles of scientific reasoning, including systematic uses of data and information systems, and appropriate use of behavioural science theory and programme planning models’.<sup>59</sup> Evidence-informed policies may enhance the efficient use of resources while simultaneously augmenting accountability of officials and quality of public resources and programs.<sup>60</sup> However, the uptake of evidence in policymaking does not exist in a vacuum. There are indeed political and institutional factors which influence the uptake of evidence in health policymaking. These factors include: the concentration of power, political centralisation, democratisation, institutional mechanisms, staff turnover in government bodies, the intentions and motivations of donors and external organisations, the pressure of wider policy strategies and political cultures, and the alignment of evidence with predominant values or existing political agendas.<sup>61</sup> Head offers a more politically-sensitive three lenses of evidence-based policy<sup>62</sup> as follows: firstly, political knowledge – political actors’ know-how, analysis and judgment; secondly, scientific (research-based) knowledge – the product of a systematic analysis of current and past conditions and trends, and analysis of the causal interrelationships that explain conditions and trends; and thirdly, practical implementation of knowledge.

Approaches based more in public administration or political science provide realistic sketches of how evidence is included in decision-making. Such an approach, for instance, is visible in the literature on evidence-based decision-making by the Overseas Development Institute (ODI) scholars.<sup>63</sup> Rationality is central to this approach. In fact, these scholars expound that rationality is one of the cornerstones of evidence-based policy-making. According to Kay,<sup>64</sup> evidence-based policy making has been criticised as a revival of the ‘rationality project’, in which democratic politics are actually the thinly-veiled only play of selfish interests. Kay<sup>65</sup> argues that evidence-based policy-making should be understood as the transition from a single, unique, and universal rationality towards multiple rationalities that vary according to different policymaking contexts. If understood in these terms, evidence-based policy making can avoid several major criticisms and maintains the potential to solve policy-making issues.

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58 Bloem et al, *supra* note 44; Bloem, Moench-Pfanner & Panagides, *supra* note 45.

59 Brownson, Gurney & Land, *supra* note 57.

60 Howard H Goldman et al, “Policy Implications for Implementing Evidence-Based Practices” (2001) 52:12 *Psychiatric Serv* 1591–1597.

61 Marco Liverani, Benjamin Hawkins & Justin O Parkhurst, “Political and Institutional Influences on the Use of Evidence in Public Health Policy. A Systematic Review” (2013) 8:10 *PLoS*.

62 Brian W Head, “Three Lenses of Evidence-Based Policy” (2008) 67:1 *Aust J Public Adm* 1–11.

63 *Evidence-Based Policymaking: What is it? How does it work? What relevance for developing countries?*, by Sophie Sutcliffe & Julius Court (London: Overseas Development Institute, 2005).

64 Adrian Kay, “Evidence-Based Policy-Making: The Elusive Search for Rational Public Administration” (2011) 70:3 *Aust J Public Adm* 236–245.

65 *Ibid.*

In Lao PDR, Indonesia's neighbouring country, the use of evidence-based decision-making by policymakers is limited by their lack of interest in research results. The influence of funding and international support affects how evidence is used in decision-making. This is because capacity to use evidence and the availability of high-quality research hinges upon these factors.<sup>66</sup> The lack of communication between researchers and policymakers is also another potential barrier to the use of evidence in policy-making processes.<sup>67</sup> Studies on evidence-based policymaking, nonetheless, have not thoroughly discussed the right to health in Asian contexts. At this point, our study fills an important gap in research by way of an empirical study into macro- and micro-level factors affecting the evidence-based policy-making process in Indonesia.

#### IV. METHODS AND DATA ANALYSIS

This study is based on mixed qualitative methods. The methods include qualitative interviews, stakeholder engagement workshop data, observation from fieldwork and the stakeholder engagement workshop, regulatory analysis from 2009 to 2017 on evidence-based decision-making in the health sector, as well as newspaper articles in Indonesia from the 2009-2017. Qualitative interviews were conducted in 2009 with 21 respondents working predominantly in the government sector. Parliamentary members and non-governmental organisation (NGO) employees were also interviewed for the purposes of this research. Interviewees were systematically selected based on their policymaking and planning functions from a list of government officials who hold administrative positions at the rank of fourth, third and second echelons within District level of government.

A *stakeholder engagement workshop* was the second phase of qualitative data collection. The stakeholder engagement workshop aimed to: 1) evaluate the extent to which evidence-based decision-making is used to inform health policy in the district of Gunungkidul; and 2) identify barriers to the integration of evidence-based public health research into public health programmes in selected Indonesian District health systems. The workshop was recorded and analysed as part of the data collection process.

Data review for documentary research consisted of critical examination of relevant laws on health in Indonesia from 2009-2017 as well as newspaper articles from the same period. We used several local and national newspapers. These included Bernas, Jawa Pos, Kompas, The Jakarta Post and *Kedaulatan Rakyat*. Newspapers were published in both the Indonesian language and English. Papers were searched for the following keywords: health and nutritional interventions, the right to health, Gunungkidul, Yogyakarta and policymaking.

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66 K Jonnsson et al, "Health systems research in Lao PDR: Capacity development for getting research into policy and practice" (2007) 5:11 Health Res Policy Syst, online: <<http://www.pubmedcentral.nih.gov/articlerender.fcgi?tool=pubmed&pubmedid=17939854>>.

67 *Ibid.*

Table 1

No.	Newspaper	Relevant Articles
1	Bernas - Yogyakarta, Indonesia	10 articles
2	Jakarta Post - Jakarta, Indonesia	14 articles
3	Jawa Pos - Solo, Indonesia	3 articles
4	Kedaulatan Rakyat - Yogyakarta, Indonesia	12 articles
5	Kompas - Jakarta, Indonesia	68 articles
		107 articles in total

Primary and secondary data collected from interviews and newspapers were carefully and methodically analysed. The information from both interview transcripts and newspapers was categorised according to a framework based loosely on the Head approach.<sup>68</sup> We then tracked how these sources of information changed over time in order to develop a historical narrative on health policy regarding nutrition in the Gunungkidul district of Indonesia. We investigated how the use of evidence used in policy-making has changed over time using a contextual analysis framework.<sup>69</sup> The analysis of health systems and policy research operates outward. This is due to the fact that the results can precipitate an examination of a broader range of relationships that may influence the outcome of interest. This in turn could lead to a change in the unit of analysis or focus of intervention.<sup>70</sup> Conversely, contextual analysis also facilitates a better explanation for the inner workings and meaning of the main variable of interest.<sup>71</sup>

## V. DISCUSSION AND RESEARCH FINDINGS

### 1. Discourse Analysis in Macro-Level in Indonesia: The Right to Health as a Norm

In our previous research findings<sup>72</sup>, we allude to how the use of evidence in Indonesian health sector policymaking runs up against issues of transparency and

68 Head, *supra* note 62.

69 Asha George et al, "Anchoring contextual analysis in health policy and systems research: A narrative review of contextual factors influencing health committees in low and middle income countries" (2015) 133 Soc Sci Med 159-167.

70 *Ibid.*

71 *Ibid.*

72 *Evidence-based decision making to strengthen local governance: nutritional health interventions in Bantul and Gunungkidul*, by Fiona McDonald et al, ANU Policy Brief 10 (Crawford School of Economics and Government, ANU College of Asia and the Pacific, The Australian National University, 2009); Fiona McDonald et al, "Penguatan Tata Kelola Pemerintahan Daerah dengan Intervensi Kesehatan Gizi: Studi Kasus di Kabupaten Bantul dan Gunungkidul" (Evidence-Based Decision Making to Reform Governance at the District Level: The Case of Nutritional Policies, Programs and Interventions in Bantul and Gunungkidul" in Puguh Windrawan & Farah Purwaningrum, eds, *Sist Pengetah Dan Desentralisasi Kesehat Indones Kaji Multidisiplin Knowl Syst Health Decentralisation Indones Multidiscip Study* (Yogyakarta: Total Media, 2014) 73; Purwaningrum & Short, *supra* note 48.

neglects to use standardised research. Laksono Trisnantoro, a scholar of health policy and administration at Gadjah Mada University, has stated: “There are several health policies which are unclear. Health financing policies in Indonesia are shifting, without them being sufficiently backed up by pilot projects. I have the impression that changes (of health policy) are based on negotiations (rather than evidence)” (Statement on 26<sup>th</sup> of March, 2010).<sup>73</sup>

During the 2009 workshop, it became clear that, in terms of the right to health, norms often invoked by stakeholders and policymakers were attached to the MDG, now revised as the SDG and related to maternal and child health. Additionally, the minimum health care standards (*Standar Pelayanan Minimal Kesehatan/SPM*) at the district level - Health Minister Regulation 741/Menkes/PER/VII/2008 - were also cited by a number of participants in the workshop. The SPM itself is intended to function as a yardstick for monitoring and evaluation by setting certain targets. In terms of basic services, those that are relevant to health are specified in Article 2 of the SPM. These include: 90% coverage of baby visits in 2010; 90% coverage of health services for children below 5 years of age in 2010; coverage of additional food supplementation programme/*Pemberian Makanan Tambahan* (PMT) to encourage the breastfeeding for of children 6-24 months from poor families in 2010; 70% coverage of active birth control participants in 2010; 100% coverage of finding and managing diseases in 2010; 100% coverage of basic health services for the poor in 2015; and 80% health promotion and community empowerment in the coverage of active Alert Village (*Desa Siaga*), in 2015. *Desa Siaga* is a programme of the Ministry of Health of Indonesia which attempts to ensure village inhabitants have resource readiness and capability as well as the willingness to independently prevent and overcome health problems, disasters, and emergency, and maintain health overall.

Several stakeholders, particularly at the district level health bureaux, invoke the usage of SPM for monitoring and evaluating the effectiveness of their nutritional programmes and interventions, though they are not specific about which SPM indicators are invoked. The case is different at the *Pusat Kesehatan Masyarakat* (Puskesmas)/Health Community Centres level. In regard to monitoring and evaluation, the indicators are checked based on their field data or other activities (interview transcript, 2009). The volunteers at the peripheral level in Puskesmas and Posyandu (*Pos Pelayanan Terpadu/Health Service Integrated Posts*). have yet to invoke the aforesaid norms as regulated by the SPM and SDG. It is possible, since they are not involved in the development planning (*musyawarah perencanaan pembangunan/musrenbang*) process, that they would not be involved heavily in monitoring and evaluation. This is the task of the Health Bureau. Cognisance of SDG and SPM norms pertaining to the right to health are mostly seen at the district government level.

In Articles 12, 18 and 298 of Law No. 23 Year 2014 on Regional Government, health is specified as one of the six main government services' affairs. The socio-economic right to health translates more to minimum standards in health services. In 2018 and 2019, this is evident in Ministry of Home Affairs Regulation No. 100/2018

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73 Kompas, “Launched: forum for health policy (Diluncurkan, Forum Kebijakan Kesehatan)”, *Kompas* (26 April 2010).

on the implementation of minimum standards, Ministry of Health Regulation No. 4 year 2019 on technical standards on the fulfilment of quality of basic services on health, and Government Regulation No. 2 Year 2018 on minimum services standards. As an example, Article 2 section (3) of Ministry of Health Regulation No. 4 of Year 2019 specifies the types of basic services in District/City Regional Health services. These consist of the following: a) health services for pregnant women; b) maternity health services; c) newborn baby health services; d) toddler health services; e) health services at the age of primary education; f) health services at productive age; g) health services in the elderly; h) health services for patients with hypertension; i) health services for people with diabetes mellitus; j) health services for people with severe mental disorders; k) health services for people suspected of tuberculosis; and l) health services for people at risk of becoming infected with a virus (Human Immunodeficiency Virus) that weakens the human immune system. Upon closer examination, these laws—especially, Law No. 36 Year 2009 on Health—neglect to reference international conventions that are relevant to the right to health as prescribed in the ICESCR. Norms about the right to health refer mainly to the existing Indonesian law.

The right to health in an evidence-based policy-making context is explored and expounded in the discourses of human rights policymakers and NGO activists. On the issue of abandoned children, for example, activists for the Indonesian NGO Children Independent Secretariat Foundation (*Yayasan Sekretariat Anak Merdeka Indonesia* or SAMIN), Fathuddin claimed that the government failed to seriously consider and address the issue. Fathuddin stated that existing programmes are reactive, dealing only with the symptoms of the issue, though the government ratified the Convention on the Rights of the Child in order to commit to addressing problems of child welfare. By ratifying the Convention on the Rights of the Child, the fulfilment of children's rights becomes the responsibility of the government.<sup>74</sup>

This right to health, in terms of SDG norms, was also explicated by a member of the Human Rights National Commission in Jakarta.<sup>75</sup> The government of Indonesia runs a national programme to administer the Measles Rubella (MR) vaccine in Java. The MR vaccine is administered to children between 9 months and 15 years, and provided free of charge. In Java, this immunisation is carried out in 6 provinces, 119 districts/cities and 3,579 health centres. This scope includes 34,964,384 children. This vaccination programme aims to eliminate measles and rubella in Indonesia by 2020 to support the achievement of Goal 3 of SDGs ('Ensure healthy lives and promote wellbeing for all at all ages'). The vaccination programme, in relation to the aforesaid goal of the SDGs, is to achieve universal health coverage. Faith based schools in Yogyakarta state that the administration of vaccines should not be forced: some even forbid vaccinations.<sup>76</sup> Rejection of vaccines also occurs in some

74 Lusia Kus Anna, "Pengaruh Ibu Kurang Gizi pada Kesehatan Janin (Effects of Mother Suffering Malnutrition on Fetal Health)", *Kompas* (23 May 2017), online: <<https://lifestyle.kompas.com/read/2017/05/23/114000620/pengaruh.ibu.kurang.gizi.pada.kesehatan.janin?page=all>>.

75 Mimin Dwi Hartono, "Vaksinasi dan Hak Anak atas Kesehatan (Vaccination and Children's Right to Health)" *Kompas* (12 August 2017), online: <<https://sains.kompas.com/read/2017/08/12/205030323/vaksinasi-dan-hak-anak-atas-kesehatan?page=all>>.

76 *Ibid.*

areas in Yogyakarta. Childhood vaccination has contributed to saving millions of children's lives, and its efficacy is well established.<sup>77</sup> Healthy living is the right of every child, as affirmed in Article 53 paragraph (1) of Law Number 39/1999, concerning human rights, which states that the right of children to live and the right of children to health is guaranteed by Article 60. Parents and the community must, according to this law, provide their support to compliment government's efforts so that the goal of providing conditions for healthy living can be achieved.<sup>78</sup>

The national health budget saw an increase between 2009-2017 but not due to a recognition of the right to health. In 2016, however, the health budget finally met its much-anticipated objective of a 5% allocation. There were also health-associated budgets allocated to other ministries in addition to than the Ministry of Health, including that of the General Allocation Fund (*Dana Alokasi Umum*) and Special Allocation Fund (*Dana Alokasi Khusus*)<sup>79</sup> which were transferred from central to district governments for a range of purposes. There was a problem in 2016 as it was not possible for the allocated budget to be fully expended until the end of November 2016. This is due to the fact that the Ministry of Health had not provided the requisite supporting documents for budget disbursements. Initially, half of the funding was meant to support *Puskesmas*.<sup>80</sup> At the central level, health-budget spending faced a profound issue. The first was the absorption of the budget allocation. In 2011, for instance, the Ministry of Health managed to absorb 87.2% of the overall budget. One of the programmes that had a high degree of budget absorption pertained to health services. The health operational assistance (*Bantuan Operasional Kesehatan/BOK*) to *Puskesmas*. *Puskesmas* returned the BOK funding because it did not suit the needs and types of services provided in *Puskesmas* (Kompas 2012).

Legislation associated with the right to health is translated in terms of normative commitments in Indonesian laws. With regard to discourse, the right to health is activated without reference to international treaty obligations, but rather towards development-oriented goals. Two reasons for a lack of understanding of the right to health are 1) lack of manpower, and 2) unequal manpower distribution. Manpower is especially relevant to understanding the norm pertaining to the right to health. In addition to optimising *Posyandu* cadres, the Supplementary Feeding Programme (PMT) is considered beneficial in enabling the recovery of malnourished children under five years of age. The Head of the Yogyakarta Health Polytechnic Department of Nutrition, Joko Susilo, SKM, M. Kes, deplored the lack of health workers in the field of nutrition in each *Puskesmas*, where there should be at least one nutritionist. The reality is that many staff members have to work as managerial personnel, in addition to being nutritionists. "Around 75% of the nutrition school graduates in Yogyakarta are from outside Yogyakarta, so much of their work/attention/energy falls outside of Yogyakarta," said Joko (Kompas 2010). Tri Komala, a member of working group IV PKK Central Mover Team, reported that the *Posyandu* staff were

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77 *For every child, every right: The Convention on the Rights of the Child at a crossroads*, by UNICEF (New York: United Nations Children's Fund (UNICEF), 2019).

78 Hartono, *supra* note 75.

79 Kompas, "Health budget allocation goes up (anggaran kesehatan naik)", *Kompas* (6 July 2015).

80 *Ibid.*



mostly volunteers working without pay. “Despite the work being voluntary, staff are expected to run several programmes ranging from immunisation to early childhood education. The burden and responsibility is huge,” he insisted (Kompas 2010). A staff member who worked on a voluntary basis in Mertelu explained the importance of manpower in an interview when she was asked to reflect on her experience: “ It has to come with manpower. If there is an equipment, but there is no one running the equipment, it makes no sense. ... Prevention is not just about equipment. Manpower is not adequate in Wonosari (Gunungkidul)... “ (Interview, Gunungkidul) 28<sup>th</sup> of April 2009).

Our previous research has demonstrated the importance of evidence as the basis for health nutrition interventions and programmes. It increases the capacity and the quality of the interventions and programmes to achieve its intended aims; namely, reducing the numbers of cases of malnutrition and at the same time improving the nutritional status. By taking evidence as scientific knowledge, our earlier study explored the barriers to incorporating scientific knowledge for policymaking in governance structures, and topographical-health related and communication factors (McDonald et al. 2009, Purwaningrum and Short 2018). These barriers are the relatively centralised governance structures, broad coverage of karst land in Gunungkidul, which makes access to water difficult, and lack of communication amongst health officials. The next section examines health policy making and how the right to health was taken into account in Gunungkidul.

## 2. Health Policymaking in Micro-Level in Gunungkidul

In the Gunungkidul Regency, within the province of Jogjakarta, the district government pays significant attention to nutritional problems. For this reason, SKPDs (*Satuan Kerja Perangkat Daerah*/district government units) programmes are focused on eradicating nutritional issues. However, there is no integration of SKPD nutrition programmes, although many activities overlap in intention and effect. For example, the district health department has a PMT programme for toddlers. Likewise, the Family Hope Programme (PKH), which is supported financially by Ministry of Social Affairs, also allocates funding and resources for PMT activities. If integrated, the impact of these two separate programmes could be more effective and efficient, but they were implemented independently. In this way, existing nutrition programmes are a project executed in a bureaucratic manner, with a lack of collaboration across sectors. The right to health in treaty obligations was rarely referred to through these Gunungkidul processes and programmes.

Thus, complex health governance processes have implications for the promotion of the right to health in processes of evidence based-policymaking. Coordination is a prominent issue that prohibits the promotion of the right to health. With regard to health services, no effective coordination between the Regional General Hospital (RSUD) and the *Puskesmas* was found. The Regional General Hospital plays a more important role in handling curative problems while *Puskesmas* plays a role in handling the promotion of health care. When patients are returning from the RSUD, the hospital provides a form of referral to the *Puskesmas* in the

local area to monitor the patient. Often, the *Puskesmas* does not report back to the RSUD. Coordination between the RSUD and the *Puskesmas* is required if nutrition issues are to be effectively addressed. The coordination problem is attributable to the Gunungkidul's diverse geographic and topographical coverage. This broad scope renders it impossible for a strict top-down approach. In three areas of Gunungkidul—Planjan, Mertelu, and Grogol — we found that the availability and application health services are influenced by a number factors. These include geographical conditions; health planning, including contestations between different arenas for health intervention that make it difficult to simply classify health programmes from an urban-rural perspective; health information technology; and socio-spatial relations.

At the institutional level, the most common obstacles to the process of incorporation of evidence into health policymaking are: limited funds; the differences in data used in programme determination; the lack of available of methods for programme evaluation a programme; and the lack of health workers, especially those who specialise in nutrition. Additionally, limited funding prevents nutrition programmes from serving all target recipients. For example, the 'US' Food Supplementation Programme cannot be implemented in all schools in the Gunungkidul region due to funding constraints. For this reason, schools are prioritised for funding allocations based on the criteria for disadvantaged areas. Another problem relates to data. There is still erroneous data, in the form of data copy-pasting, carried over from the previous year. Additionally, there are also differences in the type and source of the data used in for programme design. Often, the data used is not from scientific research because there exists an assumption amongst Gunungkidul government officials that research results are difficult to apply in the field. Further, there is no clear methodology for programme evaluation. Only a limited collection of activity reports exists.

Interviewees explained that, at the human capital level, the number of nutritional workers in some areas in Gunungkidul was not proportional to the size and condition of the area covered. For example, some identified a district that was assigned only a single nutritional officer. For areas in which access is easy, distribution and access to human capital might not be an obstacle. For areas with difficult access, evidence suggests that the posting of additional nutritional officers should be considered so that the speed and quality of service to the community is ensured. Institutional-level obstacles in ensuring the posting of sufficient nutritional volunteers vary depending on access to areas in Gunungkidul. The obstacles create socio-economic conditions that render it difficult to mainstream the right to health evenly across the district.

In Gunungkidul, it will be difficult to sustain the current habit of nutritional volunteers (*kader gizi*) recommending the use of local resources for food, due to the lack of knowledge-base with regard to the local food alternatives available, as well as a lack of interaction among stakeholders through planning (*Musrenbang/Musyawaharah Perencanaan Pembangunan*) or decision-making processes (Purwaningrum and Short 2018). Nevertheless, it is essential to note that the Gunungkidul District government focuses on health issues, especially nutrition, although funds are still limited. This is demonstrated through the Gunungkidul goal to achieve a healthy community by 2015. Therefore, the SKPDs have programmes

related to nutrition promotion, which include the distribution of PMT, Fe syrup, and Fe tablets to overcome Iron Nutrition Anaemia (AGB). Other examples include the distribution of iodised salt to overcome Intellectual and Developmental Disabilities (IDD); giving vitamin A; and the establishment of health clinics, all of which are Ministry of Health programmes. The Office of Maritime Affairs and Fisheries (DKP), as well as Bapermas (*Badan Pemberdayaan Masyarakat/Community Empowerment Agency*) and the Office of Education, offer a programme promoting fish consumption. In addition, there are already nutrition-related activities carried out by several SKPDs, including the Family Hope Programme (PKH), Family Nutrition Improvement Efforts, and the Food and Nutrition Awareness System. In their implementation, coordination between sectors is suboptimal; demonstrating that the existing nutrition programmes are still sectoral. The programme should also be able to overcome nutritional problems by considering both the food itself as well as the financial demand on families with toddlers to meet their nutritional needs.

Behavioural patterns are an influential on the nutritional state of people, as well as on processes of evidence-based policymaking. When determining the extent to which the right to health as a norm can be internalised, attention should be paid to behavioural patterns of key actors, i.e religious/faith based leaders. Nutrition programmes that have been implemented in Gunungkidul district are more geared towards direct intervention by the provision of certain foods or supplements. Sometimes, this entails PMT programmes that provide supplements, such as Fe syrup and Fe tablets to overcome AGB. These nutritional programmes are implemented in the district level of Gunungkidul, without adequately addressing the behavioural patterns.

Behavioural patterns relate to how norms are internalised and structured in social organisations. Our contention is that there is a plurality of norms that pertain to health. In this paragraph, it will be demonstrated how kinship-based norms prevail and may hinder efforts to reduce the level of malnutrition. The case of the Village of Mertelu demonstrates the difficulty in reducing the rate of malnutrition. Residents in Soko follow kinship-based norms. A norm bars mothers from limiting the number of children in families. There are also other factors which may contribute to behavioural patterns; namely, low-level education with high rates of illiteracy and poverty. Cases of malnutrition, even severe malnutrition, are significantly higher in Mertelu. Among other considerations, this is due to the fact that family planning programmes (*Keluarga Berencana*) are not popular amongst the households due to adherence to the kinship norm around bearing children. Cases of families with three to nine children, all suffering from malnutrition, have been documented. Despite the efforts of nutritional volunteers, these kinship-based belief systems often prevent the advice of the volunteers being translated into action. The norms and social practices that have been internalised within the community are often deeply established and now pose obstacles to the efforts of health practitioners to institute the right to health. Cooperation between local informal leaders and nutritional volunteers is required to provide better services for, and to increase the health awareness levels of, residents in Mertelu. This kinship-based norm which ignores family planning is currently out of sync with the SDG norms and the ICESR.

## VI. CONCLUSIONS

This study has brought to light how the right to health as a norm manifests in processes of evidence-based policymaking in Indonesia. There is a lack of research about how the right to health is constructed in discourses concerning evidence-based policymaking in Indonesia. This analysis offers a significant lens for understanding how normative commitment in international treaties and soft laws translate into the practice of policymaking. In this case study, we have identified the presence of a plurality of norms that co-exist within discourses about health in Indonesia. One type of norm is the right to health as defined by SDGs, and another pertains to the customs enforced by family and kinship ties, as shown in decision-making processes within the district of Gunungkidul. These norms are not always in alignment.

Malnutrition —particularly severe malnutrition— is a public health issue, not only a poverty issue. Thus, remedying the problem requires more than a single-handed approach. It demands interdisciplinarity. On a short-term basis, rapid measures are needed from the local government or central government to mitigate cases of undernutrition and severe malnutrition. In the long run, the intervention ought to be based on a clear and evidence-based platform focused on continuity of direction for achieving increases in the quality of maternal and child health.

In the district of Gunungkidul, within the region of Yogyakarta, nutritional volunteers provided food based on food supplementation programmes and they educated their communities about what local foods are most nutritious. The right to health, as a human rights norm, was very rarely referred to during this decision-making process in Gunungkidul. That being said, moving forward, it is imperative that capacity building is promoted within the local parliament, as local parliamentary members face ongoing challenges in their efforts to access to data concerning health (population data, maternal data) in Gunungkidul. The local parliament also receives no support, in the form of expert staff, in conducting their work. This is in stark contrast with national parliamentary members. Health programmes and interventions from the central government, in the form of Special Allocation Funds (*Dana Alokasi Umum*), usually take the form of the purchasing of specific equipment and products. Sometimes, these efforts do not always address local needs (Workshop result, 2009). These budgeting practices are bureaucratic and rarely refer to commitments under either the SDGs or ICESCR.

The study has brought to light the kinds of effort needed to address human rights issues in Southeast Asia, beyond the international legal sphere. Efforts at national, regional and district levels must take into account the intricate relationships and power struggles between various economic interests, social and cultural norms, and religions of the focal region (Menski 2017). Overall, this study contributes to the existing literature on evidence-based policymaking from the right to health perspective. Further studies on the right to health, and on evidence-based policymaking should further examine norms arising from local customs and local culture and how this impacts on the realisation of the right to health. This Indonesian case study suggests that enforcement of norms pertaining to realisation of the right to

health should be cognisant of the different normative frameworks that operate at different levels of policymaking.

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