GENERATING POLITICAL WILL FOR SAFE MOTHERHOOD IN INDONESIA

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Abstract

In 1987 an international conference brought global attention to an issue that previously had been ignored: the world's alarmingly high number of maternal deaths in childbirth. The conference ended with a declaration calling for a reduction in maternal mortality by at least half by the year 2000.

As the deadline approached, safe motherhood activists lamented the fact that the world was nowhere near to achieving this objective. They attributed this failure to a variety of causes, but were in agreement that the medical technology was available to prevent maternal deaths in childbirth, and the key was generating the political will to make such technology widely available to women in developing countries.

What 'political will' means, however, has been left as an unopened black box. What causes governments to give priority to the issue of safe motherhood, given that national political systems are burdened with thousands of issues to sort through each year? In marked contrast to our extensive knowledge about the medical interventions necessary to prevent maternal death, we know little about the political interventions necessary to increase the likelihood that national leaders pay meaningful attention to the issue.

Drawing from a scholarly literature on agenda setting, this paper identifies four factors that heighten the likelihood that an issue will rise to national-level attention: the existence of clear indicators showing that a problem exists; the presence of effective political entrepreneurs to push the cause; the organization of attention-generating focusing events that promote widespread concern for the issue; and the availability of politically-palatable policy alternatives that enable national leaders to understand that the problem is surmountable.
The paper presents a case study of the emergence, waning and re-generation of political priority for safe motherhood in Indonesia over the decade 1987-1997, to highlight how these four factors interacted to raise safe motherhood from near obscurity in the country to national-level prominence. While there are contextual factors that make this case unique, some elements are applicable to all developing countries. The paper draws out these dimensions in the hope that greater knowledge surrounding how political will actually has been generated can help shape strategic action to address this much neglected global problem.

Keywords: safe motherhood; maternal mortality; political will; Indonesia; agenda-setting
Introduction

Several recent works have expressed concern that despite widespread global attention to safe motherhood, insufficient progress has been made in reducing the number of maternal deaths in childbirth in the developing world (Maine and Rosenfield 1999; Weil and Fernandez 1999). The World Health Organization and UNICEF estimate that there were nearly 600,000 such deaths in 1990 (WHO and UNICEF 1996), an alarmingly high figure that meant that almost one in every 200 births in the world resulted in the death of the mother. In 1987 an international conference on safe motherhood was held in Nairobi, Kenya, bringing together dozens of international organizations, NGOs and country representatives. The conference resulted in a declaration of global commitment to reducing the number of maternal deaths by half by the year 2000. Expectations were high that in the ensuing decade significant progress could be made in fighting this long-neglected issue. These hopes have not been met: it was clear at the end of 2000 that the world was nowhere near to achieving this goal, and it is not even certain that global maternal mortality levels have declined in the past decade to any significant degree.

Studies have attributed this lack of progress to multiple factors, but are in agreement on certain fundamental points (Maine 1993; Maine and Rosenfield 1999; Weil and Fernandez 1999): the major medical causes of maternal death in childbirth are well understood, the interventions are well-established to prevent such deaths, and the most critical of these is ensuring access to essential and emergency obstetric medical care in the event of complications arising during childbirth. What is lacking, it is commonly acknowledged, is not technical knowledge, but political will.

In marked contrast to our extensive knowledge about the medical and technical interventions necessary to prevent maternal death - a positive legacy of the past decade - we know little about the political interventions necessary to increase the likelihood that
national leaders pay meaningful attention to the issue.\textsuperscript{1} There is one exception to this statement: past experience indicates how to get the subject on to the global policy agenda. The Nairobi conference itself was an exemplary example. Safe motherhood advocates worked together to arrange an international conference, involving all the world's major institutional actors in the health policy arena, and succeeded in grabbing the world's attention for an issue that had long been neglected. Maternal mortality, once hidden, suddenly burst on to the global policy agenda, if only for a moment. The problem is that between global attention and national action lies a major gap.

This paper presents a case study concerning safe motherhood efforts in Indonesia in the decade that followed the Nairobi conference. It traces the emergence, waning and re-generation of political priority for the cause through the year 1997. The case study begins with Nairobi, but this is only the starting point. Thereafter a significant number of developments took place within the domestic political system that brought the issue to national prominence. Nairobi was enough to jump-start the process, but not enough to sustain it. The purpose of presenting the case study is to distill elements that may help us understand how political priority for safe motherhood may be sustained at the level of the nation-state. Indonesia is unique in many respects and no claim is made that all aspects of the experience of this country are relevant for the great diversity of countries facing safe motherhood crises. Nevertheless, there are certain dimensions of the case that may be of use for safe motherhood efforts in other countries, as well as for other public health causes such as infectious disease control, health sector reform and family planning promotion.

In exploring the case the paper draws extensively from a long-standing literature in the field of policy studies on the subject of agenda setting. Agenda setting is that stage in the public policy process in which certain problems rise to the attention of policy-makers while others recede or are ignored completely.\textsuperscript{2} It is the first stage in this process and precedes three others: the formulation of policy, the enactment of authoritative
decisions, and the implementation of policy (Kingdon 1984). The central importance of agenda setting in the public policy process is expressed forcefully in a famous statement by E.E. Schattschneider (1960) that, "the definition of the alternatives is the supreme instrument of power." It is only those possibilities that become salient to national political actors that stand a chance of actualization.

In the past decade scholars concerned with safe motherhood have made considerable gains in terms of raising maternal mortality as an issue of global proportions (Rosenfield and Maine 1985; WHO and UNICEF 1996); identifying the medical causes of maternal death in childbirth (Glazener, Abdalla, Stroud, Naji, Templeton and Russell 1995); delineating the cultural and socioeconomic dynamics surrounding pregnancy care (Ministry of Health Republic of Indonesia, UNDP and WHO 1991a; Tinker and Koblinsky 1993); and, especially, specifying the medical and policy interventions needed to ensure that pregnancy is safe and that complications, when they arise, are treated (Maine 1993; Maine, Akalin, Chakraborty, De Francisco and Strong 1996; Maine and Rosenfield 1999; Ronsmans, Vanneste, Chakraborty and Van Ginneken 1997; Thaddeus and Maine 1990; Tinker and Koblinsky 1993; Weil and Fernandez 1999). This paper adds to this literature a fifth concern that has been neglected - how political will gets generated for safe motherhood - so that the fight to surmount the global maternal mortality crisis may be approached strategically on this dimension as well.

**Background**

A vast literature on agenda setting exists, much of it inspired by Schattschneider's writings. This body of work identifies systematic features shaping the likelihood that an issue will rise to the attention of policy-makers. Four factors are laid out here. This is not an exhaustive list, and many irregularities infuse the process. However, agenda setting exhibits distinct patterns.
In one of the earliest works on agenda setting, Jack Walker (1974), analyzing traffic safety policy in the United States, argued that among the factors that shape whether an issue rises to the attention of policy-makers is the presence of a clear, measurable indicator to mark that issue. Walker’s insight had great influence on the thinking of John Kingdon (1984), whose streams model of the agenda setting process subsequently become canonical in the public policy field. Investigating health and transportation policy-making in the United States, Kingdon also found that indicators had agenda setting power.

Why should indicators make such a difference? After all, they are in many ways trivial items, often unreliable and inaccurate, and unable to portray the complexity of difficult social problems. All too frequently they over-simplify matters that deserve far more nuanced treatment. On the other hand, they have a uniquely powerful effect of giving visibility to that which has remained hidden. For instance, in the population field, studies that have highlighted high total fertility rates and population growth rates have served to bring to light population problems, and contributed to the mobilization of national states and international agencies for population control. Prior to the existence of such reports, many national political figures were unaware that any problem existed at all, making it difficult to generate action. The deeper significance of indicators as agenda setting factors is that they serve not only monitoring purposes, the way they are traditionally understood. They also function as catalysts for action.

A second factor that researchers have identified is political entrepreneurship (Doig and Hargrove 1987; Kingdon 1984; Schneider and Teske 1992; Waddock and Post 1991; Walker 1974). Whether an issue rises to the attention of policy makers is not simply a matter of the flow of broad structural forces that stand beyond the reach of human hands. Much depends on the presence of individuals and organizations committed to the cause. As John Kingdon puts it, "Entrepreneurs do more than push, push, and push for their proposals or for their conception of problems. They also lie in
wait – for a window to open. In the process of leaping at their opportunity, they play a central role in coupling the streams at the window” (1984, 190-191).

Not just any person can be an agenda setter, however. Research has shown that effective political entrepreneurs possess certain distinct features. They have a claim to a hearing; they are persistent; they are well connected and have excellent coalition-building skills; they articulate vision amidst complexity; they have credibility that facilitates the generation of resources; they generate commitment by appealing to important social values; they know the critical challenges in their environments; they infuse colleagues and subordinates with a sense of mission; and they are strong in rhetorical skills.

A third factor is the occurrence of focusing events (Birkland 1997; Kingdon 1984). These are large-scale happenings such as crises, conferences, accidents, disasters and discoveries that attract notice from wide audiences. They function much like indicators, bringing visibility to hidden issues. Birkland has demonstrated that disasters, including hurricanes, earthquakes, oil spills and nuclear power plant accidents lead to heavy media coverage, interest group mobilization, policy community interest, and policy-maker attention, causing shifts in national issue agendas.

A fourth factor is the presence of feasible policy alternatives to address the issue at hand (Birkland 1997; Kingdon 1984; Walker 1974). Such presence is in turn shaped by the existence of policy communities – groups of experts concerned with policy creation who spend time and resources developing proposals to solve problems in particular issue areas. Kingdon (1984, 122) likens the operation of alternative generation to one of survival of the fittest, a dynamic of 'biological natural selection'. Whether a matter can sustain serious attention is contingent not simply upon whether it is indeed a problem. It also matters whether there exists a community of individuals concerned with devising solutions to the problem, and whether that community is successful in generating workable solutions. These best solutions will bubble up in a natural selection
process. Those that will surface will be ones that are sensible, cost-effective, technically feasible, politically palatable, and relevant to the problem at hand.

In sum, scholars working in the agenda setting field have identified clear patterns concerning the ascendance of issues to national prominence. An issue is more likely to appear on a national policy agenda if it is marked by a salient indicator, if it is backed by effective political entrepreneurs, if it is given attention through a focusing event and if policy communities develop feasible proposals to address the problems. In this section, each factor has been considered separately. However, it is clear that the four interact to shape policy priority.

Methodology

This study of Indonesian safe motherhood was part of a larger investigation of public health programmes in the country undertaken to evaluate the political and bureaucratic factors shaping policy effectiveness in industrializing nations. I spent nine months in Indonesia in 1996 conducting interviews, observing program implementation and collecting government documents and local research reports on safe motherhood, family planning and child immunization policy. For the case of safe motherhood, in-depth, unstructured interviews were conducted with the major actors involved in policy formulation and implementation, including individuals in the government, the donor and the NGO communities. I also attended several national safe motherhood seminars and visited program implementation sites in Jakarta and other parts of the country. In addition, I collected and analyzed government documents and decrees, meeting reports from major safe motherhood gatherings and local studies of Indonesian maternal mortality and safe motherhood. Information and safe motherhood data were gathered from governmental, non-governmental and research institute collections in order to cross-check data validity and reduce bias.
In analyzing the information, a process-tracing methodology was used. The aim was to employ multiple data sources to trace patterns and causal paths, and to determine the course of events that led to the emergence of safe motherhood priority in the country and to safe motherhood outcomes. Prior to gathering the information I had a set of presumptions, derived from prior research in the public policy field, concerning why and how policy issues emerge on to national agendas, but no knowledge of either the extent to which priority for safe motherhood had developed in the country, nor of the impact of any safe motherhood efforts that may have taken place. The case, thus, was not selected based on any dependent variables, but rather on its potential to advance understanding concerning the processes and forces that facilitate or obstruct the emergence of issues on to national policy agendas.

The case: Indonesian safe motherhood, 1987-1997

Indonesia has had a long-standing problem with maternal mortality. As of the early 1990s its maternal mortality ratio stood at around 400 deaths per 100,000 births; almost two-thirds of women delivered in the absence of skilled birth attendants, and almost three-quarters gave birth outside medical institutions.

Table 1: Indonesian safe motherhood indicators to early 1990s

(ABOUT HERE)

Despite the persistent problem, it was not until 1988 that the issue received significant political priority. A global focusing event, the 1987 international safe motherhood conference in Nairobi, provided the spark. The global proportions of maternal mortality – more than 500,000 deaths a year – were widely publicized during and after this gathering (WHO 1990, 5), and the meeting officially launched the international Safe Motherhood Initiative.
Immediately after the international conference a series of safe motherhood seminars commenced in Indonesia and continued throughout the 1990s. The watershed event was Indonesia's first national seminar on safe motherhood, held in 1988. President Suharto delivered the keynote address (Shah and Sudomo 1991, iii). Seventeen major organizations participated in this initial seminar, including a number of international agencies involved in safe motherhood, and pledged to reduce the country’s maternal mortality rate. That this was more than an idle commitment was reflected in the fact that for the first time in the country’s history, the national development plan included official maternal mortality reduction targets, with the aim to lower the country's maternal mortality ratio from 450 to 340 between 1988 and 1993 (Shah and Sudomo 1991, iii).

*Entrepreneurship by the Ministry of Health*

The subsequent flurry of Indonesian safe motherhood activity following the national conference was due in large part to political entrepreneurship and feasible policy alternatives coming from officials in the Ministry of Health, particularly doctors Nardho Gunawan and Ardi Kaptiningsih. A village midwife (bidan di desa) program, begun in 1989, was the first and most significant intervention. Reflecting a concern that women in rural Indonesia had poor access to skilled medical care during their pregnancies, the Ministry managed to place one midwife in most of Indonesia’s 68,000 villages to ensure that pregnant women could get both pre-natal and delivery assistance. At the time only around 13,000 midwives were available to village woman (World Bank 1991, 45), meaning that only a small portion had access. In 1991 the World Bank offered support for the program through its fifth population loan to Indonesia, covering the period 1991 to 1996, for an amount of US$ 104 million, a large part of which was earmarked for the midwife program.
The Ministry devised new training systems in order to hasten the production and placement of midwives. At one point the president intervened directly, remarking that the seven-year timeframe originally developed for program completion was too long, and requesting ways be found to shorten the length of time. The Ministry of Health’s initiative had its intended effect. By the end of the 1996/1997 budget year, 52,042 midwives were in place, covering 96 percent of the 54,120 villages that had needed midwives as of 1989 (MoH 1998).

Ministry leaders undertook a number of other initiatives to mobilize their own bureaucracy and local governments to support safe motherhood efforts. In 1993 the Ministry brought all 27 of its provincial heads to Jakarta for a seminar on maternal and child health, one of whose goals was to devise strategies to address the maternal mortality issue (DepKes 1993). The Ministry initiated a series of audits in many districts across the country that enabled local governments and health offices to identify medical and non-medical issues contributing to the maternal mortality problem. The Ministry organized provincial seminars to encourage cooperation between health and local government on maternal mortality. It cooperated with UNICEF and the Ministry for Home Affairs on a broader maternal and child health program known by its Indonesian acronym KHPPIA, one of whose goals was the reduction of maternal mortality. In the early 1990s the Ministry worked with WHO and UNDP to produce a series of five reports on the causes of high maternal mortality in Indonesia and to develop interventions needed to overcome the problem (Shah and Sudomo 1991). One of these reports was a comprehensive national plan of action for safe motherhood involving multi-sectoral collaboration.

After the Nairobi seminar donor interest in safe motherhood also grew markedly, and resources available to Indonesia rose in consequence. Aside from the World Bank with its involvement in the midwife program, WHO, UNICEF, USAID, the Asian Development Bank, the Australian Agency for International Development and several other donor agencies, also began safe motherhood projects. To help coordinate efforts, a
donor forum was organized by the Ministry of Health and WHO. By the early 1990s the majority of Indonesia’s 27 provinces had a safe motherhood program sponsored by an international organization, in addition to the village midwife program that covered the entire nation.

*Sudden burst of new priority for safe motherhood*

In 1994 information surfaced that rattled members of the Indonesian safe motherhood community. The Indonesian Demographic and Health Survey (IDHS) that included the most extensive study of maternal mortality conducted to date, reported a ratio of 390 deaths per 100,000 births, making it appear that, despite six years of attention, maternal deaths were almost as common as they had been a decade earlier (when the 1985 National Household Survey reported a figure of 450). Moreover, the country was far away from the goal set after the 1988 seminar of a reduction of the ratio to 340 by the end of the five-year plan. Even more disturbing, the 1994 IDHS reported that the ratio may have risen over time – from 326 in the early 1980s, to 360 in the mid-1980s to 390 as of 1994. ³

It was in an environment of bureaucratic dispersion of efforts and the troubling 1994 IDHS maternal mortality results that a new burst of political priority suddenly emerged, one that took government and donor agencies by surprise and that eventually led to the re-emergence of presidential priority for the program. The surprise was particularly marked because the spark appeared to come from an institution that in the past had been lethargic: the Ministry for Women’s Roles.

There was simply no way of predicting this burst beforehand. The evidence suggests it was connected to the chance embrace of the cause by a highly regarded bureaucrat at the assistant minister level who happened in 1995 to move from the national family planning agency to the Ministry for Women’s Roles (for reasons entirely unrelated
to safe motherhood). In that year medical doctor and retired general Abdullah Cholil, considered to be among the most effective leaders in the Indonesian bureaucracy in the social development sector, took up the position of Assistant Minister for Women’s Roles.

Troubled by the 1994 IDHS maternal mortality ratio, and dissatisfied with bureaucratic efforts for safe motherhood to date, in 1996 Cholil developed a national campaign to raise attention to the plight of pregnant women. Cholil had attended the international Beijing Conference on Women in 1995, where the issue of maternal mortality was raised and where he came up with the idea for a domestic campaign. Upon returning to Indonesia, with the support of international organizations, his Ministry succeeded in mobilizing the Indonesian political system for this cause, including the president, the Ministry for Home Affairs, provincial bureaucracies and donor agencies. This time, however, safe motherhood efforts had an additional dimension beyond the enhancement of service delivery. They focused not just on improving obstetric care, but also on raising social concern for the plight of pregnant women, based on the assumption that the problem had in part to do with the low status of women in the country.

Soon after returning to Indonesia from Beijing, Cholil and his minister, Mien Sughandi, paid a visit to the President and informed Suharto of Indonesia’s continuing problem with high maternal mortality. In March of 1996, the Ministry for Women’s Roles organized a national follow-up symposium to the Beijing conference (KMN UPW 1996a). Cholil was chair of the organizing committee, and maternal mortality was placed on the conference agenda as one of the four key topics. The gathering attracted President Suharto, who gave the opening address (KMN UPW 1996b).

Three months after this conference, in June of 1996, the Ministry for Women’s Roles hosted another national gathering, this time specifically on the topic of maternal mortality (KMN UPW 1996d). At this seminar were district-level chiefs and other representatives from eight provinces where the majority of Indonesia’s maternal deaths were taking place, and representatives from UNICEF, WHO and the UNFPA. Smaller
seminars on narrowly focused issues such as this did not normally generate presidential participation. However, the president was convinced again to give the opening address, the second time in just three months that the Ministry for Women’s Roles had secured Suharto’s participation in an event it had organized. Again, the president spoke on the problem of high maternal mortality, and this time his entire speech was devoted to the topic. In his remarks on this occasion, unlike those at the seminar three months earlier, he spoke of the connection of the status of women to maternal death, an issue Cholil had been concerned about since his trip to Beijing.

It was at this seminar that a name for a second national movement to promote maternal mortality reduction was found, ‘Gerakan Sayang Ibu,’ which translates roughly as ‘the Movement to Cherish Mothers.’ In the year following the seminar there was a new flurry of safe motherhood activity in Indonesia, this time under the Gerakan Sayang Ibu (GSI) umbrella. In a series of monthly meetings of all the ministers involved in the social welfare sector it was agreed that the Ministry for Women’s Roles should act as coordinator of Indonesian safe motherhood initiatives. It was also agreed that extra appropriations would be given to the Ministry for Women’s Roles for this campaign beyond the routine budget. A national GSI committee was set up, chaired by the Minister for Women’s Roles, as well as provincial and local committees to guide the movement. Primary activities included local government mobilization, the recording of pregnant women through women’s organizations so that they could be given assistance as delivery approached, and the designation of certain hospitals for safe motherhood services. Messages were developed to promote a more active role for husbands in pregnancy issues and to encourage couples to plan early in pregnancy in the case of complications at delivery (WHO, 2001). The culmination of all these events occurred on December 22, 1996, when President Suharto, on National Mother’s Day, announced the official launch of Gerakan Sayang Ibu (Kompas 1997).
Impact of bureaucratic initiatives

Indicators suggest that these ministerial initiatives had significant impact on the country’s safe motherhood situation (figure 1).

Figure 1: Change in Indonesian safe motherhood indicators following 1987 Nairobi conference

(ABOUT HERE)

In the decade following the Nairobi conference, the number of villages with access to midwives rose by 500%, from 16 to 96 percent of all locales in the country. The skilled delivery percentage rose from 34 to 62 percent by 1998, strongly suggesting the causal impact of the initiative. The percentage of women receiving ante-natal care rose from 57% in 1987, the year the international safe motherhood initiative was launched, to 88% by 1998, while the mean number of ante-natal care visits per woman rose from 3.2 in 1987 to 4.7 in just six years. While broader social development may also have been at work, the degree of change in such a short period of time indicates the impact of state-directed interventions.  

Discussion and Conclusion

Indonesian safe motherhood and agenda setting theory

After 1987 the issue of safe motherhood rose from near obscurity in Indonesia to prominent national level attention. In retrospect it appears that Indonesia experienced a phased approach to safe motherhood promotion. The first phase took place from 1988 to 1995, during which the policy elements were developed and implemented. The second phase occurred from 1996 on, with a revitalization of the initiative by a new set of political actors who pushed a program whose major elements were already in place.
Evidence indicates that these state efforts contributed to better safe motherhood conditions for Indonesian women. How in such a short time span did safe motherhood rise so high on the policy agenda?

Agenda-setting research directs us to some of the causes. First, there was a series of prominent focusing events. The 1987 conference in Nairobi on safe motherhood, attended by Indonesian representatives, brought international attention to the issue. It led to another focusing event - Indonesia’s own national symposium on the issue in the year following Nairobi - and to the emergence for the first time of serious concern for safe motherhood in the country. National safe motherhood seminars in the mid-1990s provided an additional burst of priority. Second, capable political entrepreneurs promoted the issue. Assistant Minister for Women's Roles Abdullah Cholil, a public servant with a long-standing record in political mobilization for public health causes, was directly responsible for giving the issue national visibility and bringing the maternal mortality problem to the attention of President Suharto. Bureaucratic initiative on the part of Ministry of Health doctors in the late 1980s also was critical in putting the issue on the national agenda. Third, the existence of clear indicators helped mobilize attention. The high maternal mortality ratio in the country as of the late 1980s provided an initial spur for action. The persistence of a disappointingly high ratio revealed in a 1994 demographic survey sparked additional concern, directly motivating Cholil to act. Fourth and finally, Indonesian bureaucrats developed feasible policy proposals to attack the problem. The village midwife program was a coherent, sensible means of addressing the issue, one that senior policy-makers, including the president himself, easily grasped and bought into, and that was not inordinately costly. Cholil’s campaign to raise attention to the plight of pregnant woman was also a carefully crafted initiative. In sum, a focusing event, a clear indicator, effective political entrepreneurship and workable policy proposals combined to move safe motherhood from obscurity to national prominence in Indonesia over the course of just a decade.
The case does suggest some limitations of agenda setting theory and the need for modifications in its research focus. The major works that have shaped public policy agenda setting theory have been based almost exclusively on single-country studies of advanced industrial states, especially the United States. This thrust has led to a mistaken understanding of agenda setting as largely a domestically-driven process in which forces from outside the nation-state play little or no role in setting public policy priorities. In the Indonesian safe motherhood case it is clear that agenda setting involved an interaction of national and transnational forces. For instance, the 1987 Nairobi conference was the spark for the emergence of safe motherhood priority in Indonesia, the 1995 International Conference on Women in Beijing prompted a prominent Indonesian public servant to re-cultivate attention in his country, and significant donor interest facilitated the rise of safe motherhood on to the Indonesia policy agenda. More recent studies of policy-making are paying increasing attention to the influence of external forces such as transnational advocacy networks (Keck and Sikkink 1998), epistemic communities (Haas 1992), cross-national diffusion (Deacon 1997) and international organizations (Finnemore 1996) in setting national priorities. This case study adds to this research thrust and points to the need for mainstream agenda setting theory to consider carefully how interactions of transnational and national forces shape the emergence of issues on to policy agendas.

Second, the case indicates that the power of political entrepreneurship may have been under-estimated in major works on agenda setting. Kingdon, in emphasizing that entrepreneurs lie in wait for windows to emerge, may actually understate their capacity to shape events. His analysis is based on the United States political system, one in which a multiplicity of political actors – legislators, presidents, interest groups, citizens, courts – all influence the flow of public policy amidst an environment of institutionalized rules, and where it is difficult for any individual actor to dominate the process. In many developing countries the rules of the political game are less formalized, and the power of this network of actors less stable. In such environments, a politically-savvy entrepreneur...
may not only have the capacity to couple streams at the chance emergence of a policy window outside his or her control, but actually move to create the window himself or herself, mobilizing a political system to devote priority to an issue that might otherwise have been ignored by that system. The prominent role of individual public servants in this Indonesian case study gives evidence of this power.

At the same time, the case study offers evidence in support of a trend in agenda-setting scholarship. The causal power of focusing events has raised major challenges to rationalist and incremental models of the policy process. A rationalist understanding assumes the process proceeds smoothly from problem identification to delineation of alternatives to selection of the best proposal. An incremental understanding also assumes a smooth process, one in which issues lie in wait, gradually gaining attention over time as more and more key actors take note of the problem and slowly push it on to the national agenda (see Kingdon 1984, pp. 82-84, for descriptions of these models). The demonstrated power of focusing events indicates that neither model is adequate to explain the agenda setting process. Focusing events appear suddenly, shifting priorities dramatically and allowing no time for extended deliberation. Frank Baumgartner and Bryan Jones (1993) have incorporated such insights into a 'punctuated equilibrium' model of the agenda setting process in which long periods of policy stability are juxtaposed with bursts of rapid change. The sudden rise in level of global attention to safe motherhood after the 1987 Nairobi conference, the priority given to safe motherhood immediately following the 1988 national conference in Indonesia, and the surprising re-appearance of priority in Indonesia after a set of international and domestic symposiums in 1995 all lend support to the insights of Baumgartner, Jones and other scholars investigating the punctuated nature of the policy process.

*Generalizability and replicability of the case*
In seeking to draw principles from the Indonesian case for safe motherhood advocacy elsewhere there is a need for caution. There were unique aspects to the Indonesian political context at the time that shaped the outcome of events, some of which are no longer the case even in Indonesia itself, and these limit the degree to which we can generalize. First and foremost, through the late 1990s Indonesia had an authoritarian political system, dominated by former president Suharto, in which there existed few democratic checks on the actions of the powerful bureaucracy. This changed in 1998 when political and economic crises led to the resignation of Suharto and to the establishment of a more democratic system. Second, the penetration of the Indonesian state into society, and its capacity to implement social and health policy, was greater than that of most developing countries, many of which struggled to exert authority over society. Third, Indonesia's unitary system contributed to this capacity by subordinating provincial bureaucracies to the national government. A federal system such as India's, where state rather than national governments control health policy, creates difficulties for the formulation and implementation of uniform national policy. Fourth, Indonesia was able to attract considerable donor support for its health and population programs. Such financing supplemented a state budget, giving the Indonesian government sufficient financial resources to carry out a national safe motherhood program. So in these four respects - the ability of bureaucrats to manoeuvre through the political system relatively unchecked, the ability of the state to implement health policy, the power afforded the national government through a unitary system, and the availability of extensive donor financing - the Indonesian government differed from many developing countries in its capacity to mobilize the political system in service of safe motherhood.

This being said, there are dimensions to the case that are relevant for other developing countries concerning the generation of political priority for public health causes. First is the power of a clear indicator to catalyze action. In Indonesia leaders became alarmed when a reliable indicator emerged that showed the persistence of a
severe maternal mortality problem in the country. Just as publicity of high total fertility rates has mobilized priority for population control in many developing countries, so studies showing high maternal mortality ratios have the potential to do the same for safe motherhood. Despite the costs, the ongoing measurement of such ratios is worth the effort since these indicators are one of the most promising mechanisms for alerting policy-makers of the existence and persistence of a problem.

Second is the power of focusing events. As with indicators, focusing events are one of the primary means of developing and sustaining visibility for an issue, and therefore of generating the attention of policy-makers and political leaders. In the case of Indonesian safe motherhood, for instance, the international Nairobi conference, the subsequent national symposium on safe motherhood in 1988, and the safe motherhood seminars in the mid-1990s involving President Suharto, were turning points in generating political priority for this cause. Only in rare cases can issues be sustained without concerted and deliberate action. Agenda-setting research reveals a common pattern in which issues peak for a short period, and then inevitably wane. Focusing events are the means by which attention to issues may be re-cultivated. International UN symposia, global awards for superior safe motherhood records, publicity of poor performance in this area, widely disseminated monitoring reports, national level safe motherhood symposiums - all of these are mechanisms by which attention to the cause can be sustained in the minds of political leaders. Failing to deliberately organize focusing events may result in the issue fading from national agendas.

Third is the power of political entrepreneurship, such as that exemplified by Assistant Minister Cholil in Indonesia. Until causes emerge as strongly felt needs and become widely accepted within both social and political arenas, they are not self-sustaining and remain dependent on political backing. Political backing in turn requires agents behind the scenes to generate such support: that is to say committed political entrepreneurs.
At the global level, there exists a large network of advocates who have devoted extensive effort to the safe motherhood cause. At the level of the nation-state the situation is much less stable. Few bureaucrats and political leaders inside the formal political systems of developing nations promote the cause publicly in sustained ways. Few are willing to expend significant political capital to ensure that safe motherhood becomes institutionalized within their political systems. Yet the existence of national-level networks, to complement the already existing global network, is a critical necessity for the institutionalization of priority for the cause.

Fourth is the power of simple policy proposals. Agenda-setting research shows that political elites respond to policy proposals of a certain type: those that are technically feasible, cost-effective, simple to understand, and that pose minimal threats to their political positions, or better yet, that afford a chance to acquire political capital. Political elites and policy communities filter out those alternatives that are overly ambitious, excessively costly, incongruent with social values, inordinately technically complex, and politically contentious.

The state of safe motherhood policy alternatives at present resembles Kingdon’s understanding of the policy stream in his agenda setting model: alternatives are in a state of flux, much like a biological primeval soup, with numerous options floating around. Many will be filtered out; others are destined to rise to the fore because they meet criteria such as ease of implementation, financial viability and political palatability. This process could be hastened by careful consideration of the factors that motivate political elites to accept and promote particular policies, and by designing alternatives corresponding to these guidelines. For instance, research shows that the key to reducing maternal mortality is making essential obstetric care with its sub-components of basic and emergency care available to all pregnant women. Other interventions that have been proposed, while worthy for other reasons, are less necessary to the immediate cause of reducing maternal deaths, including the training of traditional birth attendants in medical
care, the enhancing of pre-natal care services and the promotion of broad-based socioeconomic development that enhances the position of women in society. Proposals that convey a simple message to policy-makers concerning cost-effective means of making obstetric care accessible to pregnant women, and that are unclouded by a multiplicity of ideas that confuse leaders who are already overwhelmed by a wide array of issues, will be critical mechanisms for generating political attention and workable solutions.

Above all else, the case study reveals that the generation of priority for safe motherhood requires the strategic negotiation of national-level political landscapes. In Indonesia, the existence of a severe maternal mortality problem was by itself insufficient to catalyze action. The generation of political will required the development of reliable indicators to mark the seriousness of the problem, the persistent and proactive cultivation of national-level policy-makers, the creation of workable policy solutions and the organization of attention-generating focusing events. In this way a long-standing but hidden crisis came to receive meaningful priority.
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References


Ministry of Health.


Table 1: Indonesian safe motherhood indicators to early 1990s

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<tr>
<td>Maternal mortality ratio (deaths per 100,000 births)</td>
<td>450 (1985)</td>
<td>360 (1984-1988)</td>
<td>404</td>
</tr>
<tr>
<td>Percent of deliveries with traditional birth attendant</td>
<td>60.9%</td>
<td>63.7% (1986-1991)</td>
<td></td>
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<tr>
<td>Percent of births delivered in medical institutions</td>
<td>19.7%</td>
<td>20.9% (1986-1991)</td>
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Figure 1: Change in Indonesian safe motherhood indicators following 1987 Nairobi conference

Sources: DepKes, 1995; DepKes, PDI, 1999; KMNK/BKKBN, 1995; Meliala, 1996; MoH, 1994 and 1998; World Bank, 1991
Notes

1 See Atwood, Colditz and Kawachi (1997) who make a similar point concerning the subject of political will in public health policy.

2 Rogers, Dearing and Bregman (1993) divide the agenda setting literature into three segments: media agenda setting, issue salience among publics and the rise of issues to the attention of policy-makers. In this paper I am concerned with the third segment.

3 Unnoticed to all except a handful of Indonesia’s public health statisticians and safe motherhood experts was the fact that the 390 figure actually referred to the period 1989-1994, not the year 1994, so it was not a valid measure of the previous six years’ efforts.

4 One must be cautious in claiming change in the maternal mortality ratio since the rarity of the event of maternal death makes standard errors very high for this indicator (WHO 1990). It would be unwise to make a claim on maternal mortality decline until another well-designed national survey has been conducted. Nevertheless, even if the reported maternal mortality ratios have wide confidence intervals, change on the skilled delivery and antenatal care measures indicate that state efforts had impact on safe motherhood trends in the country.

