Healthy Mothers, Modern Villagers

Health, Development and Village-State Relations in Southeast Sulawesi, Indonesia

Simone Kate Alesich

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This thesis is wholly my own original work, except where otherwise cited in the text.

Simone Alesich
Department of Anthropology
Research School of Pacific and Asian Studies
Australian National University
For my parents, with many thanks, and in memory of my beautiful dog
Sacha.
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Abstract

The rural village in Indonesia is a site of negotiations on ideas of development and health practice, at the nexus of village-state relations. By examining the Indonesian health system, a development project, health practice in Southeast Sulawesi, and childbirth practice, I demonstrate the many ways that health is implicated in broader notions of development, modernity and village-state relations. The Indonesian state, and an Australian aid project in the area of maternal and child health, uses health as a way of projecting an idea of the Indonesian rural village as backward, traditional, and requiring intervention from the centres of power and modernity. Southeast Sulawesi villagers enact their aspirations for development, and their relationship to the state, through health practice. Each chapter examines the relationship between health practice, village-state relations and development from a different thematic perspective. I begin by examining the government health system and how it represents village-state relations through health, in a centre-periphery model that promotes particular ideas of modernity. Chapter Three examines the AusAID Healthy Mothers Healthy Babies Child Survival Project (HMHB), how it fits within state-village dynamics; and the manner in which it produces ideas of modernity and constructs the village within health practice. Chapter Four discusses the two villages of Waangu-angu and Linomoiyo in Southeast Sulawesi province where I conducted my field research. Village-based ideas of tradition and modernity are linked to the dynamics of village-state relations, and the role of development projects in a village setting. Chapter Five critically examines the concept of health within rural Southeast Sulawesi villages, through a discussion of village health practice; including popular, folk and biomedical healing practices. If biomedicine is assumed to represent a modern concept of health, village-based alternatives to the biomedical model are associated with all that is traditional, backward and primitive. Yet the boundary between traditional and modern health practice is often blurred. Chapter Six examines two types of healers: the government midwife or bidan, and the traditional midwife and healer or dukun. These two kinds of healers provide the vast majority of healing services in rural villages in Southeast Sulawesi, and they have impacted on both state and village ideas of health practice, and how these reflect concepts of tradition and modernity.
Chapter Seven discusses childbirth as a critical role for women within rural villages. I consider the manner in which notions of appropriate childbirth and women’s roles have been promoted by the state and development projects like HMHB; and how village women impact on ideals of motherhood and modernity. By bringing two peripheral rural villages to the centre of my argument, I explore the relevance of state and international development projects in the area of health for villagers themselves. Ultimately my thesis argues that village perspectives are critical to understanding constructions of modernity and how these are expressed in health practice, engagement with the state and understandings of development.
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Chapter One
Introduction

At Makassar airport I change planes from the larger Garuda plane which took me from Jakarta, a hectic city of twelve million people. My Indonesian friends there expressed surprise at me conducting research in Southeast Sulawesi. ‘No one goes there,’ was one person’s comment. I board a smaller, regional Merpati flight for the last one hour leg to Kendari, the capital of Southeast Sulawesi province. It is overcrowded and the air-conditioning doesn’t appear to be working, but it is not as bad as a regional ‘island-hopping’ flight I remember my Indonesian teacher telling me about where the door was held fast with a rope. The planes get smaller as we travel further from the capital, the centre of Indonesia, as do the size of the airports. Taking off, we pull away from a tangle of roads, buildings, and neatly spaced wet rice fields, towards a steep mountain range in the southern part of Sulawesi. Over the Strait of Bone I take my first glimpse at Southeast Sulawesi province. From above, the province seems entirely uninhabited, the narrow roads, villages and 1.7 million inhabitants disappear amongst the forest and jungle below. To the north is Linomoiyo, on the main Sulawesi road from Southeast to Central Sulawesi province. To the south is Waangu-angu, nestled in the mountains in the southern part of Buton, between the coastal cities of Baubau and Pasarwajo. Even as we land in Kendari airport, the houses are barely visible between the trees. Where are the roads, the buildings?

I am here to conduct research on an Australian aid project called ‘Healthy Mothers Healthy Babies’. Over the next year I will base myself in two different villages in Southeast Sulawesi province, and study how villagers engage with and view projects, and how this project fits into the wider dynamics of village-state relations and health practice. I will look particularly at how Southeast Sulawesi villagers understand development, such as notions of tradition and modernity; and how they engage with projects and the Indonesian state through health practice.
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**Arguments and hypotheses**

Health is a value-laden concept (see for example Escobar 1997; Navarro 1981). The Indonesian health system and rural villagers do not choose healing merely upon the basis of its empirical efficacy. The health system does not operate, or conceptualise its work, purely on the basis of imagined 'needs' or 'services'. Health and healing are bound up in the more complex processes of development and relations between rural villages and the state. This argument draws on Foucault's notion of bio-power, in which 'Medicine, as general technique of health... assumes an increasingly important place in the administrative system and the machinery of power' (Rabinow 1991: 283). My argument incorporates the practice of development in addition to health and state administration. In Indonesia the state has been greatly involved in the dissemination of various ideals that centre on the concept of development and its connection to the behaviour of its citizens. The Suharto (New Order) government of 1966-1998, in particular, advocated ideals such as 'the good mother', 'the ideal family' and 'the community working together'. The national health system was a key aspect of the 'New Order development strategy for economic prosperity and modernization' (Hunter 1996a: 84). Government campaigns such as the 'Mother Friendly' Movement focus on health along with other modern ideals such as women's rights.

On a global scale, health funding, and international health agencies, have been 'an important part of international diplomacy between “developed” and “developing” countries' since World War II (Hunter 1996a: 83). Health has been a key development platform since the rise of the 'basic needs' concept in the late 1970s and early 1980s within the international development industry. 'Good health' is seen as a 'basic need' along with access to clean water and basic education, and improving maternal health is one of the current Millennium Development Goals (Easterly 2006: 9). 'Health' is defined by international agencies, and by the Indonesian government, in terms of a Western, biomedical model. Recently Western countries have included some 'alternative' or 'complementary' treatments, such as massage and herbal medicine, in mainstream and government

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1 Here I am referring to gotong royong
funded health care, but the Indonesian government health system does not incorporate spiritual or non-biomedical healing in its notion of health practice. How does the Indonesian health system construct ideas of appropriate, biomedically based, health practice? How is this connected to the imagined rural Indonesian village constructed by the state, where health programs are implemented? In examining the Indonesian government health system and the international development industry, I build on the work of Scott (1998), Robertson (1984), Porter et al (1991) and others who utilise a Weberian perspective of the state and development projects as a rationalising bureaucracy.

The word ‘development’ is used widely by the international community, primarily in economic terms, and by the governments of individual nation-states. Development practice is based on a modernist theory of development which privileges an evolutionary model. In this model all societies are placed on the path from ‘tradition’ to ‘modernity’; with countries classified as ‘developed’, ‘developing’ and ‘underdeveloped’. The West represents modernity, an ideal towards which the traditional non-West progresses. Pigg defines development as ‘a process of social transformation that is brought about by specific programs, projects, and policies’ (1992: 496). Development is used politically by leaders in ‘slogans... [which are intended] to galvanise their subject populations into concerted action’ (Robertson 1984: 108). My analysis of development in Indonesia, and how it is enacted through health practice, draws on the work of post-structural theorists such as Escobar (1984; 1991; 1995; 1997; 1999), Ferguson (1994; 1999; 2002) and Pigg (1992; 1995) which demonstrates the connections between development rhetoric, development as it is practiced, and power relations – both within developing countries, and between developing countries and the Western world.

Development translated as pembangunan in Indonesian has a more specific core meaning, referring to the physical manifestations of development, such as the construction of bridges, buildings and other infrastructure, although the term has been used more broadly by the Indonesian state. Pembangunan connotes the idea of ‘raising up’, coming from the root term bangun: to ‘wake up/get up’, which

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2 Words in Indonesian are indicated in italics.
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metaphorically suggests raising backward village areas to the heights of modernity found in the city and the modern state. *Pembangunan* was a keyword used by the Suharto regime to reinforce their legitimacy, through the promotion of a program of concentrated economic development to overcome backwardness and achieve modernity (van Langenberg 1986).

International development agencies, and wealthy Western ‘donor’ countries, conduct development through typically short-term (usually five year) bilateral and multilateral projects, in developing/underdeveloped ‘recipient’ countries. Porter et al. (1991: 95) suggest that ‘for many casual observers projects are synonymous with development itself’, and constitute the majority of development finance. In Indonesia the equivalent term *proyek* is used to refer to a specifically funded and planned activity, which can include local government road maintenance and national and international development assistance to rural areas. For villagers, *proyek* are signified by the appearance of a *tim* (team) in the village, of village meetings, the composition of work groups, and sometimes the provision of funds, infrastructure or services, stamped with symbols of the donor. There are no clear translations of ‘development’ in either the Wakaokili or Tolaki languages, and village perspectives of ‘development’ were expressed either by their connection with government or international aid projects, or as personal aspirations for a modern lifestyle.

One intention of my thesis is to highlight alternatives to the binary focus on good/bad, success/failure outcomes that dominate the development industry. For many development projects, project teams and even critics of the development industry, such dichotomised outcomes are key to the way projects are assessed. For the villages where these projects are implemented, the key issue is not so much ‘was this project good or bad’ but ‘what did this project do?’ Each project can be evaluated by any villager who was touched by it. I heard, for example: ‘this project didn’t give us anything, they just had a lot of meetings.’ Another villager said: ‘Young people are disillusioned with projects. They promise us a lot of things. But nothing much ever happens.’ However, for the villages involved in the AusAID Healthy Mothers Healthy Babies project (HMHB), the impact of project implementation extends far beyond the success/failure paradigm. A large
number of their impacts fall outside the jurisdiction of the project outputs as stated in official reports. For instance, HMHB provided a mattress for pregnancy examinations at the monthly health clinic (posyandu). The mattress was also used for wedding celebrations. The basic training of government midwives (bidan) assisted not only pregnant women and those in labour, and their small children, but village health more broadly. The training of traditional midwives (dukun) by the project was part of a long-standing practice of training dukun in various skills by the Indonesian government. Although many project outcomes were excluded from the official category of ‘outputs’, they are still part of a village experience of the project.

Critics of the modernist theory of development, upon which mainstream development models have been constructed, formed the dependency and world systems theories in the 1970s and onwards. With its focus on the international sphere of economic activity, Gunder Frank, Wallerstein and others have argued that developing and underdeveloped countries are ‘peripheries’, economically exploited by the ‘centres’ of the Western world (Gunder Frank 1984; Halsall 1997). Third World nations are being kept in a dependent, underdeveloped state in order for the developed West to prosper economically. All theories share the same assumption however, that every nation has the potential for ‘development’. Centres and peripheries also operate within Indonesia, and beyond the sphere of economic activity. Southeast Sulawesi is a peripheral province in Indonesia, dependent politically, economically and culturally upon the centre of Java. Rural villages are also peripheral to the modern state, constructed as backward and dependent upon the state in order to develop and become modern.

The history of the Southeast Sulawesi region demonstrates the marginality of this area within the Indonesian state. Even within academic literature, Southeast Sulawesi has received scant scholarly attention. Upland people within the province, such as the Tolaki and Wakaokili, further experience marginalisation from the state and are the classic periphery to whom the state relates as centre. Ideas of development and modernity are invoked in village notions of self, and their relationship with the state, through themes of centre-periphery, upland-coastal, and marginality (such as Ferguson & Gupta 2002; Geertz 1980; Li 1999;
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Scott 1998; Tsing 1993; van Langenberg 1986). How do Tolaki and Wakaokili people relate to the state, and define themselves within their local region? To what extent do villagers accept state and project notions of themselves, and actively engage in producing notions of their own? This thesis highlights the views from the periphery, of marginal rural villagers in Southeast Sulawesi and how they engage with the state, development and health.

The term ‘village’ is used by the Indonesian government and aid projects to connect rural populations to a place, so that their interests belong to particular areas. This limits their authority vis-à-vis the state and international agencies which are able to ‘encompass’ local areas through their ‘universal’ appeal (see Ferguson & Gupta 2002). The Indonesian state has played a significant role in constructing ideas of ‘the village’ and ‘good citizens’, although such ideas are being contested since the downfall of the Suharto regime in 1998. In this new period of political flux, and decentralisation of state power, villages are renegotiating their identities, and have the opportunity to align themselves with alternate global visions – such as development projects and indigenous rights movements. Rural residents may identify with an administrative village (desa) to assert a sense of group identity, particularly in relation to local language/ethnic groups and their uniqueness in relation to the state and surrounding communities (see Tsing 1993). Villagers might establish differences and similarities with other groups and villages by emphasising language, ethnic group solidarity, regional accent, livelihood strategies, local knowledge and ritual practice. I use ‘village’ to refer to a physical entity (e.g. the village of Linomoiyo), as a localised identity (‘villager’), and as an opposing category to the state (such as village-state relations). Villagers may be also rural residents, officials, women or healers. It is their identification as part of a village that I particularly highlight by the use of the term ‘villager’. I explore the different meanings that ‘village’ has for the state, development projects and rural residents (‘villagers’).

In Indonesia the notion of ‘tradition’ is strongly linked to ideas of ‘the village’, and a particular notion of tradition is thought to be located in ‘backward’ rural areas (see for example Geertz 1964; Robinson 1997a; van Langenberg 1986). In a similar way ‘modernity’ is identified with the Indonesian state and their program
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of development and modernisation (particularly under Suharto). ‘Modernity’ is contrasted with the past, and commonly opposed to ‘tradition’, by both the state and rural villagers. The process of modernisation ‘treated development as a unilinear process toward the “modern”... and away from the traditional’ (Barnard & Spencer 2002: 377), and featured the ‘disembedding and... [then] the re-embedding of traditional social forms by industrial social forms’ (Beck et al. 1994: 2). Modernity also ‘serves as a broad synonym for... whatever institutional and ideological features are held to mark off the modern West from other, traditional societies’ (Barnard & Spencer 2002: 378). Modernity was an important keyword of the Suharto regime, along with development. It is expressed in Indonesian using English-derived words – moderen, modernisasi. The irreversible movement towards modernity, for some villagers, signals the ultimate demise of tradition and custom (tradisi and adat), which is relegated to history (sejarah) and the ancestors (orang tua dulu). Tradition is defined in opposition to modernity, but also in its connection to culture, history, and the time of the ancestors. ‘You are studying culture? Oh, you mean history,’ was a common reaction to my research. Modernity and tradition is also linked to the idea of progress: from backward (terbelakang) to left behind (tertinggal) to advanced (maju)³.

The relationship between modernity and tradition is complex since ‘modernity has rebuilt tradition as it has dissolved it’ (Beck et al. 1994: 56). The notion of modernity requires tradition as its polar opposite, as the Indonesian state is meaningless as an entity of progress without backward, traditional villages to modernise. ‘Modernity’ and ‘tradition’ are frames used by villagers, as well as the state and development projects, to conceptualise ‘good’ and ‘bad’ health practice (see also Whittaker 2002). For example, some health practices might be seen as ‘better’ because they are more modern, such as giving birth in a particular location. By choosing particular treatments and understanding health in particular ways villagers engage in debates of tradition and modernity through their health practice. Villagers construct ideas and aspirations of modernity in conjunction with outside actors, including state-promoted ideals, international aid projects and the televised mass media.

³ Maju is also opposed to kuno (ancient) (see Geertz 1964), but kuno was not commonly used by villagers, the state or development projects during this study.
Kleinman’s (1980) model of a health system with three parts—professional, folk and popular—is useful to examine how different health practices can form systems. These systems integrate ideas of health with specific knowledges and practices. Local health systems incorporate popular ideas of health, the practice of healers (dukun), and interactions with modern biomedical health services, through buying pharmaceuticals and visiting government health workers. How do village health beliefs and healing practices combine to form a complex local health system? Health practice is ‘a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions’ (Kleinman 1980: 24). How, then, does health practice relate to ideas of development and modernity and village-state relations?

A number of healers and health service providers in Southeast Sulawesi provide traditional as well as biomedical healing services. These healers align themselves with the village or the state in order to establish their authority and healing knowledge. Doctors, nurses, midwives (bidan), and other government health workers at the subdistrict health centres (puskesmas) represent a modern form of health knowledge based on biomedicine. Village-based healers such as traditional healers/midwives (dukun), religious healers (imam) and traditional healing specialists such as bonesetters (tukang tulang), masseurs (tukang urut) represent traditional and village-based forms of knowledge and healing practice. The Indonesian term dukun refers generally to (male or female) practitioners who treat the sick, engage in the practice of magic/spirituality and attend births (Poerwadarminta 1982). In Southeast Sulawesi dukun is used to refer to female midwives and traditional healers, although local languages have a large number of terms to delineate different types of healers. The traditional healer (dukun) and government midwife (bidan) are key health practitioners at a village level, attending childbirth as well as actively involved in village health more generally. How do the bidan and dukun negotiate their allegiances with the village and the state, with traditional and modern health practice, to establish their authority in the villages where they live and work? To what extent is the bidan really ‘modern’ and the dukun ‘traditional’?
Childbirth practice and concepts of motherhood are strongly embedded in village-state relations and concepts of development and modernity. The international development focus on maternal mortality in the last twenty years, along with a focus on gender more generally, has increased the incorporation of Indonesian women, and their bodies, into the spheres of development practice at village, state and international levels. Concerns about the intrusive nature, and state paternalism, of maternal mortality campaigns are counterbalanced by the potential such campaigns may have for reducing maternal mortality rates in rural villages. Through childbirth women enact their roles as mothers and members of a village community, while at the same time performing a state project of ‘good citizens’ (see Hunter 1996b; Jolly & Ram 1998; Martin 1987). While women may continue to observe traditional childbirth practices, to what extent do they engage with state-sponsored childbirth practice, and what new opportunities might the state and development projects offer to village women?

One emphasis in this thesis is on valuing the contributions that Southeast Sulawesi villages bring to health and childbirth practice. Yet criticisms of village childbirth practice are often based on concerns for high maternal mortality rates. The primary objective behind the Healthy Mothers Healthy Babies project (HMHB) was to address the high level of maternal mortality in Indonesia, which remains the highest in Southeast Asia and approximately twenty times higher than the rate in Australia. What is the ethical responsibility of anthropologists when conducting fieldwork research on a topic like mortality? It is important to recognise the meaning and value of health and childbirth practice in its different settings. However I am mindful, as are the HMHB project workers, government health staff and Southeast Sulawesi villagers, of the serious risks associated with pregnancy and childbirth for village women.

The descriptions of the two rural villages below give a sense of the location of my fieldsites, both geographically and in relation to the key themes of health, development and village-state relations. They also introduce some characters that are found throughout the thesis. My research in remote Southeast Sulawesi villages responds to perceptions held by Indonesians, including villagers in Southeast Sulawesi, that the experiences of rural Southeast Sulawesi villagers are
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not worthy of study. This province and the groups within it have been relatively neglected by scholarly research, limited to one text on Tolaki culture by Tarimana (1989), an article on Tolaki and gender by Bergink (1987) and some literature focusing on the Wolio Sultanate and seafaring Butonese (e.g. Schoorl 2003; Vermeij 2000). Southeast Sulawesi has also been historically neglected by government services (including health). These rural villages are at the periphery of the periphery: marginalised geographically as well as unable to contribute to popular discourse in Indonesia. Arguably, the opinions of (mostly poor) villagers in rural Southeast Sulawesi are no less relevant than those of any other group in Indonesia (poor, rich, marginal or central), and in my thesis they are given an opportunity to put their perspective forward, particularly in terms of health practice, development, and village-state relations.

Waangu-angu

When I was a little girl I remember that hardly anyone lived in this village. They lived in the forests, or in huts in their gardens (kebun). It was very quiet here – people only came down for the pesta kampung (village festival). The camat (subdistrict head) kept trying to get the Wakaokili people to come down to the village, and about twenty years ago the people relocated. About five or ten years ago, the village was divided again because it was getting too crowded, and they moved half of us up the hill to this village. The new village is called Waangu-angu – that means a meeting of people.

- Nur, Waangu-angu

Located some distance inland, in a mountainous area of southern Buton, Waangu-angu does not reflect the common reputation of Butonese within Indonesia: as proud sea-farers and traders. Some of the nearly six hundred Wakaokili residents were among the thousands who migrated to Ambon to work as farmers. Their skills are as rice and corn farmers, arak brewers and ojek (motorbike taxi) drivers, rather than fisher-folk. Historically, Waangu-angu was a remote and peripheral

4 Names of people have all been changed. The names of locations remain the same.
part of the Butonese sultanate, and had little contact with outsiders, such as the Dutch colonists. ‘Twenty years ago, we used to run away when we saw white people,’ one of Nur’s cousins tells me. Now they see white people on the numerous televisions that have appeared in Waangu-angu in the ten years since electricity was installed. Television is one of their main links with the world outside the village, along with the sealed road which leads to the nearby city of Baubau.

Nur sits with her legs outstretched on the bamboo floor of the kitchen in her sister’s house, picking leaves from a branch for our dinner vegetable. The fish is already cooked, it sits, cold, in one of the metal pots hanging on the wall. The light is soft, streaming through the gaps in the wooden boards that cover the walls, and around the outline of the doorway. The door is closed despite the heat, to prevent the chickens that insistently climb up the wooden ladder and into the kitchen, looking for food. Nur’s upturned basket is behind her, a cone-shaped basket with a flat square base, a round opening and strap to go over her head. She carries the basket on her back when she goes to the fields (kebun), usually with her mother or her sister; it goes filled with uncooked rice (beras) and implements, and comes back filled with corn, or bundles of rice (padi), depending on the season. If I am lucky it has a sirsak (soursop) in it too, meaning that Nur’s sister has climbed the tree near their fields to collect one of these large, sweet, juicy fruits especially for me. ‘I am a farmer’ Nur says, sometimes with pride, other times in embarrassment. She is in an unusual position compared to other women in the village: in her early thirties, and has never married. She has also finished high school, which is a rarity for women in Waangu-angu. ‘But I didn’t do anything with [my education],’ says Nur. ‘I got an education, but no good job. I am not yet a person (jadi orang). I am just like... like a monkey,’ she laughs, referencing a notion of development and progress that is linked to education and financial success, that is promoted by the Indonesian government.

Nur’s skin is still pale, despite her work in the fields; darker than mine, but paler than the skin of her sisters or her mother. She and her family attribute this difference to her time working as a domestic servant in Surabaya, on the island of Java, where she lived inside and never saw the sun. Whiteness is associated with
wealth and prestige, with the city and Indonesian television. ‘Why didn’t you stay in Surabaya?’ I ask, and Nur says that she wanted to be back with her family. Later she tells me that she had received news, while in Java, that her brother and his wife had just lost their baby. This made her realise that she wanted to come back home. But laughter is never far from her face, unless she is trying to be serious to have her photo taken. ‘That one looks terrible!’ she exclaims, seeing the result of my photography. ‘You can use that to guard your door [against bad spirits].’ I find the photo of the two of us amusing: she barely reaches to my shoulder. It is her favourite, though. It is a great novelty for her to have me stay with her, as it is for her neighbours to have me stay in their village.

Nur’s sister-in-law has a small kiosk in her house, next door, where we sometimes buy tea and flour. We communicate by shouting through the windows, to which I comment: ‘Are you using the telephone?’ Nur and her sister laugh delightedly. The only ‘proper’ phone is the satellite telephone in the village head’s house, down the hill in the old part of the village. Nur accompanies me as we walk down the hill to test the phone out. Sometimes it is working, and the villagers and Nur enjoy listening to me speak in English. ‘I like to practice my English’ Nur says confidingly. Speaking English is a sign of education and a way for villagers to engage with the wider world, including countries outside Indonesia. Other times the phone is rusak (not working), and I must wait for my next trip to the city, Baubau, to speak to my parents again.

Nur’s mother helps to heal others, but refuses to become a dukun (traditional midwife/healer) and attend births like her sister. She is often sought out for her skill in treating the sick. One afternoon her five year old granddaughter falls from a tree and sprains her ankle. That evening Nur’s mother massages the ankle to heal it, while the little girl screams and cries. Two of Nur’s cousins are pregnant so Nur takes me to see them. She explains that their sister lives in Singapore, where she works as a domestic servant. They show me a photo of her, wearing sunglasses and fancy clothes, sitting in a park. Nur says her cousin encouraged her to come to Singapore too, she even offered to buy Nur a plane ticket there. Nur was tempted to go, but then changed her mind and came home. ‘One day I will catch a plane,’ she tells me. After one of her cousins has given birth, we visit
the new baby. Her mother watches, quietly smiling, as a dukun warms the baby
with the flame of a kerosene stove. ‘It is more traditional to use a wood fire,’ they
tell me, ‘but we don’t have one. While modern health services are embraced by
villagers, many traditional health practices like this are also maintained.

There is great excitement and anticipation as a pesta kampung (village festival) is
organised, with the nearly six hundred residents from the ‘new’ and ‘old’ villages.
The male ritual specialists choose the day for the event. Fortunately it coincides
with my stay in the village. It is a festival for the end of the corn harvest. ‘This is
not as big as the rice harvest festival, at the end of the year,’ Nur tells me. ‘Then
we have visitors from all over the place, even the camat (subdistrict head) is
invited.’ The festival is a way for villagers to promote themselves and their
traditions to others, including neighbouring villages, government officials and
myself. The day before the festival, a group of mostly young men, and some older
men, makes the trip up the mountain to an ancestral graveyard and ritual house.
‘It is a long way, and slippery at this time of year,’ Suhar, one of my male friends,
says. ‘We can’t complain that we are tired. That is not allowed. When we get
there, we decorate the ritual house with eggs. Then we carry the drums from the
ritual house down to the village.’ We spy the group as they return, in the evening,
a trail of children in their wake, some helping to beat the drums.

On the day of the festival I help Nur and her sister prepare food for the
celebration, and Nur makes sure that I have a sarong for the dancing (see fig 1.1).
We sit in the baruga (village hall), women in a group on one side, and the married
adult men on the other. The rest of the villagers sit outside to watch, with young
men making cameo entrances with their friends. The crowd roars as I get up to
dance, laughing and cheering. The women dance in a circular fashion, holding a
scarf (selendang) in front, then behind, then over their shoulders. ‘I haven’t
danced for years!’ Nur tells me as she walks me home. The music and dancing
continues all night, with the distant humming of drums.

The day that the pesta kampung ends, I receive a visit from one of my academic
supervisors. He asks whether this is a Cia-Cia speaking area, and Nur responds
insistently: ‘Oh no, our language is not Cia-Cia, it is Wakaokili.’ (see map 7 for
an outline of ethnic groups in Buton). On a number of occasions she repeats the
sentiment to me: ‘We are not Cia-Cia people, we are Wakaokili people. Our language is bahasa Wakaokili.’ For outsiders, particularly those from the city of Baubau, Waangu-angu is administratively a village of Cia-Cia subdistrict, and historically Wakaokili people are regarded as a renegade population who refused to live in a village. A Butonese friend of mine, now working as an English lecturer in Kendari (the provincial capital) explains: ‘People in Buton know Waangu-angu as a place where people lived on a mountain. They didn’t want to live in a village, and they never washed because there was no water up on the mountain.’ Its marginality is reinforced by the common knowledge that much of Baubau’s supply of arak (an illegal distilled liquor from the lontar palm) is produced in the forests around Waangu-angu. Arak is a profitable enterprise for many Waangu-angu residents. Only men enter the forests and have the knowledge to make arak. They camp beside their stills, deep in forests that are hidden from government view, in eight-day stints. In this Muslim region, only men drink arak, and not at official occasions, although women are encouraged to drink arak, sometimes with an egg and/or honey, after they have given birth ‘to regain their strength.’ The danger of the forests surrounding Waangu-angu is reinforced by stories of huge snakes that eat pigs and dogs, and regularly kill humans, and in the minds of Baubau residents this danger extends to the village itself. ‘My family thought it was dangerous for me to live in Waangu-angu,’ says one Wolio woman from Baubau who married a Wakaokili man. ‘It is a long way from the city where I come from.’

The exotic nature of Waangu-angu’s reputation does not extend to cultural displays. Despite their elaborate rituals for the pesta kampung, I was told the following by Waangu-angu residents:

‘Our wedding outfits are not as elaborate as the Wolio in Baubau. Their weddings are much more magnificent, much more interesting.’

‘Why would you want to do your research here? There is no culture here. You should do your research in the keraton (historical fortress in Baubau), that is where Butonese culture is.’
Linomoiyo

Tolaki are all descended from the same ancestor, so everyone who is Tolaki is family. This area used to belong to the Bungku (an ethnic group of nearby Central Sulawesi). A famous Tolaki general, Kapita Larambe, fought the Bungku for control of this area. This area has many Tolaki legends, such as the story of the seven sisters. You can see the mountain over there where the couple landed (in the story), after they fell out of the sky. We call it Gunung Oheo. Oheo was the mortal (Tolaki) man who married an angel (in the story). The Bungku also have similar stories about this place.

- Linomoiyo village head

After spending some time in Waangu-angu, the much more isolated and impoverished village of Linomoiyo takes me somewhat by surprise. The unsealed roads, gouged by the heavy wheels of trucks and buses, present a muddy challenge to vehicles in the wet season and coat us with dust in the four months of the dry season. The houses are more basic, some with dirt floors and rough construction. The village is smaller, just over three hundred residents in forty seven houses. There are large spaces between each house, revealing vistas of the ring of mountains beyond. There is no electricity – unlike Waangu-angu – and no village telephone. Power comes from a few generators owned by individuals, and obtaining electricity from one or another to power my laptop computer becomes a complex, political negotiation. This is particularly apparent with one family who are related to the village head, my host. After an unsatisfactory bargaining session the village head announces that he ‘won’t be speaking to them again for a while’. We often sit in darkness at night, watching the flicker of the small kerosene lamps made with empty condensed milk tins and small fibrous wicks. The trappings of modernity, so elaborately displayed on the few televisions (powered by generators) in the village, seem to have all but passed Linomoiyo by. As a representative of all that is modern and wealthy I have frequent visitors: to use my satellite phone, to see my computer, or request various items when I go into town. ‘We are very poor,’ the village head explains.
A typical day begins at around 7am, as I sit, bundled in a checked cotton sarong, watching the clouds weave through the distant mountains from the front room of the village head’s house. Eating the sweet biscuits and drinking the sweet tea that constitutes my breakfast, I watch the village head walk up the main street in the village and down the neatly swept dirt path of his front yard. Frowning in concentration, dressed in a t-shirt, decorative sarong and barefoot, he sits down near me and drinks his own tea, which has been left on the wooden coffee table. Our silence is broken by two of his three children, aged two and five, playing noisily. The eldest has already left for primary school, picking her way across the ground in her bare feet to join her cousin, both in white shirts and red skirts. A yellow clock on the wall announces the time. It bears the symbols of the GOLKAR party – a gift for the village head from GOLKAR for the 2004 general elections. The village head both represents the village to the government, and the government to the village. He has been circling his village, laid out in a letter ‘O’, as he proudly tells me. The village layout reflects an imagined village ideal: wide streets with evenly spaced houses along either side.

The houses on the ‘letter O’ are all made up of Tolaki families, or Tolaki and in-marrying Bugis, Bajo, Bungku and Toraja (neighbouring ethnic groups from the southern Sulawesi region). Bugis families, who have not intermarried with Tolaki, live separately, along the main road that links Linomoiyo to their neighbouring villages. That unsealed, heavily rutted road continues north from Linomoiyo to the border with Central Sulawesi, 60km away, and in the other direction to Kendari, the capital of Southeast Sulawesi, over 150km to the south (see figure 1.2). Bugis stilt houses are strung along the main road, in between wet rice fields. Tolaki dry rice fields are hidden inland, and along the banks of a nearby river. Tolaki are not the only ‘original’ inhabitants of the northern part of Southeast Sulawesi province, there is also the small Landawe population (classified linguistically as part of the Bungku group), whose presence was often mentioned to me. ‘Tolaki people are everywhere, all over Southeast Sulawesi,’ Linomoiyo villagers told me. ‘You should do your research on Landawe people, they are more rare, they are *suku terasing* (isolated peoples).’ The Tolaki people see themselves as ‘common’ but to me they are still unusual, since I have only been able to find two texts written about them.
Although the village is neatly set out, many of its houses do not live up to the same expectations of orderliness that is part of the imagined village promoted by the state: some are dramatically leaning to one side, while others have planned extensions only partly built. One family moves into their house although the building materials are insufficient. There is a gap of at least a metre between the walls and the roof. Some houses are like caves: huge and dark, with a few chairs tucked into the corner of the main room. Others have barely more than a bedroom and a tiny kitchen. Families save for many years to build a house, young couples having a number of children before they have saved enough for foundation cement, boards and roofing to build their own house. Land is plentiful, though, as one village official jokingly commented to me: ‘I tell the people here that they shouldn’t use KB (contraception). They should have lots of children because there is still much land to fill.’ His statement presents the contradiction of village officials, caught between village and state ideas of village life.

After breakfast I carry my plate and cup and saucer out to the kitchen at the back, accessed by a couple of boards across an expanse of dirt. The village head’s wife (ibu desa) Wati is there, crouched by a wood fire which fills the room with a gloomy fog of smoke. She is about my age, mid twenties, and like most women of that age, has three young children. She is thin, and her arms are scarred with a skin infection that she says comes from the well water. The government midwife (bidan) has not been around much recently to provide medication, and most villagers tend to accept such minor ailments as a part of life. On leaving for the city of Kendari one day, I ask Wati how often she goes into town. ‘Not since I was twelve,’ she tells me. ‘We have no money and no reason to go.’ She accompanies me to many places around the village: to visit my friends, to go to the toilet after dark (lest I meet with a spirit), and around the village to conduct a survey.

Wati comes from one of the original Tolaki families in Linomoiyo, and they own the land where the village head’s house is located. The village head himself comes from another part of Southeast Sulawesi, some four or five hours distant. But they are all Tolaki, in fact, all Tolaki-Konawe from the old Konawe kingdom of the eastern side of the Southeast Sulawesi peninsula. ‘There are two types of
Tolaki,’ the village head explains, ‘Tolaki-Konawe and Tolaki-Mekongga (ToMekongga). ToMekongga live in Kolaka district, they were part of the Mekongga kingdom. They speak a different language to us, but we understand each other.’ If all Tolaki are family, it seems all non-Tolaki are not family, and the children of intermarrying couples have an ambivalent status. A friend of mine whose mother was ethnically Bajo was criticised when her family rejected a Tolaki suitor: ‘Her family is not Tolaki. They do not understand the customs, they were not polite when they rejected [the suitor] and this made him angry.’

Connection to place is strong for Tolaki, and permanent moves away from the Southeastern peninsula are criticised. Despite this strong connection to place, Tolaki ritual specialists express their concerns that: ‘Tolaki people are losing their culture. We are not like the Bugis (an ethnic group from South Sulawesi), their culture is still strong, their children learn the Bugis language. Tolaki culture is disappearing as the older generation are dying.’ The ritual specialists attribute this to ‘modernity’, ‘change’, and a lack of regard for ‘tradition’. Tradition and culture/custom (budaya/adat) is often considered a characteristic of villages, according to the state. But one Tolaki Member of the Provincial Parliament, arriving in Linomoiyo in a four-wheel drive on election day, says to me: ‘What are you talking to these villagers for? They don’t know about culture. You should talk to me. I know everything about Tolaki culture.’

Early in my stay in Linomoiyo, I attend a haircutting ceremony and a wedding in a house at the other end of the village to where I am staying. The house is owned by the primary school principal: as a public servant he has a higher income than the farmers who make up the majority of the population. His house is large, made of stone (rumah batu), and he owns a generator and a television. We crowd into the house for the ceremony, the women dressed up in bright colours, scarves or hats on their heads. The first event is his son’s haircutting ceremony; a few days later it is his younger sister’s wedding, Masni. She sits glumly while I take a group photo. The reason is explained to me a couple of months later, when I attend the birth of her first child. ‘She can’t pretend she wasn’t pregnant before the marriage,’ one older woman says with a chuckle. A week after the birth I
attend a special ceremony for the birth called *mesosambakai*\(^5\). This ritual, conducted by a traditional healer (*dukun*) will protect the child from illness as it grows.

**Methods, locations and actors**

My research initially arose from the desire to observe a development project in practice. In consultation with an AusAID staff member on the Indonesia desk, the AusAID ‘Healthy Mothers Healthy Babies Child Survival Project’ (HMHB) was selected as a suitable study\(^6\). As HMHB is a maternal and child health project, my focus became the practice of development in health; since it was based in Southeast Sulawesi province, that became my field site. Before my twelve months fieldwork in Southeast Sulawesi I conducted a three-week fieldwork trip to the offices of the Australian Managing Contractor (AMC) on the HMHB project, IDSS (International Development Support Services), in Melbourne. It was in the form of an unpaid internship, in which I prepared a ‘Lessons Learned’ report on the HMHB project through an evaluation of various project documents. I had the opportunity to observe the institutional culture at IDSS, although I conducted limited participant observation during this time and no formal interviews, since my presence at IDSS was largely limited to the internship. I familiarised myself with project operations by talking to IDSS staff and reading a number of project reports.

The two villages I chose for my main period of fieldwork lay within the implementation area of the HMHB Project, in two districts of Southeast Sulawesi province, Indonesia (see maps 9 and 10). I chose one field site in Buton district (Pasarwajo subdistrict): Waangu-angu, and one field site in Kendari district (Asera subdistrict): Linomoiyo (map 2). These villages are located in areas some distance from the sub-district health centre (*puskesmas*), and each has a government midwife (*bidan*) living in a *polindes* (midwife’s house or village birthing hut) in the village itself. I chose them to ensure that the *bidan* would be

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\(^5\) Words in Tolaki or Wakaokili languages are indicated in italics and bold.

\(^6\) Although I consulted with AusAID staff, I conducted my research independently of AusAID and the HMHB project.
the primary government health provider in each village. Southeast Sulawesi is a peripheral region of Indonesia: relatively poor and remote from the centres of Jakarta and Java. The two villages are also located some distance from the coast, in mountainous areas, to include an examination of upland-coastal as well as centre-periphery relations. Initial links to the villages were established through a) the Buton district Health Department, in the case of Waangu-angu; and b) the HMHB project team, in the case of Linomoiyo. I conducted a longer period of fieldwork in Linomoiyo than Waangu-angu, because HMHB had completed implementation in Buton by the beginning of 2004, while it was still in operation in Kendari. In addition, there is much less research on the Tolaki people (in Linomoiyo) than on their counterparts in Buton. Research on most ethnic groups in Southeast Sulawesi remains limited compared to other parts of Indonesia (especially Java and Bali).

The HMHB project was part of a broader movement within Indonesia, known as Gerakan Sayang Ibu or the ‘Mother Friendly Movement’. This movement was launched in 1996 by the Indonesian government to combat high levels of (infant and) maternal mortality nationwide, in conjunction with international attention on the issue. The village midwife scheme was part of a previous effort to reduce maternal mortality, initiated by the Indonesian government in 1989. This scheme dramatically increased the number of bidan and moved them from health centres to live in rural villages. Bidan attend births, conduct pregnancy examinations and post-partum care, and provide general health care services to the village population. By 1996, however, maternal mortality rates had barely decreased, and the new Sayang Ibu strategy was intended to address that fact. HMHB, running from 1998 until early 2005, reflected international as well as Indonesian concern with high mortality rates. The project worked within Indonesian Health Departments (national, provincial and district) and with government health providers, providing training and management strategies to combat a number of impediments to the provision of high quality health care to rural Indonesians in Southeast Sulawesi. These issues include poor quality of midwifery care; lack of access to health services in remote areas; and lack of adequate funding for the Health Departments.
Introduction

Unlike many projects which aim to impact on poor rural communities, HMHB worked primarily with the Health Departments and government health workers. Community participation was focused on the training of local healers (*dukun*) and health volunteers (*kader posyandu*), as well as the dissemination of various 'health messages' covering changing behaviour around childbirth, which were broadcast on the radio, and appeared in brochures, on posters, stickers and matchboxes in the villages of Southeast Sulawesi. Project team members themselves suggested that the project would be unlikely to have much of a presence at all in rural villages, and doubted that villagers would be aware of it. While I found this to be true to a large extent, it was interesting to see the ways that HMHB did 'appear' in the two villages where I conducted research, and the ways that it became visible in the range of projects that provide a variety of services, infrastructure, and ideas to villagers. My field research explored the ways in which ideas of development were constructed and utilised by villagers in negotiation with the outside world: particularly the Indonesian state, and international aid projects like HMHB.

Being in the field highlighted the fact that a variety of areas of village life are bound up in notions of development, modernity and health. Development is linked in many ways with notions of 'health', and implicated in the relationship of rural villages with the outside world — including the Indonesian state, and the international community represented by HMHB. Moreover, 'health' touches every aspect of people's lives — from belief in spirits, to births, deaths and marriages, travel, house-building and so on. My discussion includes many aspects of local life that are external to the HMHB project and even to village perceptions of development, which contextualise local concepts of health and development within this broader framework.

My field research involved a number of different methods, primarily relying on the method of participant observation. I used other techniques such as surveys, focus groups and formal interviews to complement participant observation, triangulating data from different sources to allow greater confidence in interpretation. My research utilised a number of different spatial and socio-political locations: primarily villages, but also government and project offices.
My main language of communication with villagers was Indonesian. Most villagers could speak Indonesian, although they used the local languages of Wakaokili or Tolaki in everyday conversation, encouraging me to learn some of those languages while I was there. I used Indonesian with government officials and health workers, and Indonesian and English with the HMHB project team.

Illness, like childbirth, is constituted in a particular social environment at a village level. I was able to conduct participant observation through being ill as well as visiting others who were ill. In this way I could gain an insight into how ideas of health and illness are lived and practiced by villagers in Waangu-angu and Linomoiyo. The most useful information was provided in conjunction to a specific event: I would find out a lot about health practice by being sick myself, and about a birth, by attending a birth. Unfortunately the unpredictability of the time of a birth, and the reluctance on the part of some women for me to attend, made attending births difficult. Other rituals, such as burying the placenta, were not seen as public occasions so people often forgot to invite me. Official ritual ceremonies to mark life-cycle changes, such as haircutting ceremonies, weddings and burial ceremonies, were always events where I was invited, and usually given a privileged position to 'observe' the proceedings.

Researching childbirth meant that my primary informants were women, since men play a limited role in childbirth practice at a village level. Conducting research with women was in some ways easier than with men, since men – particularly those who were married and therefore had an important position in the community – spent most of their time impressing upon me the wealth and significance of their knowledge. They sat in formal circles in the front part of the house, smoking and discussing sometimes for hours. Women, on the other hand, talked informally with one another, allowing me to be a part of the conversation. We often sat in a crowded group in a kitchen, preparing food for an event or ceremony, or grouped around a well while washing clothes.

The participant observation method was the least-understood aspect of my research, and caused some confusion for villagers. While more formal techniques (surveys, focus groups, interviews) were all considered 'research' by villagers, participant observation was often labelled 'just sitting'. This was probably an
accurate observation of my work on the part of villagers, but it was difficult to communicate the idea that ‘research’ consisted of more than specific, performative, outwardly visible activities. On the other hand, some informants became influenced by the research concept to the extent that they started to package information. A village head became so used to me asking questions that he started to provide answers as a set of numbered points.

Surveys, focus group sessions and formal interviews were useful methods of eliciting different types of information that would not normally arise in everyday conversation. I conducted one survey with mothers in each village, with a similar number of women (28 in Waangu-angu, 21 in Linomoiyo). The survey allowed me to ask some basic questions, and to get out and meet a large number of women in each village. Nur assisted me in the first survey, in Waangu-angu, to guide me around the village and also act as an intermediary (and interpreter) between me and the village women that I had yet to meet. I had made a list of ten questions to ask each woman, with the criteria that each must have given birth in the last five years. I developed survey questions from participant observation as well as from constructions of ‘the village’ in HMHB project documents. The questions focused on women’s age, number of children, level of education, age of marriage and attendance of health personnel at births.

I visited a large number of houses for the survey, where women sat on the floor but I was given a chair, giving me a disconcerting position of being above the people that I was talking to. The women all gave consent to my research, looking either excited or rather terrified. All wanted their opinions recorded however, and they watched as I took down their answers in my large notebook. In one house, tucked away at one end of the village, an older woman sits terrified in a corner as we enter. Nur gestures to a cane chair, I sit, and she sits beside me. Not moving from her corner, the woman asks Nur why we are there, speaking in Wakaokili language. Nur explains what we are doing, and translates for me. I feel unsure whether to continue with the survey, even with my innocuous questions. Perhaps she feels threatened by the types of information I want? More likely she is terrified to see me: tall, white, and different, up so close and in her house. By the time we reach the last house, I climb the wooden ladder in some exhaustion. Tired
of asking the same questions, with the same reactions, the same stares as I note the responses down in my book. It is easier to blend in, to ‘participate-observe’, than to stand out with such an obvious display of ‘research’ which blatantly constructs the villagers as research objects.

The survey was able to clarify a few issues that arose in the course of participant observation, to clarify and confirm other information that I had received. I found that if I asked if the bidan now always attended births, people usually said yes. However if I asked about a particular birth, in the survey, I found that the bidan attended only about 50% of cases. The survey was too small to be statistically significant, but it confirmed certain trends mentioned in other literature on birth in rural Indonesia (such as Cholil et al. 1998; Geefhuysen 2000; Grace 1996). For example the vast majority of births occurred in the home, and dukun attended nearly all births. It contradicted other assertions: such as that births in the home were related to educational achievement, as mentioned in some HMHB project documents. I also discovered that the average age of marriage of those interviewed was low (typically at between 13 and 18 years of age) and often occurred soon after the completion of schooling. The results of the survey helped me to identify new areas for investigation in further participant observation.

Focus group sessions were also useful as a forum for me to ask questions, and to prompt new issues through discussion with village women. I held focus group sessions after PKK (Pemberdayaan Kesejahteraan Keluarga – Family Welfare Movement) activities: such as the monthly savings collective (arisan) or the maternal and child health outreach clinic (posyandu), when I was guaranteed to have a group of women already assembled. I relied on other villagers to help organise the groups, as well as the cooperation of the women participating. I held the first focus group one morning after an arisan about a month after I arrived in Waangu-angu. The village head’s wife (ibu desa) stood up, a large woman even compared to me, and made a loud announcement: ‘the following women will stay behind after the arisan to participate in the focus group...’ The women included gave birth in the last ten years: broadening my focus from the initial survey that included women who gave birth in the last five years.
Introduction

The *bidan* opened the meeting with the formal Islamic salutation ‘*wasalaam malaikum waramatulahi warabahkatu*’, informing the women of what they were going to discuss with me. After such a formal beginning, the women seemed reluctant to expand on their brief answers to my questions, using standard responses that reflected the official health messages given in ‘education’ sessions at *posyandu*. Then one of the *kader* (village health volunteers) said helpfully: ‘when the mother has given birth, her husband must stimulate her breasts to help the milk flow’. Embarrassed laughter overflowed. The laughter seemed to relax the women and they began telling stories, including that of a woman who gave birth at the bus stop while she was waiting to catch a bus to the health centre (*puskesmas*).

The focus-group in Linomoiyo began with much less success. The *kepalci desa* (village head) enthusiastically organised a meeting of women for me, but the women were reluctant to attend. Eventually one woman arrived, walking self-consciously down the wide expanse to the house. ‘No one is coming to the focus group, so I won’t stay,’ she said, leaving again. I chose the *posyandu* for my second attempt, knowing that a number of women would come to it anyway, to get injections for themselves (usually contraception) and for their children (typically Hepatitis B). I prevailed upon a group of women to stay behind and answer my questions. The small group of women, mainly with young children in tow, showed considerable relief when my capricious tape-recorder decided not to work two minutes into the session. I abandoned this unhelpful piece of technology, recording their responses in my notebook.

Focus group sessions were more casual and free-flowing than the survey, but enabled me to focus the discussion more than I could in the informal interactions of participant observation. My questions were open-ended and drew from locally-mentioned issues as well as academic literature on childbirth and HMHB project messages. Once women were in a group, they seemed to enjoy chatting and gossiping. This was more of a familiar interaction for them. Women’s conversation focused on issues that were humorous or had a ‘good story’ to them. These included a range of experiences of childbirth, from prolonged and difficult, to easy and quick. Women were able to feed off one another with stories in a way
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not possible with a one-on-one interview. This was more the case in Waangu-angu, where women were more outspoken, than in Linomoiyo, where both the men and women were generally quite reserved.

Interviews were the most appropriate way for me to gather information from government officials, since I did not have permission from the Health Departments to spend extended periods of time observing them at work in the same way as I was able to with villagers. Interviews also conferred status on the person interviewed: since they are quite a formal research method and those chosen for interview are assumed to be an authority or expert on a particular topic (see Chambers 1997). Interview subjects were identified through participant observation and the recognition of particular hierarchies within government, the Health Departments, the project and both villages. I conducted a number of interviews with a range of people in each village who could be considered an official or expert in some way, including the village head, head of the PKK, the government midwife (*bidan*) and a number of traditional midwives (*dukun*) and village health volunteers (*kader*). I also interviewed the heads of both subdistrict health centres (*puskesmas*) in Asera and Pasarwajo, and a number of members of the HMHB project team. Due to the formality of the event I was able to obtain more ‘official’ types of information: such as statistics that provided interpretive frames for the anecdotal data of everyday conversation.

I was only able to conduct limited participant observation with the HMHB project team. In a letter sent to my academic supervisor, AusAID expressed the position that ‘following initial introductions already made by [the HMHB team leader] we would not anticipate there being continuing demands on either his or other project personnel's time in the conduct of this fieldwork’. The limited time I spent with project team members was on their day off (Sunday) or during other project activities such as meetings, and visits to *puskesmas*. I conducted these during short visits to Kendari after spending time in Waangu-angu or Linomoiyo. AusAID also required reassurance that my work was ‘not a review/evaluation… as we have given no permission for this.’ AusAID staff encouraged me to look at the villages themselves, using the project just as a case study. My field research demonstrated that the project fitted into a much wider set of values and
relationships (such as health, development, modernity and village-state relations), which justified this broader focus. Including an element of ‘studying up’ – researching aid projects, aid agencies and the Indonesian health system – allowed me to include the culture of the aid industry and the state in my analysis, as well as the culture of villagers; and to explore the relationships between villagers, aid projects and the Indonesian state. As Nader argues: ‘Anthropologists have a great deal to contribute to our understanding of the processes whereby power and responsibility are exercised… to get behind the facelessness of a bureaucratic society, to get at the mechanisms… [which] are directing the everyday aspects of our lives’ (1972: 284, 288).

In addition to field research I conducted a broad-ranging analysis of HMHB project documents; Indonesian and Australian government and international (eg WHO, World Bank) documents; academic literature on aid and development; and anthropological literature focusing particularly on development, health and village-state relations. Academic research on health is often a driving force in the adoption of new strategies and programs in the development industry. In noting the chain of events that led to the establishment of the ‘Mother Friendly’ movement in Indonesia, Shiffman (2003) highlights the role of academic literature in promoting health issues to the development community, leading to the international community adopting a ‘Safe Motherhood’ campaign to address maternal mortality. In Indonesia alone, projects incorporated into this strategy were numerous, coming from a range of multilateral and bilateral donors. A large number of projects means a large number of communities affected by a new development trend. Academic focus on maternal health has changed over time, reflected in changes or ‘fashions’ in the focus of development programs. In the 1960s, for example, academic literature extolled the virtues of training indigenous midwives (Sargent & Rubel 1976). The change in focus of academic literature on health over time has had a significant impact on the incorporation and roles of both traditional and trained midwives in health provision and birth attendance in Indonesia. Academic literature both informs the debates on maternal mortality and health interventions, as well as providing new models for the development industry in creating new activities.
Chapter outline

Chapter Two takes the perspective of the Indonesian state. Here I introduce the broader context of the Indonesian health system, and the practice of biomedicine. The role of the state, ideas of the typical rural village in Indonesia, and how the state interacts with villages through the health system and biomedical health practice are presented. Chapter Three builds on this perspective by introducing the Healthy Mothers Healthy Babies Project (HMHB), looking at the different project actors in both Indonesia and Australia, and how the project fits into village-state dynamics in Indonesia within the context of health practice. Chapter Four provides a turning point for the thesis, introducing village-level perspectives in contrast to the focus of both the Indonesian state and aid projects like HMHB. Chapter Four explores how villagers interact with state notions of the village and construct a sense of village identity that includes difference with other ethnic groups in the region, shared histories and ritual practice. This chapter explores village perspectives of development, and interactions with development projects at a village level. Chapter Five brings the focus on the village to the area of health, examining village health practices as a complex system. I consider how village health practice fits into wider notions of tradition, modernity, and relations with the state. Chapter Six brings the discussion to two healers, the government midwife (bidan) and traditional healer/midwife (dukun), looking at how the state and the village assert particular types of knowledge and authority in health practice at a local level, embodied in the ‘modern’ bidan and the ‘traditional’ dukun. This chapter also introduces the gendered dynamic of healing in a village setting, since the majority of bidan and dukun are women, which has an impact on their authority within both the village and the health system. Women are again a key focus of Chapter Seven. This chapter examines how village women engage with village-state dynamics and development projects through childbirth practice. I discuss the gendered division of labour and the implications of this for childbirth practice and women’s roles within the village and the state. Chapter Eight reflects on the HMHB project and the implications of development projects for the health system and the villages of Southeast Sulawesi. I highlight the issue of mortality and risk in childbirth, which has been a recurring theme throughout the thesis.
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Discussions of mortality both engage with and provide a counterpoint to discussions of tradition and modernity in village health and childbirth practice.
Figure 1.1 Dancers at Waangu-angu village festival

Figure 1.2 The main road linking Southeast and Central Sulawesi, near Linomoiyo
Chapter Two
The state of health in Indonesia: governing, developing, and imagining 'the village'

The *kalosara* (figure 2.1) is a rattan circlet used as a ceremonial item in important Tolaki rituals, including weddings, and in resolving conflict between different parties. Rattan grows in the forests of mainland Southeast Sulawesi and is an important export product. The circlet is made from three intertwined pieces of rattan, which Tolaki people tell me symbolise the intertwining of customary/traditional practices (*adat*), religion (in this case, Islam) and the government, in the village. The Indonesian state also appears in more concrete forms in the villages of Southeast Sulawesi, such as the government representative who officiates at weddings, and the Health Department which provides health cards for the mostly poor rural residents.

The state negotiates its relationship with marginal rural villages in Southeast Sulawesi through the ideas and discourse of development. Notions of development and the tradition-modern dichotomy are constructed by both villagers and the state in an active engagement in which they are both implicated, typically as 'modern' state and 'traditional' or 'backward' village. This chapter explores the relationship between the state and marginal rural villages in Indonesia, and the way this is mediated by the health system and international development projects. The Indonesian state relates to rural villages in remote parts of eastern Indonesia, such as Southeast Sulawesi, through a model of centre-periphery relations. Drawing on a legacy of kingdoms and colonial regimes, the modern Indonesian state constructs ideas of the village as well as its relationship to those villages as an authoritative centre. The centre-periphery dichotomy is reflected in the Indonesian health system, which is characterised by a high degree of centralisation and hierarchy, and a focus on 'modernity' in health practice. The centralising tendencies of the Indonesian state during the twentieth century are breaking down with the recent, aptly-named process of decentralisation. National, provincial and district Health Departments are now negotiating their new
responsibilities and authority. Bilateral health projects, like the AusAID Healthy Mothers Healthy Babies project (HMHB), fit within this structure of centre-periphery relations. Health projects reinforce ideas of health and childbirth practice which are based on a Western biomedical ideology and notions of modernity. By assisting the state in its reach into villages, projects maintain the positioning of villages as part of the periphery – and upland villages as isolated from the state. Implicit in this analysis are the ideologies of development represented by the traditional-modern distinction, which the state, international aid projects, and villagers all identify with and define in various ways.

**The Indonesian state as centre**

The notion of the ‘centre’ and ‘periphery’ arises in theories of political economy, particularly the dependency and world systems theories which responded to the modernisation theory of development. Anthropological literature discussing development has used the concept of ‘centres’ and ‘peripheries’ to conceptualise relationships between urban and rural, developed and underdeveloped, and the first and the third worlds. Geertz uses ideas of centre and periphery in his analysis of state formation in nineteenth-century Bali (1973). With reference to central Sulawesi, Velthoen (1997) points out the bias of the centre-periphery approach in the relegation of the ‘periphery’ as merely an echo of, or reaction to, the ‘centre’. However the notion of centres and peripheries remains strong in village-state interactions, for both those in the ‘centre’ and those in ‘peripheries’.

Indonesia had a pre-colonial history of dynastic kingdoms throughout the archipelago, including the well-known Majapahit kingdom, and these kingdoms were characterised by the centralisation of power in a particular location. In Hinduized kingdoms throughout pre-colonial Southeast Asia ‘the capital stood for the whole country… it was the magic centre of the empire’ (Heine-Geldern 1956: 2). In Southeast Sulawesi, there were at least three significant historical kingdoms, including the Wolio Sultanate, based in Buton, and two Tolaki kingdoms of Mekongga and Konawe, which existed until the late nineteenth to the mid twentieth centuries (see map 3). The Dutch colonial regime, beginning in the 17th century, tended to centralise power and authority on Java. They established their
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capital at Batavia, site of the present-day capital Jakarta. As a colonial power, the Dutch ruled the different islands of the Indonesian archipelago in a coordinated fashion, with its ultimate centre in the Netherlands. More remote areas of the archipelago, such as eastern Indonesia, were seen primarily as a source of slaves, particularly in the seventeenth to nineteenth centuries (see Reid 1983; Velthoen 1997). This included people from the island of Buton, who were traded as slaves by the nearby Bugis and Makassarese people, establishing regional linkages of interdependence and hierarchical power relations (Sutherland 1983: 266-7). Most colonial resources (including health services) were concentrated on areas of agricultural production, and colonial administration in Java. In Sulawesi, the Dutch ruled Southeast Sulawesi from Makassar, the capital of present-day South Sulawesi (Kristanto et al. 1989).

The post-colonial state of Indonesia became a republic rather than a federation, with power still focused on the centre. The discourse of nationalism in the construction of an independent Indonesian state focused on the actions of particular people such as Sukarno and Hatta, the 1928 Youth Pledge and the War of Independence (1945-1949) (see Anderson 1991). Such people and events remain the focus of much nationalist discourse in Indonesia today. Although the country’s motto was ‘unity in diversity’ (*Bhinneka Tunggal Ika*), there was much greater focus on ‘unity’ than ‘diversity’. Schwartz notes that ‘maintaining national unity has been the... preoccupation of all of Indonesia’s leaders’, with great pressure on a model based on ‘the stylised collectivism of the ancient Javanese kingdom’ – one where the leader was the centre (Schwartz 1994: 7-8). The use of Indonesian as a national language was strategic, to reduce the emphasis on difference by using a language that was not identifiable with any one ethnic group (Anderson 1991; Warren 1993). The New Order period, 1966-98, under Suharto, reinforced this centralising tendency, with the government ordered in a strict hierarchy with the central state at the top (see van Langenberg 1986). During Suharto’s regime, the reach of the centralised state extended into villages, and the state began to define village activities as part of a state project of development.

The Indonesian government under Suharto promoted a particular notion of development through the employment of the word *pembangunan*, with a specific,
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government-generated definition. *Pembangunan*, although originally used to refer to physical types of development, such as the construction of buildings and other infrastructure (Carnegie 2003), was also used more broadly as a keyword of legitimacy for the Suharto government, combined with other keywords such as *terkebelakang* (left behind) and the ‘floating mass’: the idea of a populace that needed to be ‘free of grass-roots political ties... [in order to devote themselves to] the interests of national development’ (van Langenberg 1986: 9, 19). President Suharto himself was the *Bapak Pembangunan* (‘Father of Development’) (Wieringa 1992), identifying himself and his government strongly with development and modernity. Villages on the other hand were ‘left behind’ (*terkebelakang* or *tertinggal*). They were part of a periphery that the state as centre intended to develop.

Through the SARA policy, the New Order government outlawed political rhetoric invoking distinctions of *Suku* (ethnic group), *Agama* (religion), *Ras* (race) or *Antar-golongan* (between groups). Along with the ‘floating mass’ concept, discussed above, this effectively marginalised localised identities, and imposed a standardised idea of the state onto remote and rural areas. The state confines non-national languages and practices to ‘local’ spaces, denying it wider legibility in the Indonesian state (Robinson 1997a). The state positions itself as centre through ‘encompassment’, by which the state is seen to be ‘located within an ever widening series of circles’ (Ferguson & Gupta 2002: 982). In Indonesia, the strategy of encompassment is elicited spatially: the centre is located at the seat of government in Jakarta. The state stands ‘above’ villages through its strategy of ‘verticality’, a hierarchical structure of bureaucracy and surveillance that positions the state in an imaginary ‘top’, above the villages and bureaucrats that serve it. The lowest, most peripheral regions are the islands of Eastern Indonesia: poor, sparsely populated provinces like Southeast Sulawesi. Vertically, the villages are below the state, as described in phrases like *turun/terjun ke desa*: ‘going down/falling down to the village’ (see Grace 1996).

One way that the Indonesian state, under Suharto, developed these peripheries was through presidential instructions, or *Inpres*. These presidential instructions ‘blanketed rural Indonesia with village construction projects such as roads and
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village-halls, schools, health centres, markets, reafforestation programmes, and so on’ (Dick in van Langenberg 1986: 23). The peripheral local governments were themselves given a degree of autonomy ‘in certain aspects of rural development planning and implementation’, particularly through the provision of grants or annual subsidies (bandes – bantuan pedesaan), from the central government (Warren 1993: 214). Through this top-down strategy, peripheral rural areas were developed in the image of ‘the village’ constructed by the state, discussed below.

The ‘presidential instruction on backward villages’ or Inpres Desa Tertinggal was implemented in 1994 (Marlessy 1995), quite late in the New Order period, and has subsequently received little scrutiny. Its language reflects the general emphasis by the New Order government on rural areas as backward or ‘left behind’ (tertinggal).

Scott’s model of state simplification correlates with the centre-periphery model, whereby villages are standardised into ‘a “one-size-fits-all” formula that negates local… knowledge’ (1998: 37). Drawing on Leach’s work in Burma, Scott discusses state control, based in the centre and ‘the relative autonomy of… social units’ in non-state spaces of the peripheries (1998: 38). The advantage of state simplification for state control, argues Scott, is to bring certain aspects of their gaze under close control and scrutiny, to make the messy world outside the bureaucracy legible. By constructing the desa or administrative village, the Indonesian government attempts to make rural Indonesia legible. In order to attend school, vote or receive assistance from a health centre, citizens must have identity cards that connect them to particular villages. In this way they can be counted, their literacy and health measured (in theory at least), and they become legible and part of the state. The health cards for the poor (kartu miskin) are an important part of health service provision to the impoverished periphery in rural Southeast Sulawesi villages. Through these cards, and the statistical data gathered on villages by the health centres (puskesmas), poor villagers in Southeast Sulawesi become visible to the Indonesian state, placing them in a hierarchical power relationship of centre-periphery state-village dynamics.

‘Non-state’ spaces stand outside state control, and are invisible, due to their bureaucratic illegibility. Isolated rural villages in Southeast Sulawesi exist on the
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imagined border between ‘state’ and ‘non-state’, incorporated into the state through government services in health and education, among others, but standing apart as sites of illicit practice and spaces of tradition and backwardness against which the modern state identifies itself. Non-state spaces exist on the periphery of the periphery. For example Waangu-angu and Linomoioy villagers can be considered peripheral to the peripheral Southeast Sulawesi province. This relates to the concept of *masyarakat terasing*, or the official classification of indigenous people in Indonesia, literally translating as isolated group, but also implying foreignness and estrangement (Tsing 1993: 154). Neither Tolaki nor Wakaokili are officially classified as *masyarakat terasing*, although given that the main characteristic of isolated groups is standing outside state control, classification as such by the state would suggest that they have been brought under their surveillance in some form. Li (2001) suggests that state discourse on the periphery ignores long histories of interaction and interdependency between the two, with non-state spaces romanticised as sites of resistance which express a desire for isolation. This correlates with the rise of indigenous knowledge and *adat* (custom) and the indigenous rights movement, providing an alternative to state discourse (Li 2001). From the perspective of villagers, however, most desire to be counted, to be visible to the state. For example they delight to see their village appear on maps. Some Linomoioy villagers became excited by my research, saying ‘now everyone will know about our village, we’ll be famous’. Villagers, even in peripheral areas, are eager participants in the state. Some, like the village head and the government midwife (*bidan*) derive considerable benefit from their connections to the state (both in monetary and prestige terms). It is in their interests to make sure the village is legible and accessible to the state.

Part of the way in which the state as centre interacts with peripheral rural villages is through the dialectic of tradition-modernity, which is part of the framework of government and international development strategies. The modernisation theory of development, which is still essentially embraced by the development industry, argues that each country is progressing along a continuum from ‘primitive’ to ‘modern’ in a process of (economic) development, and that the Western world is the model of modernisation for the ‘primitive’ non-West (see Rostow 1960). More recently (1970s-80s), the idea of development has expanded from its
economic roots to encompass a notion of basic needs (including health) (e.g. Morris 1979). In Indonesia, modernisasi was the ‘essential underpinning to the authoritarian, developmentalist state’ of the New Order period (1965-1998) (van Langenberg 1986: 19).

The state imagining the village

Images of the ideal-type ‘village’ in Southeast Asia were part of the discourse of colonial governments. In Indonesia, such ideas have been extended and built upon by post-colonial governments, such as Sukarno (1945-65), and Suharto’s New Order government (1966-98) (see Warren 1993). As Kemp reflects, in the case of India: ‘the British believed in the fundamental significance of the village system’ and dealt with people as villages, rather than individuals (1988: 25). The administrative village in Indonesia, or desa, was in many ways an “invention”...by colonial authority’, and has been treated ‘as the smallest unit of local government since [Dutch] colonial times’ (Warren 1993: 4, 240). The administrative ‘desa’ became a key aspect of state-local relations in Indonesia with the passing of the 1979 Village Government Law, which was an attempt to create a uniform local administrative structure by using a ‘Javanised’ village model (Breman 1982; Warren 1993). The nature of village-state relations during the Suharto era was remarkably effective, such that commentators suggest the modern state has ‘gone beyond its colonial predecessor in penetrating the lowest levels of socio-political organisation’ (Warren 1993: 297).

One important way that the village was conceptualised in the New Order period was through the practice of gotong royong. This term, which is translated as ‘mutual obligation’, is a concept abstracted from local practice and ‘reworked by the state... to become an instrument of political control’ (Warren 1993: 280). This pseudo-Javanese term was promoted by the state as a neutral term, not the preserve of any particular ethnic group, that could be applied universally in the image of the ‘Indonesian village’ (see Bowen 1986). Bowen suggests that such ‘pseudo-traditional’ terms which are not common, everyday terms can be ‘filled more easily with ideological meaning’ by the Indonesian state (Bowen 1986: 554). The use of English-derived terms in development projects (such as ‘tim’(team),
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‘proyek’ (project), ‘siklus’ (cycle) can also perform this function. Such terms link the performance of everyday tasks in the village with a broader state (or development) project. Performing voluntary work to aid other members of the village becomes part of the state project of gotong royong, and women seeking health assistance at a monthly village health clinic (posyandu) becomes part of a state project of health care, with prescribed behaviour and functions. As Warren demonstrates in the case of Bali, ‘state ideology becomes the legitimating ground’ for activities at the village level (Warren 1993: 282). The fact that gotong royong has Javanese roots is no accident. The archetypal Indonesian village relies heavily on Javanese notions of the village and tradition which were used as ‘official cultural symbols’ of Indonesia during the New Order period (van Langenberg 1986: 27).

Colonial powers established an idea of the rural village that was supposedly timeless, existing in a pre-colonial past. This idea was continued in post-colonial independent states. This is common across a number of colonised states, in Asia and Africa, and ignores the involvement of villages in structures of modernity and the state, seeing them instead as sites of tradition and backwardness (see Robins 1998; Robinson 1986; Schrauwers 1999). A notion of tradition is an important part of the image of rural villages. As timeless products of a pre-colonial past, ‘the village’ is conflated with the preservation of tradition, expressed through ceremony, ritual practice (including healing) and adat or custom/traditional law (see Peacock 1968). The rediscovery and codification of tradition in the post-Independence and New Order eras presents tradition as ‘that which is not modern, something which is of the villages, not the modern urban centres’ (Robinson 1997a: 74). By contrast, the state is seen as representative of a modern future. In fact, both the state and the village are products of modernity: since the timeless village is a modern notion, and one that is produced by the state as well as villagers.

Southeast Sulawesi villages represent the backward, traditional village imagined by the state. It is an impoverished province at the margins of Indonesia’s political organisation and cultural imagination. As in the case of gotong royong, above, village activities are representative of tradition and of the preservation of
Indonesian culture (Bowen 1986; van Langenberg 1986). In the reformasi period (post-1998) adat (custom) and tradition has resurged as a symbol of ethnic and local identity, particularly through the rise of indigenous rights NGOs, known as lembaga adat (further discussed in Chapter Four). This new adat movement, while asserting the rights of particular, often marginalised groups, vis-à-vis the state, builds on the idea of the state as modern and the margins, such as rural villages, as traditional. It also builds on the Dutch colonial codification of adat as a system of local administration and basis for establishing community boundaries (Tsing 1993: 42, 274), fusing Dutch colonial governing structures with the contemporary global indigenous rights movement.

Development projects are involved in creating ideas of the village, as Pigg (1992) demonstrates in the case of Nepal. State development projects, as well as international aid, promote the idea of the backward, isolated, passive village, ripe for intervention. From the perspective of the Indonesian state, and international projects that support it, the village is a site of intervention from tradition, along an evolutionary path towards modernity that is promoted by development ideology. International and state ideas of the village fit well together, moreover, they turn all villages into the generic 'village' (Pigg 1992). Development is representative of all that is modern: development itself presupposes an idea of linear change towards modernity, and development projects like HMHB represent modern nations (such as Australia) as well as the modern Indonesian state (van Langenberg 1986). Development becomes an interface of meaning and interaction for the state and villagers, frequently located in the space of the village itself.

The village is incorporated into the Indonesian health system in a number of ways. Through the collection of statistics on births, deaths, and population, villages appear as names and points on maps posted in the subdistrict health centres (puskesmas). At a district level, and above, the village disappears into statistics that generalise to a greater degree, until at the national level the village is conflated with the province. Health Department activities reach out to villages in a number of ways: such as the maternal and child health outreach clinics (posyandu), held in villages once a month. The village-placement scheme of government midwives (bidan) from 1989 onwards has been another effort to link
villagers with the government health system. *Bidan* living in villages themselves, in houses built for them by villagers (*polindes*), provide an important link between villages and government in the area of health. The village, located far from daily health interventions of the Indonesian state, is constructed as sick, in the same way as it is constructed as backward: requiring health interventions from outside. Modern health practice becomes an organising principle of everyday life in villages, bringing them into line with the bureaucratic priorities of the state.

*The state and village women: PKK*

An effective institution linking national development concerns with village behaviour is the PKK (*Pembinaan/Pemberdayaan Kesejahteraan Keluarga* – Family Welfare Movement), which explicitly focuses on the roles of village women – in a number of areas of their life, including health. The Family Welfare Movement was a key New Order initiative which promoted specific roles for (married) women. The PKK trained women in particular skills which prepared them to be good mothers, wives, housekeepers, and citizens. Women performed many of these tasks on a daily role as a matter of course, but their inclusion into the PKK and subsequent instruction of ‘correct’ models of behaviour meant that they were now performing them as ‘part of a state ideology and practice’ (Hunter 1996b: 169). The PKK creates ‘a homogenous, pervasive image of women’ and ‘docile bodies’ for the Indonesian state (Parnell 1996: 141).

The original acronym of PKK used the term *Pembinaan Kesejahteraan Keluarga*, translated as the ‘Family Welfare Guidance Movement. *Pembinaan* (guidance) was an important keyword of legitimation during the Suharto era, emphasising ‘the mobilisation of the society to serve the needs of the state’ (van Langenberg 1986: 13). Since 2000, as part of the *Reformasi* movement in the post-Suharto era, this part of the acronym was changed by the government to ‘pemberdayaan’ – ‘empowerment’ (*Pemberdayaan Kesejahteraan Keluarga* – Family Welfare Empowerment Movement). ‘Empowerment’ fits with current international development discourse (for example Gururani 2002) as well as reflecting the change from a paternalistic and authoritarian Suharto regime to the present transition towards a democratic system. The name of the organisation refers to
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‘family’, rather than ‘women’, since the Indonesian state relates to women primarily through their role as members of a family (see Chapter Seven). The PKK, which is structured from the central government ‘right down’ to the village, is part of a global movement in which ‘the domestic unit [has become] an object of social policy’ (Ong 1990: 258).

PKK is an organisation run by, and for, women, on behalf of the Indonesian state. Married women join the local branch of the PKK as a matter of course. The PKK began as a national movement in 1967, focusing on ten programs of family life. Women staff the PKK at all levels, determined by their husband’s position, thus the village head’s wife (ibu desa) was head of the village PKK, the subdistrict head’s wife (ibu camat) was head of the subdistrict PKK, and so on up to the level of Province. At the national / central government level the PKK was headed by the wife of the Minister for Home Affairs (Depdagri). The main structural change to the PKK in the post-Suharto reform period has been the introduction of elections for the village PKK. The current elected head of the PKK in Waanguangu is the wife of the kepala kampung or village sub-unit head, while the elected PKK head in Linomoiyo is the village head’s wife. This structural change has thus not lead to significant change in representation in either village so far, with the women chosen still reflecting their husband’s positions in the village and state bureaucracy.

The current programs of the PKK (2001) are:

- Be good citizens according to the state ideology (panca sila)
- Work together and help one another (gotong royong)
- Be responsible for the provision of food
- Preserve culture and abilities in handicrafts
- Look after the house and household responsibilities
- Be responsible for education and skills (of their children)
- Be responsible for the health of the family
- Work together in economic production
- Protect the natural environment
- Plan for a healthy life, including healthy reproduction
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These ten activities are closely related to the five duties of women (*panca dharma wanita*) which are the forefront of Dharma Wanita, another women’s organisation sponsored by the state, which is comprised of wives of government officials. Those duties are:

- Be loyal companions of husbands
- Procreate for the nation
- Educate and guide one’s children
- Regulate the household
- Be a useful member of society

PKK activities involve women in a wide range of duties which reflect the programs above, and the ideals of *panca dharma wanita* (Five Duties of Women). Common PKK activities in the village are the monthly health outreach clinic for women and children (*posyandu*), small-scale savings cooperatives for women (*arisan*), and voluntary cleaning and gardening in public buildings, organised by the *dasa wisma* subgroups of PKK. PKK activities enable village women to ‘act out’ their mother role, participating in activities established from above that are seen as ‘appropriate’ for women. Under the Suharto New Order government, participating in the PKK was compulsory for all married women – although with varying levels of participation.

Some authors have noted some of the changes in PKK operations in the post-*reformasi* period in other parts of Indonesia (Marcoes 2002; Satriyo 2003). In 2004 a large number of women still participated in PKK activities in Southeast Sulawesi. The PKK structure is still noticeably hierarchical, with many activities in the village initiated at a district or subdistrict, rather than village, level. PKK activities such as *arisan* (savings collectives), *posyandu* (health outreach clinics) and voluntary cleaning/gardening groups seem well-established and fairly routine, particularly in Waangu-angu. Although the language around gender has started to change in Indonesia since the late 1990s, this does not seem to have reached the village level (see Niehof 2003; Robinson 1997b). For example, no discernable effort has been made to change the PKK in those villages to something that is ‘empowering’ in line with its name change in 2000. The decreasing participation in PKK activities across Indonesia may reflect a general reaction to the end of an
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authoritarian era (since they felt that no one would force them to participate). It may also reflect a generally held attitude that PKK activities are not as beneficial and essential as, for example, working in the fields or taking care of household tasks. The percentage of women participating was generally higher in Waanguangu than for their counterparts in Linomoiyo. One possible reason may be the poverty of Linomoiyo compared with Waangu-angu, requiring women in Linomoiyo to spend more time working rather than participating in PKK activities. In general, rural women are less able to participate in PKK activities due to their other economic activities (such as farming), than urban wives of civil servants, whose domesticity can be seen as a sign of their urban, upper-class status (see Martin 1987; Niehof 2003; Robinson 1985).

In the area of health, the PKK has been heavily involved in posyandu through the appointment and coordination of volunteer health workers (kader), who in many cases run posyandu activities themselves when puskesmas (health centre) workers are absent. At a women’s savings collective meeting (arisam) in Kaongkeongkea (the village next to Waangu-angu) in Buton, village PKK officials promoted state-sanctioned health and childbirth behaviour, demonstrating these with the use of cartoons from a state-produced publication (figure 2.2). The PKK was involved in the HMHB project as a quasi-NGO, as part of their ‘Social Mobilisation Strategy’ which aimed to change village behaviour around health and childbirth through training village health volunteers (kader posyandu) and traditional healers (dukun), as well as through promotional health messages. (HMHB Project Team 2000). A number of HMHB project reports mention the PKK as the key NGO involved in the project (eg AusAID 1995; HMHB Project Team 2002a; HMHB Project Team 2005).

Western medicine in Indonesia: linking health with modernity

Health services developed as part of the overarching social structure during the colonial period (Cohen & Purcal 1989: 6). Western medical models were introduced into Indonesia by specialists with the Dutch East Indies Company (VOC) in the early colonial era (Sciortino 1995: 56), along with a number of ‘new foreign diseases... [and] new social and economic inequalities’ (Hunter 1996a:
Pre-colonial societies of Southeast Asia are generally described as having 'high health status', due to sparse populations, well-developed folk health practice and plentiful food resources (Cohen & Purcal 1989: 4; Hunter 1996a: 77). Most of the colonial medical efforts were directed towards combating infectious diseases such as smallpox, cholera, and typhoid fever (Boomgaard 1989: 189) and tropical diseases such as malaria which had an adverse affect on the previously unexposed European population (Cohen & Purcal 1989: 6). The Dutch combated these illnesses with a number of introduced Western technologies such as vaccinations. Documentation of illness and medical practice during the colonial period mostly focuses on Java (such as Abeyasekere 1989; Boomgaard 1989; Boomgaard et al. 1996); (corresponding with the focus of academic research at the time) where Dutch colonial administration was primarily based, rather than other islands in the archipelago (such as Sulawesi). It is to be assumed that the populations of these other islands experienced similar health conditions at the time, to a greater or lesser extent; indeed, as the periphery reflects (or echoes) the centre more generally (see Velthoen 1997). Alternatively, with less colonial influence, isolated areas such as Southeast Sulawesi may have retained a pre-colonial health status such as described above. This model would see them as lagging behind the progress of central parts of Indonesia (such as Java) in terms of illness and resulting vaccination campaigns.

It was not until the early twentieth century that Western medicine was promoted among the indigenous Indonesian population, when 'public health became a concern of colonial governments' throughout Southeast Asia, and there was 'growing pressure in Holland to improve the... [health] of the indigenous population' (Hunter 1996a: 78). Part of the motivation for improving indigenous health was to ensure the viability of agricultural labour, since 'successful agricultural export production was considered particularly dependent on the health of the population' (Weber et al. 2002: 19). Such programs included widespread vaccinations to combat diseases such as smallpox, and hygiene campaigns to address water-born illnesses and an outbreak of the plague. The independent Indonesian state inherited a colonial system of government, including a colonial model of health provision. Many of the colonial health education campaigns were continued by the Indonesian state in the Sukarno
The state of health in Indonesia (1949-65) and Suharto (1966-98) eras, and indeed health education campaigns remain a significant part of the monthly health outreach clinics for maternal and child health (posyandu) in rural villages today. During colonial times, 'poor health... was blamed on... [indigenous] cultural and religious resistance obstacles... [to] Western technology' (Worth in Hunter 1996a: 79) (also see Cohen & Purcal 1989), and such views have been largely maintained, and reinforced, in recent times by the modern Indonesian state, as well as international development agencies.

The post-colonial modern Indonesian state was active in its development of health interventions, becoming a participant in the World Health Organization (WHO) and a member of the United Nations in 1948 (Hunter 1996a: 83-4). The New Order government integrated health services into their development strategy and its program of Five-Year Plans (Repelita). The New Order government succeeded in greatly improving a number of key health indicators such as infant mortality and life expectancy (Jones & Hull 1997: 1), although maternal mortality has remained comparatively high, lagging significantly behind its neighbours. Greater efforts were concentrated on controlling Indonesia's high fertility rates during the New Order, with some significant success, than on addressing the issue of mortality (Jones & Hull 1997: 3). At a local level, health services were first brought to villages in the form of subdistrict health centres (puskesmas), which were originally established as maternal and child health centres in the 1950s and 1960s (supported by UNICEF). These centres were incorporated into the state as community health centres in the 1970s (Hunter 1996a: 84). Government midwives began to be placed in villages themselves, rather than subdistrict health centres, from 1989 onwards (Shiffman 2003), bringing maternal and child health to the location of the village.

The provision of health services in Indonesia, from colonial times until the late 20th century, has been based on a diffusion of biomedicine from the centre. Biomedicine is defined as 'the name given to a form of western professional medicine that asserts that illness is largely caused by deviations from universal biological norms' (Birx 2006: 370). Although it has been shown to be 'freighted with Western cultural assumptions' (Kleinman 1980: 18), biomedicine has been
promoted as an acultural system of healing by Western scientists in countries such as Indonesia. Ethnomedicine explores models of health and illness as they relate to cultural values and beliefs, including biomedicine and other medical models (see Kleinman 1980). Any analysis of health and illness in Indonesia must take into account the moral and ideological aspects of health, and the way that health systems are constructed as modern or traditional, with different values placed on them by the state as well as local communities. Verrips suggests that the success of the biomedical physician lies in his/her image ‘as the prototypical representative of a radically rationalised and professionalised scientific community’ (2003: 227). Therefore health workers, more so than other representatives of the Indonesian state, embody the rational and professional aspects that form key aspects of the modern state and modern biomedical health practice.

Health provision has paralleled other government development programs in its diffusion from the centre, particularly during the New Order period. While the new policy of decentralisation may impact on the centralised nature of health services, the dynamics of village-state relations and health service provision have been strongly based on a centre-periphery model for a considerable period of Indonesia’s history.

**Health in the modern Indonesian state**

Health has become a key indicator of development progress, along with other development indicators (such as literacy) with the public health system ‘established... as a monitoring mechanism’ and a form of social control (Hunter 1996a: 81). Health is conceptualised in development projects, and government interventions as part of a wider process of development, along with education and other hallmarks of the modern state. Health care is therefore part of a process of modernisation from a primitive or backward, village-based method of healing, in a linear direction towards a modern, advanced method of healing based on state-sponsored and Western ideas and norms of development. Modernity in the area of health is conceptualised in terms of a binary opposition between traditional medicine, and spiritual healing, and ‘modern’ biomedical practice which
The state of health in Indonesia originates in the West (see also Whittaker 1999). Western medical models, and biomedicine in particular, are promoted in connection with development as incompatible with traditional healing methods. For example, they do not incorporate the spiritual, or religious, aspect of health which is a key aspect of many traditional health practices.

Health is an integral part of the Indonesian state’s project of modernisation, and listed in the national ‘Guidelines for State Policy’ (Garis-garis Besar Haluan Negara) along with other key development platforms such as the economy, religion, politics, social welfare and security (see for example Departemen Penerangan RI 1999; MPR 1990). Health was a plank of the Suharto government’s development program, and it remains a key sector in development agencies internationally. The national health system mirrors the hierarchical structure of the state itself, and its centre-periphery relations (see also Hunter 1996b). During the New Order period, the Health Department was highly centralised, with the national Department of Health (Departemen Kesehatan / Depkes) overseeing the provincial (Dinas Kesehatan), district (Dinas Kesehatan) and subdistrict (Puskesmas) levels. Information flowed upwards: from bidan in villages, to puskesmas, to district Dinas, provincial Dinas and finally the national Depkes. This was the case with all sectoral ministries during the New Order period.

The Indonesian health system is also accountable to international bodies such as the WHO and the World Bank. They form another centre of governance in health practice: the World Bank has conducted a number of health projects in Indonesia, such as the ‘First/Second/Third/Fourth Health Project’ (for example The World Bank 1995) and the WHO collects health statistics at a global level. The 1987 international conference on Safe Motherhood drew world attention to the high rates of maternal mortality in many developing and underdeveloped countries (Shiffman 2003; Starrs 1997). Participating nations announced their commitment to reducing these mortality rates by implementing a series of campaigns, programs and aid projects. The Indonesian government announced their own national Safe Motherhood strategy in 1988. This was followed by the maternal mortality movement Gerakan Sayang Ibu (GSI) (Mother Friendly Movement), in
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1996, which had an additional focus on ‘raising social concern for the plight of pregnant women’ (Shiffman 2003: 1201).

In the area of family planning and maternal health, Depkes has shared the stage with the National Family Planning Board, BKKBN (*Badan Koordinasi Keluarga Berencana Nasional*) (Cholil et al. 1998). It was the BKKBN head who instigated the 1989 village placement scheme of midwives (*bidan*) in villages throughout Indonesia, when the Indonesian state was under significant international pressure to reduce maternal mortality rates (Hull 2005a). This scheme reduced *bidan* training to one year post-secondary school, in order to increase the numbers of *bidan* to be sent to villages over a short period of time. In what was deemed a great success, 52,000 midwives were in place in villages by the end of 1997 (Shiffman 2003). The *bidan* placement scheme has been a comprehensive effort by the Indonesian state to involve villagers in state-organised interventions in maternal and child health, and into biomedical health practice more generally.

In recent times the Health Department has sought to regain authority over the *bidan* training scheme by requiring all post-1989 *bidan* to retrain for an additional two years, to complete a three year diploma (Hull 2005a). With the international focus on maternal mortality now reduced, Depkes and their provincial and district counterparts have been able to regain some of the authority they lost to the BKKBN in the maternal mortality crisis period. Thus, in addition to coordinating health behaviour at a village level, the Departments of Health have their own concerns in carving out an area of authority within the Indonesian state, in relation to other government departments.

**Decentralisation and health provision**

The post-Suharto era in Indonesia has been characterised by a process of ‘decentralisation’, formally beginning in January 2001, which has been common to a number of Southeast Asian nations in the last decade (Lieberman & Marzoeki 2002). Much of the formal political power in Indonesia has been devolved from the central governments to districts, or *kabupaten*, who are large enough to play a coordinating role but small enough not to be thought to become the basis of a
separatist movement from the Indonesian state, unlike provinces (such as West Papua, Aceh, Maluku). Decentralisation represents the first clear move in a long time to a more ‘federal’ structure, and challenges the centralising tendency of the Indonesian state which was so prevalent under Suharto. The peripheries themselves, in the form of districts, are creating their own centres, which are in many ways becoming more relevant to their local populations than the central government. For example, new boundaries are being established in accordance with particular ethnic or religious identities, and such boundaries are established, at least in part, by pressure from ‘below’. At the district and subdistrict level, proposals for new districts and subdistricts have flourished, as more and more groups attempt to gain control over their own resources and budgetary authority. This devolution of power to districts has not been without contestation: particularly from central government departments who are reluctant to relinquish their power and authority.

Health provision expanded in Indonesia in a centralised manner throughout the 1980s and 1990s. In the area of maternal and child health, in particular, the provision of contraception, maternal and child health clinics (posyandu), subdistrict health centres (puskesmas) and the bidan village-placement scheme were all features of the centralised government during this period. A 2002 World Bank publication expresses concern that decentralisation may adversely impact the provision of health services in Indonesia (Lieberman & Marzoeki 2002). For example, the ability of the Health Departments to maintain certain health services is now uncertain. During the previous centralised government of the New Order, redistribution of resources significantly advantaged the resource-poor province of Southeast Sulawesi. New decentralisation laws may challenge the ability of district Departments of Health, and sub-district health centres (puskesmas), to provide such activities as training of village health volunteers (kader). One government midwife (bidan) said to me that training for kader (and traditional midwives (dukun)) has only been provided with funds from the HMHB project. The puskesmas does not have sufficient funds to conduct training at other times.

Decentralisation has focused on reducing the power of the central Indonesian government generally, rather than advancing the priorities of one particular sector
such as health. However decentralisation may allow the community to play a greater role in decision-making on health issues in the future. It is only in the recent (post 2001) period of decentralisation that significant authority for planning, training, and budgets has been devolved in the health system, mainly to the district Health Departments. In the health system today, the central Department of Health (Depkes) now plays an overseeing role. The Provincial Health Department (Dinas Propinsi) plays a coordinating role with the districts. The provincial Kanwil (provincial representative of the central Health Department) was merged with the provincial Dinas in 2000 (HMHB Project Team 2005: Exec summ 5). The District Departments of Health (Dinas Kabupaten) have been given the most responsibility under decentralisation, including significant budgetary and programming powers.

The extent to which decentralisation has been successful in devolving power and authority is as yet unclear. In this decentralised era the ability of the central government to access information about, or control, peripheries is being contested. However, bilateral development projects from international donors primarily work in partnership with the central government, allowing the Indonesian state to continue its project of surveillance and control at the village level in much of Indonesia through such projects. In the area of health, at a village level, little appears to have changed. The decisions may be coming from a ‘lower’ level of government: district, rather than national, but they still appear as the same activities: such as subdistrict health centres (puskesmas) and monthly maternal and child health clinics (posyandu).

Activities at the district Dinas and the sub-district puskesmas are significantly affected by the large number of development projects that come and go. Multilateral, bilateral and government-funded projects cover a large range of health issues: from vitamin A to iodised salt, tuberculosis to maternal mortality. Aid projects make a significant contribution to the financial status and activities of the Health Department who are not always capable of continuing project activities independently. Much of their own budget is spent on salaries for health staff and maintenance of infrastructure. Under decentralisation the district Health Department now has to lobby for funding to the district government, providing
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another challenge to funding for health provision (Collins 2003; HMHB Project Team 2005). The Healthy Mothers Healthy Babies project (HMHB) was the largest health project in the area of maternal health in Southeast Sulawesi province in recent times, and it spent much time in its latter years working directly with district counterparts on the issue of ‘health services management’.

HMHB: International development and the health system

The Healthy Mothers Healthy Babies Project was an active participant in the state-village dynamics of late-New Order and early-reformasi Indonesia, reflecting both state interests and their own ideas of health, tradition and modernity. HMHB was a jointly funded bilateral project, supported by the Government of Australia (through AusAID) and the Government of Indonesia. It was implemented in the provinces of Southeast Sulawesi from 1997 to the start of 2005, and in Maluku from 1997-2000 (after which it was closed abruptly due to civil unrest). HMHB arose as one of a number of international aid projects in Indonesia as part of the international movement for maternal mortality. HMHB modules reflect Indonesian national health policy, and one project staff member said ‘we would prefer that none of the recipients knew it was a project, that they just thought it was part of the [Indonesian] government.’ HMHB also reflected international health policy, which also tends to dominate policy in Indonesia, through international pressure from agencies like the WHO and the World Bank.

HMHB had as its primary goal to ‘improve the health of women and children in selected Districts of Southeast Sulawesi’ (HMHB Project Team 2005: Executive Summary). The project worked with various levels of the Departments of Health, and health workers, in order to improve health service delivery, increase the capacity of counterparts (in the Departments of Health); and later to increase the capacity of the district Departments of Health to deal with the increased responsibilities and challenges of decentralisation. HMHB had three primary strategies: training of health workers, health services management within the Health Departments, and social mobilisation of villagers. Of the three strategies, two (training and health services management) involved working closely with government personnel. The third, the social mobilisation strategy, focused
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primarily on the public education of village communities around maternal and child health practice. Through these three strategies HMHB aimed to improve the organisation and funding of health services, and the quality and access of service delivery in maternal and child health, in order to reduce the likelihood of births ending in either a maternal or infant death.

As a bilateral aid project, HMHB worked with, and within, the Indonesian government system. A key aspect of bilateral projects is that they are intergovernmental: thus the HMHB project team involved both the Australian government (through AusAID) and Indonesian government counterparts at the district, provincial and central Departments of Health (Dinas and Depkes). At a practical level, the HMHB project offices were located within the Health Department buildings, as were a number of other bilateral and multilateral health aid projects. The ‘Health Services Management’ (HSM) component of HMHB involved working directly with Health Department staff to improve organisational structures in the Health Departments as well as their ability to lobby government for funding in this new decentralised environment. The Australian government agency (AusAID) and the Indonesian Health Department were acknowledged side-by-side in all project materials (such as stickers, posters and information pamphlets). This reflects the high degree of collaboration between the two governments in bilateral aid projects.

Upon hearing that I wanted to examine how a project worked in the village, the HMHB project manager suggested I might prefer to look at another project. Apart from the ‘social mobilisation’ component, the HMHB project did not work directly with villages, and therefore its impact at that level might be difficult to determine. Therefore I chose to look primarily at those aspects of the project which did appear in the village: including the training of government midwives (bidan); but primarily the social mobilisation strategy which included training of traditional healers (dukun) and health volunteers (kader); as well as the physical changes that the project made to the village: the provision of motorbikes to village midwives, the upgrading of midwives’ houses or polindes, and the provision of furniture, posters and stickers with ‘HMHB AusAID/Depkes’ branding.
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HMHB project messages and village-state relations

The social mobilisation component of HMHB promoted a number of messages to rural communities focusing on current policies on maternal and child health practice. These project messages were a key aspect of the way that the project interacted with and targeted rural villages; conveyed ideas of modernity; and posited the village in opposition to the centre. HMHB project messages fed into wider Indonesian government health campaigns, and a number of existing public-education programs in maternal and child health, such as *suami siaga* ('husbands alert'). HMHB project messages were designed to change attitudes and behaviour in relation to specific aspects of health. These aspects included the health of pregnant and postpartum mothers, health during childbirth, and health of infants up to five years of age (known in Indonesia as *anak balita* or child under five years). Messages were communicated through the training of *puskesmas* health workers, *bidan*, *dukun* and *kader*; and the distribution of materials such as brochures, stickers, posters and matchboxes to villagers.

Many project messages were based on a narrow understanding of childbirth experience that did not encompass local experience in implementation. For example they did not tend to acknowledge the important role played by extended family members during pregnancy and birth, instead focusing primarily on the husband. This could be seen as the projection of a Western/Northern ideological model of the nuclear family onto recipient communities (see Chambers 1997). These messages were also based on central government campaigns in health that similarly ignore local realities, projecting an ideal of biomedical health behaviour onto a generalised idea of ‘the village’. HMHB project messages aimed to change certain behaviours that were typical in rural villages, such as birth in the home, rather than working within those conditions. This has the effect of negating locally-based knowledge and practice (Scott 1998). In reality, only a hybrid model incorporating local and project ideas of health was supported by villagers.

Since HMHB was a bilateral project emanating from the centre, project messages have suffered from the association of ‘rules’ with the authoritarian regime in Indonesia that existed until 1998. People knew what the rules were, but they didn’t necessarily feel obliged to follow them. At the village level, there were
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often discrepancies between what villagers – and the bidan – told me they were ‘allowed’ to do, and what they actually did. This may be reinforced in the post-authoritarian era, where corruption is rife at all levels of government and those supposed role models such as police or politicians are not following the rules anyway (Antara 2004). Mass media encourages criticism of government and authority-figures at all levels, particularly on the charge of ‘corruption’. Unfortunately for the project, many of these messages fall into the same category as ‘rules’. Since they are enforced by government officials such as the puskesmas and bidan, they are associated with top-down, centralised authority. People referred to project messages by saying ‘we aren’t allowed to do that anymore.’ In fact, messages are more likely to be effective if they are proven by local experience. In Linomoiyo, one woman died while giving birth in a hut in the fields (kebun) a couple of years ago. Subsequently, no women give birth in the kebun anymore. Such an experience was much more effective than a bidan in providing local women with a reason for changing their behaviour around childbirth.

International development agencies, and the Indonesian state, work on the premise that local populations have a large amount of time to devote to learning and thinking about project messages, attending meetings and talking to the bidan. In reality, childbirth is one activity in many that village women are involved in, which include farming, housework, childcare, assisting relatives, collecting water and firewood; and the bidan is often overworked and/or not in the village frequently enough to do more than give out these messages in brief. A plethora of messages can just be confusing, and can generate a lack of interest among the recipient population. Posters with cartoons were simply not observed by adults, although children took great delight in them. Women tended to scold children for looking at or touching the cartoons, considering such posters to be displays for the benefit of government, not for the villagers themselves (see Sciortino 1995).

In general, villagers incorporate such project messages into their existing understandings of health and the childbirth process. Information about health comes to villages from a number of sources, including official information from health ‘professionals’ and the central government, and what is called ‘lay
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epidemiology’, or local observation of patterns of illness and death in the community (Davison et al. 1992). The nature of popular health-seeking practice in Southeast Sulawesi villages confronts Indonesian state, and international development, notions of village health practice as backward and dangerous. Rather, village health practice is complex and villagers actively engage with the state and the international community in using pharmaceuticals, biomedical practitioners, folk healers, and herbal and spiritual healing.

**Statistics, projects and the state of health**

The global movement to address maternal mortality arose in part through the promotion of certain statistics or indicators which demonstrated a ‘crisis’. More than 500,000 women were dying globally every year, and 400 in every 100,000 births across Indonesia resulted in a maternal death. ‘Mortality rates... serve bureaucratic purposes of the state and the international community’ (Kleinman 1995: 69), and they ‘treat people and cultures as abstract concepts’, reducing their identities to statistical figures (Escobar 1995: 44). Quantitative, statistical information is an important element of state-village interaction in the health system. Statistics of population numbers, births and deaths, are collected at the village level for the subdistrict health centre (*puskesmas*), where they are collated for the district Department of Health, and then the provincial and central Departments of Health. Statistics are also an important data source for international aid projects such as HMHB. Maternal mortality statistics were used to create a ‘problem’ for which ‘change’ was required (Shiffman 2003), in this case, in the form of the HMHB project. Maternal mortality statistics are utilised as part of a state (and international) discourse of development which posits villages as geographically defined spaces of illness, defined as high maternal mortality, that require intervention in their ‘backward’ childbirth practice (see Hunter 1996b). Such statistics introduce a moral element to village-state relations, criticising village health practice as ‘dangerous’, and creating political will for

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7 This number has reduced to 230 in 2000, although allowances must be made for under-reportage and inaccuracies in data gathering techniques
power shifts from local to state centres of power (Scott 1998) (see also Foucault 1990).

At a macro level, the statistic of maternal mortality seems high, particularly in comparison to Australia’s current rate of eight maternal deaths per 100,000 live births (World Health Organization 2004). Yet even at the highest estimated rate, 0.4% of births resulting in death across Indonesia is a tiny amount in a rural village of five hundred people. There are an average of ten births in a village that size in one year (UNICEF 2005), of which 0.04 deaths occur, meaning an average of one maternal death in that village every twenty-five years. Moreover, these deaths are unevenly spread across the country, and Southeast Sulawesi does not have particularly high maternal mortality rates in comparison to other provinces. The use of macro statistics at a micro, village, level demonstrates the gulf of difference between central government, and international, perceptions of ‘the village’, and daily experience at the village level.

Villagers are mindful of the risks associated with birth, and village childbirth practice incorporates rituals to manage risk. Although the frequency of maternal mortality is low at a village level, even one maternal death is a devastating and tragic event for villagers. In a small community, each death is personal, and in villages where most people are related, maternal morality is experienced as the death of a family member. As in the case of death of a woman in the kebun, above, even one maternal death can have a profound impact on village childbirth practice. But villagers do not see childbirth in terms of ‘crisis’ in the way that it is projected by the state. Such state and international discourse is not meaningful for them. Villagers do not politicise and moralise maternal mortality in the same way as the state (Douglas 1992: 13, 31). Villagers create their own understandings of issues such as maternal mortality. These meanings are strongly influenced by local experience as well as engaging with state, and development project, notions of mortality and appropriate health and childbirth practice.
Figure 2.1 The *kalosara*

Figure 2.2 Women at *arisan* with booklet
Chapter Three
The HMHB project, village-state relations, and modern health practice

A long banner outside a subdistrict health centre (puskesmas) proclaims the Healthy Mothers Healthy Babies Project, complete with logos from AusAID and the Indonesian Department of Health. ‘Ibu Sehat, Bayi Sehat’, the banner announces in its Indonesian translation of the project title. This is the last stage, and last year, of the project, so a few months later when I pass the same puskesmas it is now announcing a UNICEF Vitamin A project with a smiling cartoon child: one banner replaced by another.

Aid projects sit both outside, and within, the recipient states that form their counterparts, and the villages where the implementation of many community-oriented projects occurs. The AusAID Healthy Mothers Healthy Babies project (HMHB) plays an important role in village-state relations in Southeast Sulawesi. Although most of its activities are removed from the location of the village, it has as its central tenets the centre-periphery dichotomy, the concept of health as an integral part of modernity and the state project of development. Images of the village are located in project reports and project materials (stickers, posters, brochures and so on). Project materials, branding and key project messages play an important role in how ‘the project’ appears in the village. Such material objects, as well as interviews and discussions with project staff and government counterparts in the Indonesian Health Departments, reveal imagined and actual links with village-state relations, and suggest how health is conceptualised as part of development. HMHB also links villages into global networks of ideals and interventions in the area of development – in this case, in international health practice. In the light of the chapters that follow, which take a village-level perspective, I reflect on HMHB interventions in village health practice, and the disparity between idealised conceptions of the village and village-state relations, that are created by projects and their personnel, and the situation that I found myself in. While I do not claim to have a privileged view of the two villages
where I lived, my fieldwork research achieved a much more in-depth knowledge of those villages than can be obtained from project reports; including knowledge of the people within villages, and some of their aspirations and concerns in the wider world.

This chapter begins with a general description of the project, before considering the various levels, or actors, of the project. Actors include AusAID, the Australian Managing Contractor (AMC), the HMHB project team, and project counterparts in the Indonesian government. This discussion draws on information from written reports and verbal accounts from various actors, including their perceptions of how the project, and project actors, created ideas of the village, and placed themselves within village-state relations. The concept of health promoted by HMHB reflected internationally-established norms of biomedical health practice, as well as development practice and ideas of modernity. The project constructed ideas of the village, and of the state, and interacted with existing village-state relations in Southeast Sulawesi through health practice and development. The impact of a project like HMHB cannot be isolated from the wider impacts of development interventions, in health and other areas, from both Indonesian government and international sources, which are operating in Southeast Sulawesi villages. My analysis of the role of HMHB also includes references to the strategies, programs and ideals in the wider development industry.

The HMHB project

As noted earlier, the ‘Healthy Mothers Healthy Babies Child Survival Project’ was a bilateral project between the governments of Australia and Indonesia. The initial request for such a project arose from the Indonesian government, in accordance with their National Safe Motherhood Strategy and the Mother Friendly Movement (AusAID 1997), and the project was designed (during 1995-1996) and implemented by AusAID on behalf of the Australian government. Funding was provided by both governments, with the Australian government providing the majority contribution. Project implementation commenced in December 1998 and was designed as a five year activity in two provinces of the Eastern Indonesia region (Southeast Sulawesi and Maluku). The project withdrew
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from Maluku Province in 2000 due to an outbreak of violent unrest. Implementation continued in Southeast Sulawesi Province until January 2005, as a result of a one-year extension on the original five-year time-frame. Southeast Sulawesi was described in initial project documents as an impoverished province (ranking 24th out of 27 Provinces in terms of per capita income), in Eastern Indonesia—a region expressly targeted by AusAID in recent years (AusAID 2005b; HMHB Project Team 1999a). Few other projects in the area of maternal health were in operation in Southeast Sulawesi province at the time of HMHB. Southeast Sulawesi province has been generally neglected in terms of health assistance by the central Indonesian government in the past (see also Kristanto et al. 1989).

People in the central government, in the Health Department (DepKes), disliked coming to Southeast Sulawesi. They thought it was a dirty province—corrupt. There were no exotic places to visit. When the Health Department implemented a new program, they would just send the package and money to the Health Departments (Dinas) in Southeast Sulawesi. They wouldn’t implement it themselves. This is the situation we had to deal with when we came to implement the HMHB project. It was like starting from the beginning.

- HMHB Project Team member

The project consisted of five key components:

- Training of government midwives (bidan) and midwife supervisors (bikor)
- Upgrading of infrastructure such as motorbikes, and renovation of midwife houses (polindes)
- Improving maternal and child health service delivery at a primary care level
- Strengthening the capacity of counterparts to deliver health services within a decentralised system
- ‘Collaborating with counterparts to manage the Project effectively and efficiently’ (HMHB Project Team 2005: 3)

These components were addressed using three strategies discussed in Chapter Two: Training, Social Mobilisation and Health Services Management. Project
activities were carried out in provincial and district Health Department offices as well as subdistrict *puskesmas* (health centres). The project established a ‘competency-based training system’ (HMHB Project Team 2005: 7) for *bidan* and *bikor*, establishing two training centres and training ‘Master trainers’, who then carried out training of the village-based *bidan*. Training was considered one of the most successful outputs of the project, according to evaluation reports (for example HMHB Project Team 2005).

As a bilateral government-to-government project, HMHB supported existing Indonesian government campaigns in maternal health, extending both government health services and government surveillance in villages. HMHB’s counterparts were the Indonesian Department of Health (*Depkes*), and they worked primarily with *Depkes* rather than with other government departments. This was particularly apparent at lower levels of government, where HMHB assisted the district Health Departments in lobbying the district government for health budget funding. While HMHB worked directly with the Indonesian Health Departments at central, provincial and district levels, they did not work directly with other government offices, such as the offices of provincial, district, and sub-district heads. Local officials, such as the subdistrict head (*camat*), felt circumvented by the HMHB project implementation process, as the wife of one *camat* commented to me, saying ‘HMHB is a good project, but it should work with government, with the *camat*, not with LPM (*Lembaga Pemberdayaan Masyarakat* – a village-level NGO). The situation in Southeast Sulawesi is different to other places, like Java’ she said. Formal chains of command still have considerable influence in Indonesia, particularly at a village level. This confusion of authority expressed by the wife of the *camat* is partly explained by the lack of connection perceived by many between health practice and government. As Cholil et al. note: ‘Heads of districts, subdistricts and villages [do] not pay careful attention to community awareness and efforts to reduce maternal mortality… [and] causes of maternal mortality are perceived as purely medical problems’ (1998: 50). The Mother Friendly Movement has attempted to increase the involvement of government in

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8 In fact, while HMHB did work with village heads – in allocating funds for *polindes* (midwife house / birthing hut) renovation, there is no evidence that they worked with LPM.
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health through greater inclusion of local government officials at village, subdistrict and district levels in their campaigns.

Many in the development industry have recently expressed disillusionment with recipient governments, which are perceived as ‘inefficient, wasteful, and ineffective’ (Crewe & Harrison 1998: 5; see also Fisher 1997), and they perceive ‘elites and ... [high] officials’ to have a preference for ‘top-down...trickle-down oriented’ programs (Porter et al. 1991: 139). They prefer to work with non-government agencies, and lower levels of government, ‘to bypass regional and district levels of bureaucracy and disperse cash grants directly to villages whose “leaders usually have quite clear ideas about the needs of the local community”’ (McCawley in Warren 1993: 258). This is moving in the opposite direction now: with AusAID placing increased emphasis on governance and institutional strengthening, so that projects are now increasingly working more with government than with communities directly (AusAID 2005a). Due to the implementation of decentralisation in Indonesia in 2001, the project team spent much more time working with the district Health Department (Dinas) than had been initially planned, with the addition of a new component titled ‘Health Services Management’ to the project (HMHB Project Team 2005). Through the Health Services Management strategy, HMHB assisted the Health Departments to adjust to the new system of decentralisation, in order to ensure sufficient budgetary funding in the future and maintain the provision of basic health services to the community.

Most project activities were implemented outside of the villages themselves: in Health Department offices, and sub-district health centres (puskesmas). HMHB explicitly worked with and within Health Departments rather than local communities. Villagers are described as stakeholders in HMHB reports, with one report stating that ‘The Goal of the Project is to improve the health of women and children in selected Districts of Southeast Sulawesi’ (HMHB Project Team 2005: Exec summ 3). However the interventions of HMHB were largely carried out at locations external to the village. In addition, the reporting requirements of bilateral projects required the project team to spend considerable amounts of time
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writing ‘milestone’, ‘six-monthly’ and other reports, and attending meetings, which were located close to the Health Departments but distant from villages.

At the village level the project upgraded a number of midwife’s houses (polindes), as well as some village-based health centres (puskesmas pembantu / pustu) (94 polindes and pustu in total). It also provided chairs, tables, medicine cabinets and examination beds for a number of polindes which were not upgraded; and upgraded 574 village health clinic posts (pos posyanda). Another feature of HMHB was increasing spatial mobility – of government midwives (bidan) through the provision of 266 motorbikes, to enhance the ability of bidan to service the villages for which they were responsible; and of pregnant women experiencing difficulties, through messages to encourage families and neighbours to organise transport for pregnant women to the health centre. This was part of an attempt by the government to relocate births from the home to health centres, hospitals, or at least the midwife’s house in the village (polindes). In one way this was ‘moving forward’ (maju = move forward, progress, advance), moving women from huts in the fields (keban) where they used to give birth, to homes, and then towards centres of modernity and greater state power (midwife’s house, health centre, hospital). It was also a ‘moving into’, an increased visibility and penetration of state power in villages through the midwives’ motorbikes, with which they have greater access to villages, as they move quickly around on government business.

Communities within Southeast Sulawesi Province are described in project documents as poor and isolated. This accords with the poverty alleviation requirement of AusAID projects and conveys a sense of marginality of those communities. Project reports provide a ‘mythic’ image of the generic village in Southeast Sulawesi (see also Pigg 1992: 504), an image that is supported by the comics and cartoons of the village, and villagers, used in project materials. ‘Images of villages and village life accompany the promotion of development ideals’, providing an imagined space in which development interventions can be comfortably planned (Pigg 1992: 491, 503). Discussions of local culture in project reports often refer more generally to Indonesia, with a brief discussion about Southeast Sulawesi province limited mainly to statistical facts, such as population
density, birth rate, mortality, per capita income and so on (AusAID 1995: 20-21). A later version of this Project Design Document (PDD) suggests that culture is an obstacle to quality health care, although the specificities of this concept of ‘culture’ are not discussed (AusAID 1997). References in project documents suggest that concepts like ‘culture’ and ‘community’ are unproblematic and can be generalised across Indonesia:

As a young female in a village setting, the BDD (bidan – government midwife) faces many cultural barriers, as well as ‘competition’ from older traditional birth attendants, that may limit her acceptance into a local community (HMHB Project Team 2001b: 17).

The qualitative survey indicated that poverty, cost, lack of availability of village midwives and cultural beliefs and practices were the main reasons why women did not receive adequate health care during delivery (HMHB Project Team 2003b: 37).

The TBA (Traditional Birth Attendant – dukun) has a high status in the community and provides spiritual, cultural and traditional authority to health information (HMHB Project Team 2000: 26).

Such comments highlight the difference between how the notion of culture is perceived by the development industry and the discipline of anthropology. For development agencies, culture is an explanation, while for anthropologists, culture is something that needs to be explained.

A common misperception, cited in HMHB project reports, is the idea that Muslim communities (and Southeast Sulawesi is predominantly Muslim) take a fatalistic attitude towards death, and that they will respond to deaths in childbirth with the attitude ‘it is God’s will’ and subsequently engage in ‘low levels of care seeking’ (HMHB Project Team 2001a: 4). While it is undoubtedly the case that villagers in Southeast Sulawesi saw deaths as God’s will, such an attitude was apparent after a person had died, not before. Villagers were highly concerned about the risks inherent in pregnancy, despite considering it to be a normal and important role of women, and they would do whatever they were able to in order to prevent the death of a woman giving birth.
Project actors: organisations and individuals

Bilateral projects like HMHB involve a large number of actors, each with different perspectives, incentives and goals. Robertson (1984: 155) argues that 'the ideal of the bureaucratic hierarchy assumes a unanimity of interest which is always at variance with reality'. Each project actor takes a different approach to their roles, expresses different values, and perceives the other actors in different ways. These actors include the two governments: Indonesia (represented by the Department of Health) and Australia (represented by AusAID); the Australian Managing Contractor, IDSS; the project team; and the sub-district health centre (puskesmas) staff and midwives (bidan) who were involved in much of the project implementation. This section explores the perspectives of different project actors, and addresses the following questions: How do actors in the project conceive of and interact with the state, the project, and the village in the context of health and development in a marginal area of Indonesia? How are these ideas imagined, contested, and grounded in experience? What is the culture of the aid industry and how is it played out through its actors?

AusAID: Politics, reports, and the imagined 'village'

AusAID is an autonomous government body under the Department of Foreign Affairs and Trade (DFAT) that coordinates Australia’s official development assistance (ODA) on behalf of the Government of Australia. AusAID is the current name for this specialist development assistance unit (formerly ADAB, AIDAB), and has been part of DFAT since 1976 (Harris 1983). Indonesia is one of the primary recipients of Australia’s ODA, the largest recipient in Asia, and Australia is now the second largest donor to Indonesia. Due to Indonesia’s close proximity and key importance as both a diplomatic ally and trading partner, Australian ODA to Indonesia plays an important role in enhancing and strengthening diplomatic and trade relations between the two countries. Australia was the eighth largest exporter to Indonesia in 2005, and Indonesia was Australia’s 11th largest trading partner (Department of Foreign Affairs and Trade 2005). As a donor country, Australia plays an important ‘partnering’ role,
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providing the bulk of its aid funds through bilateral projects, and playing the primary role in project design, implementation, monitoring and evaluation. Although Indonesia must also approve all ODA projects (through the National Planning Body, BAPPENAS), the balance of authority for aid projects rests with the government of Australia.

The term ‘AusAID’ contains the key term ‘aid’, although this comes from the acronym for ‘Agency for International Development’. Using such a term underscores the important public appearance of such agencies. AusAID, as part of the Australian government, is ultimately accountable to the Australian public. The focus of AusAID publications, and its website, tends to be the appearance and multitude of projects, rather than in-depth detail on projects themselves (AusAID 2003; AusAID 2005a). Large photos of smiling children at school, or women harvesting rice, feature on AusAID posters and brochures, suggesting, along with the slogan ‘making a difference’ that their projects have a direct benefit for the people pictured (see figure 3.1). Yet the outcome of projects is much less certain than their public appearance would suggest. AusAID runs a large number of projects in a variety of countries and sectors (such as health, education, governance), meaning that the overall impact may be diluted, and may cause difficulties for organisational coherence within AusAID. However a plethora of projects provides a more convincing justification of the value of aid work to Australian taxpayers, since ‘they are under constant pressure to be effective and produce results’ (de Herdt & Bastiaensen 2004: 877). This desire for an appearance of success and activity is equally supported by the recipient government, for which development projects can demonstrate to their citizens that the government is ‘doing something’ for them.

AusAID plays a coordinating role in bilateral projects: tendering projects, once a project design is complete, to an Australian Managing Contractor⁹ – typically a private Australian company specialising in development assistance. HMHB was contracted to IDSS Pty. Ltd. (in conjunction with the Burnet Institute) which is discussed below. Monitoring of these projects is mainly outsourced to consultants

⁹ This policy has now been changed to permit non-Australian companies to tender for work and be awarded contracts. At the time of HMHB they were still known as ‘Australian Managing Contractors’
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who conduct periodic one to two week visits to the implementation site to evaluate specific project components, and present their findings and recommendations to AusAID. Throughout the implementation process AusAID maintains an overall supervisory role, primarily conducted through reports from the project team. AusAID staff rarely visit the project site, although they retain considerable control over the project, including the establishment of budgets and added/changed project components. The high staff movement and turnover within AusAID exacerbates their arms-length approach. There were four different desk officers at AusAID responsible for HMHB at various times during its six-year implementation period (HMHB Project Team 2005: 5).

Project reports can often give a misleading impression of the project. Reports are tied to fixed reporting structures and an emphasis on success-failure evaluations, so the project team is encouraged to show the project in the best light in terms of specific components and outputs. As mentioned in Chapter One, the impact of projects like HMHB extends far beyond what is stated in reports, and also beyond the intentions of the project as it was designed. A key feature of international aid projects (including AusAID projects) is the use of ‘logical frameworks’ or logframes, reflecting a bureaucratic mentality that tries to ‘control the uncertainty created by... development projects’ (Porter et al. 1991: 92). Logframes are part of a ‘control-orientation’ strategy which tends to give agencies such as AusAID the impression that they have greater control over their projects than they might actually have. The development industry now considers logframes established at the start of a project to be too inflexible to cope with the changing circumstances during project implementation. A new strategy has been adopted: the ‘changeframe’, which allows changes to the logframe to be charted and planned in an orderly fashion. The ‘changeframe’ is essentially a ‘logframe’ of changes. The HMHB project used logframes and changeframes in their reports, to plan activities, demonstrate achievements, and allow for changing circumstances during project implementation. Project reports state that ‘The Project logframe is structured into a series of components and outputs which serve as a useful planning tool,’ (HMHB Project Team 2005: 5) however reports also note the over-ambitious nature and poor articulation of activities in initial logframes, which were revised a number of times during implementation.
If the project is somewhat distant to AusAID, the villages, and ‘women and children’ – who are cited as stakeholders in HMHB project documents – are barely visible. Scott notes that ‘the utopian (immanent) tendency of the modern state, continually frustrated, is to reduce the chaotic, disorderly, social reality beneath it to something more closely resembling the administrative grid of its observations’ (1998: 49). The messy reality of village life and the specific needs of women and children do not conform to the orderly image of ‘the village’ that appears in project reports. As previously discussed, village-specific information rarely appears in project reports, even information on Southeast Sulawesi province is limited to generalised, abstract statistics. Although one AusAID desk officer visited the HMHB project site in July 2003, including some villages in the area of implementation, she has now relocated to a position in another country and her impressions were not recorded by AusAID. To AusAID generally, the villages who are the recipients of projects remain unclear, in the figures, statistics and brief descriptions in project documents. The alternative to this is the photos of the generic village that adorn their walls, giving the impression that one village is much like another in the developing world where these projects operate.

Southeast Sulawesi villagers are encouraged to be aware of AusAID. Chairs, tables, posters, and stickers provided by the HMHB project all display the AusAID logo along with the Indonesian Health Department logo and the name of the project. This is a feature of a number of different projects that operate in rural Southeast Sulawesi, including projects from UNICEF, the World Bank and Indonesian government sources – all of which have their own signage. Discussion with villagers in both Waangu-angu and Linomoiyo elicited the impression that no one knew what the term ‘AusAID’ referred to – it is merely one acronym among many that adorns t-shirts, stickers, and water tanks. Stickers, posters and t-shirts are particularly popular with villagers for decorating their houses, but seem to do little to increase villager awareness. Only one village midwife (bidan) was aware of the connection between the HMHB project and the word ‘AusAID’ (she had attended HMHB training) but although she knew HMHB came from Australia, she thought that AusAID was a private company. The team leader on HMHB was also part of the branding strategy: an Indonesian team leader was not
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acceptable because AusAID considered it important for Indonesians to be aware that the project was from Australia.

A common feature of aid projects is that their success or failure is often attributed to the socio-cultural aspects of a recipient, rather than the need for a particular development intervention provided by the project (Crewe & Harrison 1998; Robertson 1984). In HMHB, for example, the key role played by the traditional midwife (dukun) is seen as preventing the government midwife (bidan) and other government health providers from playing a greater role in birth attendance. As indicated in a quote above, 'culture' was identified by HMHB as an obstacle to the provision of 'quality health care'. However the culture of AusAID and the development industry itself is rarely called into question. The language used by project actors, and in project reports, classifies the rural villages of Southeast Sulawesi as appropriate targets for intervention through the use of statistical data, and locates their current health and childbirth practices within the purview of 'culture', as something to be overcome with project techniques. The appropriateness of project interventions is not called into question since the aims of the project are ostensibly 'good'. Yet AusAID is as much influenced by development 'culture' as the villagers in rural Southeast Sulawesi are influenced by traditional culture. The successes and failures of a project are nuanced by the culture of all the actors in a project, not just the recipients.

IDSS: The (hidden) contractor and the development industry

In 2003 the IDSS (International Development Support Services Pty Ltd) head office was located in a small complex near Swanston St in Parkville, Melbourne. Resembling a generic office setup which can be found throughout Australia, most employees were tucked in cubicles, with more senior staff in individual glassed-in offices at one end. The small kitchen was hidden around the back, and a large room in the centre was used for training, which IDSS conduct with their own staff as well as for other agencies.

IDSS, along with the Burnet Institute (formerly the MacFarlane Burnet Centre for Medical Research Inc.), were employed by AusAID as the Australian Managing
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Contractor (AMC) on the HMHB project. My research focused on IDSS, rather than the Burnet Institute, who were employed as specialists in the health field. Private Australian development firms implement the majority of AusAID’s official development assistance (ODA) projects, with 10 percent of funds allocated to Australian NGOs. All AusAID projects are contracted out, and there are many requirements on contractors to be accountable for activities performed and money spent. As de Herdt and Bastiensen suggest, ‘accountability runs counter to the flow of finance’ in aid projects, so that decision-makers higher up in the chain of command ‘acquire disproportionate weight’ (de Herdt & Bastiaensen 2004: 876). The project team, and the contractor, are unable to make changes to a project without first gaining approval from the top, even if they are responding to demands on the ground.

The Australian Managing Contractor, in their office in Australia, coordinates the activities of the project team, who are based at the site of implementation, and manages the flow of reports from the project team to AusAID. Termed ‘milestones’, the multitude of reports accounts for every aspect of the project implementation: such as budgetary spending, project activities, and reviews of particular project components. They can be quite onerous for the project team, who spend much of their time during implementation writing reports. Although AusAID contracts out its projects it retains full control and authority over every activity at every point. This has to do with the accountability of donor agencies to their donors – in this case, the Australian public. The accountability to the donors is also related to the invisibility of the contractor. None of the brandings of HMHB indicate the name of either contractor – all display AusAID and the Indonesian government logos. As part of the contract, the Australian Managing Contractor – and the project team – is an arm of the Australian government when implementing projects, and their identity is hidden behind the mantle of the government. As far as the Australian public is concerned, AusAID projects are implemented by AusAID staff themselves. AusAID staff may also feel a great deal of ownership over their projects, despite not implementing them directly.

IDSS was established by Community Aid Abroad (now Oxfam CAA) in 1983. They were the ‘first commercial consulting company to be established by an
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international NGO’ (International Development Support Services 2005). In October 2005 they were ‘acquired by the multi-disciplinary consulting firm Connell Wagner’, after the HMHB project had completed implementation (International Development Support Services 2005). IDSS have worked with clients including the World Bank, the Asian Development Bank (ADB) and AusAID, and a number of NGOs, in the health, water supply and sanitation, rural development, agriculture, natural resource and environmental management and governance sectors in a number of countries (International Development Support Services 2005). IDSS emphasises their good reputation and relationship with AusAID. The HMHB Final Evaluation Report received a ‘gold standard’ in reporting from AusAID, and other reports were also highly commended. Although they are not visible as a separate entity in implementing projects, IDSS maintain a comprehensive website which advertises their current activities, as well as employment opportunities; and run a ‘consultant register’.

IDSS defines its institutional focus as ‘implement[ing] people-centred approaches in bilateral and multilateral international development projects’ (International Development Support Services 2005). Anecdotal comments from employees suggested that this contractor has a different approach to its staff and projects to other development contractors. One project team member said that IDSS, as a contractor founded by an NGO, was more focused on values and principles than profits. Employees highlighted IDSS’s five ‘guiding values’: ‘sustainability, capacity building, ownership, environmental integrity and gender equity’. The terminology used by IDSS is similar to that used across the development field, so terms alone are not sufficient for IDSS to differentiate themselves from other development agencies. One additional method they use is the selection and interaction of personnel. IDSS head office is a relatively small office where all employees know each other well. Head office emphasised the idea of ‘learning’ rather than ‘critiquing’ in projects, and in relation to project teams. The report I prepared during my internship was termed ‘Lessons Learned’.

IDSS, in its head office in Melbourne, has little more to do with projects – and to the villagers of Southeast Sulawesi – than AusAID. This is the nature of most

10 It is unclear how this particular ethic of IDSS might have changed as a result of its acquisition by Connell Wagner.
ODA projects, in which the managing contractor who wins the contract employs a team to implement the project on the ground. IDSS manages the flow of reports from the project team to AusAID, and their primary focus is on securing contracts for new projects from AusAID. They are responsible for employing Australian project staff, and the success of their projects is an important factor in winning new contracts. IDSS manage a number of projects in different areas and countries. Its website says they have managed 200 projects in 46 countries over the past 20 years (International Development Support Services 2005). Their concern with HMHB is restricted to a few staff members, and once the project has finished, IDSS redirects its focus to other projects. As with AusAID, village recipients of projects remain indistinct, part of a large number of project activities and contracts that constitutes the development industry in Australia.

The project team: Idealists getting the job done

When I visit the project team during my year in Southeast Sulawesi, the team leader, John, shows me through their house in the Konawe district capital, Una’aha. He indicates the bedrooms at the front where he and the other team members sleep, and the large table at the back where they eat meals, and hold project meetings. At the time of my visit the Project Director is staying here, on a short visit from Australia. He works as a paediatrician in Australia, as well as working for the Burnett Institute as HMHB Director. The house is large, to accommodate a number of staff, their meetings and project documents, which fill bookcases on the wall. It is conveniently located walking distance from the district Department of Health offices. A four-wheel-drive provided by the project sits in the driveway, to take them to meetings with Department of Health staff as well as visits to subdistrict health centres (puskesmas) where project activities are being carried out. Most of the Australian staff speak Indonesian, including the Team Leader, Project Director and Training Adviser. After lunch we visit another two of the Indonesian team members, both women, who share a house a few streets away. The older woman laughs as she introduces me to her husband. 'This man hung out washing while I was pregnant,' she tells me, referring to the matchbox image (discussed below) that was part of the HMHB project.
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The HMHB Project Team was employed by IDSS to implement the HMHB project in Indonesia. Project reports state that 'the AMC (IDSS) and Project Team [had] a good collaborative relationship' (HMHB Project Team 2005 section 2: 4), although the project team considered themselves to be distinct and independent from IDSS. The team consisted of Australian staff, some expatriates based in Southeast Sulawesi, others visiting for periods of time and based in Australia; as well as locally-employed Indonesian staff. The Project Director and Project Manager, both Australian, were located outside of the implementation site (in Australia and Bali respectively), and visited Southeast Sulawesi a number of times each year. The Team Leader was also Australian, living in Southeast Sulawesi. Australians took on the roles of Deputy Team Leader, Gender Advisor, and Training Advisor. Indonesian staff held positions as advisors and consultants, as well as project team members. Although most Indonesian staff were not originally from Southeast Sulawesi, some had spent a considerable number of years living in the Province. The project team spent a large amount of time interacting with project counterparts – the provincial and district Health Departments – and a limited amount of time with government health service providers (puskesmas and bidan) and village dukun and kader posyandu (health volunteers). Of all the Australian project actors, the project team had the most interaction with rural Southeast Sulawesi villagers during project implementation.

Among the project team staff there were a number of different opinions about the project, its implementation, and the villagers in the implementation area. Australian project team staff generally took an idealistic approach to implementing aid projects like HMHB. While attuned to the realities and limitations of daily project implementation, Australian staff generally felt that it was their role to help people, to improve the situation, and that local communities would benefit from the project they were implementing. They emphasised the ethical nature of their work, relating to the fact that HMHB addressed mortality issues. This gave them the sense that they were dealing with life and death, and that the project was critical to the survival of recipient villagers.

The project team generally had a positive attitude to the counterparts in the Department of Health. John, the Australian team leader, suggested that project
counterparts outperformed AusAID and IDSS in some aspects. For instance, the Health Department was much quicker in working out a new contract for the project extension phase 2003-4 than AusAID and IDSS, and he ‘felt embarrassed about the lack of efficiency on the Australian side.’ This efficiency had significant implications for the work of the project team. He was generally impressed by the performance of Indonesian staff on the project team. A final evaluation report states: ‘The Project Extension in 2004 would not have been possible without the continued technical and management input of the Indonesian team members’, and ‘the Indonesian technical and administrative staff are of a very high standard’ (HMHB Project Team 2005: 43, 57).

Project evaluation reports reflect the difficulties the project team experienced with AusAID: ‘the performance of AusAID’ was ranked lower than other performance indicators (HMHB Project Team 2005). Concern was expressed over the burdensome level of reporting required by AusAID, the lack of site visits by AusAID staff, and the lack of experience of AusAID ‘TAG’ (Technical Advisory Group) members, who monitored HMHB progress, with the health sector in Indonesia. Project staff felt that AusAID had little understanding of the situation in Indonesia, including factors like decentralisation and their impact on project implementation. On the other hand, project reports express the difficult challenges faced by Indonesian counterparts on such issues, stating: ‘Counterparts are constantly facing competing challenges to their systems, demands on their time, shrinking budgets and lack of clarity in regards to available budgets’ (HMHB Project Team 2005: 45).

A contrasting attitude to villages to that in project reports was provided by one of the Indonesian project team members. He was particularly critical of health and childbirth practices in villages of Southeast Sulawesi, in comparison to his own home of Java. He remarked that most villagers in Southeast Sulawesi didn’t speak Indonesian, and gave birth in a hut in the kebun (fields), remarks that directly relate to ideas of progress and modernity and development in Indonesia. Speaking Indonesian is a mark of a modern community, as Tolaki villagers in Linomoiyo commented to me, in contrast to other parts of Indonesia where people didn’t speak Indonesian and ‘were like monkeys’ – referencing evolutionist ideas. The location of a birth is also highly significant, with the kebun being close to the
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forest, and far from the village and sites of modernity. He also suggested that
gender roles were more equal in Java than Southeast Sulawesi, alluding to
contemporary development discourses about gender. His remarks contrast with
the neutral language employed in project reports of ‘socio-cultural’ obstacles to
quality health care. However, as Crewe and Harrison argue, while words such as
‘local’, ‘poor’, or ‘culture’ are ‘not derogatory in themselves, [they] can...
become euphemisms for tabooed words [in development discourse] such as
primitive, savage, or native’ (Crewe & Harrison 1998: 29). The perspective of the
Indonesian project team member might reflect broader concerns within the
development industry on the backward and dangerous nature of village health
practice. The Indonesian state and HMHB posit the villages in Southeast Sulawesi
as places of backwardness that form legitimate sites for development intervention.

The project team was located in Southeast Sulawesi, but insulated within the
project offices, which are in the Department of Health, located in an urban area
where ideas of ‘the village’ are produced. The project team did not spend much
time in the villages of Southeast Sulawesi, interacting with them mainly in terms
of graphs, statistics, and mapped locations, or through the subdistrict health
centres (puskesmas). Some team members conducted visits to some of the villages
where HMHB has been implemented, making brief stopovers to villages in their
project four-wheel drives (places where only the wealthy can afford to own a
motorbike) and leaving hours later. They had little opportunity to acquaint
themselves with villagers due to the priorities of project implementation, such as
working with Health Department counterparts and writing reports.

District Health Departments: The new counterparts

The project team conducted a number of consultative meetings with counterparts
during 2004. I attended part of one meeting, held in the large conference room
behind the provincial Department of Health offices in Kendari. A large semi-
circle of tables and chairs faced a table and two whiteboards at the front. A
number of men and women, dressed in their khaki Department of Health
uniforms, sat chatting as they broke their meeting for lunch. One woman spied
me and smiled in welcome, encouraging me to have some lunch with them.
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People introduced themselves to me one by one, including the head of the District Departments of Health for both Konawe and Konawe Selatan, and their assistants. I stayed for the afternoon session, conducted in a mixture of Indonesian and English, with a presentation by the project team leader. At the end of the day one team member organised a list of people who were interested to go on a tour to a few different puskesmas that were involved in the project. I was encouraged to join a group, and I spent the next day driving through Konawe district, along with the HMHB Project Director and some representatives of the national Department of Health in Jakarta.

As a bilateral project, HMHB worked closely with the Indonesian government system. The district Health Departments received a great deal of assistance from HMHB. The limit in capability of Indonesian Health Departments is constantly stressed in project documents, while the project evaluation reports (HMHB Project Team 2003a; HMHB Project Team 2005) enthusiastically endorse the improvements in their capability that HMHB interventions have achieved. For example: ‘The standards and practices used by the [HMHB] Project team became models for counterparts’ (HMHB Project Team 2005: 44).

When the project first began implementation in 1998 the primary counterparts to HMHB were the national and provincial Departments of Health. After the passing of decentralisation legislation in 1999 and 2001, greater responsibility was decentralised to the district Health Departments, including responsibility for training, programs, and budgets. In Southeast Sulawesi, the relevant districts for HMHB were Buton district, and Konawe and Konawe Selatan (Konsel) districts (previously Kendari district, until 2004) (see maps 9 and 10). Stuart Collins (2003), a former deputy team leader on HMHB, described the Butonese as ‘proactive and aggressive’, considering them to be a more positive counterpart to the project team than the Kendari Health Department. HMHB Project documents written at a later stage of project implementation indicate that the youthful management team in Kendari had become more receptive to the Project as implementation continued than the older, conservative bureaucrats, and authoritarian management style, in Buton. Butonese counterparts in the Department of Health were also preoccupied with the relocation of the district
administrative centre from Baubau to Pasarwajo at that time (HMHB Project Team 2003a; HMHB Project Team 2005).

More recent project documents, evaluating the project extension phase in Konawe and Konsel districts in 2004, suggest that while the Konawe Health Department was left with much of the senior personnel from the former Kendari district, the newer Konsel staff ‘made greater progress’ in changing their ‘management culture’ (HMHB Project Team 2005: exec summ 6). HMHB project team members associated the Konawe Health Department with the ‘old guard’, likely to be less transparent in activities (such as the counterpart budget for HMHB, discussed below) than the newer staff of Konsel, which represented, for HMHB, a modern future for the Indonesian health system. Buton is seen as ‘older’ again and even more set in their ways than Konawe. Comparisons like this suggest that HMHB prefer to work with a health system that is receptive to change and outside influence, and willing to work as a team, possibly in a similar model to that of the project team.

HMHB gave the Departments of Health an opportunity to conduct a number of activities, such as training, which are not always available due to limited government funds. During the final year of HMHB (2004), the ADB (Asian Development Bank) began to provide funds to the district Health Departments to conduct government midwife (bidan) training in Southeast Sulawesi. Without such projects, it is uncertain whether there would be sufficient funds in Health Department budgets to conduct many of these activities. On the other hand, the numerous projects from bilateral and multilateral sources enables Health Departments to spend their funds in alternative areas. One example of this is the puskesmas keliling (mobile health centre). These are brand-new white minivans, complete with a bed and supplies in the back, and freshly inscribed Health Department lettering on the side. They are designed to visit all the villages in a sub-district over the course of a month. Their top-heaviness and lack of four-wheel drive capability means that they are too difficult to take into many villages, particularly in areas where the roads are unsealed. The puskesmas keliling never visited any villages while I was there, although one did visit part of urban Pasarwajo (the capital of Buton district). In another example, cited by project
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reports, a counterpart budget for HMHB was spent by the district Health Departments on computers and motorbikes, which did not accord with 'the agreed counterpart budget' (HMHB Project Team 2005: 47).

HMHB has enabled the district Health Departments to play a much more authoritative role in the current environment of decentralisation. Although legislation passed by the national parliament devolved much of their power and authority to the districts, primarily the district parliaments, all levels of government are currently negotiating their new authority and responsibilities in the decentralised system while it is still in flux. New provinces, districts and sub-districts are springing up throughout the country, in an attempt to assert more authority over their region. Elements within the central government have also been resistant to a devolution of their power. Within this environment HMHB has actively assisted the district Health Departments with 'training in improved management practices at district and health centre level, and improved reporting mechanisms' (HMHB Project Team 2005: 46). They have assisted the district Health Departments in advocacy to the district parliament for budgetary funds, with some significant results: 'an increase in the health development budget for 2003 of 36% in Kendari district and 20% in Buton district' (HMHB Project Team 2005: exec summ 7). HMHB enabled some Health Department staff to be employed as consultants on the project, who mediated between project activities and Department of Health activities. These consultants become another set of project beneficiaries. Although the end of the project may signal a downturn in opportunities for those staff, when the next project inevitably appears, such staff may be recommended for further consulting work, given their previous experience with HMHB.

For the Health Departments, as for most of the HMHB project team, the villages of Buton, Konawe and Konsel districts are distant, far from the white-painted Health Department offices in the government precinct of the cities where they are located. Robertson (1984: 150) argues that 'community and bureaucracy are two... antithetical styles of organisation', and development interventions driven by bureaucracy tend to subordinate the needs of community to their own. Similar to the project team, Health Departments deal with villages largely through
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statistics. When I was looking for a suitable field-site in Buton, the head of the maternal and child health section of the district Department of Health suggested Waangu-angu as an appropriate village. ‘I know the bidan there,’ she said, explaining that she was once a bidan herself. ‘It is a good community, a good village head, good kader, a good bidan.’ In addition to her familiarity with bidan, she also had significant familiarity with HMHB project staff: she could name a number of them, for example. Health Department staff have more interaction with project teams than with villagers. The Health Department interacts with villages in an organisational frame that locates them within the health bureaucracy: so many villages to one bidan, so many villages to one puskesmas; and so many puskesmas to one subdistrict.

Health centre (puskesmas) staff and midwives (bidan)

The Indonesian health bureaucracy is structured in a strict hierarchy, reflecting the form of the Indonesian state as a whole under Suharto (1966-1998). Hierarchical operations have moved down to the district level under decentralisation, bringing the top closer to the bottom. Located at the lower (subdistrict) levels of this hierarchy, bidan and puskesmas staff implement policies from above. I noticed a sign outside the provincial hospital in the capital Kendari promoting the virtues of ‘KB Pria’ – male contraception. In an interview with one bidan, I asked her what the sign was referring to. ‘I’ve heard of it,’ she said, ‘but we haven’t done anything because it hasn’t been ‘socialised’ yet’. The roles and responsibilities of bidan and puskesmas staff are in many ways still determined from above, since knowledge is provided to them by the Health Department through ‘socialisation’. Puskesmas staff and bidan are major beneficiaries of the HMHB project, due to the amount of training conducted by HMHB with puskesmas staff and bidan, which formed a major component in the project.

Similar to the district Departments of Health, HMHB funds enable puskesmas to carry out activities that they would be otherwise unable to due to a lack of funds. This includes the training of kader posyandu – village women who become health volunteers in return for some form of compensation, such as accessing puskesmas
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services free of charge. Many puskesmas, like the one in Asera subdistrict (in which Linomoiyo is located), are normally unable to conduct training of kader. While puskesmas appreciate the support offered by projects, their appreciation is tempered by issues arising during implementation. For example, the head of the puskesmas in Pasarwajo (the subdistrict in which Waangu-angu is located) said that HMHB was ‘very effective’ with a ‘positive impact’, but he also related a difficulty with installing electricity in two midwives’ houses (polindes) in his area where funds had been withheld by the project. The HMHB team leader explained that there was no nearby electricity line, so funds were withheld for installing electricity. The project has completed implementation in that area so funds will not be granted at a later stage. The puskesmas head was concerned that the polindes was denied an opportunity to install electricity at a later stage. In this case the budgetary priorities (and the accountability chain) of the project on the Australian side led to disappointment on the part of Indonesian counterparts at the subdistrict level.

Subdistrict puskesmas staff and village bidan spend a large amount of time interacting with villagers as part of their daily activities. They spend more time with villagers than the HMHB project team and the Departments of Health. However they do not necessarily interact with villagers on an equal level, with puskesmas staff in particular identifying more with the government and health system that they represent, than with villagers. If the subdistrict puskesmas and bidan come low in the health system hierarchy, villagers fall somewhere at the bottom. Puskesmas staff have little interest in reciprocal interaction with the community or traditional midwives/healers (dukun). Learning is a one-way process, such as the health education messages given at monthly health clinics (posyandu), which are read out over a loudspeaker. Training modules provided by HMHB for dukun do not recognise the knowledge and skills that dukun possess, rather they promote a new ‘assistant’ (pendamping) role for dukun according to what HMHB (and international norms provided by the WHO) defines as appropriate (see Chambers 1997; Robertson 1984). Bidan, government midwives based in villages, similarly distance themselves from villagers, although this can be more difficult for them than puskesmas staff since they live in the village semi-
permanently and their job requires regular interaction with villagers, particularly women and children (see also Sciortino 1995).

Government and health officials are demarcated from villagers by their clothing and method of interaction with villagers. They almost always wear uniforms (white for health workers, khaki for government officials), which indicate their status, and confine their discussion to other officials such as the village head or health volunteers (kader). An exception to this is the bidan, who only wears a uniform in the village at posyandu, and interacts with villagers on a day-to-day basis. In official Health Department documents, and HMHB materials, the bidan appears in her uniform of a white blouse and skirt with a government patch on the shoulder (Fig 3.2). In these publications she is rarely portrayed how she is often seen in a village context: wearing casual clothes and a jilbab (Muslim headscarf). In fact, bidan only wear their uniforms to the puskesmas and the Health Department, suggesting that this uniform is a more powerful symbol to the government than to the community at large. Health Department staff enter and leave the village on motorbikes or in cars. The priorities of their work mean that they visit a number of different village posyandu in one day, so they often arrive and depart in a rush. Hence even the project actors who spend the most time interacting with villagers still retain a sense of distance from them, enabling ideas of ‘the village’ produced by the Indonesian state and development projects to be maintained.

**Project messages: branding and material objects**

Project materials like posters and brochures appear in the AusAID offices in Australia, on AusAID and IDSS websites, and in Southeast Sulawesi villages. Materials in Australia and Indonesia both project the idea of ‘the village’ which is the site of development interventions. Like the schoolbooks used to promote development in Nepal, these project materials ‘propagate and legitimate’ notions of the village and development, including progress and backwardness (Pigg 1992: 502). The following section documents two examples of HMHB printed materials, to consider how they portray the village and the state, and how health is conceived of in a ‘modern’ or ‘developed’ way. Project publications like these
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reinforce ideas of the typical Indonesian village, the role of the state, and modern health practice that are promoted in other ways throughout the project: such as through training, interaction with counterparts, and in reports. These publications have the additional impact of appearing within the villages, giving a more immediate dimension to village experiences of the HMHB project.

The ‘Minum Obat’ comic

‘Minum obat’ (‘take medicine’) tells the story of a man and his pregnant wife. Extracts from this comic are displayed in figures 3.3 to 3.8. The comic begins with a man solicitously asking how his wife is feeling, and bringing her food, standing while she is sitting. The pregnant woman then goes to visit the government midwife (bidan) at her house (polindes), where she is given a small amount of medicine and informed not to take any other medications during her pregnancy. The woman tells her husband this, who thinks that the bidan is wrong and goes to the market the next day to get some more medicine for his wife. The pregnant woman remembers what the bidan said and tells her husband she is scared (‘saya takut’) to take the medicine he has purchased. In anger, the husband feeds the medicine to his chickens. The comic ends with the bidan visiting the couple’s home, where she explains to the husband and wife the adverse consequences of taking other types of medicine for their unborn child, and encourages the husband to support his wife. The husband thanks the bidan for her advice.

This story centres around village knowledge and authority – represented by the couple – and government knowledge and authority, represented by the bidan. At first, the authority of the bidan is challenged by the husband, who seeks alternative treatment for his wife. In the end, the husband yields to the bidan’s authority. There is no tangible proof provided in the comic to validate the knowledge of the bidan, instead the husband (and the readers) must simply trust that her knowledge is better than his. This is reinforced by his pregnant wife, who takes the side of the bidan because she is scared of the consequences of going against her advice. It suggests that government authority in health is wielded through power (causing fear) and an assumption of greater knowledge and
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superiority over villagers. The bidan is portrayed throughout in her Health Department uniform, clearly representing the state and demarcating herself from villagers.

The comic reflects a generic, idealised version of a village that could potentially be found throughout Indonesia. In fact it is so generic that it runs the risk of not applying to any village at all. The style of housing shown throughout is commonly found in Indonesian rural villages: wooden houses with cement floors; windows with wooden bars rather than glass in the windows, and simple wooden paling fences. The houses shown in the comic are built on the ground, rather than on stilts. This reflects an earlier campaign by the government to encourage villagers to build ‘healthy houses’ (rumah sehat) on the ground, which are considered more modern than stilt houses. The extent to which these houses are actually healthier is questionable, given that mosquitoes seem to prefer to lurk in the dark corners of houses built on the ground, and are driven away by the breezes underneath stilt houses. Building houses on the ground thus increases the potential for mosquito-born illnesses which are common in Southeast Sulawesi province, such as malaria and dengue fever.

Images in the comic suggest that these villagers are quite wealthy. The only characters shown in all but one of the frames of their house are the husband and wife – implying that they are the only ones living in the house; this suggests that the couple are sufficiently wealthy to afford their own house. In Southeast Sulawesi this is quite unusual for villagers, and many young couples live in a parent’s house until they can afford a house of their own – sometimes after they have had two or more children. The house appears to be built of stone, rather than wood (although curiously the midwife’s house is wooden), which is another sign of wealth in Southeast Sulawesi. Further, the husband is not pictured going out to work in the fields or the forest, rather he has time to go to the market – suggesting that he is wealthy enough to afford not to work every day. Many men in Waanguangu and Linomoiyo were not present while their wives gave birth because they were out working in fields or forests, some distance from the village.

The comic also suggests unusual gender relations between the couple: the man and his wife sit together at the table to eat, and the husband serves his wife food.
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This would be very uncommon in Southeast Sulawesi, since men and women often eat separately (women normally eat in the kitchen) and women almost always serve the food. Like the matchbox image which I discuss below, gender roles represented in these comics are often inappropriate and emasculating for married village men (see Pringle & Game 1983). This comic is intended for a male audience (‘untuk Bapak’), challenging their role as husband as well as their knowledge and authority vis-à-vis the state. The project team explained that the comic was drawn by a ‘local artist from Buton’, and the qualities of the comic suggests the artist shared a similar idea of the generic village to that promoted by the project and the Indonesian state (HMHB Project Team 2000: 23). Sixty-five thousand ‘minum obat’ comics were produced for the HMHB project. A stack of these comics sat in the polindes. The bidan there explained that they had already been distributed two years ago. I showed one to a friend of mine, a married woman in Waangu-angu. She laughed as she read it. ‘This is funny,’ she said, ‘can I keep it?’

Cartoon on a matchbox: Suami Siaga

This cartoon (in figure 3.9) depicts a heavily pregnant woman resting on a bench outside a house, her hand resting on her stomach, while a man, assumed to be her husband, is stooped over, hanging out the washing. It was part of the suami siaga ‘husband alert’ campaign, an Indonesian government health campaign to encourage men (husbands) to be more involved in childbirth, that was also implemented by HMHB during the time of the project. This cartoon featured on matchboxes which were sold to men, the primary smokers in Southeast Sulawesi, who were the target of the cartoon message.

This image suggests a role for married men that did not occur in either village where I conducted research. No married men hung out washing, although some young unmarried men did so for their mothers. Men were involved in other domestic tasks, such as carrying water. They rarely cooked, cleaned or washed clothes/dishes. Marriage confers adult status on both men and women (see Niehof 1987), and childbirth is proof of a man’s fertility and potency. In one case in Buton a man took a second wife because his wife had not born him any children.
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(see also Jennaway 2002b). Such domestic tasks would be seen to reflect badly on their status. Secondly, the message disregarded the significant role played by other family members during a woman’s pregnancy. Indeed the *suami siaga* campaign focuses almost exclusively on the role of the husband, and a Western concept of the nuclear family where children are not seen to take on domestic responsibilities. When a woman is pregnant in a Southeast Sulawesi village and cannot hang out washing, this role would most likely be taken on by a female relative: daughter, female sibling, cousin, niece, aunt, mother, mother-in-law; or possibly an unmarried, young male relative.

Villagers paid little attention to cartoons in stickers and posters displayed in the village, which suggests that they didn’t consider such messages to be meaningful for them. Some villagers misunderstood messages portrayed through cartoons, for example one woman thought that a cartoon of a woman giving birth in fact depicted a sick woman. Only little children seemed really interested by the entertaining appearance of the cartoons. As a campaign, *suami siaga* was only known by its catchcry: ‘husbands alert: ready, take care, to look after’ (*suami siaga*: *siap antar jaga*). At an *arisan* (a voluntary savings collective for women), a *dukun* stood up to introduce me and helped to discuss my issues. ‘One of the project messages was *suami siaga*’ she said. ‘What does that mean?’ ‘Suami siaga – siap antar jaga’ a woman replied, and everyone laughed.

According to the HMHB project team, this cartoon, as part of the ‘*suami siaga*’ campaign, was intended to encourage men to take on more responsibilities and reduce the risks associated with heavy work during pregnancy – especially in the final trimester. This included housework and carrying water. The cartoon was created by the project’s Gender Adviser, and was intended to provoke discussion. However it was based on an understanding of gender relations in Australia, rather than engaging local understandings of gender. HMHB field testing of this message recorded positive reactions from women, who liked the idea of men doing more work during their pregnancies. Some men reacted negatively to the idea of them having to do more work. However no field testing was conducted of a change in behaviour. For example, the number of men hanging out washing for their pregnant wives was not recorded. The number of men receiving matchboxes
was also not clear, since matches are also popular for lighting kitchen fires (which is a task mainly performed by women). My only sighting of the matchboxes was in a *polindes* kitchen, used by the *bidan* to light her kerosene stove.

This example demonstrates a tendency of projects to export their idea of reality onto recipient populations (Chambers 1997), so that the villages become, for the project, what the project imagines them to be, rather than what the villagers live every day. Reflecting Australian social and gender norms, the Gender Adviser sought to introduce what, even for some people in Australia, could be considered a provocative statement about appropriate roles for men. The cartoon message was de-masculinising for married village men, while at the same time ignoring the important role that men do play in villages of Southeast Sulawesi when their wife is pregnant. For example, a husband in Waangu-angu, Buton, prepared a coconut shell for the burial of the placenta of his newborn child. Another husband in Linomoiyo bought food and drink for the guests in his house just after his wife had given birth. This project message implies that gender roles in rural Southeast Sulawesi are unequal, therefore backward, and villagers should modernise by taking on roles that have been circumscribed by ‘developed’ countries like Australia. Australian notions of modern health practice, and modern gender roles, combine with Indonesian government notions to promote a particular type of modernity in health practice in Southeast Sulawesi villages.

John, the HMHB team leader, suggests that the project has been more effective at the level of understanding and awareness of new health models, rather than at the level of implementation and behavioural change. One of the most effective HMHB messages at a village level was: ‘when you give birth, there must be a *bidan* and there must be a *dukun*’ (*harus ada bidan, harus ada dukun*). This message was widely known and supported by villagers, *bidan* and *dukun*. In fact, not only was it supported as an idea, it was generally carried out in practice. In many of the instances where women gave birth without a *bidan* present, this was due to the fact that the *bidan* was not in the village, rather than villagers not wanting her to be present. Although increasing the role of the *bidan* may challenge local health practices, by suggesting that they are backward or

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11 Many *bidan* were not in villages due to retraining, which is discussed in Chapter Six.
dangerous, villagers highlight the importance of the *bidan* in attending births to prevent maternal deaths. The adoption of this message could be considered one of the most successful aspects of the project at a village level. By encouraging the *dukun* and *bidan* to work together, this message recognises the value placed on *dukun* by villagers as well as the important role played by the *bidan*, which is valued by both villagers and the government health system. This message relates to the *pendampingan / kemitraan* (partnership) campaign to encourage *dukun* and *bidan* to work together. The *pendampingan / kemitraan* campaign addresses maternal mortality while still ensuring that some of the traditional childbirth practices of the *dukun* are maintained.

One strategy to address infant mortality was messages focusing on *Hari Nol*, ‘Day Zero’ of an infant’s life. These messages included initiating breastfeeding quickly after birth, so that the baby received colostrum from initial breast milk; and ensuring that newborns were inoculated against Hepatitis B as soon as possible after the birth. Such messages focused on the potential health risks that newborns faced in rural villages. For example, the colostrum in initial breast milk strengthens a baby’s immune system against disease. The initiative to immunise babies against Hepatitis B soon after birth was a concern to some villagers who said that injections so soon after birth could cause illness. There was also some confusion among health staff about the timing of the injection. One *puskesmas* official suggested that babies could only be immunised within a short timeframe after the birth, and refused to immunise babies at *posyandu* who were older than the stipulated number of days. As the team leader suggests, in many areas the project may have been effective in improving the understanding and awareness of messages about changed health practice, but these are taking a while to translate into changed behaviour at a village level.

**HMHB, modern health practice and the village**

HMHB project interventions were designed to achieve a number of ‘health status objectives’ from the Indonesian government’s 1994-1999 Five Year Development Plan (*Repelita*) (HMHB Project Team 2005: 1). These included improvements in maternal mortality rates, infant mortality rates, malnutrition in children under five
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(balita) and low infant birth weights. This information, and its remedy, is presented in the language of epidemiology and population health, couching it in a form of knowledge inaccessible to villagers. This type of language conceals the developmentalist assumptions that underlie such interventions: such as the causes for these particular issues, and the suitability of particular interventions. Issues such as mortality rates, malnutrition and birth weight correspond to measurements established by the international health community which are defined as acceptable, or unacceptable, in comparison to other nations. While maternal mortality is a serious concern for both villagers and projects like HMHB, there is a correlation between the value-neutral objectives of projects and the modernist, developmentalist priorities that underpin those objectives. Measuring the mortality rates of mothers and children in Southeast Sulawesi villages links them into a globalised health movement that draws (albeit implicitly) on notions of tradition and modernity. Such concepts are reflected in the interventions that the development industry sees as appropriate to address these health issues.

HMHB interventions are supported by international health bodies like the World Health Organisation (WHO), who promoted the Safe Motherhood Initiative from which Indonesia’s Mother Friendly Movement has been drawn (HMHB Project Team 2000; World Health Organization 2001). International health bodies play an important role in two ways: by setting the agenda on particular health issues and stipulating appropriate health interventions; and in their role as donors and implementers of projects and programs themselves. The WHO ‘creates an overall policy climate... cautious enough not to appear dictatorial, yet specific enough to endorse a policy direction’ (Pigg 1995: 58). In addition to HMHB, the Indonesian government and UNICEF conducted health programs on various health issues in Southeast Sulawesi during the same period. Since all these programs draw on similar, internationally-established codes of health intervention, their multiplication produces a consistency in ideas of modern health practice that are promoted in Southeast Sulawesi. Moreover, within one project like HMHB, the combination of each project actor, all with their own ideas of modern health practice, produces a composite of images of modernity within health that draws on international health standards.
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The HMHB project has been actively engaged in the production of ideas of the village, the role of the state, and the concept of modern health practice in Indonesia. HMHB and its project actors – AusAID, the contractor, the project team and its counterparts – have projected alternative ideas of ‘the village’, and the role of the state in the village, in terms of health practice. Yet variations on state models of ‘the village’ provided by HMHB may be largely limited to the discourse employed by the project, since the images that appear in HMHB material objects bear considerable similarity to ideas of ‘the village’ already existing in Indonesian national discourse.

Project reports and project actors present different, but mutually reinforcing, ideas about the role of the project in rural Southeast Sulawesi in terms of modernising health practice. These ideas of modernity in health draw on international and biomedical models of appropriate health interventions, allowing villagers and health workers to participate in modernity through health practice. Project interventions continue to be framed within a tradition-modernity dichotomy, although the outcome is portrayed as value-neutral (i.e. the desire to reduce maternal mortality rates).

HMHB has broadened the scope of project beneficiaries to include the Indonesian state itself, in the form of the Health Departments, which places the state closer to the villages than to the international development industry. This sits uneasily with the perception of themselves that health officials and workers hold. Much of the work of Health Departments and health providers, with villagers, reinforces a differentiation between themselves – as representatives of modernity and development – and the distant, marginal, ‘traditional’ village. HMHB, the Health Department, and government health service providers, present themselves as a model of modern health practice to which villagers should aspire.

The picture of ‘the village’ in Southeast Sulawesi presented in this chapter is quite different to my experience of living and researching in the two villages that formed my field sites. For development projects like HMHB, the simple idea of the imagined village justifies HMHB project interventions, but the complex picture of actual villages makes them more problematic. As Gasper remarks, ‘Institutions and people seek to survive and go on’ (1996: 160). The next four
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chapters seek to contrast with the viewpoint of the Indonesian state and the development industry, as the centre looking at and creating ideas of the village. Instead I will present the view of the periphery, of villagers looking ‘out’. By highlighting the experiences of villagers themselves, I address the relevance of HMHB and other development interventions for them. As HMHB imagines ‘the village’ in Southeast Sulawesi, villagers in Southeast Sulawesi also imagine development interventions and the potential they may have for transforming their lives.
Bersama-sama
Membantu Persalinan
yang Aman dan Selamat

Figure 3.2 Image of bidan in HMHB materials
Ini sayur bu........
makan banyak-banyak

Suatu hari di Polindes........

Ini obatnya........dan ingat
ya bu, tidak boleh minum
obat sembarangan

Yaa.. bu Bidan
Keesokan harinya, menjelang tengah hari La Kadiri pulang dari pasar di pulau seberang

Eh... bapak sudah pulang. Bawa apa itu pak?

Ini oleh-oleh untukmu.

Saya belikan RB. Ada juga obat.

Kenapa bu?
Kau tidak suka saya belikan itu?

Saya takut.

Takut apa?

Takut minum obat itu, kota itu Bidad kalau sedang hamil tidak boleh minum obat sembarang.

Ah... I Bidad itu sok tau.

Gygi! minum obat ini bisa kau sehat dan banyak bertelur.
Tetapi... Bapak juga harus ikut membantu
Kalau begitu kesehatan istri saya, saya percayakan pada ibu Bidan
Terima kasih... atas nasehat ibu Bidan
Sama-sama
Chapter Four
The village negotiating the state, development and marginality

Once, a villager, who had never been to town, caught a bus. As he alighted, he left his shoes outside the bus, as you do when you enter a house. When he got off the bus at his destination he asked, ‘where are my shoes?’

In our language, *apa* is the word for mat; in Indonesian *apa* means ‘what’. Once a foolish villager went to town to buy a mat. He was looking around the shop for a mat, but he didn’t want to ask because he couldn’t speak Indonesian. The shop assistant came out and said, ‘*cari apa*?’ That means ‘what are you looking for?’ in Indonesian, but the man only understood the local language so he said, ‘yes, yes!’

- Jokes told to me by Waangu-angu villagers

The iconic rural village has been imagined by successive regimes: the Dutch colonial administration, the post-Independence Sukarno government, and Suharto’s New Order regime. Development projects also project an idea of the village, where the implementation of rural development projects occurs. The Indonesian health system, and health projects like HMHB, uses this idea of the village in order to promote interventions. The village is constructed as traditional, backward, and in need of intervention. But are these constructions of the state and development projects meaningful at a village level? The modern state has been conceptualised as hegemonic and all-encompassing (for example Escobar 1995; Ferguson 1994). However I intend to show that villagers are not passive recipients of development and state authority. They actively engage in the process of defining the village and in negotiating village-state relations. Villagers themselves create ideas of the village, engaging with state definitions of the village as well as shared local history, customs and myths. Villagers in Indonesia are often portrayed by the state and city-dwellers, and they sometimes portray themselves, as diametrically opposed to the city: backward, where the city is modern; ignorant,
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where city-dwellers are secure in their knowledge, with higher education attainment and access to modern technologies (see Peacock 1968). Villagers negotiate varying notions of the village, the state, tradition and modernity to establish their position within the region, the state and internationally. I use the term village to refer to a site of origins, family and identification, as an administrative category and as an oppositional category to the modern state. The notion of the village at a local level is much more complex, since villagers differentiate themselves on the basis of local identification rather than a generic category of ‘the village’.

The province of Southeast Sulawesi can be considered peripheral to the Indonesian state, although the dynamics of its marginality in relation to the state is less certain within the current decentralisation of the central government in the post-reformasi era. Southeast Sulawesi rural villages are peripheral, indeed at the periphery of the periphery, but this chapter (and the three that follow) brings them to the centre (see Velthoen 1997) to see how their own perspectives of development, tradition-modernity and health practice informs village-state relations in Indonesia, and to consider the relevance of development projects for villagers themselves. The seemingly inextricable connection of modernity to centre/coastal, and tradition to periphery/upland is not clear-cut. The periphery may be actively involved in development, and engaging with modernity, and the centre may be rediscovering its relationship with tradition. I argue that village perspectives of development are relevant, both for themselves and in terms of village-state relations and development projects. Aid projects and government health may be located in centres (the United Nations, Australia, Jakarta, Kendari), but much of their implementation occurs in the villages themselves. Therefore villager perspectives are key to understanding village-state relations, notions of tradition-modernity and development in practice.

The region: Southeast Sulawesi as periphery

The Australian National University library has a curious collection of Indonesian government-sponsored documents, primarily from the 1970s, with such labels as ‘The history of Southeast Sulawesi province’, ‘Customs and traditions of
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Southeast Sulawesi province’ and ‘Folktales from Southeast Sulawesi province’ (Chalik 1977-78a; Chalik 1977-78b; Sidu 1995). When trying to find information about particular ethnic groups within this province, I had to rifle back and forth through each section. The books are divided primarily in terms of topics, rather than local geographical areas or language groups. The administrative division of a province is important for the purpose of government documents such as budgets and planning for provincial departments. However the post-colonial Indonesian state subsumed ethnic groups within their provincial, or island-bound, borders (see Boellstorff 2002). This links administrative borders with the ‘rediscovery’ and codification of traditional practices, placing tradition within the borders of present-day Southeast Sulawesi (Robinson 1997a: 72). Ethnic groups such as the Bungku have been excised from these volumes. While they live ‘mainly’ in Central Sulawesi province, some live on the border with Southeast Sulawesi, and they have also lived in Southeast Sulawesi in the past. Connections with other provinces are not addressed; in the state discourse, each province stands as a discrete entity with its own language groups, industries and so on.

This province-level identification has become remarkably discordant in the current era of decentralisation, when the authority of provinces has been significantly reduced and emphasis is now placed on districts, or kabupaten. While new provinces have also been created, the drive to create new kabupaten based on ethnic divides is unequalled. People hidden within and across central-government defined boundaries are suddenly announcing their desire to be visible; dividing communities and causing ethnic tension which has, in some cases, resulted in fatalities (such as Jakarta Post 2004). These tensions illustrate the reaction within local populations to the New Order’s attempt to reduce the importance of racial and ethnic difference, in order for people to support the national government rather than fracture into divisions based on ethnicity. Despite the fact that I use this provincial and district classification as part of my own analysis, it will soon become apparent that Southeast Sulawesi extends far beyond its borders in its interactions with historical kingdoms, the colonial government, and successive Indonesian governments.
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In pre-colonial, and early colonial, times the peninsula of Southeast Sulawesi was dominated by two kingdoms: the Mekongga and the Konawe kingdoms: based on the west and east sides of the peninsula respectively (map 3 indicates historical kingdoms in southern Sulawesi). These were both Tolaki-speaking kingdoms, and current Tolaki ethnic identity is divided between the ToMekongga and the Tolaki-Konawe, including differences of language. However, as the Linomoiyo village head explained: ‘ToMekongga language is still used by us in important ceremonies like weddings. It is a more formal language than Tolaki (Konawe).’ In relations with the wider world, however, both the Mekongga and Konawe kingdoms were minor players in a landscape dominated by the Wolio kingdom, on Buton island, to the south of the peninsula; the kingdoms of Gowa (Macassarese), Luwu and Bone (Bugis) in present-day South Sulawesi; and the kingdom of Ternate in Maluku, to the east of Sulawesi. As essentially upland kingdoms, Mekongga and Konawe were limited in their access to the financially lucrative and politically powerful trading routes to which coastal kingdoms were exposed. The historical dominance of the Butonese sultanate in the region, based in the Wolio keraton at present-day Baubau, was contested in the twentieth century by the Tolaki. The province of Southeast Sulawesi was formed in the mid twentieth century, with its capital established at Kendari, a Tolaki-speaking area. The sultanate of Buton was officially disbanded at a similar time, however members of the Sultan’s family, and upper class Wolio, still retain the prefix La Ode and Wa Ode before their names to denote their status.

The Butonese sultanate, and the Wolio people of that area, are the most comprehensively studied of the Southeast Sulawesi region (for example Schoorl 1990; Schoorl 2003; Vermeij 2000; Zuhdi et al. 1996). The coastal access of the Butonese sultanate to significant trading routes enabled the sultanate to establish a dominant position in the area. Coastal trading became much more important during the VOC (Dutch East Indies Company) and Dutch colonial eras, when kingdoms like Gowa and Wolio were able to negotiate Dutch patronage for their kingdoms in return for safe passage of ships carrying spices from Maluku back to Europe. Wolio was a smaller and less powerful kingdom than Bone, Gowa or Ternate (Velthoen 2002; Vermeij 2000), thus forming an alliance with the Dutch was key to their continuing viability as a sultanate in the region. The strategic
The village negotiating the state placement of the Wolio kingdom, on the trade route between Gowa and Maluku, enabled such an alliance to be possible (Vermeij 2000: 5). The fortress (keraton), sitting high above Buton’s capital Baubau, is a contemporary reminder of the influence of the Wolio kingdom, particularly within the immediate region: the islands of Buton and Muna, and the outlying Tukang Besi islands (see map 4). Vermeij argues that ‘the culturally and linguistically diverse group of people who live on the islands of Southeast Sulawesi continue to identify themselves as Butonese in accordance with their allegiance to the former sultanate of Buton [Wolio]’ (Vermeij 2000: 96), although anecdotal evidence suggests a diversity of allegiances in that region.

Sulawesi, like most of Indonesia, came under Japanese rule during the Second World War, and some elderly people in Linomoiyo still remember this time, and recall some words of the Japanese language. During the War of Independence from the Dutch (1945-1949) the ToMekongga kingdom was allied with the (Indonesian) nationalists, while the Tolaki Konawe kingdom was allied with the Dutch. This proved to be an unwise alliance for the Konawe kingdom, and its stronghold in the eastern part of the peninsula. After Independence, South and Southeast Sulawesi were soon consumed by the appearance of a regional rebellion, from 1952-1965, led by Kahar Muzakkar. Muzakkar was a Bugis man from South Sulawesi who had held an important position fighting against the Dutch during the war of Independence. In the new independent Indonesian state, Muzakkar and his soldiers were sidelined in favour of soldiers who had previously fought on the side of the Dutch (Gaynor 2005a; Velthoen 2002). Kahar’s rebellion soon joined forces with Islamic separatist movements in other parts of Indonesia (such as Java and Sumatra) under the banner of Darul Islam (DI), and they declared the establishment of a separatist Islamic state in South and Southeast Sulawesi.

Kahar Muzakkar found much support for his cause in the ToMekongga stronghold of Kolaka (see map 8), which gave him protection and a base from which to operate in the Southeast Sulawesi peninsula. The Tolaki (Konawe) resisted his ‘gangs’ (gerombolan), forming a militia to oppose his forces, known as ‘Pasukan Djihad Konawe’ or PDK (Velthoen 2002: 7). Unfortunately, due to their alliance with the Dutch during the War of Independence, the Indonesian
Armed Forces (TNI – *Tentara Negara Indonesia*) were less than sympathetic to the Tolaki (Konawe). Rather than being protected by the TNI, the Tolaki were attacked by both them and Kahar’s DI gangs. Kendari, the present-day capital of the province, was neutral territory: and the destination of many Tolaki refugees, a number of whom have remained in Kendari to this day. Other Tolaki fled to more isolated parts of the province, such as the location of present-day Linomoiyo village in the far north of the province. Tolaki today have vivid memories of the time of the DI rebellion. ‘My mother went and hid in the forests,’ the Linomoiyo village head told me. Others recall mass slaughters of Tolaki villagers, who were shot and buried in mass graves, and entire villages that were destroyed by fire. Tolaki men were forced to join Kahar’s gangs or be killed. Villagers who were knowledgeable about spirits, or *'orang ajaib'* , were buried alive. One Linomoiyo villager pointed out a place close by where a number of people were killed.

This period is generally referred to by Tolaki as *zaman gerombolan*, the ‘time of the gangs’, and is mentioned more frequently than the Japanese occupation. The difficulties faced by Tolaki, in particular, during that time suggests it was more traumatic to them than the earlier Japanese occupation. Kahar is well-known as a Bugis man, and while many people participated in DI Rebellion, in Sulawesi it was dominated by Bugis people, which contributes to a general attitude of the dominance and suspicious nature of Bugis people held by Tolaki today (see Velthoen 2002). This violent history has important implications for how the Tolaki interact with and perceive the Bugis and South Sulawesi, the ToMekongga in western Southeast Sulawesi, and the central Indonesian government. Buton was not affected to the same extent by the Darul Islam movement, being further removed geographically, and it did not affect the people of Waangu-angu, in the interior of Buton island. Gaynor (2005a) discusses the impact of the DI rebellion on Sama (Bajo) communities on the southern coasts of Southeast Sulawesi, who were largely caught in the middle of the violence between the gangs and the military forces. A few participated, but most tried to avoid it. The DI rebellion in Southeast Sulawesi officially ended in 1965 with the death of Kahar Muzakar in the Lasolo region of Southeast Sulawesi.
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Southeast Sulawesi became its own province in 1964, splitting off from South Sulawesi, with its capital at Kendari, despite lobbying by Buton to have the capital established at Baubau (Kristanto et al. 1989; Velthoen 2002). An outline of the economic situation of Southeast Sulawesi province (in Kristanto et al. 1989), vis-à-vis other provinces across Indonesia, demonstrates the province’s peripheral status. Economic indicators suggest that Southeast Sulawesi province has ‘the third smallest population in Indonesia and a per capita GDP well below the national average’ (Kristanto et al. 1989: 568). It is ‘one of the least industrialised provinces’, and its underdeveloped status is further reinforced by poor-quality educational and health facilities, high fertility and infant mortality rates and high rural poverty (Kristanto et al. 1989: 576). Seen in this way, it is a prime candidate for development projects which seek underdeveloped areas to transform, and a classic upland periphery.

The marginality of Southeast Sulawesi Province in relation to the Indonesian state is marked. In discussions with the HMHB project team, quoted in Chapter Three, a project team member underscored the difficulty of working in Southeast Sulawesi, in this particular government bureaucracy. Southeast Sulawesi was considered corrupt, not ‘exotic’, and the central government was reluctant to visit the province. Kristanto et al take this further, arguing that the province has had a ‘history of neglect, dating back to colonial times when the region was administered from Ujung Pandang’ (now Makassar), which has, among other things, ‘bequeathed a legacy of very basic educational and health infrastructure’ (1989: 582). People in more urbanised parts of Indonesia, such as Jakarta and Bali, expressed surprise and incredulity at my research site of Southeast Sulawesi. Little research has been conducted on the area by scholars from outside the province itself. Residents of Southeast Sulawesi, too, were surprised that I should research in their villages. I was adjured to relocate to Tana Toraja, in South Sulawesi, or at least to the keraton, site of the Sultanate of Wolio, where other foreign researchers had been known to study.

Compared to the previous turmoil of the DI rebellion in 1950-65, Southeast Sulawesi appears today to be a generally calm and stable province, albeit one which is at the margins of political power in Indonesia. It has been mostly free of
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the large-scale civil unrest and political-religious violence that has plagued other parts of Sulawesi, and Indonesia, in the last eight to ten years. The current population of Southeast Sulawesi province is approx. 1.77 million people, according to the 2000 census (Badan Pusat Statistik 2006). Southeast Sulawesi has a majority Muslim population (~95%), and a small minority of Protestant and Catholic Christians (2%): consisting of some Tolaki, Chinese-Indonesians and migrants from Tana Toraja (South Sulawesi). Other religions, such as Hinduism, are limited in numbers to transmigrants who have come from other parts of the country. The main language groups of Southeast Sulawesi are Tolaki, Moronene, Wowonii, Muna, Buton (including Wolio, Cia-Cia, Pancana, Kulisusu, Kamaru, Lasalimu, Tukangbesi, Winongko, Kobaena) (see maps 5 and 6). Southeast Sulawesi has a significant number of migrants from South Sulawesi, including Bugis and Toraja; as well as Bungku from Central Sulawesi; Bajo communities, and transmigrants from Java, Bali and West Timor. The provincial civil service in Southeast Sulawesi is generally dominated by Bugis migrants from South Sulawesi, transmigrants from Java and Bali, and some Butonese and Munanese. The first Tolaki man I met in Kendari was the driver for my sponsor at the university, and Tolaki appear to dominate the lower levels of industry in many areas.

Decentralisation has prompted a rise in the participation of Tolaki (and other local ethnic groups) in formal government structures. Devolution of power from the central to the district governments has bypassed the province, enabling a growing number of district governments which almost entirely consist of Tolaki in the eastern and southern part of the peninsula. In Buton, too, the establishment of a new district capital at Pasarwajo (in Cia-Cia territory) has challenged the Wolio dominance of Butonese politics. New districts and sub-districts are being constantly proposed, with the village-head in Linomoiyo informing me of plans for a new subdistrict with its capital at Linomoiyo. Waving his arm across the expanse of the village, he said ‘They think it is in a perfect location. It is flat, with plenty of empty land: the ideal place for building a sub-district capital.’ Decentralisation has also caused a rapid rise in the creation of new villages which have split off from larger villages (*pemekaran*). The establishment of a new
subdistrict requires a certain number of villages, hence villagers have also become participants in this nation-wide decentralising movement.

*The village: state administration and local identity*

The concept of a village as a cohesive social structure in a defined physical environment has been promoted since colonial times in Indonesia (Breman 1982). In fact the rural community is ‘a “product” of social and cultural complexity’: a product of interaction between the rural and the urban, the state and its population; rather than merely ‘a survivor of... pre-state formation’ (Kemp 1988: 24). The Indonesian state skillfully utilised a generic model of the village in Indonesia to construct the administrative category of *desa*, and their interaction with that *desa*. All activities in the village, from mutual self-help or ‘*gotong royong*’ to women’s management of the household, became part of a state project (see Bowen 1986). The *desa* was posited as an oppositional type to the city, or *kota*. In this way the term refers to a state of objectification and a position of lesser power in relation to the city. The ‘*inpres desa tertinggal*’ or ‘presidential instruction on villages left behind’ refers to a top-down development initiative to help ‘backward villages’ (van Langenberg 1986). The idea of *desa* exists most strongly in its relationship to the *kota*, and villagers who have relocated to the city are often the most highly critical of ‘backward’ village practices, despite the fact that many of their relatives still live in the backward *desa* which they criticise.

Villages took on a new importance in the Indonesian state during the New Order period of 1966-1998, when state penetration down to the local community level became much more comprehensive, even in marginal areas like my two field sites. My field research in Indonesia in 2004 was tied to a state definition of the village: for the purposes of government permission and administration, as much as my own ease of defining a field site. This state definition of a village is, at least to some extent, shared by villagers where I was located, particularly officials such as the village head. There remains a distinction between the idea of *desa*, referring to an administrative village; and *kampung*, which has been used by the state to mean a sub-village category or hamlet, but is used by villagers to refer to the village in terms of where one is from. When I bought goods in the city and prepared to take
back to the village, a friend of mine said, ‘this is what we call pulang kampung’ (going home to the village). Kampung means more than ‘village’ though, since cities in Indonesia have their own kampung, in this case a residential area for the lower classes (see Guinness 1986; 1997). In Indonesia, most people come from a kampung (and 60% of Indonesia’s population still lives in rural areas (IFAD 2006)), even if that is not where they now reside. Hectic and large-scale travel across the country during Idul Fitri celebrations, when people pulang kampung to visit their relatives, attests to the strength of the connection to kampung for Indonesian citizens.

As Kemp (1988) notes, the administrative concept of a village can bestow social identity. On the way to visit another subdistrict, the Linomoiyo village head noticed that his borrowed motorcycle had a flat tyre. Stopping at a roadside mechanic to have it repaired, the village head discovered he had no money. He asked the mechanic if he could receive credit. ‘Where are you from?’ the mechanic asked. ‘I am the village head of Linomoiyo’ he replied. ‘I would give you credit,’ said the mechanic, ‘but I already did that for another man from your village. He owes me a large amount of money but he has never paid.’ The village head immediately enquired as to the name of the man. When told, he smiled. ‘That man is part of a different village, he is not part of my village anymore,’ said the village head. Finally he was able to receive credit for the repair.

The notion of a village with a group, rather than individual, identity, does not preclude disagreement and contestation about what constitutes the village. Such contestation is a continual process and involves villagers – old and young, powerful and powerless, men and women – negotiating ideas of the village that engage with notions of tradition and modernity, and ideas of the ‘generic Indonesian village’ promoted by the Indonesian state. Anecdotes from both Waangu-angu and Linomoiyo suggest that village cohesion is sometimes no more than an ideal, and in many cases does not resemble a community of shared interests, but a number of individuals and families working for their own ends (Rigg 1994: 126). The Linomoiyo village head purchased a large number of sacks of rice called ‘raskin’ (an abbreviation of beras miskin - rice for the poor) to distribute at a subsidised price in the village. He decided to allocate one to each
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family, defined as a man, his wife and children. One unmarried man came to ask for a sack. The village head refused, saying that he was single, so the man explained that he was collecting it for his brother’s family, and received the rice. An hour or so later his brother’s wife came to get their share. When she found out that it was gone, she was very upset. Apparently her brother-in-law had sold the sack of rice for a profit. The village head showed me a book where each family was listed. He ticked the families off as they came to get their rice. ‘I have to do this, so everyone gets some,’ he said. ‘Otherwise some people will take too much and others will miss out.’

The Linomoiyo village head attempted to demonstrate village cohesiveness in a variety of ways. Before the Independence Day celebrations on 17 August, he promoted a fence-building competition which was organised at a sub-district level. Each village competed for an unspecified prize. All villagers had to build their fences to a certain design of the village head’s choosing. ‘What if some people don’t want to?’ I asked a friend of mine. ‘They don’t get the choice [not to participate],’ he replied. The unification of fence designs throughout the village is a powerful visual statement, demonstrating to villagers, as well as outsiders, a sense of cohesion of village desires and aspirations. It is also an engagement with a type of ‘development’: a state-sponsored program that extends beyond basic subsistence needs, requiring villagers to contribute time and labour to a project that is ostensibly a symbolic gesture of solidarity with the Indonesian state.

Waangu-angu: mountain dwellers

(figures 4.1-4.3, map 7)

Approaching from below, a winding road presents the old village (kampung lama) first, where half of the Waangu-angu villagers originally lived, before being moved up the hill to the present village. Each village along this major, sealed, road between the city of Baubau and the district capital Pasarwajo is neatly defined. Separated from previous villages by lush forest, rows of wooden Butonese stilt houses line the road, some painted in bright colours: blue and white, or green and white. Some have concrete stairs; others have only a rickety ladder
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made of logs. A PPK (*Proyek Pengembangan Kecamatan*) (World Bank project) information board is to the right, sparsely plastered with information, beside a kiosk where a group of people huddle. They glance around as the bus approaches, a small bus in red or blue, laden with people and packages. At the edge of the old village is the PKK (Family Welfare Movement) garden that the women tend: neat rows of vegetable plantings on a steep hill. The overcrowded bus, laden with goods and people returning home, groans up a short incline, around another corner and past the guard house (*pos kambling*) that forms an informal bus-stop.

The new village, where half of the village was moved by the government about five years ago, lies off the main road, down a rough sealed road to the left. There are now about three hundred people living in each village. The road into the village curves downwards from the bus stop, lined with stilt houses where women sit in profile beside windows, their turning heads framed by the large wooden openings. At a fork in the road there is a small kiosk, staffed by a large, broadly smiling woman who minds a baby in a hanging cot or *ayun*. The road becomes steeper, falling away on the right to a large concrete well. It is well patronised: a large number of women wash clothes, whole families gather to bathe and husbands and wives collect water with plastic buckets on rope. Past the well is the concrete wall demarcating the *polindes*, which technically means ‘village birthing hut’ but is generally used as the government midwife’s house.

Waangu-angu is comprised mainly of villagers who identify themselves as ‘Wakaokili’, classified by the government as part of the Cia-Cia language group. There is a small number of villagers who are originally from Ambon (Maluku), and a few from other parts of Buton: mainly Wolio from Baubau. Most non-Wakaokili residents have married Wakaokili villagers. Waangu-angu is exoticised throughout Buton as a place which is estranged from common society: a place where *arak* is brewed, an illegal liquor made from the lontar palm; a place where the people lived in small huts in their fields (*kebun*) and in the forest up on a mountain, who never washed and refused (until about twenty five years ago) to live in a village. This notion of an isolated community is somewhat contradicted by the extensive links that Waangu-angu has with the outside world: from selling *arak* to attending school, Wakaokili men working as motorbike taxi drivers (*ojek*)
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in Baubau, and of course, their location on the main road from Baubau to Pasarwajo. Waangu-angu may not have seen the massive rallies in urban areas that accompanied the 2004 general elections, but anyone who was near the roadside on a particular day would have seen dozens of trucks piled high with campaigners, decked out in the colours of the twenty four different parties, waving flags as they passed.

In noting down words for the local language, I made two columns: Cia-Cia and Indonesian. When Nur saw this she became annoyed. ‘We are not Cia-Cia people,’ she insisted. ‘Cia-Cia language is different. In Cia-Cia, cia means no, but in our language taina means no. We’re not Cia-Cia, we’re Wakaokili.’ This sense of localised identity was continually reinforced, such as by locals making fun of the accent of nearby villages (such as Rongi and Kaongkeongkea), and explaining to me how they have a completely different language, even though they are only a couple of kilometres away. ‘Po!’ one woman says, imitating a woman from Kaongkeongkea. ‘People from Rongi speak very roughly’ another one tells me. ‘If they call you it is like this. Like a grunt. So don’t be surprised when you talk to them.’

Ethnicity is a contested topic in contemporary Indonesia (see for example Boellstorff 2002; Persoon 1998; Robinson 1997a). The Indonesian nation is composed of a large number of ethnic groups, however such ethnic identification has been superimposed by an idea of a pan-Indonesian identification, by central governments for much of Indonesia’s history since Independence. In the early Independence era (1945-65), the idea of an Indonesian republic was supported by the notion of ‘Indonesian-ness’: an identity created during the movement towards independence from Dutch colonial rule in the early twentieth century. Suharto’s New Order government (1966-1998) extended this emphasis on pan-Indonesian identity, retaining only cultural elements of local ethnicity with visual attractiveness: such as dance, architecture, music and dress (Persoon 1998). Villagers in Southeast Sulawesi identify first and foremost as ‘Orang Wakaokili’ (Waangu-angu) and ‘Orang Tolaki’ (Linomoiyo), only identifying themselves as Indonesian in relation to national identifiers – such as language – and in communicating with outsiders, such as myself. Such local ethnic identification
The village negotiating the state has been attributed (at least in part) to Dutch colonial efforts to localise the concerns of particular ethnic groups through the establishment of *adat* boundaries (see Tsing 1993).

Despite – and perhaps in response to – official denial of ethnic differentiation, people in Waangu-angu express a strong sense of identity based on difference to other ethnic groups, although some have intermarried with other Butonese. Their language, identification with place, shared history and ritual practice is strong. While they take great pride in being ‘Wakaokili’, Waangu-angu residents are much more deferential and humble in relation to urban Butonese. My friend Nur and her mother, who had become like a sister and mother to me, accompanied me to the city of Baubau when I left for Australia. I visited the house of a student friend of mine, Nisa, whose father had recently died. As we sat in the house Nur and her mother looked increasingly uncomfortable, sitting in one corner and shunning offers of tea and cakes. I smiled at them encouragingly and Nisa asked where they were from. ‘Waangu-angu,’ Nur said, staring at the floor. ‘What do you do there?’ ‘We’re farmers,’ Nur said, laughing in embarrassment, transferring her gaze to her browned hands. Many people in Waangu-angu talked about how ‘black’ they become, working in the fields. A city dweller becomes white from sitting in offices all day, protected from the glare of the sun. People who do become browner in the city are the *ojek* drivers, motorbike taxi drivers, who are from poorer parts of the city as well as from villages like Waangu-angu.

In the contemporary post-*reformasi* era, ethnic identity has become a contentious issue. This issue has appeared hand-in-hand with the decentralisation of the Indonesian government, and represents a significant power shift from the central government to groups in local government and civil society that take as their power base these resurgent ethnic identities. New provinces, districts and subdistricts are being created along ethnic lines throughout the country. Currently, most people in Southeast Sulawesi identify themselves first and foremost with an ethnic group (such as ‘Tolaki’ or ‘Wakaokili’), and a related place, language and shared history.

Rather than identifying groups according to ethnicity, a common – and more easily identifiable – distinction is language. People throughout Buton remarked to
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me that there were seventy two languages in Buton. This seems to be a widely-known figure, and ethnic and village identification in Buton is strongly connected to these language divisions. Each language group has a leader, known as parabela in some parts of Buton and as bonto in Wakaokili language. The emphasis on Indonesian as a national language has suppressed the use of local languages in official discourse – such as the media, and government documents – and the dominant language of bureaucracy of the Indonesian state, and Indonesian nationalism, is Indonesian (see Anderson 1991). At a national, or even provincial, level, such an emphasis on a commonly-understood language appears logical. At a local level, however – in interactions of health workers with villagers – for example, the use of Indonesian (and the use of unfamiliar terms and acronyms) serves more of an ideological purpose: as a means to continually integrate villagers into the Indonesian state. Most villagers in both Waangu-angu and Linomoiyo speak Indonesian, the main exception being a few elderly people. ‘Everyone in Linomoiyo speaks Indonesian,’ one man said proudly. ‘We are more advanced (maju) than some other people in Indonesia.’

Waangu-angu villagers have a strong sense of connection to place, although this is not the place of the village itself. Some distance from the village there is a mountain where ancestral graves and a ritual house are located. As described in Chapter One, a procession of (mainly male) villagers visits the ritual house before each village festival, performing rituals and returning to the village carrying drums that are stored there, symbolising the connection between the present village and the ancestral site. There are two village festivals a year: one to celebrate the corn harvest, and another to celebrate the rice harvest. Despite such elaborate rituals, Waangu-angu people downplay their own significance in the context of Buton-wide identity, insisting that rituals such as weddings are more spectacular in other parts of Buton, particularly the Wolio people of the keraton, a large fortress that was the site of the Butonese sultanate. Wolio is the common language of Buton, so most Wakaokili villagers can speak this as well as their own language. This is probably due to the influence of the sultanate on the rest of Buton. The main city of Baubau is located in the Wolio language area, near the keraton.
Waangu-angu has undergone a significant transformation in the last twenty years: moving into village houses from huts in the fields, and the recent demarcation of the village into two separate villages, to the introduction of electricity sometime between 1996 and 1998. At midnight, during one of the village festivals, there was a power cut. People started to laugh and chatter, and my friend Nur said to me 'This is just like zaman dulu (the old days). Now they will have to find a gas lamp.' As the gas lamp was lit, electricity also returned and the people started to dance again. Electricity has had a number of impacts on village life: notably, the televisions appearing in every house that can afford one. ‘Before we had electricity, only my brother-in-law had a television,’ Nur explained. ‘Everyone used to come over and watch it here. Now, lots of people have televisions.’ Through television, villagers have access to a world presented to them by the centres of power and wealth, which reinforces the peripheral experience of those in Southeast Sulawesi. For example, most television programs are set in Java, news bulletins rarely mention Southeast Sulawesi, and villagers are exposed to the world outside Indonesia. ‘We only ever see white people on television,’ people in Waangu-angu told me.

Linomoiyo: a clear lake
(figures 4.4-4.6, map 8)

Linomoiyo village, and the villages that surround it, appear like a welcome mirage after the long trip from the subdistrict capital. Already three or more hours distant from the provincial capital Kendari, the subdistrict capital of Andowia and its dusty, orderly surrounds give way to long tracts of forest, mountains and winding unsealed roads. Linomoiyo appears long before we reach it, due to the large mountain that signals its location. The wide flat land is covered in green rice fields. The fields are divided by a corroded red-brown dirt road that leads, eventually, to the border with Central Sulawesi. We stop some sixty kilometres short of that, turning left off the main road to the village. The houses are spread out along neat squares of road, a population of just over three hundred. The soccer field is still green although the dry season has started. It is studded with bamboo
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goal posts and occasional grazing cows. Spidery tracks connect houses with one
another, cutting through swept dirt paths and tall grass. The air is dry and hot.

The midwife’s house is on the right, at the edge of town. An overgrown yard
faces the road, walls peeling from white to brown, the rooms dark. Stickers and
curling posters from various health projects provide some gaudy blue and white
colour for the windows and doors. A small creek runs beside the house, which
provides water for the midwife and her neighbours. One of her neighbour’s
houses is grand: made with stone, with glass windows, curtains and a sloping
veranda roof. It dominates a tiny house beside it, which has thatch covering its
single window, a small one-roomed house with a lean-to kitchen. The school is on
the left at the entrance to the village, its white and red painted buildings a
stunning sight with the mountainous backdrop. Children crowd around in the
schoolyard and at the windows of the schoolrooms, staring out with their fingers
curled in the wire mesh of the windows. A ‘water tower’, built by a development
project, sits in the school yard, a bright blue plastic tank with a concrete circle as
its base. Over a small bridge the road curves. The central road is wide and dotted
with small kiosks, displaying their modest range of goods on wooden boards at
the front: tea, coffee, sugar, cigarettes, instant noodles. The village is quiet: it is
mid afternoon. A scattering of small children completes the picture, resplendent in
brightly coloured clothes and bare feet. The road is dry and filled with rocks,
potholes and small pebbles. The houses gradually fall away towards the
mountains, which encircle the village on three sides.

The concept of an ideal physical appearance of the rural village in Southeast Asia
is discussed by a number of authors (for example Breman 1982; Kemp 1988; Li
2001; Rigg 1994; Warren 1993). Li (2001: 61) notes the importance of ‘houses
neatly aligned’ in the development of the rural village, its visible legibility aiding
government bureaucracy, for example in keeping track of the number of houses in
one village (see also Scott 1998). Tsing (1993: 104) likens the orderly appearance
of government-issue houses in Kalimantan to the neat lines of contraceptive pills
consumed by village women. Linomoiyo village has been relocated a number of
times, with villagers indicating that its previous location was much closer to a
nearby large river. This became ‘too crowded’ and the village was moved to its
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present position, laid out neatly in a ‘letter O’ formation as the village head proudly informed me, on a flat stretch of land. Waangu-angu was also relocated by the government: its people first moved from huts in their fields (kebun) to an initial village site, around twenty five years ago, and then half moved to a new location a couple of hundred metres away about five years ago, when the initial village became ‘too crowded’.

Linomoiyo village is composed primarily of Tolaki people, as well as a small number of Bugis; and Bungku, Torajan, Javanese and Bajo who have intermarried with Tolaki. Linomoiyo villagers define themselves in terms of a historical and kin connection with the Tolaki population across the eastern part of the Southeast Sulawesi peninsula. This mirrors the former Kendari district, and the area covered by the old Konawe kingdom. Village boundaries in Linomoiyo village are fluid, due to the recent demarcation of one village into three and several shifts in the location of the village over a number of years. Tolaki consider themselves to descend from one common ancestor, and therefore to be all related (see also Tarimana 1989). By this definition, anyone who is Tolaki is ‘family’ and anyone who isn’t Tolaki is not. Marriages are usually arranged between Tolaki, endogamy within families is common although first-cousin marriage is disapproved of. According to the village head, ‘the best type of marriage is third-cousin marriage (sepupu tiga kali).’ In general, arranged marriages are the most favoured and elopements the most condemned. As in Buton, polygyny is quite common.

Like the Wakaokili people in Waangu-angu, Tolaki people in Linomoiyo express a strong sense of their connection to place. Many Tolaki villagers in Linomoiyo are originally from another part of the Southeast Sulawesi peninsula and have settled further north due to the prolonged conflict of the 1950s and 60s. However the Tolaki identify themselves as being from the whole southeast peninsula and indeed consider that Tolaki have the rights to the land in Linomoiyo village, inherited from their ancestors. Unlike other ethnic groups, such as the Bugis, it is rare for Tolaki to move permanently away from Southeast Sulawesi, and those who do are generally castigated by others, as discussed below. Tolaki own the land surrounding the village of Linomoiyo, and a number of stories like the one
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below relate to physical landmarks near the village – asserting their connection to that place.

Once, long ago, said Linomoiyo villagers, the Tolaki had a rice god. This god was generous, so generous in fact that the people had to continually harvest the rice that the god provided. The people became very tired from harvesting, and they had no time to eat the rice that they had harvested. So they became angry with the rice god. They tried to get rid of the god by throwing him in the river, but the river wasn’t deep enough so he came back. They tried throwing him into a shallow lake, but it was still not deep enough so the rice god came back. Finally they threw him into a deep lake, located near the present location of Linomoiyo village, and the rice god sang sadly as he descended to his death. The name of the village itself, ‘lino moiyo’, means ‘clear lake’ in Tolaki. When the rice god died, all the rice – that in the fields, bushels of rice hanging to dry, and sacks of rice in people’s houses – flew away, and the people starved to death. His spirit still resides in the lake, and attacks people who try to catch fish there. At a cave some distance from the present location of the village, many seashells half-buried in the soil attest to the desperation of the ancestors to find food. ‘They didn’t know how to fish in the rivers, only the sea.’ The ancestors starved, and some of their bones can still be found in those limestone caves. The story references an idea of the ancestors as ignorant and backward, unlike the contemporary Tolaki people who are intelligent enough to find food in the rivers.

There is another story about an ancestor who was a giant, Onggabo. Giant bones are said to be found in a cave near the village. A limestone structure close to Linomoiyo resembles a pile of folded clothes: also said to belong to Onggabo (fig 4.7). One villager commented that these stories were ‘between truth and fiction’; and they are myths according to the definition that they ‘provide... an account of origins’ (Barnard & Spencer 2002). These stories are similar to Bungku stories of that same area, who previously occupied the land where this village now stands. The venerated Tolaki ancestor Kapita Larambe (whose name suggests he was prominent during the Dutch colonial era) was said to have fought the Bungku for this area. His name now graces the local indigenous rights NGO: ‘Lembaga Adat Kapita Larambe’ or LEMAKALA. Velthoen (1997) discusses a nineteenth
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century southward expansion of the Bungku kingdom of Tambuku into previously-held Konawe land, which accords with local assertions that, historically, the site of the present-day Linomoio village may have been subject to some conflict and contestation between Tolaki and Bungku.

The Indonesian translation for ‘local’ is ‘setempat’, but this term is not commonly used in my field sites. The connection between people and a place is denoted by the term prihumi, which is translated as ‘indigenous’ (Echols & Shadily 1997) and refers to the owners of land. This was occasionally used in Linomoio, but is generally a more formal term. The term asli translates as ‘original’, ‘authentic’ or ‘indigenous’, connecting identity with place, and was often used by villagers to assert their connection to a particular location. In discussing concepts of the village, and identity as connected to place, I acknowledge the writing of Kemp (1988) and others (Li 2001; Pigg 1992; Rigg 1994; Warren 1993) which highlights the often tenuous link between the social links that form a community and the physical boundaries of a village in rural Southeast Asia. For Tolaki, one village may consist of orang asli as well as other people who are also Tolaki but originate from other parts of the Southeast Sulawesi peninsula. Although Tolaki who are not originally from Linomoio always mentioned their place of origin to me, they perceive a strong connection generally between the land where the village is located and the Tolaki people as an ethnic group.

Tolaki define themselves in opposition to other ethnic groups in the area. This particularly relates to the Bugis, who are seen as outsiders, coming from South Sulawesi. Tolaki opinions of Bugis are also coloured by their experiences during the time of the DI rebellion, discussed above. There is a small Bugis population in a neighbouring village. They tend to live separately (Bugis houses are visually different to Tolaki houses) and farm differently (Bugis farm wet rice, Tolaki farm dry rice). While there is a lot of common interaction, in problematic situations people will often comment on the ethnic difference. One Bugis man tried to buy a number of sacks of subsidised rice from the village head in Linomoio. The village head refused, suspecting that he was going to on-sell it for a higher price. ‘He’s Bugis’ someone commented to me, in explanation, as the man walked out. Bugis, being generally better-off in the village, are seen by Tolaki as ungenerous
or profit-seeking. Tolaki are seen by Bugis as lazy and not motivated to earn money. Tolaki generally feel less animosity towards transmigrants than to Bugis, although there are none currently living in the immediate vicinity of the village. In 2004 there was a proposal to establish two new transmigrant villages near Linomoiyo village. This will involve the seizure of land by the government to give to transmigrants to farm. As Rigg (1994) has noted, pre-colonial rulers in Southeast Asia focused on the control of people, rather than land. Land is still in significant surplus in outlying areas of Indonesia such as Southeast Sulawesi, which has become one destination for transmigration programs. Land is seen as valuable if it is being used. The village head said, ‘the land that is given to the transmigrants is not being used by Tolaki people. You know why it isn’t being used? Because the (Tolaki) people who own it plan to sell it to the Bugis. Better that it is used by transmigrants.’ As migrants, Bugis have no rights to inherit land in Southeast Sulawesi unless they purchase it from Tolaki, even though Bugis have lived in Southeast Sulawesi for more than a hundred years.

*Relating to others: upland, coast, peripheries and centres*

Within the context of Southeast Sulawesi, both Waangu-angu and Linomoiyo could be defined as peripheral to centres (Ferguson & Gupta 2002). They are peripheral to the cities of Pasarwajo and Baubau (for Waangu-angu) and Kendari and Una’aha (for Linomoiyo). Linomoiyo is considerably more isolated from the centres of power – large cities and coastal areas – than Waangu-angu (see map 2). It is also more impoverished: with no mains electricity, unsealed roads and less ownership of private transport. To reach Kendari from Linomoiyo, I had to wait for a number of hours for the daily bus – if I was lucky, one of two – which took up to seven hours to reach Kendari. From Waangu-angu to Baubau is forty five minutes to an hour on a sealed road, in one of the many mini buses that runs between the two (relatively) large cities Pasarwajo and Baubau every day. Within Sulawesi, the Southeast Province is peripheral to Makassar (the largest city on Sulawesi and the third largest city in Indonesia), and Southeast Sulawesi is also a periphery to the centre of Jakarta and Java.
Waangu-angu has a reputation in Buton that makes it peripheral to other parts of Buton, particularly the centre of Wolio culture at the keraton (on the island of Buton). Wakaokili were considered 'backward' people who didn't live in a village (a symbol of modernity) or wash (another symbol of modernity); they are also engaged in the brewing of illegal alcohol, which again places them outside the mainstream, and at the margins of state legibility (Scott 1998). Butonese from Wolio and the Cia-Cia heartland of Pasarwajo expressed the opinion that Waangu-angu was a dangerous place, far away from the city. Wakaokili people responded to this by defining themselves against these dominant ethnic groups.

Tolaki of Konawe were more peripheral than the ToMekongga kingdom, which was more powerful than the Konawe kingdom and strategically aligned with the nationalist movement. The ToMekongga language continues to dominate official ceremonies for the Tolaki. Tolaki around the area of Linomoiyo village felt themselves peripheral to the centre of Una’aha, the administrative capital of the district. They suggested that development funding only ever went to the ‘Una’aha complex’ and never reached their village. They described themselves as being ‘made into step-children’ by the government, neglected in favour of the ‘real children’ in Una’aha. This description is common to other parts of Indonesia (see Robinson 1986).

The upland-coastal model extends the centre-periphery model within localised areas, such as on one island or peninsula. This model is used in Geertz’s analysis of the nineteenth century Balinese state (1973). Due to its rugged terrain, alliances in Bali were developed around coastal-upland relations, with uplanders significantly dependent on coastal communities and their access to trade and communications. Li expands this discussion of the coast and the uplands to the context in Sulawesi, which has geographic similarities to Bali, with rugged and isolated uplands and coastal trade (1999; 2001; also Nourse 1999). The upland-coastal distinction is a gradual one, with people becoming ‘more isolated’ (in coastal terms) as they get closer to the ‘uplands’ end of the spectrum. Both Wakaokili and Tolaki could be seen as uplanders, marginal from the coastal centres of power (primarily the cities of Kendari and Baubau).
Access to the coast has been a crucial way for people to engage in trade in Indonesia, an island archipelago. Colonial powers reinforced the importance of coastal interaction through their ship-based trade, bestowing power on coastal kingdoms in return for protected sea passage (see Velthoen 2002). The uplands were places to flee: from raiders and marauders, and from the Dutch and Japanese powers, among others (Velthoen 1997). In Velthoen’s discussion of raiders in nineteenth century Sulawesi she suggests that the ‘coast of Southeast Sulawesi, the island[s] of Wowonii and Buton were uninhabited, because the population had either been captured or had moved inland’ (Velthoen 1997: 379). The Darul Islam rebellion again posed greater challenges for coastal peoples. Gaynor demonstrates the difficult situation for coastal Sama people during the DI rebellion in the 1950s (2005b). Upland peoples were able to more successfully evade raiders, colonial forces, and the DI ‘gangs’. The location of upland villages is a double-edged sword, however. Providing protection from violent outsiders, and allowing them to stand outside government spaces, upland communities have also become a symbol of backwardness in Indonesia, and the focus of government development projects which attempt to increase state control over their citizens.

Success in government regulation of upland areas has been limited by isolation and lack of access (due partly to limited transport and poor road quality), and the disinclination of government to engage in ‘uncomfortable’ areas that are considered backward. These areas have, however, come under the hierarchical power of the state during the Suharto era. This can be seen clearly in the role of the state in relocating the population in a village (in the case of Waangu-angu) and in relocating the village on a government-approved site (in the case of Linomoiyo village). Indeed, for ‘villagers’ to be named thus, they must have connection to a village. By modernizing or civilizing rural inhabitants, moving them to a village, they become ‘villagers’ and ‘citizens’.

Wakaokili and Tolaki perceptions of the outside world are strongly shaped by mass media in the form of television. There are no newspapers in the village, and radio is used infrequently. Therefore the most common form of mass communication is the television, with sometimes a large number of villagers gathering in one house to watch. It is a one-way transfer of information: allowing...
villagers a glimpse of a wider world, without being able to project their own aspirations onto the technology for others to see. The outside world is also encountered through travel. While overseas travel is generally prohibitively expensive, wealthier villagers have the opportunity to travel, or send their children away to study.

Travel is common for Butonese: sea-faring Butonese are known throughout Indonesia, like the Bugis. Villagers from Waangu-angu are not sea-farers though, but a number have spent time in Maluku (close in proximity to Sulawesi) and some still have relatives living there. Some men from Waangu-angu have also travelled to more distant places such as Nabire, in West Papua, to earn money in mining. Most Butonese travellers are young men, but sometimes couples or families. Women rarely travel by themselves. My friend Nur was most unusual in having reached Java, where she worked as a domestic servant, and her cousin now lives in Singapore, working as a maid. In many parts of Indonesia generally, men seek their fortunes abroad (merantau) while women stay close to home. Successful returnees are those who have made a significant amount of money, and who have built good houses and sent their children to high school. Unsuccessful returnees are those who are still poor, and must now depend on the indulgence of the state. This includes many who were part of a mass ‘exodus’ of Butonese forced to leave Maluku during the civil violence in 2000. One morning, sitting outside the midwife’s house in Waangu-angu, I was joined by the village head, and soon by a group of quietly spoken men who huddled in one corner and smoked cigarettes. The village head explained that these men were waiting for a government ‘team’ to come and give money to them as returnees from Maluku. He said that they might wait many hours.

Merantau is more common for some ethnic groups than others, such as the Minangkabau people of West Sumatra whose pattern of outmigration has been well-documented (see for example Murad 1978). Permanent moves away are more unusual for Tolaki, who maintain a strong connection to place. Tarimana (1989: 50) notes, ‘Tolaki rarely leave their homes to work in other places like, for example, the Butonese, Munanese or Bugis’. It is not considered desirable for Tolaki to move away permanently. ‘A cousin of mine went to Java for many years,
and when he finally came back, he could speak no Tolaki,' the village head’s wife said to me in a tone of consternation. One woman in Linomoiyo village told me about her son, who had left the village and gone north to Central Sulawesi province. He married there, and she was very concerned about him. When he returned to his natal village, she made sure to marry him off to a local girl. ‘That way he wouldn’t leave, he would have a stronger connection to this place,’ she explained. However in another village, near the district capital of Una’aha, the midwife told me that Tolaki men and women have left in droves to work in Malaysia. She suggested it would not be a good field site for me to choose: ‘There are just children, and old people. The adults have all left.’

Some, more prosperous, Tolaki villagers send their children to study in Makassar (another centre). For most of Southeast Sulawesi, Makassar is the centre to which they are peripheral. The fact that wealthy Tolaki send their children to university in Makassar underscores an ambiguous relationship between the Tolaki and Bugis. While the Bugis are sometimes disliked and ostracised in Southeast Sulawesi, Makassar, considered by Tolaki to be the home of the Bugis, bestows prestige upon Tolaki who can afford to study there. Graduates of UNHAS (Universitas Hasanudin) in Makassar are almost guaranteed a job at the local university, UNHALU (Universitas Haluoleo). Such travel is beyond the means of most villagers, however. The village head’s wife in Linomoiyo hadn’t been to the city since she was twelve, since she had no money or reason to travel. One Tolaki woman in Linomoiyo joined a program to become a domestic servant in Saudi Arabia on a two-year contract, leaving behind her two young children in the care of her husband. This is extremely rare, however. Although some Tolaki do merantau, it is often criticised, as the discussion above shows; while in Buton it is actively encouraged and praised. While men may obtain prestige by travel, for the Tolaki this travel must include returning home.

**Isolated communities: masyarakat terasing and AMAN**

Both Linomoiyo and Waangu-angu could be considered isolated communities, although the location of the two villages means that Linomoiyo is more geographically isolated, being five to six hours from the nearest city, while
Waangu-angu is less than one hour away. Wakaokili people are unique to Waangu-angu, however, while Tolaki people inhabit much of the southeastern peninsula of Sulawesi. As ethnic (or language) groups, therefore, Wakaokili are more isolated than Tolaki.

My friend Nur recounted the legend of Wakaokili *gelap* to me, which refers to something dark, obscure or illicit (Echols & Shadily 1997). On the same site of Waangu-angu village there is another village, called ‘Wakaokili *gelap*’. That village is mostly invisible. Sometimes when a Wakaokili villager is walking the village around they might see a person, a house or a field (*kebun*) which then disappears. This other village was able to hide itself from the Dutch because they didn’t want to be colonised. Nur said that other Butonese that she meets are scared of her because they have heard the ‘Wakaokili *gelap*’ stories. She laughs. ‘It’s not me,’ she tells them. ‘You can see me, can’t you?’ This legend may refer to times when Wakaokili villagers might have been able to conceal themselves from raiders, unlike coastal people, (see Velthoen 1997).

Most of the anecdotes about Wakaokili told by other Butonese are supported by Wakaokili villagers in Waangu-angu. In this way Wakaokili represents a classic concept of the *masyarakat terasing*, ‘the official designation for isolated, tribal communities’ (Li 2001: 60; see also Persoon 1998). These communities have become the focus of government development projects which attempt to increase state control over their citizens. Although the Wakaokili villagers moved ‘down’ to the current village site about twenty years ago, after great pressure from the sub-district head, legends like ‘Wakaokili *gelap*’, and the illicit brewing of *arak* (a distilled liquor made from the lontar palm) which is not subject to state tax or regulation, means that they can still be seen to stand outside state authority.

When looking for a suitable second field site in Konawe district, some people suggested that I study the Landawe, an ethnic group located in the north of the district, who were described as *terasing* (isolated). Non-Landawe locals said that they used to live in the forests and didn’t go to school until ten years ago. This seemed unlikely, since the Landawe village located near Linomoiyo village was well-integrated into the rest of the subdistrict, had well-built houses and was generally more wealthy than the Tolaki village that I ended up choosing. Another
Landawe village further north was supposedly more isolated, but I had no opportunity to visit it. For the Tolaki, Landawe were more exotic because the Tolaki lived all over the peninsula and were ‘common’, but the Landawe lived in one particular area and were, they told me, ‘white and tall, like you’.

Although *masyarakat terasing* is an official term, used by the government to identify communities considered essentially ‘backward’ or ‘left behind’ (*terkebelakang*) in terms of ideas of modernity, and in reference to urban areas and centres like Jakarta or Makassar, these terms are also used by villagers themselves to classify one another. This is similar to Li’s discussion of uplanders in Central Sulawesi who use (what she defines as) coastal-derived terms to define themselves as less backward than those further inland. The Landawe, far from cities in the north of the province; and the Wakaokili on their mountain, are constructed as relatively ‘more’ backward than surrounding communities.

*Masyarakat terasing* was a key term used by the Suharto regime to challenge ideas of indigeneity and ethnicity (Persoon 1998). Rather than being distinguished by their connection to land, or a shared history, *masyarakat terasing* were defined by their isolation from the centres of power. Integration, therefore, involved a process of incorporation into the modern state: rather than a recognition of the rights or solidarity of a particular group. This notion is beginning to be challenged in the post-*reformasi* era with the appearance of a number of indigenous rights NGOs, and the pan-Indonesian movement AMAN (*Aliansi Masyarakat Adat Nusantara* – Alliance of Customary Communities of the Indonesian Archipelago). This extends to Linomoiyo village itself – and their indigenous rights NGO. A village representative of this NGO was flown to Jakarta to meet with the Minister for Forestry, to discuss a local issue of exploitation with a forestry company. It seems there is beginning to be a shift in the centres of power, at least at a symbolic level. However it is uncertain to what extent individual ethnic groups may be able to assert their unique identities, given that AMAN still relies on the continuation of an idea of national culture, or the ‘nusantara concept… with the implication that, for all its variations, Indonesia is one’ (Taylor in Robinson 1997a: 72). It also relies on a notion of *adat* that was established by the Dutch during colonial rule (Tsing 1993: 42, 274).
Aid projects in Southeast Sulawesi villages

Aid projects are a common phenomenon in contemporary rural Southeast Sulawesi. As a marginal, impoverished province in Eastern Indonesia, Southeast Sulawesi is a prime candidate for projects targeting poverty reduction in the more neglected eastern part of the country, which is described as more ‘remote’ (see AusAID 1997). AusAID’s current development strategy in Indonesia, described on their website, states: ‘The geographic focus of the aid program remains eastern Indonesia, which includes some of Indonesia’s poorest provinces’ (AusAID 2005b). AusAID’s focus reflects broader concerns within the international development community, and there are thus a variety of international and Indonesian government-sponsored projects and programs in rural Southeast Sulawesi. HMHB, while the focus of my study, was not extensively active at a village level. This discussion includes a variety of projects, examining how they appeared at a village level, how villagers interacted with and defined them, and how villagers portrayed themselves in certain ways in order to gain access to this purported wealth of projects.

For villagers, one of the primary features of projects is that they come and go. There are always more, to replace those which have gone, and they are generally characterised by overwhelming jargon, acronyms and official language. Visually, projects from Indonesian government and international donors all merge: being reduced to branding on the infrastructure and posters that they leave behind. A project usually begins with a ‘tim’ (team), consisting of one or more people, arriving at the village on a motorbike or in a car. Public meetings, or meetings with the village head, ensue, and lists of village members (also organised in teams) to carry out the projects are constructed by the village head and his assistants. I saw a number of these lists while in Linomoiyo. Often this feverish early activity is followed by a long period of inactivity, at which point most villagers expect that the project has folded. If they are lucky, a water tower, bridge, road or building is constructed. For example, PPK – a World Bank loan project supporting small-scale village activities – has enabled the installation a water
storage facility and a small bridge in Waangu-angu, where it began a few years earlier.

Many projects involve limited, one-way interaction with villagers themselves, and an expectation that villagers will contribute their own labour in order to reap the benefits. Villagers are expected to spend a large proportion of their time attending meetings and participating in project activities which are usually aimed at poverty alleviation. The outcome is often somewhat ironic, since in attending project activities villagers must neglect their own subsistence and income-earning activities. Given the poor success rate of many projects in the eyes of villagers, it is perhaps not surprising that they don’t attend project activities in great numbers.

In rural villages projects are continuously followed by other projects, each carving out its own jurisdiction in terms of which village activities it engages in. The PPK project gave money to villages, but only for particular schemes. It would not, for instance, give money for fertiliser. The HMHB project rebuilt the midwife’s house in Waangu-angu; in Linomoiyo it provided a bed, chairs and desk for the midwife’s house. UNICEF gave Vitamin A supplements to young children. I was told about a number of projects while I was in Linomoiyo: all known by their acronyms and major infrastructural improvements. The source of the project is often unknown, although villagers can usually differentiate between Indonesian government and foreign aid projects, suggesting that they are sufficiently integrated into the state and development practice to be able to recognise some difference within projects and organisations.

One afternoon, as the Linomoiyo village head and I drink our afternoon tea, we are graced by a visitor. He announces his presence with a new motorbike, that purrs smoothly and runs quickly, not the self-evident bombs that most of the young men in the village parade on in the late afternoon. He wears a shiny helmet, which he removes as he enters. He taps his shoes briefly on the rag at the front door before entering, shoes still on (usually villagers wear sandals, and take them off at the door) and helmet in his hand.

The village head stands and leans forward to greet him and I do too. He is wearing wraparound sunglasses, which he removes, before settling into one of the
orange chairs opposite us, crossing his legs. He tells us that he is from PPK (Proyek Pengembangan Kabupaten – District Development Project), a World Bank project that gives funds and loans to villages. I have heard of PPK from other sources, and the village head knows about PPK too. He knows, for instance, that the PPK information board has been deliberately hung upside down on the back of the village guard post (pos kambling) as an expression of the disillusioned attitude of village youth towards projects generally. The visitor explains that he is a PPK facilitator, who has also worked in Java, and tells the village head that they must organise a village meeting. The village head thinks awhile, and proposes a date a few days away, the day after an important ceremony that most villagers will be attending. The facilitator agrees, presses our hands again and leaves on his motorbike.

A few days later and the villagers, who came down from their fields and the forests for a death ceremony, have almost all left to work again. Mid morning, I am visiting a friend, Rani, an unmarried woman of a similar age to me. We sit chatting with her younger sister and a neighbour, when the village head arrives on a noisy, borrowed, motorbike. ‘The PPK facilitator is here,’ he says in some agitation. ‘Please can you all come to the village hall for the meeting.’ He leaves quickly and I encourage the somewhat reluctant women to come with me to the meeting. I am sure Rani is thinking about preparing lunch for her younger siblings and older brother, but she and the others come with me, carrying our chairs to the hall. A few other women are there, and we watch as the village head rushes from house to house on the noisy borrowed motorbike, wearing his official uniform, which clashes with the lurid orange and green spray-paint of the bike. He comes back finally and sits on the stage with the PPK facilitator and the local PPK representative: a village woman who has recently given birth. Her husband is also an appointed village representative for PPK, but he is not present at the meeting.

The facilitator introduces himself and the project, making a snide joke about the large number of women who are attending the meeting. He then scolds us because there are so few people there – probably twelve of us in all. ‘There are over three hundred people in this village,’ he says. ‘If only 10 percent turned up, that would already be thirty people.’ We don’t bother to inform him that the others, including
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the absent men, are away working in the forests and fields to support their families. I sit silent: I have been infected with the same passivity as the villagers. The facilitator explains that we are now in the ‘fourth cycle’ (siklus empat) of the project, and if we want to ‘optimise’ (optimalisasi) our chances we will have to send in a ‘good’ proposal. I am already finding him hard to follow, with his extensive use of jargon and assumption of project knowledge that I don’t have. From the looks of the other villagers, I feel they are in a similar quandary. He writes notes on butcher paper, in small writing too far away to read, but close enough for me to see that he writes in acronyms, further encrypting the text. We are all relieved when he finishes: we refuse his invitation to ask questions, and look around at one another.

The second part of the meeting involves choosing people to form a ‘team’ (tim) that will ‘represent’ the proposal at a subdistrict meeting. The facilitator uses the method of picking anyone who catches his eye, so we all study the floor and I feel relieved that I am not actually a member of the community, and therefore excluded. One young man, the only one there, is asked to head this team. He hesitates, and the facilitator coaxes him, saying ‘Are you ready to represent your community in this?’ What else can he say but yes? My friend Rani is chosen as a team member, and slowly the positions are filled. The facilitator finally leaves and we drift off home for lunch. I notice that someone has restored the PPK board to its rightful place, outside the village mosque and up the right way.

The village head is busy over the next few days, organising the ‘proposal’. I see various forms of the written document at his house. The air is full of discussion by villagers about ‘cycles’ (siklus) and other keywords that had so daunted us at the meeting. The team must go down to the subdistrict capital to present the proposal. It starts to come unstuck when the team leader comes back to the village, unsuccessful in obtaining a position on the daily bus. Others manage to get a ride in the back of a truck. The next day I find the team members, and the village head, all looking despondent. ‘What happened?’ I ask. ‘Nothing, we didn’t get anything, it’s just like the other projects, a waste of time.’ Not long afterward the PPK board becomes the victim of graffiti, just another background detail in village life.
The village negotiating the state

Waangu-angu villagers showed less interest in projects than villagers in Linomoiyo, seeing them more as a chance for compensatory money (for attending meetings), a good meal or a chance to meet a foreigner than a source of income or prosperity. Linomoiyo villagers, generally poorer, viewed projects as a tantalising potential for future prosperity: tantalising but elusive. I was asked many times for suggestions for how to attract development projects, and sometimes asked to bring them myself. As a Westerner I was assumed to have contacts with projects, particularly as someone researching a project myself. Some villagers portrayed themselves to me as impoverished in order to ask for money or project support. Discussing the child sponsorship scheme in Australia with me, the village head said excitedly ‘Perhaps I could get Sisma (his young daughter) to join?’ However projects are generally seen as unreliable and unsuccessful in village terms. The expectation that new projects will continually appear is constant, hence little expectation is given to the longevity or sustainability of projects by villagers – and possibly, by those employed to carry out the projects themselves. Many Indonesians make a career out of moving from project to project, getting a new job on the basis of their previous project experience.

Projects engage with the village-state relationship by both defining, and redefining, the ‘village’, and by representing the interests of the state through the structure of bilateral project funding. Villages appear in projects in long lines of names, indexed along with the number of personnel trained, number of structures improved, percentage of behaviour changed. They also appear in images: photos and cartoons that adorn paraphernalia of AusAID, UNICEF, the World Bank and many other multilateral and bilateral development agencies. In the same way that the majority of a project’s activities – such as HMHB – are invisible to villagers, most of the village’s activities are invisible to the project. The villagers and the project meet at a point where their interests supposedly converge: at project meetings where the needs of the project, and the needs of villagers, are ostensibly discussed. The PPK example above suggests that such a process is by no means clear, involving some negotiation on both sides. The PPK did not give funds to Linomoiyo villagers, and many villagers did not attend the meeting. Both the project and the villagers weigh up their priorities and broader needs with the desire to engage in a contract with one another. Project activities cannot simply be
The village negotiating the state

seen as an extension of the state: even HMHB, which was mostly carried out as an extension of government services, also reflected international priorities as well as an attempt to understand the village itself. Projects blur the boundaries between village and state; portraying the state to the village and the village to a state in a third interpretation of those relations.

The village, development and health

Villages have complex histories and connections with the state, as well as relations with other local groups. People in Waangu-angu and Linomoiyo negotiate complex identities based on place – periphery and uplands; shared histories; as well as interactions with the state and development projects. Although the Indonesian state and the development industry have constructed the village as poor, ignorant and dependent; villagers themselves to some extent attempt to utilise such discourses in order to achieve ‘development’ for themselves and the villages where they live. Li (2001: 61) argues that uplanders are generally worse off (compared to coastal people) in ‘struggles over meaning’, and are generally tied to outsider descriptions of themselves. People in Linomoiyo and Waangu-angu may never succeed in projecting their view of the world outside of their immediate village context. In the same way, Southeast Sulawesi as a marginal province may have difficulty in projecting a view of themselves and their perspective of the broader Indonesian society that will be accepted by those in the centres of power. However this does not mean that such a process is not occurring, though it may be within the space of the village, and the space of provincial Southeast Sulawesi politics, respectively. The experiences and perspectives of Southeast Sulawesi rural villagers are significant, not least in that they contribute to an understanding of development and its engagement with tradition-modernity and village-state relations that challenges dominant modes of how development is practiced that emanate from the state and development projects.

Health can be considered a particular type of development that is brought to villages by the state and international development projects, but health practice also offers opportunities for villagers to engage with tradition and negotiate
The village negotiating the state meanings of health, development and modernity that contrast with those produced by the state. The next chapter discusses local health practice as a distinct system of meaning and behaviour that interacts with the government-sponsored health system, building on this idea of the village as centre, within the area of health. The following two chapters continue this focus on village-level perspectives, examining first the relationship between traditional and government midwives (dukun and bidan) as the embodiments of village- and state-based systems of healing and health knowledge; and secondly the particular experience and perspectives of village women in childbirth, examining village-state relations, and how they are explored through health and childbirth practice.
Figures 4.4, 4.5 and 4.6 Images of Linomoiyo
Figure 4.7 Rocks that appear like folded clothes
Chapter Five
Popular notions of health and illness: A model of the local health system

Conceptions of health and illness, and the ways that villagers seek out healing methods, reveal much about the way that Southeast Sulawesi villagers negotiate their way through a world of health that is nuanced by ideas of development and modernity, as well as their relationship to the state. The way that health is practiced and understood in villages can be said to constitute a system: ‘a set of ideas, values and practices’ (Polunin quoted in Raftos 1999: 20). As a system it rivals the highly bureaucratised government health system, rather than being dismissed as merely a hotchpotch of local practices and ideas absorbed from a variety of locations. Local health practice in both Linomoiy and Waangu-angu is markedly affected by external influences: such as powerful healers and curses from other parts of Sulawesi, pharmaceuticals sold in small village stores and on display at local markets, the supply of pharmaceuticals and information about biomedically defined illnesses by various aid projects, and the ever-present television advertisements for pharmaceuticals and quasi-pharmaceuticals (such as herbal medicines from Java known as jamu). However, while these influences have the power to change the way that health and illness are conceptualised and understood in rural villages, villagers also leaves their mark on these external ideas. More often than not, ideas, medicines and practitioners are actively assimilated, and reinterpreted to fit, into existing understandings of health and illness in the village.

Health practices and knowledge in a village context is a system that is used and viewed differently by different people. Kleinman (1980) outlines a model of a local health care system which incorporates biomedical and non-biomedical healing practices. This model includes three overlapping parts, described as the ‘popular’, the ‘professional’ and the ‘folk’ healing sectors. Bidan (government midwives) and dukun (traditional healers/midwives) can be considered to represent significant parts of the ‘professional’ and ‘folk’ healing sectors.
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respectively. *Bidan* are the primary government health care providers in both Waangu-angu and Linomoiyo, since both these villages are a significant distance from the subdistrict *puskesmas* (health centres) and the *bidan* lives in the village itself. *Dukun* are an important part of the ‘folk’ healing sector, although they are by no means alone, with *imam* (Islamic religious leaders), specialists such as masseurs and bone-setters, and other villagers also providing healing services in addition to *dukun*. This chapter focuses on the ‘popular’ sector of healing, and how it interacts with the professional and folk sectors. According to Kleinman’s model, this aspect of the local health care system is constituted by the community itself and not by biomedical or traditional health ‘experts’. This sector includes popular ideas of health and illness, its causes and treatments, and health-seeking behaviour.

**Illness and the popular sector**

In Linomoiyo I became ill with stomach cramps and diarrhoea for about ten days. It was after attending a wedding where I had the rare opportunity to eat red meat. I suggested that it might have had something to do with the meat I had eaten. ‘That’s it,’ some of the people looking after me agreed. The village head’s wife explained further. ‘It is the way they kill the cow (for the ceremony). They say that sometimes they twist its tail when they kill it, and then everyone goes home after the wedding with a stomach-ache.’ Later they suggested that it might also have been due to them slapping the cow on its stomach after killing it. The cow’s stomach seemed to have some connection to mine. ‘But why would they do that?’ I asked. The village head’s wife shrugged. Cow sacrifices are performed by men, and the one who kills the cow is an *imam* (Islamic religious leader). She was not in a position to know that kind of information. I saw a cow sacrifice a couple of months later. There was no stomach-slapping or tail-twisting that I could see.

I divide my discussion of the popular notions of causes, or aetiology, of illness, into ‘natural’, ‘spiritual’ and ‘biomedical’ causes. This draws on other common models such as Sarwono (1996: 84), who divides causes of illness according to naturalistic, personalistic, and modern concepts. Many illnesses will not have a discernible cause, or the cause may be determined in conjunction with treatment.
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This is expanded upon at length, below, but I start by trying to define the concepts of health and illness as they are understood by people in Waangu-angu and Linomoiyo.

**Popular definitions of health and illness**

The word for being ill or sick in Indonesian is *sakit*. In Wakaokili the word for sick is *panaki*, in Tolaki it is *meohaki*. In both cases the word can be seen as closely related to the Indonesian word. *Sakit* is also used in Malay and Tagalog to refer to illness, so it has Austronesian linguistic roots. In addition to ‘sick’, *sakit* also refers to ‘pain’, and to the onset of labour in childbirth. ‘She is already *sakit*’ people would say to describe a woman in the early stages of labour. *Penyakit* is a generic word meaning ‘illness’. The connection of pain with village conceptions of illness is important. Indonesian ideas of illness reflect an idea of a state of being – usually physical – that is temporary, or fixable, with a method of healing; or in extreme cases, results in death. Our next-door-neighbour in Linomoiyo had suffered a stroke, and had difficulty walking and speaking. He was not described as ‘sick’ however, since this was a long-term illness. When he and his son came down with a bad case of *flu*, this was described as *sakit*. Sickness can be a result of natural, spiritual or biomedical causes.

In general, the concept of health is equated with a positive notion of ‘good’, and lack of illness or pain. *Sehat* can also be used to refer to something – not necessarily a person – that performs well, or is without defect. Thus someone could be between the states of health and illness – such as by having an absence of great health (good physical functioning) with an equal absence of pain. The neighbour who had a stroke was in that category: not *sakit*, but also not *sehat*. The Wakaokili word, *mela*, equates ‘healthy’ with ‘good’, ‘well’ and ‘recover’, implying that even an imperfect state of health (the process of recovering) is equivalent to ‘good health’. In both of these cases, health does not mean the absence of sickness, but another more complicated state. The Tolaki word for healthy is *mendidoha*. They use two words for recovery, *waraka* (formal) and *ari-ari* (more colloquial). None of these local words are related to the Indonesian terms. There is no equivalent term in either dialect for *kesehatan*, the abstract
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The social experience of illness and healing is important. Health, and particularly illness, is experienced as a social event by villagers: with villagers making a point of visiting the sick, women who have given birth, and the elderly who are thought to be close to death. Sickness is experienced in a group sense, and in the same way, treatment from healers is also a social experience. Not only in the case of dukun, but also bidan, the sick come for treatment accompanied by others, and a group of people will enter the house – and the treatment room – of a bidan together. The social experience of illness is disrupted by modern, Western, biomedical practice – particularly in the private practices of doctors and hospitals in the city – where the patient is separated from friends and family, and enters the treatment room alone, with only the medical practitioner and the patient present. However bidan practice has adapted, or been adapted, to the local health system which values the social experience of illness.

The humoral system and ‘natural’ causes of illness

Niehof (1985: 223-4, 230-1) notes that concepts of ‘hot’ and ‘cold’ and their importance for health and healing, can be found throughout Southeast Asia. Categories of ‘hot’ and ‘cold’, and the humoral system, are discussed by Laderman (1983: Chapter 3) in Malaysia, Raftos (1999: 121-32) in the Philippines, Sarwono (1996: 84) in Java and Grace (1996) in Lombok. Ideas of ‘hot’ and ‘cold’ are used to categorise foods, diseases and treatments, which are understood to be interrelated. Villagers in Southeast Sulawesi emphasise the importance of ‘hot’ and ‘cold’ in relation to health, however the foods they identify as hot or cold vary across regions and ethnic groups, as do the practices that relate to them. They also refer to other categories, outlined below, which are not necessarily hot or cold.
Popular notions of health and illness

Panas or ‘hot’ is usually a word to describe illness, often connected to fevers. Sejuk, dingin, ‘cool’ and ‘cold’ are often considered healthy, as is sweating. Treatment for illnesses caused by an imbalance of hot and cold are often sourced from the opposite elements (hot for cold illnesses, cold for hot illnesses). In Linomoiyo a bunch of bananas is hung in a new house before the family moves in. Since the banana is considered a ‘cold’ tree, this will keep the house cool, and by extension, keep the family healthy. They bury placentas under cool trees such as banana or sago trees, to keep the baby healthy and cool.

Sweating, keringat, is healthy, since it is considered to mark the end of a fever. One morning I went to visit a friend. After walking in the hot sun, I arrived at her house quite sweaty. ‘Oh you look very healthy,’ she said. ‘You’re sweating.’ Dry, by comparison, describes illness. In Linomoiyo one teenage boy was learning the trade of knife-making from his father. I asked the village head if anyone could learn this trade. He said no, it had to be within a family. Knife-making was dangerous, and someone could become ‘dry’ and sick from the iron. This is also connected with ideas of childbirth, where a birth with lots of fluid is considered healthy. Some women with very large stomachs while pregnant are diagnosed by the dukun as having a kembar air or ‘water twin’. Thin is another word to describe illness, with fat meaning healthy. Fat is a compliment, one that I received far more frequently than I desired. Therefore an ill person might be described as hot, dry or thin, or a combination of those. Pale skinned people are considered more vulnerable to illness. According to one mother in Linomoiyo, her baby had died ‘because he was too white. My next baby was ugly, black, but at least he is healthy.’

Other ‘natural’ causes of illness are attributed to the changing weather at the start of a new season, for example, expressed as musim batuk (the season of coughs). On my second visit to Waangu-angu, I stumbled upon this unhappy season. Faced by adults and children everywhere coughing in every direction, I soon succumbed to batuk too. My nose constantly running, my throat sore and with a general feeling of exhaustion, villagers nodded at me with a mixture of satisfaction and sympathy. ‘It is musim batuk, you know,’ they said, in explanation for my illness. Minor illnesses such as headaches and stomach-aches are attributed to familiar
behaviour and everyday events, often connected to nature. Headaches, I was informed, are caused by rain hitting one’s head. I told someone I had a headache and they said ‘Oh, it was raining before. That must have been why.’ Stomach-aches have a variety of causes, relating to their various symptoms. I was warned not to lie on a cold concrete floor, even though the day was very hot. ‘Don’t lie on the concrete,’ they said. ‘You’ll get a stomach-ache.’\textsuperscript{12} ‘I never get stomach-aches from lying on concrete floors!’ was my indignant response.

The belief in natural causes of illness is not contradicted by faith in the efficacy of mass-produced pharmaceuticals: indeed, \textit{flu} and other ailments are catered for with a wide variety of plastic-coated tablets and capsules, as well as injections from government health workers. An advertisement for an air conditioning system (a highly unrealistic, and unrealised, luxury in either village) shown on satellite televisions all around each village, showed ‘bad’ particles in the air (represented as grey-coloured circles with frowning faces), which were surrounded by ‘good’ particles (yellow-coloured sun-like circles with smiles) from the air-conditioner which removed them.

Another way that illness and injury to the body is seen as related to the natural world is through the observation of taboos: particularly those regarding behaviour, and dietary restrictions, at ‘dangerous’ times. Such risks are higher during times of travel, pregnancy and childbirth. Travel-related injuries and birth complications together provide for a high number of health patients. These restrictions on behaviour and food are not strictly followed, but they are known and disseminated widely throughout the community. They are often, although not always, observed after the event of injury, illness or death. A couple of days before I visited Linomoiyo for the first time, two young men died in a terrible accident between a car and a motorbike. The young man on the motorbike was going to be married the next day, in a village not far from Linomoiyo, and the village that he was from was devastated by the accident. ‘The bride and groom should never travel just before the wedding’ I was told by more than one person. ‘It is a dangerous time’ (see also Niehof 1987).

\textsuperscript{12} Possibly \textit{masuk angin}, although this term was not used.
There is a considerable number of behavioural taboos surrounding pregnancy and childbirth, for both the pregnant woman and her husband. These include: not locking doors or cupboards (which could cause an obstructed labour), not climbing in through windows (which could cause a breech birth), and husbands not killing animals for sport (which could cause deformities in the baby) (see also Niehof 1985: 232). ‘When I felt my waters breaking,’ one woman told me, ‘I heard all these people outside the house but I wanted to be alone. I didn’t want them to come inside, so I locked the door. Then my husband yelled at me, he said I had to unlock the door otherwise there would be a problem with the birth.’

There are a variety of food restrictions observed in Southeast Sulawesi during pregnancy and immediately after giving birth (see also Whittaker 1999). For the Tolaki in Linomoiyo ‘cold’ foods are avoided while pregnant, because they cause the blood in the womb to freeze, which results in a large baby and a difficult birth. A number of other foods are considered to have important properties which affect the health of villagers. For example, ‘sour’ foods like citrus fruits or tamarind are banned after pregnancy in Linomoiyo, because they are thought to cause the blood in the womb to congeal, resulting in an immediate subsequent pregnancy. In Buton, Wakaokili women avoid ‘sweet’ foods after birth such as bananas, cassava and pumpkin so that their stomachs won’t become bloated and unattractive. Food taboos have come under criticism from biomedical health practitioners, who are concerned about the possible adverse affects of avoiding certain foods while a woman is pregnant or post-partum. Laderman (1983: 31) writes: ‘Emphasis on dietary beliefs has had an unfortunate impact on health programs in the Third World which, too often, have centred on efforts to educate mothers, on the assumption that changing their beliefs would lead to good nutritional health for their families.’ Through her study of a Malay community, Laderman (1983) demonstrates that food avoidance does not affect the health of pregnant women, since much of what is avoided is food that is rarely eaten (such as fish which are difficult to catch). Certainly food avoidance did not appear to have an impact on the health of women in Southeast Sulawesi, and is generally not followed too strictly in any case.
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Spiritual causes of illness: setan and sorcery

One evening I heard that the bidan had arrived in Linomoiyo, and I wanted to go and see her. I hadn’t seen her for some months so, despite the fact that it was already dark, I expressed my intention to visit her, at the polindes, to the village head. He was startled, immediately frowning in concern. ‘I have to go to a meeting,’ he said. His wife was busy cooking dinner. ‘You can go with my daughter.’ My escort was Sisma, a slight girl of seven years old, who stayed silently in my shadow as we walked through the darkening village. A man had died recently in Linomoiyo, and we had heard a number of sightings of his ghost – mostly from children – over the past couple of days. I smiled at Sisma, after we passed the house where the body had lay, asking, ‘Are you scared?’ ‘No,’ she replied, solemnly, her eyes wide.

Papua New Guinea notions of illness conceptualise sickness in terms of a visitation or personal transgression (Dundon 2005). In Indonesia, equivalent ideas relate to the spiritual causes of illness, including illness from accidental encounters with spirits, illness from inappropriate conduct (such as a pregnant woman walking outside after dark) or from sorcery. Spiritual causes of illness, and spiritual healing practices, demonstrate the strong connection between health and religion (in this case, Islam) for rural villagers in Southeast Sulawesi.

In Waangu-angu and Linomoiyo there are a number of different spiritual causes of illness. One type of illness is caused by encounters with spirits of the dead. The spirit of a dead person is believed to affect people in the first hundred days after death, before they ascend into heaven. In this case, ghosts could appear to people in the village, and sometimes cause them to faint. Fear of the spirits of the dead is especially apparent among young people, and children, who are afraid to go out at twilight or after dark for fear of encountering one. Twilight and dark are seen as particularly dangerous times, when one should be inside. The village head mentioned an encounter that he had with a ghost of a villager, where he kept fainting every time he saw it appear. He had to be ritually bathed by a dukun to be cured of these sightings. An incident in the village, below, relates another encounter with ghosts.
As mentioned above, the day before I planned to arrive in Linomoiyo, there was a terrible accident between a motorbike and a car, where two men died. The site of the accident lay between Linomoiyo and the subdistrict capital, an hour or more south of the village, on an uninhabited stretch of road. Although neither man was a resident of the village where I was staying, the man on the motorbike was related to many people in the village and the accident was very well-known. A number of villagers reported strange occurrences in relation to vehicles that passed by the accident site. ‘We were going past there the other night,’ a friend of mine recounted to me. ‘It was dark, and it felt as though the motorbike tyre was flat. It was too dark there to see, so we stopped up the hill a bit. We checked the tyre, but it wasn’t flat at all. By the time we reached Andowia (the subdistrict capital), the tyre was completely flat. We had to replace it.’

Spiritual illness can also be caused by encounters with roh halus or ‘unseen spirits’, which can cause illness and destruction by accidental contact. The village head said that if he walked outside during a sun-shower, this was when the roh halus were walking around and he could accidentally brush against one and get sick. The following story outlines an encounter with roh halus:

One afternoon during my regular nap I heard a strange sound, like a banana tree falling. When I woke up the village head’s wife told me that someone’s house (under construction) had fallen down. Later that afternoon I went for a walk and met my friend Rani, who lived next door to the house that had fallen down. She was talking with some other women, sitting in a circle outside one of the roadside stalls, including the daughter of the man whose house fell down. ‘The poor man,’ they agreed sadly. ‘Such bad luck.’ The daughter told us that her parents were very upset. The women who were gathered remarked on how fortunate it was that he left the house before it fell, however. Rani said ‘I told him that it was one o’clock and he should [have a break from building his house and] go and have lunch. Actually it was only twelve but I thought he needed a break.’ Later I commented on the strength of the wind, which always started up in the early afternoon during the dry season. ‘Actually there was no wind,’ Rani said. ‘It was really still, and then the house just fell down.’ The next day Rani and her sister explained that the house had fallen down due to spirits. These ‘roh halus’ had a
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path that ran through where the house was being built. The path would need to be moved or the house would keep falling down, or someone in the family would die. They needed to get a dukun to ‘kasih pindah’ or move the path where the roh halus walked. ‘It’s true,’ Rani said. ‘I always feel ngeri (scared, unsettled) when I walk past there at night’.

Spirits have a strong connection to place – such as trees, forests or bodies of water – where they are thought to reside. By inhabiting the physical landscape, spirits give meaning to the physical world that surrounds rural villages. Spirits constitute a bond between the unknown and dangerous physical world that bounds the village, and the social world of the villagers. Near Linomoiyo there are three small lakes, or telaga, that are very deep, almost perfectly spherical, but no more than ten or twenty metres in diameter. One gave Linomoiyo its name (lino means small lake or telaga, moiyo means clear or jernih). Each telaga has a spirit protecting it, and its spiritual status is reflected in the unearthly blue of its water. No one fishes in these telaga, despite the large number of fish there, or they will be attacked by the guardian spirit.

Spirits can be both good and bad, or a combination of both, as the guardian spirit suggests. The main category of bad, or malevolent, spirits who can cause spiritual illness or death are typically referred to as setan. This is a generic word used throughout Indonesia to refer to demons and bad spirits, or the devil (from the English word ‘satan’). Setan are thought to take a number of physical forms. Danger due to setan is related to darkness, sleeping by oneself, and uncivilised and distant places from the village like forests. This is where the setan are thought to reside. ‘You see that banyan tree over there?’ the village head asked me. ‘It looks like a tree, but actually it is the house of a setan. We cannot cut that tree down, or we will disturb it.’

The types of spirits vary between Waangu-angu and Linomoiyo, but they are given the same term ‘setan’. They are also thought to arise in similar places, such as forests. Although they are commonly referred to as setan, there are a number of local words for different types of evil spirits. Setan can be warded off by using light, staying indoors, and sleeping in a room with others. Setan are dangerous during pregnancy, since they can enter a womb and cause a difficult birth, or
death in childbirth. Pregnant women are warned not to go out at night for fear of being entered by a *setan* (see also Niehof 1985: 232). This is one reason why the *dukun* has such an important role in attending births, protecting the woman in labour from spiritual disturbance by ritually bathing her, or chanting prayers, if she thinks the woman is at risk.

Linomoiyo seemed to be infused by *setan*, in various forms, and the dangers may be considered higher in villages, which are close to the forests and edges of civilisation, than in cities. I was warned of *setan* which may apprehend me in the dark, when I went to visit the outdoor toilet. The village head was so concerned that he asked his wife to accompany me to the toilet at night. I was again warned of *setan* when I slept in a bed by myself, with stories of a dangerous nightmare where I could be strangled to death. ‘It happened to me, once,’ the village head told me. ‘The *setan* was on top of me, strangling me, but then someone sleeping in my bed reached out and touched me, and I woke up. Sleeping by yourself is very dangerous, you could die from this dream.’ There was a type of *setan* that hid in dark corners of rooms, making a sound like a bird, and would supposedly try to strangle me if I lay on my back as I slept. The strength of belief throughout the community made these *setan* and *roh halus* more tangible for me. In Waanguangu *setan* were less apparent, at least among the people I spent most of my time with, but all had stories of sightings and experiences of *setan*, such as the *setan* who appears as a person, and then disappears; and the *setan* who appears as a baby crying under a tree, and bites people who try to hold and comfort it.

*Setan* have been immortalised in a number of television programs in Indonesia, appearing nightly on satellite television sets in village houses. The majority of these programs are set in Java, and feature *setan*, spirits of the dead (appearing as wrapped corpses termed ‘*pocong*’) and supernatural beings who fight with heroic warriors and *imam* (Islamic religious leaders). Spiritual healing is connected to Islam through the popular belief that Islam can keep *setan* at bay. Like Christianity’s ability to overcome vampires and other creatures connected with the devil (through use of the Bible and the crucifix), Islam is represented in television shows as keeping people safe from the dangers of spirits who reside on the edges of development, such as in forests and in the mountains, far from the
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coast. Imam, therefore, have an important role in rural villages in ensuring the spiritual safety of the inhabitants. Many of these television series are set in idyllic constructions of the past, featuring traditional Javanese dress and great kingdoms. This suggests that setan are linked to practices of the past. The connection of spirits with the past reflects a continuing theme of the connection of villages (as places where spirits appear) with tradition and backwardness.

Another type of spiritual illness is caused by people through sorcery or magic. This commonly takes one of two forms: either love spells or curses. Curses affect both men and women, and are often related to jealousy, but love spells only seem to affect young (unmarried) women. Curses cause a variety of physical effects, such as hair falling out, and psychological effects, such as madness. A curse that causes madness is called a penyakit kampung, literally ‘village illness’. Since kampung is used by city dwellers as a rather derogatory term equivalent to ‘the sticks’ or ‘hillbilly’, this description suggests disdain for primitive, peripheral types of illness. In one case, a woman who was violently attacking others was sent home to her village from the hospital because they said ‘we can’t help her. She has a penyakit kampung’. She was, instead, treated by village healers. In another case related to me, one man became mad after another man desired his wife and cursed him. He was affected for at least a year, during which time he was not able to work, and drank his own urine, amongst other things. He cured himself by journeying to Central Sulawesi, where the man who had placed the curse on him had come from.

Love spells are typically attributed to men who have had a number of wives or lovers, and who are characteristically unfaithful to them. Many parents are concerned about the vulnerability of their unmarried daughters to love spells. In my case, I was told that these love spells ‘didn’t affect me.’ They were right! One man in Linomoiyo with a notorious love spell came from Central Sulawesi. Types of spiritual danger and cures are considered stronger in different places. For the Tolaki, magic is stronger with the Bungku of Central Sulawesi, and their villages can be ‘dangerous’ places to go. As Raftos (1999) has also argued, danger is considered greater far from home, and conversely, healing powers are also stronger far from home. When I became ill in Waangu-angu, Nur and her mother
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warned me to stay close to home and avoid strangers. Some areas are seen as particularly potent, such as one Tolaki village in the same subdistrict as Linomoiyo. ‘If you go there, do not drink anything,’ I was told. ‘They put poison in their drinks.’ These areas of great potency and danger are almost exclusively rural; and the knowledge of spiritual healing and cursing is connected to ritual, and the ancestors. This places these practices in the realm of tradition and custom (adat), and far from the realm of biomedicine, which mostly denies their existence at all (see also Raftos 1999).

Illnesses and biomedicine

One of my most memorable television advertisements in Indonesia is a corny jingle about the flu. As a heavily made up middle aged woman sang about the symptoms of the flu, and treated her husband, lying in bed, with a commercial formula, the words of the jingle appeared below. Karaoke is a popular form of entertainment in Indonesia, and it is hard not to sing along with the woman – or to learn the words of the jingle. One striking aspect of television advertising in Indonesia – and indeed, many television shows – is its lack of resemblance to reality. This is something found in television throughout the world, and yet in Indonesia it takes on an extra dimension of unreality. For example, toilets on Indonesian television are all of the sit-down, flushable, Western style. Kitchen benches are the full height to use when standing; people sleep under doonas. Indonesian television rarely, if ever, shows kitchens where all cooking is done on the floor, or bathrooms containing non-flushing squat toilets and square bak (water tubs) for bathing. From watching Indonesian movies in Australia, I was under the mistaken impression that, at least the wealthy, all lived in pretty much the same way that I did in Australia. The contrast between television and urban living in Indonesia, not to mention life in rural villages, is startling. Rather than presenting a cleaner, shinier version of reality, Indonesian TV presents an image that essentially does not exist outside of the television. It presents an idealised version of reality, one that resembles a potential, modern, Western future.

Pharmaceutical advertising covers a wide range of products: from tablets to control diarrhoea, mah (stomach disorders) and flu, to slimming diet tablets and
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baby milk formula – for stronger, healthier babies. Most of these products are out of reach for villagers: they are not usually sold outside city areas, or even in the capital city of Southeast Sulawesi, which is a considerably remote province in Indonesia. Even those products that are available are not particularly affordable – in comparison to generic brand pharmaceuticals sold in small shops and at market stalls throughout the province. The advertised pharmaceuticals, like the television images, represent commodities that are beyond the reach of rural villagers: modern, expensive, and located in the modern Indonesian centres of urban Java.

By contrast to television advertising, government and aid project health advertising – through brochures, posters, stickers and so on – presents a more realistic version of life in villages, although it is still different in many ways from the actual situation. While it attempts to reflect village life as it exists for Southeast Sulawesi villagers, health advertising also projects an ideal of behaviour that has yet to be realised. As well as a modern ideal, this type of health advertising reflects the ‘ideal citizen’ – smiling children waiting to receive their vitamin A supplement; a freshly white-clad bidan smiling as she assists a pregnant couple. In health advertising, biomedicine is coupled with ideas of modernity, and a future in which rural people are ideal citizens in a developed Indonesian state and health is a duty of citizenship.

Village understanding of biomedical illnesses is closely linked to the identification of physical symptoms in conjunction with the promotion of different types of illnesses by health practitioners: such as posters advertising the dangers of TBC (tuberculosis) or gaki (goiters). Villagers refer to most biomedically-based illnesses by their symptoms (physical and sensory), or, more rarely, by names used by health practitioners (eg TBC). This suggests that most villagers understand biomedical illnesses by the symptoms they produce, rather than the location or cause of the illness itself (such as bacteria).

Penyakit kuning (‘yellow disease’) is the commonly used name for Hepatitis B, which turns the skin yellow. Another disease name used in Linomoiyo is penyakit lefer, which derives from the Dutch word ‘lever’ (meaning ‘liver’), is used as an alternative name for Hepatitis B in Linomoiyo. Muntah darah (‘vomiting blood’) is a common term for Tuberculosis, although this term also covers other types of
illness where coughing up, or vomiting, blood is a noticeable symptom. For example, in Wakaokili *muntah darah* also refers to a spiritual illness which is characterised by the vomiting of a large amount of blood, followed closely by death (referred to as ‘beri-beri’). Colds are known by the English-derived term *flu*. Sometimes colds are referred to by their symptoms, such as *batuk* (‘cough’), and *pilek* (‘runny nose’). The term for influenza is *sakit tulang*, which literally means ‘sick/sore bones’. Fevers are referred to simply as *panas* (hot). One disease is referred to as *penyakit kulit*, or ‘skin disease’. It is thought to be caused by *darah pahit*, ‘bitter blood’.

For Tolaki in Linomoiyo, *khosa* (in Indonesian *sesak nafas*) refers to ‘shortness of breath’(Echols & Shadily 1997). The Tolaki term is used to refer to all illnesses where difficulty in breathing is a symptom. This covers mild conditions such as asthma, to more serious conditions such as emphysema and lung cancer. The vast majority of men smoke in both Waangu-angu and Linomoiyo. I attributed this disease to the high level of smoking, however villagers themselves appeared to attribute no blame to the ill person on the basis of their behaviour. While in Australian society, lung cancer would be seen as significantly connected to one’s behaviour (smoking), in Linomoiyo there is little, or no, connection (Davison et al. 1992). Given that smoking is so widespread, particularly among men, and not seen as a ‘bad’ thing to do, this is not surprising. A midwife’s house (*polindes*) in a nearby subdistrict was emblazoned with large banners advertising cigarettes, and health personnel on the *puskesmas* (health centre) team frequently smoked during monthly health outreach posts (*posyandu*), especially in Linomoiyo. Despite HMHB (Healthy Mothers Healthy Babies Project) stickers suggesting health dangers associated with smoking, and Indonesian government health warnings on cigarette packets, there is very little connection between smoking and ill health in either village. One informant was quite mystified by the health warnings on cigarette packets. ‘If they’re so dangerous,’ he reasoned, ‘then why are they selling them?’ Since smoking (for men and women), and previously betel nut chewing, has important ritual significance for both Tolaki and Wakaokili, as well as for masculine identity, it is unlikely that this attitude will change in a hurry.
Western health practices were first introduced to Indonesia in the Dutch colonial era, through colonial administration as well as the provision of medical assistance by Protestant missionaries (see Aragon 1992). Given the relative isolation of both Waangu-angu and Linomoiyo from missionary influence and colonial power – as Islamic populations in upland areas – biomedicine probably took a stronger hold during the post-independence era, and particularly under Suharto’s New Order regime (1966-1998) when penetration of upland areas by government authority and health services became more extensive. As new biomedical treatments for illnesses become available, so too does village awareness of new biomedically defined illnesses expand. This is also the case with new health projects from government and international sources: promoting such illnesses as goiters (Indonesian government) and vitamin A deficiency in children (UNICEF). On a number of occasions, a bidan was visited by elderly people complaining about feeling ‘weak’ and asking for an injection (A similar attitude to injections in Vietnam is found in Craig 2002: 157). The vitamin B that she injected, along with the ritualised drama for the patient of dropping one’s pants and suffering the fear and pain of injection – all in front of an audience, of course – made for the establishment of a significant illness in the eyes of villagers.

One disease that was widespread in Indonesia was penyakit mah (deriving from the Dutch word ‘maag’ which means ‘stomach’), which roughly translates as ‘stomach disorder’. It appeared to be a chronic illness, and the symptoms were described to me as ‘feeling weak, and not able to eat rich foods’. The cause was suggested as ‘not eating regularly.’ Although there are a large number of biomedically-defined stomach disorders, mah seemed to be a particularly Indonesian version, along with its own unique symptoms. There are a variety of pharmaceutical products in Indonesia that claim to cure it, or alleviate the symptoms. This suggests that biomedicine may have been assimilated into existing ideas of health in Indonesia, rather than limiting itself to the representation of Western-defined illness.
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Healing, health seeking behaviour and ‘cocok’

As Nur and I walked home to Waangu-angu after watching a volleyball match at the nearby primary school, a flurry of people rushed up to us. ‘You must come quickly,’ one woman told me. ‘My son has been injured playing volleyball.’ Sensing her concern, we hurried along to the road outside Nur’s sister’s house, where a crowd had gathered. The young man was sitting on one of Nur’s sister’s wooden chairs, in the middle of the road, looking a bit shocked and fairly pale. A large lump had formed on his forehead, just below the hairline, and blood was running from above it. ‘What should we do?’ his mother asked me. Caught up in the moment, I didn’t wonder until later why they had asked my opinion. ‘He needs ice,’ I said, and his mother ran to one of the shops to buy some ice. In the meantime, an elderly woman applied a poultice of mashed leaves to his forehead. There was some confusion, when his mother got back, about where the ice should go. I pointed to the poultice, which was covering the lump. ‘It should go there.’ The young man held the ice to his head awkwardly, half covering the poultice. The drama over, the crowd started to disperse, and we went home.

The main idea behind the concept of cocok in healing practice is to match the cause of the illness to the treatment (and the healer to the patient), in which healing is conducted in conjunction with the patient’s ‘unique individual circumstances’; and their relationship to their environment, community and belief system (Slamet-Velsink 1996: 75) (see also Jennaway 1996). Cocok itself translates as ‘agree’, ‘tally’ or ‘suit’. In some cases, villagers considered me incompatible with herbal and spiritual healing, since I came from a Western country. Then, they considered pharmaceuticals to be the best option for me. This was further reinforced to them by the atypical nature of my illnesses, such as violent reactions to certain foods and frequent dizziness, which they did not experience. In general, illnesses that are thought to be caused by nature – the weather, for example – are first treated by natural means – such as herbal medicine, or basic pharmaceuticals to alleviate the symptoms. Illnesses thought to have a biomedical origin – such as boils – are often treated by pharmaceuticals, usually with a trip to the bidan. Illnesses thought to be caused by spirits or sorcery are first treated by spiritual means – by a dukun or imam; and indeed biomedical
practitioners are seen as incapable of treating illnesses caused by spirits and sorcery (see also Raftos 1999).

Apart from this perception of cause, treatments are tried and discarded with no great preference, sometimes simultaneously, with one type of treatment seen as pretty much as effective as any other. Sometimes I asked people about medications that they were taking that were prescribed by the bidan. ‘I’m not taking that anymore’ my friend said. ‘I felt better for a while, but now I don’t feel any improvement (anymore).’ The initial diagnosis must then have been wrong, and another cause is determined. However, some treatments are seen as particularly potent, such as the strength of Western medicines, particularly ampicillin (a commonly used antibiotic), and injections of any kind (see also Craig 2002). My own supply of pharmaceuticals was seen as more potent than locally purchased medicines, and people would often ask me for some, always asking where I bought them. One man, after asking what medicine I took for an illness, said, ‘It must be good. It’s from Australia!’

Cocok enables illnesses to be treated more holistically, by uniting the illness, its cause, the body of the ill person and its environment. In this way patients are more able to relate to the illness they are suffering, and to have the emotional and psychological aspects of their illness addressed at the same time that their physical symptoms are relieved (see also Raftos 1999). Cocok can refer to the site of treatment, and the healer, as much as the treatment itself. For example, some people may give this as their explanation for visiting, or not visiting, a particular subdistrict health centre (Sciortino 1995). Cocok also ensures that treatment more fully considers the impact on the entire body: in contrast to biomedicine, which treats symptoms, conditions and body parts as separate and independent of one another.

Local use of traditional medicine and dukun

Early afternoon, after eating lunch with Nur’s family in Waangu-angu, we received a guest – a woman and her baby, who was probably about one year old. After some discussion in Wakaokili language, Nur’s mother took the baby and
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shook it: on one side, holding one arm and one leg; on the other side, holding the other arm and leg; and upright, holding its neck. The baby had started screaming and crying, and I asked Nur – surprised, and not a little concerned – what was she doing? ‘The baby is sick and she is helping to make it better,’ Nur replied. ‘It is a type of massage that is only used for young children. My mother helps people when they are sick.’

Villagers in both Waangu-angu and Linomoiyo identify two types of traditional or non-biomedical healing: spiritual healing through ritual bathing and/or prayer; and the use of traditional massage and herbal medicine using particular leaves and roots. Often these two healing methods are used in conjunction, depending on the supposed cause of the illness. While herbal medicine is usually administered by a dukun (female healer), the skills are known by a wide variety of people with no particular status in the village. Spiritual healing is generally performed by dukun, imam and male ritual specialists. This depends on the type of healing required, for example, ritual specialists generally only officiate at public ceremonies. Imam are sometimes considered to be more powerful spiritual healers than dukun, particularly in the case of illnesses with a spiritual cause (although not childbirth), probably because of their connection to Islam.

Despite the fact that traditional and spiritual healing is usually performed by dukun, imam and ritual specialists, the skills and knowledge for these healing practices are shared by a number of people in the village. This type of knowledge is passed down from generation to generation, thus it is a kind of shared knowledge owned by the community themselves. Compared to biomedicine, in which practitioners exert exclusive and hierarchical control over knowledge and practice, the border between practitioners and patients in traditional and spiritual healing is much more blurred (see Raftos 1999).

Although villagers generally share similar attitudes to health and healing, in practice their health-seeking behaviour often varies. In one case that was related to me in Linomoiyo (also mentioned above), a woman had given birth to a baby that was, she said, ‘very white, and beautiful.’ The baby was sickly, and died very young. The baby’s mother explained to me that the baby was ‘too white’ and therefore vulnerable to illness. There was nothing she could do to help the baby.
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Another woman in the village disagreed with this, telling me privately ‘the baby had diarrhoea. She should have called the bidan but she just let it die.’ In another case, a woman had postpartum haemorrhaging and was very ill. She had been treated by dukun, as it was thought to be due to evil spirits, but with no success. Her sister-in-law came to visit her, and the woman’s husband said ‘there is nothing more we can do.’ ‘What do you mean?’ she said, ‘call the bidan.’ In this case, the bidan was able to help her recover.

In both of these cases, villagers do not question the ability of the dukun, but rather the appropriateness of the treatment (cocok) given the presumed cause. Both dukun and bidan are seen as legitimate practitioners of different kinds of healing: the former, spiritual and herbal treatments, and the latter, biomedical healing. As both Dundon (2005) and Raftos (1999) reflect, villagers may opt to visit a traditional healer first, since they are usually closer, therefore easier to reach, and their services are more affordable than biomedical practitioners. Since the preparation of herbal medicines, in particular, is a type of knowledge shared by a number of members of one village, a sick person can usually find a relative who has the appropriate knowledge and skill to assist them in providing herbal medicine at no cost. Serious illness usually requires a visit to a biomedical health practitioner, which involves significant financial expense and is a serious decision for any village family to make.

Use of pharmaceuticals and biomedical practitioners

Early morning in Waangu-angu, the government midwife (bidan) and I have been eating breakfast, when the first of her patients arrive. A group of women flick the curtain aside curiously, that conceals the kitchen from the clinic room, commenting on our late start. They then take up various positions in the small polindes, the house that has been provided for the bidan to live and practice in, while they wait. They assemble in the tiny clinic room with her, which has a bed at one end and a wooden table and hard wooden chair at the other. Coloured, handmade charts cover the walls of the polindes, and its outside is decorated with health posters, stickers, and a large painted sign proclaiming ‘POLINDES’. The village women discuss their interpretation of the problem with the bidan. The
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*bidan* waits patiently before explaining her view, while the women nod sagely. When the women have gone, the *bidan* comes back into the kitchen. ‘I like to talk to women in groups,’ she explains to me. ‘That way I can disseminate health messages more quickly and easily.’

Biomedical healing is provided in rural Southeast Sulawesi in a variety of ways: through the sale of pharmaceuticals in shops and markets; by *bidan* who live scattered in villages throughout the province; at subdistrict health centres (*puskesmas*) and at monthly health outreach clinics (*posyandu*). The use of these various services depends greatly on the ability of villagers to access them: in both villages, most households had no access to private transport, and were some distance from the *puskesmas*. *Posyandu* are generally restricted to family planning, and maternal and child health care, and many *bidan* only stay intermittently in villages. Pharmaceuticals are by far the most accessible – however they come with limited instructions, and are often supplied by people (shopkeepers and market sellers) who have little to no knowledge of their use. In many ways, using biomedical methods of healing in rural villages is a haphazard kind of service – this was certainly what I experienced – and highly dependent on what is available at the time when one is sick.

Villagers have a limited understanding of biomedical pharmaceuticals, referring to them by appearance (*‘kapsul’* (capsule) or *‘suntik’* (syringe)) or by their function (*‘headache medicine’, ‘stomach-ache medicine’*). This lack of information is not supplemented by biomedical practitioners. Pharmaceuticals are typically prescribed by doctors or sold by *bidan* and pharmacies with no information about their contents, only a simple instruction of how often to take them (see also Hunter 1996b: 184). I frequently asked villagers what the pills or injection contained, and they would usually have no idea, or guess a commonly known name. Some pharmaceuticals are well-known in the villages, such as ‘vitamins’, mainly ‘vitamin B’, and the antibiotic ‘ampicillin’. In Linomoiyo, ‘ampicillin’ is used for a variety of health reasons. One villager broke his leg playing soccer, and was taken to a nearby *puskesmas*. In one version of the story, he was given an injection. ‘What was the injection?’ I asked. ‘I think it was ampicillin,’ the storyteller told me. ‘But that doesn’t make sense, he wouldn’t be
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given an antibiotic,' I said. The storyteller looked confused, and admitted that he wasn’t sure what it was.¹³

Pharmaceuticals often appear at market stalls, where they are, again, bought and sold without any additional treatment information. These include the contraceptive pill, some which have been supplied by projects and still display their project branding. Van der Geest and White (1989) note the sale of a variety of pharmaceuticals in markets across the developing world. This consumer-controlled access to pharmaceuticals can be considered part of the ‘popular sector’ of healing outlined by Kleinman (1980) (see also Craig 2002). The role of medicine sellers at markets and local kiosks is important in providing access to a wide range of medicines to villagers. Such local access is contested by the Indonesian Health Department and aid projects such as HMHB, who attempt to control the method of supply of pharmaceuticals as well as their use. This attempt at control has not been particularly effective. It is widely known that a large range of pharmaceuticals stamped with the label ‘hanya dengan resep dokter’ (only with a doctor’s prescription) can be easily bought over the counter at pharmacies, not to mention at markets.

One important feature of biomedicine in rural villages is the almost exclusive control exerted by biomedical practitioners (such as doctors and bidan) over biomedical knowledge and practice. Only those who have been officially trained by the Department of Health are permitted to practice biomedicine, unlike local healing knowledge – which is passed down through generations, and shared to a significant extent with a large proportion of the village population. Villagers have no access to biomedical practice, except in self-medicating with pharmaceuticals. The lack of knowledge and understanding of biomedicine among villagers means that their biomedical self-medication is potentially more dangerous than the use of locally-based healing practices. For competent biomedical treatment, then, villagers are dependent on government medical practitioners that provide a highly variable service due to problems with access, limited medications and the often negative attitudes of government health worker towards villagers.

¹³ Geertz also relates a story of the potent power of penicillin in Religion of Java (1964: 104-5)
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Villagers seek assistance from the *bidan* in the village for medication, particularly for contraception, which mainly consists of supplier-controlled techniques of injections and implants. While some villagers visit the *bidan* for medication for sick children, or injections for ‘energy’, others complain that the *bidan* only has a limited range of medicines. When the *bidan* is in the village, she is highly sought out to assist people with medications and advice. In the frequent periods that the *bidan* is away, villagers have very limited options in gaining biomedical health assistance: apart from buying pharmaceuticals at local shops and markets, they can travel the significant distance to the *puskesmas* (health centre), or wait for the monthly *posyandu*. The unreliability of biomedical services encourages villagers to engage in medical pluralism, utilising both local healers and government health workers, herbal and spiritual healing as well as pharmaceuticals.

**Delivering government health care to villages: *posyandu* and *puskesmas***

The early 1980s saw the advent of *posyandu* (Hull 2005b), a village outreach health ‘post’, designed for women and young children as part of the family planning campaign, with a team from the subdistrict *puskesmas* attending each village once a month to provide immunisations, antenatal examinations, contraceptives and health education messages.

A large number of women, their babies slung against their bodies in sarongs, or small children tagging along, mill around noisily as they wait for the *puskesmas* team to arrive for a *posyandu* in Buton. The health volunteers for the village (*kader posyandu*), often older women, busy themselves weighing babies and noting down the numbers in thin booklets with the name ‘Kartu Menuju Sehat’ – Road to Health card – that compares the infant’s weight for their age on a chart, indicating whether they are in the appropriate green band. The women talk loudly amongst themselves and nurse their babies, trying to prevent little children from running around with treats of lollies and biscuits. I sit on a chair in one corner, next to a *kader* who stares at me in some bemusement and wants to touch my skin. Finally the team from the *puskesmas* arrives, in a white four-wheel drive, and a group of two men and two women get out.
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There is a nutritionist (gizi), who doles out vitamin A capsules from a UNICEF project. She breaks them carefully and tips the contents down the throat of each child. Once all the women have filed past with their children, she notes some details down in an exercise book. She sits on a chair beside me, along with the inoculator (jurim) and a man who gives penyuluhan, a type of health education that consists of reading out a number of health messages using a portable loudspeaker. He needs the loudspeaker just to penetrate the noise of the women chatting, but by their faces, his messages don’t seem to register. I am more fascinated by the jurim, or more specifically, the reactions on the babies’ faces as they are immunised. I involuntarily grimace in sympathy as the babies, in sudden shock from the prick of the needle, start to wail and cry. The women, on the other hand, laugh in great amusement, at the babies and at my reaction. A final member of the team is a bidan from the health centre, in addition to, or sometimes substituting for, the bidan who lives locally in the village. She and the village bidan disappear into a room some distance away where they examine all the pregnant women.

Bidan encourage pregnant village women to have a monthly antenatal checks from the three month point of their pregnancy onwards, either by attending the monthly posyandu or visiting the bidan at the polindes separately, when she is in the village. The examination is fairly basic – the midwife will use a tube to listen to the baby’s heartbeat, check the woman’s blood pressure and ask her a few questions about the progress of her pregnancy. The number of actual antenatal checks does vary widely depending on the woman’s own inclinations, but HMHB project evaluations suggest a generally access to antenatal care by village women. The bidan also carries out at least one postnatal visit – up to three or four – where she offers medication and administers a Hepatitis B shot to the baby. Each bidan keeps a record book with details of each pregnancy – including the number of checks, and the estimated date when the woman will give birth. These details are reported monthly to the puskesmas.

Although surrounded by village women, the team from the puskesmas avoid any interaction with them beyond health messages, which are always provided one-way (such as through the use of the loudspeaker). The information provided is
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often confusing or unclear to villagers, such as referring to breast milk with the acronym ‘ASI’ (air susu ibu), a term that is rarely used by villagers themselves. Some of the puskesmas team talk to the kader, who have an official connection with the government health system (as health volunteers and PKK representatives) after all, but village women generally are often scolded for not attending frequently enough, or not having the ‘right’ health behaviour. This patronising attitude of puskesmas staff dismisses the local health knowledge of village mothers, many of whom have a number of children – and therefore considerable experience in child care (see also Hunter 1996b: 178). The group disperses once the puskesmas team have left, rushing off in their four-wheel drive to the next village on their list. Women amble back home on foot, their children in tow.

Village women in Linomoiyo and Waangu-angu generally attend posyandu if they need contraceptive injections, and sometimes if their babies need immunisations. Posyandu were generally better attended in Waangu-angu than Linomoiyo, although children were rarely brought to posyandu after the age of two or three – instead of five, the age recommended by the Health Department. Rather than a community-oriented health service, posyandu operates as a kind of civic duty for all women who are pregnant or have small children. Women are criticised by puskesmas team members for not attending every month, and the decision as to which pharmaceuticals and nutritional supplements are supplied is controlled by the puskesmas team. Occasionally, villagers not in the appropriate category (such as my unmarried friend Nur) attend posyandu to source supplies of pharmaceuticals if the bidan is not around. They are generally discouraged from participating, however. The somewhat chaotic atmosphere of posyandu in Waangu-angu and Linomoiyo, as well as the superior and dismissive attitudes of puskesmas staff towards villagers, is remarkably similar to descriptions of posyandu provided by Sciortino (1995), in Java, and Hunter (1996b) in Lombok. Hunter (1996b: 176), in particular, suggests that ‘the disorganisation of posyandu reflects a bureaucratic assumption that women’s time is of no value compared to that of the [health workers]’.

A typical morning at the subdistrict health centre (puskesmas) in Java described by Sciortino (1995) also bears a number of similarities to the situation in
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Southeast Sulawesi – despite the fact that it was recorded some ten years before my fieldwork, in a different part of the country, and during the Suharto regime. Puskesmas open early and close early: dealing with patients, who form a queue, only in the morning. A skeleton staff remains at puskesmas after about one in the afternoon, and many puskesmas have limited or no beds to provide for in-patients. Like the polindes, puskesmas walls abound with posters for various Indonesian government and international health projects: such as the World Health Organisation, UNICEF and Medecins Sans Frontieres. All government health buildings are painted white, with blue trim, including polindes and puskesmas, which reflects the uniforms of government health staff: all white, or white blouses with blue skirts/pants. In this way government health workers are easily identified with their place of work, and distinguished from villagers. Puskesmas vary in the extent of their service from area to area. The description below, from a Linomoiyo villager, indicates one village encounter with a puskesmas:

One of the young men in our village broke his leg during the Independence Day celebrations, playing soccer at the subdistrict capital. First we laid him down on the stage, because it was close (to the soccer ground). There were lots of people there and they said we should take him to the health centre (puskesmas) which was just on the other side of the field. We took him there but the place was all locked up, there was nobody there. It was really difficult just to find a key. One member of staff appeared, but s/he didn’t seem to care about the injured person. The other staff were probably out watching the sports games for the 17 August celebrations. There was no equipment, or medicine, there even to carry an injured person or corpse. We weren’t given any medicine or injections. The injured man’s family decided to take him back home since there seemed to be no service at the puskesmas, and no concern for the injured person.

They used the services of a bonesetter, and while the man was bed-ridden for a number of weeks, he appeared again walking around during the last part of my stay in Linomoiyo.
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The subdistrict health centre (puskesmas) is generally the last port of call for villagers seeking medication. It is distant from the village, up to an hour by public vehicle. While it is a potential supply of medications, it is generally used as a last resort option for treatment of illness. Many villagers expressed reluctance to go to the puskesmas, saying that the doctor would tell them off for not coming earlier. There are a number of accounts of poor people not visiting a health centre, where treatment might be expensive, until the later (and often more critical) stages of an illness. In other instances, such as the incident described above, villagers visit the puskesmas and are turned away without assistance. It is unsurprising, then, that villagers rarely go to the puskesmas. Rarely do villagers visit a hospital, since these are located in cities at a considerable distance from them, and are prohibitively expensive. In general, biomedical healing services are not sufficiently reliable for them to be the only method of treatment for villagers – too expensive, and not always available – despite the fact that they are promoted as the best – and indeed, only – choice by both the Indonesian government health system and international aid projects.

Enacting health and modernity

When Nani visited the bidan in Linomoiyo for an antenatal examination, she was told that, due to her small size, she would be best advised to give birth by caesarean section in the hospital in Kendari. Despite the considerable expense to her family, she travelled to Kendari when it became time to have her baby, and gave birth in the hospital as indicated by the bidan. Nani didn’t return to Linomoiyo, though, and villagers began to gossip about her reason for the prolonged visit to the provincial capital. ‘She doesn’t want to come back to the village,’ one told me. ‘She says it is dirty and poor. She just wants to live in the city.’ Her husband, apparently, was beside himself with worry – he had no way of subsidising her expensive city life working as a farmer on the fields near Linomoiyo. Finally, she appeared in the village again one day. I sat in a neighbour’s house, eating nangka (jackfruit) while we watched Nani walk past at a distance, carrying her baby with her. Her tiny frame was decked in fancy clothes
Popular notions of health and illness

– not the sort of attire for a day in the fields – and she picked her way across the dirt roads in high heel shoes.

Nani is perhaps an extreme case, but her story is illustrative of the ways that villagers engage with ideas of modernity and development through their health, and childbirth, practice. Through choosing particular sites of healing, healers and healing methods (massage, injection and so on) villagers ally themselves with, and express their desires for, particular ideas of tradition and modernity. Such ideas are in many ways promoted by the Indonesian government health system in an attempt to eradicate the ‘traditional’ and ‘dangerous’ practices occurring in rural villages. Villagers themselves engage with these practices and their related values, expressing their own ideas, and ideals, of tradition and modernity within health practice.

**Reflexivity and modern health practice**

Friends of mine in Kendari, the provincial capital of Southeast Sulawesi, reacted with laughter and embarrassment to my experiences of being treated with traditional methods in the village. They insisted that the methods were backward, and wrong, and seemed incredulous that I, a Westerner and therefore representative of all that was modern, would be prepared to engage in such backward methods of healing. There is a significant divide between village or kampung people and those living in the city, even though many people living in Kendari (including my friends) had originally come from villages. Having moved to the modern world of the city, they seemed anxious to leave all signs of backwardness or village-like behaviour behind. Health Department personnel are also dismissive or critical of local practice, as has also been noted by a number of researchers in a variety of countries (such as Kleinman 1980; Laderman 1983; Raftos 1999; Whittaker 1999). Moreover health workers and some aid project staff felt that I should assist them with their work and support their modern, biomedical view of health practice.

Biomedical perceptions of the validity of local healing practices are polarised when dealing with the dramatic, essential, notions of life and death. Ritual for
ritual’s sake can be tolerated, or even celebrated, by a wide variety of people (including aid projects), but no ‘traditional’ health practice should endanger the life of those who are treated. This preference for ‘life’ above all else fits within a modern, Western, biomedical framework, which is promoted as part of aid projects such as AusAID’s HMHB (Healthy Mothers Healthy Babies). Through engaging with the HMHB project villagers have the opportunity to choose such a modern future in which quantity of life is the most important factor. At the same time, the practices of local healers who sit outside the biomedical system are denigrated as ‘dangerous’, and their authority in rural villages is significantly challenged.

Southeast Sulawesi villagers negotiate a health system that is greatly affected by outside interests, their relationship with the state, and ideas of development and modernity. Villager understandings of health and illness, and their health seeking behaviour, reveal a variety of ideas, knowledge and practice that comprises the popular sector of the local health system. Although biomedical knowledge and practice is greatly limited in rural villages, biomedical ideas of health and illness still play a role in shaping villager attitudes to health and illness, and are actively incorporated into the local health system. The local health system expands healing practice beyond the realm of ‘professional’ biomedical practitioners, allowing traditional healers (dukun, imam and others) as well as villagers themselves (such as those selling pharmaceuticals) to participate in healing practice. In engaging with various types of healers and healing practices, villagers negotiate and redefine their experiences of tradition and modernity. The next chapter explores the embodiment of the local health system, and the government health system, in two types of female healers: the government midwife (bidan) and the traditional healer and midwife (dukun).
Chapter Six
Village healers, government midwives: the dukun and bidan

A photo from a 1998 promotional text about the ‘Mother Friendly Movement’ in Indonesia (Cholil et al. 1998), features a traditional midwife and healer (dukun) sharing a white-painted wooden bench with a government midwife (bidan) (Fig 6.1). The dukun is dressed in a traditional blouse and dark checked sarong, her rough feet bare, toes curled into the ground. She appears to be about seventy years old, or possibly older, and she sits facing the bidan, her eyes half-closed and mouth open in speech. Her gnarled hands curl into the folds of her sarong. The bidan, on the other hand, is dressed neatly in a white short-sleeved dress, the uniform of government health personnel in Indonesia. Such uniforms ‘underscore their role of political emissaries’ in addition to identifying them as health workers (Sciortino 1995: 158). Her feet are neatly shod, her hair tied back, and a polite smile is on her face. She looks barely thirty years old, if that. As indicated by the sign behind them, they are sitting in front of a ‘village birthing hut’ or polindes, which is built and maintained by villagers, and is the typical home of a village bidan. Below the picture, the caption reads: ‘Traditional meets modern: birth attendants.’ The shared bench can be seen as symbolic of their shared role – as healers, and midwives, who should attend births together – according to current Indonesian Health Department policy. The accompanying text includes a variety of information about the ‘Mother Friendly Movement’ to reduce maternal and child mortality in Indonesia, incorporating a number of strategies: such as posyandu – the monthly outreach health clinic for mothers and children, established in the early eighties; the family planning movement; and the role of the Department of Health, particularly in its provision of services in maternal and child health at hospitals and health centres (puskesmas). Throughout the text and photo illustrations, government health care is promoted as a safer and more modern alternative to village healing practice, as represented by the diametrically opposed ‘traditional’ dukun and ‘modern’ bidan (see also Robinson 1985). In villages themselves, such contrasts may not be as apparent: the ages, and dress, of
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dukun and bidan may vary widely, as may the relationship of healers with the communities where they work.

This chapter focuses on these two key healers, the dukun or traditional midwife and healer, and the bidan, or government-trained biomedical midwife, as emblematic of two health systems. The dukun is considered by both the Indonesian government, and local communities where they live, as emblematic of the local health system. This system is firmly embedded in the community, with knowledge passed down through generations. The bidan is emblematic of an Indonesian government-sponsored health system which is operating in the village. The interaction between these healers, and their juxtaposition as ‘modern’ bidan and ‘traditional’ dukun, has important implications for how they perceive their roles in the provision of healing services in rural villages, and for the interaction of those healers with the government and local health systems. Concepts of tradition and modernity have a significant impact on health behaviour in the village generally, including the use of healing services and pharmaceuticals, and childbirth practice. To what extent do bidan really embody government health? To what extent do dukun represent an ideal of village healing practice, and how does this compare to other village healers? How does bidan and dukun practice reflect, and differ from, official portrayals of their roles in rural Indonesian villages? In many ways, bidan and dukun will be shown to represent traditional and modern healing practices in villages in similar ways to how they are portrayed by the government. It is the nuances and differences that I intend to tease out.

The bidan: government health in the village

In response to high rates of maternal mortality in rural Indonesia, the Indonesian government instigated a village-placement scheme of biomedically trained midwives (bidan) in 1989. This scheme involved dramatically increasing the number of bidan nationwide, with an estimated ‘56,000 young midwives’ (bidan) placed on government contracts in rural areas around Indonesia between 1991 and 1997 (Geefhuysen 2000: 63); moving them from subdistrict health centres into rural villages. The AusAID Healthy Mothers Healthy Babies project (HMHB)
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supported this national initiative. The bidan forms a link between government and local health practice in the village. She is involved at the health centre as an employee who reports monthly and participates in regular rounds of service as a health centre midwife. She is also highly involved at the village level, both as a midwife and a general health service provider.

Nila (pictured in fig 6.2, 6.3) became a bidan over ten years ago, graduating with a one-year diploma in midwifery after completing three years of a nursing qualification. She comes from the capital city of Buton, Baubau, but she has been placed in three different villages across Southeast Sulawesi province over that time as a government midwife. Some midwives have resisted being moved, preferring to remain with communities with which they are familiar. Otherwise they are moved every five years to a new village, although official policy states that they be replaced with new midwives, and return to the cities. The contract-status of bidan in rural areas accords with a Presidential decision in 1991 requiring all medical personnel to spend a period of time working in rural areas, to encourage improvements in rural health care (Hunter 1996a: 86). The lack of midwives to replace those on contracts has meant that bidan have remained in villages on rolling short-term contracts, rather than taking up public-service positions in the cities.

The one-year training of this particular batch of midwives, in response to a publicised crisis in maternal mortality rates, has been highly criticised, but after over ten years of practice, these midwives are now considerably experienced in attending real births. Nila is new to this village, working two weeks of every month and spending the other two weeks in the city, attending a retraining course in midwifery that is an initiative of the Health Department. The training will take anything up to three years, and if she is lucky, enable her to achieve public servant status.

In the village Nila lives in a house (polindes) provided for her by the community (figure 6.4), and recently upgraded by the HMHB project. But villagers complain that she is rarely there. Her commitment to this community is low: she barely knows any villagers, and can’t speak the local language. In fact few bidan work in villages that they come from, increasing the social distance between the bidan and
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villagers (Grace 1996: 149). Nila uses her project-provided motorbike to visit the health centre and report at meetings, to buy medicines, as well as to visit her friends, family and her boyfriend in the city. She spends all weekends in the city, and as the months go by she spends even less time in the village. ‘Now she only comes a couple of days a month’ villagers tell me, when I visit a few months later. She is impatient with village life, finding it boring, and longing for a better position or further study. This is an experience common to many village bidan, and has resulted in an apparent oversupply of bidan in cities and a shortage in remote areas. Some city-based health centres are staffed with up to ten bidan, while one bidan may service six rural villages (as in the case of Linomoiyo) (Lang 2004). While urban populations are denser, requiring more staff, city women also have access to the services of private bidan after hours, and other health personnel.

For most of the time that Nila is in the village, there are no births to attend. She spends her time updating her books for the health centre, attending to minor injuries and illnesses in the community, and selling a limited range of medicines. In this way she legitimates her existence in the village: there are too few births on a daily basis to justify her existence there otherwise. In providing medicines and treatment, as well as attending births, Nila mimics the role of village dukun, who also provide a service that extends beyond ‘birth attendance’. This is common to village bidan across Indonesia (Hull et al. 1998: 6).

Nila finds it difficult to fill the gap that the previous midwife left behind. The previous bidan had lived in the village for a number of years with her husband and two young children, learnt the local language and generally integrated herself into the community. ‘If she came into my house,’ one villager told me, ‘she would just help herself to food in the kitchen. She was like family.’ Villagers still visit the previous bidan if they go to the city, where she now lives. Through her knowledge of the local language and good relationship with villagers, she was seen as a more committed bidan. As a single woman, Nila’s social life is actively scrutinised and her opinions less respected than that of a married woman, particularly one with children. After all, ‘what do single women know about
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childbearing? is a commonly cited attitude of villagers to the placement of young, single women as village midwives in Indonesia.

Despite the promotion of officially sanctioned health practice, Nila often acts, and speaks, in contrast to their directives: ‘If I’m not in the village when there is a birth, a trained dukun is sufficient’ she tells me, directly contradicting the Health Department messages which insist that all births must be attended by a bidan. Ironically, she jokes, women usually give birth when she’s not in the village. While villagers are also generally confident that a dukun will be sufficient to attend a birth without a bidan, some villagers express concern about haemorrhaging if there is no government midwife present. Support for the government directive that bidan must attend all births varies among bidan themselves. In another instance, I asked Nila how often she used syringes, and she said ‘only once, we’re only allowed to use a syringe once.’ In fact I observed her reusing syringes with different people on a number of occasions. Once she used it four times, disposing the excess from the last patient’s dose out of a nearby window. Reuse of needles is also observed by Grace (1996: 151) in Lombok. Nila is far more critical of villager health behaviour than censuring of her own. She is also critical of birth control medication: according to her, the contraceptive pill is dangerous, and women only take it because the government tells them to. Nila is aware of the ‘rules’, but she applies them as she sees fit in her village practice.

In this majority Islamic region, bidan are almost the only women in the village to wear the Islamic headscarf on a daily basis. This physically marks them as different, and as outsiders, since most women in Southeast Sulawesi wear these headscarves when away from their homes. It reflects a common practice among Muslim public servants to wear headscarves while working. Women in the city, and those in higher education (such as tertiary students) are most commonly seen to wear headscarves: in visible contrast to the usually bare heads of village women. Although both villagers and the bidan are Islamic, they express their religiosity in different ways: bidan, like most city-dwellers in Southeast Sulawesi, pray five times a day, visit the mosque regularly and frequently wear Islamic headscarves (jilbab). In the city of Kendari, women are frequently seen wearing long headscarves (jilbab besar) or even those covering their faces. Women in
villages rarely wear *jilbab*, except for outsiders, and schoolgirls. This fits within an Islamic religious practice that is generally more relaxed in rural areas: apart from the many village *imam*, most villagers only visit the mosque during special Islamic ceremonies (such as Ramadan, or the Birth of Mohammed). City-dwellers demonstrate their ‘modern’ lifestyle through religious piety: villagers are often unable to visit mosques or pray five times a day, particularly if they work in distant fields or forests. ‘We are too busy to pray all the time,’ one Linomoiyo villager explained to me. In the same way, villagers find it difficult to fast during Ramadan: since it is difficult to carry out taxing physical labour while fasting. The *jilbab*, and religious practice, of the *bidan* marks her as more ‘modern’ than the villagers, and as ‘away’ while in the village, even while emphasising their common Islamic identity.

Many *bidan* like Nila were retraining during 2004, resulting in long periods away from the village. This was a Health Department initiative to increase the training of *bidan* from one to three years, and funds for this retraining are being provided by the Asian Development Bank (ADB). All *bidan* now need to attain a three year Diploma to qualify for public-servant status. The public service provides guaranteed income and benefits, such as a pension, which are not accessible to the many contract *bidan*. *Bidan* enter the profession as contract *bidan*, and later sit an exam to achieve public servant status. Since the many *bidan* who entered the profession during the village midwife placement drive only achieved a one year Diploma, and are all contract *bidan*, many are now going back to retrain (see Geefhuysen 2000; Shiffman 2003). This included *bidan* in both of my case-study villages, who have now been contract *bidan* for about ten years.

The structure of this retraining is having a serious impact on access to government health services in rural and remote areas. *Bidan* attendance at births will presumably decline across the board, as it did for the two villages where I was located, during 2004. In the time I was conducting research, only one birth out of at least twenty that occurred was attended by a trained midwife. The gruelling schedule of part-time work, part-time study, as well as frequent travel between cities (where training was conducted) and the villages where they were supposed to be based, reduced the frequency of *bidan* visits to villages. The HMHB project
team attempted to have some of their training modules recognised by the Health Department, since HMHB materials were being used in retraining. That way, *bidan* who had undergone training with HMHB would not need to repeat those modules, and could achieve their diploma more quickly.

Since reliance on *bidan* in the case-study villages has been a fairly short term experience, over the last 5-10 years only, many villagers are seeking traditional medicine rather than using costly transport options to seek biomedical assistance elsewhere. For example, if the *bidan* is not in her village, village women give birth with only a *dukun*, rather than summon a less (or un-) familiar *bidan* from the health centre. The provision of motorbikes to *bidan* by the HMHB project, while allowing the *bidan* to cover her area of responsibility more effectively, has paradoxically enabled her to leave the villages more easily. For some *bidan*, having a motorbike means being able to leave the village on weekends or at other times for personal reasons.

Nila demonstrates the coexistence of two health systems in the village: one which is sanctioned by government and international health bodies, and the other which is generated and sustained at a local level. These two systems have coexisted and interacted for a long period of time, with the official health system demarcating what is acceptable and appropriate health behaviour, and what lies outside this. Health personnel are usually involved in both systems, through their work as well as their personal lives, but they may prefer to align themselves with one or the other system. By allying herself with the government health system, Nila achieves respect and authority in the village where she works, as a representative of the government. However, by also allying herself with the local health system, she is able to stand apart from the government system which controls and limits her authority.

**Housing the bidan: the polindes**

I pull my thin mattress away from the corner of the bedroom wall, and roll up the red carpet square beneath it (figure 6.5). I do this every week or so, to clean away the snaking film of sawdust produced by the termites that seem to riddle the
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polindes in Waangu-angu. The midwife’s house was only rebuilt a few years ago, stone on the outside but inner walls of wood. Termites build tracks all over the place: above the wardrobe, in the eaves, and on the wall that separates the living room from the small clinic. I ask the bidan how we can remove them, but she shrugs: they are inevitable. Soon the polindes, so painstakingly renovated by the HMHB project, will be falling down again. ‘There is another polindes in this subdistrict, near the sea’ she tells me. ‘It is only built with stone half-way up. The wooden section at the top is already starting to fall down because of the termites. That was also rebuilt by the project.’ Questioning the HMHB project team about this problem at a later stage, I am met by another shrug of the shoulders. Termites, it seems, are one of the building hazards around here: ensuring that no wooden-built infrastructure is sustainable.

I share the small bedroom with the bidan, two mattresses on the floor and a small wardrobe in one corner. The spare room, next door, is half the size, and sometimes visitors – like the bidan’s mother, or her boyfriend, stay with us overnight. The bedroom doors open to a living/kitchen area with a shiny, concrete floor that is frequently traversed by trails of small red ants. The bathroom is at the back, a dark room with a slippery floor, a toilet, a bak (tub of water) and usually a pile of dirty dishes. There is no fridge in the kitchen, so the bidan puts her vegetables under a small table covered with a cloth. ‘This is my fridge’ she says, laughing. She wants to buy a fridge, but she is still paying off her bright red motorbike, which is kept in the capital city of Baubau, twenty six kilometres away. The front of the polindes contains two rooms: one to entertain visitors, furnished with a group of red plastic chairs. Charts and pictures cover the walls of that room and the clinic, put up by the previous bidan, with information about the local area interspersed with health and childbirth statistics. The clinic itself is barely the size of our bedroom; with a bed at one end, covered in white sheets, a wooden desk, medicine chest, and hard wooden chair. All of the furniture is stamped with ‘AusAID’, ‘DepKes’ (The Indonesian Department of Health) and ‘HMHB’ (The Healthy Mothers Healthy Babies Project) (see figures 6.6, 6.7).

Outside, the polindes is surrounded by a stone fence, covered in concrete and painted white, like the polindes, to keep the wild pigs from the forest from rooting
around in the vegetable garden. Frustratingly, there is no door to access the nearby communal well, so the bidan fetches well water and passes it across the fence to me, and I navigate the slippery path into the house with the heavy bucket. The trees, and veranda, at the front of the polindes, are a popular place for children to play, climbing in the trees or sitting on the wooden bench out front and singing songs. Located on the main road, next to the well, and between two small shops (kios) I entertain myself with the sight of a large number of villagers passing every day, especially to bathe and collect water in the early morning and early evening. This becomes important when the bidan is less and less in the village, and I spend much of my time there alone.

One of the HMHB project strategies aimed to increase the desire of bidan to live in villages by upgrading a number of midwives’ houses or polindes (also translated as ‘birthing hut’, although rarely used for this purpose). Hull et al (1998: 4) have noted the variability in quality of midwife’s house construction across a number of provinces in Eastern Indonesia, from poor constructions described as ‘chicken houses’ in Maluku Province to well-built polindes using voluntary village labour in NTT (Nusa Tenggara Timur). The midwife’s house in Waangu-angu was upgraded by HMHB, and this was an incentive for one midwife to live there. Although she previously lived in a villager’s house, she was able to relocate to the midwife’s house with her husband and small children, once it had been renovated. The midwife’s house in Linomoiyo (figure 6.8) was not upgraded, despite requests by the bidan to the project and the district Health Department to do so.

Rather than a site of healing, or government service, the polindes in Linomoiyo appears as a deserted eyesore: with peeling posters, uncut grass, and a broken septic tank out the back. After living in the polindes in Waangu-angu, I was surprised by the overgrown garden and unswept floors of the polindes in Linomoiyo. The bedrooms were tiny: the bidan had, at one point, divided one small room into two. ‘And the toilet is broken,’ she told me, gesturing to it. ‘The top of the septic tank has collapsed. I have told the village head, but so far it hasn’t been fixed.’ Even the posters and stickers, displayed on the walls, showed yellowing with age: it was certainly not displaying the latest materials from the
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Health Department. While in Waangu-angu people showed great pride in their polindes, particularly in its renovation, the polindes in Linomoiyo was shabby, and located on the edge of town, far from most of the houses. When she visited now, the bidan preferred to stay in a neighbour’s house, and the empty polindes was broken into at least once while I was living in Linomoiyo.

Although the polindes in Waangu-angu was upgraded by the HMHB project, and a number of other polindes have been upgraded independently by the Health Department, the polindes is generally viewed as a village structure, with responsibility for maintenance resting with villagers themselves. Hull et al. (1998: 8) describe it as such: ‘The construction of a polindes depends on... funding from the [Health Department]... and provision of land and/or labour by the community’. Bidan live in the polindes free of charge. Villagers provide for the bidan in other ways too, such as food. One evening the bidan was given a large bunch of corn during the corn harvest. ‘The villagers are happy that I am here to help them,’ the bidan explained to me. ‘So they give me food.’ Dukun are not provided for in the same way in the village: as villagers themselves, they provide their own housing. ‘I built this house myself,’ one dukun in Waangu-angu told me proudly. The burden of much government work at the village level falls to the voluntary labour contributions of villagers themselves: as is also the case with many aid projects. This assistance to the bidan marks her as an outsider, and as a representative of the government.

**Traditional or village healers: the dukun**

Classifying healers such as dukun as ‘traditional healer’ reflects a ‘traditional-modern’ dichotomy that suggests that dukun practice is outmoded or old-fashioned. Certainly this is how they are portrayed by the Indonesian state, which views dukun practices as at best ignorant, at worst dangerous to the health of those they assist (see Whittaker 2002). Health Department officials and city dwellers depict these healing practices as ineffective and external to ‘modern’ biomedical practice. Classifying such healers as ‘village’ healers has similar connotations, since by definition villages are far from the ‘modern’ cities and centres of development and modern health practice. This localisation also
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dismisses the perceived impact of such practices. In reality, people will travel a long distance to seek out a healer seen as more effective or powerful. For example, one dukun in Linomoiyo travelled all around the district to assist people with childbirth. As Pigg (1995) notes, dukun and other (mostly) women in the non-Western world who attend childbirth are all classified as ‘traditional birth attendants’ or TBA, in the world of international development. Such a term denies the complexity of their functions and the difference in their roles according to local social and cultural factors. TBA is used by HMHB and other projects to describe dukun. This term fails to recognise the range of healing services provided by the dukun.

Dukun is used to refer to a variety of healers, ritual practitioners and midwives in Waangu-angu and Linomoiyo, however their local languages delineate between these different healers and their roles in providing various healing services. Osando refers to a female midwife and traditional healer in Tolaki language in Linomoiyo, while bisa is used in Wakaokili. For the purposes of comparison, however, I use the term dukun, since this term is commonly used in both villages. Other texts discussing dukun (such as Geertz 1964) have used this term to refer to male practitioners who are the equivalent of ‘sorcerers’. Dukun bayi (midwife) is used to delineate female healers who attend births. This term was not used where I did research, and female healers were more frequently called dukun than any male practitioners (such as ritual specialists).

I first met dukun Hana (pictured in figure 6.9) at the first birth I attended. I climbed the wooden ladder to the kitchen, where a hastily assembled curtain had been strung to conceal one corner. One woman pushed the curtain aside and gestured for me to enter. I sat to one side, near the head of the woman giving birth – Mina – while Hana sat at her feet, feeling every now and again as Mina pushed, her hands under the sarong that covered Mina from head to foot. Hana had discarded her sarong and was wearing a thin t-shirt and shorts. Her face and greying hair showed age, but the lines at the corners of her eyes revealed her cheerful personality. As Mina rested, Hana reached back to a spot on the wooden floor where she had left her cigarette, and began puffing away. Hana, and other older women, began to tell lewd stories, and graphic stories of quick births, long
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births, easy births, difficult births, laughing heartily at each tale. When the baby finally appeared, the mother and baby lay to one side while Hana, her assistants and I were all offered cups of sweet tea, the old women puffing on their cigarettes. Hana fixed up her top and retied her sarong before leaving, giving me a grin.

Hana has been a traditional healer (dukun) ‘since she was a girl’. She is now in her fifties, and is well-respected in the village. She is related to many people in the village, including a number of children and grandchildren. She performs a variety of functions in the village where she lives, and in surrounding areas where she is called to assist people. She is well known in a number of regions, through her family connections, as a competent and knowledgeable dukun. Apart from assisting with childbirth, she can perform a number of healing services such as traditional medicine, massage and spiritual healing. Dukun like Hana also perform particular rituals related to childbirth such as the burial of the placenta, and ceremonies for the newborn which are different for each ethnic group.

In the area of childbirth, the dukun is considered almost indispensable in the village, drawing on practical and spiritual knowledge of childbirth that has been passed down to her through generations. Hana learnt her skills from her dukun mother and other female relatives. Hana is one of a number of dukun in her village. She is usually referred to as a senior dukun, and is frequently called to attend births. Dukun are involved in the childbirth process from the time that a woman becomes pregnant, since dukun usually diagnose a pregnancy before the woman visits a bidan. During labour, Hana sits with a woman from the time she first feels labour pains, until well after she has given birth. By contrast, bidan like Nila prefer to come and go in the early stages of labour, and only stay during the actual delivery. In the postpartum period, dukun are supposed to visit the woman every day for forty days after the birth. In reality, this is an ideal rather than general practice. Hana visits postpartum women infrequently since she must work in the fields to support her family.

While dukun are well-respected for the services they provide, they are often required to do demanding work, such as attend the birth of a child in a distant field, with little remuneration for their services. Hana, and fellow dukun, do not appear to have any formal status in the village. They take no part in public ritual
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performances, only presiding over private rituals such as birth ceremonies. This is probably due to the fact that they are mostly women, since in both villages all official ritual specialists are men. As Parker (2005) notes, ceremonies performed by women are usually more low-key affairs than those performed by men, and women have a lower status in the village, including dukun (see also Jennaway 2002b). This is further discussed below. Both male ritual specialists and female dukun work with the spirit world. Dukun can be called on to remove spirits who are causing trouble, such as ritually bathing a pregnant woman who is thought to have been entered by an evil spirit or setan. They can move the path that spirits take so that people are not harmed by them. They can also ritually bathe people who have seen the ghost of a dead person (as discussed in Chapter Five).

One informal ranking system for dukun is by seniority, which relates to their age, as well as their experience in attending births. Hana is a senior dukun – a woman who is now a grandmother, with many years experience attending births. Dukun are selected to attend a birth on the basis of their seniority, and also their relatedness to the woman giving birth. Many times when Hana attended births, she was an aunt, mother-in-law or other close relative of the woman, and her child. This connection contrasts with the bidan, who is an outsider. The importance of the social relationship established between a dukun and a pregnant woman is noted by a number of researchers in Indonesia (for example Hay 2005; Niehof 1985). It is sometimes formalised in ritual (for example, at seven months, or at the marriage of the parents), although this did not occur in either of my field sites.

Dukun demonstrate their connection with the mother and child by using their bodies. A dukun in one village washed a newborn baby by placing it on her own, bare, outstretched legs, sarong pulled out of the way. The use of the body is contrasted with the bidan, who placed the baby in a basin to wash it. Bidan are pictured in government documents (like the one discussed above) wearing clean, crisp white uniforms and thus distancing themselves from the villagers and their basic, non-white clothing. In appearance, dukun look like villagers, bidan do not. This is reinforced by their respective social connections in the village, which are discussed below.
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Despite their characterisation by government, and aid documents, as practitioners of an outdated healing tradition, dukun practice has changed and adapted to new circumstances in many ways. One of these is the cutting of the umbilical cord. The first time I saw this done, in Waangu-angu, the elderly dukun pulled a pair of scissors out of a ‘kit’ that she explained had been provided by previous ‘training’, probably ten or fifteen years earlier. Nur’s family told me later that they used to use bamboo to cut the cord, ‘but we don’t do that anymore.’ In Linomoiyo, Hana smiled as she told me about how the dukun used to use her teeth to sever the umbilical cord. ‘If the cord is cut with teeth, then the child will be protected throughout its lifetime from metal – in knives and bullets. That doesn’t happen if the cord is cut with metal. It is a type of ilmu (magical knowledge).’ Hana made a face at the idea of biting the cord. ‘I could never do that,’ she laughed. In cutting the umbilical cord the dukun also invokes Islam, not only local tradition. Before the cord is cut, it is tied in four places with string. Three of these ties are left on the piece still connected to the baby if it is a boy, two for a girl. This is an Islamic practice, Hana explained. Projects like HMHB, then, are just another step in a long road of changing dukun practice, where some sense of tradition is maintained, while ‘modern’ practices are also adopted.

The dukun, the state and the HMHB project

During the six year implementation period of the AusAID Healthy Mothers Healthy Babies Project (HMHB) (1998-2004), a number of dukun were trained in non-clinical skills. Unlike earlier dukun training, which focused on practical aspects such as hygiene and neonatal care, HMHB training had an explicitly non-clinical focus, in order to discourage dukun from attending births on their own. Instead, this training was designed to encourage dukun to work with bidan in attending births, as their assistants. Dukun did not discuss the usefulness of this training, but some dukun expressed an interest to me in obtaining clinical equipment to use when assisting in childbirth, such as scissors and disposable gloves. Dukun assessment of their own needs included clinical equipment and the assistance of a bidan when there were biomedical complications in a birth.
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These training sessions featured a one-way dispersal of information, with the bidan, on behalf of the government health system, providing all the information. Any recognition of dukun knowledge was limited to ‘mixing herbs’ and assisting the bidan. The discussion of one training session below demonstrates that messages tended to focus on dukun practices around childbirth that were considered ‘harmful’ or ‘dangerous’, consistent with other literature on the Indonesian government health system (such as Cholil et al. 1998). Dukun are divided by the Indonesian government health system into two categories, those who have been trained, and those who are untrained (dukun terlatih, dukun tidak terlatih) (Hull et al. 1998: 5). The basis for this evaluation is government-based training, rather than the more informal apprenticeship that dukun undergo in villages. Even where there are efforts on the part of health projects to respect traditional health practices, this is difficult to achieve in practice since ‘the explicit aim of these [projects] is to alter [traditional practice]’ (Pigg 1995: 48).

Some dukun who had attended previous government-based training did not consider the HMHB training to be necessary. This included the woman discussed above, who was in her late sixties, and had been trained in clinical skills a number of years ago where she was provided with a ‘kit’ with scissors and other implements (see also Hunter 1996b: 180). Hana had never attended any government training, a fact which she announced with some pride. She joked that she had not attended training because the health centre forbade cigarette smoking inside the building. In proffering this explanation, she did not challenge the knowledge provided by the training, or the authority of the project. Other, younger, dukun welcomed the new role that this training gave them, such as in delivering health messages at the monthly outreach clinic (posyandu) and women’s savings collectives (arisan).

Dukun were also provided with special t-shirts by the HMHB project, which contain the slogan ‘Kemitraan Bidan-Dukun Bayi’ (Partnership of Government Midwives and Traditional Midwives), using project-derived terms (Fig 6.10). ‘Kemitraan’, meaning partnership, is not a commonly used term in the village. The t-shirts depict a young bidan dressed neatly in a white uniform, sharing a bench with an older, traditionally dressed dukun. This image seems to have been
appropriated from the picture described at the start of this chapter. A photo
caption in the same document on the ‘Mother Friendly Movement’ reflects the
project title: ‘Healthy Mother, Healthy Baby’ (Cholil et al. 1998: 92). Below the
cartoon on the t-shirt is the project name, and the symbols for the Indonesian
Health Department and for AusAID. Like the chairs, desks and medicine cabinets
stamped with the project logos, the dukun is also branded by the project. The t-
shirt was supposed to be worn by all dukun at the outreach clinic (posyandu),
which they were all supposed to attend (despite not having a clearly defined role
there). In reality, the t-shirts were rarely worn and I saw one dukun’s husband
wearing one. This demonstrates one impact of the project at a village level as a
source of clothing, in a similar way to the political campaigns provision of t-shirts
to all who attended rallies. Political party t-shirts were commonly seen in both
villages, particularly since 2004 was an election year.

Dukun practice in attending births contrasts strikingly with the instructions and
visual examples provided by HMHB and the Indonesian Health Department. Even
those who attend HMHB training sessions often put little, if any of the
recommendations into practice. One dukun, after attending a training session only
a few weeks earlier, continued to use her own knowledge of birth attendance
when attending a birth in the village: bathing the baby before giving it to the
mother to breast-feed, for example. One concept, promoted by HMHB and the
Health Department, that all dukun do seem to agree upon in principle is the
important role of the bidan in attending births, particularly if there is post-partum
haemorrhaging.

The lack of support of traditional healing practice by Indonesian government
health workers has ensured that dukun are marginal to government health practice.
Bilateral aid projects enhance this marginality by only providing ‘non-clinical’
training. Assigned to the role of assistant, dukun are made secondary to the bidan
in childbirth practice, which reduces their authority. By engaging with Health
Department activities the dukun becomes part of a hierarchy of health practice
where they are firmly positioned at the bottom (see also Hunter 1996a; Whittaker
2002). Dukun were conscious of the downgrading of their healing practice. One
dukun told me, after a birth: ‘[The mother] can’t breastfeed yet, so we’re going to
Village healers, government midwives get her sister-in-law to breastfeed the baby. It’s called *pinjam tete*. You don’t do that where you come from, do you?’ Hana said ‘[The health staff] call me the best *dukun*, but they don’t pay attention to what I want, they don’t give me medicines.’ At the monthly health clinic (*posyandu*), *dukun* are generally ignored, along with other village women. Health centre (*puskesmas*) staff give more attention to the health volunteers (*kader posyandu*) at *posyandu* than to the *dukun*, although *kader* may not have an important status in the village itself.

*Training of dukun and health volunteers by bidan*

HMHB training of *dukun* and health volunteers (*kader posyandu*) was conducted by *bidan*, who were initially trained at the subdistrict health centre. This training reflected a one-way vertical distribution of information and instruction in a top-down direction. The attitude of the *bidan* towards local knowledge and healing practice was therefore important to the approach they took when training *dukun* and *kader*. I observed two training sessions, one with *bidan* and *dukun*, and the other with *bidan* and *kader*. Each session was held for one day – from 8:30am until 1pm. *Dukun* and *kader* participants were all remunerated for their attendance at training sessions, and provided with lunch. One *dukun* and one *kader* attended from each of the ten villages in the area of responsibility for the two *bidan* who conducted the training.

The *dukun* training session started an hour and a half late because three of the *dukun* had not arrived. One *bidan* had to return to some of the villages she was responsible for on her motorbike and bring the latecomers back with her. Both *bidan* were visibly annoyed by this lack of commitment to the training demonstrated by these *dukun*. At least half of the *dukun* were wearing the purple partnership t-shirts provided by the project. *Dukun* were quiet, and showed little knowledge of project messages such as giving the infant Hepatitis B injections within twenty four hours of the birth, breastfeeding for 6 months with no supplementary food, or the husband involvement campaign (*suami siaga*). As Laderman (1983) also notes, *dukun* are markedly more confident and outspoken in their local communities than in training by the Health Department. *Dukun* are generally assumed to have low literacy (although this was not discussed at the
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training session). Training activities, therefore, used cartoon-style pictures to communicate project-endorsed roles for the *dukun*.

In the first activity, *bidan* and *dukun* sat together on the floor and had to assign certain picture cards, which depicted the pregnancy and birth process, to either the responsibility of the *bidan*, the *dukun*, or both together. The implementation of this project training undermined the idea of equality that was part of the project design. Instead of working together, the two *bidan* decided between themselves where the cards went, and then told the *dukun*. The *bidan* found it difficult to remember which cards went where, in terms of the information that they had been given from the health centre. In the end the *bidan* allocated most of the cards to themselves, or to the *dukun* and *bidan* working together. The two allocated just to the *dukun* indicated the following: the *dukun* mixing herbs, and the *dukun* referring the pregnant woman to the *bidan*. This role was a benign one, to control the perceived ‘dangerous’ nature of *dukun* practices (see Kleinman 1980; Whittaker 2002). It distanced the *dukun* from the childbirth process, negated her knowledge and her authority. No picture cards showed the typical activities of the *dukun* as I observed them, such as chanting prayers, massage, burying the placenta or any other of their many activities. Although this was a ‘refresher’ training session, *dukun* showed little interest or engagement with the activity.

Another activity involved the picture cards again, which showed project-endorsed behaviour during the childbirth process. They included such messages as:

- You must cut the umbilical cord before the placenta is expelled
- Establish breast-feeding immediately, before the placenta is expelled
- There must always be a *bidan* at a birth. If there is no *bidan* in the village, call one at the health centre
- *Dukun* must attend the monthly outreach clinic (*posyandu*)
- You are not allowed to wet-nurse anymore (*pinjam tete*)

The *bidan* explained that the aim of the training was to reduce the incidence of infant and maternal death. In the final part of the training, a HMHB project car
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arrived with project staff and the head of the subdistrict health centre. One of the
Indonesian project staff gave a long speech to the dukun on various project
messages, while the assembled dukun listened.

Throughout this entire training session, the dukun ‘learnt’ while the bidan ‘taught’.
There was no exchange of information or consideration of what the dukun already
knew. Dukun knowledge (that wasn’t produced by the project or the Health
Department) was not considered relevant by the bidan. Many of the project
messages were expressed in terms of rules: what they were and weren’t ‘allowed’
to do. In practice, dukun did not observe most of these messages. The most widely
supported message was for dukun and bidan to attend births together. As observed
above, dukun did not generally attend the monthly outreach clinic (posyandu)
because they had no formal role there. Sometimes dukun would attend the
outreach clinic as a member of the community, but their knowledge and healing
practice was not seen as appropriate in that forum. By engaging with Health
Department activities the dukun becomes part of a hierarchy of health practice
where they are firmly positioned at the bottom.

The next day, training was conducted with bidan and health volunteers (kader
posyandu). The kader used HMHB and Health Department books, and took notes.
Again, the training was conducted by bidan. Kader tend to be younger overall
(between 20s and 40s) than dukun (who are closer to 40s-60s), and almost all
wore their white kader t-shirts that had been provided by the Health Department.
Kader were generally more aware of project messages and more willing to speak
up. In one activity, kader formed two groups and wrote down the main points
from HMHB brochures onto large sheets of paper. Another activity was a
discussion of project messages, some of which show a clear bias to a Western
ideal of childbirth, which is often used as a model for Indonesian childbirth
practice. For example, the message that breastfeeding increases the mother/baby
bond suggests that women do not have other ways of becoming close to their
children. It reflects an ideal where the mother is the primary carer, and ignores the
social bonds that the baby will have with other members of their family and the
community. Other messages, such as women washing their hands and breasts
before breastfeeding, are impractical at a village level. In any case, kader have no
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formal role during the childbirth process at the village level, except as members of the community. This is in contrast with the key role played by the dukun. The only formal role of kader is at the monthly outreach clinic. The final activity of the training session involved instructions on giving health education messages to women at the outreach clinic. A team from the HMHB project (the driver, an Indonesian team member and the subdistrict head) arrived as they were finishing the training session. Far from being criticised for their lateness, the team were invited to share the lunch.

During health volunteer training the bidan introduced a number of new vocabulary terms which were unfamiliar to the women and not used in the village. They included the acronyms ‘PUS’ and ‘WUS’. The first time the bidan referred to these terms, the kader present looked quite confused. ‘This means pasangan usia subur, or a married woman of childbearing age,’ she explained. ‘WUS’ meant wanita usia subur, which was a single woman of childbearing age. These terms come from the National Family Planning Board, BKKBN. The bidan got the women to repeat the meanings, and then asked ‘now, what terms do we want to use?’, prompting them to reply ‘PUS’ and ‘WUS’. At the village level, terms like this are not used, nor are they familiar. Use of such complex terms and acronyms to refer to concepts which are easily explainable using common language, suggests a hierarchy of terms which subordinates local knowledge and makes it difficult for villagers to engage meaningfully with the state health system.

Comparing dukun and bidan practice

For the dukun in Southeast Sulawesi, healing practice is an integral part of her identity and relationship with others in the village. A dukun can be called upon at any time, day and night, and remuneration for her services is often nominal or symbolic. The dukun has an important position in rural society as a powerful figure who can summon spiritual authority and heal people. She is related to many of her clients, who explicitly use this familial connection to seek her services (see also Grace 1996: 151). She is descended from a family of dukun, thus in some ways her practice can be classified as a ‘calling’. This is common to other parts of Indonesia, such as Madura (see Niehof 1985: 250). She is trained by
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elders of that dukun family in a form of apprenticeship, although it may not be as formal as the apprenticeship of traditional midwives in Malaysia described by Laderman (1983: 115-9).

In the area of childbirth, dukun and bidan are entrusted with the responsibility of ensuring the wellbeing of the mother and child. While spiritual and traditional medicine practices are known by a number of people in the village, dukun are set apart by the extent of their knowledge and experience (Hay 2005). A dukun must be skilful in wielding spiritual power to help their clients (Slamet-Velsink 1996). When attending births, dukun use their spiritual knowledge and experience to ensure the spiritual and physical health of the woman and her child. Grace argues that dukun ‘speak the same language, literally and metaphorically’ as their clients (1996: 164), offering reassurance to the woman giving birth on a number of levels, in a way that cannot be duplicated by the bidan.

In any one village, there will be a number of dukun, all resident in that village, while one bidan may service six or more villages, depending on population density and availability of bidan. Bidan services are often sought, particularly for biomedical treatments and birth attendance, but difficult to access: since bidan are not always resident in villages, and must spread their services over a large area and number of patients. Bidan services are also more expensive than dukun services: unless villagers hold a kartu miskin (health card for villagers who are below the poverty line), they must pay for medications and between Rp 50,000 and 200,000 (~AU$10-$40) for a bidan to attend a birth. The head of the puskesmas in Asera subdistrict, which includes the village of Linomoiyo, said that around 80% of households in Asera subdistrict are eligible for kartu miskin. Whether they receive one or not is another issue, since most villagers in Linomoiyo did not have a current kartu miskin and were unsure when they would next receive one from the health centre.

Dukun are both more plentiful and accessible in villages than bidan, and their services cost little or nothing, in terms of financial outlay. As reflected above, dukun are usually sought on the basis of their family connection with the patient, thus while a transaction with a bidan is primarily financial, seeking the services of a dukun is chiefly a social and familial transaction. By seeking her services, the
patient bestows importance on the abilities of the chosen *dukun*, while at the same time creating a sense of obligation towards the *dukun*. Since these obligations are contained within families, assistance to a *dukun* may be seen as merely an extension of familial obligations themselves. Such relationships would be significantly altered if the *dukun* started behaving like a *bidan*, travelling to an area where she was not related to any inhabitants, and charging a monetary fee for her services. *Dukun* practice, therefore, reflects broader relationships within the village community, as well as enacting local health knowledge.

The *dukun* retains her identity as a healer in much of her life, coming from a family of healers. Her personal identity is important in a number of ways in her healing practice, contributing to relations with family, as well as a local reputation as a competent healer. The *bidan* is able to separate parts of her life while in the city or in training, but in the village she is the *bidan*, addressed as such, and called on at all hours in the midwife’s house, where she lives and practices. The ideals and practice of village health are embodied in the *dukun*, and her healing practice reflects the strength and authority of local health practice within the village (see also Whittaker 1999). The *bidan* embodies the government health system and the authority of the government in the village. However the identities of both healers are ambiguous, since they are affected by both the authority of the state and the local community where they live.

**Authority, knowledge and the gendered dimension of healing**

In addition to the *dukun*, there are a number of other people in rural villages who provide healing services of various kinds. These include bone setters and masseurs, as well as Islamic religious leaders (*imam*), male ritual specialists (also sometimes called *dukun*) and people who are knowledgeable about healing (called *kabantu* in Wakaokili language). Both *imam* and ritual specialists are men, and their healing practice is mainly in the area of spiritual healing, often pertaining to public ritual ceremonies. *Imam* practice and authority relates to the Islamic faith, and their healing consists of Islamic rituals, such as the chanting of prayers, blessing of water, or warding off evil spirits using their authority as representatives of Islam. While *dukun* also use Islamic prayers in their healing,
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_imam_ are often seen as more effective healers in the area of spiritual healing. Men usually have no official healing role at birth (except for a few male _dukun_), however, until the time of a birth ceremony or haircutting ceremony, some days after a birth has taken place. The exclusion of men from birth practice allows _dukun_ — and _bidan_ — to play a much more important role than on other occasions in villages.

Men officiate at all public ceremonies, while ceremonies where female _dukun_ officiate are generally hidden from view (such as births and the Tolaki birth ceremony _mesosambakai_). In Islamic ceremonies, _imam_ officiate, while all those present wear the appropriate dress. In other ceremonies where (male) ritual specialists officiate, dress is also important as a reflection of the status, and public nature, of the ceremony. While ritual specialists are generally chosen for their knowledge of ceremonial practice and formal language, as well as seniority (usually in age) in the community, they also practice spiritual healing in these ceremonies by protecting the participants from ancestral spirits who are attracted to them. ‘The ritual specialist is there to make sure everything is done right,’ the Linomoiyo village head explains. ‘These ceremonies are times of great danger, so he protects us. That is why we use water [in the ceremonies].’ Hence male spiritual healing practice demonstrates the connection between healing, religion and spiritual belief, more publicly and explicitly than the practice of female _dukun_.

Male healers have a number of important statuses in the village where they live, which conflate in their status as healers and ritual specialists; while for female _dukun_ this is their only official status in villages. This reflects the gendered division of roles in both Tolaki and Butonese society: where women rarely hold ritually or socially significant positions, external to that of the government (such as the _bidan_).

_Dukun_ and _bidan_ both hold ambiguous authority in the village: their position as healers makes them often more highly regarded than other women, but compared to men, they have limited authority outside of the scope of their healing practice. As demonstrated above, women are kept in the background at official ceremonies, performing tasks such as cooking. They serve the men food before serving themselves, demonstrating the high status of men. In the government, too, they
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face a system that generally keeps women in lower positions – through the association with Dharma Wanita, for example, which ties a woman’s status to her husband’s position. Female bidan hold relatively junior positions in the Health Department, compared to the puskesmas head, a doctor, who is frequently a man. The aim of such government programs as PKK (Pembinaan / Pemberdayaan Kesejahteraan Keluarga – Family Welfare Movement) to produce women who are good mothers, wives and citizens, further reinforces the lower position of women within the Indonesian state (see Hunter 1996b: 171). Dukun and bidan both stand outside this, as healers, but also within it, as women. Although healing can be seen as an extension of women’s roles as carers and nurturers, it also enables female healers to have some authority in a system – local, and state – that otherwise regards women as relatively powerless.

Blurring the boundaries: old and new, dukun and bidan

Due to the government training of bidan, and her lack of local social connections, the bidan tends to promote a biomedical model of health in the village and is dismissive of local health practice as dangerous, outdated or ignorant. These views may not be so different from those that the bidan grew up with, if she came from a rural area with similar health practices. By moving to, or living in, cities (where bidan training is conducted), people attempt to demonstrate their rejection of rural lifestyles and embrace a type of modernity that consists of access to consumer goods, education and health services. In going back or ‘down’ to the villages, the bidan reflects those city sentiments back on the village (see also Grace 1996: 150). The most highly criticised village bidan tend to be those who are unsuccessful in assimilating into the community, rather than those who are inattentive to village health concerns (see Laderman 1983). Although the bidan does not always practice what she preaches, her attitude influences the way that she interacts with the dukun and other healers at the village level. While all bidan and dukun that I observed got along well on a daily basis, and cooperated in attending births, the bidan generally holds the attitude that her knowledge is superior to that of the dukun. The dukun for her part views the bidan as playing a valuable, but separate, role to that of the dukun. In her view the bidan can in no
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way replace the *dukun* since she is not knowledgeable about spiritual and herbal healing. The *dukun* needs the *bidan* for specific tasks, such as giving injections to women who haemorrhaged after giving birth. *Dukun* are aware that their knowledge and skills are downgraded in a government-sponsored discourse, however they do not perceive them in the same way themselves.

Tension between two health systems – local, and government - at the level of the village in Southeast Sulawesi, Indonesia, interact and conflict in the persons of the *dukun* and *bidan*. The Indonesian government promotes a hierarchical, power-laden health system in rural villages, which is reinforced by health centre staff, the *bidan* and projects like HMHB. The HMHB project has tried to increase the role of the *bidan* at the village level, particularly in attending births, and to sideline the *dukun*, reflecting Indonesian government and international health policy. This has been unsuccessful for a number of reasons, such as the unwillingness of *bidan* to live in villages, *bidan* training and other factors preventing her from attending births in the village. Some *dukun* have subverted the authority of the government and the project by not engaging with it, while others have enthusiastically taken up new roles. *Bidan* have also contested the authority of the government health system through their own practice in the village.

The picture presented in this chapter is somewhat more complicated than the photo described at the start would suggest. Far from representing the ‘old’ and the ‘new’, both in terms of age and their relevance to village health; both *dukun* and *bidan* are engaged in an ongoing process of demonstrating the relevance of their knowledge and healing practice to villages where they work. In rural villages of Indonesia both *dukun* and *bidan* healing practice continues to be called upon. The roles of the *dukun* and *bidan* reflect two different healing systems that are both practising at the local level. The *bidan* has attempted to make connections with the community, for example by selling pharmaceuticals. However the authority of the *bidan* in the village is based on her connection to the government health system, so she must appeal to ideas of modernity, complex jargon and state-sanctioned health behaviour. *Dukun* authority is based on her knowledge of spiritual healing, her position as one of a family of healers, the general support in
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the community for local concepts of health, and social and family connections at
the village level. The next chapter narrows my focus further, examining childbirth
practice at the village level, as part of a wider idea of health knowledge and
practice, looking how bidan and dukun engage with childbirth as well as the role
of village women themselves, and how the performance of childbirth is at once a
medical, a social and a cultural act that reproduces the community, and their
relationship with the state.
Figure 6.1 Dukun and bidan

Figure 6.2, 6.3 Bidan Nila
Figure 6.4 Waangu-angu *polindes*

Figure 6.5 *Polindes* wall showing termite damage
Figure 6.6, 6.7 Furniture with HMHB stamps

Figure 6.8 Linomoiyo *polindes*
Figure 6.9 *Dukun* Hana

Figure 6.10 *Dukun* t-shirt from HMHB
Chapter Seven
Childbirth, women and village-state relations

The house is full of people by the time I arrive. There are men out the front, standing or sitting in a huddle, smoking cigarettes. They look at me as I enter: the researcher who comes to watch births. Inside the house a number of people point the way to the kitchen. Past the piles of buckets and dishes, and then up a wooden ladder of a few steps. Tina is concealed behind a swathe of mosquito nets and hastily strung curtains. I smile as I enter; they must have been expecting me. One woman shifts so that I can sit down, tucked into a corner behind Tina’s head. Tina’s sister-in-law Niar is there, she is heavily pregnant and sitting on a wooden chest. The traditional midwife (dukun) is a woman I haven’t seen practicing before, but she was there at the project training. I wonder idly if she is going to put into practice any of the messages that were drilled into the women that day. She smiles at me, but faintly, she is an older woman that I haven’t spoken to, at least as far as I can remember. Usually it is the men who speak to me, who line up on the chairs in the village head’s house so they can tell me their opinions and become my instant friends. Tina is in fairly advanced labour, which, I suppose, is why there are so many people in the house. She is pushing almost constantly, back arched, bracing her hands behind her head against the chest which her sister-in-law Niar is sitting on. At one point the chest starts to move, so I, sitting beside it, brace it too. In that small act I suddenly feel that I have moved from observer to participant, feeling her strength as she pushes against the chest. Later women ask me if I was at Tina’s delivery. ‘Oh, yes, you delivered the baby!’ they joke.

Childbirth is part of village life. It is embedded in wider social and gendered relations in the village. It is also an event that mediates outside influences, such as that of the state. Giving birth fulfils a number of roles for women, for the rural villages of Southeast Sulawesi where they live, and for the Indonesian state. It is constituted in a particular social environment in these rural villages, requiring the participation of a large number of villagers. Childbirth reinforces the legitimacy of the local community, who assembles for each birth, to witness the arrival of a new member. It is a ritual allowing villagers to demonstrate the importance of
social ties and local knowledge. This social experience contests the desire of the state to have childbirth performed as a controlled practice, supervised by biomedically trained health personnel in a health facility that is far from the dangerous influences of local knowledge and non-biomedical health practice. Giving birth is a bodily experience of women, a display of their fertility which they explore through the process of pregnancy and birth. Women's pregnant bodies are conceptualised by villagers through a number of metaphors which relate to the behaviour of the pregnant woman and her husband. The passage of birth is likened to moving through a doorway or across a threshold. Indonesian women's bodies have been politicised by the family planning movement, which centres its efforts on female contraception in order to build a modern society where 'two children are enough' (dua anak cukup). Childbirth also reflects wider gender roles for women and the sexual division of labour. It is one of the key ways in which women contribute to village society, transforming them from girls to women, and allowing them to participate fully in village society as adults (see also Niehof 1987). Being good wives and mothers is further invoked by the Indonesian state as a duty of women, along with being good citizens. These roles are enacted through the essentially compulsory participation of all married women in the Family Welfare Movement (PKK), whose hierarchical structure reaches down from the central government to the household level. In each of these three ways: as a social experience, a bodily experience, and a gender role; village experiences are contested by external influences – by the Indonesian state and projects like Healthy Mothers Healthy Babies (HMHB) – which seek to introduce their own ideas about the appropriate way that childbirth is performed in rural villages.

Laderman (1983) provides a comprehensive model for the analysis of childbirth in non-urban areas of Malaysia. The proximity of her study, and the many similarities in demographic factors, with my field sites makes it a useful comparison to my analysis of childbirth. She argues that any analysis of childbirth ‘must include investigation into sex roles, rules of marriage and divorce, and the status and training of childbirth attendants, as well as the medical system of which these practices are a part’ (Laderman 1983: 1). I also take the 'ethnomedical' model used by Raftos (1999), analysing health beliefs and childbirth practice
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within their wider social, cultural and symbolic contexts. This chapter explores the social and bodily aspects of childbirth, and how it can be seen as part of women’s gendered social roles; in the context of assertions of local knowledge in traditional childbirth practice, and the role and implications of biomedical interventions promoted by state and international influences. By giving birth, village women negotiate these two healing systems, to enact their own aspirations as mothers and modern citizens.

Childbirth as a social experience

The day that Mina gave birth is a good example of how birth is experienced in villages in a particular social environment, and demonstrates the variety of roles played by different villagers during the birth process. A large number of people attended this daytime birth of Mina’s fifth child: both men and women, children and adults, relatives and neighbours, the dukun and her assistants.

The village head’s wife accompanied me to Mina’s house but left soon after: she didn’t like attending births, since she often fainted. A number of men, including Mina’s husband, sat in the front room or outside the curtained area, in the kitchen. Inside the curtained area where Mina was giving birth were a number of women and children. Others watched from gaps in the curtain outside. Three older women surrounded Mina: dukun Hana sitting at her feet, another woman placing her hands on Mina’s stomach, while a third braced Mina’s knee against her pushing. Hana held her hands out under the sarong, between her legs, to feel for the baby, and gave instructions about when to push. In between contractions, Hana reached back for her burning cigarette, which was sitting on the floor behind her. The children watching moved restlessly the whole time. One boy of about five observed, wide-eyed, while clutching a packet of biscuits.

About an hour after I arrived the baby suddenly appeared. It happened really quickly, Hana scrambling to turn it around. Suddenly a number of women appeared, holding the curtains shut and yelling at all the children to leave. This is a time of high stress, when a mother may die from excessive bleeding if the placenta is not expelled. Hana placed the baby between the mother’s legs as the
other two women massaged the placenta out and Hana held onto the umbilical cord. It took them less than five minutes. Immediately the placenta had been born the women tied a piece of green cloth around the mother’s stomach. Women then started to reappear, to have a look at the baby. The mother was still lying down, her legs straightened. Men started to appear too, to have a look. The baby was wrapped along with the placenta in a sarong and placed on a large round tray by Hana. Some black thread was prepared for the umbilical cord by one of the women helpers, who looped it over a toe a number of times and then twisted it together to form a cord, rolling it across her legs. At this point everyone had a rest. Tea and coffee was made and coffee, and later milk, was brought to the mother, as well as some water that she was fed with a spoon. Everyone chatted and women – especially older women – made jokes about childbirth experiences. A number of older women smoked, including Hana.

The baby’s grandmother stood outside the house, at the entrance to the kitchen. She was sick so she didn’t come inside during the delivery. The husband could now be seen wandering around, and the curtains were folded back. It was really noisy with everyone talking, smoking, children crying, just the mother and baby lying there quietly side by side. A razorblade (silet), still in its paper wrapper, was brought and soaked in a bowl of hot water. Hana sat the baby on her legs and tied the umbilical cord in a number of places with the black cord. She pushed the contents of the umbilical cord back a bit from the placenta to the baby. She cut the ends of the thread with the razorblade, then soaked it again. One of the assistants fetched a small coin, which Hana soaked in the water and then held below the umbilical cord while she cut it. After cutting the cord (about 10cm long left) Hana wiped the placenta end of the cord on the baby’s belly button, leaving a smear of blood. Then she wrapped the baby tightly in a new sarong, and placed it on a fresh sarong on the woven tray again. The placenta was wrapped up again in the sarong it had shared with the baby, and placed in a black plastic basin.

Mina’s husband brought a bunch of special leaves (daun ta’umo – a leaf used in traditional medicine) and I was ushered downstairs so that the mother could bathe in warm water infused with the leaves. Mina’s male relatives kept me entertained in the front room, asking me numerous questions. After about half an hour I asked
to go back up to see the baby being bathed. Hana unwrapped the baby and held it on her legs to wash it. She wrapped the baby up again tightly in a fresh sarong and this time placed it on a mattress on the floor. Not long after this Mina held the baby on her lap and began to breastfeed it. When I left a number of women were preparing an *ayun* (hanging cradle) for the baby.

In Southeast Sulawesi, a large number of community members take part in any reproductive process. This period begins when pregnancy is confirmed (2-3 months after conception), and ends with the post-partum period of roughly between two weeks and forty days (see Niehof 1985). The childbirth process typically involves a large number of relatives, particularly sisters, sisters-in-law, mothers, mothers-in-law, and daughters of a sufficient age to assist with household tasks. Many of these relatives will help a woman during her pregnancy with cooking, washing and fetching water, although this is more likely to occur towards the end of a pregnancy. Women in Waangu-angu described their pride in being able to work up until the later stages of pregnancy. A number of older women in Linomoiyo, including a *dukun*, described their ease of giving birth and continuously working during their pregnancies. ‘I went to the well to fetch water’ the *dukun* said, ‘and I had the baby on the way.’

During labour a number of women, who are related to the birth mother, attend and support her. This mainly includes older women and other women of a similar age. Children do not have any role in the childbirth process, although they are often observers. More distantly related women, including neighbours, visit women while giving birth in Linomoiyo. They are not as closely involved, especially when the woman has a large extended family. A survey conducted in both Linomoiyo and Waangu-angu covering births that had occurred over the period 1999-2004 suggests that births are attended by a variety of people: including government midwives (*bidan*), traditional midwives (*dukun*), husbands, family members and neighbours (see Table 7.1). This data supports my observations of a number of births during 2004.
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Table 7.1:
Attendance at births by bidan, dukun, family members, neighbours

<table>
<thead>
<tr>
<th></th>
<th>Waangu-angu (total: 28)</th>
<th>Linomoiyo (total: 21)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bidan</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>43%</td>
<td>57%</td>
</tr>
<tr>
<td>Dukun</td>
<td>27</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>96%</td>
<td>86%</td>
</tr>
<tr>
<td>Husband</td>
<td>27</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>96%</td>
<td>76%</td>
</tr>
<tr>
<td>Family</td>
<td>21</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>75%</td>
<td>76%</td>
</tr>
<tr>
<td>Others (eg neighbours)</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>20%</td>
<td>76%</td>
</tr>
</tbody>
</table>

In Linomoiyo the house where labour occurs must be lively, ‘like a party’ during the time of labour. It is a quieter affair, for practical reasons, if the birth takes place late at night. The mother and mother-in-law of the woman giving birth have an important role, particularly after she has given birth. They are often the first to hold the baby after it has been washed by the dukun. Men and children are usually placed some distance from the site of the birth. Children have a more ambiguous status than men: they are allowed to watch, but chased away during the period when the placenta is expelled. Men tend to stay in another room – usually at the front of the house – talking and smoking while labour is in progress. When asked for the survey, some women reported that their husbands were ‘off in the forest’ while they were giving birth. Other women commented that the husband was ‘now by their side’ when giving birth, comparing this to earlier periods of time when men had been absent. However, although the husband plays an important role when his wife gives birth he is usually not present during the actual period of time when she is giving birth.

Throughout the pregnancy and birth process, the husband plays an important role. While his wife is pregnant, a man should not kill animals for sport, lest his unborn child are born with the injury that he inflicted on the animal. During the birth itself, the husband usually sees the baby after it and the placenta have been born.
In the post-partum period, a husband’s role takes the more practical focus of looking after his wife (buying food and so on), although in practice this is performed by a large number of relatives including the husband. Husbands performed a variety of roles in the two villages where I conducted research. In Waangu-angu one husband helped to prepare a coconut, removing the flesh, for the burial of the placenta. In Linomoiyo a husband bought food for his wife and guests (at the birth) at the local shop. In one case in Waangu-angu, a husband was the only person supporting his wife when she gave birth. This was quite an unusual case, however, as was made plain to me by villagers and the midwife. In Linomoiyo one husband was injured playing soccer and away from home while his wife gave birth. The role of the husband is not fixed, so in that respect they cannot be seen as playing a key role in the birth process.

While birth is a social experience, it is not a public performance. At a number of public ceremonies, including hair-cutting ceremonies and funerals, I was encouraged to bring my camera, and ushered to the front to get a better look. At births, however, cameras were seen as inappropriate and intrusive. When I brought one, to a birth that turned out to be a false alarm, people looked at me, and the camera, with consternation and disapproval. Other women avoided having me attend their births by not informing me until after the event, or even, in one case, lying about their labour pains. Instead, located in the family home, and surrounded by relatives and neighbours, the woman giving birth reinforces familial and village ties. In this way, birth can be seen as a ritual: requiring the assembly of a large number of members of a village, it demonstrates to them the importance of the village as a social entity, and the validity of local knowledge. Birth in a health centre can be seen to do the same thing for the medical profession: the rituals, personnel and biomedical knowledge of a hospital birth reinforces the value of modern, biomedical ideals (see Davis-Floyd 1994).

**Role of the dukun and bidan at births**

The role of the *dukun* and the *bidan* was extensively discussed in the previous chapter, so here I will just highlight some aspects of their work in relationship to birth practice. The *dukun* attends a large number of births. According to the
survey (in table 7.1), the dukun was present at approximately 90% of the births of respondents during the last five years (1999-2004). When a dukun was not present, this was often because another family member who had similar skills to a dukun attended. This is in comparison to the bidan, who attended around 50% of births surveyed (43% in Waangu-angu, 57% in Linomoiyio), in the two villages. Although the dukun is considered almost indispensable in birth, she does not work alone but in cooperation with a number of others, usually women. One important role in addition to the dukun is that of guiding the baby by placing their hands on the woman’s stomach during labour. A dukun in Linomoiyo explained to me the importance of the dukun and the person guiding the baby to work well together. In Masni’s case, detailed below, three different people were summoned before she found one that worked with her effectively. Childbirth practice necessarily extends to the community as a whole. The relatives and neighbours attending the birth have a role: if there is a problem, they can be summoned to seek help or provide advice or assistance. Dukun may also have limited time available to assist birthing women, particularly in the post-partum period. While they ostensibly visit a woman who has given birth a number of times in the post-partum period, many have other responsibilities: such as working in their fields (kebun) to support their families. As one elderly woman said to me, ‘My mother was a dukun but I didn’t want to become one. It is a lot of work: you can be called away at any time.’ In cases where dukun are unable to attend post-partum women, the responsibility falls to other villagers.

Women often visit a dukun first to determine whether they are pregnant, before they go to see a bidan. This is justified by village women because the woman is embarrassed (malu)\textsuperscript{14} to see a bidan. One reason for this may be the nature of bidan examinations, which are felt to be more intrusive, such as the example of buka sarung below. Usually a woman sees the bidan when she is around three months pregnant. The dukun protects a woman’s spiritual health, and is, for instance, able to ritually bathe her if she is in danger of being disturbed by evil spirits during her pregnancy. The dukun plays an important role during the labour process, ensuring the woman’s physical and spiritual safety at a time when she is

\textsuperscript{14}The word malu is ambiguous in its English translation, meaning shyness, embarrassment or shame.
Considered particularly vulnerable. A number of *dukun* expressed dislike at attending births without *bidan*. This included both those who had been involved in government training and those who had not. The reason for this was mainly due to fear of haemorrhaging. One *dukun* explained that there were two types of haemorrhaging, one that was caused by spirits – described as 'normal' or 'magical' – and another that could only be fixed by an 'injection' or a 'doctor'.

The *bidan* works more independently of villagers, since she is the only one considered by the government to be sufficiently trained in childbirth attendance. Women who described a *bidan* attending a birth said that she ‘*buka sarung*’ – ‘opened the sarong’ – and actively examined the women. They also said that the *bidan* dislikes other women being present when she attends births – except for the *dukun*. She thus challenges local childbirth practice on a number of levels: including the social and bodily experience of women giving birth. The *bidan* is not a local member of the community. Her status and her separation – physical (by frequently leaving the village) – and in other areas (in some cases, language) is apparent when she deals with the community during the childbirth process. When the *bidan* in Waangu-angu came to wash a baby after birth, the women sat to one side and did not participate in the process. They did not engage in the same way as when a *dukun* bathed the baby, working cooperatively to fetch and heat water. The *bidan* told the women what to do, implying a power relationship based on knowledge.

Moreover the biomedical knowledge of the *bidan* is not accessible to the women in the same way that the knowledge of the *dukun* is. *Dukun* knowledge is socially produced, within the community, and passed down through generations; whereas *bidan* knowledge is taught from above, by the state, which is inaccessible to the community due to its one-way interactions with the community. Development projects and the Indonesian state promote biomedical childbirth practice, distancing knowledge around childbirth from villagers; denying *dukun* clinical skills and discouraging anyone who has not been biomedically trained to attend births. The social roles that the *dukun* and other family members play are not encompassed by the current maternal mortality campaign. The *bidan* reflects this government perspective by limiting the number of people allowed in the
screened-off birth space, challenging the social experience of birth in villages. The attempt, by HMHB and other government campaigns, to relocate births to an impersonal *polindes* (midwife’s house), *puskesmas* (health centre) or hospital further disengages the birth process from the community.

According to the maternal mortality campaign (which the HMHB project supported), the mother is considered to be in serious danger of morbidity or mortality due to current practices in the village. She is encouraged to give birth at the *polindes* or *puskesmas*, and the expertise for childbirth lies clearly with the *bidan*, or doctor at the *puskesmas*, rather than with the mother herself or a locally-defined understanding of childbirth that the mother might share. As Douglas (1992: 13) notes, ‘the discourse on risk is...politicized’, and maternal mortality can be attributed to ‘negligence’ on the part of local *dukun* and villagers. Such an accusation implicates them in a power struggle with the state in which a lack of obedience to the government health system is confused with the issue of maternal mortality. Moreover, risk, which may be an automatic condition of such events as birth, old age and travel, becomes conflated with the idea of danger, in which the practice of *dukun* can be dismissed by the state and aid projects as dangerous, and therefore outside the bounds of acceptable childbirth practice (Douglas 1992: 24).

During antenatal examinations the *bidan* often diagnoses potentially high-risk births, such as high blood pressure, pre-eclampsia or the small body size of a pregnant woman. These women are encouraged to give birth at a *puskesmas* or hospital. There are also some tertiary options for village women who experience complications occur during labour. In the case of a retained placenta, an attending *bidan* can give a woman an injection to expel it. This can be performed in a village home. For any other complications, the *bidan* or villagers may attempt to transport the woman to a *puskesmas* or hospital. The government health system encourages villagers to go to a *puskesmas* first, but many villagers will bypass this step and go direct to a hospital, since *puskesmas* doctors do not have the equipment to perform caesarean sections – therefore their ability to assist a woman with major birth complications is limited. *Puskesmas* and hospital visits are expensive, not to mention the difficulty of villagers accessing transport, so this option is usually considered only as a last resort. Apart from the case of Nani,
discussed in Chapter Five, village women in Waangu-angu and Linomoiyo rarely gave birth outside their village homes. The nearest puskesmas to Waangu-angu was in Pasarwajo, half an hour away by vehicle, in the opposite direction to the nearest hospital, forty five minutes away in Bau Bau. For Linomoiyo, the nearest puskesmas was in Andowia, more than an hour away, while the nearest hospital was over four hours away by vehicle (on an unsealed road) in Una’aha. The majority of people in both villages would not have the financial resources or transport access to easily reach either health facility.

Role of the mother

During the labours that I observed in villager homes, the mother was swamped by a group of (mostly) women: placing their hands on her stomach, bracing her knees; reinforcing the impression that childbirth is a social experience and not performed by one person alone. The mother herself often cannot express a preference for how the birth is conducted. In Waangu-angu a woman who gave birth with only her husband assisting her was notably condemned by community members. Women may cry out when giving birth if there are only a few people around, ‘but if there are lots of people, we just stay quiet. We feel malu (embarrassed, ashamed) to cry out.’ In none of the births I witnessed did the women in labour cry out. This restraint reflects on how women perceive their role within these communities – in general to be quiet and stay in the background.

After the baby is born the mother is assisted in expelling the placenta: the dukun and other women massaging energetically to expel it. Once the placenta is born, both mother and baby lie quietly while others busy themselves, making tea or organising water for bathing. The mother does not often touch the baby, although she turns to look at it. Often an older female relative is given the baby to hold while the mother bathes, such as a mother, mother-in-law or the dukun herself. The mother does not bathe her own baby: rather this is the responsibility of the dukun or bidan. The baby is breastfed briefly by the mother before being placed on pillows or held by another.

First-time mothers have a particularly passive role in the post-partum period. Seen as inexperienced and sometimes incapable (especially in terms of breastfeeding), these young women assert little authority over their mothering role and are guided
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by older women – including dukun – who are considered more knowledgeable and experienced. They ‘teach’ her, and incorporate such practices as wet-nursing (pinjam tete – literally ‘borrowing the breast’) if she has difficulty breastfeeding. This is usually identified by the new baby crying frequently, particularly while breastfeeding, suggesting that it is having trouble drinking enough. Women generally breastfeed children until they are at least a year old, sometimes longer. It is a much more affordable option than powdered milk formula, which is used by rich city dwellers – at least in the eyes of villagers. Breastfeeding is also used as a method of pacifying children if they are crying. In my observations, wet-nurses were used in the initial stages after birth, until the new mother was sufficiently competent to take over the breastfeeding herself. The practice of wet-nursing reinforces the social basis of childbirth. Some older women described themselves to me as being more assertive than young women nowadays, who appeared less capable. ‘I never needed to pinjam tete,’ one older woman told me. A senior dukun insisted that she had been practicing as a dukun since before she was married. All of the dukun that I met on fieldwork were older, and I knew no dukun who were young and/or unmarried. The social aspect of birth means that the mother plays a generally limited and passive role as an individual. Rather, it is social knowledge: the knowledge of older people, which is passed down, which is emphasised.

Throughout the reproductive period, the mother has a changing role. At some stages she is a focus of great attention, at others, merely the provider of a baby. In the post-birth period, the baby (now separated from its mother) becomes the focal point and the mother is sidelined, or fades into the background, in many post-birth rituals. In biomedically-controlled births, the role of the mother is sidelined in favour of an ‘objectivist medical depiction’ (Jolly 1998: 2). In both cases, then, the role of the mother is sidelined, although the reasons are different (see Martin 1987). In the case of home births in villages, priority is given to the social nature of birth, in which a number of people (dukun and other women in particular) play a key role in labour, in addition to the woman giving birth. In the case of births conducted in government health premises or by biomedically trained personnel, the knowledge of the birthing woman (and other villagers) is subordinated to the expert knowledge of biomedical health staff. This is subsequently reinforced by
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the attitude of government health personnel at monthly health clinics (posyandu), where the assumed ignorance of mothers regarding the care of their children is continually evoked.

In the period immediately following birth, women generally stay at home for up to forty days. They rest, have warm baths to heal their injuries (luka dalam), and are massaged by a dukun. Sometimes in this stage they are considered unclean, or polluting, to the wider community (Niehof 1985: 237) (see also Jennaway 1996). This period is generally more liminal than the birth itself, requiring more separation from other villagers than time of the birth when a large number of villagers are present. The actual time women spend out of the public space of the village varies: often depending on their economic status, requiring poorer women to move more quickly out of the house to resume their economic activities. It is keenly observed by village women, such as a group sitting outside one of the local kiosks in Linomoiyo one afternoon. As we sat, one woman spied Tina walking away from her house to an adjacent kiosk – probably to buy staple foods like tea, flour, sugar or cigarettes. ‘How long has it been since she gave birth?’ she asked. ‘Only seven days,’ another woman answered. Later a Bugis resident of a nearby village expressed her surprise to me at how soon Tolaki women resumed work after giving birth. As women become more active, they take over the primary care of their babies: carrying them almost continuously in slings across their chest for a number of months.

In post-birth village ceremonies the mother has a limited active role, although she is always present. Ram (1998: 288) reflects that the post-birth ritual is important in a number of Asian and Pacific societies to reintroduce the woman into society after an experience focusing only on women, which threatens the ‘male-dominated social order’. The passive, background nature of much of women’s roles in post-birth ceremonies reflects the emphasis on women’s roles in the background of society – playing a vital but mostly unseen role.
Post-birth rituals

While a number of people may be present during the period of labour, the post-birth period can also be festive and lively. In Waangu-angu a birth is marked by a feast where a chicken is killed (usually by the husband), and family members are invited to share a meal. Births are also marked by a number of formal and informal ceremonies, which are routinely practiced by villagers after the birth of a child. One of the key ceremonies, performed for each birth, is the burial of the placenta.

Burying the placenta has an important place in the immediate post-birth phase, as is common in many Southeast Asian countries (see Laderman 1983; Niehof 1985; Nourse 1989; Whittaker 2002). Burial of the placenta can take a number of forms in Indonesia, such as hanging in a tree, hanging under the eaves of a house, placement in an earthenware jar or burial in a coconut shell. In Lombok the placenta was wrapped in newspaper and cloth, and buried in the ground. In the case of my two field sites, placentas were buried in a coconut shell, a few days after the birth. I observed a number of differences between Tolaki and Wakaokili methods of burying the placenta. Firstly, the placenta was washed in coconut milk and turmeric in Waangu-angu, but washed with water and then rubbed with salt and dried sour mango (asam) in Linomoiyo. Secondly, although the placenta was buried in a coconut shell, in Waangu-angu it was buried under the house, at the front for a boy, the back for a girl (similar to Niehof 1985). In Linomoiyo the placenta was buried under a ‘cool’ tree such as banana or sago, to ensure the health of the child as it grew. In one case the placenta was buried in a bright pink plastic soap container, since this placenta was too big to fit in a coconut shell (see Fig 7.1-7.3).

The placenta has an important connection to the health and prosperity of the child. It is referred to in both Waangu-angu and Linomoiyo as kakak or older sibling, and as a good elder sibling, it looks after the child and protects it from illness as it grows. Disturbance of the placenta by ants, dogs or pigs can have a serious impact on the health of the child. Despite the fact that burial of the placenta poses no biomedically-defined danger to the mother or baby, government health personnel are not necessarily supportive of this ritual. In Madura, Niehof notes: ‘People
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abhor the idea that after hospital deliveries the placenta is sometimes thrown away’ (1985: 222) (see also Whittaker 2002). This suggests that the lack of regard for village health practice extends beyond warning against practices viewed by the biomedical profession as ‘dangerous’, to encompass those practices which are not defined as part of a modern state - in which burial of the placenta constitutes a backward tradition.

The Tolaki mesosambakai ceremony is performed for a first boy and girl born to each family (see Fig 7.4 and 7.5). In Linomiyo, this ceremony is performed by an elderly dukun who has inherited a particular stone with mystical qualities, which is the key to this ceremony. It is held exactly seven days after the birth, and it is a private ceremony where only close family generally attend. There are no elaborate costumes, and no feast, which would signify an important public ritual. In a ceremony I observed, a young female relative held the (female) baby while the dukun prepared a basin of water, then added the stone, some leaves, a ring and some pieces of the trunk of a wild banana tree. The girl passed the baby to the dukun, who ritually bathed the baby a number of times, wiping its back with the leaves and placing the items from the water on the baby’s head. After this was complete the dukun asked the parents of the child to sit back to back. She took some leaves from the basin and anointed the heads of the parents with the water.

A different birth ceremony is practiced in Waangu-angu, called pisa ba’a. In the pisa ba’a ceremony, the mother sits behind the participants and observes the ceremony, but does not take an active part. Pisa ba’a is held in the week after a child is born, but it is a more public ritual: involving a large feast and a number of guests (usually all family). It is conducted by a dukun (who, in this case, was the mother’s aunt). A number of women cook coconut rice, using a particular coconut that has been carefully hollowed out. They refill the coconut shell with the coconut rice and some hard-boiled eggs. The coconut shell is brought to the bedroom, where the participants are located. A special stick is placed in the coconut, and it is stirred ceremonially by the dukun, the baby’s father, the father’s mother, and the mother’s grandfather. The rice and eggs are distributed among the guests, sitting in the front room, who must eat until there is none left. Any leftovers are placed back in the coconut shell, which is tied with the stick, and
hung in the eaves of the house (the back of the house for a female child, the front for a male). ‘This ceremony is conducted differently in Waangu-angu compared with other villages’ an elderly villager commented to me.

Haircutting ceremonies are the most formal and elaborate type of birth ceremonies that occur in the majority Islamic communities in Waangu-angu and Linomoiyo. Similar to a christening or baptism for Christians, the haircutting ceremony inducts a baby into the Islamic faith. While the purpose is similar in both villages, the way that ceremonies are conducted reflects the different traditions and rituals common to each area, which combine local beliefs and practices with Islam. Haircutting ceremonies require inviting some imam, to conduct the ceremony, as well as a large number of guests (typically family). Chickens, or a cow, are killed in order to provide a lavish feast. A haircutting ceremony is a large and elaborate event by village standards, similar to a funeral although not as elaborate as a wedding.

Haircutting ceremonies in Waangu-angu are timed to coincide with two other important life-stage ceremonies: circumcision (and female genital cutting) and pingit, which roughly translates as a coming-of-age ceremony for girls which involves seclusion, fasting, and elaborate costumes. All the participants dress in formal clothes for the ceremony, with men and women wearing traditional Butonese sarongs (checked for men, striped for women). The girls who have been circumcised, or come-of-age, walk in a procession from the back to the front of the house (figure 7.6), accompanied by an adult who carries the child to have its hair cut. The important men of the village sit around the edges of the room in a square (these men are all married and have children), while the girls and the baby are placed in the centre, along with a few imam who face them (figure 7.7, 7.8). While the hair is cut, the imam chant a number of prayers, at the end of which the ceremony is complete, and the group eats a meal prepared by the women in the kitchen, at the back of the house.

In haircutting ceremonies in Linomoiyo, the ceremony starts with the imam in one corner reading from the Qu’ran for about half an hour. An adolescent relative of the child (not the mother or father) carries the baby in and holds it during the ceremony: a boy for a boy, a girl for a girl (Fig 7.9) When the baby is brought in,
the imam and all the guests stand. The imam cuts the baby's hair while chanting a prayer, and the hair falls into a bowl of water. Then the baby is laid on the ground in front of a group of women and another woman, not the mother, is asked to cradle it (Fig 7.10). ‘Quick, pick it up!’ one older woman said to another, who cradled the crying infant for five or ten minutes before it was taken away again. A number of haircutting ceremonies in Linomoiyo were timed to coincide with Idul Fitri celebrations, which may have ensured a greater number of guests, or (more likely) ensured that the family would not have to kill too many animals for the feast, which is prohibitively expensive for many.

Post-birth rituals are generally ignored by the Indonesian government and aid projects, seen as an innocuous aspect of ethnic identity and religious beliefs, which is not considered risky in the same way as childbirth practice. These rituals are not encompassed by the medical gaze of the health system and projects like HMHB. They are not generally considered as part of health practice by villagers either, although some ceremonies may have a prophylactic function for the child: by protecting them against spiritual danger and ensuring their health as they grow.

**Risk, mortality and childbirth practice**

While birth can be described as a natural function of women, it is certainly not without its risks (see also Whittaker 2002). Models of behaviour around childbirth promoted by HMHB and the Indonesian state address some of the risks around childbirth by moving births from homes to health centres or hospitals where risk is thought to be better managed. In a village setting, however, dukun and villagers have their own methods for managing risk. The birth described below, in Linomoiyo, highlights some of the strategies that are employed by dukun to address risks during birth. This birth took place in the evening, so the number of people attending was limited. It was Masni’s first child, and the labour was prolonged, heightening the drama of the birth.

I arrived at Masni’s brother’s house at 7:30pm, a few hours after dukun Hana had arrived when she heard that Masni’s contractions had started. It was one of the largest and most expensive houses in the neighbourhood: Masni’s brother was the
school principal, on a regular government income. I entered the house by the back
door, near the room where children assemble to watch television; and walked
through the darkened kitchen to one of the bedrooms. Masni was resting on a
mattress on the floor, next to a large bed. She was wearing a t-shirt and a large
sarong wrapped around her waist and covering her legs. She sat up every so often
and went to the toilet twice, in a small bathroom attached to the bedroom. Only
the wealthy have indoor bathrooms, and they are extremely rare in Linomoiyo.
Masni moved in discomfort as contractions gradually increased, and Hana and
Masni’s sister-in-law massaged her back and legs. Hana and Masni’s mother both
smoked and we kept up a flow of light conversation. Hana asked me why I was
studying births, and I told her that my mother had been a midwife. She seemed to
agree that this was a good reason for me to be interested in births myself. This
was Masni’s first birth, and she sat quietly, listening to the advice of her sister-in-
law (who had two children) and Hana, and staring at me warily. Her sister-in-law
called out to Masni’s husband for a hairclip to tie her long hair back from her face.
Jokingly, he clipped it on her hair at a foolish angle, but her angry look prompted
him to retreat quickly from the room.

By 11pm Masni had started pushing, lying on her back and clutching at the sheets,
but not making any sound. After pushing for a while she rested on her side, lying
on the mattress. A second dukun was summoned to assist Hana. There seemed to
be some concern about the length of time of the labour, as well as general concern
for a woman bearing her first child. The second dukun placed her hands on either
side of Masni’s stomach. There were periods of activity during contractions, when
everyone focused on Masni, and then periods of rest. Masni changed her t-shirt
for a singlet. At about midnight or 1am a third dukun was summoned. An hour
later they turned Masni around so she was lying lengthways on the mattress,
bracing her hands against the wardrobe when she pushed. Occasionally Hana
would ask for water, which she said some prayers over and poured (siram) over
Masni’s stomach, then passed the glass downwards through Masni’s sarong. I had
not seen this at other births, and it reflected general concern with Masni’s
difficulty in giving birth. The passing of the glass reflected the passage of the
baby – down through the sarong and out between the legs. The three dukun took it
in turns to brace Masni’s legs, guide the position of the stomach, and feel for the
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emergence of the baby, assisted by Masni’s sister-in-law. Masni rested, pushed, and then had her arms massaged. Hana held a piece of turmeric under Masni’s nose so that she inhaled the scent. The smell of the spice was supposed to encourage her body to give birth. The generator supplying our lights was kept on until about 3am. This was a rarity – all the other houses around had been long in darkness.

At 4am, after a brief nap on the bed, I awoke to find the room lit by a hissing gas lamp. It was quite crowded, with two new people in the room – both older men. Masni was resting. One of the men left the bedroom when Masni started pushing again. The other man was a dukun. Male dukun are uncommon in Southeast Sulawesi, and are not able to deliver the baby for reasons of modesty. Later dukun Hana explained that this male dukun was very experienced and skilful. Masni had removed her top and bra, but a sarong still covered most of her body. The male dukun held her stomach, one female dukun braced her legs; Hana – the senior dukun – felt for the baby, and another dukun sat back to back with her. At 5am the baby was delivered. Masni’s mother rushed in to see it. The placenta was expelled after about twenty minutes by the frantic and stressed work of all four dukun. The baby had spent a long time in the birth canal, so her head was elongated, with swelling on one side, and she was crying a lot. She was a small baby.

The baby was wrapped loosely in a sarong with the placenta, still attached. Hana tied four pieces of string at various points on the umbilical cord and then cut it with (unsterilised) scissors. The baby was then wrapped in a new sarong and placed on pillows, near the mother’s head. The placenta was wrapped in a sarong and placed in a plastic basin. Another dukun was massaging Masni’s arms when she became concerned about haemorrhaging. ‘I heard a ‘tkk’ sound,’ she told me later. The male dukun rushed back into the room, a glass of water was called for and prayers were said as they rubbed Masni’s stomach. The danger seemed to be over. Masni seemed very weak. A couple of dukun helped Masni roll onto her side to face the baby.

This birth, while presenting a number of potential risks, did not result in the death (or morbidity) of either mother or child. Hana, the dukun, used a number of methods: prayer and water, turmeric for Masni to inhale, and working together
with a number of different assistant *dukun* to achieve a successful birth. Due to the length of labour, Masni was very tired, and she was encouraged to rest between contractions and massaged by the healers to keep up her strength. Biomedical practitioners acknowledge that a successful birth is ‘affected by a woman’s environment and emotional state’ (Martin 1987: 61). The comfort of giving birth at home, surrounded by one’s family, may be much more reassuring to women than the impersonal environment of a health centre or hospital, and its unfamiliar personnel. The practice of the *dukun*, familiar to village women, is more reassuring than the unexpected and intrusive rituals in hospital births (see Davis-Floyd 1994). Thus by giving birth in the home many of the risks of birth that are associated with a woman’s psychological state can be successfully addressed.

Notwithstanding the reassuring role that *dukun* play at the birth, births are still very risky events and maternal mortality is higher in Indonesia than in any of its neighbouring countries in Southeast Asia. In the concluding chapter I will provide a brief discussion of some of the possibilities for reducing maternal mortality in rural areas, based on my own research in two Southeast Sulawesi villages.

*Pregnancy, childbirth and the gendered body*

The reproductive process, from pregnancy to the post-partum period, is experienced and symbolised in terms of women’s bodies. Women’s bodies and their fertility symbolise their role in communities in ways that are contested by the Indonesian state. Pregnancy has a very visual aspect, and women in South East Sulawesi accentuate the latter stages of their pregnancies by tying sarongs under their arms, over their other clothes, accentuating – while at the same time concealing – their pregnant bulge. One morning the village head in Linomoiyo announced to me that a woman had given birth the night before. ‘Who?’ I said, wondering. I was sure I had not seen any women recently who were visibly in late pregnancy. ‘You know her,’ the village head insisted, ‘she comes to this house often. You have talked to her.’ When I met up with the woman later, I recognised her – but not as a pregnant woman. Unmarried, and fearful of her parents’ opinion,
she had concealed her pregnancy by wearing baggy t-shirts and shorts, rather than the typical garb of a pregnant woman.

The vast majority of women in both Linomoiyo and Waangu-angu give birth in their homes. Women typically give birth in the kitchen, or a ‘back’ room of the house such as a bedroom, which is part of the domain of women. One reason stated by villagers for giving birth in the kitchen is proximity to hot water (heated on a fire) for bathing the mother and baby. Laderman (1983: 10) suggests that it may also relate to ease of cleaning, since kitchen floors have large gaps between the floorboards to allow such ‘effluvia’ to be washed through. In addition to blood from birth, most people use kitchens as informal toilets, particularly for urination. In the majority of births I observed women lay on a thin mattress covered by a plastic sheet and a number of sarongs, which soaked up the blood. Giving birth in the kitchen accords with the day-to-day separation of male and female space: men in the ‘front’, and women in the ‘back’. While both men and women must inhabit both spaces for practical reasons, each seems awkward when entering the other’s space, appearing more as a visitor than an inhabitant. This locates childbirth as an almost exclusively female social experience. The husband waits in the front room or outside the front of the house, in that male space. One woman in Waangu-angu told me ‘he used to just wait in the front of the house until he heard the baby cry.’

The space allocated for a birth is surrounded with curtains. There is a kind of double modesty in births, since births take place in the women’s section of a house, in an area cordoned off visually by curtains. Even inside those curtains, the woman is covered while giving birth. At the woman’s head is a wall, or in one case a heavy chest, which she uses to brace herself against while giving birth. Women are covered by sarongs during their labour, particularly on their bottom half. In the intense later stages of labour, the sarong may slip down and women discard their t-shirts for bras. All of these conventions are flexible, depending on the situation and needs of each birth. The dukun assists mostly by feel, rarely lifting up the sarong to see beneath. Laderman (1983) argues against the idea that traditional village midwives deliver entirely by feel, suggesting that they occasionally look under the sarong (see also Whittaker 1999). She argues that this is part of a general mystical assumption of ‘traditional’ childbirth practice. While
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I acknowledge the force of this argument, it was extremely difficult for me, even as a close observer, to see the dukun do more than feel.

Women’s lives can be defined by the cycles of childbirth, beginning from their new status as mother from their first birth, especially when they have had no access to contraception (see Liamputtong Rice & Manderson 1996). Their role as child bearers fits with the idea that women are ‘closer to the earth’, and bodily functions, while men are closer to the spirit world (Martin 1987). Women give birth in the kitchen: a women’s space, associated with bodily practices. Men’s spaces are reserved for discussion: a more ‘spiritual’ pursuit. At a local level, pregnancy and childbirth reflect social practices, norms and rituals through the body of the woman itself. Women enact their roles in the community through childbirth. Helliwell (2000: 800, 802) notes that while both men and women have the capacity to nurture children, it is considered to be women’s work since they do it ‘better’ (see also Manderson 1983).

The separation of men from the process of birth, and the double modesty of the screens around the birth place and the sarong that the woman giving birth wears, may suggest that birth, as ‘in many societies’, is considered polluting to men (see Jennaway 1996; Liamputtong Rice & Manderson 1996: 7). However this concept is not universal in Indonesia, as Helliwell indicates in her study of the Gerai in Kalimantan (2000). Women’s bodies, as well as having a reproductive function, are sexualised in a way that portrays them as dangerous or polluting to men. Islamic men and women cannot pray in the same place, or look at, talk to or brush against one another during prayer. Women cannot pray during menstruation, when their bodies are considered unclean, polluted by menstrual blood. The double modesty in childbirth may reflect the continued sexualisation of women’s bodies, and the idea that a woman’s body is not for public display. The bidan challenges this by ‘opening the sarong’ and examining the woman’s body, causing malu. Giving birth in the home ‘fits with understandings of female modesty’ (Liamputtong Rice & Manderson 1996: 4), giving women some measure of control over intrusive examinations by biomedical health personnel, and the presence of unrelated health staff (particularly men) during labour.
More recently, women’s lives have become defined by the cycles of birth control promoted and imposed by governments and international bodies (see Hunter 1996b; Newland 2001). Indonesia has had a long history of ‘family planning’: primarily through the state body of BKKBN (*Badan Koordinasi Keluarga Berencana Nasional* – National Family Planning Coordination Body) which was empowered to encourage widespread participation in family planning, using the model of *dua anak cukup* (two children are enough). This has been primarily achieved in the form of government-supplied contraception, mainly controlling the fertility of women: through injections, implants and sterilisations (see Bennett 2005; Niehof & Lubis 2003). Women’s reproductive role has been the target of these state-sponsored programs which have been described as authoritarian and an expression of autocratic government surveillance (Hunter 1996a; Newland 2001; Parker 2005). One particular recruiting technique of the family planning body involved the personnel of the Indonesian armed forces, ABRI, conducting family planning ‘safaris’ to increase the use of contraceptives by Indonesian women (Newland 2001).

The body is a key focus of literature discussing the Indonesian family-planning program, particularly concerns with the surveillance, control and invasion of women’s bodies by the Indonesian state. This literature tends to neglect other aspects of reproductive health in which women’s sexuality is objectified: such as pregnancy and birth. Women’s bodies are integrated into an Indonesian state and international modernizing movement which focuses on an ideal, modern family of husband, dutiful wife, and two children, as embodied in statues across Indonesia (see Bennett 2005; Newland 2001; Ong 1990). This movement encompasses the concerns expressed about maternal and child mortality sparked by an international conference in 1987 (Shiffman 2003). International discourse, and Indonesian state policy, focuses its attention on women and their childbirth role. The HMHB project, and other international and Indonesian government projects focusing on maternal health, has named women as stakeholders, particularly pregnant women and mothers of young children, as well as women who assist births and provide health services at a village level; using project training and messages to change behaviour around childbirth. The bodies of Indonesian women are evoked in descriptions and photos in government publications (Cholil et al. 1998); as well as
posters and stickers exuding ‘correct’ childbirth behaviour and warning against the ‘dangers’ of traditional practice for birthing women’s health. The fertility, and sexualisation, of women’s bodies is continually evoked in family planning and maternal mortality movements, reinforcing local ideas of women’s bodies as sexualised and polluting.

Despite the argument that family planning campaigns are invasive for rural village women, many women see birth control as having a practical and useful function. ‘I had two children, then took KB (contraception) so I could have a break (istirahat), then I had two more,’ explained one woman in Waangu-angu. A woman in Linomoiyo, pregnant with her third child, said ‘I had two children, then I went on KB. But now, I am still young, I should have more children.’ Villagers on a bus joked to me: ‘The government says two children are enough (dua anak cukup). Here, we have two children, then we have two more children, then two more…’ (laughter). Contraception is used by village women in order to space their births and give themselves a break, demonstrating their active engagement in the use of family planning techniques. Women speak openly about whether or not they are on KB; this is part of the social experience of health, illness, and childbirth in a village context. Thus village women actively engage in the government’s family planning system, deriving their own meanings which challenge both state ideals and local notions of modesty (see also Jennaway 1996). Men, too, are seemingly undaunted by discussions of contraception and family planning. ‘I asked the bidan about KB Pria (male contraception)’ one man told me, laughing. ‘I said, I’ll take it, not my wife. But she laughed and said that there was no such thing.’

**Childbirth and gender roles**

One of the most significant roles for women in many parts of Asia is childbirth. Particularly in rural areas, giving birth is a marker of adulthood for women, signalling their entrance into a new role within their communities (see Jennaway 1996; Laderman 1983; Niehof 1985; Whittaker 2000). Girls become women through giving birth after marriage, taking on the ‘adult’ title of ‘the mother of [their first child]’ rather than their own name, which unites them with other adults.
and separates them from children (see also Laderman 1983; Niehof 1985). This also applies to men, whose fertility is proven by the attainment of a child, giving him the new title ‘father of [child’s name]’. Since girls become women through giving birth, marriage (a prerequisite for a legitimate birth) and childbirth are key aspects of the gender roles of women (see Niehof 1987).

In general, women and men perform noticeably different roles in the community, although they are often able to substitute for one another if the need arises (such as in farming, collecting firewood or household tasks) (see Manderson 1983). At the village level, men have a higher formal, or ritual, status than women, particularly those who are married with children. Women cook and serve men food before they eat, both at ceremonies and often at home (unless the family is small enough to warrant eating together). At ceremonies in Linomoioyo, women did not start eating until all the men had finished eating and their plates were cleared away. Married women do most of the cooking at ceremonies, with elderly women cooking the rice, while unmarried girls and some unmarried boys help to serve food. Girls learn to assist their mothers in household tasks from a young age (see Laderman 1983; Robinson 1985). At one funeral, an older woman scolded some unmarried girls. ‘Look at all of you, sitting here’ she scolded them. ‘Go and help [serve food]’. As Manderson (1983) notes, women’s work behind the scenes is less prestigious, but just as critical, as men’s work in conducting the more public rituals, for the success of a ceremony. This is the same in daily life. Men’s work in collecting rattan in the forest near Linomoioyo is highly regarded, since it is difficult, heavy work and involves spending nights sleeping in the forest, considered to be an extremely dangerous place. After I scrambled into a limestone cave to see the evidence of human bones, the village head proudly told others ‘If she’d been here two years, she could collect rattan!’ Both women and men work in the kebun (fields), although women do not classify themselves as ‘farmers’ in official government documents. At village meetings, women gave their occupation as ‘none’ while men called themselves ‘farmers’. Women’s official status as citizens is generally mediated through their identity as part of a family, rather than as workers (such as farmers), and through their husband as head of the family (see Niehof 1987).
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**Women as mothers and carers**

In many parts of Indonesia, women are expected to act as carers, particularly when they are married (see for example Niehof 1987). They are responsible for the welfare of their families, and are expected to stay close to their homes. As Blaxter (1997) has noted, responsibility for health and illness can be seen in terms of personal responsibility and morality. The story below, from Linomoiyo, demonstrates village attitudes toward a woman’s responsibility for the health of her family.

We hadn’t seen our next-door-neighbours for a while. I commented that I hadn’t seen the woman who lived there for some time, and I was told that she had taken her teenage daughter to start high school in Una’aha, the district capital about four or five hours away. Her husband never went out much, he walked unsteadily and appeared to have had a stroke. A few days later the village head’s wife’s brother-in-law went to the house next door. He was the woman’s cousin. He came to our house afterwards, and we found out that the man and his son were very sick and couldn’t leave the house. There was only the two of them there, with no one to look after them. The village head was critical of the woman who had left her husband and son to fend for themselves. ‘It’s a pity she’s not here,’ I agreed, ‘But it’s not her fault they got sick.’ ‘You don’t understand,’ the village head replied. ‘You can’t just go and leave your family if you’re married. That’s your responsibility.’ Later, people extended their disapproval of this woman. ‘She prefers living in Una’aha, that’s where her family lives,’ one person told me. Another said ‘she only married him for the money, now that he can’t work she doesn’t want him anymore.’

Knowing a number of men who regularly left their wives (and children) by themselves, including a number who had multiple wives, I felt that this reflected village opinions of the particular duty of women to marriage and children, which does not apply to men. Manderson (1983) notes the acceptability of both unmarried and married men in travelling away from home to find work (or *merantau*). For men, travelling can be important in establishing one’s social status. For women, the opposite appears to be true. Duty to one’s home and family was
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continually stressed by villagers to me, and as Laderman (1983: 12) notes: ‘Women must be sick indeed before they abdicate their daily tasks’. One man that I knew had at least two wives, one in Linomoioyo, and the first one was jealous of the second. Consequently he spent most of his time on the road between the two (they lived about five hours from each other by motorbike), and I reflected that, ‘He spends more time on the road than in a house!’

Foucault argues that caring for the health of the family, particularly children, has become an important objective linking the family unit with the organisation of state power through health interventions (Rabinow 1991: 280). Woman’s role as carer in Indonesia is incorporated in state ideology, and expressed through institutions such as the PKK (Family Welfare Movement) as well as a number of government development programs. The maternal and child mortality movement in particular challenges the ability of village women – both dukun and mothers – to care for mothers and children. By promoting increased reliance on the bidan, the state suggests that women are less able to care for their children independently, or according to their own knowledge of the needs of their children. Women in both villages valued the access that they had to bidan services, and complained when she wasn’t there. However they expressed considerable agency in deciding when and for what reasons they would take their child to the bidan, using their own judgment to ascertain the probable cause of an illness and the required treatment.

The role of female dukun and bidan evokes the responsibility of women as carers – since healing is a type of caring. Most of the dukun in both villages are women, although some male dukun do assist in births. Male dukun are generally rare, but some are seen as particularly skilled, such as the one described above assisting Masni’s birth. Male dukun are also descended from (usually female) dukun. In these two villages, the process of childbirth reflects strongly on the roles of women. As one dukun commented to me ‘childbirth is the role of women’. This is not always the case, however, as Nourse (1989: 108) notes in her study of two communities in Central Sulawesi, childbirth ‘is associated with continuity and fatherhood’, while the mother’s role is diminished. In one of the communities that Nourse discusses, male dukun deliver the baby, reinforcing the connection
between childbirth and men, and the important role that men play in the childbirth process. In this case, men are associated with a caring role, while women are seen as neglectful. This contrasts with the idea of women as carers of their families.

**Good wives and mothers**

A small survey that I conducted indicated that, of the women surveyed (28 in Waangu-angu, 21 in Linomoiyo), the majority married soon after leaving school. This included women who had never finished primary school to those who had completed high school. The importance placed on marriage, particularly in rural villages where women have little to no other career options, reflects the importance placed on women’s roles as wives and mothers – for both villagers, and for the Indonesian state (see Jennaway 2002a). Once, returning to the village on a bus, a man sitting next to me saw a group of schoolgirls walking along the road. He leaned out and said ‘What are you doing at school? Hurry up and get married and have children’. Both he and the girls laughed. Childbirth follows marriage as quickly as it can, although in some cases conception predates marriage. Unmarried couples have no legal access to government-supplied contraception (see Bennett 2005: 35), which no doubt lowers the age of marriage in a number of cases. A woman’s married life is supposed to be one of childbearing and child-rearing. A woman’s success in bearing children reflects positively on her as a good wife, as well as demonstrating her husband’s potency.

Early in my time in Waangu-angu, a woman came to talk to the *bidan* in the evening, when the other women weren’t there. The *bidan* explained to me afterwards that the woman was concerned about her husband: she thought he would leave her because she had born no children. The man did marry again, we heard later, to a young woman in another village. In another case, a man had a number of wives, but was apparently infertile, according to gossip. His wives all had children which were conceived (secretly) with other men.

Polygyny is commonly acknowledged in both Waangu-angu and Linomoiyo, and reflected in Indonesian law. This topic is discussed by men with some pride or amusement, but by married women in whispered gossip and disapproval. ‘She’s married to someone else’s husband’ is the typical way that women phrase it. On
the surface, it is not obvious how many polygynous marriages there are in a village, since it is rarely talked about, and often men had wives in different villages. Women did not tend to introduce themselves to me as ‘second wife’ and so on, only indicating whether or not they were married. It is a sign of status for men, such as a boastful (and ugly) bus-driver who tried to charm me in front of his friends, saying ‘I have seven wives!’ ‘Some men have nine wives,’ the village head in Linomoiyo told me. ‘How can they?’ I asked. According to the 1974 Marriage Law, men are allowed to have a maximum of four wives. ‘If a man and woman are caught together, they must get married,’ he explained ‘even if he already has four wives.’

The different way that men and women talk about polygyny suggests their differing experiences. While for some women being in a polygynous marriage can have advantages, giving them status as a wife and mother while allowing them freedom from constant attention from a husband, for many women being a second or third wife is an ambiguous state. Although men are technically responsible for the financial upkeep of all their wives, in practice they do not look after all of them and many secondary wives live and are supported by their own families. They marry, but still live with their parents, and their children. Women are not free to marry again unless they divorce, and divorced women are stigmatised (see also Jennaway 2002a). One of my friends married at a young age (fifteen, I guessed) and divorced again soon after. This was mentioned to me, first in whispered gossip and then in jokes. Some people made derogatory jokes about men who could ‘only’ find divorcees, called *janda* which is the same as the word used for widow. For men, like travel, marrying a number of women increases their prestige and perception of potency, while for women it is almost the reverse.

In addition to women’s key role in the village as wives and mothers, the concept of the family incorporates women into the Indonesian state, in both a concrete and metaphorical sense. President Suharto was called the ‘Father of Development’ (*Bapak Pembangunan*) and the Indonesian state, for most of the twentieth century, exerted a paternal influence over its citizens, with authoritarian leadership meaning that Indonesian citizens did little more than obey the instructions filtering down from the central government. Women are literally incorporated into
the Indonesian state as part of the family which, in modern Indonesia, consists of a husband, wife, and two children. While they also have duties as ‘citizens’, it is their identity as part of a family that is emphasised over an individual identity as an Indonesian woman. Their roles as ‘good wives and mothers’, as well as ‘good citizens’, have been promoted under the banner of the Family Welfare Movement (PKK), which specifies particular roles for women in Indonesian society which are explicitly connected to their duty, or destiny (kodrat), to become wives and mothers. ‘Familial metaphors figure in many narratives of nationhood,’ (Jolly 1997: 158) denying women agency as individuals vis-à-vis the state, and in the communities where they live. These familial metaphors directly relate to the act of childbirth: the (re)production of children and the creation of mothers (and fathers) through the act of giving birth. Women are subordinate both to the state and to their husbands through the structure of the household, in which the husband is the head of the family (kepala keluarga - KK). When collecting village statistics, the village head queried whether women and children should be included as part of the village population. I asked him for the total number of residents and he furnished me with the number of heads of households. Women only become the head of a household if they are widowed. ‘Even then,’ a former village head in Linomoiyo explained, ‘we call them ‘kk-janda’ (head of household – widow).’

Gender roles and the development industry

In addition to their role in villages, and the Indonesian state, as wives, mothers and citizens, women have become a focus in gender-oriented ideology in the development industry in recent decades. As Baillie (1998) notes, the appearance of a gender focus in development ideology paralleled the rise of feminism in the West. Gururani (2002: 314) describes this as a ‘feminist political project of focusing on women’s knowledge’. Women have been encompassed by development initiatives through the WID (Women in Development) and, later, GAD (Gender and Development) strategies. While WID focused on ‘modernising Third World women, not on understanding their lives and experiences,’ (Baillie 1998: 6) GAD, introduced in the mid 1980s, shifted the focus to gender roles.
Despite the fact that women in Third World countries have embraced many of these ideas, Third World women still remain ‘other to their development expert “sisters”’ (Baillie 1998: 10), largely objects of change rather than subjects of decision-making and autonomy. In Indonesia, the Mother Friendly Movement (*Gerakan Sayang Ibu*) had an explicitly gendered focus: of reducing mortality while achieving greater gender equality (Cholil et al. 1998). More recently, projects refer to the process of ‘gender mainstreaming’ (eg HMHB Project Team 2002a).

The HMHB project operates within this assumed framework of gender relations developed at an international level. When the HMHB project chose to promote an increase in the role of the husband in childbirth, they ignored the role that the husband already played, and downplayed the role that other extended family members not included in the gaze of the project also played. The provocative ‘Suami Siaga’ cartoon of a man hanging out washing for his pregnant wife, discussed in Chapter Three, reinforces this gap between views expressed by HMHB gender advisor and Indonesian rural villagers of the appropriate roles for men. In the maternal and child health campaign, the behaviour and roles of women are central to project efforts. In this case women are doubly targeted, in looking after their own health as well as that of their children. The role of woman as carer of their children is specifically targeted, and existing practices challenged.

In the same way as PKK and government dictums attempt to create women as ‘good citizens’, projects and project messages create an ideal type of the good mother. Pigg (1995: 58) argues that an ‘unspoken notion of “proper childbirth” lies behind negative interpretations of birthing customs,’ which are contrasted unfavourably with the project / state model. The project gaze means that only the medical aspects of birthing are considered, and birth is redefined as a ‘medical act’ (Pigg 1995: 57). In this way some acts in the birth process are defined as ‘legitimate’ while others are excluded. In particular, the social and ritual aspects of birth experiences in villages are ignored. This includes the important ritual and spiritual role played by the *dukun* during childbirth and in post-birth rituals, where she conducts particular ceremonies to safeguard the health of the mother and child from disturbance by spirits. The burial of the placenta, and post-birth ceremonies
such as mesosambakai, pisa ba’a and haircutting ceremonies, are similarly excluded from the medical gaze.

As trends in childbirth have changed in countries like Australia (such as the move from bottle-feeding to breastfeeding, and the role of the father) so have approaches to childbirth models in development programs. These models have been applied to the generic ‘village’ created by development discourse, in which local practices are classified as generically ‘traditional’ (Pigg 1995). The Indonesian government too, attempts to find a ‘one size fits all’ solution for village maternal health based on bureaucratic rationality, treating all villages as the same and allocating bidan across villages on the basis of macro population numbers (rather than, for example, access to transport, or other issues on a village-by-village basis). The HMHB project assists government efforts to incorporate village childbirth practice into a state structure of appropriate behaviour. Childbirth statistics are reported by the bidan to the puskesmas, who report to the Health Department. The project enables surveillance of village practice in an era of decentralisation, when existing forms of surveillance are being broken-down or challenged. In the area of childbirth, women’s lives become the object of statistics, their bodies a target for ‘results’ of behavioural change.

By focusing on birth as solely a medical experience, HMHB project messages disregard village sociality, which is key to experiences of childbirth, as well as the idea of pregnancy as a ‘normal’ condition for women (see Laderman 1983). As targets of project messages, women are required to change their perception of birth from a social and spiritual to a medical one; to redefine their pregnant bodies from normal or healthy to sick and vulnerable; and to perceive the assistance of local healers as dangerous rather than reassuring. Liamputtong Rice and Manderson argue that ‘obstetric definitions of pregnancy and birth as “unnatural events of illness” are diametrically opposed to indigenous understandings of birth as natural and normal’ (1996: 5). While villagers are highly aware of the risks associated with giving birth, as reflected above in Masni’s birth by the number of personnel and traditional methods used, they conceptualise birth as a natural part of a woman’s bodily function, and her gender role, rather than as an unnatural
event that necessarily requires medical intervention in a location external to the village. At the local level, project and government definitions of birth have many points of difference and contestation with local ideas of childbirth, and the birth experiences of village women.

However, childbirth can be an opportunity for women to enact their aspirations for development and modernity, such as the example of Nani in Chapter Five. Such aspirations can be enabled by projects like HMHB. Having only a *dukun* attend births can be a sign of ‘the old days’, or *zaman nenek-moyang*, the era of the ancestors. ‘In the past we just had a *dukun*, now we have a *dukun* and *bidan*’ one woman reflected to me. This phrase ‘*zaman nenek-moyang*’ was used frequently to refer to ‘the old days’, even if they were only five or ten years ago. The *bidan* has only been in both villages for between ten and fifteen years, and the *bidan* village-placement scheme has only been in place since 1989. Giving birth in huts in the fields (*kebun*), far from the village, is now considered old-fashioned as well as dangerous, after one woman died giving birth there in 2001. Women told me ‘we only give birth in the village now.’ One woman in Linomoiyo said ‘I am afraid that the *bidan* won’t come back to the village before I give birth. I don’t want to give birth with just a *dukun*.’ Having a *bidan* attend births is a way for village women to manage risk, as well as to engage in a modern birth.

**Women negotiating birth experiences**

Childbirth in Southeast Sulawesi incorporates variable practices, even within the same village. According to the survey I conducted, some women choose to have both *bidan* and *dukun* present, some one or the other, and even one chose to have no health provider present at all. Some women’s experiences of giving birth are a result of circumstance – in many cases the *bidan* did not attend because she was not in the village at the time. The births that I observed demonstrated the importance of birth as a demonstration of village sociality: encompassing rituals conducted during and after birth, the role of the community, and the skills and knowledge of the *dukun*. The social aspect of childbirth in a village home is considered positive by women, the majority of whom give birth in the home.
unless there is a good reason (such as a life-threatening condition) that requires birth in another environment. Biomedical practitioners acknowledge the importance of psychological factors in achieving a successful birth. Despite this, government health staff may prioritise other concerns before the mental health of the patient: such as obeying higher-level dictums about appropriate health behaviour, or criticising tradition; rather than recognising that the home, and the presence of relatives, may be considered by women to be a safe and comforting environment for the vast majority of births.

Childbirth practice has been the explicit focus of the ‘Healthy Mothers Healthy Babies’ (HMHB) project. The worldwide maternal mortality campaign, reflected in such projects, identifies maternal and child health as a key focus of primary health interventions. This is not a new idea: biomedical midwifery training, and efforts to train indigenous midwives, have occurred in Indonesia since the Dutch colonial period; and the subdistrict health centres (puskesmas) were originally established with the assistance of UNICEF as maternal and child health centres in the 1950s and 60s, only incorporating other health services from the 1970s onward (Hunter 1996a: 84) (as mentioned in Chapter Two). Childbirth practice reflects on women’s role as both bearer of children and carer for her family. These roles have long been incorporated into the Indonesian state, through institutions such as the PKK which seeks to incorporate women into state ideologies of the family. The PKK has been actively operational at a village level since it was established in 1967. The maternal mortality campaign, and projects like HMHB, is having an impact on the way that birth is performed, by increasing the options available for women when they give birth. These projects are also enabling state surveillance of women’s choices and behaviour in childbirth, in an era of decentralisation when the state’s reach into the villages has weakened.

Village women engage in a constant negotiation with village and state expectations of how childbirth should be practiced. Faced with an imperfect system: in particular, limited by access to government services, village women engage in producing meaning out of their childbirth experiences in a variety of ways, which also reflect their aspirations for development and incorporate both tradition and modernity. The weakening of state authority in villages under
decentralisation, and the fact that the PKK has been less supported by village women in recent times, suggests that women in Waangu-angu and Linomoiyo may have an opportunity in the future to define their childbirth experiences with less influence of state discourse and their models of the ideal Indonesian mother.
Figure 7.4, 7.5 *Mesosambakai* ceremony
Figure 7.6
Procession before a haircutting ceremony, Waangu-angu

Figures 7.7, 7.8 Haircutting ceremony in Wangu-angu
Figure 7.9 Haircutting ceremony in Linomoiyio

Figure 7.10 Haircutting ceremony – baby in Linomoiyio
Chapter Eight
Conclusion

The completion of HMHB has left a temporary gap in the life of the district Department of Health and its maternal and child health division. The office in Baubau, Buton, consists of rows and rows of empty wooden desks, with a few uniformed personnel filling a couple of desks in the front. ‘Look,’ the head of the maternal and health division said to me, indicating with a sweep of her hand the lack of activity. ‘When HMHB was here we were busy, there was a lot of things going on. Now it is gone, there is nothing.’ Similar sentiments were expressed to the assembled health centre (*puskesmas*) staff and subdistrict *bidan* at a monthly *puskesmas* meeting. ‘Thank goodness we have [Simone],’ the head of the *puskesmas* said, only minutes after I had finished interviewing him about the HMHB project. ‘She has reminded us about the HMHB project. Since the project has finished, and there is no longer a project budget, we have forgotten about it. We are no longer doing HMHB activities.’

The HMHB project is part of a cycle of projects from bilateral and multilateral sources that fit into the Indonesian health system: providing short term budgetary support, and disappearing after a few years to be replaced with new projects, and new health activities. During HMHB (1998-2005) there was a UNICEF Vitamin A project, an Indonesian government iodised salt project, and health projects from the World Health Organisation, the Global Fund and Medecins Sans Frontieres. In 2004, the Asian Development Bank began funding the retraining of midwives (*bidan*) by the district Departments of Health. Project names adorn the doors of a number of offices at the Provincial and District Departments of Health in Southeast Sulawesi. Far from standing alone, HMHB conducted just one phase in a long history of the training of midwives that has been occurring in Indonesia since Dutch colonial times. And HMHB will no doubt be replaced by new health projects that may have different health priorities and different implementation strategies. As long as health forms one of the key platforms for the international development industry, and the Indonesian state’s development strategy, projects will continue to be there, in some form, in the Indonesian health system.
The appearance of new projects is also a constant factor at a village level in rural Indonesia. During my field research in 2004, I encountered the signs of a number of different development projects, in different areas of village life. There were World Bank stamps on water tanks and HMHB stickers on the windows of the midwife’s house (*polindes*). Work groups were constantly formed, and ‘teams’ with ‘leaders’ designated, for projects focusing on small loans for village enterprise, tree-planting projects and projects to introduce new types of corn crops. It is with a sense of inevitability, and no great expectation, that villagers attend project meetings and volunteer for ‘teams’. In a similar way village women attend the monthly health clinic (*posyandu*) and dutifully have their children weighed.

Hence projects, like government programs, are an inevitable, and often desirable, feature of everyday life in rural Southeast Sulawesi villages. As the discussion in my thesis demonstrates, the impact of projects falls well beyond a simple success/failure dichotomy. Firstly, projects become a meaningful part of the lives of villagers in ways not anticipated by the project designers, meaning that projects have a variety of impacts in a variety of aspects in villagers’ lives which do not tally up to a project-defined set of successful and unsuccessful outcomes. Secondly, individual projects are not known for their unique qualities in villages, but rather for their cumulative impact. Distinguishing the success of one project in a village is irrelevant, it is more important to consider how the project adds to a larger villager experience of development and government service provision.

*Project evaluations and conclusions*

For AusAID, the Australian Managing Contractor, and the project team, HMHB is seen as a success, the final report stating ‘The Project team and Health Department staff have reason to feel proud of their achievements along a path of progressive development’ (HMHB Project Team 2005: preface). The strength of the project mainly centred on its impact on the Indonesian Health Department system, rather than their impact on villages or the health of women and children. In any case, measuring the impact of the project on the community, and particularly on the health of women and children, is a difficult process. HMHB acknowledged that they have had little impact on the site of birth – with most
villagers still giving birth at home, not in the polindes or another government health facility; or on the rate of bidan attendance at births, which did not change significantly from 2000 to 2003, sitting at around 50% in both districts (HMHB Project Team 2003a). This is partly explained in reports by the argument that ‘some family and community practices and attitudes, particularly in relation to birth practices and infant feeding, are resistant to rapid change’, despite the fact that ‘the skills and capacity of village midwives to deliver services has greatly increased’ (HMHB Project Team 2005: exec summ 11). This argument places responsibility on village attitudes rather than the appropriateness of interventions: HMHB has provided the training and facilities, the community is blamed for not ‘modernising’ – it is their tradition (glossed as ‘community practices and attitudes’) that is holding them back. As Robertson has argued: ‘while the official frameworks of the state remain sacrosanct, failure to implement an ambitious development plan will be blamed on various kinds of cultural, social or even congenital incapacity’ (Robertson 1984: 152).

HMHB Project evaluations support the unstated premise of the development industry (see Crewe & Harrison 1998: chapter 2), including international agencies and national governments, that development is an evolutionary process, moving in a linear direction from tradition to modernity, from ‘developing’ to ‘developed. Rural villages in the implementation area of the project are posited as ‘traditional’, with their cultural practices holding them back from the modernity promised by HMHB development interventions. These reports are rituals of the development industry: to be written and filed, but rarely read or acted upon (Crewe & Harrison 1998: 24). These reports reinforce the legitimacy of donors and projects by couching them within a neutral development rhetoric which is rarely questioned. Yet development projects are as influenced by culture as the villagers they assist. The culture of the development industry places restrictions on the type of activities that a project can do, and requires constant reportage and accountability of projects to their donors. These restrictions have impacts on recipient villages. Needs at the local level may not be met due to the complex bureaucratic requirements and different priorities of various project actors.
Conclusion

HMHB evaluation reports state that the impact of the project on rates of infant and maternal mortality cannot be measured due to a variety of other factors external to the project’s control – such as the decentralisation of power to the districts (HMHB Project Team 2005). HMHB is one small part of a larger campaign to address maternal and child mortality, and one of the myriad of different projects that made a fleeting appearance in the life of villagers. Such issues are also influenced by broader political and economic realities, such as changes of government and decentralisation, which small-scale and short-term projects like HMHB are unable to address. But we should not ignore the responsibility that projects like HMHB had in terms of trying to reduce maternal mortality, one of their stated goals. After all, village mothers are mentioned in their project title. Gasper (1996: 157) suggests that:

Something is clearly wrong when policies with very high requirements are considered as in no way inappropriate or flawed, but merely as let down by contingent weaknesses, which somehow exist in an inferior and separate realm from that of the virtuous policy concept.

Maternal mortality is a complex issue, and attempts to combat it are limited just as much by the structure and priorities of interventions as by the social and political environment in which projects are implemented.

*Anthropology, mortality and a moral engagement*

In giving seminars and conference papers on my doctoral research, audience questions always come back to the issue of maternal mortality. At first I found this somewhat divergent from my research: I was looking at different health and childbirth practices, and what they meant to villagers in terms of modernity, development and engagement with the Indonesian state. I was not looking at mortality. Yet the questions persisted. In the light of the work by Nancy Scheper-Hughes (1995) and others (such as Wolf 1992), I feel that I need to address this question of maternal mortality, and my own role as a researcher in engaging with such an emotive, morally-embedded issue.
Conclusion

In fact, giving papers was not the first inkling I had of my possible role within the issue of maternal mortality. At a number of meetings with HMHB project team staff, comments were made about what I did in the field, and whether it would benefit their project. ‘While we are trying to change things, you are just observing,’ said one team member, with some consternation. ‘I couldn’t attend births,’ said another, ‘What if the woman died?’ Similar statements were echoed by the government midwives (*bidan*) who were working in the villages where I conducted field research. I caught a bus from Linomoiyo back to the city of Kendari with one *bidan*, who adjured me, upon reaching Kendari: ‘If any women give birth while I am not in the village, and you are there, please tell them to call a *bidan* at the *puskesmas* (health centre).’ I continually felt that such requests were inappropriate to my role as researcher. How could I research if I was trying to change things? How could I understand village health practice if I was trying to get rid of it, in favour of a project-promoted biomedical model?

No women died giving birth while I was in either village. No babies died either. In a nearby village to Linomoiyo, though, a woman and her baby died in childbirth while I was conducting research. I heard the story from a number of different sources in Linomoiyo, as well as the *bidan* (who was responsible for that village, in addition to Linomoiyo). ‘She had pre-eclampsia,’ the *bidan* explained. ‘She doesn’t live in [the village where she died]. She lives closer to Andowia (the subdistrict capital). The *bidan* there told her she must go to hospital to give birth. But she decided not to, she wanted to go home to her mother’s village to give birth. She told no health workers, so I didn’t know she was there.’ The sorrow expressed by Linomoiyo villagers for this loss, along with elaborate funeral preparations, underlines the risky business of birth. Villagers, the Indonesian state, and the HMHB project, are all aware of the risks associated with childbirth, and manage it in various ways. Villagers engage with state and international development projects to manage the risks around childbirth, as well as conducting their own risk management: such as through the observance of behavioural and food taboos.

I became implicated in managing risk around child illness and mortality, through the illness of the daughter of a close friend of mine. Erna had been sick for over a
week: feverish, not eating, and only drinking water. Her mother confessed her fears to me that Erna would not get better: the three-year old was already looking worryingly thin. ‘I have run out of milk powder for her,’ she explained. ‘When you go into town, could you buy some for me?’ I accepted her request without a moment’s thought, since her family had looked after me so well while I lived in their village. I refused her offer of payment, saying ‘you are just like family to me.’ I later encouraged her to take Erna to see the bidan, on the rare occasion when she visited the village, and the little girl recovered soon after. At another time when an elderly healer massaged the sprained ankle of her granddaughter, while she screamed in pain, it was difficult for me to remain calm as I asked ‘Are you sure it’s not broken?’ I elaborated a little, suggesting that massage of a broken bone may exaggerate the injury, but this prompted only a critical look from the grandmother, suggesting that my comment was inappropriate and disrespectful of her healing knowledge. I later reflected on these incidents, and the difficulties I felt in trying to be respectful of others’ beliefs, and not interfere, when discussing such emotionally-charged topics as illness and death.

Yet while some inroads have been made into the high rates of maternal mortality in Indonesia, it remains high in comparison to its neighbours. In 2005, it was estimated that between 230 and 307 women died per 100,000 live births nationwide (Ryan 2005). The vast geographical spread of Indonesia, its majority rural population, and its limited capacity to deliver government services – including health, welfare and transport – all contribute to high maternal mortality as a continuing problem. Although the main intention of my argument has not been to solve the problem of maternal mortality, I can offer some suggestions on ways to address it at a village level, based on my own research. I will consider the issue from two aspects: giving birth in the home attended by a bidan, and giving birth in hospital.

Giving birth in the home in a way that would reduce the likelihood of maternal mortality requires the attendance of either a government-trained bidan or a village dukun with some biomedical skills. Apart from a generally sterile practice, the biggest role the midwife plays here is to administer an injection of oxytocin to induce the birth of the placenta in the event it is not expelled soon after the birth
of the baby. A retained placenta is the most common form of post-partum haemorrhage and maternal mortality in rural and remote areas. Indeed some dukun identify it as one of the bidan's most important roles in birth attendance. The WHO recommendation to not allow dukun to be trained in biomedical practice is understandable, given the risks associated with someone having limited biomedical training in being relied on to attend births in isolation. But the reality in Indonesia is that it is difficult for bidan to stay in villages, for all the reasons given in Chapter Six, and for a long time they have often not been in the villages when births take place. Thus birth attendance still falls almost exclusively to the dukun, regardless of whether they have had biomedical training. This dilemma is identified in HMHB project documents. It is also useful to be mindful of the fact that any new regime of dukun training will build on the previous training that has been implemented over the past decades in villages. The oscillation between training dukun and not training dukun in biomedical practice has a long historical trajectory with older dukun still practising who were trained under a previous system – and they still have the ‘kits’ they were given more than twenty years ago.

Assuming that hospital births are the most likely way to reduce maternal mortality, the main obstacles for villagers – as identified by the HMHB project – are poverty and access to transport. However the suggestions and assistance to overcome these by such projects are insufficient. For instance, organising a transport plan in advance to overcome the difficulties of finding transport once a woman has gone into labour is not adequate if the vast majority of villagers own no vehicles whatsoever. It is remarkably rare to see a village-owned car in remote Southeast Sulawesi villages, where only some families can afford to own a motorbike. Secondly, while the HMHB project encouraged a referral system for complicated pregnancies, so that bidan would refer these women to the puskesmas or hospital, most villagers do not go to hospital due to the prohibitive costs associated with a hospital visit. Moreover, attending hospitals is a sign of prestige for villagers – as I previously discussed in the case of Nani. Improving the basic wealth of villagers and their standing in society could very likely have the flow-on effect of encouraging more women to attend hospitals to give birth.
Conclusion

Another factor discouraging villagers from going to *puskesmas* and hospitals to give birth, or receive any type of health service, is the attitude of biomedically trained government health staff towards villagers. The assumption of villagers as backward and ignorant means that staff often treat them derisively, giving them a patronising lecture on the ‘wrong’ habits of villagers, and not respecting the traditions and beliefs of villagers that surround how health is practiced in a village context. A number of authors, including Niehof (1985) and Whittaker (1999) have commented on how village women are treated in hospitals in Indonesia and Thailand, and the experiences of Southeast Sulawesi villagers in visiting *puskesmas* similarly suggests that they are not generally treated with care and respect.

Thus maternal health projects ultimately need to engage with the much broader and more complicated issue of village living standards, along with the provision of maternal health services to isolated villages. Many of the issues I have highlighted throughout the preceding chapters – in particular village conceptions of health, development and spirituality, point to areas with which projects need to engage in order to capture the imagination of rural dwellers in changing their lifestyles to bring about better health outcomes. They also need to engage with the culture of the government health system, recognising that institutional culture change is a long and slow process.

As the discussion of project evaluations above suggests, the project acknowledges it had no measurable impact on the rates of maternal and infant mortality. Since the project had no discernible impact, neither my research nor any critique I make of the project, the Indonesian health system or the development industry more broadly is likely to impact on mortality either. Yet I am mindful that academic literature on health may play a role in the subsequent drafting of new health policy at an international level, and subsequently on the design of new development projects.

There are a number of values underpinning even such difficult and emotionally-charged topics such as maternal and infant mortality that may be clouded by the supposed urgency of the need to reduce mortality rates. Health is not a value-neutral concept. The fact that health workers may save the lives of others does not
exclude them from a value-laden world in which Indonesian rural villagers are constructed in terms of backwardness and tradition while the health system represents modernity and progress. Health interventions continue to be framed in terms of modernity and development, even when they are disguised by the rhetoric of need and the emotion of mortality.

**Living modernity and blurring the boundaries**

Despite the limitations and challenges posed by development projects, they may still provide a significant opportunity for Southeast Sulawesi villagers to improve their own lives. Development may represent something of a hope or aspiration for villagers, despite the implications of ‘backwardness’ for villagers themselves that it entails. As Scheper-Hughes (1995) also notes, local concerns are very much centred around the opportunities that development can bring, allowing them to transform their impoverishment, engage in state projects of health and become modern citizens. In the case of maternal mortality, villagers are equally concerned about the possibility of women dying in childbirth, and in many ways the aspirations of projects like HMHB reflect village concerns. Villagers believe in the transformative power of change, just as project workers and the Indonesian government does. We are all implicated in notions of development, since we all aspire to some notion of it. Development projects are involved in many aspects of the lives of rural villagers, even in the appearance of researchers like myself.

Nur’s sister said to me:

> Thank goodness we had the [HMHB] project. Without it you would never have come here to be with us.

While the reality of the village situation might be quite different to the images of the village presented by the state and development projects, villagers engage with such images in order to interact with the outside world and achieve development. This is an active process of engagement with meanings of the village established by outsiders as well as local identities that are articulated through shared histories, language and ritual practice. Idris was the head of the local indigenous rights NGO in Linomoiyo. He was sponsored by the overarching indigenous rights
alliance (AMAN) to fly to Jakarta in order to speak with the Forestry Department regarding a logging company near the village who was not paying sufficient compensation to villagers. Upon returning to Linomoiyo, Idris was full of stories of the sights he had seen. At one point he pulled me aside, saying:

You know, we think we are poor here. But in Jakarta, I saw people living under bridges and on the streets. We have land, we have houses to live in. They are poorer than us.

His story is a nice inversion of the pity many city-dwellers feel for villagers. In his eyes, villagers have many opportunities that poor people in cities are denied. It highlights the blurred boundaries between city and village, development and backwardness, in Indonesia. Villagers move between the city and rural areas and ultimately identify as modern citizens despite their connection to the backward traditional villages of rural Indonesia.

The intent of my thesis is to demonstrate how health practice is nuanced by notions of development, tradition and modernity; and how villagers explore their understandings of development, and relationship with the state (and the international development community), through health practice. The Indonesian state, through the government health system, relates to villages using notions of development, and creates an idea of the rural village that is ‘traditional’ to the government’s ‘modern’ image. Development projects such as HMHB are implicated in these village-state relations, and the project itself creates ideas of the village, the state, and modernity in health practice. Villagers also express their own notions of tradition and modernity, with reference to Indonesian state and international images of the village. Village-state relations are mediated by health practice and development projects, allowing villagers to express their connection to the state and a pan-Indonesian identity, as well as maintaining their own sense of local identity and promoting their own needs.

Through engaging with the state, notions of development and health practice, villagers enact their own aspirations for modernity. Villagers participate in development projects to try and maximise the benefit that these can have for them: from providing money for attending meetings, to constructing an image of
themselves as poor and needy in order to obtain development funds. By choosing particular healing methods, villagers redefine modern pharmaceuticals and modern biomedical treatments to fit with village-based notions of health, illness and healing. By interacting with the state health system, villagers and village-based healers (such as *dukun*) are able to define themselves within a tradition-modernity continuum. Healers such as *dukun* and *bidan* assert the authority of their healing practice by aligning themselves with local health knowledge and practice, and with the modern biomedical practice of the government health system. Village women enact their modern aspirations by choosing to have government health workers present at the birth (such as the *bidan*) or to give birth in hospital. At the same time they incorporate traditional practices in their childbirth experiences, expressing the important role played by *dukun* at births and continuing to observe post-birth rituals.

The intention of those chapters is to bring the periphery of poor, remote rural villages of Southeast Sulawesi to the centre. This approach contrasts with both the Indonesian government, which is historically centralised around the national government; and international aid projects, which reflect internationally-established development norms. This study has implications far beyond the scope of rural Southeast Sulawesi villages. It contributes to debates on centre-periphery and the role of the state in contemporary Indonesia; engages in broader discussions on health practice, childbirth practice and change in the Southeast Asian region; and expands the academic literature focusing on the Southeast Sulawesi region. While some detail contained within the chapters is particular to the case-study I examined, the way that rural villagers engage in notions of tradition-modernity, development and village-state relations through health practice gives this thesis much wider applicability than the two rural villages in Southeast Sulawesi from which it derives.
Glossary of Terms

ADB  Asian Development Bank
AMC  Australian Managing Contractor
Arisan Local (women’s) savings collective
AusAID Australian Agency for International Development
Balita (bayi di bawah umur lima tahun) Child under five years old
Bayi  Baby
Bidan Government-trained midwife
Bikor Bidan Koordinasi
Midwife coordinator / supervisor
BKKBN Badan Koordinasi Keluarga Berencana Nasional
National Family Planning Board
Cocok  Appropriate
Depkes National Department of Health
Desa Village (administrative)
Dinas (Kesehatan) Provincial/District Department of Health
Dukun Traditional healer / midwife
Gerakan Sayang Ibu Mother Friendly Movement
HMHB Healthy Mothers Healthy Babies Project
IDSS International Development Support Services
Imam  Islamic religious leader
Jilbab  Islamic head covering
Kader (posyandu) Health volunteer
Kampung Village
KB Keluarga Berencana
Contraception / Family Planning
Kebun Garden, fields
Kemitraan Partnership
ODA Official Development Assistance
Pendampingan Partnership
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tr>
<td>Penyakit</td>
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<td>PKK</td>
<td>Pembinaan/Pemberdayaan Kesejahteraan Keluarga</td>
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<td>Pos persalinan desa</td>
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<td>PPK</td>
<td>Proyek Pengembangan Kecamatan</td>
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<td>Pos pelayanan terpadu</td>
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<td>Man</td>
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<td>Mobile health centre</td>
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<td>Pustu</td>
<td>Puskesmas pembantu</td>
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<td>Suami siaga</td>
<td>Husbands alert</td>
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<td>Blow</td>
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<td>United Nations Children’s Fund</td>
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<td>United States Agency for International Development</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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Appendices

Appendix 1: Project messages

From training with dukun:
- You must cut the umbilical cord before the placenta is expelled (within 30 mins)
- Establish breast-feeding immediately, before the placenta is expelled
- There must always be a bidan at a birth. If there is no bidan in the village, call one at the health centre (puskesmas)
- Dukun must attend the monthly outreach clinic (posyandu)
- You are not allowed to wet-nurse anymore (pinjam tete)

From training with kader (health volunteers):
- Don’t wash baby or mother straight away – wait two hours
- Women wash hands and clean breast before breastfeeding
- Breastfeed equally from both breasts
- Breastfeeding increases closeness of mother/baby bond

From stickers:
- The bidan and dukun together help to deliver babies in a safe manner (bidan dan dukun bayi bersama-sama membantu persalinan yang aman dan selamat)
- Neighbours alert: prepare transport in advance to support a safe delivery (warga siaga menyiapkan transportasi untuk mendukung persalinan yang aman dan selamat)
- Husbands alert: organise a blood donor to support a safe delivery (suami siaga menyiapkan pendonor darah untuk mendukung persalinan yang aman dan selamat)
- Husbands alert: prepare any equipment in advance to support a safe delivery (suami siaga menyiapkan keperluan untuk mendukung persalinan yang aman dan selamat)
- Husbands alert: put money aside to prepare for the delivery (suami siaga menabung untuk persiapan persalinan)
- Health volunteers: give health education about a healthy life (kader posyandu memberi penyuluhan tentang hidup sehat)
- Watch out! Cigarette smoke has a bad impact on health – don’t smoke near where women are breathing (Awas! Asap rokok berpengaruh buruk pada kesehatan. Jangan merokok dekat ibu nifas)
- Watch out! Don’t smoke near where women are breathing – cigarette smoke can have a bad impact on the health of babies (Awas! Jangan merokok dekat ibu nifas. Asap rokok dapat berpengaruh buruk pada kesehatan bayi)

Other messages:
- Don’t throw away the colostrum
- Husbands should help their pregnant wives (Suami bantu ibu hamil)
- Husbands alert! Prepare, look after, care for (Suami siaga! Siap antar jaga)
- Give a hepatitis B shot to the baby within the first twelve hours of birth

Appendix 2: Curriculum of bidan training

Training of bidan by the HMHB project used a competency-based training system in clinical and non-clinical skills. Bidan were trained in some or all of the following programs, depending on their needs (for example, bidan in remote areas were trained in life saving skills due to the difficulty of transporting women to government health facilities):

- Basic/normal delivery care – including using controlled cord traction and oxytocin injection in order to decrease blood loss during delivery
- Life saving skills (LSS) – to address post partum haemorrhage, peurpural sepsis and eclampsia when attending births in a remote setting
- Communication and community entry – to increase the communication skills of the bidan, as well as give her skills to enable her to gain access to communities. There were five key activities: village map, the road to health card, women’s daily workload, counselling, and group health education and presentations at village meetings
- Pendampingan – training to encourage bidan and dukun to work together to attend births
- Integrated management of childhood illness (IMCI)
Maternal and perinatal audit

Administering Hepatitis B to newborn infants – initially within seven days of birth, later trained to administer the first injection within the first twelve hours of birth
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