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CHILD CARE STRATEGIES OF JAVANESE FAMILIES WITH MOTHERS ON OVERSEAS LABOUR CONTRACTS

by

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at The Australian National University

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Except where indicated in the text, the analysis in this thesis in my own original work

Sri Sunarti Purwaningsih

(July 1998)
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ABSTRACT

Deteriorating economic conditions in the rural areas of Java have forced many families to reconsider how they are going to make ends meet, both now and in the future. Temporary female migration is increasingly seen as a viable option for families to improve their standards of living. Since the early 1980s thousands of Indonesian women have gone abroad, particularly to the Middle East, to work on two-year contracts as domestic servants. Many were married and already had young children. Under the conditions of their contract families had to remain in Indonesia, so children were entrusted to caregivers. This study examines the strategies for care of children under 5 years of age used by the caregivers of these female migrants in the rural district of Purworejo, Central Java, Indonesia. Issues relating to how these children were cared for, and how these childcare strategies affected their morbidity and nutritional status are examined. The study also explores how the impact of remittance transfers on household incomes affected childcare and children’s well-being. The analysis was based on the qualitative data collected specifically for the study and quantitative data drawn mainly from the 1992/93 AIDAB-funded Project on Women’s Work and Child Welfare (the 1992/93 Survei Ibu).

Quantitative and qualitative data are used in a complementary manner to construct a comparative analysis of childcare strategies between families with migrant and non-migrant mothers.

The results of the study show that the children of migrants and non-migrants had
similar patterns of care. There was also no difference in the distribution of illness reported by caregivers in any of the age groups, whether or not the child belonged to a migrant woman. The study villages were relatively socially homogeneous and childcare was provided to migrants' children by caregivers who had much in common with those caring for non-migrants' children. This may explain much of the similarity in care and patterns of treatment of illnesses among migrants' and non-migrants' children. The similarities in the pattern of illness may also be due to limitations in the data: there were no data on the duration of illnesses and some illness episodes were included more than once because they were collected every three days. Similar percentages of illness observations among groups could conceal differences such as more episodes, or fewer episodes of longer duration.

The analysis of child-nutritional status shows a higher proportion of stunting among children of migrants. Despite the high earnings of women workers, the poverty that had originally motivated the mothers to migrate remained a factor in this situation. Children of migrant mothers did not benefit from their mothers' earnings partly because of the consequence of spending patterns among the family left behind. Remittances were often shared with the wide-kin network due to their role in taking care of the children while the mothers were away, reducing the potential benefit for the migrants' children. Fathers, who usually controlled the spending of remittances, also tended to place a lower priority on food and health expenditures than mothers. Thus, it is possible that the children of migrant mothers were stunted because of that initial poverty and the spending pattern of remittances, not because of the effect of their mother's migration.
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CHAPTER 1

INTRODUCTION

1.1 Background to the study

The phenomenon of maternal migration, where a mother migrates temporarily or in a more or less regular cycle of circulating movement, leaving behind her spouse and children for an indeterminate period, has been noted in a number of studies (Brydon and Chant, 1989: 128; Connell, 1984: 982; Guest, 1989: 139; Hetler, 1990: 175; Keyes, 1990: 107; Oztek, 1989: 129; Spaan, 1989: 67; Brochmann, 1993: 227; Dias, 1986: 177; Hugo, 1993: 110; Cumaranatunga, 1990: 188). Improving the standard of living for their families is frequently cited as the reason for the migration.

Many Asian women, particularly those from the Philippines, Sri Lanka and Indonesia, seek work overseas. This is probably a response to the limited employment opportunities for them in the agricultural sector arising from the defeminisation of agriculture associated with mechanisation and the evolution of farming systems (Boserup, 1970 cited in Illo, 1985: 71). When job opportunities in agriculture for poor women decrease, migration for work becomes a viable option. Women work to supplement their husband’s earnings in order to ensure the survival of the family, even though men continue to be considered generally as the breadwinners.

Although women work longer hours in agriculture than men, they often receive lower wages. This is another reason for the migration of women. White (1985: 122) noted that:
the movement of women from home-based work to wage-work and their new status as independent wage-earners may represent one step on the long road of struggle for social and economic emancipation.

Many women have been migrating overseas to work on contract. Since most of these are married and in the prime child-bearing ages, an important question that should be asked is what happens to the children they leave behind?

Maternal migration can be expected to have an impact, either positive or negative, on the lives of the children left behind. Maternal migration may result in improved household income or better information on nutrition or other aspects of childcare or health care (preventive and curative). For example, a study in Yogyakarta found indications of increased health awareness in the households of most returned migrants from Jakarta and concluded that migration positively influenced women's attitudes toward health care (Rusman, 1991: 55). As successful temporary migrants usually send remittances to their families, the resultant higher household income may also contribute to a better standard of living, including the provision of more nutritious food for young children. Conversely, there may be a negative effect if remittances are lower than the original contribution of the mother to household income.

The migration of mothers requires the provision of an alternative source of care for their children, particularly for health, nutrition and access to health care, because the mother is usually the primary caregiver for young children. Young children will be most affected because they are dependent on the care given by substitute caregivers. In some cases, the mother's absence may result in them receiving care from a number of substitute caregivers. When the mother is away, relatives, particularly grandparents, are often called to care for the children and run the households in which the children live. This has lead to the emergence of 'granny fostering', that is, placing children in the care
of grandmothers (Brydon and Chant, 1989: 129; Spaan, 1989: 64). Granny fostering may affect both the wider family and the children. It may not only strengthen the extended family system, which is common in Java, but may also increase the share of remittance income outside the nuclear family. However, DeRose (1992: 11) noted that mother substitutes may not be able to provide the same type of care that a mother provides (such as breastfeeding). In addition, the absence of mothers from home for long periods may have a developmental or emotional impact on children, particularly young children.

A study in Sri Lanka (de Bruijn et al., 1992: 178) found that, while the migration of mothers had positive financial effects on their families, the socio-psychological effects were often negative. The remaining family members often had to take part in a wider range of household tasks than normal and, in some cases, the separation of spouses for approximately two years led to marital instability. The remaining members of the migrants' families at the place of origin had to cope with the separation and other changes brought about by the migration. They had to adjust not only to the absence of the migrants but also to the influences of the newly acquired wealth, goods, ideas, attitudes, behaviour and innovations transmitted by the migrants (Hugo, 1995: 290). Gonzales (1961 cited in Hugo, 1995: 290) noted that family structures have been affected differentially by various types of migration according to the degree of permanency, kinship linkages and patterns of family residence. Patrilocal societies generally are more adaptable than matrilocal, and also those in which the joint family dominates over the nuclear family (Connell et al., 1976: 47 cited in Hugo, 1995: 290). The migration of mothers may have a multi-dimensional effect on the whole family.
Women's international labour migration has not been as well documented as the migration of men. The international migration of women contract workers has become 'big business', but has received little attention:

The various dimensions of male migration in the region have been well documented. However, no attention was paid to women workers and it is recognised that very little information and research exist in the area of international migration and women (Heyzer and a Nijeholt, 1987, quoted in Gurung, 1994: vi).

However, women's international migration for employment now affects large numbers of women and their families. Large numbers of the women migrants are married and leave young children. There are a substantial number of Indonesian women migrants. Women's migration overseas for improving personal and family life is important, and assistance programmes are required in response to the problems that migrant women may encounter (Women's Information Network for Asia and the Pacific (WINAP), 1989: 1). However, research is needed to establish just what those problems are and how they might be addressed.

The consequences of maternal migration for the health and welfare of the children they leave behind is an important issue in Indonesia. However, it is one that has received little attention. Information on the families of Indonesian women working overseas on labour contracts is lacking. One reason is that existing research is not sensitive to family-related issues (Hugo, 1995: 273). The limited research on international migration from Indonesia and the role of the family which shapes that movement has been due to four factors (Hugo, 1995: 274):

- The relative recency of international labour migration as a phenomenon of significance in Indonesia. As with nearly every country in the region, the amount of international movement was very small until about two decades ago, and has mainly been restricted to elite groups.
- A lack of adequate data collection systems, either to measure stock (via censuses) or
flows (via border-crossing registration) in nearly all countries in the region (Hugo, 1993a).

- An increasing proportion of international migration is now occurring at and beyond the margins of official immigration policies. It is therefore necessary to take into account the increasing flows of illegal migrants when attempting to delineate international migration systems in Asia (Hugo, 1993b).

- Research into the causes and consequences of contract-labour migration has paid little attention to the family as a unit of study.

The level of temporary and circulating migration in Indonesia is high (Hetler, 1989: 54; Hugo, 1981, 1989; 1991; Robinson, 1991: 37; Stahl, 1988: 11). Increasing pressure on families to earn cash incomes in rural areas, combined with increasing employment opportunities for women in urban areas, may lead to the increased involvement of young women, including those with young children, in circular migration (Corner, 1990: 3; Brydon and Chant, 1989: 122). In some circumstances, women may be able to obtain jobs more easily than men, particularly as domestic servants and in low-paid factory employment. For example, in Java, women were able to obtain jobs in the Middle East more easily than men because of the low skill requirement for domestic servants and the lower cost of international contracts for women. In 1990 a fee of Rp. 300,000 - Rp. 500,000\(^1\) had to be paid to the recruiting agency to arrange contracts for women to work in the Middle East. However, the fee was much higher for men: Rp. 1,000,000 - Rp. 1,500,000. Robinson (1991: 48) noted that there were few job opportunities for poorly skilled male workers. Men were required to have a specific skill in order to work abroad. Few of the men in the families of the women migrants from Central Java had such skills or the education to acquire them.

\(^1\) In December 1990, the exchange rate was A$ 1 = Rp. 1,450.
Although Hetler (1990: 189) found that some internal migrant women took their children aged less than two years with them to their destination, most young children in Purworejo, Central Java remained at home when their mothers migrated. A number of women migrated to the Middle East leaving behind children under five years old. In Indonesia, and in Java in particular, women traditionally bear the primary responsibility for child rearing. Thus, when women are absent from home, it affects the organisation of childcare (Brydon and Chant, 1989: 131). With a growing number of Indonesian women being recruited as domestic servants to the Middle East (Mantra and Kasnawi, 1986: 4; Cremer, 1988: 76; Robinson, 1991: 47), the impact of maternal migration on the health and welfare of the children left behind is a significant and growing problem for Indonesia. It is important to know to what extent and under what circumstances the migration of mothers leads to a negative or positive impact on the health, nutrition and welfare of the children.

What is known from existing research on the effects of maternal migration on the health of children left behind? The answer is surprisingly little. Several scholars have addressed both the positive and negative effects of mothers' migration, but only in respect of family composition (Hetler, 1990; Youssef and Hetler, 1983; Parasuraman, 1986), household income (Connell, 1984; Keyes, 1990), the status of women (Williams, 1990; Ware, 1981; Murray, 1981) and attitudes towards nutrition and health (Hugo, 1987; Todaro, 1976; Goldscheider, 1981; Ware, 1981). Some research is indirectly relevant because it deals with related issues. For example, many studies have examined the effects of household income on child health (Mosley and Chen, 1984; Vial et al., 1989: 146; Da Vanzo, 1984; Ruzicka and Hasluwka, 1982; United Nations, 1985; DeRose, 1992), and the effects of knowledge of health on child health (Ware, 1981;
Streatfield et al., 1990; Preston, 1989). An interesting body of literature exists on the
effect of maternal employment on the nutritional status of infants from low-income
households in Central Java. However, only a handful of studies in developing countries
have specifically investigated the effects of mothers’ migration on the health of children
left behind (Bilquees and Hamid, 1981; Parasuraman, 1986; Soekirman, 1984;
Chowdhury, 1986; Brockerhoff, 1990). There is, therefore, a need for further research on
this important topic.

1.2 Women's work, migration and child health: a review

From the literature on the relationship between women's work and the health of
children, some tentative hypotheses can be formulated concerning the effects of maternal
migration on the health of children who remain behind. The impact of maternal absence
due to migration is similar in some ways to the effect of mothers' work outside the home.
This is because both usually arise from the desire to increase household income and may
increase the flow of cash into the household. Both also involve some reduction in the
time the mother has available for childcare (United Nations, 1985: 149).

(i) Women's productive and reproductive responsibilities

In any society, the rearing of children is one of the most important
responsibilities of parents, particularly of mothers (Soekirman 1984: 24). In the
traditional division of labour, the woman was a housewife who was responsible for all
household affairs and the husband was the breadwinner. However, economic
development and modernisation has resulted in changes in the role of women. A modern
woman is not only a housewife but also a contributor to the family economy. In the past
in the USA, for example, women’s work was at home, but this is changing.
During most of this century the typical family has been portrayed as consisting of a father who was the breadwinner and left home each day for his job in the workplace and a mother who stayed home and took care of the children and managed the household responsibilities. Today, more than ever, the family does not fit this stereotype...(O'Reilly and Briscoe, 1993: 260)

Many American mothers no longer stay at home to look after their children, even mothers of young children have entered the paid labour force. Similar changes are also beginning to take place in Indonesia. Today, many women in Indonesia enter the labour force. The 1980 and 1990 censuses show that female participation rose from 33 per cent to 39 per cent, while the male rate increased from 68 per cent to 71 per cent (Simanjuntak, 1993: 46). Many Indonesian women have left their children in order to work outside the home or even overseas. Childcare becomes a great concern for women who enter the labour force, particularly for those who have to migrate for work without their children.

Leslie and Buvinic (1989: 2-9) argued that child health and socio-economic roles of women in developing countries are of interest for two reasons: first, the balance between women's productive and reproductive responsibilities; and second, the consequences of women's work for children's health. These issues have not been addressed adequately by research or policy, resulting in a recent rise in interest in the relationship between women's labour force participation, including women's migration, and the health of children left behind.
(ii) The impact of women's absence on child health

In many cultures, the care of children consumes much of their mothers' time. Despite the lack of reliable data on the subject, women who participate in the labour market seem to spend less time on childcare (UN, 1985: 149). Because of the increase in women's work responsibilities, the time and energy spent on childcare may be limited and its quality may also be affected. This in turn may affect children's nutrition and health, since the immediate environment of young children is especially important in their physical development. Elmer (1960: 717 cited in Soekirman, 1984: 29) noted:

As the infant's environment is largely the mother, there is sound reason for suspecting the mother of playing a key role in the infants' health.

The health of infants depends in many ways on their mothers. This is reflected by the powerful motherhood norm that exists in most cultures that 'women should bear children and be primarily responsible for their care' (Russo, 1976 cited in Paludi, 1993: xii).

Da Vanzo and Lee (1983 cited in Broekerhoff, 1990: 610) suggested that mothers' economic activity outside the home has a negative impact on child survival by reducing the amount of maternal time devoted to child rearing. This might affect the children in a variety of ways, including what they eat. Since 'less-supervised' children may eat less regularly and eat less nutritious food (Corner, 1990: 6), they may become malnourished. Florencio (1980: 2) pointed to another link between the nutritional status of children and the family environment. The family and household environment influences the pattern of food intake among children because secure and happy children are likely to have bigger appetites and better nutritional status than children who are insecure and unhappy.
1.2.1 The probable effects of migration on child health and nutrition

(i) Migration and knowledge about child health and nutrition

It might be expected that knowledge of nutrition and childcare has an impact on child health. Preston (1989: 66) noted that improved knowledge of diseases can lead to better personal hygiene, as well as to greater acceptance of public preventive health programs. Lindenbaum (1983 cited in Preston, 1989: 75) stated that knowledge of hygienic practices is one of the most important routes through which this variable operates. A study in Yogyakarta (Streatfield et al., 1990: 447) showed that, irrespective of mother's education level, specific immunisation knowledge was associated with an increased likelihood of using immunisation.

Initially, education is a vehicle for transmission of knowledge. Migration and education are usually closely related. Within the labour market, people with higher education have better chances of gaining better jobs. Thus, people with a high level of education are more likely to migrate because they are more likely to gain greater economic benefits. Migration is generally observed to increase as education increases (Todaro, 1976; Goldscheider, 1981; Hugo, 1987: 147). However, although it is more educated individuals who migrate, migration typically occurs from areas of lower to areas of higher education.

It might be expected, therefore, that migration also has the potential to act as a means of disseminating information. Such information might include new knowledge and health practices. The out-migration of family members has an 'active' impact on the family because the out-migrants can improve the family's socio-cultural environment (Hugo, 1987: 147) by, for example, disseminating new ideas that affect attitudes and behaviour or sanitation practices. Migration, therefore, may increase demands for a
better life, raise health awareness and motivate people to use modern health practices. Migration may also provide an avenue for new modes of belief and action (Ware, 1981: 173). The migrants may return from the recipient country or area with better knowledge of health and nutrition and other aspects of childcare, both preventive and curative. Skeldon (1990: 187) suggested that migration may even contribute to a reduction in mortality because of the increased contact of migrants with modern medicine, and beneficial hygiene or dietary practices.

(ii) Migration, income and child health

Migration may affect child health and nutrition through its effects on income via remittances. Migration is usually aimed at increasing the family's income. It might be expected that the family's economic conditions would be improved, since most successful temporary migrants send remittances to their families. Remittances might be used to purchase better facilities, for example, modern sanitation facilities and clean (piped) water. Thus, remittances may enable households to meet their basic needs and obtain improved health services.

Guest (1989: 13) argued that the migrant's absence also contributes positively to the household economy because the migrant is excluded from household consumption. The reduction of one resident adult unit of consumption will decrease the household's per capita food needs (Palmer, 1985: 2) and may contribute to better nutrition of children. Income is generally a powerful determinant of child health. Higher income influences child health because it increases food-purchasing power and access to alternative resources. This should enable the family to improve infant nutrition and child development (Mosley and Chen, 1984: 34-36; Ruzicka and Hansluwka, 1982: 582; Vial
et al., 1989: 146). Healthier children in households with higher incomes should experience lower mortality because of more adequate fulfilment of basic needs and improved health services (UN, 1985: 191).

Children in higher income households are likely to consume more health-enhancing goods and services per capita than children in lower income households. The better the socio-economic status and family characteristics such as education, literacy, income and housing conditions, the lower the infant mortality rate (Ruzicka and Hansluwka, 1982: 582). Household income is likely to be correlated with mother's and child's nutritional intake and use of medical care (Da Vanzo, 1984: 312; Soekirman, 1984: 32). A study by the International Centre for Research on Women (ICRW) (1980: 5 cited in Soekirman, 1984: 41) found that in Africa, South and Southeast Asia, and Latin America:

Women's contributions to household income improve the means to meet basic survival needs such as food, clothing and shelter. Ultimately, women's contributions make possible improvement in the health and nutritional status of young household members.

It is clear from the literature that the involvement of women in gaining income is intended to help the family to attain a better standard of living. Women, particularly married women, contribute their labour in order to fulfil the survival requirements of their respective families (Illo, 1985: 72). The women’s contribution is mainly to ensure that the family is able to provide the children with basic needs.

However, income is not the only factor determining child welfare, and income can only affect child health through other variables (UN, 1985: 192; ICRW, 1980: 120). The power structure of the family, and roles in allocating household resources are also important because children do not allocate resources to themselves. Bruce's (1989: 985)
study in Kerala, India, reported that children's nutritional levels did not increase in direct relation to increases in paternal income. Rather, a greater improvement in child's nutritional status occurred if the additional income went directly to the mother. Mothers were found to spend most of the income under their control on their families, particularly their children. Men were more likely to spend increased incomes on personal consumption.

Income is also related to the nutritional status of individual members through hygiene practices and environment, which act through food intake or food absorption (Bhuiya, 1983: 6). Foster (1984: 135) noted that in developing countries the incidence of respiratory infections is high in households with low economic status and crowding. However, household income determines the power to purchase better facilities, which may affect child health. For example, a study in Malaysia by Da Vanzo (1984: 315) found that a lack of modern sanitation and piped water led to higher infant mortality.

The extent to which migration affects household economic well-being and, in turn, the health of the children also depends on such factors as the distance involved in migration, the migrant's financial success, and remittances (Palmer, 1985: XV). Corner (1990: 5) argued that the impact of migration on economic support depends partly on whether the missing mothers are permanently or only temporarily absent. The effect on the health and nutritional status of the children also depends on factors such as the amount and frequency of remittances received, who receives the money and how it is spent. In Purworejo, Central Java, the location for the field work on which this thesis is based, small amounts and regular remittances were more likely to be spent on food, whereas large amounts and irregular remittances were more likely to be spent on durable goods. In the study area, remittances under the control of women were more likely to be
spent on food and health care than those in the hands of men. Thus, knowing what the remittances are spent on is important in assessing the net impact of maternal migration on child welfare (Ware and Lucas, 1988: 6.1.12).

1.2.2 Possible negative effects of migration on child health

In the short term, migrants may not be able to send remittances home because their incomes may not be sufficient even to support themselves. Migrants have to pay their living costs in the place where they are working. In the case of unsuccessful migration, the family members left behind have to seek support from other families. In the short term, the migrant may even have to be supported by the family left behind through transfers sent to the migrant, thereby reducing household income. Since migrants have often borrowed money from relatives or neighbours to finance their movement, they may have to repay this debt from their initial earnings, or, in cases of less successful migration, from household income (Purwaningsih, 1991: 14). This consequent decline in household purchasing power could put further pressure on the household economy and affect child health. As the migrant finds work and obtains an income, these effects can be expected to decline. When the migrants succeed financially and are able to remit money home, the standard of living of their households of origin may begin to increase. If the money is used to purchase food, health care and health-related facilities, the health status of the children left behind may also improve.

In some countries remittances are sent not to the nuclear family itself, but to the extended or joint family (Youssef and Hetler, 1983: 238; Palmer, 1985: XV). Remittances may then be used on larger family obligations rather than on the direct nuclear family. In addition, remittances may not go to children, but sometimes to other
relatives (Connell, 1984: 984).

Improvement in the living environment, particularly housing, has been reported as a popular use of migrant earnings (Palmer, 1985: 11; Spaan, 1989: 67). In Africa, Ware and Lucas (1988: 6.1.2) raised the question ‘Does household nutrition benefit from remittances?’ They found that remittances tended to be used to buy bicycles or sewing machines. Some studies show a large proportion of remittances used for family consumption, suggesting that nutrition would be improved (see Palmer, 1985: 10).

In general, child nutrition seems to be closely related to household income or wealth. However, the nature of women's work, work time and income determines strategies for childcare and thus also affects child nutrition and health (Leslie and Buvinic, 1989: 9-21). Even though increases in household income enable them to purchase additional goods, working women have to limit their time for home production and childcare. For example, they may be able to spend less time on food preparation and be more likely to purchase ready-made foods, which may be less nutritious. Alternatively, they may have less time to take children to health clinics, particularly for preventive health care. This may result in poorer child welfare. A study from Honduras (O’Gara, 1989: 124) showed that maternal employment had no effect on child nutritional status; the health and nutritional status of children with working mothers did not differ from the status of children of non-working mothers. Problems existed only for very poor households who were unable to provide adequate substitute child caregivers.

1.3 The objectives of this study

This thesis is about the migration of Indonesian women on overseas labour contracts in the Middle East and the well-being of the under-five children they leave
behind. It examines the childcare coping strategies that families adopt in the absence of the mother, and the effects of these strategies on the well-being of the children. If the mother, who is usually the primary caregiver, is absent then who will care for the child and how is the child cared for? The way the child is cared for may influence its well-being, particularly in relation to nutrition and morbidity. The situation of children under five years of age whose mothers are absent is explored to establish whether the absence of the mothers is likely to affect the children’s health or nutrition. The study also identifies specific ways in which mothers' migration might affect child health and nutrition and indicates areas in which further research is needed. Specifically, the study will:

1. Describe and explain patterns of childcare in the families of migrant and non-migrant mothers.
2. Identify patterns of reported illness and treatment among children in migrant’s and non-migrant’s families.
3. Identify patterns of child nutrition among migrant’s and non-migrant’s families.
4. Identify the role of the family in providing childcare assistance in the absence of the mother.

In view of the lack of research on the topic, I decided to conduct a more detailed analysis of the childcare coping strategies used by Javanese families where mothers worked on overseas labour contracts. I chose to locate the study in two sub-districts of Purworejo regency, a rural area of Central Java, Indonesia. The choice of Purworejo as the research site was not an arbitrary one. A longitudinal survey on child morbidity and Vitamin A (the Morvita study) that had previously been conducted in this area provided some data on the health of under-five children in the area. A study investigating the relationship between mother’s work and child welfare (the 1992/93 AIDAB-funded Project on
Women’s Work and Child Welfare or the 1992/93 Survei Ibu\(^2\) provided an opportunity for the research on which this thesis is based to be linked to a quantitative data set. My marginal involvement in the Morvita study had also given me contact with many families in Purworejo. This made it easier for me to gain their co-operation and produced a good basis for the qualitative field work associated with this investigation.

1.4 The nature of the study

It was necessary to use a number of complementary approaches to data collection in this study, which utilises both quantitative and qualitative methods. Quantitative and qualitative data are used in a complementary manner to construct a comparison analysis of childcare strategies between families with migrant and non-migrant mothers. The quantitative data sets were derived from the 1992/93 Survei Ibu which aims at examining how the health, nutrition and access to health care of children in Purworejo, Central Java, was affected by their mother’s work in the labour force. The 1992/93 Survei Ibu was a longitudinal survey which was conducted collaboratively between Graduate Studies in Demography, the Australian National University and the Epidemiology and Bio-statistics Unit (CEU) of Gadjah Mada University in Yogyakarta, Indonesia. The survey was funded by the Australian International Development Assistance Bureau (AIDAB) (now AUSAID, Australian Agency for International Development) (a more detailed explanation on the 1992/93 Survei Ibu will be given in Section 4.2). The fact that the survey was collected for purposes other than a study of the relationship between women’s labour migration and child welfare, and the sample of migrant children for

\(^2\) Throughout the thesis the term the 1992/93 Survei Ibu will be used to describe this source of the data.
which quantitative data were collected is small, a qualitative approach such as in-depth interviews and focus group discussions was also conducted. The use of in-depth interviews and focus group discussions were to identify the mechanisms through which the pattern of care that children receive affects their nutritional status and morbidity. Further, the approach was used to explore the reasons for attitudes, perceptions, beliefs and traditions that produced the specific behaviour of caregivers in caring for the children of migrant and non-migrant mothers (a more detailed explanation the use of qualitative approach will be given in Chapter 4.4).

This study is exploratory. Relatively few comprehensive studies of the children of migrant women workers have previously been conducted in Indonesia. Although there are some recent studies on labour migration and its impact on the well-being of children in Pakistan and Sri Lanka (Bilqueez et al., 1981; de Bruijn et al., 1992: 159), few studies in Indonesia have addressed the issues explored here. In contrast to the extensive literature on migration in the receiving countries, the literature on its impact on the children left behind is extremely limited. The lack of previous micro-level studies on the impact of women’s international labour migration on child survival and the lack of a well-developed methodology for studying the issue means that the findings of this study provide a basis for further research rather than a definitive set of conclusions on the issues raised.

Information about the effect of a mother’s absence on her children cannot be readily obtained by asking very specific and closed questions. Such information can be better obtained through in-depth interviews, observation of the behaviour of those who care for the children during the mother’s absence and a comparison with the care observed to be provided by a comparable group of mothers. It has been noted that
qualitative data provide information and insight into the specific kinds of problems that may be faced by the communities being studied and give insight into their problems in the socio-cultural context (Rusman, 1991: 56).

On the other hand, a qualitative study on its own cannot indicate the extent of the phenomena under study in the population as a whole. Although it can identify certain effects of mother's absences, it cannot indicate what proportion of children are affected. It also cannot establish definitely that the experience of children of migrant mothers is clearly different from that of other children. For this reason, the findings of this study can only be regarded as tentative.

In an exploratory study of this kind, both quantitative and qualitative approaches are important. The quantitative data establish the overall context of the study. For example, the characteristics of the households of absent mothers and the health of their children are compared with the characteristics of households and children of resident mothers. A large data set that provides detailed and high-quality information on childcare, child morbidity and nutritional status would be required to establish the differences in health and welfare between a group of children of migrant mothers and a comparable group of children of non-migrant mothers. However, as noted, the existing level of knowledge on this topic is insufficient for such a study to be carried out. Thus, the present study places more emphasis on qualitative analysis. It was initially hoped that data collected for other research objectives in the 1992/93 Survei Ibu could be utilised to enable valid statistical comparisons between the two groups of children that were the focus of my thesis research. However, due to the pioneering nature of the study and complexity of the research design, this proved impossible. Consequently, the study remains exploratory, providing the essential ground work that may enable others to
achieve that objective.

1.5 Research design

This study compares the well-being of the children of migrant mothers (as the case) and non-migrants’ children (as the control). Because childcare strategies are analysed in a particular area, this is therefore a case study. Miles and Hubberman (1984, cited in Soesilo, 1990: 46) pointed out that the purpose of case studies is to ‘describe, understand and explain what has occurred in a single, bounded context’ with the aim of explaining the particular relations under consideration. Given the emphasis on detailed understanding, case studies commonly employ qualitative as well as quantitative research techniques, as in this study. The data are drawn from field work conducted by the investigator and the quantitative data set provided by the 1992/93 Survei Ibu. Detailed information about the 1992/93 Survei Ibu is provided in Chapter 4.

This study may not be statistically representative. However, the data relating to people’s behaviour are of good quality because the information was collected in-depth according to a careful research design and paying special attention to the need for objectivity. Observation over a prolonged period enabled actual behaviour to be verified.

The quantitative data available in the 1992/93 Survei Ibu establish the overall context of the case studies and enable the correlates, such as characteristics of the households of absent mothers and the health of children in these households, to be examined. Data on the anthropometry and illnesses of the children were also obtained from the 1992/93 Survei Ibu.

This study first examines the quantitative data in order to establish whether a direct relationship exists between childcare and maternal absence. Quantitative analysis
also describes the characteristics of the migrant mothers and their households compared with those of non-migrant mothers. A qualitative approach was then used to gather information that could not be derived from the survey questionnaires, particularly for the variables that underlie people’s behaviour and play an important role in caring for children. These variables include childcare behaviour and feeding practices.

Field work for this study was undertaken in a number of villages in two sub-districts of Purworejo region, Central Java. The study site is located near Yogyakarta, a large regional city on the island of Java. Rural poverty and easy access to public transportation contribute to a high level of population mobility in this area, much of it of a temporary or circulating character. Most of the study population are engaged in agriculture. The main crop is rice grown in paddy fields (sawah), and cultivation is small-scale and labour intensive. Despite the ‘Green Revolution’, many farmers produce only one crop of rice a year. Villages located in the coastal area are subject to unpredictable flooding, which can destroy the harvest. Many villagers experienced poor harvests during the late 1980s, resulting in increased pressure for migration in search of higher earnings elsewhere.

The study postulates that the quality or type of substitute childcare will affect the health status of children in situations where mothers migrate without their children. The following factors will be examined in investigating the quality of care: beliefs and health practices; the use of health clinics (for the children to be immunised, weighed, or treated when ill); provision of nutritious food for children; the type of care--exposure to pathogens--through poor hygiene practices; and the illness experience of children.

Relevant information on mothers, caregivers, health personnel, and persons with influence on health matters are considered in relation to children in the households of
migrant and resident mothers.

1.6 Analytical framework

It is assumed that factors that affect the village, such as flood or drought and the availability of job opportunities, that influences household income, as well as the availability of means of transportation and access to main roads and health facilities, contribute to children's health. These factors, together with household characteristics such as husband's education and the mother's individual socio-economic and demographic characteristics, such as age and education, also influence children’s health, both directly and through their effect on household income. Thus, household and individual characteristics may influence children's health status, regardless of whether the mother migrates.

The study examines whether mother’s migration affects the welfare of their children left behind. By migrating to other countries and obtaining a better job women are able to gain higher income. In the long term, they may also absorb knowledge about health and nutrition, as well as the use of health and nutrition services, that would tend to improve their children's health and nutritional status. The migration of mothers to obtain jobs means increased income, which might lead to nutritionally higher quality foods and more or better medical care for their children.

However, the potentially positive effect of remittances from the migrant mothers may not be felt if they are used for other purposes, such as debt repayment or repairing houses (unless the quality of housing also has a health impact). The effect of remittances on the health and nutritional status of the children depends on such factors as the amount and frequency of remittances, who manages the remittances, and how the remittances are
spent. The more income is spent on the provision of nutritious food and preventive and curative health care, which improves nutrition and lowers the likelihood or severity of illness, the better the health and nutritional status of the children.

The effect of the absence of the mother can also operate through variables such as the presence of substitute caregivers, which can affect child health and nutrition during her absence. In Purworejo, grandmothers, other female relatives, and other siblings were the preferred substitutes for the mother (Purwaningsih, 1991: 13). However, they may not provide the same type of care that a mother does. Their care is likely to be significantly different from, and may be inferior to, that of mothers, particularly in the areas of health and nutrition (Corner, 1991: 4). The absence of mothers may also affect their children’s access to health care, particularly preventive care, if the substitute caregiver has different attitudes toward or capacities to access health care. Health-care facilities are often directed at young married women and often appear to assume that these women are the only child raisers. Older, more traditional women and men caring for children may find the atmosphere of the clinics inhospitable and communication with medical staff difficult. Where the caregivers are less educated than the mothers, they might be less able to profit from modern concepts of health care.

Substitute caregivers play an important role in managing and providing care for children. Their beliefs and attitudes towards health and nutrition can influence patterns of child-related consumption and care for the children in their care. This study hypothesises that these factors might result in poorer nutrition and a greater risk of child morbidity for the children of migrant women workers who are absent from their families.
1.7 Operational definitions

To explore the relationship between the mother's absence and the health of the children left behind, the variables used in this study are defined as follows:

1. *Migrant mothers* are mothers who were absent from home due to migration overseas for employment for at least six months, leaving behind children aged between six and 59 months. A six-month period is used because it is assumed that this period would be sufficient for the effects on their children of the mothers absence, a substitute caregivers’ influence and the impact of remittances to be apparent. To be eligible for this study the mother had to have migrated alone without an intention of staying permanently in the country of destination. Thus, children are said to have had migrant mothers if their mothers had migrated alone to another country for employment and been absent for at least six months continuously at the time of the survey. Qualitative data were also gathered on those children whose mothers had migrated for at least six months continuously and returned to the place of origin during the previous two years. A child is classified as having a non-migrant mother if his or her mother had never migrated during the lifetime of the child or migrated for less than six months.

These definitions lead to some analytical problems. For example, interpretation of the anthropometric data was difficult because the cycle of data collection in the 1992/93 *Survei Ibu* was every four months. Some potential cases were ‘lost’ to the study because the mothers had migrated for less than six months.

2. The *substitute caregiver* is defined as the person who was primarily responsible for looking after the child while the mother was away from home. If several people shared the job of childcare, the substitute caregiver was defined as the one who took
the main responsibility for the child in terms of daily care (dressing, bathing, and providing food), as well as provision of health care.

Child health was assessed by the nutritional status of children aged between six and 48 months at the beginning of the study. Nutritional status was determined by anthropometric measurement. The indicators used were weight-for-age, height-for-age and weight-for-height relative to the WHO standard, which is considered appropriate to Indonesia (Soekirman, 1984: 58). Data on the incidence of illness as reported by the caregiver during the six-month period of the survey (August 1992 - March 1993) was available. However, since illness was described according to the perception of caregivers about the illness and its treatment this data could not be used as an indicator of child health status. It is used primarily in relation to an examination of caregivers’ perceptions and treatment seeking behaviours.

1.8 How the data were analysed

In case-control studies, individual cases and controls can be matched for various factors so that each case essentially has a pair mate (Lilienfeld and Lilienfeld, 1980: 198). If the factors are not too many and there is a large reservoir of persons from which the controls can be chosen, case-control pair matching may be readily carried out. In this study, all children whose mothers were migrants (41 children) were matched with around 237 children whose mothers were present. On the basis of the information presented in the census conducted by the 1992/93 Survei Ibu, matched pairs of children of migrating and non-migrating mothers were selected. These pairs are analysed in terms of their morbidity, nutrition and care experiences. The cases and controls were matched based on the following criteria: a) similar socio-economic status; b) similar age of the
mothers; c) both from legally married parents; and d) similar child nutrition status before the mother migrated. The last criterion might result in selection bias because children of mothers who migrated might already have been poorer and have had lower nutritional status than those whose mothers had not migrated.

This thesis relies primarily on qualitative data. This was analysed by careful coding, classification and comparison of cases. The qualitative data are also related to the quantitative data. Thus, the quantitative data from the 1992/93 Survei Ibu are used to support the qualitative findings, using descriptive bivariate statistical techniques. Simple cross-tabulations are used to examine the relationships between socio-economic and demographic correlates and the children's nutritional status.

1. 9 Organisation of the study

This thesis is organised into nine chapters. The present chapter describes the background to the study and presents a review of the literature on women’s work, and migration on child health. It also describes the objectives of the study, the nature of the study, research design, analytical framework, operational definitions and how the data were analysed.

Chapter 2 presents an historical overview of Indonesian women’s labour migration to the Middle East, placed in the context of international labour migration in general. The first section of this chapter reviews the socio-economic determinants of Indonesian women’s migration for work in the Middle East. This is followed by a comparison with the experiences of other countries. The trends and levels in Indonesian women’s international labour migration and the specific context of Central Java are then described.
Chapter 3 describes the two study communities. This chapter presents the characteristics of the study area. The chapter also describes the general impact in the study area of the migration of women as international contract workers to provide the broad context for the examination of the specific impact on children in the subsequent chapters.

Chapter 4 presents the methodological approach. This chapter describes how the data were collected. The 1992/93 Survei Ibu and the quantitative data collection methods are also described, together with the nature of the study and the qualitative methodology used.

In Chapter 5, the theoretical background to childcare behaviour in Java within the family and community context is discussed. Social and community beliefs are examined, as well as traditions concerning the role of grandmothers and fathers in providing childcare, and attitudes and beliefs about the determinants of good health. This provides the context for the more specific questions arising in the case of migrant mothers absent in the Middle East, including the role of the father when the mother is absent and when the grandmother is the main caregiver.

Chapter 6 is an analytical chapter based on quantitative data collected by the 1992/93 Survei Ibu and qualitative data. After a detailed profile of background characteristics of the sampled migrants, the analysis and discussion focus on the care provided to children by various caregivers. The discussion describes who provided the care and how the children were cared for, and examines patterns of caring for children by the various caregivers.

Chapter 7, is concerned with reported child illness and treatment behaviour in the study area. This chapter discusses people’s perceptions about children’s health and
illnesses and how these affect treatment behaviour. The chapter analyses the qualitative data and presents a quantitative analysis of illness and treatment behaviour.

Chapter 8, the last analytical chapter, examines the nutrition and feeding patterns of the children in the study area. The analysis and discussion focus on two main questions: (i) how food and feeding factors are affected by variables such as age, availability of resources and the identity of the person giving the food, and (ii) how patterns of feeding differ by age and socio-economic status. In addition, family and community beliefs about food and feeding practices and how these relate to child growth and illness are discussed. The anthropometric data in terms of weight-for-age, height-for-age, and height-for-weight are presented in this chapter.

Chapter 9 concludes and synthesises the study and suggests implications for further research on the area of maternal migration and the well-being of the children left behind.
CHAPTER 2

INDONESIAN WOMEN CONTRACT WORKERS IN THE MIDDLE EAST

This chapter describes the context of Indonesian women on overseas labour contracts, particularly those who work in the Middle East. It reviews the history of Indonesian women's participation in the international labour market in comparison to the experience of other countries. This chapter also discusses the history of Indonesian women's participation in the international labour market in comparison to the experience of other countries, policies and mechanisms for Indonesian female international labour migration and the consequences of sending women workers abroad based on the existing literature.

The demand for housemaids in West Asia offers opportunities for unskilled women to work abroad and earn much higher incomes than would be possible in the domestic economy (Perera, 1991: 167). The oil boom of the 1970s in Middle Eastern countries created centres of demand for male labour in the construction and transport sectors (Hossain, 1994: 198). Improving economic conditions in these countries have led to a demand for female domestic helpers among the wealthy middle class (Tanaka, 1994: 72).

Many Asian women have moved independently of their families to the Middle East to work on contract, especially in domestic service, since the late 1970s. Initially, most women who worked as domestic servants in the Middle East were recruited from Pakistan, India, Bangladesh and the Philippines (Eelens et al., 1992: 5). However, due to
bans on the outflow of female domestic servants working overseas later imposed by those countries, Sri Lanka and Indonesia have become the major suppliers of domestic servants. After the Gulf War in August 1991, in response to a request from Kuwait, the Government of Bangladesh allowed Bangladeshi women to work in the Middle East as domestic servants (Sobhan, 1992: 28-29 cited in Heyzer and Wee, 1994: 41). The Arab preference for religious conformity and a knowledge of Arabic has favoured some countries and sects (Hossain, 1994: 200). The fact that Indonesia is a Muslim country helps explain the strong demand for Indonesian women contract workers in the Muslim countries of the Middle East.

The involvement of women in contract labour migration is usually a family strategy (Dias, 1989: 216), and the presence of young children is not strong enough to keep women at home. A large number of married women migrating to the Middle East have left behind children under five years old (Rural Development Foundation, 1992; Robinson, 1992).

The numbers of Indonesian women who have been moving to other countries to work on a short-term basis have increased markedly since the late 1980s. Female international labour migration affects, and is affected by, changes in the roles and status of women (Hugo, 1993: 50; Brochmann, 1993: 227-231). As more women migrate to work overseas, they are no longer perceived as just wives or mothers, but as the breadwinners for their households. However, the reality is that most of those moving from Indonesia are wives and many are also mothers of young children. Therefore, the impact of their migration on their roles as mothers, particularly the effect of their absence on their young children, must be considered.
The scarcity of economic opportunities in Indonesia for women with low level skills and education, particularly for women from rural areas, has pushed these women to take up jobs in the Middle East as domestic servants. The number of Indonesian women workers in the Middle East outnumbers men workers mainly because the recruitment fees for women are lower than for men and there are no particular skills or educational requirements for women to work as domestic servants. Thus, poor families tend to send their women rather than their men into the international labour market. However, the effects of women’s migration on the families left behind are different from those of men’s migration because in most societies women are mainly responsible for family domestic affairs and childcare.

2.1 The history of Indonesian female international labour migration

Before discussing further about the history of Indonesian female international labour migration, it is considered to be relevant to discuss other migration streams in which women are involved. Among the migration streams, internal and undocumented migration are alternative migration options for women. Among other reasons, economic reasons were cited for the move, including search for a job, better education, occupational mobility, better economic well-being or to support children (see Hugo 1991; 1998).

There have been two major types of internal migration in Indonesia which women involved in: (a) Migration from the densely population settled islands of Java and Bali, much of it officially sponsored through the transmigration programme, to Sumatra and other islands with lower population densities. (b) Major movements of
people from rural areas throughout Indonesia to cities (Suharso and Speare, 1981: 299 cited in Anaf, 1986: 5).

Male domination is especially significant in internal migration (Hugo, 1981: 118; Koentjaraningrat, 1975: 111; Suharso et al., 1981: 6), particularly to urban areas (Suharso et al., 1981; Heeren, 1956; Hugo, 1981). However, scholars noted that the importance of female migration to Jakarta has been increasing (Jellinek, 1978; Lerman, 1983; and Hetler, 1989; in Hugo, 1991: 11). In addition, substantial differences in the economic activities of male and female migrants in urban areas have been documented (Hugo, 1991: 11). There was a tendency for single females to migrate to urban areas for economic reasons and to work in services or manufacturing sectors (see Suharso and Speare, 1981; Anaf, 1986; Hugo, 1991). However, there are women who migrate because of marriage. Thadani and Todaro (1978: 16 cited in Anaf, 1986: 2) proposed that one of the most important variables influence the migration of women on rural-to-urban migration was the probability of marrying an eligible urban male.

Undocumented migration is the other stream of migration which Indonesian women engage in. Men form a significant majority of the undocumented migration flows, nevertheless women are also involved (Raharto, 1996: 113). It has been reported that the existence of undocumented migration is mainly caused by the difficult and complex bureaucratic procedures in processing migrant work application (Firdausy, 1996: 99; Hugo, 1998: 119). The undocumented migration fees are also regarded as cheaper than the ones organised by formal channels (Bandiyono, 1998: 2). The undocumented migrants tend to migrate to close neighbouring countries. For instance, a number of women choose to be undocumented migrants in Malaysia either to work (Raharto, 1998: 1) or for some reasons other than work such as to look for their husbands.
who have absent for long periods (Graham, 1997 cited in Hugo, 1998: 412). Another factor which influences undocumented migration is the presence of relatives or friends in the destination area (Raharto, forthcoming). In a study of East Flores, Raharto (1997: 4) found that women left the country officially for some reason other than work but, upon arrival at their destination, take up work, often overstaying their original visitor visa or permits. Their undocumented migrant status is related to the absence of working permits (Raharto, 1996: 108; 1998: 1). Undocumented migration among women became more common as more people in the studied village of East Flores were going and back to Malaysia and Brunei. Being undocumented migrant is not without consequences however. The migrants are at risk of exploitation or being caught as they were exposed to be caught by the police (Raharto, 1997: 4). However, the exploitation is not so great among the women travelling from Eastern Indonesia to work in Malaysia as in the case for women moving to work as domestic servants in the Middle East (Hugo, 1998: 5).

The migration stream that has been the focus of this study is international migration, particularly to the Middle East. From the beginning of the 1980s, like other Asian countries, Indonesia participated in the flow of labour migrants to the Middle East. The principal individual incentives for migration have been the very wide differentials between the low earnings, particularly of the low-income group, in the country of origin and the much higher earnings offered in the international market (Gunatilleke, 1991: 167). At national level, the impact of migration on foreign exchange and unemployment is an important incentive for government to promote international migration. Such migration was encouraged by the Indonesian government as a means of reducing the deficit in the balance of payments that had emerged in the early 1980s due to the fall in the value of oil exports (Rural Development Foundation, 1992: 14; Hugo, 1992: 181).
At this time, job opportunities for women in rural areas in Indonesia were declining. The new technologies introduced in agriculture greatly affected many rural women. Types of agricultural work that had been mostly undertaken by rural women declined because of the Green Revolution, which particularly displaced women labourers and initiated population movement (Hugo, 1985 cited in Hugo, 1992: 187). For example, the new variety of rice which is very short, could not be harvested by the ani-ani, a finger knife used by women for harvesting the mature paddy. The spread of mechanical hullers also limited work opportunities for women. For instance, Collier et al. (1974: 120 cited in Hugo, 1992: 187) estimated that around 125 million days of wage labour had been lost due to the introduction of mechanical hullers, which replaced the hand-pounding of rice by women in the early 1970s. In addition, many landowners tended to sell their crops before the harvest to middlemen (tebasan), replacing the bawon system of participation in harvesting in return for a share of the crop. In the 1990s, other new agricultural practices replaced as many as one third of the agricultural workers, many of them women. Some examples were the replacement of transplanting by direct seeding of rice, the replacement of labour-intensive weeding by pesticides, and the use of hand tractors (Hugo, 1993 cited in Hugo, 1995: 283). In the agricultural labour market, women labourers were disadvantaged by institutional changes that favoured the employment of men (Sajogyo, 1985: 149). The jobs lost were women’s jobs, but the new jobs created were largely taken by men.

In the cultivation of irrigated rice in most parts of Indonesia, there was traditionally a segregation of labour. Men did hoeing, ploughing, harrowing, and the construction or repair of dykes, while women engaged in agriculture worked on a seasonal basis, mainly weeding, transplanting and harvesting (White, 1985: 131).
In Java, women from landless households generally worked to exchange their labour for cash or a percentage of the crop harvested (Sajogyo, 1983 cited in Unnevehr and Stanford, 1985: 2). The wages received by women in this sector are generally low. My field study in 1992 in a rural area of Purworejo, Central Java, indicated that most rural women working in agriculture earned around Rp. 1,000 - 1,500 a day compared to the average male earnings of around Rp. 2,000 - Rp. 2,500 for the same hours. These low wages, together with limited employment opportunities, made the life of many rural women increasingly difficult. This, together with family need for additional income, forced many women in the survey villages to search for new avenues to improve the economic status of their families.

In addition, work as a domestic servant fits the pattern of female socialisation:

Domestic service is regarded as ‘unskilled’ labour because it requires no formal education. However, women are regarded as more suitable than men for this work precisely because they have had skills training as part of their female socialisation. Domestic service operates as part of the informal, or unregulated, sector of the economy (Robinson, 1992: 50).

The wages offered to women domestic servants in the Middle East are relatively high by Indonesian standards. In 1992, earnings of 600 Saudi Arabian riyals (equivalent to Rp. 270,000) per month (Rural Development Foundation, 1992: 23) were very attractive to women from economically vulnerable households. Such an income was 10 times higher than the average in rural Indonesia at the time, representing a substantial increase in earning and purchasing power. During two years work in the Middle East, migrants could earn around Rp. 7,000,000, an amount that would be quite unattainable in the village if they worked as farm labourers.

Beginning in the early 1980s with a rapid increase in the late 1980s, many women took advantage of this opportunity to become migrant workers in the Middle
East. Year by year, the numbers of Indonesian women migrants increased steadily. The Indonesian government set a minimum age for contract workers sent to the Middle East. The minimum was originally 30 years of age, on the assumption that only at this age were women mature enough to work abroad (Rural Development Foundation, 1992: 38). However, from 1986, women aged 25 years and over were accepted as overseas workers. Women seeking to work in the Middle East still have to present a statement to the recruiting agent that they are more than 25 years old. This age limit means that most women migrants are married, since the average age at first marriage for Indonesian women is 22 years (Adioetomo, 1993: 45). Thus, since 1986, thousands of Indonesian women, many of them mothers with very young children, have become international labour migrants.

Between 1983 and 1990, it was estimated that at least 230,000 women left Indonesia to work in the Middle East, mostly in Saudi Arabia (Weinert, 1991: 22 cited in a Nijeholt, 1992: 16). In Repelita V, the Indonesian Five-Year Development Plan for 1989-1994, the target was to send 500,000 contract workers overseas, especially to the Middle East (Tempo, 6 January 1990: 15 cited in Hugo, 1992: 196). By the end of 1993, the number of Indonesian overseas workers exceeded the target, by a total of 116,206 workers (Data Statistik Pusat Antar Kerja Antar Negara (AKAN), n.d: 2). It was projected that, by the end of Repelita V (March 1994), the number would be even larger. The current official target for the Sixth Five-Year Development Plan (1994-1999) is to deploy 1.5 million workers overseas and to attract remittances of around US$3 billion (Hugo, 1995: 277). According to the Minister of Manpower, in the year 2000 the cumulative number of Indonesian overseas workers is projected to be 2.5 million, who can earn US$12.5 billion annually (Kompas, 24 April 1996: 2). Table 2.1 shows the total
number of Indonesian workers migrating overseas during the Fifth Five-Year Development (*Pelita V*).

Of the Indonesian women migrating to the Middle East to work between 1984 and 1989, 99 per cent went to Saudi Arabia (Hugo, 1993: 110). Around 83 per cent of the Indonesian workers in Saudi Arabia during that period were women (*Kompas*, 28 February 1990: 1). During the period 1989 - 1992 the proportion of Indonesian workers in Saudi Arabia declined to 58 per cent of the total placements (Soeramsihono, 1993: 12). Between 1989 and 1993, the number of Indonesian women overseas workers in Saudi Arabia amounted to 320,808 workers, which was around eight times the number of males (40,574). By 1993/1994 the number of Indonesian workers working in Saudi Arabia was declining, probably because of the Gulf War in August 1991.

Table 2.1 Indonesian workers (*TKI-AKAN*) migrating overseas during *PELITA V*\(^a\) by sex (to 31 December 1993)

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Sex</th>
<th>Per cent</th>
<th>Total</th>
<th>Number of</th>
<th>Saudi Arabia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>female</td>
<td></td>
<td>countries</td>
<td>Male</td>
</tr>
<tr>
<td>1989 / 1990</td>
<td>21,969</td>
<td>62,105</td>
<td>74</td>
<td>84,074</td>
<td>30</td>
</tr>
<tr>
<td>1991 / 1992</td>
<td>48,879</td>
<td>100,903</td>
<td>67</td>
<td>149,782</td>
<td>37</td>
</tr>
<tr>
<td>1992 / 1993</td>
<td>60,189</td>
<td>111,968</td>
<td>65</td>
<td>172,157</td>
<td>54</td>
</tr>
<tr>
<td>1993 / 1994</td>
<td>33,282</td>
<td>90,647</td>
<td>73</td>
<td>123,929</td>
<td>42</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>200,623</td>
<td>415,583</td>
<td>67</td>
<td>616,206</td>
<td>196</td>
</tr>
</tbody>
</table>

*Source:* Adapted from *AKAN* (Centre for Overseas Employment) Office, Jakarta, n.d. Table 24.

*Note:* \(^a\) *Pelita V* is the Five-Year Development for 1989/1994

*Kompas* (30 May 1995: 1) reported that the number of Indonesian overseas migrants to Saudi Arabia had declined dramatically since the beginning of 1995, partly because the Government of Saudi Arabia preferred to obtain workers from other
countries. *Kompas* gave several reasons for this. The long waiting period for ordering domestic servants and the delayed arrival of the domestic servants was frequently mentioned as a reason. The time from the acceptance of the order until the arrival of the workers at the place of work, is about two months (RDCMD, 1986: xxxxiv). Another was that the Saudi government wanted all migrants who intended to work there to have HIV tests. The Government of Indonesia was reluctant to approve this, partly because it believed that not many Indonesians were affected by this disease. The fee of Rp. 70,000 for medical tests including the HIV test was also considered too expensive for the migrants, who already spent approximately Rp.300,000 - Rp. 400,000 for ‘administrative fees’. According to the Consul General of the Republic of Indonesia in Jeddah, the number of Indonesian contract workers in Saudi Arabia in March 1996 was 1.2 million people, only 400,000 of whom came through official channels (*Kompas*, 1996: 19 March: 1). Table 2.2 presents the numbers of Indonesian workers in various countries, including Saudi Arabia, from the First to the Fifth Five Year Development (*Pelita*).
Table 2.2 Destinations of official Indonesian overseas migrant workers by five-year development period

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>1</td>
<td>114</td>
<td>34</td>
<td>7</td>
<td>165</td>
<td>321</td>
</tr>
<tr>
<td>Belgium</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>35</td>
<td>38</td>
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<tr>
<td>Brunei</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>920</td>
<td>9,640</td>
<td>10,560</td>
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<tr>
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<td>-</td>
<td>67</td>
<td>1</td>
<td>26</td>
<td>94</td>
</tr>
<tr>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>122</td>
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<tr>
<td>Egypt</td>
<td>-</td>
<td>-</td>
<td>36</td>
<td>345</td>
<td>381</td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>-</td>
<td>4</td>
<td>664</td>
<td>1,018</td>
<td>811</td>
<td>2,497</td>
</tr>
<tr>
<td>Germany</td>
<td>337</td>
<td>9</td>
<td>1,097</td>
<td>148</td>
<td>608</td>
<td>2,199</td>
</tr>
<tr>
<td>Greece</td>
<td>-</td>
<td>300</td>
<td>1,232</td>
<td>971</td>
<td>907</td>
<td>3,410</td>
</tr>
<tr>
<td>Hong Kong</td>
<td>144</td>
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<td>1,761</td>
<td>1,735</td>
<td>4,725</td>
<td>9,662</td>
</tr>
<tr>
<td>India</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>Iran</td>
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<td>935</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>935</td>
</tr>
<tr>
<td>Iraq</td>
<td>-</td>
<td>-</td>
<td>2,258</td>
<td>303</td>
<td>-</td>
<td>2,561</td>
</tr>
<tr>
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<td>-</td>
<td>215</td>
<td>25</td>
<td>100</td>
<td>340</td>
</tr>
<tr>
<td>Japan</td>
<td>292</td>
<td>451</td>
<td>920</td>
<td>395</td>
<td>4,256</td>
<td>6,314</td>
</tr>
<tr>
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<td>-</td>
<td>-</td>
<td>179</td>
<td>1</td>
<td>-</td>
<td>180</td>
</tr>
<tr>
<td>Korea</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>3,190</td>
<td>3,190</td>
</tr>
<tr>
<td>Kuwait</td>
<td>-</td>
<td>-</td>
<td>1,210</td>
<td>952</td>
<td>3,004</td>
<td>5,166</td>
</tr>
<tr>
<td>Malaysia</td>
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<td>536</td>
<td>11,441</td>
<td>37,785</td>
<td>151,900</td>
<td>201,674</td>
</tr>
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<td>Monaco</td>
<td>-</td>
<td>14</td>
<td>188</td>
<td>859</td>
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<td>2,345</td>
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<td>4,375</td>
<td>5,273</td>
<td>29,721</td>
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</tr>
<tr>
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<td>311</td>
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<td>9</td>
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<td>88</td>
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<tr>
<td>Romania</td>
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<td>-</td>
<td>-</td>
<td>16</td>
<td>4</td>
<td>20</td>
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<tr>
<td>Saudi Arabia</td>
<td>-</td>
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<td>55,976</td>
<td>223,573</td>
<td>361,382</td>
<td>644,748</td>
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<td>5,007</td>
<td>10,537</td>
<td>45,405</td>
<td>63,389</td>
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<td>6</td>
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<td>-</td>
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<td>-</td>
<td>7,122</td>
<td>7,337</td>
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<tr>
<td>Thailand</td>
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<td>42</td>
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<tr>
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<td>3,578</td>
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<td>372</td>
<td>77</td>
<td>308</td>
<td>781</td>
</tr>
<tr>
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<td>176</td>
<td>2,981</td>
<td>6,897</td>
<td>13,000</td>
<td>23,200</td>
</tr>
</tbody>
</table>

Total 5624        17,042     96,410    292,262    616,206    1,027,544

Source: Indonesian Ministry of Manpower, Centre for Overseas Employment, 1995.

Note: Pelita is the five-year development.

* Data only for 1 April 1989 to 31 December 1993.
2.2 Comparison with other Asian countries

Most international migrants from countries such as Pakistan, South Korea, and Bangladesh have been men with above-average levels of education (Stahl, 1986: 93; Arnold and Shah, 1986: 28 cited in Eelens et al., 1992: 5). However, those from Indonesia to the Middle East are mainly women with very low levels of skills and education. The large numbers of Indonesian women going to the Middle East to work as domestic servants was partly due to weaker competition in the domestic service sub-market in the Middle East compared with other labour markets (Hagul and Suardiman, 1986: 29; Lycklama, 1989: 3). In March 1986, it was reported that, of the 50,031 Indonesian workers in Saudi Arabia, 36,244 (or 61 per cent) were women domestic workers (Women’s Study Centre, 1992 cited in Heyzer and Wee, 1994: 42). The number of males per hundred females among official labour migrants fell significantly from 141 in 1983 to 85 in 1984, 31 in 1985 and 29 in 1988 (Hugo, 1992: 181). Of a sample of 400 Indonesian contract workers who migrated to the Middle East in 1985, 78 per cent were female (Cremer, 1988: 18). Most were relatively young, aged between 20-39 years (around 97 per cent), and 71 per cent were married. The highest educational attainment for most was primary school (62 per cent), but 26 per cent had never attended school. A study of 72 female Indonesian migrants in Saudi Arabia in 1992 showed that 83 per cent were aged between 15-30 years and 63 per cent were married (Women’s Study Centre, 1992 cited in Hossain, 1994: 201).

The involvement of Indonesian women in labour migration to the Middle East was relatively late compared to that of women from other countries such as the Philippines (Stahl, 1986: 82; Hugo, 1992: 181). Compared to countries such as Sri Lanka, the number of Indonesian contract workers abroad has also been rather low. In
the mid-1980s, it was estimated that between 185,000 and 215,000 Sri Lankan women were involved in labour migration to the Middle East (Eelens et al., 1992: 3; Cumaranatunga, 1990: 182). The number of Sri Lankan women working in West Asia increased very rapidly. In 1983 there were 200,000 migrants, rising to 500,000 workers abroad in 1992 (Dias and Weerakoon-Goonawardene, 1992: 45 cited in Heyzer and Wee, 1994: 43). In 1983 Thailand sent 285,000 male workers overseas, 30 per cent of the total unemployment in that country (Singhanetra-Renard, 1985 cited in Mantra et al., 1986: 1). Singhanetra-Renard (1995: 1) noted that around 100,000 Thais were working in Japan, about half of whom were illegal female migrants. The Philippines sent around 205,000 workers to Saudi Arabia in 1985 (Arcinas, 1985 cited in Mantra and Kasnawi, 1986: 7). By 1987, there were already at least 275,567. Filipino domestic workers abroad, including 134,642 totally new hires and 140,925 re-hires. In 1991, land-based workers totalled 489,260 (Philippines Non Government Team, 1992: 33 cited in Heyzer and Wee, 1994: 42). Except for Sri Lanka, most workers from these countries were men who worked in the construction and production sectors.

Beginning in the mid-1970s, labour migration to the Middle East has been an important international flow of migrant labour (Appleyard, 1988:91-93 cited in a Nijeholt, 1992: 8). From 1975 to 1985, Asia has been the most important source of migrant labour for the Middle East. From 360,000 in 1975, the number increased markedly to about 3.5 million by 1985 (Appleyard, 1988: 40-1 cited in a Nijeholt, 1992: 9). Between 1976 and 1988, the out-migrants from Asian countries were 3,595,400 from the Philippines, 1,584,000 from Korea, 1,340,600 from Pakistan, 690,530 from Thailand, 603,700 from Bangladesh, 378,000 from Indonesia, and 262,900 from Sri Lanka (Tanaka, 1994: 69). Due to the drop in oil prices in the mid-1980s, the skill composition
changed from construction and production to the main labour-shortage sectors such as services, manufacturing and agriculture. Since then the number of female workers in the service sector has increased substantially.

Unlike South Korea and the Philippines, where international labour migration has largely involved people with professional qualifications and high educational levels, a large proportion of Indonesian migrants have been unskilled (Stahl, 1986: 93). Gunatileke (1986: 16) also noted that, in most countries except for the Philippines, the vast majority of migrants to the Middle East were recruited from among the unemployed and underemployed. In 1986, 89.2 per cent of Indonesian workers sent to Saudi Arabia had attended primary school, 8.5 per cent were junior high school graduates and 2.3 per cent were senior high school graduates. The percentage of Philippine senior high school graduates was 84 per cent, India 55.4 per cent, Bangladesh 43.1 per cent and Pakistan 35.1 per cent (Research and Documentation Centre for Manpower Development-RDMCD, 1986:xxvi). Female migrants from the Philippines appear to be drawn largely from among the better-educated and more skilled workers, whereas the majority of Indonesian women labour migrants work in domestic service. The low educational level among the Indonesian women contract workers has limited the choices open to them to work in the Middle East. Domestic service seems to be the only work available for most Indonesian overseas workers in the Middle East.

Indonesia receives a relatively small amount of remittances from its overseas contract workers compared to Thailand, Pakistan and the Philippines. In 1982, Indonesia received remittances from contract workers in the Middle East of around US$33 million, only 0.75 per cent of total export earnings (Singhanetra-Renard, 1985 cited in Mantra and Kasnawi, 1986: 7). Another source suggested that at the end of Repelita III,


2.3 Policies and mechanisms for Indonesian female international labour migration.

This section examines Indonesian female international labour migration in terms of government policies on the migration of women contract workers, the mechanisms
used to recruit the women, and the specific context and patterns of women's international labour migration from the province of Central Java.

International labour migration has been important in alleviating unemployment problems in many Asian countries. The Government of Indonesia has also viewed international labour migration as an element of employment policy. Rising unemployment, together with a heavy foreign debt incurred to finance development, is a major problem facing the Indonesian government. After the era of the petro-dollar in the early 1980s, the country experienced a deficit balance of payments (Rural Development Foundation, 1992: 1; Cremer, 1988:10; Singhanetra-Renard, 1988: 3).

To overcome this, the Government has sought to increase foreign exchange earnings through increased exports of non-oil commodities, including the export of labour (RDCMD, 1986: xix; Robinson, 1992: 47; Rural Development Foundation, 1992: 1). It has been estimated that contract workers will remit at least 50 per cent of their earnings. As successful temporary migrants usually send remittances to their families, the export of contract workers, including women, has been encouraged by the Indonesian Government to increase domestic earnings and foreign exchange. Opportunities for working overseas are also seen as a means of increasing employment opportunities for Indonesian workers.

The high demand for housemaids to work on two-year contracts in the Middle East provides an opportunity for a large number of unskilled women with little education to earn cash incomes (Perera, 1991: 167; Tanaka, 1994: 72). Job opportunities for domestic servants in the Middle East seem likely to be available for the long term. The presence of overseas domestic workers enables some women to work outside the home, perpetuating the demand for domestic servants. A new style of social behaviour among
Middle Eastern families, in which family status is measured by the number of household servants employed, also contributes to a steady demands for servants (Sherbiny, 1984: 646 cited in Lycklama, 1989: 35; Eelens et al., 1992: 5; Heyzer and Wee, 1994: 37; Licuanan, 1994: 109; Tanaka, 1994: 72).

The Indonesian Government has implemented a closed recruitment policy for Indonesian workers seeking to seize these opportunities in the Middle East. Only job seekers registered by the Ministry of Manpower can apply to work overseas (Cremer, 1988: 35). A private recruitment network undertakes the recruitment process. Recruitment agencies are represented in the central office of the Ministry of Manpower. In order to become a recruitment agency, a company must meet certain requirements including the receipt of a Notary Act, meeting conditions for avoiding environmental disturbance and provision of appropriate office facilities (Rural Development Foundation, 1992: 163).

The recruitment of workers is initiated from Saudi Arabia. The demand for workers is reported to the Indonesian Embassy of Saudi Arabia through labour-recruiting companies in Saudi Arabia and in Indonesia. These are authorised by the Centre for Overseas Employment in Indonesia. In response to demand, labour-recruiting companies may recruit new workers in Indonesia or send reserve recruits who are ready to depart. If new workers are to be recruited, the recruitment process is undertaken by field workers employed by the recruitment agency, which also employs assistants from urban and rural areas to work as intermediaries, middlemen and brokers. These field assistants then recruit the women who will become domestic-service workers (Rural Development Foundation, 1992; 165).
In some cases the recruitment process involves relatives, neighbours, friends or siblings, some of whom are returnees with success stories. An extract from my field notes on one informant in Purworejo, 1993 illustrates this:

Indri, a 28-year-old woman, is the mother of a two-year-old girl. With senior high school education, she migrated to Saudi Arabia following her sister-in-law, Bekti, who was a relatively successful migrant. When Bekti finished her first contract she came back to the village and told her success story to her sister-in-law. Indri was attracted by the story, and finally flew to Saudi Arabia when Bekti renewed her second contract. After working for five months in Saudi Arabia, she was able to send home about Rp.1 million, equivalent to around US$475.

A 1986 study conducted in Yogyakarta, Central Java and West Java found that the main source of information for migrants from Central Java and West Java seeking to work in the Middle East was from labour-recruiting agencies (58 per cent and 38 per cent respectively). For 24 per cent of the migrants from Yogyakarta, the source of information was family and friends in the village and in the Middle East (Mantra, Kasnawi and Sukarmadi, 1986: 32). A study from East Java in 1992 found that 72 per cent of overseas workers from rural areas were recruited through neighbours, friends and siblings (Rural Development Foundation, 1992: 82). A Malaysian study found that 60 per cent of the Indonesian domestic workers in the sample were recruited through a kinship network, especially through relatives living in Malaysia (Dorall and Raja, 1992: 39 cited in Heyzer and Wee, 1994: 48).

The labour-recruiting companies’ field staff visit rural villages to recruit new labour migrants. Sometimes, field staff also employ agents to help them recruit women in the villages. These intermediaries receive a commission from the field workers depending upon the number of women workers recruited. In 1992, I found that at least
Rp. 20,000 (equivalent to US$9.5) was received by the field assistant for each migrant she or he recruited.

Prospective female migrants usually apply to the field workers. Applicants are selected and their reports are sent to the local office of the Department of Manpower and later to the Centre for Overseas Employment. They are then trained by the labour-recruiting company and, if they pass the final examination at the end of the training, are accepted for placement. The documents needed for their departure are organised by the labour-recruiting company in Indonesia, known as PPTKI (Perusahaan Pengerah Tenaga Kerja Indonesia) (Labour Recruiting Company). However, many Indonesian women in Saudi Arabia work illegally, and the number of illegal migrants is estimated to be almost double the number of legal ones (Kompas, 20 March 1996: 1). Illegal migrants usually get to Saudi Arabia using a visa for a pilgrimage to Mecca. Table 2.3 presents information on the number of Indonesian overseas workers sent through the PPTKI.

Table 2.3 Indonesian overseas contract workers sent through PPTKI to Saudi Arabia, by sex and year of departure 1989/1994

<table>
<thead>
<tr>
<th>Year</th>
<th>PPTKI</th>
<th>Per cent</th>
<th>Non-PPTKI</th>
<th>Non-PPTKI</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>1989/1990</td>
<td>7,074</td>
<td>52,037</td>
<td>88</td>
<td>147</td>
<td>883</td>
</tr>
<tr>
<td>1990/1991</td>
<td>4,921</td>
<td>36,094</td>
<td>88</td>
<td>57</td>
<td>394</td>
</tr>
<tr>
<td>1992/1993</td>
<td>10,476</td>
<td>84,877</td>
<td>89</td>
<td>28</td>
<td>192</td>
</tr>
<tr>
<td>1993/1994</td>
<td>7,695</td>
<td>69,945</td>
<td>90</td>
<td>50</td>
<td>11</td>
</tr>
</tbody>
</table>

Source: Pusat AKAN Depnaker, n.d, Table 25.

In 1991, a survey of 220 overseas workers conducted by the Minister of Manpower found that the costs incurred before migrating ranged between Rp. 350,000 (US$233) and Rp. 800,000 (US$533) (Hugo, 1995: 289). Such an amount was large for villagers, especially considering the scarcity of cash income in rural villages. The

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1 Lately PPTKI was changed to PJTKI (Perusahaan Jasa Tenaga Kerja Indonesia).
recruitment fee depended on the directness of the recruitment process: recruitment through a third person would involve a higher fee.

The Indonesian government attempts to maximise the export of workers while minimising the negative consequences that may result. Sending women workers abroad should be a legal process performed through official recruiting agents who follow the procedures laid down in regulations (Rural Development Foundation, 1992: 36). This system was initially instituted because in some cases women were found to have been recruited through private agencies without being paid.

Priority for overseas employment is also given to semi-skilled and skilled workers who register with the Ministry of Manpower. This system is designed to match the number of workers sent with the numbers of workers demanded by receiving countries. Indonesia would like to send more skilled workers overseas in order to increase remittances; however, Indonesia was a late entrant into the labour market for migrants, in which competition is increasingly tight. Despite this policy, unskilled migrants continue to comprise the largest number of migrants from Indonesia.

The Indonesian Government, through the Department of Manpower which acts as both recruiting and regulation agency, is responsible for the training and orientation program given to the migrants. The Department has also set various regulations, including minimum standards for work contracts and limited protection for women workers. The government has also attempted to establish protection for domestic workers, who are especially vulnerable to exploitation and abuse. For example, women contract workers sent to the Middle East must be at least 25 years of age.

Before departure to the Middle East, a prospective worker has to undertake training conducted by the labour-recruitment company. The training is mainly related to
the work that the women will perform in the Middle East. The women are also taught to speak the Arabic language in order to be able to communicate with their employers. During the training, all participants are required to live in the training institute, although this is not mentioned in the regulations of the Minister of Manpower. A decision of the Minister of Manpower in 1987 states that Indonesian women workers sent to Saudi Arabia should be skilled. Accordingly, prospective women workers are expected to hold a certificate in dress making, food preparation or baby sitting (Rural Development Foundation, 1992: 169).

Some women are not able to depart for the Middle East immediately after finishing their training because jobs have not yet been found for them. They are then kept waiting, to be sent as soon as they can be placed. This waiting period adds to their expenses because they need money for meals and other necessities. The longer they are kept waiting, the greater the expenses involved. Some women have to mortgage property, either their own or that owned by their families, in order to pay the recruitment fee. To recover the fee, they often have to work for at least six months. If they borrow from money lenders, it may take up to a year for them to repay their debts. Meanwhile, the family must wait for remittances to pay for their daily household expenses or to send the children to school.

A significant number of Indonesian women were involved in international migration by the early 1980s (RDCMD, 1986: xxxiv; Hugo, 1993: 21; Rural Development Foundation, 1992:1). At that time, the price of oil declined dramatically and the Indonesian government launched de-regulation and de-bureaucratization policies and emphasised export orientation in order to overcome the resulting economic crisis. As noted, the export of migrant workers was one response to the drive to increase exports.
The increased involvement of Indonesian women in overseas labour migration to the Middle East has occurred for two major reasons. On the supply side, the scarcity of economic opportunities for women in Indonesia, due to their low levels of education and skills, has motivated many women to seek overseas employment (Dias, 1986: 216). On the demand side, the high demand for housemaids to work on two-year contracts in the Middle East has provided an opportunity for a large number of unskilled women with little education to earn relatively large incomes (Perera, 1991: 167). Indonesian men have been unable to join the migrant flow to the same extent. Like the women, most were also poorly educated and unskilled. However, the demand for male workers in the Middle East has been mainly for skilled and educated workers. In addition, as mentioned before the cost of recruitment fees for men was much higher than for women.

As mentioned in Chapter 1, the involvement of women in contract labour migration was mainly a family oriented strategy directed toward meeting the interest of the women's families (Dias, 1989: 216). In this context, marriage and the presence of young children, was not a sufficiently strong deterrent to keep the women at home. Husbands and the wider extended family were recruited to take over some of the roles and responsibilities of the women during their absences.

The majority of those who have migrated to the Middle East have come from Java, with West Java the dominant province (Hugo, 1995: 277). From the beginning of 1990 to March 1992, the number of Javanese women labour migrants totalled 90,028, of whom around 50 per cent were from West Java (Pusat AKAN, 1992). Central Java was also one of the largest sending areas.

The very wide differential between the low earnings, particularly for the low-income group, in Indonesia and those offered in the international market was one of the
principal incentives for international labour migration (Gunatilleke, 1990: 167). This was
certainly the case in the study area. The wages earned in the Middle East in 1992 were
around 600 - 800 Saudi Arabian riyals a month, equivalent to Rp 275,000 to Rp 350,000
or five to 10 times higher than an average monthly income earned in the villages.

With rising levels of development in Indonesia, job opportunities have declined
for those with low levels of education. This is mainly due to the increase in the number
of graduates entering the work force (Simanjuntak, 1993: 44) and an increasing demand
for skilled rather than unskilled labour. The agricultural sector has continued to absorb
large numbers of workers, even though the proportion in agriculture in 1990 was less
than half of all employed Indonesians (Simanjuntak, 1993: 44; Hugo, 1995: 274). The
jobs available to unskilled labour were mainly in the agricultural sector, where
employment was also often uncertain because of natural disasters.

It has been noted that, throughout the world, women play a major role in rice
cultivation, post-harvest processing and marketing (Swaminathan, 1985: 1). This is also
true for women in rural Java, who work in small-scale rice cultivation mainly as wage
labourers. The women work for longer hours than men, and receive little income. This is
what White (1985: 121) called ‘too much work for too little income’. The fact that
irrigated rice (sawah) is considered one of the most labour-intensive of all crops,
seasonal or perennial (Sajogyo, 1985: 152), helps explain the long hours rural Javanese
women spend in agricultural work.

The introduction of High Yielding Varieties resulted in the threshing of harvested
stalk paddy, which traditionally was mainly a female task, being done by men. In
addition, the replacement of the bawon system by cash seems to have disadvantaged
women because women generally received higher real wages when paid in kind rather
than cash (White, 1985: 131-137). The wages from paddy harvesting were an important source of family income for women in Java (Sajogyo, 1985: 153). The loss of this source of earning hit many rural Javanese families very hard.

As agricultural employment declined, off-farm employment opportunities expanded due to the expansion of major service industries, manufacturing and construction. The contribution of manufacturing to GDP increased from 12 per cent in 1980 to 19 per cent in 1990. By contrast, the contribution of agriculture decreased from 25 per cent in 1980 to 19 per cent in 1990. This resulted in an increasing gap in income between the agricultural and the manufacturing sectors. Agriculture employed 50 per cent of the labour force, but generated only 19 per cent of GDP. Thus, returns in agriculture were much lower than in other sectors. People in the rural areas, especially in Java, tended to receive the lowest wages, whereas those who worked in formal-sector activities received the highest average wages. With the expansion of off-farm employment opportunities, more and more people from rural areas have begun to work in the non-agricultural sectors. Over the 1980 - 1990 period, the proportion of people working in the manufacturing sector increased from 10 to 13 per cent and in the service sector from 34 to 37 per cent (Simanjuntak, 1993: 45-46).

Initially, migration was not the only alternative because work was still available in rural areas. However, since the early 1980s migration has been the best alternative for many families because of the limited employment opportunities in the village, especially for women. The expansion of off-farm employment opportunities has been generally quite limited in rural areas.

As mentioned before, agricultural employment for women in Java, especially in Purwodadi and Ngombol sub-districts, decreased because of the new agricultural
technologies. In addition, infertile soil and the occurrence of natural disasters such as floods further reduced employment opportunities in agriculture, the area that provides most paid work for women in rural areas. Working outside the village or even working overseas became increasingly seen as an alternative to release them from the stress of debt, to provide a better living or to save for the future.

2.4 The consequences of sending women workers abroad: evidence from the literature

Javanese migrants are part of a society with a tradition of sharing work by men and women in subsistence production. Just as both men and women worked to sustain the household, so many women have migrated independently, sharing paid work with their husbands to support their households. Women working on overseas contracts may have significant economic and non-economic consequences at the national, community and family levels, as well as for individuals. This first section examines the consequences of sending women workers abroad, based on secondary sources.

The economic impact of the remittances sent by the overseas contract workers is a positive consequence of international labour migration for sending countries. Remittances are the most attractive aspect of international labour migration for both governments and individual migrants and their families. The amount of foreign remittances received by a labour-exporting country depends principally on the number of workers it has sent abroad, their earnings, the percentage of their earnings they are able to save, and the percentage of savings which they actually remit (Stahl and Arnold, 1986: 899).

Thus, at the aggregate level, remittances sent by overseas workers have contributed little to the Indonesian economy. According to the Coordinating Team on the Middle East (CTME), remittances from Indonesian workers in the Middle East totalled US$48 million in 1982. This amounted to only 0.3 per cent of merchandise exports in that year. From January through September 1983, remittances amounted to US$43.1 million (Stahl, 1989: 83). Between 1983 and 1989 an amount of US$552 million was remitted by migrants through official sources (Hugo, 1995: 277). By the end of 1993, remittances sent by migrants amounted to US$263 million, of which US$252 million originated in Saudi Arabia (see Table 2.4). The Indonesian Minister of Manpower projected that by the year 2000 Indonesia would receive approximately US$12.5 billion annually sent by migrant workers (Kompas, March 27, 1996: 2).

Table 2.4 Foreign exchange derived from countries receiving Indonesian overseas workers (TKI AKAN) during PELITA V, 31 December 1989 - 1994

<table>
<thead>
<tr>
<th>Year</th>
<th>Saudi Arabia</th>
<th>Per cent of total</th>
<th>Non Saudi Arabia</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>US$</td>
<td></td>
<td>US$</td>
<td>US$</td>
</tr>
<tr>
<td>1989/1990</td>
<td>186,012,250</td>
<td>99</td>
<td>1,650,998</td>
<td>187,663,248</td>
</tr>
<tr>
<td>1990/1991</td>
<td>173,282,412</td>
<td>96</td>
<td>6,689,171</td>
<td>179,971,583</td>
</tr>
<tr>
<td>1991/1992</td>
<td>230,798,656</td>
<td>96</td>
<td>8,150,415</td>
<td>238,949,071</td>
</tr>
<tr>
<td>1992/1993</td>
<td>244,609,794</td>
<td>93</td>
<td>19,499,911</td>
<td>264,109,705</td>
</tr>
<tr>
<td>1993/1994</td>
<td>252,256,948</td>
<td>96</td>
<td>11,132,361</td>
<td>263,389,309</td>
</tr>
<tr>
<td>Total</td>
<td>1,086,960,060</td>
<td>96</td>
<td>47,122,856</td>
<td>1,134,082,916</td>
</tr>
</tbody>
</table>

Source: Pusat AKAN Depmaker, (Department of Manpower, 1994: Table: 30)

Note: Data for Saudi Arabia includes recruiting fee
Data from Bank of Indonesia
Transfer from Saudi Arabia since August 1988, including remittances recorded in the TKI’s arrival Unit in Ciracas.

Wood (1982: 301 cited in Lycklama, 1989: 23) suggested that the international movement of labour would lead to 'a gradual convergence in the level of economic growth and social well-being'. The migration of people to work overseas should reduce unemployment, as domestic employment opportunities do not have to accommodate the
job-seekers. Overseas employment should also result in an in-flow of scarce foreign exchange in the form of workers' remittances and returnee savings. This may facilitate development by alleviating balance of payments difficulties and increase savings and investment by increasing income (Stahl, 1989:80). One of the conventional arguments favouring labour migration is that it is an inexpensive and rapid method of relieving unemployment (Stahl, 1982: 876). The effect of labour migration on the employment situation is a direct one if unemployed workers secure jobs in the Middle East (Arnold and Shah, 1984: 302). The effect is indirect if the migration of employed domestic workers creates openings for the local unemployed. In the case of Sri Lanka (Spaan, 1988: 62) and Indonesia, the effect of labour migration in decreasing unemployment is not so significant because the bulk of migrants are women who were previously not active in the formal labour market.

Gunatilleke (1988: 15) noted a popular belief that the incomes earned by low income households of migrants workers are 'frittered away in wasteful consumption and various forms of extravagant spending'. In real terms, international migration increases family incomes, so that there is an upward movement in life style. Gunatilleke (1986: 1) also noted that labour migration has had far-reaching socio-economic, cultural, and demographic consequences. The magnitude of the migration is significant enough to make it an important factor in national employment strategies and manpower planning. The workers participating in this flow of migration most often come from the young, reproductive age group, which may have a significant demographic impact.

Overseas employment may also improve the quality of the domestic labour force. Workers going abroad may have an opportunity to acquire skills that, when employed upon their return, will be useful to the development effort (Stahl, 1989: 81). However,
this has not been the case for women workers from Indonesia and Sri Lanka because the women work as domestic servants, work which does not require particular skills (Stahl, 1989: 82).

The overseas migration of women workers also has consequences for the local economy. Studies of international migration have indicated that migration has a major impact at the household and village level (Abella and Atal, 1986: 223; Stark et al., 1986: 722). This is partly due to the wide gap between the wages received in the host country and average wages in the country of origin. In the case of Central Java, where a large proportion of migrants to the Middle East are domestic servants from low income households, female labour migration could be expected to have a direct impact on poverty. Potentially, the money earned by the women overseas could have been used to relieve the poverty of their families. However, the popular view has been that most remittances have gone into increased consumption expenditure on ‘wasteful’ consumer durables and unproductive investment, mainly in land and housing (Amjad, 1989: 15). A study in the Philippines found an increase in farm production capacity among the families of migrant households, where remittances went into purchasing hand tractors, water pumps and other farm inputs (Priterria, 1992:5).

The impact of labour migration on individuals varies greatly. Some migrants may accumulate greater debts than others in order to finance their move. Some migrants are able to save a considerable sums of money, which they use to build a house, buy land, educate their children or start a small business (Appleyard, 1989: 101). Following employment in the Middle East for wages several times higher than what they had earned at home, some workers have also been reluctant to take employment in the same occupation that they held before migrating (Appleyard, 1989: 102).
The absence of wives who take up work in the Middle East may change the roles of the remaining individuals and affect family stability. Husbands who were not previously involved in household work might take over the household tasks that were usually carried out by their wives. However, Spaan (1988: 63) found that the effect on men left behind by a migrating wife was often minimal or of a temporary nature. The extended family frequently share in assuming the roles of the absent member (Arnold, 1984: 20). Huguet (1989: 101) argued that many social problems that derive from, and are exacerbated by, the family’s social and economic situation before migration may also affect individuals’ roles and family stability after migration.

Women’s international labour contract migration may also have non-economic consequences for families, particularly through the socio-cultural impacts of migration, remittances and returning migrants on the family. These include a changing relationship between spouses, between mothers and children, and other adjustments by the families of women migrants. The households of migrants from extended families sometimes cope more easily because the kinship network provides greater support, control and capacity to replace missing workers (Connell, 1976: 45 cited in Harbinson, 1981: 225). The kinship network can provide migrant families with both financial and social support, which is especially important when children are left at home.

Studies on international migration of women conducted by the Asian and Pacific Development Centre (1994) in various countries suggested that the migration of women also has non-economic consequences for the members of the family who are left behind:

...the domestic workload of the migrant female worker is shifted to other women and girls, generally unpaid family members - such as unmarried daughters, sister and aunts, or mothers, mothers-in-law and grandmothers. The burden of housework, childcare and other dimensions of social reproduction thus continues to be seen as the sole responsibility of girls and women, rather than as the shared responsibility of both men and women or the shared responsibility of family and the State. This leads to
an increase in unpaid female labour with its attendant consequences - such as the educational and employment deprivation of the unpaid female worker, which in turn leads to transmission of female poverty (Heyzer and Wee, 1994: 39).

An absence of two years from home may not be easy for the migrant herself to cope with. When a mother who is the main responsible actor in family affairs leaves her husband and children, the everyday routine will be greatly disturbed and the responsibility for activities such as cooking, washing and childcare will have to be taken over by somebody else.

Although women working overseas usually benefit from the higher incomes they earn, these may be short lived and they may pay a high price for them in terms of broken homes or neglected children. Poplin and Doan (1989: 123) noted that women are more likely to play an important role in purchasing food while men are involved in purchasing other types of goods and services. Thus, the migration of women may change household consumption patterns. The proportion of money spent on daily necessities may also be reduced if the migrants return with expensive consumer goods rather than remitting money on a regular basis.

2.5 Summary

The chapter describes the history of Indonesian women’s participation in the international labour market in comparison to the experience of other countries. This chapter also discusses policies and mechanisms for Indonesian female international labour migration and the consequences of sending women workers abroad based on the existing literature.

The flow of Indonesian women labour migrants overseas, particularly to the Middle East, began in the 1980s. Thousands of Indonesian women have gone to the
Middle East to work on two-year contracts as domestic servants (housemaids). Most of these women were married and had young children, and the conditions of their contracts meant that their families remained in Indonesia.

The export of contract workers, including women, has been encouraged by the Indonesian government to increase domestic earnings and foreign exchange, as Indonesia has experienced a deficit in the balance of payments due to the drop in oil prices in the mid-1980s. In addition, the government of Indonesia sent thousands of women contract workers in response to a demand for female domestic helpers among the wealthy middle class in the Middle East. In the meantime, job opportunities for women in rural areas have declined.

The decline in job opportunities in rural areas as a result of the green revolution has pushed the women to take up jobs overseas as domestic servants because it has displaced women labourers. In addition, in the agricultural labour market institutional changes that favoured the employment of men disadvantaged women therefore limited the job opportunities for these women. Overseas migration which was restricted to the contract period and offered comparatively high returns, was preferred to urban migration within Indonesia. Women were able to obtain jobs in the Middle East more easily than men due to the low skill requirement for domestic servants and the lower cost of international contracts for women. In the study area, international migration offered very high potential gains and was more feasible for women because most of the men were unskilled and had low levels of education. In the study area, where the majority of households relied on subsistence farming, it was difficult for them to provide the amount of money required to meet migration fees and travel costs, even for female international labour migration. However, families attracted to the potentially high earnings of
international migration were more likely to arrange for the wife to become the migrant since the fees were more affordable for females than males.

Indonesian labour migration to the Middle East has been dominated by women with very low skills and education. This is different from migrants from other countries such as those from Pakistan, South Korea, and Bangladesh who are mainly men with above-average educational levels. The high number of women working overseas outnumber men because no skills or education are required for female domestic servants and because the recruitment fees for women are much lower than for men. Domestic service is regarded as unskilled labour which requires no formal education. Because of this factor, domestic work is considered to be appropriate for females as it is considered part of the female socialisation.

The recruitment process for migration to the Middle East is undertaken by a private recruitment network. The cost incurred before migrating ranged between Rp. 350,000 and Rp. 800,000 in 1991 which was a very large amount for villagers in the poverty-stricken community. Nevertheless, there were many Indonesian women working on overseas labour contracts especially in the Middle East because they could get earnings of around 10 times more than the income that they could earn in their villages. Therefore, in the last 10 years many poor families have sent women household members to work in the Middle East.

It is very difficult to determine the economic and social costs and benefits of women's international labour migration in order to consider appropriate policy responses. Women's international labour migration involves economic, social, cultural and psychological factors. Migration of women for work is sometimes regarded as not being socially acceptable. Women's involvement in migration may create numerous
problems for the migrants themselves and their families left behind, particularly the young children. In the short term the absence of mothers involves potential health costs for children. Separation of young children from mothers may cause emotional deprivation in the children which, in turn, could result in poor growth. The absence of the mother may affect the child's appetite, resulting in the child being undernourished. However, in the long term the children may also benefit from economic gains. Migration is part of a search by poor families for a better life for themselves and their children. Financial security and material comfort seem impossible if migrant women just stay in the village.
CHAPTER 3

THE STUDY COMMUNITIES

This chapter describes the social, demographic and economic characteristics of the study communities to provide an understanding of the context of data collection. The first section describes the research area and the profile of the community, while the second presents an overview of the employment opportunities in the study area. The third part describes the general impact of the migration of women as international contract workers on the study area to provide the broad context for the examination of the specific impact on families and children in the subsequent chapters.

3.1 The research area and profile of the community

The 1992/93 Survei Ibu was implemented in 19 villages in two sub-districts of a rural area of Central Java. The study site is located approximately 60 kilometres from Yogyakarta, a large regional city on the island of Java. The particular sub-districts were chosen because they were the location of an existing longitudinal study of child morbidity and vitamin A (known as the Morvita study) also conducted by the CEU in collaboration with the Johns Hopkins University in the USA. That study had examined the effect of vitamin A supplementation on child morbidity, especially diarrhoea and upper respiratory tract infection. The established relationship between the 1992/93 Survei Ibu teams and the people in the study area and the existence of an experienced, highly skilled and well-organised field team were essential pre-requisites for the complex data collection operation required by the 1992/93 Survei Ibu.
The two sub-districts, Purwadadi and Ngombol, are in the Purworejo region of the Province of Central Java. Although this study describes each of the sub-districts, it does not intend to either compare or contrast Purwadadi and Ngombol. Children in the 1992/93 Survei Ibu study sample were drawn from both sub-districts. The sample was not evenly distributed between the two sub-districts, which were similar in some respects but different in others. Both were agrarian communities dependent on subsistence agriculture, and both had substantial populations of poor people. The main difference was that farmers in Ngombol could grow rice only once a year because the soil was not very fertile whereas in Purwadadi farmers could grow rice twice a year. In addition, Ngombol was relatively more isolated and had poorer facilities than Purwadadi. Except where indicated in the text, the study area mentioned in this thesis refers to Purworejo Kabupaten (region), covering both sub-districts. The population covered by the study was limited only to the villagers included in the 1992/93 Survei Ibu. Although I have used the real name for the study area, to protect the identity of the villagers the names used for people throughout the thesis are pseudonyms.

3.1.1 Purwadadi sub-district

*Description of the area*

Purwadadi sub-district is situated around 12 kilometres to the south of the regency town of Purworejo, through which the main road from Yogyakarta to Bandung (two of the major cities in Java) passes. This area is about 90 minutes drive by bus south of the city of Yogyakarta. The centre of Purwadadi sub-district is around two kilometres from the main road connecting Yogyakarta and Bandung. In 1992 it could be reached by
mini-buses or colts¹, which passed about once every thirty minutes. Several private mini-buses operated daily along these roads. Because many public servants, as well as traders, worked in the district of Purworejo and nearby, the service was more frequent between 6.00 and 7.00 am, 2.00 pm and 3.00 pm in the afternoon. Senior high school students also used this transport to commute to Purworejo or nearby districts.

The sub-district was comparatively well served by public transport. Inter-city transport for both passengers and goods included minivan-type vehicles (colts), buses, and mini-buses. Horse-drawn carts and passenger motorcycles, usually called ojek, were the most important forms of public transport within the sub-district area, particularly on market days. In December 1992, there were 35 ojek and 30 horse-drawn carts (delman), 5912 bicycles and 770 motorcycles owned by families in Purwodadi (Monografi Kecamatan Purwodadi, 1992).

According to the sub-district statistics, the total length of roads that could be travelled by motor vehicles (four-wheeled vehicles) was 68 kilometres, of which 28.50 kilometres were asphalted roads. The total length of sealed roads (jalan diperkeras) amounted to 24 kilometres, with 12 kilometres of dirt road.

In 1992 Purwodadi was composed of 40 villages, which were further divided into 117 hamlets, 90 Rukun Warga and 270 Rukun Tetangga (neighbourhood units). Thirteen of the 40 villages were included in the 1992/93 Survei Ibu. The villages were separated by dry and unirrigated land. A total of 325 hectares was residential, including houseyards (pekarangan). The total area of irrigated rice fields was 2,529 hectares, while the area of rain-fed cultivation land (sawah tadah hujan) was 201 hectares (Monografi Kecamatan Purwodadi, 1992).

¹ A colt is a small van, seating 12 - 20 people.
Demographic characteristics

The total population of Purwodadi in 1992 was 37,903 people. They formed 8,633 households with an average of between four and five members in each household. Females outnumbered males in the sub-district: 19,398 compared to 18,505. This probably reflected the out-migration of males to Jakarta and other places. Thirty eight per cent of the total population were under 15 years of age, of which 11 per cent were children aged four years and younger (0-4) (Monografi Kecamatan Purwodadi, 1992). Unfortunately, the sub-district statistics did not specify the number of people by sex in each age group. The distribution of the population in the sub-district is presented in Table 3.1.

Table 3.1 Population by age group, Purwodadi sub-district, December 1992

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 4</td>
<td>4313</td>
<td>11</td>
</tr>
<tr>
<td>5 - 9</td>
<td>5038</td>
<td>13</td>
</tr>
<tr>
<td>10-14</td>
<td>5246</td>
<td>14</td>
</tr>
<tr>
<td>15-19</td>
<td>4375</td>
<td>12</td>
</tr>
<tr>
<td>20-24</td>
<td>2941</td>
<td>8</td>
</tr>
<tr>
<td>25-34</td>
<td>4196</td>
<td>11</td>
</tr>
<tr>
<td>35-39</td>
<td>1653</td>
<td>4</td>
</tr>
<tr>
<td>40+</td>
<td>10145</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>37903</td>
<td>100</td>
</tr>
</tbody>
</table>


Education and occupation

Illiteracy in Purwodadi had been reduced by the effective efforts of an official literacy campaign described as Bebas Buta Angka, Buta Aksara dan Buta Bahasa (literally, meaning ‘free from blindness to numbers, letters and language’). According to the sub-district statistics (Formulir Isian Monografi Kecamatan Purwodadi, 1992) no-
one in the sub-district was illiterate. The educational attainment of the population of Purwodadi, as shown in the official statistics, is presented in Table 3.2.

The majority of the population had only low levels of education. Almost 90 per cent had education less than or equal to completed junior secondary school; 10 per cent had completed senior secondary school, and only 1 per cent had Academy or University education. Unfortunately, there was no information on education according to sex.

Table 3.2 Educational attainment, Purwodadi sub-district, December 1992

<table>
<thead>
<tr>
<th>Educational attainment</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illiterate</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Not yet reached school age</td>
<td>6214</td>
<td>21</td>
</tr>
<tr>
<td>Incomplete primary school</td>
<td>3811</td>
<td>13</td>
</tr>
<tr>
<td>Completed primary school</td>
<td>11669</td>
<td>39</td>
</tr>
<tr>
<td>Completed junior secondary SMP</td>
<td>5029</td>
<td>17</td>
</tr>
<tr>
<td>Completed senior secondary (SMA)</td>
<td>3164</td>
<td>10</td>
</tr>
<tr>
<td>Academy &amp; university</td>
<td>280</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>30167a</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: *Monografi Kecamatan Purwodadi*, 1992
Note: Totals may not add to 100 due to rounding.

Occupations in Purwodadi included farmer, labourer, civil servant, trader and pensioner (Table 3.3). In 1992, around 61 per cent of the study population of working age (10 years and over) were engaged in agriculture with access to land, of which 36 per cent were farmers who controlled land through renting or sharing arrangements. Those who worked as labourers were 25 per cent of the working age population. Around 90 per cent of these were farm labourers (*buruh tani*); the remainder were construction labourers (*buruh bangunan*). Only 2 per cent of the population worked as small-scale traders. The remaining 11 per cent were civil servants and pensioners (including members of the armed forces). Those whose occupations were categorised as ‘other’
were people who worked in transportation and the small home industry (*Monografi Kecamatan* Purwodadi, 1992).

Table 3.3 : Heads of household by occupation, Purwodadi sub-district December 1992

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Farmer</td>
<td>17819*</td>
<td>61</td>
</tr>
<tr>
<td>Labourer</td>
<td>7275</td>
<td>25</td>
</tr>
<tr>
<td>Civil servant and ABRI</td>
<td>1237</td>
<td>4</td>
</tr>
<tr>
<td>Trader</td>
<td>450</td>
<td>2</td>
</tr>
<tr>
<td>Pensioner</td>
<td>1930</td>
<td>7</td>
</tr>
<tr>
<td>Others</td>
<td>204</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>28915</td>
<td>100</td>
</tr>
</tbody>
</table>


* includes fishermen (66)

The village economy was centred mainly on irrigated-rice cultivation. Rice grown in the paddy fields was the main crop, and cultivation was small scale and labour intensive. Most farmers harvested rice twice a year, with yields varying from low to average: around 6.90 tons per hectare. In 1992, 2,430 hectares of land in Purwodadi could be cultivated, producing 16,845 tons of rice in that year.

Many households also had a small number of cattle, goats and chickens, which were invaluable to the household during the period before the harvest. This was partly because the cattle or the poultry could be sold for cash. Many villagers also grew vegetables in their yards.

In addition to rice, other cash crops were coconut, cassava, fruit and vegetables. Chilli and watermelon were also popular but were often damaged by flooding. During my stay in the study area in 1992, both crops were destroyed by floods, and villagers lost produce worth thousands of dollars. Villagers also grew vegetables and fruit in their *pekarangan* (the yard around the house site).
Table 3.4 shows that only 25 per cent (2,032) of the 8,633 households were served by electricity. The supply was frequently interrupted. No house in Purwodadi had access to piped water. Wells were the main source of water. Most villagers in Purwodadi, particularly in the study villages, used kerosene lamps as the main source of light. Kerosene stoves and brick ovens were commonly used for cooking. Television sets were owned only by the well-to-do. Some of these families who had no electricity used rechargeable batteries for their TV sets. People of higher socio-economic status, mostly local government employees or pensioners, built their houses from brick, with tiled or cemented floors. Most poor people lived in houses made from thatched bamboo with dirt floors. During my stay, I noticed that not every house had its own latrine. Unfortunately, the sub-district statistics did not provide information about the sanitary facilities.

Health services were quite good. In 1992, Purwodadi had one Puskesmas (community health centre) with four medical doctors, seven nurses and nine midwives. The community health centre was situated in the main part of the sub-district and served by relatively frequent transport during the day. In addition to health centres, there were five puskesmas pembantu (health sub-centres). As in other parts of Indonesia (Frankenberg, 1995: 147), the health sub-centres were located in the more peripheral villages of remote sub-districts in which travel was difficult. During the period July to December 1992, attendance at the Puskesmas Pembantu was higher than at the Puskesmas: 13,045 and 10,027 visits respectively. This may have been because the Puskesmas Pembantu were closer to the villages. Approximately 35 traditional healers also practiced in the sub-district, and 200 posyandu (integrated health service post) offered services such as child weighing and child immunisation (Isian Formulir Monografi Kecamatan Purwodadi, 1992).
Table 3.4 Type of housing and public facilities available in Purwodadi, December 1992

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing type</td>
<td></td>
</tr>
<tr>
<td>- <em>Dinding batu</em> (brick walls)</td>
<td>4254</td>
</tr>
<tr>
<td>- <em>Setengah batu</em> (half-brick)</td>
<td>1065</td>
</tr>
<tr>
<td>- <em>Dinding kayu</em> (timber walls)</td>
<td>613</td>
</tr>
<tr>
<td>- Bamboo</td>
<td>2105</td>
</tr>
<tr>
<td>Total</td>
<td>8037</td>
</tr>
<tr>
<td>Houses served with</td>
<td></td>
</tr>
<tr>
<td>- well *</td>
<td></td>
</tr>
<tr>
<td>- hand pump *</td>
<td></td>
</tr>
<tr>
<td>- electricity</td>
<td>2032</td>
</tr>
<tr>
<td>Households owning</td>
<td></td>
</tr>
<tr>
<td>- Bicycles</td>
<td>5912</td>
</tr>
<tr>
<td>- Motor cycles</td>
<td>770</td>
</tr>
<tr>
<td>- Dokar/becak/gerobak (horse-drawn cart/pedicab/cow-drawn cart)</td>
<td>74</td>
</tr>
<tr>
<td>- Car</td>
<td>39</td>
</tr>
<tr>
<td>- Truck &amp; mini bus</td>
<td>53</td>
</tr>
<tr>
<td>Public facilities</td>
<td></td>
</tr>
<tr>
<td>- Puskesmas (Community Health Centre)</td>
<td>1</td>
</tr>
<tr>
<td>- Puskemas Pembantu (Community Health Sub-centre)</td>
<td>5</td>
</tr>
<tr>
<td>- Posyandu (Integrated Health Post)</td>
<td>200</td>
</tr>
<tr>
<td>- Schools:</td>
<td></td>
</tr>
<tr>
<td>- Kindergarten</td>
<td>24</td>
</tr>
<tr>
<td>- Primary</td>
<td>52</td>
</tr>
<tr>
<td>- Junior secondary</td>
<td>2</td>
</tr>
<tr>
<td>- Private junior secondary</td>
<td>4</td>
</tr>
<tr>
<td>- Senior secondary</td>
<td>1</td>
</tr>
<tr>
<td>- Private senior secondary</td>
<td>1</td>
</tr>
<tr>
<td>- Mosque</td>
<td>44</td>
</tr>
<tr>
<td>- Church</td>
<td>7</td>
</tr>
</tbody>
</table>

Note: * no information

3.1.2 Ngombol sub-district

Description of the sub-district

Some villages in Ngombol are located along the coast, not on a main road. The six villages in Ngombol which were selected as the study site had agrarian
characteristics. They were relatively remote by Javanese standards and had no public transport. Although Ngombol is only 20 kilometres from the regency centre (Purworejo), communications with that town were poor. In some cases, people had to walk or ride bicycles around two kilometres to Purwodadi to catch mini-buses. Villagers frequently went to the nearest sub-district (Purwodadi) on market days and occasionally to sell surplus produce. This usually consisted of palm sugar, coconuts, papaya, young jackfruit, and fish. Compared to Purwodadi, Ngombol was more isolated and poorer, as demonstrated by the dirt roads and very poor quality housing. In 1992, the total length of asphalted road in Ngombol was only 11 kilometres. The total length of sealed roads (*jalang diperkeras*) was 20 kilometres. Most roads in the villages were dirt and very muddy during the rainy season. During field work in 1992, the only motor vehicles that passed through the study villages were the 1992/93 *Survei Ibu* vehicles (to drop the 1992/93 *Survei Ibu* team to collect data).

**Demographic characteristics**

According to the sub-district statistics, in 1992 Ngombol had a population of 33,922 living in 7,707 households. As in Purwodadi, on average each household consisted of between four and five people. According to the sub-district statistics, women again outnumbered men: 17,400 compared to 16,522 males, again apparently reflecting an out-migration of men. As can be seen from Table 3.5, eight per cent of the total population were children aged four years and younger. Again the sub-district statistics did not specify the number of people in each age group by sex. Those aged 40 years and above were grouped in one age group, representing more than 30 per cent of the total population.
Table 3.5 Population by age group, Ngombol sub-district, December 1992

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>2603</td>
<td>8</td>
</tr>
<tr>
<td>5-9</td>
<td>3699</td>
<td>11</td>
</tr>
<tr>
<td>10-14</td>
<td>4645</td>
<td>14</td>
</tr>
<tr>
<td>15-19</td>
<td>3286</td>
<td>10</td>
</tr>
<tr>
<td>20-24</td>
<td>2183</td>
<td>6</td>
</tr>
<tr>
<td>25-34</td>
<td>2097</td>
<td>6</td>
</tr>
<tr>
<td>35-39</td>
<td>4209</td>
<td>12</td>
</tr>
<tr>
<td>40+</td>
<td>11200</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>33922</td>
<td>100</td>
</tr>
</tbody>
</table>


**Education and occupation**

The level of education in Ngombol was relatively low. Despite the literacy campaign, nine per cent of the population were buta huruf (illiterate). There was no information about educational attainment according to sex. Table 3.6 presents the educational attainment of people in Ngombol as at December 1992.

Table 3.6 Educational attainment, Ngombol sub-district, December 1992

<table>
<thead>
<tr>
<th>Educational attainment</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illiterate</td>
<td>2603</td>
<td>9</td>
</tr>
<tr>
<td>Not yet reached school age</td>
<td>2603</td>
<td>9</td>
</tr>
<tr>
<td>Primary school not completed</td>
<td>5714</td>
<td>19</td>
</tr>
<tr>
<td>Completed primary</td>
<td>12665</td>
<td>43</td>
</tr>
<tr>
<td>Completed junior secondary (SMP)</td>
<td>3434</td>
<td>12</td>
</tr>
<tr>
<td>Completed senior secondary (SMA)</td>
<td>2351</td>
<td>8</td>
</tr>
<tr>
<td>Academy &amp; university</td>
<td>245</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>29615*</td>
<td>100</td>
</tr>
</tbody>
</table>

Note: Total may not add to 100 due to rounding.

According to the sub-district statistics, around 70 per cent of the population of working age worked as farmers dependent on subsistence agriculture. Around 60 per
cent of the farmers cultivated their land through renting or a share-cropping arrangement. Agricultural crops such as rice and coconuts dominated the economy of the area, although in some parts of Ngombol rice could only be harvested once a year because cultivation was rain-fed (26 per cent of all rice fields).

Most farmers used a *cangkul* (hoe) to cultivate the fields. Wealthier farmers often hired tractors or men with teams of oxen. Work in agriculture was not predictable because of flooding, salination, and the consequent pests and algae that affected the growth of rice. Some villagers were also engaged in fishing and working on sugar plantations. The sugar plantation was on the outskirts of the study area, only a few minutes from the village. The sugar plantation provided many villagers with additional income. In 1992, the wage for plantation labourers was around Rp. 1,200 and Rp. 1,400 for women and men respectively for four hours’ work. However, many villagers also suffered from land shortage and unemployment. The rice fields and coconuts trees in the village provided the villagers’ staple food. According to sub-district statistics, 90 per cent of the population who worked as labourers were agricultural labourers.

Table 3.7 shows that around 70 per cent of the total heads of households were engaged in agriculture. The occupations classified as ‘others’ included those who worked in transportation and home industries, the latter being mostly production of palm sugar and *tempe* (soya-bean cake). Making palm sugar is heavy work bringing in a low income (Singarimbun, 1984: 50). The work is relatively high risk because the palm-sugar makers have to climb coconut trees twice a day, regardless of the weather, to collect the *nira* (nectar water). Soedarwono (1971: 11 cited in Singarimbun, 1984: 50) noticed that people would not make palm sugar if they had enough land. This was apparently also generally true in the study villages. However, manufacturing palm sugar provided cash
for daily necessities and some families of women migrant workers preferred this kind of work. They seemed to prefer producing palm sugar to cultivating their land because then they did not need to wait at least three months in order to obtain a cash return, and because they could mind their children while they worked.

Table 3.7 Heads of household by occupation, Ngombol sub-district, December, 1992

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Farmers</td>
<td>18567*</td>
<td>68</td>
</tr>
<tr>
<td>Labourers</td>
<td>6847</td>
<td>25</td>
</tr>
<tr>
<td>Civil servants/ABRI (armed forced)</td>
<td>1001</td>
<td>4</td>
</tr>
<tr>
<td>Traders</td>
<td>465</td>
<td>2</td>
</tr>
<tr>
<td>Pensioners</td>
<td>256</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>309</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>27445</td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>


Note: *a* includes fishermen (220)

In some parts of Ngombol, especially near the coast, the soils were textured sandy loam or clay and not so fertile. This meant that villagers were not able to grow crops other than rice. Located in the coastal area, the land was flooded in the rainy season and very dry in the dry season, making it difficult for the villagers to cultivate. In addition, the level of salt in the water was quite high due to over-exploitation. Many villagers had tried to plant a variety of crops, but the yields were not satisfactory.

In addition to rice, the major crops grown in this area were jackfruit, coconuts and cashew nuts for home consumption, although any surplus was sold. Some villagers benefited from selling the nuts from cashew trees. In 1992, the price of 100 unpeeled cashew nuts was Rp. 600. Villagers also owned livestock such as goats, chickens, ducks, buffaloes and cows. Ducks and chickens were kept for meat and eggs.
Table 3.8 shows the type of housing and facilities available in Ngombol in 1992. Around 45 per cent (3,135 houses) of 6,992 houses were made from bamboo and 2130 houses (30 per cent) were built with plastered walls. Around 24 per cent of all houses were served with electricity by Perusahaan Umum Listrik Negara (The National Electricity Corporation), and another 1 per cent (100 houses) had access to electricity through a diesel motor organised by some villagers. There was no information about the number of houses with sanitary facilities. However, my own observation indicated that many houses had no sanitary facilities. Many people used the stream for toilet facilities. It was also customary for children to use house yards.

During my stay in the study villages, I saw that some families, particularly those who lived along the coast, lived in two-roomed houses, one room for the kitchen and the other for sleeping and general purposes. Wooden fences were commonly used to separate the houses. Most poor villagers owned wooden furniture, mainly bamboo. Kerosene lamps were the main source of light at night. Fireplaces built on the ground using fire wood and wood-fired brick ovens were commonly used for cooking, although kerosene stoves were used by more well-to-do families. Wells were the main source of water. Around 15 per cent of the 6,992 houses used hand pumps to draw water. Some villagers along the coast of Ngombol used public wells that were around 25 meters below the surface. In 1992, in at least one village, villagers had to draw water from wells in common courtyards. One well was used by approximately five households. A plan to build a well for every house had not yet been implemented.

The usual mode of transportation in Ngombol was bicycles. According to the sub-district statistics, in December 1992 there were 4,992 bicycles and 604 motor cycles in the village. Every market day (once every five days, following the traditional Javanese
calendar), chartered vehicles took people from the village to the market. The market rotated among the villages. Some people gave lifts on their motorcycles to others for payment, a practice known as ojek, but the fare was relatively expensive for rural people.

Ngombol was less well served than Purwodadi by health services. In 1992, there was only one community health centre with two doctors, four nurses and four midwives. There were also 33 traditional healers and 88 posyandu. The community health centre was a few kilometres away, but transport was relatively difficult because the villages were not on a tarred road. Transport was also not easily available to the district town of Purworejo. Personal observation and in-depth interviews revealed that villagers were more likely to visit community health centres in another region because of the better accessibility to transport. They usually rode bicycles to the colt station and took a minibus or colt to that health centre.
<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing type</td>
<td></td>
</tr>
<tr>
<td>- <em>Dinding batu</em> (brick walls)</td>
<td>2130</td>
</tr>
<tr>
<td>- <em>Setengah batu</em> (half-brick)</td>
<td>1643</td>
</tr>
<tr>
<td>- <em>Dinding kayu</em> (timber walls)</td>
<td>84</td>
</tr>
<tr>
<td>- Bamboo</td>
<td>3135</td>
</tr>
<tr>
<td>Total</td>
<td>6992</td>
</tr>
<tr>
<td>Houses served with</td>
<td></td>
</tr>
<tr>
<td>- Well</td>
<td>*</td>
</tr>
<tr>
<td>- Hand pump</td>
<td>1061</td>
</tr>
<tr>
<td>- Electricity</td>
<td>1664</td>
</tr>
<tr>
<td>Household owned</td>
<td></td>
</tr>
<tr>
<td>- Bicycles</td>
<td>4992</td>
</tr>
<tr>
<td>- Motor cycles</td>
<td>604</td>
</tr>
<tr>
<td>- <em>Dokar/becak/gerobak</em> (horse-drawn cart/pedicab/ cow-drawn cart)</td>
<td>16</td>
</tr>
<tr>
<td>- Car</td>
<td>9</td>
</tr>
<tr>
<td>- Truck &amp; mini bus</td>
<td>7</td>
</tr>
<tr>
<td>Public facilities</td>
<td></td>
</tr>
<tr>
<td>- <em>Puskesmas</em> (Community Health centre)</td>
<td>1</td>
</tr>
<tr>
<td>- <em>Posyandu</em> (Integrated Health post)</td>
<td>88</td>
</tr>
<tr>
<td>- Schools</td>
<td></td>
</tr>
<tr>
<td>- Kindergarten</td>
<td>26</td>
</tr>
<tr>
<td>- Primary</td>
<td>40</td>
</tr>
<tr>
<td>- Junior secondary</td>
<td>2</td>
</tr>
<tr>
<td>- Private junior secondary</td>
<td>2</td>
</tr>
<tr>
<td>- Mosque</td>
<td>39</td>
</tr>
<tr>
<td>- Church</td>
<td>6</td>
</tr>
</tbody>
</table>


Note: * no information
Figure 3.2
Map of Kabupaten Purworejo

Kabupaten Purworejo

1. Grabag
2. Ngombol
3. Purwodadi
4. Bagelen
5. Kaligesing
6. Banyuurip
7. Bayan
8. Kutoarjo
9. Butuh
10. Pituruh
11. Kemiri
12. Bruno
13. Gebang
14. Loano
15. Bener

Source: Adopted from the Morvita Study
3.2 Employment opportunities in the study area

In both sub-districts, employment in non-agricultural occupations was limited, particularly for women. Even though no data were available from the sub-district, my own observation suggested that, excluding a few who worked as government servants, the majority of women were unpaid family workers who helped their husbands in tasks such as planting and weeding. Some women also worked on the sugar plantation, some worked as paid farm labourers, but most were housewives who stayed at home looking after their children and helped on the family farm.

In the early 1980s, heavy and unpredictable flooding in the coastal area forced a number of people, particularly women, to take up work outside the village. At the end of 1992, many villagers in this area again experienced poor harvests due to flooding. The loss of income resulted in increased pressure for mobility by at least one member of the household. This happened to coincide with a high demand for housemaids to work on two-year contracts in the Middle East, providing an opportunity for a large number of unskilled women with at least primary education to earn money. The opportunity to work in domestic service in the Middle East was very attractive to these women. The potential income to be earned there was much greater than anything available in the village. Since their husbands lacked the higher levels of education required for men to work in the Middle East, the migration of the women was seen as the only way for many poor families to alleviate their poverty.
3.3 The consequences of sending women workers abroad: evidence from the field work.

This section examines the consequences of sending women workers abroad, based on primary sources. The section discusses the consequences at community and family levels, as well as at individual levels.

At the community level, the economic consequences of women's international labour migration are also mainly the result of the flow of remittances sent by the migrants. Remittances, by raising local incomes, may stimulate demand and reduce unemployment in the local economy. For example, many of the remittances sent by female migrants from the study area were used to buy farm land or cattle. Others were utilised to renovate housing. To some extent, this created job opportunities within the study area. Households that were not able to cultivate their farm land due to overseas migration could employ other people to work for them.

The management of the money earned depends very much on the cooperation and temperament of the husbands and on the status of the wife vis-a-vis the husband. To finance their migration, some women have to mortgage their property. The salary they earn in the early months of their work will then go to repay the debts incurred.

In the study area, many husbands of migrant women preferred to produce palm sugar rather than work on their farm land to produce cash crops because the income gained from the sale of palm sugar was seen to be better and they received cash immediately after selling the product. For example, 20 palm trees produced four kilograms of palm sugar, which sold for around Rp. 500 per kilogram. An additional advantage was that the men could mind their children at the same time because the palm
sugar was manufactured at home. These men often paid others to cultivate their land, thereby creating wage employment.

House renovation also created job opportunities in construction. For example, one young man had worked on his farm land and also made palm sugar prior to his wife's emigration. When his wife left to work in the Middle East, he used some of the remittances (he received about Rp. 3 million) from his wife to pay others to cultivate his land so he could concentrate on making palm sugar. The rest of the considerable amount received from his wife was used to build a new house. Thus, he provided jobs for others, most of them men.

The community also benefited in other ways from remittances. For example, some migrant households were able to buy a television set. Neighbours who did not have television were able to watch the migrant household's set, thus allowing other community members to have access to the mass media and information. In one of the study villages, there were 36 households which had at least one woman working in the Middle East. At least ten television sets had resulted directly from the migration to Saudi Arabia. Since the study area was relatively poor, access to television had been very limited prior to the impact of migration. Another economic benefit took the form of direct contributions to the community from returnees. One village headman in the study area had decreed that every returnee should contribute an amount ranging from Rp. 10,000 to Rp. 50,000 for village development. The money had mainly been used to buy furniture for the village office.

Alongside these positive impacts of women working in the Middle East, the negative impacts on the community must also be considered. Some people in the study area complained that the price of land was increasing because of the high demand for
land created by remittances from women working in the Middle East. In-depth interviews indicated that the families of the women migrants tended to buy land from remittances received from the women who worked overseas. Another negative impact for the community was an increase in the rate of interest charged by local money lenders. Because many women needed money to meet the recruitment fees, they borrowed from the money lenders at relatively high rates of interest. A 'patron-client' relationship existed among the sugar distributors, who were also the money lenders, and palm-sugar makers. Prospective migrants could borrow from money lenders only if they sold their palm sugar to the money lenders. This created a strong relationship between the palm-sugar makers, in this case prospective migrant families, and the sugar distributors. The disadvantage for the producers was that the price of palm sugar was slightly lower than that in the public market, adding to the effective rate of interest they paid.

Another impact noticed by the community was that the absence of a significant number of women affected participation in village activities, such as the weighing of young children at the integrated health post (Posyandu). The substitute caregivers of young children from migrant families often forgot to bring the children to the weighing post. One man also complained that he could not be appointed as one of the village-office staff because his wife was away. A requirement for village office-holders was that their wives had to participate in village programs such as the Family Welfare Movement, known as PKK (Pendidikan Kesejahteraan Keluarga).

The popularity of new motor cycles was another impact. Some young men in the families who received remittances from the Middle East were able to purchase new motor cycles. This encouraged other teenagers in the village to ask their parents to buy
them motor cycles, which were very expensive by village standards. Dodo was an example:

Widodo (Dodo), a 30-year-old man and the father of 9-year-old girl, was able to buy a motor cycle ‘Suzuki Crystal’ worth Rp.3,500,000 in 1993, a result of his wife’s money earned in the Middle East. Dodo’s wife, Marsina, worked for two years in the Middle East as a domestic servant. Her employer was quite pleased to have her, as indicated by the income that she always received on time. Sometimes, the other members of her employer’s household also gave her bonuses. For the first contract (two years) Marsina earned about Rp. 275,000 per month. With this income, she was able to send about Rp. 7,000,000 which was used to buy a motor cycle for her husband and jewellery for her daughter. When her employer asked her to renew her contract, she was given a return ticket to visit her husband and her only daughter back home in the village.

Another less desirable side effect reported by a village headman was the emergence of extra-marital relationships between the husbands of migrant women and other women in the area. Separation between husbands and wives of at least two years was considered to cause marital instability:

Pak Lurah, one of the village headmen in the study villages, reported that at least two cases of men having relationships outside marriage had been noticed in his area. He said that one man whose wife was in the Middle East established a close relationship with his sister-in-law. Another case was where the husband of a migrant woman had a close relationship with a school-age girl. Pak Lurah called this phenomenon a ‘hasil Arab’ (literally meaning, ‘result of Saudi Arabia’). He said that he felt so sorry for the women who worked hard to earn money for their family, but the money was misused.

The consequences of women’s international labour migration for the families in the study area were both economic and non-economic. The economic consequences of having a household member working in the Middle East were very obvious in the study area. The increase in household income meant increasing purchasing power for the household, and families were able to buy goods that they could not afford before. For
example, one household was able to buy a new set of household furniture from the money earned from the Middle East.

House renovation was another of the benefits gained by the families of many migrants. The results of the renovations could be easily seen. Some houses that belong to the migrant households have new roofing, cemented floors or glass windows. For example, Im, was able to build a new house using money his wife earned in Saudi Arabia (for detailed information see the case study in Chapter 5, page 152).

In some households, remittances sent from the Middle East enabled the household to meet educational expenses for their children:

Jamila served as a domestic servant for two years. She was not lucky in the sense that she was nine months in *penampungan* (temporary accommodation for workers before departing for the Middle East). This cost her around Rp. 900,000 for recruiting fees and additional expenses during her stay in the *penampungan*. She left three children, two of them in school. Jamila’s husband told me that his wife’s remittances (on one occasion she sent about Rp. 1,500,000) enabled him to pay the education expenses for his children. Even though there was no school fee, there were ‘*turan*’ (donations) and also the cost of school uniforms for his two children.

The family left behind benefited to some degree from increased prestige due to having a household member working overseas. Some households felt that their social status had increased, as indicated by the material goods they had been able to acquire since the women had worked in the Middle East. Some migrants’ families were proud that they had new-model motor cycles, something seen as a luxury in the village. For example:

Mati, a 26 year-old woman and the mother of 3-year-old girl returned from Saudi Arabia after working as a domestic servant for two years. In Saudi Arabia she worked for an army family and earned about Rp. 310,000 per month. During the first few months, she remitted her salary home. Her husband, together with her parents managed the household satisfactorily. With the income she earned from Saudi Arabia, she was able to buy four large chairs for the living room, a buffet and a motor
cycle ‘Yamaha Alfa’. She said that with her new motor bike she or her husband could go anywhere without any difficulty. Before purchasing the motor bike, a bicycle was the main transportation used by her husband to go only short distances.

The purchasing power of the household was increased by the income earned from the Middle East. However, most households also had to repay debts incurred before the migration of the women, including many incurred as a direct consequence of the migration, as in the case of Wahyono. At the time of field work, Wahyono’s wife had been working in Saudi Arabia for ten months. During the first few months, his wife was able to remit her salary home, amounting to around Rp. 1,600,000. This money was used to repay the debt incurred to finance her migration. The debt totalled Rp. 710,000, made up of the original debt of Rp. 550,000 and Rp. 160,000 for the interest.

The absence of wives working abroad created emotional problems for some husbands. However, the problems were sometimes alleviated by the presence of children at home. For example, in-depth interviews suggested that the presence of children reduced the impact of loneliness for some women migrants’ husbands. In 1993, Pak Pri, a 35-year-old man, and the husband of a migrant, showed me a cross-stitch embroidery he had made entitled ‘memory duda sesaat’, meaning ‘memoirs of a temporary widower’. It was a woman’s face. He told me that it enabled him to express his lonely feelings resulting from the temporary separation from his wife. Nevertheless, in at least one case a husband apparently turned to alcohol in response to the strains created by his wife’s absence.

By contrast, another potential social impact was the strengthening of family ties. The migration of married female workers appeared to have increased familial interdependence in some households. Some husbands often called upon their mothers or
other adult female relatives to provide help in caring for their children and managing their households. For example, Pak Im asked his mother to live with him during his wife’s absence in order to take care of his daughter. In other cases, the husbands and children moved into their parent’s house to get support and childcare. Saryan, whose wife left to work in Saudi Arabia for two years, asked his grandmother to live with him while his wife was away. However, his grandmother agreed to help him care for his daughter only if he and his daughter moved into her house. Pak Saryan then moved to his grandmother’s house located a few kilometres from his own house.

The migrant worker faces an unenviable dilemma in weighing up the net effect of migration on the family and individual. The need to provide for the economic well-being of her family pushes the worker to a foreign land; in the process, she deprives her family of the social and emotional support that a mother alone can provide. To reach her destination, the domestic worker has had to sell or mortgage whatever family or personal property she has of marketable value. Those who succeed in obtaining overseas employment subsequently obtain the means to re-acquire these properties and more. Those, however, who are not so fortunate, or who get deported to their countries of origin, have found themselves poorer from the experience, losing property and self-esteem in the process.

The absence of mothers also affected the division of household tasks. In the study area, for example, I found that Sapti, the 10-year-old daughter of an absentee mother had assumed adult female responsibilities. In the absence of her mother, Sapti helped her father with cooking as well as taking care of her younger brother. Before going to school (in 1992, she was in Grade 4) she would cook rice and clean the house. After coming
home from school, she played with her brother. In general, I noticed that the absence of mothers seemed to increase the independence of young household members.

I found that some male household heads cooked, washed, and cared for children while their wives worked in the Middle East. Thus, the involvement of women in migration sometimes increased the involvement of fathers in the development of young children. However, the wife often took over the responsibility again after her return. In other families, her absence was offset by the fact that related females managed the household during her absence.

International labour migration by women can also be considered as a 'household strategy for survival'. Especially for the poorest strata of society, women’s work overseas enables them to greatly increase household purchasing power. 'Need for income' is one of the reasons for migration most commonly found in studies of labour migration. In some households, the female migrants earnings contribute significantly to family maintenance and even to survival (Dias, 1989: 214). The following illustrates a case in the study area of women’s migration as a household survival strategy:

Siti was a 23-year-old woman who dropped out from the third grade of Senior High School. She lived with her widowed mother and her uncle. The economic conditions of Siti's household were harsh. For years she had been unable to find a job after withdrawing from school. Siti had an illegitimate 18-month-old son. This made it more difficult for her mother to support Siti and her son. Her uncle borrowed money (Rp.500,000) from one money lender in the village to enable Siti to join the flow of migration to the Middle East. After six months working in the Middle East, Siti was able to remit a considerable amount of money (Rp.900,000) to repay her debts and to buy the daily necessities for her son and her mother.

Working as an overseas domestic servant was not the first choice of most women in the study village. Rather, it was the only alternative open to them after a long search for jobs by women who only had primary school education. As most of the women were
farmers, work as a domestic servant with a salary of around 600 Saudi Arabian Arab riyals (around Rp. 350,000) a month was an attractive alternative.

In the study area it was relatively common for children to be brought up in households where one or both parents were absent. In addition, childcare was generally undertaken by people other than the child's mother. Therefore, the social mechanisms for caring for children of absent mothers seemed to be well developed. I also found that it was common for children to be offered food at any house they might visit. Thus, other people in the community were often responsible for feeding and caring for the children of migrating mothers.

Individual migrants had to be re-integrated into their society, economy and households on their return from overseas. I observed this process in the case of Sri, a young married woman aged around 28 years. Sri returned from the Middle East after completing a two-year contract. She found that it was difficult for her to adjust to working as a farmer again because she had not done it for two years. As a result, she planned to return to work in the Middle East again. She complained that the money that she had earned from the Middle East had been used to buy daily necessities so she had no savings or capital.

Sometimes the money earned by the migrant women has disappeared upon completion of their contracts. Even though in the Middle East the women were able to earn around Rp. 300,000 per month, the first months or the first year of their salary usually went to the money lender from whom they borrowed money to meet the recruitment fees. In the meantime, their families also expected them to send remittances to pay all daily household expenses.
3.4 Summary

This chapter describes the study communities. It begins with the description of the research area and the profile of the community, followed by an overview of the employment opportunities in the study area. The last part of the chapter discusses the general impact of the women overseas contract workers in the study area.

The majority of the population in the study area had only low levels of education, with almost 90 per cent having education less than, or equal to, completed junior secondary school. Despite the literacy campaign, nine per cent of the population in Ngombol were officially recorded as being illiterate. The socio-economic conditions of the people in the study area contributed to the out-migration of women to work in domestic service in the Middle East. Poverty and a scarcity of job opportunities pushed a significant number of women to take the decision to work abroad, leaving the responsibility of caring for their young children in the hands of other people.

In the study area, employment in non-agricultural occupations was limited particularly for women. The majority of women were family workers who helped their husbands with tasks such as planting and weeding. Some women worked on the sugar plantation, some as farm labourers, and others were housewives who stayed at home looking after their children. Most of the women who chose to migrate to work in the Middle East had been unemployed before they migrated. Even though most of the migrant women were not previously active in the formal labour market, the introduction of the green revolution affected them. The decline in the job opportunities in agriculture limited either themselves or family members from earning an income.

The opportunity for women with and no education and no skills, other than in domestic work, to obtain work in the Middle East attracted village women. The potential
income to be earned was much greater than anything available in the village, so migration was seen as perhaps the only way for poor families to alleviate their poverty. Thus, international labour migration by women can be considered as a household strategy for family maintenance or even survival. It enabled families to alleviate their poverty by increasing household purchasing power.

The migration of women also affected the division of household tasks. Some families experienced a reorganisation of work roles. Some husbands were suddenly forced to take on domestic chores now that their wives were away in the Middle East. Thus, the involvement of women in migration sometimes increased the involvement of fathers in the development of young children.

However, field work observation suggested that any improvement in the economic situation of the migrants' families was often only temporary. There is no doubt that in the short term the income earned by women labour migrants in the Middle East enabled them to improve the economic position of their households. This was especially true of households where husbands continued working during the absence of their wives, so that the women's earnings could be saved. However, most households did not manage their higher earnings in ways that would sustain a higher income after the migrant returned home. With the sharply increased income earned from the Middle East, migrant households tended to buy luxury consumer goods. By the time the contract was over there was often little capital or savings left for the family in the future.

The next chapter will discuss the methodology used to gather the data analysed in this study.
CHAPTER 4

METHODOLOGY

As explained in Chapter 1, the main objective of this study is to examine the well-being of children left behind by their mothers who were overseas contract workers in the Middle East. To achieve the objective, the study uses both quantitative and qualitative methods. The quantitative data were mainly taken from a longitudinal survey conducted collaboratively between Graduate Studies in Demography, National Centre for Development Studies (NCDS), the Australian National University and the Clinical Epidemiology and Bio-statistics Unit (CEU) of Gadjah Mada University in Yogyakarta, Indonesia (the 1992/93 Survei Ibu). As a graduate student in Demography in NCDS, I was attached to the 1992/93 Survei Ibu and participated in the field data collection as a member of the CEU field team.

The 1992/93 Survei Ibu collected data on women’s work, childcare, child anthropometry, child illness, and child psychological development. The objective of the 1992/93 Survei Ibu was to examine how the health, nutrition and access to health care of children in Purworejo, Central Java, was affected by their mother’s work in the labour force. These data were collected by the field team of the CEU using open-ended questionnaires that were jointly developed by CEU and NCDS. The quantitative data sets used (1992/93 Survei Ibu) were collected for purposes other than a study of the relationship between women’s labour migration and child welfare. In particular, the sample of migrant children for which quantitative data were collected is small and differs markedly in characteristics from the sample of non-migrant children. However, the 1992/93 Survei Ibu cannot fully capture the dynamics of human behaviour.
Individual behaviour may change in different situations and may be influenced by many factors at different times. The 1992/93 *Survei Ibu* tended to refer to a specific example of a particular behaviour at a particular time. Thus, the 1992/93 *Survei Ibu* data set could not provide a detailed explanation of the mechanisms that gave rise to a specific behaviour. Recognising this gap, the 1992/93 *Survei Ibu* included a qualitative component to complement the quantitative data set. In addition to participating in the formulation of the quantitative questionnaires and survey data collection methods, I was responsible for qualitative data collection. The qualitative study focused specifically on a comparison of childcare among children of women migrant workers and those of non-migrant mothers. I was also able to accompany some of the survey data collection teams, thus providing a qualitative perspective on the quantitative data collection methods. The population covered by the quantitative survey had been selected to include as many households with migrant mothers as possible.

While the CEU field team collected data through spot observations and structured questionnaires, I collected data using qualitative methods. The qualitative approach was used to collect data on attitudes, perceptions, beliefs and traditions concerning childcare, child feeding, and child health as well as migration-related issues, and to observe childcare and feeding behaviours. My main focus was to compare the well-being of the children of migrant mothers compared with those of non-migrant mothers. This chapter first describes the sources of data used in the study, and how the data were collected. It outlines the various methods used in the study to collect both the quantitative and qualitative data.

This first section below discusses the research design of the 1992/93 *Survei Ibu* including the sample design. The second section describes the data collection
instruments. The third section discusses the quality and limitations of these quantitative data. The fourth section describes the research design I used when I collected my own qualitative data.

4.1 Quantitative research design

The quantitative data were mainly drawn from the 1992/93 Survei Ibu. The main data sets of the 1992/93 Survei Ibu, the household census, child spot-observations, child anthropometric measurements and child illness survey, were analysed for this study. The variables used from the household census were education of parents, marital status and working status of parents. The variables used from the child spot-observation data set were child activities, location of the child, its facial expression (for example, whether it was happy or sad), the person accompanying the child, the relationship of that person to the child, the location of the caregiver, the availability of the child, the activity of the caregiver and child, the interaction between caregiver and the child, and the activity of the caregiver. The variables used from the child illness data sets were the type of child illness (as perceived by the caregivers), symptoms, cause of illness, treatment, source of treatment, and person suggesting the treatment. The variables taken from the anthropometry data sets were child’s age, sex, weight, height, length, and breastfeeding practices.

The 1992/93 Survei Ibu focused on the health and welfare consequences on children of the work status of the mother. Thus, the impact on child health of mothers working as contract-labour migrants was one aspect of the study. Information on childcare behaviour, illness and anthropometry were considered essential to the objectives of the study. A prospective longitudinal research design was considered the
most appropriate way to study childcare behaviour, so that childcare could be observed
directly and the care given to the children could be examined over an extended period.

The 1992/93 Survei Ibu was conducted over six months between August 1992
and March 1993. The research team began by explaining its objectives to the target
group in order to obtain their informed consent to participation in the study. Four teams
were formed to cover observation, surveillance, anthropometry and psychology. The
activities of the various teams were complementary. To obtain information on childcare,
random spot observations were conducted by the Observation Team. The Surveillance
Team was responsible for collecting data on child illness. Data on the weight and height
of each child were gathered by the Anthropometry Team, and the Psychology Team
collected data on child development.

4.1.1 The sample

The 1992/93 Survei Ibu conducted a survey of approximately 1000 households
with children under five years of age which were purposively selected in the 19 villages
of the two sub-districts in the study area. The survey recorded the name, age, sex, marital
status, and occupation of each member of the households in the 19 villages selected for
the initial demographic survey.

From the survey, an initial sample of 360 mothers was purposively selected
according to their work status and children’s age, selecting only mothers of children
aged from six months to 59 months. The study was limited to children aged more than
six months because it was less likely that mothers would leave children younger than
that age to go away to work. The study included children aged between six months and
five years because these were the ages considered to be most affected by alternative
childcare arrangements and most at risk from the ill effects of the mothers’ absence. This was also the age range that had been covered by the previous CEU Morvita study in the same study area. In that study, children under six months had been excluded because they were still receiving vitamin A from their mothers through breastfeeding.

Mothers, or caregivers in the case of migrant families, and children were studied for six months. Information on the demographic and socio-economic characteristics of the household and mother's economic behaviour was collected at the time of the first home interview. Over the following six months, information on childcare behaviour, child anthropometric indicators and child illness experience was also obtained using both quantitative and qualitative methods.

Data were collected for six age categories of children (6 - 8 months, 9 - 11 months, 12 - 23 months, 24 - 35 months, 36 - 47 months, and 48 - 52 months) and a range of different employment categories of mothers: not working, working in the village, working outside the village, and working as a migrant worker in the Middle East. The sample planned to include at least 15 children in each category, yielding a total target sample size of 360 children. However, it was not easy to reach the target number. Eighty-two cases had to be dropped because the parents moved to other villages or did not want to participate in the survey. If parents no longer agreed to their children's participation in the research or families moved out of the study area, replacements were sought that met the criteria. There was an additional loss of cases due to the aging of the study children. As the children aged, some moved out of each age group to be replaced by others from the lower age group. Some children dropped out of the study altogether when their ages exceeded five years.
Of the 360 mothers and children recruited for the study, only 278 who met the selection criteria remained at the end of the study. The final sample of 278 cases provided data on childcare observations. The final sample for the anthropometry data was only 260. This was because some children moved temporarily to other places (64 per cent) and were not measured at the appropriate time or the parents did not agree to their participation (36 per cent).

4.1.2 Household characteristics of the sample

Of the 278 households in the study, 41 were households with migrant mothers and 237 were households with non-migrant mothers. This analysis compares the care of children by substitute caregivers and mothers in these 41 migrant and 237 non-migrant families.

The 41 mothers, aged between 18 and 30 years, migrated independently of their husbands and children. Their mean age was 22.6 years, making them much younger than the resident mothers, who were aged between 15 and 44 years with an average age of 25.9 years. The average age of the migrants from the study area was actually slightly lower than the minimum age required by the Indonesian government for women contract workers in the Middle East. This had originally been 30 years but was reduced to 25 years in 1986. Many young women in the study area had apparently reported higher ages than their actual age in order to enable them to become contract workers.

The minimum age of 25 years, especially for those from rural areas, meant that most of the women migrants were married and had young children. In 1985 the age at first marriage for women was 20.7 years in Java and 21.0 years in Central Java (Hull, n.d cited in Adioetomo, 1993: 45, Table: 2.11).
The average age of husbands of migrant mothers in the study sample was 27.6 years. This was also younger than the husbands of non-migrants, who were 29.9 years old on average (Table 4.1)\(^1\).

Table 4.1.: Age of parents in the study sample, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Age group of parent</th>
<th>Migrants</th>
<th>Non-migrants</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age of mother</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 - 29</td>
<td>98</td>
<td>73</td>
<td>77</td>
</tr>
<tr>
<td>30 - 44</td>
<td>2</td>
<td>27</td>
<td>23</td>
</tr>
<tr>
<td>Mean age (years)</td>
<td>22.6</td>
<td>25.9</td>
<td>25.5</td>
</tr>
<tr>
<td><strong>Age of father</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 - 29</td>
<td>73</td>
<td>53</td>
<td>55</td>
</tr>
<tr>
<td>30 and over</td>
<td>27</td>
<td>48</td>
<td>45</td>
</tr>
<tr>
<td>Mean age (years)</td>
<td>27.6</td>
<td>29.9</td>
<td>29.6</td>
</tr>
<tr>
<td>Number of cases</td>
<td>41</td>
<td>237</td>
<td>278</td>
</tr>
</tbody>
</table>

Note: Totals may not add to 100 due to rounding.

The migrant mothers from the study area were generally from the lower middle group in terms of socio-economic status. They were not from the poorest households because they had to be able to finance their migration. Most of the migrants (87 per cent) had at least some years of schooling. Around 23 per cent had completed junior and senior high school (Table 4.2). The level of education of two per cent of the migrant mothers was not known because when the data were collected the women were already in the Middle East, and the person who gave the information did not know their education level.

The level of educational attainment of husbands of migrants was similar to that of the husbands of non-migrant mothers. Around 12 per cent of migrants’ husbands’ education was also not known, probably because the survey respondents did not know the education level of the children’s fathers. In addition, three migrants were not legally

\(^1\) Tables 4.1 and onward were derived from the 1992/93 Survei Ibu
married and were not living with the fathers of their children and thus did not know the education level of the father.

Table 4.2 Educational level of parents in the study sample, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Education</th>
<th>Migrants</th>
<th>Non-migrants</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother's education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>11</td>
<td>17</td>
<td>15</td>
</tr>
<tr>
<td>Primary</td>
<td>65</td>
<td>56</td>
<td>57</td>
</tr>
<tr>
<td>Secondary</td>
<td>23</td>
<td>27</td>
<td>26</td>
</tr>
<tr>
<td>Don't know</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Father's education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>3</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Primary</td>
<td>47</td>
<td>58</td>
<td>57</td>
</tr>
<tr>
<td>Secondary</td>
<td>38</td>
<td>33</td>
<td>34</td>
</tr>
<tr>
<td>Don't know</td>
<td>12</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Number of cases</td>
<td>41</td>
<td>237</td>
<td>278</td>
</tr>
</tbody>
</table>

Note: Totals may not add to 100 due to rounding.

The main occupation of most husbands, whether migrants or non-migrants, was agriculture (56 per cent of migrants and 59 per cent of non-migrants) (Table 4.3). A significant minority worked in the service sector (government and non-government), as casual labourers or in home industry (making palm sugar).

Manufacturing palm sugar became an important source of livelihood in the study villages. This was mainly because it generated ready cash even though the income was low compared to the labour they spent. Twenty trees tapped every day could produce four kilograms of palm sugar, which could be sold for around Rp. 600 per kilogram in 1990 (Supanto et. al., 1990: 23). While men usually tap the trees, cooking the sap is usually done by women and is very time consuming. However, in the study area, some husbands of migrant women undertook both the tapping and cooking of the sap.
Table 4.3 Occupation of fathers in the study sample, Purworejo, 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Migrants</th>
<th>Non-migrants</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pegawai*</td>
<td>15</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Farmer</td>
<td>56</td>
<td>59</td>
<td>59</td>
</tr>
<tr>
<td>Labourer</td>
<td>14</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Home industry</td>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Others</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Number of cases</td>
<td>41</td>
<td>237</td>
<td>278</td>
</tr>
</tbody>
</table>

Note: * refers to white-collar workers.
Totals may not add to 100 due to rounding.

4.2 The 1992/93 Survei Ibu data collection

4.2.1 Childcare behaviour data

The data on childcare were collected over the course of six months (August 1992 to March 1993) through spot-observations of the children to record the caregiver's interactions with each child at the moment the child was located. Such 'instant' observations were used in order to minimise the effect of the observer on the interaction. (The concept of the spot-observations was based on Reynolds, 1990).

The Observation Team was responsible for observing all the children, who were grouped into 12 areas, each area consisting of at least 10 children. The teams worked in three shifts: morning 5.00 am - 10.00 am, mid-day 10.00 am - 3.00 pm, and evening 3.00 pm - 8.00 pm. Each shift of four observers was responsible for four areas.

The observations were conducted by trained observers who had had close contact with the people in the community due to their previous working experience as research staff on the Morvita study. This previous contact benefited the 1992/93 Survei Ibu because the people being observed were more likely to behave naturally. It seemed from
my observations of the team’s work that the relationship between the spot-observation team and the villagers was well established: the observers’ arrival did not appear to significantly change the behaviour of the caregivers or children.

A sampling frame of half-hour units of time between 5.00 am and 8.00 pm was used, and each visit was randomly assigned within these hours. The sampling of time was designed so that all units would be covered equally over the six-month period. Each visit took around 30 minutes, including 15 minutes for conversation or to locate the child and 15 minutes for travel between households. The observation schedule was fixed but not regular, so that the caregiver could not predict when the Observation Team would visit. Six tempos or starting times: A, B, C, D, E, and F were used to schedule the visits (see Figures 4.1, 4.2, and 4.3).

Figure 4.1. Pattern of visits per tempo (12 respondents)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>VI</th>
<th>VII</th>
<th>VIII</th>
<th>IX</th>
<th>X</th>
<th>XI</th>
<th>XII</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
<td>6</td>
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<tr>
<td>c</td>
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<tr>
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<td>4</td>
<td>5</td>
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</tr>
<tr>
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<td>7</td>
<td>8</td>
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<td>3</td>
<td>4</td>
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<tr>
<td>i</td>
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<td>j</td>
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<tr>
<td>l</td>
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<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Notes: I,II,III...............X: pattern of visits
      a,b,c,d....................j: child’s name
      1,2,3,....................12: sequence of visits per group
Figure 4.2. Pattern of visits per tempo (10 respondents)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>VI</th>
<th>VII</th>
<th>VIII</th>
<th>IX</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>b</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>c</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>9</td>
<td>10</td>
<td>6</td>
<td>7</td>
<td>8</td>
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<td>5</td>
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<tr>
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<td>3</td>
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<td>6</td>
<td>7</td>
<td>8</td>
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<td>10</td>
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<tr>
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<td>2</td>
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<td>g</td>
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<td>7</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tr>
<tr>
<td>h</td>
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<td>7</td>
<td>8</td>
<td>3</td>
<td>4</td>
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<td>2</td>
</tr>
<tr>
<td>i</td>
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<td>7</td>
<td>8</td>
<td>9</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>2</td>
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</tr>
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<td>6</td>
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<td>5</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Notes: I,II,III, ..........................X: pattern of visits  
  a,b,c,d...............................: j: child’s name  
  1,2,3,..............................10: sequence of visits per group

Figure 4.3. Starting times of visits

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Sequence of visit</th>
<th>Morning</th>
<th>Afternoon</th>
<th>Evening</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>a</td>
<td>1</td>
<td>5.30</td>
<td>5.45</td>
<td>10.30</td>
</tr>
<tr>
<td>b</td>
<td>2</td>
<td>6.00</td>
<td>6.15</td>
<td>11.00</td>
</tr>
<tr>
<td>c</td>
<td>3</td>
<td>6.30</td>
<td>6.45</td>
<td>11.30</td>
</tr>
<tr>
<td>d</td>
<td>4</td>
<td>7.00</td>
<td>7.15</td>
<td>12.00</td>
</tr>
<tr>
<td>e</td>
<td>5</td>
<td>7.30</td>
<td>7.45</td>
<td>12.30</td>
</tr>
<tr>
<td>f</td>
<td>6</td>
<td>8.00</td>
<td>8.15</td>
<td>13.00</td>
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<tr>
<td>g</td>
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<td>8.30</td>
<td>8.45</td>
<td>13.30</td>
</tr>
<tr>
<td>h</td>
<td>8</td>
<td>9.00</td>
<td>9.15</td>
<td>14.00</td>
</tr>
<tr>
<td>j</td>
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<td>10.00</td>
<td>10.15</td>
<td>15.00</td>
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<tr>
<td>l</td>
<td>12</td>
<td>blank</td>
<td>blank</td>
<td>blank</td>
</tr>
</tbody>
</table>

Notes: 1. Group who was responsible for observing  
  2. a,b,c, ...........................: child’s name.  
  3. 1,2,3,...........................12: sequence of visits  
  4. A,B,C,D,E,F ........................: tempo or starting times

Every three days the tempo was changed. For example, the first morning group might observe from 5.30 am to 10.00 am (tempo A). On its next visit, this group would observe
from 5.45 am to 10.15 am (*tempo B*). The mid-day group would observe from 10.30 am to 15.00 pm for the first tempo (*tempo C*) and would start at 10.45 am for the next tempo (*tempo D*). Each child could be observed only once a day by any of the three groups.

The spot-observation visits were unannounced. The activities being performed by the child and the caregiver at the moment of the observer's arrival were recorded. This avoided the bias that would have arisen if the caregiver had been given advance warning or sufficient time to adjust their behaviour to the presence of the observer and the fact of being recorded. If the child was away from the household at the time of observation, the team had to search for the child in order to record its activities. Sixty visits to each child yielded approximately 16,292 separate observation of individuals. Sometimes the observer could not find the child by the time the next observation for another child was due. Thus, 1,700 observations (1 per cent) were not valid for these or other reasons, leaving 14,557 valid observations.

The observation focused on what was happening to the child at the time. Data were recorded on what was actually happening to the child in relation to its care. The location of the child, its facial expression, the identity of the person accompanying the child (where this was not the caregiver), the location of the formal caregiver, her/his distance from the child \(^2\), and any concurrent activity of the caregiver were recorded at the time the child was first located. If two childcare activities were simultaneous, such as playing and being fed, then the one that required more active attention by the caregiver was recorded. Data on the age, sex and relationship of the person accompanying the child were also recorded. This was often not the formal caregiver but may have been

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\(^2\) four categories were included
  a within close proximity
  b within hearing distance
  c outside hearing distance but within sight
  d not visible
someone (another child, a neighbour, for example) occupying a temporary or informal caregiving role. Any concurrent activities of the formal caregivers were recorded because these could affect the quality of care.

On completion of the observations, the results were coded for statistical analysis. Each type of behaviour and the information related to that behaviour were coded to show the pattern of care.

4.2.2 Child illness data

Data on child illness were collected during the six-month period by the Surveillance Team. The Surveillance Team consisted of ten staff for data collection, and two field supervisors. Except for one field supervisor who had graduated from university, all members of the Surveillance Team had completed senior high school education. As with the Observer Team, this team also had had previous experience on the Morvita study and close contact with the community. They spoke the local language (Javanese) and had some knowledge of local traditions and beliefs.

Before collecting the data, the team was trained in terms of the objectives of the study, data collection methods, interviewing, and interpreting the illness information reported on the cards by two anthropologists who worked for the 1992/93 Survei Ibu. I was also able to be involved in the illness data collection. I soon realised the value of the team’s local knowledge. Although I am Javanese and speak Javanese, I sometimes found it difficult to grasp the meaning of local terms and had to ask the team or villagers for clarification.

The Surveillance Team visited each household once every three days to collect information on the child’s illness experience during the three days preceding the visit.
For example, if the child was reported to have been sick, the caregiver would be asked when the sickness had occurred, the symptoms noted, what was thought to have caused the illness, and the treatment sought. The Team recorded all the information as reported by the caregiver. In addition, the caregiver was given a card to be filled in with information about any symptoms that the child may have over the next three days. The card was very simple and easily filled in even for household members with a very low educational level. Every three days, the card was collected by the Surveillance Team and replaced with a new card. During the Team’s visit the information on the card was checked for consistency and the condition of the children was also observed. The data obtained on the health status of the child represent the caregiver's point of view. This was considered most appropriate for a study of childcare because it is the caregiver’s perception that motivates care and treatment of illness.

4.2.3 Child anthropometry data

Anthropometric data were collected monthly. Thus the 1992/93 Survei Ibu included five rounds of anthropometric data collection. The first round collected both basic measurements: weight and height, either recumbent length or standing height depending on the child’s age. The child was weighed using the standard Salter scale. Every month the accuracy of the scale was checked. Data on the height of the children were obtained every two months. By the end of the survey, each child had been weighed five times and its height or length measured three times.

The anthropometric data collections were conducted by the Anthropometry Team who were trained nurses. The Anthropometry Team was experienced in collecting data on anthropometry and had conducted research in the same area for around two years.
The team was familiar to and had a very good relationship with the people in the study area.

Data on child age were collected at the beginning of the 1992/93 Survei Ibu. The age information was mainly based on birth certificates. If there was no birth certificate, the researchers asked for the day, month and year of birth, which were recorded as three separate variables. Although the interviewers prompted for information, sometimes it was not possible to obtain the day or month or even the year of birth. Where necessary a date of birth was calculated from the day, month and year variables according to set rules (detailed information on the date-of-birth calculations is described in Appendix A).

Completed anthropometric data were collected for 260 children aged under five years. The child was put in a sarong and attached to a scale hanging from the roof. This method enabled the Team to observe the weight of the child accurately within approximately 100 grams. The height of the child was collected only every two months since the height of children does not change very much over a month. The instrument used to measure the height of the child was based on the WHO standard: a flat wooden board that enabled the child to stand up. For children aged less than one year or who were not able to stand up, length was measured instead of height. The equipment used was the same except that to measure the length of the child, the wooden board was placed flat and the child was lying down. To obtain an accurate measurement the child's knees were pressed down.

In some cases, the Anthropometry Team were unable to obtain an accurate measure of weight, height or length. This was partly because some children had had previous experience of blood being taken to check their health for the Morvita study.
The blood sample was usually taken after the children had been weighed, causing them to associate anthropometric measurement with pain.

Anthropometric measurements were then computed using the National Centre for Health Statistics (NCHS) (WHO Working Group, 1986) standard to calculate the Z-score. Based on the Z-score values, the nutritional status of the children was defined.

4.2.4 Child development data

The Psychology Team collected data on child development. During the six-month period of the study, the children were visited by the Psychology Team twice, once in the morning from 8.00 am to 12.00 am and later in the afternoon from 15.00 pm to 17.00 pm on a different day. The Team members were different for each visit. On each visit, the Team followed the child and recorded the activity of the child every ten minutes. The morning visit lasted four hours and the afternoon visit only for two hours. The present study does not make any use of the psychology data. These data were collected to be used by specialists in conjunction with specialised psychological techniques, and have little direct relevance to the objectives of this thesis.

4.3 Quality and limitations of the 1992/93 Survei Ibu data

The 1992/93 Survei Ibu provided a rich variety of high quality data for this study. To check for consistency and missing data, questionnaires were edited in the field in the evening following the observations and interviews. Although the data were generally of a high quality, there are several limitations to the data from the perspective of this study. The present study was incorporated as a component of the 1992/93 Survei Ibu. Despite this, the overall research design for the quantitative data collection did not meet the
formal requirements of this study. Cell sizes were too small to yield statistically significant results because of the relatively small number of migrant households in the study area. The age structure of the overall sample reflected the needs of the analyses of women’s work rather than those of the comparison between migrants and non-migrants. As a result, the quantitative data cannot provide the main focus for this study. Instead, they are used as a complementary.

The childcare data set covered an extensive range of activities for each study child for six months through on the spot-observations. However, some detailed information to explain the relationships among particular variables was lacking. For example, the socio-demographic information was only available for parents in the sample. Such information was not available for the caregivers or other persons accompanying the children at the time of observation.

The illness data gathered were based on the perceptions of the caregivers. As noted, this was relevant to the caregivers’ behaviour in relation to the child’s illness but cannot be used as an indicator of actual illness occurrences. Thus, it cannot be used as an indicator of the children’s health status. In addition, the person who filled out the illness-monitoring form was not necessarily the person who actually took care of the children. This occurred mainly because some caregivers (particularly older persons) could neither read nor write.

4.4 Qualitative research design

In demographic studies, the conventional sample-survey method most frequently used relies on structured questionnaires to produce quantitative data based on the
answers of respondents. This method produces objective data that can be statistically
generalised to the population from which the sample was drawn. However, this approach
by itself is not completely adequate when studying childcare behaviour, because
respondents are often not entirely aware of their behaviour. Furthermore the complex,
multi-dimensional nature of behavioural interactions cannot always be meaningfully
reduced to quantifiable variables. Observation to produce qualitative data is also needed
in this case. This method produces specific, descriptive data relating to individual cases
that cannot be statistically generalised.

Each approach has its strengths and limitations:

Quantitative methods used in isolation tend to jump ahead to a focus on
reliability and replicability, but if validity is compromised, these efforts
are wasted on data which do not reflect reality. Qualitative methods can
capture actual behaviour with great accuracy, and can produce detailed
information and insights applicable to both development of testable
hypotheses and the interpretation of quantitative data (Scrimshaw, 1989: 1).

For the purposes of this study, the qualitative approach was needed in order to
establish the reasons for attitudes, perceptions, beliefs and traditions that produced the
specific behaviour of caregivers in caring for the children of migrant and non-migrant
mothers. A qualitative approach was used to observe behaviour and explore the
mechanisms through which substitute caregivers provided care for these children.

I was especially interested in identifying the mechanisms through which the
migration of mothers might affect the health of their children, and whether the behaviour
of substitute caregivers differed from that of mothers. Thus, I used anthropological
methods, including participant observation, in-depth interviews and focus group
discussions, to explore the special situation of the children of migrant mothers. However,
I also used the quantitative data obtained by the field teams, particularly the spot-observations of actual care and the standardised survey interviews with caregivers. Quantitative data were especially needed to provide an objective answer to the question of whether the care given by substitute givers was different from that provided by mothers. The quantitative anthropometric data similarly enabled me to compare the outcomes of the care of mothers and substitute caregivers in an objective way. The combination of quantitative and qualitative data enabled me to both establish 'the facts' and explore the underlying reasons for any differences between the two groups of children.

The micro-approach used in this study enabled the care given to particular children to be examined in its social, economic and physical context. Care-giving practices are integrated into particular cultural contexts, which could be explored through the approaches used in this study. The micro-approach allowed the study to identify who actually provided the care for the children and how the children were cared for. Thus the nutritional status and illness experience of the children of migrating and non-migrating mothers shown by the quantitative data could be related to particular aspects of care.

As part of the cultural context, health beliefs and attitudes towards child health and nutrition practices shape and modify people's behaviour in caring for, as well as supervising, children. Therefore, data on beliefs about disease causation, illness behaviour and therapy management, child-rearing practices (feeding practices and food preferences in the family), and the provision of nutritious food for children were collected for this study, from key-informants, participant observation and in-depth interviews, as well as focus group discussions. Each of the methods is described below.
4.4.1 Participant observation

Qualitative data collection began with observation. In the first stages of the study, observation provided valuable clues as to what was happening in the study area. It provided contextual information and ethnographic detail on community activities pertinent to the research. During participant observation, I was able to examine the relationship between what people said and what they did. I was able to better understand how the things I was told actually worked in practice. Through observation, I learned how behaviour corresponded with what I was told.

During field work, I stayed with a family in a house that had been located for me by the Secretary of the 1992/93 Survei Ibu. The particular house was chosen for practical reasons: it had electricity and 'proper' sanitary facilities. In addition, it was located close to the 1992/93 Survei Ibu office and relatively near and accessible to the study villages. Since I lived in the community, participation became second-nature as I took on a variety of roles as a resident of the community (see Hull et al., 1988: 64).

My first research contact with the villagers in the study area was through the Observation Team. When the Team was gathering data I frequently accompanied them, so that the villagers knew that I was part of the Team. While the Team recorded the child's activities, I took notes and recorded in more detail what happened. Sometimes I stayed on in a particular house and observed the family in more detail.

Some of my time was spent in the village visiting the children and the caregivers, interviewing, and listening to the latest news about what was happening in the village. At the beginning of my stay in the village I spent my time getting to know the people. My day-to-day interactions resulted in the development of confidence and trust so that respondents seemed able to give information freely. As I became accepted as a member
of the community, I was able to observe their habits and daily routines. In my day-to-day interactions, I automatically tended to focus my attention on matters related to my research. For example, I found myself particularly interested in chat or gossip about the migration of mothers who had left their children behind and to observe the care of these children.

For example, one day the grandmother caregiver of Mud, a 16-month-old boy of a migrating mother told me that she always fed the child with 'nutritious food' so that he would grow fat even though his mother was absent. What I saw over a long period of observation was that Mud was often given sweet tea rather than what a nutritionist might have described as 'nutritious food'. This seemed to be what made him fat; I would not have realised this just by asking questions about feeding practices.

I was able to note how my informants' actions compared with what they said. For example, I observed how one caregiver (Mbah Ben), prepared food for Enny, her granddaughter. I noticed that when Mbah Ben said that Enny was given powdered milk, in fact she was given coklat, a mixture that was bought in packets in the local store and made from rice flour, cocoa and sugar; local people bought it for children because it was sweet and cheap. Sometimes coklat was mixed with water, but it was more often eaten dry with a spoon. I could also observe other cases of how mothers or other caregivers treated children when the children were sick and who cared for them.

Since children did not always stay at home, community areas such as the posyandu (integrated health post), meeting areas, markets, and rivers were also important places for observation. Both caregivers and children were involved in many activities in these areas. Additional classes of subjects for observation that I had initially overlooked, such as the children's peers, were also identified during the course of field
work. They were observed in terms of who they were, how they acted and the context. For example, one day as I watched a group of children at play I noticed a baby boy (aged around seven months) sitting alone in a backyard near the rice field where they were playing. After a while one of the girls I was observing (aged around seven years) came to pick him up. I realised only then that the girl was actually minding her younger sibling while playing with her peers.

During fieldwork I was mainly 'observer as participant' rather than 'participant as observer'. As Glesne and Peshkin (1992: 40) suggest, 'observer as participant' places the researcher primarily as an observer but with some interaction with the participants. At the time of observation, I often took notes to record what I had observed, including relevant conversations with informants. I usually wrote up the results of my observations when I was waiting for the Team to finish their work. Sometimes I noticed that villagers or children in the study area wondered what I was doing. I told them that I wanted to learn how people in the study area looked after their children, particularly when the mothers were away. I explained to them that my task was different from the task of the other members of the Team. I needed to collect and write detailed information so I would not forget what I had learned. This explanation seemed to satisfy them because the idea of learning from other people's experience (belajar pengalaman dari orang lain) is familiar to Javanese. In addition, they recognised that as a member of the Team I should make a laporan (present a report) to the head of the research project.

4.4.2 Key-informant interviews

People who were knowledgeable on issues related to care of children, such as community officials leaders, village headmen, teachers, health cadres and senior
residents in the community, were interviewed personally and their profiles compiled. These interviews provided inputs from a variety of people at various times in order to confirm my data from as many sources as possible. The selection of individuals was purposive. For example, the issue of women’s migration was discussed with village leaders who were considered to know much about this issue. The information then was checked by asking others who were involved or knowledgeable the same questions.

4.4.3 In-depth interviews

In-depth interviews have been defined as ‘repeated face-to-face encounters between researcher and informants directed towards understanding informants’ perspective on their lives, experiences or situation as expressed in their own words’ (Taylor and Bodgan, 1984: 77 cited in Adioetomo, 1993: 168). In this study, in-depth interviews were conducted with people to collect a diversity of information. I conducted the interviews in a flexible manner to obtain an overall picture of the society and of related issues. However, I used an interview guide in order to ensure that each interview covered the basic topics of interest.

I conducted interviews with 18 people who provided care for children such as mothers (6), fathers (6) and other caregivers of the children (6) in order to obtain detailed information about their decisions and choices related to actual behaviour. For example, a grandmother was interviewed in depth about why she did not seek medical treatment when a child in her care suffered from measles. A set of guidelines to probe for specific topics was used in the in-depth interviews, and modified to emphasise the informants’ personal experience. Interviews were sometimes conducted within the family when all the family members were present. At other times, the interviews were
conducted individually in order to avoid the debate that could occur among the family members, especially on sensitive issues such as the misuse of remittances.

The informants were selected depending on the subject matter. The informants were mainly the caregivers of the children, particularly the family members of the migrant women, partly because the study was concerned with the children of migrant mothers. Friends or relatives of the informants were sometimes interviewed to cross-check information gathered. The topics of the interviews were listed in the initial outline but additional subjects were incorporated where necessary. These covered a wide range of issues including the use of remittances and other topics related to the well-being of children. Particular topics, such as a decision to seek treatment for the sick child, were discussed in detail before moving to another topic.

In addition to taking notes, I sometimes used a tape recorder to record the interviews. However, I preferred to take notes rather than using the tape recorder because tape-recorded information could not catch the behavioural reaction of the subjects (Volante, 1984: 124). In addition, some people were uncomfortable when they were being recorded.

4.4.4 Focus group discussions

Six focus groups were held: three groups of mother caregivers and three groups of substitute caregivers. Each group consisted of six to ten women of similar age and socio-economic background. One focus group discussion consisted of six men who were husbands of the migrant women. Following the recommendations of Scrimshaw and Hurtado (1987: 15), the participants were chosen from a target group whose opinions and
ideas were of interest to the research. In addition, the participants were relatively homogeneous with respect to individual characteristics so that they could discuss freely.

Focus group discussions were conducted particularly to gather general information on the nature and pattern of caring for under-five children. In addition, they were aimed at obtaining community views on utilisation of health care alternatives, attitudes towards the migration of women without their children, as well as views on the health of the children left behind. The focus group discussions investigated the community's beliefs about child feeding and child health. The discussions were taped with the participants' consent to enable me to capture all of the discussion. In addition, I also took notes the participants' expression, body language etc. Transcriptions of the recorded information derived from focus group discussions were then coded and analysed by topic, together with the notes.

A discussion guide, which was used to keep the session focused (Scrimshaw and Hurtado, 1987: 16), was originally prepared in Indonesian (a more detail about the topic of the discussions see Appendix B). However, the focus group discussions were conducted in Javanese because the participants could speak Javanese more fluently than Indonesian. The guidelines were flexible and modified to accommodate new information and the particular emphasis of each group. Since I am a Javanese and can speak Javanese fluently, I transcribed the tapes and notes into Indonesian. The analysis was then carried out in Indonesian.

Two members of the 1992/93 Survei Ibu team helped me to conduct the focus groups. One acted as the moderator while the other helped to record the discussion. Both were familiar with people in the study area and able to communicate accurately and effectively in the local language. My role was to observe and take notes. The focus
groups were held in the village hall (*balai desa*) where the participants felt comfortable and able to talk openly.

One planned focus group discussion among husbands of non-migrants could not be conducted due to time constraints. Unfortunately, the focus group coincided with the harvest, when most men in the study area were busy harvesting in the paddy fields. It had to be abandoned as it proved impossible to gather a sufficient number of participants.

### 4.5 Summary

This chapter describes the sources of data used in the study, and how the data were collected. The chapter begins with a discussion of the research design, including the sample and data collection instrument followed by a brief evaluation of the limitations of the quantitative data followed by a description of collecting the qualitative data.

Although primarily a qualitative study using descriptive, anthropological data, this study also uses quantitative data. The main quantitative data set used was from the 1992/93 *Survei Ibu*, which provided data on the overall picture of childcare-related behaviour. The childcare data set covered an extensive range of activities for each study child for six months through spot observations. The quantitative data were used to complement the qualitative data that were gathered to observe behaviour in-depth and explore the mechanisms through which substitute caregivers provided care for the study children. A qualitative approach is considered appropriate for this study in order to ascertain the attitudes, perceptions, beliefs and traditions that produced the specific behaviour of caregivers in caring for the children of migrant and non-migrant mothers.
Detailed analysis of the data will be presented in Chapters 6, 7 and 8. Chapter 5 will first present an overview of childcare behaviour in the Javanese family and social context.
CHAPTER 5

THE FAMILY AND SOCIAL CONTEXT OF CHILDCARE IN JAVA

This chapter provides background information on the family life of rural Javanese children so as to place the specific findings from this study on childcare behaviour into context. Throughout this study childcare is defined as the time an individual allocates to such interactive behaviours as nursing, feeding, holding, and socialising with children (Hames, 1992: 89).

In particular, the chapter deals with community beliefs and traditions concerning childcare, including beliefs about the determinants of good health. This provides the context for more specific questions arising from the situation of children whose mothers were absent in the Middle East, including the roles of the father and the grandmother as main caregivers. The discussion draws on literature on the Javanese written mainly by anthropologists, and qualitative data gathered during field work for this study. In addition, my personal experiences as a Javanese brought up in a rural Javanese village are used where relevant.

The chapter begins by describing the role of children and the family in Java. The second section reviews Javanese customs during pregnancy and at childbirth. The third section outlines child-rearing practices including bathing, feeding, putting the child to bed, toilet training, learning to walk, protection of the children and general care. The fourth section discusses the role of caregivers. The chapter concludes with a summary of the discussion.
5.1 Children and the family

Children are highly desirable for the Javanese because they are considered to bring fortune to their families. The arrival of children is very much desired because they are expected to create a warm family atmosphere, which gives the family ‘calm and peace in the heart’ (Geertz, 1961: 83; Koentjaraningrat, 1985: 100). The care of parents in old age is also frequently mentioned as one of the motivations for Javanese to have children (Geertz, 1961: 83). The birth of a child means the full recognition of adulthood for parents (Hull, 1975: 321), and is regarded as the greatest spiritual blessing that a husband and wife can experience (Jaspan, 1987: 3). Some Javanese believe that it is economically advantageous to have many children, as expressed in the common sayings ‘banyak anak banyak rejeki’ (literally, ‘the more children the more fortune’) and ‘anak membawa rejeki sendiri’ (‘each child brings its own fortune’). Children are also considered to be the determinants of the relationship between spouses (Jay, 1969: 97). A husband may divorce his wife if the woman does not bear any offspring.

Recently such beliefs as the economic advantages of having many children have gradually tended to change because of the increased resources needed to bring-up many children. My field work in the study area revealed that many women used contraception in order to limit the number of children. Most said that they could not afford to have more than two children because they thought they would not be able to fulfill the daily necessities as well as education with their limited resources. Some said that having large number of children would prevent them joining their counterparts to work on overseas labour contracts.
5.2 Pregnancy and childbirth

It is not unusual to hear Javanese people say that, no matter how rich people are, if they do not have a child, then something is lacking. Couples often become concerned if the wife does not fall pregnant within 10 to 12 months of the marriage ceremony (Jaspan, 1987: 3). Having a child is considered to be the beginning of a happy life for the newly wed couple. Jay (1969: 97) noted:

In much of Javanese popular romantic literature the boys gets the girl, and the two are wed, but the tale does not end there. Only with the first birth or first pregnancy do they begin to live happily ever after, and there the story is brought to an end.

The expectation that a child should be born soon after marriage is symbolised by the presentation to guests of a bunch of sugar bananas (tuwuh) during the wedding ceremony. The word tuwuh (‘exist’) signifies that something (a baby) will be brought into existence by the wife after the marriage. It is common for the guests at the wedding ceremony to be asked to pray that the newly wed couple will have a baby within a year (setahun ngemban). Guests will often say to the newly wed couple ‘ben ndang bathi’ meaning literally, ‘gain a benefit (a baby) very soon’. Despite such beliefs, many couples now delay the birth of their first child. However, the median age at first birth for women remains low in Central Java: it was 20.5 years in 1991 for women whose current age was 25-29, 20.1 years for women aged 30-34, and 20.2 for woman aged 35-49. The median age at first marriage was 18.4, 17.8, and 17.5 years for women whose current age was 25-29, 30-34, and 25-49 years respectively (Indonesian Demographic and Health Survey, 1991: 36, 92).

Childlessness leads to unhappiness for Javanese couples and is sometimes a reason for divorce. The childless couple tends to be the subject of gossip (Jay, 1969: 97).
If a wife fails to become pregnant after a certain period (usually two to three years), childless couples may consult a dukun or doctors for advice. A dukun is someone whose knowledge enables him/her to know about and cure illness (Azwar, 1975: 19 cited in Iskandar, 1981: 27). According to Suparian (1978: 195 cited in Iskandar, 1981: 27), a dukun is someone who has special skills that are related to temung (sorcery) and curing. A dukun who assists women in pregnancy and child birth is called a dukun bayi or, in English, a Traditional Birth Attendant (TBA). The TBA is a person (usually a woman) who assists the mother at child birth. She usually acquired her skills delivering babies through experience or by working with other TBAs (WHO, 1975: 7, cited in Sukardi et al., 1989: 24). A dukun bayi is responsible for the safety of a child from when it first develops in the womb of its mother (Rienks, 1979: 24).

Traditional remedies are sometimes suggested to barren women to overcome their infertility. For example, during field work I met Yu Mi, a 45-year-old woman who had been married for more than 15 years and did not have a child. She told me that her relatives and neighbours had advised her to eat uncooked uritan (intestines of a chicken) in order to produce keturunan (descendants). She had followed the suggestion, but unfortunately it did not work. Yu Mi, who was still childless, lived with her two adopted children. Childless couples were also often advised to adopt a child (mupu anak), as this was thought to be a panuijan (lead) to the barren wife to become pregnant (Hardjowirogo, 1980: 15). In Java, the wife is often blamed for infertility (gabug) and is usually expected to allow her husband to take another wife. However, the family planning campaign in Java has raised awareness that men can also be the cause of childlessness (Koentjaraningrat, 1985: 101).
Javanese women commonly believe that, together with the cessation of menstruation, vomiting induced by certain smells, particularly rice, or a sudden intense craving for foods such as rujak are the first signs of pregnancy (Geertz, 1961: 85). Other signs include when a woman does not like eating as usual, feels nek (nauseous), aras-arasen (does not want to do anything), or likes eating fruit that is kecut-kecutan (raw fruit with a sour taste). Women in the study area described these conditions as nyidam, or 'craving', something that happens to pregnant women. Women may be nyidam (craving unusual foods) or ngebo (have no intense desire for particular foods) during the early stages of pregnancy. Many Javanese feel that the intense desire for unusual foods comes from the unborn baby rather than the mother. It is believed that if the craving is not fulfilled, the baby will dribble a lot (ngiler). To avoid this, husbands of pregnant women often try to fulfil their wives' wishes. A study in Ngaglik found that 'morning sickness', unusual behaviour and cravings were more likely to be found among younger educated women (Hull, 1973: 6).

Throughout pregnancy, the woman and her husband should behave in certain ways and observe certain taboos. The pregnant woman should not see anything bad or frightening. If she should happen to see such things she should say 'amit-amit jabang bayi' (literally, 'it should not happen to my infant child'). She also should not mbatin (have in her mind bad thoughts about other people), otherwise the unborn baby will niru (be like those people). The woman should or should not eat certain foods for the sake of the future child. For example, eating kepel (a fruit the seeds of which run in a horizontal line) and tebu (sugar cane) is believed to cause difficulty in child birth. However, she should drink young green-coconut juice (degan ijo) to clean the baby and turmeric juice to avoid the bad smell of blood (arus). In late pregnancy the woman is also advised to
drink a spoonful of coconut oil (*minyak klentik*) daily to ease the baby’s delivery. The husband should not kill or wound any animals during his wife’s pregnancy because the same thing might happen to his child (Geertz, 1961: 86). During an eclipse of the moon (*gerhana bulan*), a pregnant woman should wave her hands over her abdomen so that the baby will not become *cacat* (have a physical defect). In one Wonosobo village, it was believed that if there was an eclipse of the moon or the sun, a pregnant woman should immediately take a bath to avoid bad luck (Jaspan, 1987: 57).

When the swelling of the abdomen of the pregnant woman becomes visible, people often try to guess the sex of the unborn baby. Javanese women often predict the sex of the unborn baby from the shape of the abdomen. If the shape is round it will be a girl; if the unborn child is a boy the shape of the abdomen will be *lancip* (pointed). Many Javanese believed that if the *rujak* (a type of food made of fruits and chilli sauce) made by a pregnant woman is tasty (*sedep*), the unborn baby will be a girl. If the pregnant woman likes to dress up, do housework, or her face looks more beautiful during pregnancy, these are also considered signs that the baby is a girl. In the absence of such signs, the unborn baby will be a boy. Although there is no sex preference among the Javanese, it is desirable that the first child should be a son because a son is expected to *mikul dawur mendhem jero*, which means that he can praise his parent’s good names and bury deeply any negative things that might affect the family (Hardjowirogo, 1980: 18; Mulder, 1994: 31). However, Singarimbun has found that many Javanese prefer the first child to be a girl, because she will be better able than a boy to take care of younger siblings (Singarimbun, 1989).

Newly married couples are usually pleased if the wife becomes pregnant within a year of the wedding. The immediate community will be informed of the pregnancy
through a *selamatan* held in the seventh month of the pregnancy. During pregnancy, particularly the first pregnancy, the family usually conducts certain rituals to protect the mother and the foetus.

The *tingkeban* or *mitoni* is a family ritual frequently conducted in the seventh month of the first pregnancy for either the mother or father to protect the foetus and mother from danger (Geertz, 1961: 87; Jaspan, 1987: 5; Koentjaraningrat, 1985: 103; Peacock, 1973: 98). The *tingkeban* also introduces the pregnant woman to motherhood and informs relatives and neighbours that she will soon be a mother. The *tingkeban* ceremony reflects 'an ambivalent attitude where the happiness of the announcement of a birth is mixed with worry about the dangers of childbirth' (Koentjaraningrat, 1985: 103). It is usually held on the Saturday closest to the beginning of the seventh month of pregnancy (Geertz, 1961: 39), and is often conducted in the house of the parents of the expectant mother.

The *tingkeban* ceremony varies depending on the socio-economic status of the family involved. However, certain basic ceremonies are usually required. The pregnant woman is usually bathed by a midwife and older female kin with water taken from seven wells containing *kembang setaman* (flowers, usually including rose, *kenanga*, and *kanthil*). Two coconuts (*kelapa gading*) are used, on which a picture of Dewa Kamajaya and Dewi Kamaratih are drawn. (Kamajaya and Kamaratih are respectively the god and goddess of love) (Jaspan, 1987: 64). The Javanese believe that these offerings will ensure that the unborn baby will be very handsome if it is a boy or beautiful if it is a girl. Meanwhile, the pregnant woman's female kin make *rujak*. As noted, according to
Javanese, the *rujak* will be *pedas* (spicy) if the unborn baby is a boy, otherwise the baby will be a girl.¹

The climax of pregnancy is the arrival of the baby, which the Javanese call *babaran*. The arrival of the first child introduces a change in the parent’s status:

The arrival of the baby introduces a marked change in the parents’ mutual relations and in their kin and community relations. Children tie together their parents’ separate property rights and certain of their social and ritual ties to each other’s kinsmen in such a way that these ties remain joint even in the event the marriage is terminated by divorce or death. Further, the birth of the first child gains the parents much attention and increased respect from kin and village-mates, for attainment of parenthood in village society clinches a person’s position as a fully mature adult (Jay, 1969: 67).

A *selamatan* called *brokohan* or *sewengan* is held on the first night after the child is born. In the *brokohan* ceremony guests are served rice arranged in a cone shape with fried salty fish, red-white rice porridge, *urab* (vegetable stew) and hard-boiled eggs. A vegetable stew called *klwiąh* (similar to raw jack fruit) is often served so that the child be *linwiąh* (literally, ‘a respectful person’) (Hardjowirogo, 1980: 19). Sometimes guests stay awake at night *lek-lekan* (chatting) or playing cards for five days or until the umbilical stump has fallen off (*puputan* or *pupak puser*).

The Javanese believe that the placenta or afterbirth is the younger brother of the baby and the water is the older brother, *kakang kawah adi ari-ari* (Geertz, 1961: 89). The placenta is usually buried on the right side of the front door for a boy and the left side for a girl. Some mothers also discard some of their milk at the place where the placenta is buried. I remember that whenever I had finished breastfeeding my baby, my mother would ask me to throw any surplus breastmilk on the spot where my child’s afterbirth was buried.

¹ For a detailed description of the *tingkeban* ceremony see Geertz (1960); Geertz (1961); Jaspan (1980); and Supanto et al., (1990).
On the sepasaran or the fifth day after the arrival of the baby, a larger ceremony is held. Food will be given to relatives and neighbours, and those who are better off will provide entertainment. Neighbours are often given rice, urab (vegetables served with spiced shredded coconut) and lodeh klwih (vegetable stew) to inform them of the arrival of the newborn baby. Those who receive the food will then visit the family to greet the newborn and to extend a gift of money or goods. Neighbours often help in cooking for the sepasaran. The baby is usually named on the fifth day.

A family meal known as selapanan, is usually held every 35 days after the birth until the baby is one year old. The baby’s hair is cut (digundhuli) for the first time at 35 days (selapan). This is believed to make the hair grow thicker. On the baby’s weton, when according to the Javanese calendar seven-five-day weeks have passed representing 35 days after birth (Peacock, 1973: 98), a small family ritual known as among-among is also conducted.

For the first five days after birth, the baby remains in the care of the dukun bayi (traditional birth attendant). Until the baby is 35 days old, the dukun bayi will come regularly to massage the baby and the mother. Some women, even though they give birth in the hospital or were assisted by a medically trained midwife, still ask the traditional midwife to massage them and their babies\(^2\). Because giving birth is considered to be very hard work, the mother needs ‘treatment’ to make her strong again. The dukun bayi will give dadah walik ‘to massage [her] back to the original state’ (Geertz, 1961: 90).

At the same time, the mother will also be given tapel, bobok and pilis (Geertz, 1961: 90). Tapel is a mixture made from lime juice, oil and a small amount of salt that is placed on the woman’s abdomen. A long wide belt (kember, bengkung or gurita) is also

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\(^2\) As observed by Jaspan (1980: 39) in Sewon.
worn very tightly to return the mother’s body to its original shape and to keep the pranakan (uterus) in its proper place. The baby also wears a gurita around its abdomen. Some mothers place a coin over the baby’s navel to make it shrink.

Bobok or bobok beras kencur made from rice-flour paste and a root, kencur, is applied over the mother’s body. It is thought to ngicalaken raos kesel, or banish tiredness after giving birth. The bobok, which is usually made into a coin-like shape and dried in the sun, can be bought from tukang jamu (jamu sellers) in the market. Some babies are also given bobok to make their body adhem or ‘cool’. The bobok is usually put on the baby’s face and body.

Another ointment used for the mother is pilis. It comes in paste form and is also readily available from the tukang jamu at the market. Pilis is placed on the woman’s forehead to ensure good eyesight. Otherwise it is believed that a woman might experience a problem with her eyesight after giving birth.

For the first 40 days after birth, a woman is usually advised to take jamu (potions made of various herbs and roots) to maintain her health. The jamu can be prepared at home or bought from the market. Nowadays, many modern jamu manufacturers produce jamu bersalin (for use after childbirth) such as Nyonya Meneer, Jamu Jago, and Simona. Simona, a modern jamu manufacturer, advertises that among the advantages of the jamu bersalin produced by Simona are the washing away of all the dirty blood in the womb and an increase in energy and flow of breastmilk so that mother and baby will always remain in good health.
5.3 Child-rearing practices

Infants are considered to be vulnerable and in need of close attention. The pattern of childcare is fairly similar throughout rural Java (Geertz, 1961; Jay, 1969; Jaspan, 1987; Koentjaraningrat, 1980; Keeler, 1987; Hull, 1985). During the first 35 days, the infant traditionally is under the supervision of the traditional birth attendant (dukun bayi) who attended the delivery. The dukun usually visits twice a day to massage the mother and the newborn until the baby’s umbilical stump falls off, then she calls daily. For village women, the dukun bayi plays an important role during pregnancy and birth. The dukun bayi is ‘a trusted village resident who gives the needed attention and moral support during delivery and at frequent visits following the birth’ (Hull, 1979: 19).

The relationship between dukun bayi and her clients is very close, as described by the WHO:

The traditional birth attendant is more than just a useful source of physical help to the family, she is a reassuring familiar figure, who is unhurried and patient in the assistance given to her clients, who speaks in a language and concept they can understand and accept and who learned by experience the proper approach to village people. Because there is a family-like relationship between the Traditional Birth Attendant and those to whom she gives assistance, her influence is felt in daily life and the community. (WHO, 1975: 7 cited in Sukardi, et. al., 1989: 27).

Village women can freely talk to her at any time about their health concerns without worrying about the fees that would be charged by modern health practitioners.

Some conservative mothers in the study area did not take newborn infants out of their homes until 40 days after birth. Young children were considered very susceptible to disease. Mothers who believed in spirits were afraid to take their newborn children out of their homes during the first 40 days for they feared that spirits would harm their
children. Were it necessary to take a newborn child outside, it would wear a bonnet containing pins and turmeric intended to ward off misfortune.

The pattern of residency in traditional Javanese villages, where people live in close proximity to their kin, provides parents with considerable help in rearing children. The responsibility for childcare falls not only on the parents but is shared widely among the various members of the household and extended family. Members of the extended family assist in minding children and in providing treatment when a child is sick. Kin have a right to share in a child’s upbringing, and the child is regarded as ‘communal property’ (Jaspan, 1987: 24). However, the main responsibility for childcare remains with the parents.

The role of other household or extended family members increases in importance should the mother be absent. The child’s maternal grandmother, mother’s sister, and older siblings were especially important in the study area. In the families of the migrant women workers, the main alternative caregivers were the husband and the mother’s mother and sister. If they were not available, the husband’s family usually provided help. Other kin living in the same village also provided childcare at times.

Infants in the study area were cared for very carefully. While awake, they were held, rocked and fed, and at night they slept beside their mothers. Infants’ needs were closely attended to: babies were constantly in the immediate care of the mother. Mothers tried to be close to and to hold the infant as much as possible. Babies were nursed on demand; therefore, mothers were reluctant to leave the child in case it needed to be fed. Babies were not allowed to cry unattended, particularly if they were thought to be hungry. The breast was offered as the primary response to infant distress. Babies were
considered vulnerable to the effect of the 'evil eye' (*badan halus*), and it was thought that a fright could cause illness and even death.

Javanese mothers have frequent skin-to-skin contact with their children. They cannot bear to see a child crying or feeling unhappy (Geertz, 1961: 93; Mulder, 1980: 60; Keeler, 1987: 58), and babies’ demands are rarely denied:

Javanese babies are held by their mothers almost constantly, during the first year of their lives at least. Babies can nurse at any time and will be given the breast at the slightest fussing. Even when not nursing, babies are normally held by their mothers. If she is busy at some activity, a woman will carry her baby by her side, usually supported by a long piece of cloth. Those few times when she cannot carry the child in this way, she will try to find someone else, usually a female relative or neighbour, to carry the child briefly. (Keeler, 1987: 57).

In a focus group conducted in the study area of Purworejo women reported that, if mothers were away for an hour or so, someone else would be asked to look after their children. However, if they were to be away for a night they usually took the children with them.

Young children were constantly dependent on their mothers and others. Geertz suggested that this could result in a lack of opportunity to develop initiative and independence (Geertz, 1961: 115). However, Koentjaraningrat (1985: 115) argued that Javanese children when they got older had opportunities to develop their initiative and independence because they were *dipunumbar* (free to run and play wherever they wished).

However, children in the study area were rarely given toys to play with or educational games that could stimulate them and develop their skills. Some children constructed their own toys from local materials such as trunks of banana trees, leaves, and bamboo. During one visit, I saw that a number of boys had constructed a small
wooden cart (gerobak) in which a child could ride. I also saw that girls had made a necklace from cassava leaves.

Because infants should not cry, mothers constantly held them. Mothers often carried their infants using a cloth (slendang) to enable them to perform household tasks. In rural Java, a young child is usually carried in an upright sitting position in a cloth (slendang) tied on the mother’s left shoulder with its legs astride the mother’s waist (digendong). The child is carried on the left side to enable the mother to do other work. If the child fusses, the mother can easily nurse him/her. The position of the infant varies depending on its age. Infants less than seven months old are not carried (dipekeh) with their legs astride the mother’s waist because it is feared they will become pengkar (bandy-legged). An older child is sometimes carried on the mother’s back to free the mother’s hands for other tasks.

Housework and childcare were largely compatible in the study area. Mothers were considered to be wholly responsible for the care of their children until they reached around two years of age. Thus, they had to combine infant care with their domestic work. Men rarely helped in domestic chores. The main role of Javanese men was considered to be supporting their families economically and earning an income.

In a household with girl children, a mother could expect considerable help. A daughter could mind a younger sibling while the mother finished her housework. By the age of six or seven girls were expected to help their mothers to care for younger siblings or to perform household chores such as washing dishes and cleaning the house. It was common for girls to carry siblings only a few years younger than themselves. With the availability of so many caregivers, infants’ cries were responded to quickly. Babies were given intensive attention.
Children were rarely left alone to play by themselves, being kept under continual close supervision. The Javanese believe that children need to be protected against the perils and upsets of life. Despite the generally hot climate, Javanese mothers fear the effects of cold weather on infants and young children. To keep children warm, most mothers wrap young children in shawls and/or warm clothes. In hot weather, an umbrella is often used to protect the infant from the sun. Should children have a high temperature because of fever, they will be clothed in warm clothing. Mothers think that this will cause them to perspire and so reduce the high temperature. In fact, modern medicine teaches that this will not reduce temperature, but rather cause it to increase. The practice can actually be quite dangerous.

When alternative childcare was not available, mothers in the research area carried their children to the rice fields. The children would stay in a shady place where the mother could supervise them from a distance. The mother would bring food for the children so they would be calm while the mother was busy working. Should they cry for some reason, the mother could quickly come to attend to them. During my visit in the study area I saw Tug, a 4-year-old girl, crying under a banana tree close to the rice fields. When I approached her to inquire what was the matter, she pointed down the path where her mother was busy harvesting rice in the field. Apparently, her mother had asked her to stay in the shade as it was a sunny day.

Childcare involves a number of specific activities related to the feeding, hygiene, education and development of children. The specific aspects of childcare that are considered in this study include bathing, feeding, putting the child to bed, toilet training, learning to walk, measures taken to protect the children from danger, and general child minding.
5.3.1 Bathing

Mothers in the study area normally bathed their infants twice a day, at 8 - 9 o'clock in the morning and 4 - 5 o'clock in the afternoon. Most used warm water, but some bathed their children in cold water which they believed would help their children to become strong and healthy. The mother or caregiver usually decided when it was bath time. During my fieldwork I often saw mothers or other caregivers ask their children to take a bath at sunset. They often had to ask the children many times since the children were busy playing with their friends.

Young children were bathed by the mother in the bathroom, if there was one, or at the back of the house if not. Some infants were bathed by their caregivers in the bedroom. Older children usually bathed themselves, but the mother or another family member sometimes supervised them. The mother often soaped and dried the child. At seven or eight years a child could usually bathe without adult supervision.

In the study area, a young child was often put in a bucket of water by its mother or another responsible person when being bathed. If a child became fussy during the bath, a toy or something that attracted the child was usually given to keep him/her calm. Some children were showered using coconut shells or plastic water dippers.

Some households which had limited access to water bathed their children only once a day with a bucket. My field notes record an instance when Ari, a 22-month-old-girl, was bathed by her mother when I was visiting her during my fieldwork. Ari was being bathed in the front of her parent’s house. She stood in a plastic bucket three-quarters filled with water. The mother carefully cleaned Ari’s body and used her hands to pour the water. She told me that that she usually used only that much water because she had to fetch it from a well around 20 metres deep.
5.3.2 Feeding

Young children were usually fed by their mothers or other caregivers. They were given either rice, mashed bananas, or a mixture of rice, ripe bananas and palm sugar. In the study area, young children aged seven months and over were given rice served with vegetable stew often made from vegetables from their gardens. *Tahu* (soya-bean curd) and *tempe* (fermented soya-bean cake) were the most popular side-dishes (*lauk pauk*). Some children were given meat or eggs if they were available.

During feeding the child was usually given a *mainan* (toy) so that the caregiver could easily feed the child. If the child was fussy, the caregiver would carry the child in a *slendang* and find something to attract its attention.

Older children often ate by themselves under adult supervision. Mbah Mar who looked after her grandchild Dwi, a four year-old girl, explained that she often supervised Dwi while the girl was eating. At times when Mbah Mar was busy (she was a traditional masseur, *dukan pijat*), she would ask her daughter (Dwi’s aunt) to supervise Dwi. Mbah Mar explained that Dwi was a fussy eater and would often only eat the side-dish when no-one fed her. During my field work, I met Dwi one day when she was at her aunt’s house. She was given a plate of rice with a piece of fried fish. She ate a few handfuls of rice and the side dish. When she had finished eating, some rice was left over on her plate. Mbah Mar (her caregiver) asked Dwi to finish her food but Dwi did not pay attention to her grandmother, preferring to run away to play with her friend. Mbah Mar seemed to be unhappy when Dwi behaved in this manner, but she did not say anything to her. Mbah Mar told me: ‘Dwi always does this. If no-one feeds her, she will only take the dish. Actually, I don’t like her to behave like this but what can I do. Her mother is not here.....’
5.3.3 Putting the child to bed

Putting the child to bed is usually the responsibility of the mother or the principal caregiver. When the mother is not present, someone else will comfort the child before it falls asleep. In urban areas, where some families can afford to hire housemaids, putting the child to bed is the maid’s responsibility (Koentjaraningrat, 1985: 238). In the study area, I witnessed other persons who were around at the time being asked to put a child to bed. For example, during my field work I saw Mbah Kar, a 65-year-old man, carrying Santi, his two-year-old granddaughter, while Mbah Kar’s wife was sweeping the yard. Santi’s mother was a teacher and was away teaching at the time. Santi’s father was absent because he was sailing to another island. Mbah Kar carried her on his chest using a slendang while he sang a traditional lullaby (rengeng-rengeng) to persuade Santi to sleep. After Santi had fallen asleep, Mbah Kar asked his wife to put Santi to bed.

Young children are usually carried (digendong) whenever they display signs that they are sleepy. The mother or other caregiver will puk-puk (pat rhythmically) the child’s bottom until he or she falls asleep. If the child fusses the mother or caregiver might sing to it (dilela-lela). Children under one year of age are usually carried by the mother in her arms, supported by a selendang (sling). The mother will rock and sing so that the child may sleep peacefully. It was also common in the study area to see a grandmother carry a child and sing (rengeng-rengeng) it to sleep. A shady place with a little breeze was preferred in which to put the child to sleep.

Children are also often cuddled by their mothers until they fall asleep (dikeloni). Mothers usually breastfeed young children before putting them to sleep. While asleep, especially at night, children usually maintain skin contact with either the mother or
father. Children and adults usually sleep together in one bed (Geertz, 1961: 103; Koentjaraningrat, 1985: 106).

Parents usually slept in the same room as their children. Some parents could not afford to buy separate beds or to build additional bedrooms. Parents also found the arrangement convenient since they could nurse their infants at night and quickly attend to the needs of young children.

Some children in the study area were put in an ayunan (cradle) made from clothes or split bamboo. This enabled the mother to perform other household chores while the child was sleeping. The cradle was usually placed where the mother could easily see it. It was often put in the kitchen so that the mother could work in the evening. Some families used a sarong cradle instead of bamboo. Older children often pushed the cradle so that the sleepy child would be quiet, especially during the day when the mother or caregiver was working in the kitchen. For example, during my visit I noticed Joko, a nine month-old boy, placed in a cradle as his mother was cooking nectar water (legen) to manufacture palm sugar. Joko’s mother tried to persuade him to sleep by pushing the cradle. However, Joko was still crying. His mother asked his sister, Par, a six year-old, to push the cradle because she was busy stirring the boiling nectar water.

Children in the study area were not accustomed to sleeping according to a fixed schedule. They usually slept whenever they wanted to. Children were allowed to stay awake until midnight if a traditional performance was being held in the village. The only time that children were not allowed to sleep was during the maghrib prayer in the early evening. Villagers believed that a child sleeping at around 6.00 pm, who suddenly awoke, would be ‘startled’ and fall ill at candhik ala (when the sun is almost ready to set, a particularly dangerous transition period to the Javanese). Thus, sleeping at maghrib
time was not encouraged, especially for sick children who were thought to be weak and particularly vulnerable at this time (Supanto et al., 1990: 126).

I observed that reading a story before putting their children to bed was not a common practice in the study area. If a child did not want to sleep, even though she or he had already been in the bed for quite some time, a parent or the person responsible for putting the child to bed would pretend to fall asleep in order to persuade the child to sleep quickly. Sometimes, a child was told a brief story (dongeng) before falling asleep. For example, on one occasion I watched Mbah Amin, who looked after Minah, a three year-old girl, tell a brief story to the little girl on the bed. Minah was told that her mother was busy working in the Middle East to buy Minah earrings (anting-anting). The girl was asked to sleep quickly so that the time before her mother came home with the promised anting-anting would go by swiftly. The story was effective, as Minah soon fell asleep.

5.3.4 Toilet training

Toilet training did not receive much attention from mothers or other caregivers in the study area. This was evidenced by the number of children I observed who urinated or defecated wherever they happened to be. Children were not expected to urinate in a specific place, partly because of the absence of proper sanitary facilities in many households. It was not customary for children to use a pot when they defecated or urinated, as was also observed in Sewon (Jaspan, 1987: 18). Soap was also seldom used by caregivers to wash their hands after washing the child’s bottom.

To facilitate toileting, children in rural Java often wear clothes only on the top of the body and are naked from the waist down (Koentjaraningrat, 1985: 109; Geertz, 1961:
I noticed that many children did not wear underwear. Coconut shells were commonly used as water dippers (*gayung*) to clean a toileting child, although well-to-do families bought plastic dippers from the shop.

In Purworejo, I observed that some children defecated in the yard close to their houses. Their faeces were swept away or simply covered with sand. The mattress-less bamboo bed covered by a woven mat was easily washed if soiled by an infant (Geertz, 1961: 101; Koentjaraningrat, 1985: 108). If a child defecated or urinated while she/he was being carried using a piece of cloth (*slendang*), the mother or other caregiver simply removed the child from the *slendang* and held it away from her body, in a vertical position, until the child had finished (Jaspan, 1987: 18).

In rural Java, children are toilet trained without any element of coercion. Training is carried out in a relaxed, supportive, gentle, and unemotional way (Koentjaraningrat, 1985: 108). If children wish to defecate or urinate, parents ask them to go to the river. Should the children refuse, they are allowed to defecate anywhere. The parent then covers the faeces with soil or disposes of it, often in nearby water.

I noticed that the relatively well-to-do families in the study area paid more attention to their children's toilet training. Children in these households were taught to use the latrine rather than to urinate or defecate wherever they wanted. From an early age, these children were accustomed to urinate or defecate in the latrine with the help of other family members. During my visit, I often saw Bu Paul, a village health cadre, asking her daughter Moni, 28-months old, to urinate or defecate in the latrine. She said that it was *saru* (not proper behaviour) to urinate or defecate other than in the proper place.
5.3.5 Learning to walk

Javanese children are not pressured into learning how to walk until their muscles are strong enough to support their bodies. Parents do not force their children to walk because of the fear that this will affect normal growth. When children show an inclination to walk, they will be guided to their first step (ditetah). A parent will hold the child's hands and help it to walk step by step. In the study area, some parents put a slendang around the upper part of the child's body, and this holds the child steady as it walks. Parents or other caregivers would encourage the child to walk back and forth between them. Some parents used a geritan, a bamboo frame fastened to the ground by a stake with a protruding arm that pivots on the stake. When a child pushes the handgrip on the arm, the frame pivots, supporting the child as it walks in a circle. In urban areas parents bought the modern version of the geritan, a baby walker, available in many department stores.

Children usually start to walk at between one and one-and-a-half years of age. Beyond this age, parents in the study area often began to worry that their children would not walk at all, especially when other children of the same age were already walking. Such parents would often ask the dukun or doctor for advice. I observed how some parents rubbed (mencambuk) their children's legs with an eel in the hope that their children would be able to move as quickly as the eel.

5.3.6 Protection of children

Soon after birth, certain rituals are held and practices followed to protect children from danger. Javanese conduct ceremonies (selamatan) at life cycle events such as birth, circumcision, marriage and death to ensure that they will live with slamet, 'a state in
which events will run their fixed course smoothly and nothing untoward will happen to anyone’ (Koentjaraningrat, 1960: 95 cited in Mulder, 1994: 15). Selamatan are particularly important for rural Javanese:

Among Javanese, especially those of abangan type, it is very important to maintain a state of slamet (tranquillity and order) throughout the life cycle, especially during crises of transition such as birth, adolescence, marriage, and death. To ensure slamet, the Javanese hold frequent selamatan (communal feasts). Those attending are male members of the household (though the food is prepared by female members), close male neighbours, and perhaps others. Squatting on the floor of the host’s domicile, listening to a high-Javanese speech and Arabic prayer, quietly eating a few mouthfuls of rice, the selamatan participants feel as one with each other and with the supernatural figures to whom the speech, prayer, and feast are oriented. The social and cosmic harmony issuing from the selamatan soothes the soul of the individual, smoothing its surface so that dangerous spirits cannot penetrate (Peacock, 1973: 98).

If selamatan are held to maintain a good relationship with supernatural powers, rukun are held to maintain good relationships with others in the community. The ‘maintenance of social harmony’, or in Javanese rukun, is one of the core Javanese values (Geertz, 1961: 146). Everyone is expected to live in a way that does not endanger social harmony. Deviation for whatever purpose is not good (Mulder, 1980: 50). Selamatan are held to ‘demonstrate the desire to be safe-guarded from danger in an unruly world’ (Mulder, 1995: 15).

People also try to protect themselves from poverty and sickness. Being in harmony with the spirits is believed to prevent misfortune and illness (Meyer, 1981: 86). Ritual family meals (selamatan) are just one of many means used by the Javanese to maintain a balance between themselves and their physical and social environment. Javanese villagers placate the spirits in order to prevent disorder by feeding them offerings of rice, flower petals and incense (Peacock, 1973: 146). They believe that good relationships with other humans and the spirits will protect them from danger.
In order to protect a child from danger, the Javanese often hold a series of *selamatan* such as during the seventh month of pregnancy (*tingkeban*), at birth itself (*babaran* or *brokohan*), five days after birth (*pasaran*), and seven *weton* after birth (*pitonan*) (Geertz, 1960: 30). *Pitonan* or *dhun-dhun* or *tedak siten* (Supanto et al., 1990: 78; Bratawidjaja, 1988: 32; Sukardi et al., 1989: 71) is the ritual performed when a baby’s feet are allowed to touch the ground for the first time.

The *tedak siten* ceremony symbolises the hope of the parents that in the future their child will be independent and will be able to cope with any problem that challenges its ultimate goals. The main core of this *selamatan* is the presence of *juadah* (a traditional snack made from glutinous rice), *anda tebu* (a ladder made out of sugar cane) and *kurungan ayam* (a chicken cage). Each of them has a symbolic meaning. *Juadah* made in different colours, represent the different kinds of problems the child may face in the future. In the *tedak siten* ceremony the child will step on the *juadah* which means that she/he will be able to handle all the problems that may arise in the future. Climbing the sugar cane ladder means that the child will have a strong commitment or determination in reaching her/his ultimate goals. The chicken cage in which the child is placed signifies that the child will be able to adjust into the social environment of the community where she or he lives (Bratawidjaja, 1988: 33).

Although the *selamatan* cycle celebrates all life events *selamatan* up to marriage (Mulder, 1994: 25), the degree of completeness in performing it varies. For example, *pitonan* or *turun lemah* are now rarely conducted by the majority of Javanese (Sukardi et al., 1989: 71).

In addition to *selamatan*, villagers also follow certain practices to protect their children from spirits. For example, some women in the study area placed a herbal
mixture, *dlingo bengle* or mashed onions, on their children's fontanelle. Women would also wash their faces after attending a funeral before they could touch their children. This was believed to protect the children from *sawan* (evil spirits).

Special precautions were taken for those considered particularly at risk. One group considered to be at risk were the children of migrant women working overseas. Migrant children in the study area were usually taken to traditional healers (*disuwukke*) soon after their mothers left home. It was thought that children would cope better with the emotional problems arising from their mothers' absence if protected by the healer's remedies.

### 5.3.7 General child minding

Minding a child, particularly an infant, is usually the responsibility of the mother. The mother is also usually the person who does most of the daily household chores. Therefore, women have to combine household tasks with child minding. In the study area, it was not unusual to see a mother carrying a child in a *slendang* while she was doing other household work. Some mothers carried their children on their backs to ease movement and to free their hands enabling them to perform multiple tasks. For example, Bu Parmi carried her 13-month-old girl on her back while she was cooking nectar water (*legen*) to make palm sugar. Bu Parmi explained that she could not put her daughter down while she was cooking because there was no-one else to mind her. She told me how her neighbour’s son had accidentally burned his leg because he had crawled up to the pot used for cooking the nectar water.

In the study area, if there was no-one else present in the house, a busy mother or caregiver would usually put a child down on the ground (*digenjahke*) while she
continued her work. The child was often given a toy to keep him/her quiet. I recall the
instance of Bayu, a 10-month-old boy, who was put on a mat by his grandmother because
the grandmother was busy cooking in the kitchen. This lack of adult supervision was not
usual when family members and relatives were also involved in childcare.

5.4 The role of caregivers

As previously noted, rural Javanese children are cared for not only by their
parents but also their close kin. Although most families live in nuclear units, the
extended family is strong and provides wide kin support for childcare. However, the
immediate nuclear family plays the most important role in childcare.

In the study area, rural families included women, men, children and elderly
people. The home-based care provided by mothers and the immediate family was the
primary care arrangement for children under three years of age. However, the role played
by fathers, grandparents and other relatives as well as their neighbours increased
substantially for overseas migrant workers. When the mother worked outside the family,
the remaining family members adjusted their work (Hood, 1986: 349, cited in Perry-
Jenkins, 1993: 245).

5.4.1 The role of parents

Parents are responsible for managing the household and are the key actors in
bringing up children. Mother and father complement one another in rearing children.
However, when children are still very young, the mother is usually responsible for
matters concerning their well-being. The husband’s main responsibility is to provide a
steady income for the family, and he does not usually take direct responsibility for
childcare.
The role of the mother

Javanese women are considered to be more deeply committed than men to the social and economic welfare of the family (Geertz, 1961: 131). The household is considered to be a woman’s domain (Koentjaraningrat, 1985: 139), and the child's relationship with the mother is the warmest and most intense (Jay, 1969: 99). A mother's care is thought to be safest and most dependable. Thus, the mother is the most significant person in the young child's life. Caring for young children is a full-time job, as children are rarely left alone to play by themselves. Mothers provide close supervision to protect their children from danger. The relationship between the mother and her baby is characterised by 'nurturance, unconditional emotional support, and love' (Geertz, 1961: 105).

Javanese mothers consider themselves the main caregivers of their children and responsible for their daily care. The villagers in the study area shared the view that women had a special role in family life, particularly in extending care and guidance for the younger generation. Some women tried to combine the roles of wife, mother and caregiver with the task of being the breadwinner. They became not only housewives but also contributors to the family economy. The availability of older children and support from kin enabled some women, even with very young children, to take up work. A number of mothers (20 per cent) worked as agricultural labourers during busy periods in the agriculture cycle, such as ploughing and harvesting. In such cases, the older children in the family usually helped in running the household, or the grandmother assisted by providing childcare.
The role of the father

The father’s role in childcare has been as an occasional helper to the mother (Jay, 1969: 102). In Javanese society, the division of work and family responsibilities places the onus for domestic management on the woman. The man is considered responsible for financial provision, regardless of whether the woman also earns an income. In most societies, males take less responsibility in caring for infants and children than females. Similarly, in most rural Javanese families in the study area the father shared very little obligation for housework or childcare. Even though he sometimes played with the children, the responsibility for the child’s care and feeding was still in the hands of the mother. This reflects the social norm that the husband is the financial provider, whereas the wife is dominant in most of the everyday affairs of the family (Jay, 1969: 87).

Even the dual housekeeper and breadwinner roles of those women who worked did not necessarily result in major changes in men’s behaviour. When the mother was absent, as in the case of migrant workers, some husbands did make major adjustments to their work and family roles. Many husbands of migrant mothers in the study area carried significant responsibility for managing their households, including childcare. However, other husbands only marginally increased their childcare responsibilities because grandmothers or other female kin became the primary substitute caregiver. Perhaps, this is perceived to be in the child’s best interests, as female caregivers are seen as more capable of looking after children than their male counterparts. Thus, changes in the role of women from housekeeper to breadwinner did not necessarily change men’s role or at least their role vis-a-vis their children.

Male parental behaviour was highly variable in migrant mother families, with some husbands playing a significant role in household work including childcare, while
others played little or none at all. Some fathers fed, bathed, played with and minded their children and carried out other general baby-sitting activities. The experience was new for many of them (see the cases of Pak Im and Pak Sap page 152 and 153). The men said that because of their work, they had previously had no time to help their wives in doing household chores. However, during the absence of their wives, these men gradually transformed their role from one of worker only to that of a housekeeper and caregiver of children. Some informants said that they received instructions from their wives about how involved they should be in fathering. One example was Pak Sus, the 30-year-old father of two children. He, like some of other husbands whose wives worked in the Middle East, took care of his children with the help of his mother. He said that his wife frequently sent letters telling him what his role should be:

...even though our parents help us in looking after our children, you should do other household duties by yourself. You should not always ask your mother to cook, clean the house and momong (look after) Agus.

However, only a small percentage (10 per cent) of fathers cared for their children while their wives were away. This reflects both the fact that mothers were usually much more important than fathers in the day-to-day care of children and that a number of female substitute caregivers were readily available.

Fathers were less involved in childcare for households with alternative caregivers such as grandparents, aunts, or older siblings. Where other female members were present in the households, they usually took over the role of the absent mothers. For example, Pak Agung was still busy working as a farmer and a middleman, both when his wife was present and absent. The absence of his wife did not change his role from worker to caregiver, partly because he had two wives and it was his second wife who worked in the
Middle East. Pak Agung lived with his first wife, his mother and his mother-in-law (his second wife’s mother). His second wife’s child was looked after by his mother and mother-in-law.

**Pak Tug**, the father of three girls (aged eleven, seven, and four years), was another typical non-migrant case in the study area. Pak Tug was busy cultivating his land. His wife, who also worked as an agricultural labourer, did all the household work with the help of her daughters. When Bu Tug worked in the rice field, her eldest daughter took over the responsibility of looking after her young sisters.

I often saw fathers dressing, feeding or bathing their babies or doing other household chores in those families where the mothers were absent. However, the father’s increased involvement in childcare in migrant families was often just temporary because the wives usually resumed their traditional family roles upon returning from the Middle East. An example was Bu Parmi, a 27-year-old mother of two children with completed primary school education. She had worked in the Middle East for two years and returned to the village two weeks before I met her:

> When I was away for two years, my husband helped my mother in looking after my child. He not only worked in the rice field, but also bathed and fed the child. Now, I am back. He will *pensiun momong lare* (cease his work in taking care of the child). I will do all the work as before.

Where an adult female was present in the household, fathers were often involved only in playing with their children without any responsibility for childcare or feeding. Feeding a child was usually considered to be a woman’s responsibility. A man was considered not patient enough to feed a small child. Bu Sinta, a 26-year-old mother of one child whose husband worked as a village official said that her husband sometimes helped her feed her 1-year-old daughter, but he was not *telaten* (patient). Bu Sinta
explained that her daughter was a fussy eater so the person feeding her needed to be quite patient.

In the study area, some fathers in the migrant mothers’ families did gradually transform their role from worker to caregiver and housekeeper. This phenomenon is explored in the following five case studies:

**Pak Ag**, a 35-year-old man, was the father of three children. The oldest was a 12-year-old girl, Par, who was in Grade 5 in 1992. The middle child, Ton, an eight-year-old boy, was in Grade 2. The youngest was Sur, a three-year-old boy. Sur’s mother left for the Middle East when he was two years old. He had been weaned when he was nine months old. Pak Ag complained that his son preferred to eat his meals ‘kering-keringan’ (this literally means ‘dry’, that is, without vegetables or other side dishes), and he did not like to drink milk. He weighed only 13 kilograms, inadequate for a 4-year-old boy.

As a farmer, Pak Ag had usually been busy working in his rice field before his wife (Bu Ag, aged 35 years, with primary education) left for the Middle East. When she left, he found himself in charge of caring for his three children. When I visited him in 1992, Pak Ag’s wife had been working in the Middle East for 16 months and was due to return in six months’ time. She had sent one remittance of Rp. 1,500,000 (equivalent to A$1000). It was used to repay debts of almost Rp. 900,000 incurred for her travel. She rarely sent letters home to her family.

Even though Pak Ag lived in the same compound as his aged mother, he could not expect help from her because in fact she also needed care. She was aged 70 years but looked older than her age. She suffered from chest infections and was almost blind. She was unable to help Pak Ag because she herself needed others to cook her food and help her to move around. Pak Ag’s sister-in-law also lived close to his house, but she was very
busy with her own family as well as looking after her aged mother. Pak Ag’s eldest daughter, aged 12 years, helped him to care for the younger children. She washed the dishes and clothes. He said that he felt sorry to see his daughter doing household chores at her age, but he could not do much about it. He helped her to fetch water from the well, which was 20 metres deep.

Cooking for the family was the most time-consuming chore for Pak Ag. His house was very small and made from split bamboo (gedhek), around six square metres in size. Thus, it did not take much time to clean it. Pak Ag told me that he had gone to the village where his wife came from to ask for help in looking after his son when he went fishing or to market. I often heard him complain, ‘If we were rich enough we would not need to suffer like this’. Pak Ag explained to me that his wife had to leave her family and he had to do domestic chores which were the responsibility of his wife because of poverty.

Pak Ag’s house was close to the puskesmas (community health centre) just across the road, where he could take his children for treatment when they were sick. His son, Sur, often suffered from batuk-pilek (cough and runny-nose).

Sur often accompanied his father to the coast to catch fish or to the market to sell the fish. When Pak Ag could not take Sur, he took his son to his wife’s natal village a few kilometres away from his house. There, his sister-in-law minded the child. I asked why he did not move to his wife’s natal village while his wife was away. He answered, ‘It is my responsibility to look after them because my wife has to work hard in Saudi Arabia’.

Pak Ag’s case suggests that minding children without the help of other family members was a heavy task for a man. This is mainly connected to the traditional division
of labour where women are responsible for managing domestic affairs and men are the primary breadwinners. As a result, men lack the skills and experience needed to provide good childcare. The burden on them might be reduced if there was someone else, such as an older daughter, to help look after the child. In addition, readily available cash could also assist, as illustrated by Pak Ben’s case.

**Pak Ben**, a 27-year-old man, was the father of a 3-year-old girl. His wife (Bu Sun) went to the Middle East when their daughter was two years old. Pak Ben changed his main occupation after she left. He asked his neighbour to work his rice field while he made palm sugar with the help of his parents who lived next door. He said that making palm sugar was very time consuming but it could be done at home where his child was. Every morning, regardless of the weather, he had to climb seven palm trees to *deres* (collect) the *legen* (nectar water) to make palm sugar. He then cooked the *legen* until it was thick, put it in the *bathok* (coconut shells) and dried it in the sun. Pak Ben usually sold his palm sugar to a patron, although the price was lower than in the market. He said that he did this because his patron had lent him money to finance his wife’s migration. He told me that since his wife left, his daughter had become closer to him than ever before. He said he rarely left her alone at home and frequently took her to the market. He put his daughter in a basket on his bike together with the sugar or coconut that he brought to sell. His mother helped him to look after his daughter when he was busy making palm sugar.

On one occasion when I visited Pak Ben, he was busy making milk for his daughter. He made *susu Dancow* (Dancow is a brand of powdered milk) that was quite popular in the village. He gave the milk to his daughter and told her ‘*Ditelaske ben sehat!*’ (‘Finish it all so you will be healthy!’). Pak Ben said that his daughter Kum
usually drank sweetened condensed milk (Indomilk chocolate). A tin of Indomilk could last for two-three days. Pak Ben told me that he sometimes gave Kum coklat, a mix of cocoa, rice flour and sugar because she liked it and fresh milk was relatively expensive by village standards. Pak Ben said that since his wife left his daughter did not like eating. Instead, she drank a lot of es (frozen flavoured sugar water). When his daughter fussed, he told his daughter that ‘mamak nang Arab golek duwit nggo tuku susu’ ('Mother has gone to Saudi Arabia to buy milk for you').

Pak Ben said that while his wife was away, his daughter usually slept with him and that he would tell her a story before she went to sleep. He did not want his wife to take another contract when this one finished.

Being responsible for housekeeping, child minding and earning an income seemed difficult for men such as Pak Ben. His task as a palm-sugar maker was very tiring. Even though his mother lived next door, he managed most of the daily domestic tasks by himself. His mother sometimes helped him nitis (cook nectar water) if she was not busy working in her rice field.

The husband might become closer to his children when his wife was away than when his wife was present because she usually provided the direct care to the children. Pak Im, who had been educated up to junior high school, cared for his only daughter while his wife was working in the Middle East.

**Pak Im** was only 23 years old. His wife (Bu Sum) went to the Middle East when their daughter was two-years old. Pak Im said that in the beginning he had not wanted his wife to work overseas, mainly because it would mean leaving her daughter behind. Pak Im worked as a fisherman and usually went to the coast at night. He and his wife had
quarrelled before she left. However, he finally realised that he could not earn enough to meet his family's needs so he allowed his wife to leave.

Pak Im had asked his mother to help him raise his daughter. He said to me 'Sugih bandha ati melangsa' ('Although we earn a lot of money, we have to sacrifice'), because he lived so far away from his wife. He told me that his daughter sometimes became upset easily and looked for comfort before falling asleep. She even sucked his nipple when she was upset. In the beginning it was very hard to combine his role as the breadwinner with taking care of his daughter. Although he was helped by his 60-year-old mother who lived with him, he said that he felt sorry for his mother, who was very old and, moreover, in need of care. He said that now he could manage to be both father and mother to his daughter. He comforted his daughter whenever she needed it, and even offered his nipple to her to make her happy. He was not embarrassed about this and even asked me to take a photograph of his daughter sucking his nipple. He wanted to show his wife how great his sacrifice was for his daughter. I often watched him bathe and feed the child.

A man who had never before been involved in daily household chores and child minding might consider the absence of his wife a greater price than the money that she earned. One who seemed to feel this pressure was Pak Sap, a 35-year-old carpenter, and father of a 10-year-old girl and a 3-year-old boy. Primary educated, he often worked outside the village to build houses for other people. His wife had previously stayed at home to look after their two children. When his wife left for the Middle East, he cared for his two children with the help of his mother-in-law who lived nearby. Pak Sap explained to me that his wife's absence was 'cotho' ('like something was missing'). He had never been involved in the housework when his wife was at home. Now, he had to manage all the housework. He described his situation as 'oleh bandha nanging jiwo ora
merdiko' ('having money but under pressure'). Pak Sap said that his son Ton, had now become 'pendiam'(quiet), whereas before his mother left he was very naughty.

Even though the migration of the wife to a distant country might result in an increased burden for the husband and the other family members, some husbands were able to cope well. This was most likely the case when the migration of wives to distant countries offered the best available opportunity to improve their lives, as reflected in the following instance.

Pak Mud, aged 23 years, was the father of a 2-year-old boy, Im. After his wife (Bu Sum) left for the Middle East, he said that he had been able to manage his only child quite well. He received a lot of help from his mother (Mbah Suki, 50 years old), who lived next door. Pak Mud used to work his irrigated rice field before his wife left. However, while his wife was working in the Middle East, he had asked a relative to work the rice field for him. He started to manufacture palm sugar because he was then able to mind his son at the same time. His wife had remitted Rp. 2,000,000, which he had used to buy building materials for a house. He said that the rest of the money was used to pay other people who worked for him to cultivate his land while he was building his new house.

When I visited him, I saw the new house almost finished at the rear of the old one. The new house was bigger and made from brick, whereas the old house was small, made from plaited bamboo and had a dirt floor. The old house was around seven square metres in area with two doors, one at the front and another at the back. The walls were fragile (rapuh), possibly because they were infested by termites. The house was furnished with a wooden table, a long bamboo chair (limcak), and a bamboo bed
(amben). On top of the cupboard for the family’s clothes stood a wooden-framed photograph of Bu Sum wearing a long dress.

Pak Mud told me that building a permanent house had long been his dream. He built his house with the help of relatives, making the bricks himself. He really wanted to finish the house before his wife returned, and intended to present the house to her as a reward for working so hard in the Middle East.

Pak Mud said that he had often been criticised by his relatives for letting his wife work abroad. A man who was helping Pak Mud to build his house told me, ‘Yen temen-temen jane nyambut gawe ten mriki nggih padha mawon’ (‘whether she works hard here in the village or elsewhere, it is the same’). Pak Mud responded, ‘Ah, ya, beda wong olehe tikel yen nyambut gawe nang kana’ (‘Ah, but this is totally different. If she works there, her income will be increased manyfold’).

The case studies show that, as a result of migration, some men began to participate in domestic chores which were formerly the exclusive domain of women. However, not all the husbands of migrant workers in the study area shared the experience of these five cases. This was mainly because of the availability of other female family members who were able to run the household and to mind the children.

5.4.2 The role of grandparents

In Java, grandparents are considered a fount of material favours and esoteric wisdom (Jay, 1963). Grandparents are considered to know more than a young couple because of their long experience of life. Many parents lean heavily on the knowledge of grandparents. However, between grandparents’ ideas and those of parents conflict
sometimes occurs, particularly in the area of health. Conflicts may also occur over the handling and disciplining of children.

The caring role of grandparents differs from that of parents. Grandchildren usually enjoy the affectionate companionship of their grandparents. With more leisure time, grandparents often give more attention to their grandchildren than they gave to their own children. When children cannot get something that they want from their parents, they often turn to their grandparents. In Java, it is customary for children to visit their grandparents at *Idul Fitri* to receive gifts of money. A couple may become lonely when their children have moved from home to establish their own households. To compensate, they may shower more love and attention on their grandchildren than busy parents are able to. As a result, grandparents may tend to spoil and indulge their grandchildren.

Grandmothers often take over some aspects of the nurturing role, particularly where the mother is absent or divorced. Grandmothers often manage the households of absentee women. They are also an important source of knowledge and advice for mothers.

Indonesian grandmothers, particularly maternal grandmothers, often share the responsibilities of childcare with the parents. In Java, the relationship between grandmothers and their grandchildren is usually established soon after birth. The grandmother is often considered an important source of knowledge on childcare, especially for the first child.

Many Javanese women move to their parents’ house for the birth of their first child. However, the grandmother’s role in caring for children is sometimes regarded as a negative influence because of their more traditional attitudes. For example, some
grandmothers in the study area believed that colostrum should not be given to a newborn baby. Some mothers also believed that colostrum *susu kuning dan encer* (yellow and watery milk) could make the newborn baby sick. This point of view can be detrimental to the child's health, because colostrum provides valuable immunities to the baby.

Several children in the study area, particularly those of migrant mothers, lived with their grandmothers. Some children were raised by their grandmothers even though their mothers resided in the same village. This was especially true when the mother had two babies closely spaced.

5.4.3 The role of siblings

In many societies, girls appear to be more nurturing and responsible because girls are assigned more childcare tasks than boys (Weisner and Gallimore, 1977: 178). Girls are assigned more responsibility for the care of infants and young children, probably as training for anticipated adult roles since women usually bear the primary responsibility for child rearing (D'Andrade, 1974 cited in Weisner and Gallimore, 1977: 178).

Siblings, particularly girls, contribute significant help in household work and childcare. It was not unusual in the study area to see a six-year-old girl carrying her three-year-old sibling, and girls aged between six and 10 years were often asked to care for younger children for a large portion of the day. As school did not occupy much of the children's time (junior classes usually ran from 7.30 -11.00 am while senior classes ran from 7.30 am - 13.00 pm), they could spend many hours caring for small brothers and sisters. In fact, it could be said that the main after-school activity of children was caring for younger siblings. Many boys also helped their mothers to care for siblings, especially if there was no daughter old enough to assist the mother. These young caregivers were sometimes left at home alone with quite young babies. One day during field work, I
found Har, a five-year-old boy, entertaining his nine-month-old brother, Sri. His mother had gone to the rice field.

In the presence of a younger child, Javanese children are expected to play a nurturing and caretaking rôle. Older siblings are expected to ngalah (surrender) to the younger ones. If younger children became upset or cried while under their care, the older children were often blamed for ora bisa momong adine (not being able to look after the younger siblings). Older siblings should be protective and affectionate to infant siblings:

...older children must start learning to accept the fact that many of their wants will go unfulfilled as soon as a younger sibling is born. Even though their fathers may provide them much of the attention that their mothers, now preoccupied with tending for the newborn, no longer grant them, older children must learn always to defer to a younger sibling’s wishes. Whereas an American parent may go to elaborate lengths to be “fair” in satisfying several children’s wants, a Javanese parent invariably blames the older child if there is a conflict of wills. As a result, older children do not present arguments or scream for justice: they give in (Keeler, 1987: 62).

In extreme cases, the older children of poor families sometimes make sacrifices for their younger siblings. For example, an older child might have to terminate her/his education to care for the younger siblings and/or enable parents to pay for their education. There is little differentiation between the sexes, although girls are expected to take more responsibility in caring for younger siblings than boys. Older girls, are expected to play a mother’s role to some extent. A girl should devote part of her time to caring for her younger siblings. In addition, she should behave as her mother does towards her siblings. Girls, after reaching 10 years of age, are their mothers’ main helpers and providers of childcare. A 10-year-old girl is expected to be able to help her mother in all household work (Keeler, 1987: 69).
The involvement of boys in the Javanese household differs from that of girls. Boys are often responsible for looking after cattle. In rural areas, boys often look for grass (*merumput*) or herd (*angon*) their cattle. If a boy has to take care of his younger siblings, he will often do so actively while playing in the company of his peers. However, boys usually find their own playmates in peer (*umbar*) groups (Koentjaraningrat, 1985: 115) and seldom play together with their younger siblings. Alternatively, a boy will be in the company of his sister to prevent her from being abused by other people. To his younger sister he seems a hero figure (Jay, 1963).

5.4.4 The role of others

One of the Javanese ideal virtues is *tepa selira*, placing oneself in the situation of the other (Koentjaraningrat, 1985: 122). Javanese believe that people cannot stand alone; they need someone else. Therefore, the Javanese tend to be highly conscious of the existence of others (Mulder, 1994: 36). Every member in the society should offer help to their neighbours when they are in need and maintain good relations with others because they might need their help at some time in the future.

Non-kin and peer networks sometimes provide support in caring for children, particularly when the children’s mothers are busy or cannot attend to the children’s needs. Other people, especially next-door neighbours, are often among those from whom mothers ask for assistance in childcare. People consider that a neighbour is similar to kin; people in the study area often claimed that most people in the village were their relatives. Neighbours were often involved in taking care of children, especially those whose mothers were absent.
5.5 Summary

This chapter has briefly described childcare practices among the Javanese in the context of the family and community. It has focused on the care and protection of children in the family, which begins before a child is born.

Having children soon after the religious marriage ceremony is still desired by many Javanese couples. When a wife conceives then she will take great care in order to protect the unborn baby.

Javanese children receive great attention from their parents, especially in the first year of their life. Their needs are seldom denied and every effort is made to prevent them from being upset. The children are often carried in a slendang and enjoy close physical contact with their mothers or main caregivers.

Javanese women have the primary responsibility for childcare and daily household work. Men are usually not greatly involved in these tasks. This is mainly due to cultural beliefs that identify men’s role as the financial provider for their families. In the study area, however, some husbands were taking responsibility for childcare and for housework. This was particularly the case for the husbands of migrant workers for whom alternative childcare and domestic help was not available. Such coping strategies adopted by the husbands of migrant workers were considered socially acceptable under the circumstances. However, it is likely that this new role for men was only temporary while the mothers were absent. How the children were actually cared for in practice will be discussed in detail in the next chapter.
CHAPTER 6

CHILDCARE BEHAVIOUR IN PURWOREJO

In most societies, mothers bear responsibility for domestic affairs and are considered the primary caregivers for children. However, in many societies 'exclusive maternal care is not the typical practice today' (Lamb and Sternberg, 1992: 2). Mothers are increasingly involved in work outside the home, and even working outside the country. As a result, they delegate their responsibility for children to others. The children are then cared for by substitute caregivers, in some cases by a number of caregivers. The effect of mother's work and substitute caregivers on children has attracted the attention of a number of scholars. The publication in 1989 by the American Association for the Advancement of Sciences (AAAS) of a selected symposium on Women, Work, and Child Welfare in the Third World (Leslie and Paolilso, 1989) indicated the growing interest in studying the consequences of mothers' work on child welfare.

With the absence of the mother, the responsibility for caring for children is transferred to that of a substitute caregiver. The mothers' responsibilities for household management are also allocated to other family members. Grandmothers, if present, often assume the principal responsibility for childcare. However, in some families fathers take responsibility for childcare. In societies where extended families are common, the responsibility for childcare is shared among all household members including older siblings. In Cameroon (Nsamenang, 1992: 422) an older sibling or peer was the major supplementary childcare provider for young children who had been weaned. Another African study found that fosterage of children was common in the case of parental absence. Isiugo-Abanihe (1983: 21) noted that maternal grandmothers also played an
important part in child rearing in such circumstances. The duties and responsibilities associated with child rearing were considered to be a matter of concern to the entire extended family (Fapohunda, 1982: 277; Li, 1989: 45). The childcare provided by the extended family was especially important for low-income working women.

However, many women live apart from their extended families, and have no co-residential kin. Some also do not have older children able to look after their younger siblings. In these circumstances non-residential kin, friends or neighbours external to the domestic unit, or an institution, may provide substitute care (Joekes, 1989: 65). In some countries, well-to-do families may have female servants to do domestic work, including caring for the family's small children. In urban Java, female servants usually reside in the house and become very close to the children for whom they care (Koentjaraningrat, 1985: 237). In Cameroon (Nsamenang, 1992), the bulk of the day care of children from about six months until two to three years of age was provided by permanent live-in caregivers, usually girls between 11 and 15 years of age, who were either older siblings, relatives, or non-relatives (Nsamenang, 1992: 423). A study in Cameroon found that many children were closer to the caregivers than the child's own mother (Nsamenang, 1992: 424).

It is generally stated that migration is 'a highly selective process, migrants are never a cross section of the population residing at origin or destination... One of the most universal of features of migration across the world is its age selectivity' (Hugo, 1998: 46). In addition to age selectivity, migration of women in this study is selective of women who know that childcare is available for their children. Results from the focus group discussions among the substitute caregivers indicated that most of the women who migrated to the Middle East knew that their children would have substitute caregiver
acceptable to the mothers themselves. The participants of the focus group discussions said that the migrant women would not have gone if they thought that nobody would look after their children. Thus, differences in outcomes among migrants and non-migrants are confounded by this selectivity, and must be interpreted with caution because they cannot be ascribed solely to the effects of migration.

This thesis is concerned with the impact of the mother’s absence on the children’s well-being. Information on childcare behaviour in the study area can show us who provides care, how the children are cared for, and any differences between the care given by mothers and that given by substitute caregivers. The type and quality of care which a caregiver, whether the mother or a substitute, provides for a child is one of the most important factors affecting the child’s well-being and future development (Yudkin and Holme, 1969: 57).

Mother substitutes may not be able to provide the same type of care that a mother does (DeRose, 1992: 11). Breastfeeding is the most obvious difference. Substitute caregivers usually cannot breastfeed the child, although ‘wet nurses’ have been used by more affluent women in the past in both Asia and Europe. Older caregivers are sometimes handicapped by age or ill health. In the study area, one 65-year-old woman, who looked after her grandchild said that she always gave her dried breast to her 4-year-old grandchild, Nur, for comfort so that the child would not play far away from her home. The woman said that at her age she tired easily, particularly if she had to find the child.

Paid caregivers may have a lower level of commitment to the child. Substitute caregivers from the family may have different characteristics from the mother; for
example, they may be older (grandmothers), younger (siblings), have less education (grandmothers), or less skill (children).

This chapter examines the impact of substitute caregivers on the health of the children whose mothers were absent due to migration in the study area in Purwodadi and Ngombol sub-districts. The first section describes the age distribution of the children, since age is used as a control variable in most of the analysis. Age influences the child’s need for care and thus affects the care given to them. The second section describes the childcare arrangements, type of care and characteristics of the caregivers. Finally, the pattern of childcare, defined in terms of the identity of the person accompanying the child, the location of the caregiver in relation to the child, the interaction between the caregiver and the child, and any concurrent activity of the caregiver, will also be discussed.

6.1 The characteristics of the children in the study sample

Data on the children of migrant mothers were confined to those under five years of age because they are most dependent and thus were considered at greatest risk. The study covered 278 children aged between six and 47 months at the beginning of the study period. The study included only one child per household. The analysis presented in this chapter compares the children of overseas migrant mothers and those of non-migrant mothers. Of the 278 children under study, 41 (15 per cent) were children of migrant mothers working in the Middle East. The age composition of the migrants’ children differed from that of children in the study population as a whole.

Of the 41 children of migrant mothers, only two (4 per cent) were under one year of age, eight were aged 12 - 23 months, and 31 were two years or older (Table 6.1) The
average age of migrants’ children was 34.1 months, whereas the average age of children of resident mothers was much younger (23.7 months). There were few infants among the children of migrant mothers. Apparently, few mothers of infants or young toddlers migrated. The sex distribution of the children of both migrants and non-migrants was similar (54 per cent male and 46 per cent female).

Table 6.1: Child’s age group, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Age group</th>
<th>Migrants</th>
<th>Non - migrants</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 - 11 months</td>
<td>4</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>12 - 23 months</td>
<td>17</td>
<td>41</td>
<td>37</td>
</tr>
<tr>
<td>24 - 48 months</td>
<td>79</td>
<td>44</td>
<td>49</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Number of cases</td>
<td>41</td>
<td>237</td>
<td>278</td>
</tr>
</tbody>
</table>

Note: Totals may not always add to 100 due to rounding.

6.2 Childcare arrangements

For the purposes of this study, caregivers were defined as persons who provided care for the children, both formally and de facto. If several people shared childcare, the caregiver was defined as the person mainly responsible for the child/ren in terms of daily care (cleaning, bathing, and providing food), as well as providing health care.

Childcare arrangements varied. The prevalence of extended families in the study area influenced arrangements for childcare, particularly in the migrants’ families. Due to the availability of other family members, particularly women, most substitute care was provided within the family. The presence of more than one woman often allowed families to share the responsibility of childcare, even when the mother was present. The number of female adult members in the migrants’ families was slightly higher than in the
non-migrants’ families. Around 8 per cent of the migrants’ families had at least four adult female members (aged more than 15 years) compared to only 4 per cent for the non-migrants’ families; 22 and 11 per cent of migrants’ and non-migrants’ families respectively had three adult females in the household. The higher percentage of female adults present in the migrant families were in fact facilitating the mother to work abroad.

Family support networks included relatives and neighbours who often also provided childcare. Each member in the support network assisted the others; recipients of childcare support at one point in time might become substitute caregivers at another. Reciprocity often included, in the case of the migrants’ families, giving a financial reward to the caregivers. A fairly typical case is that of Pak Su 30 years old and father of an eight-year-old girl and a four-year-old boy:

Pak Su’s wife worked in the Middle East, leaving Pak Su in charge of his two children. Pak Su lived in his parents’ house where he received support from his extended family: his mother and also his older sister who lived nearby. When Pak Su’s wife remitted money from the Middle East, Pak Su gave some to his parents, sister and brother whom he said ikut momong (shared the responsibility for childcare).

Another case is Mbah Amin (household no. 18085), a 60-year-old woman who looked after her granddaughter:

Mbah Amin’s daughter (Siti) worked in the Middle East, leaving her two children, a six-year-old boy and a three-year-old girl. Mbah Amin explained that she shared childcare responsibility with her besan (Siti’s mother-in-law), Mbah Pandi, who lived nearby and with whom Siti’s husband stayed. Siti remitted her wages to her husband and asked him to distribute the remittance between Mbah Amin and Mbah Pandi. Mbah Amin explained that Siti’s money was distributed to her husband to repay a debt incurred before she left, and to her mother-in-law (referring to Mbah Pandi) and herself because they shared the care of her children.
In the migrant mothers’ families, non-parental care was widespread because the father was often not available. Fathers in the study area also did not usually perform household duties or childcare. Factors associated with the particular kinds of arrangements made for the child included the occupation of the father, the age of the child, and marital stability. The father's occupation affected his availability for care and his capacity to pay for care. Husbands who worked in the government service were more likely to ask their own mothers to live with them in order to assist in caring for the children. However, some fathers cared for their children personally. Most of these made palm sugar, an occupation that was often chosen so that they were able to work at home and care for the children.

The age of the child also influenced care arrangements. In one instance, the migrant’s parents cared for her two children who were under one year of age. Perhaps their own mothers were more willing to help than their mothers-in-law, or it may have been partly because of the couple's choice of residence. If the couple resided in the wife's parents' house or nearby, it was likely that the wife's mother was the person who did more childcare than the mother-in-law (seven cases out of nine families were living with or near the wife’s parents). In this situation, the migrant women might trust their own mothers more than their mothers-in-law to care for their children because the relationship between the children and their maternal grandmother would have been established from the birth of the child. In the study area, interactions between a couple and the wife's parents seemed to be more frequent than with the husband's parents because young couples tended to live near the wife’s parents.

Children were especially likely to have been cared for by their maternal grandparents if the marital stability of the couple was affected by the absence of the wife
(in three cases out of five where the wife’s absence had apparently affected the marriage). During my field work I noticed that some children of migrant women did not appear to benefit from their mothers’ earnings. Instead, the money was used by their fathers to buy motorcycles, for gambling or, in one case, even spent on another woman. In such cases, the children were usually cared for by the migrants' mothers. In two households the children were cared for by their maternal grandmothers because their migrant mothers were not officially married.

Where the couple had not resided with the wife’s parents before her migration, the fathers seemed to find it more convenient to stay with their parents after their wives’ absence rather than with their parents-in-law. Around 60 per cent of migrants’ children who were looked after by grandmothers stayed with their paternal grandmothers (17 cases out of 28). In three cases the father asked his own mother to come to his house to help rear the children. In two others, the father moved into his parents’ house while his wife was overseas.

6.2.1 Characteristics of formal caregivers

In this study, the formal caregiver is defined as the person designated as responsible for the children at the time of observation. Mothers were the main caregivers in resident mothers’ families, although a number of caregivers were often involved, as has been noted in other countries, including Fiji (Katz, 1985: 286). By contrast, grandparents were the most important caregivers in migrant mothers’ families, although infants and young children also spent a considerable amount of time with fathers, siblings, other relatives and peers.
The extended family, although not usually the unit of residence, was widespread and strong in the study area. As previously noted, child rearing was considered to be a matter for the whole extended family. Thirty-four of the 41 migrant households and 97 of the 237 non-migrant households consisted of three-generations. These households usually contained a single nuclear family, the couple and their children, and either the wife's or the husband's parents. In some cases, the couple and their children joined their parents' household (nine cases). This situation conducive to mothers to work abroad. Further, this could also explain why grandmothers are the most common caregivers.

In six of 41 the migrant households, the children lived only with their fathers while their mothers were in the Middle East. Two children of migrant mothers lived with their siblings, and five migrants' children lived with a relative, either their parents' older sister or their parents' younger sister (bu dhe, bu lik). Only one migrant's child was cared for by someone who was not a relative: this child was cared for by a close friend of the migrant woman. In-depth interviews with this family revealed that this was partly because of the experience of the migrant woman during her first contract in the Middle East. The child she had left behind at that occasion had been neglected by her husband, and the money she sent from the Middle East was used for the leisure of the husband.

Of the 14,557 valid observations (refer to Section 4.2.1), 2,161 observations (15 per cent) were of migrants' children and 12,396 (85 per cent) were of non-migrants' children. In 51 per cent of the observations, the children were found to be under the care of grandmothers, 25 per cent fathers, 2 per cent siblings, and 22 per cent other adults. (All comparisons between migrants' and non-migrants' children have been standardised by age structure of the non-migrant' children because of the marked age differences between the two groups). Grandmothers were thus the most common caregivers,
particularly if they lived in the same community as the migrant women. In 10 per cent of the cases of migrants' children who were not cared for by grandmothers, both grandmothers lived outside the child's village. In 5 per cent of cases both grandparents were deceased, and in 2 per cent, the grandmothers lived with their other child. For the children of non-migrant mothers, 74 per cent of caregivers were parents (mothers), 14 per cent were grandparents, 7 per cent siblings, and other adults contributed around 6 per cent of the total valid observations. In the non-migrant households, the principal responsibility for intensive childcare fell on the mothers, although grandmothers provided support. Siblings, particularly the older daughters in the family, were also valuable caretaking resources for the mother. The subsequent analysis of childcare observations refers to only 14,400 of the 14,557 valid observations. One hundred and seven observations (two cases) were excluded due to the atypically high educational level of the mother, who held a University degree. Both were non-migrant mothers.

Table 6.2: Observations of children by person providing care, standardised by age of child, Purworejo 1992/93 (Percentage *)

<table>
<thead>
<tr>
<th>Caregiver</th>
<th>Non-migrants</th>
<th>Migrants</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>unstandardised</td>
<td>standardised</td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>74</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td>Grandparent</td>
<td>14</td>
<td>51</td>
<td>51</td>
</tr>
<tr>
<td>Sibling</td>
<td>7</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Relative</td>
<td>6</td>
<td>18</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td><strong>Number of observations</strong></td>
<td><strong>12396</strong></td>
<td><strong>2161</strong></td>
<td><strong>2161</strong></td>
</tr>
</tbody>
</table>

Note: Totals may not always add to 100 due to rounding.
* refers to percentage of observations
Since Javanese families consider that the financial affairs of the family and the lives of the children are in the hands of the wife (Jay, 1969: 124), Javanese fathers usually do not act as primary caregivers for children. In the absence of mothers in the study area, it was very rare for fathers to be involved in primary care, such as feeding, bathing or dressing young children. However, men often spent their time in the company of children, often playing with the older children. Men viewed women as more appropriate caregivers and more able to take charge of a child's physical well-being. However, a few (five) fathers had different views. For example, Par, a 32-year-old man whose wife had migrated to the Middle East almost two years previously, explained:

Since the absence of my wife, I have taken over the responsibility of caring for my children, including feeding, bathing and taking my daughter to the weighing post (pos penimbangan). I do not hesitate to do so because I think a father should also be able to take charge of his child's physical well-being (momong). Even though my mother-in-law lives with me, sometimes I also cook for my daughter.

The fathers seemed to grow closer to the children when the mothers were absent. Some children were observed being bathed or fed by their fathers. As described previously (see Chapter 5) one 28-month-old girl was even observed sucking her father's nipple for comfort before going to bed or whenever she was upset. The father (aged 32 years) said that he had not been very close to his daughter before because he used to spend most of his time either in the rice fields or fishing in the sea. When his wife left for the Middle East, he stopped fishing and spent most of his time caring for his daughter.

The characteristics of the formal caregiver affect the kind and quality of care provided. This discussion of the characteristics of caregivers is limited to the parents because the survey data set did not provide information on the demographic
characteristics of caregivers except for the parents of the children. Since the qualitative data collection concentrated on the formal caregivers and covered all of the migrants families, data on their characteristics were available from my field notes. Observation and in-depth interviews revealed that some grandmothers who looked after migrant mothers’ children were quite old (some were above 60 years of age). Some grandmothers appeared too old to take care of young children. The grandmothers themselves seemed to be exhausted and needing to be cared for. Caring for children is demanding at any time, and especially in the absence of mothers. Young children are active and some migrant mothers’ children had been affected by their mothers’ absence.

Mbah Amin who appeared to be around 60 years of age told me:

_Wiwit keblegan momongan_ (since I have had to take care of my granddaughter) I am so busy and am not able to go anywhere (_repot, pun blas mboten saged mingket_). My daughter works in the Middle East, leaving her two children, a six-year-old boy and a three-year-old girl. I look after the youngest one. The other lives with his father [who lives with his parents]. I get tired very easily because the girl [whom she was looking after] is quite naughty, always wants to be _gendong_ (carried in a sling). She does not want to get up from bed if I do not pick her up and carry her in a sling. _Kulo leren nek bocahe turu_ (I can rest only when the child is sleeping).

Some grandmothers had insisted that their daughters migrate to the Middle East only when their children were older or at least able to walk. For example, Mbah Ger, who said she was 65 years of age, had told her daughter:

_Lunga ya lunga yen bocahe wis isa mlaku dadi aku ora repot banget._ (If you wish to go you can, providing your child is able to walk, so my burden will not be too heavy).
Because of their advanced age, grandmothers could be reluctant to take care of very young children. Mbah In, a 60-year-old woman illustrated this:

_Wong tuwo kok dikon rewang bayi mane. Iso-iso kepekso. Neng kana golek gawean, neng kene ninggal gawean jan karepe ki piye._ (Old people are asked to look after babies). I can do that but...Sub (referring to her daughter-in-law who worked in the Middle East) leaves lots of things to do. Over there she is looking for jobs. I do not know what she wants to do.

However, although the burden that grandmothers carried in the absence of their daughters was heavy, many still encouraged their daughters to work in the Middle East.

Mbah Mati, a 55-year-old woman was one of these;

_Kersane kulo repot anggere anak kulo saged golek pengalaman, katimbang nganggur utawi namung masak ten nggriya nyambut damel ingkang mboten wonen telase. Golek pedamelan ten mriki nggih rekaos badhe buruh nggih mboten kiat._ (It's okay for me to look after my grandchild while my daughter works in the Middle East. It is better for her to seek experience than to stay here unemployed. At home she does cooking and other things that will not last. Seeking a job here is very difficult. She is not strong enough to work as a labourer).

### 6.2.2 How the children were cared for

In this study the quantitative pattern of care is defined in terms of the following variables: the identity of the person accompanying the child (at the time of observation), the location of the caregiver in relation to the child, the interaction between the child and the caregiver, and any concurrent activity of the caregiver. Since childcare needs vary according to the age of the child, the pattern of care varied with the age of the child. Therefore, for the analysis the children were grouped into three age groups: infants (six - 12 months), toddlers (12 - 24 months), and older children (24 - 52 months). The analysis
also identified the persons who were accompanying the children at the time of observations. Unfortunately detailed information about these persons was not available in the survey data set.

As can be seen from Table 6.3, regardless whether the children belong to migrants or not passive play or idleness was the main activity of all three groups of children during observations (30 per cent). Older children aged 24 to 54 months were more often engaged in active play (37 per cent of total observations) than toddlers (25 per cent). Only 4 per cent of observations involved hygiene practices such as being cleaned, bathed, or dressed. My field work notes showed that many children looked 'dirty' as evidenced by running noses and dirty nails. I also noticed that children were rarely asked to wash their hands before taking food. A fairly typical example is provided by my notes on a visit to Su, a three-year-old girl (a migrant’s child):

Su was having rice and *pindang* (dried salty fish) for her lunch when I visited her. She began to eat after her grandmother offered her the food. She did not wash her hands. Her nails as well as her hands were dirty. I asked her why she did not wash her hands first. Her grandmother answered me: ‘Oh, *mpun kebacut*’ (‘Oh, it is too late’). (It seemed that the grandmother was ashamed when I asked the question).

Hand washing, which is important in reducing transmission of the infectious organisms that can cause diarrhoea (Paolisso, 1989: 225), was not common among the children. Children were also not accustomed to using a latrine whenever they wanted to urinate or defecate. As noted earlier (see Chapter 5), it was not unusual to see a child urinate or defecate near the house; the mother or caregiver simply covered the faeces with sand or swept it away. Many little girls also wore skirts without underwear; this also made it easier for them to urinate anywhere. For example, I saw Su, finish urinating in the front

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1 The figures for tables 6.3; 6.4; 6.5; 6.6 are for all children regardless of whether they are migrant or non-migrant children.
of her house. When she said to her grandmother that she wanted to defecate, the grandmother, who was in the backyard of her house, simply lifted up Su’s skirt and told her to go ahead. When Su finished, the grandmother took a bucket of water and cleaned her buttocks without using soap. Such behaviour may have been related to the scarcity of latrines and water, especially in Ngombol, where wells were around 30 metres deep, and one well was used for several houses. However, people also lacked hygiene awareness. I often noticed that people did not wash their hands with soap after cleaning children’s buttocks. Washing hands with soap after cleaning the buttocks disinfects and has been found to be effective in reducing the incidence of shigellosis in a community in Bangladesh (Khan, 1982 cited in Bhuiya et al., 1989: 475).

Table 6. 3: Observations according to child's activity and age group, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Activity</th>
<th>6 - 11 months</th>
<th>12 - 23 months</th>
<th>24 - 54 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping</td>
<td>24</td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>Hygiene</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Eating/drinking</td>
<td>17</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>Watching/idle</td>
<td>35</td>
<td>31</td>
<td>28</td>
</tr>
<tr>
<td>Active play</td>
<td>20</td>
<td>25</td>
<td>37</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>1983</td>
<td>5365</td>
<td>7052</td>
</tr>
</tbody>
</table>

Note: Totals may not always add to 100 due to rounding.
Six months is the youngest age group in the sample.

Eating, an important activity for child nutrition, was recorded in only around 20 per cent of observations. This included breastfeeding (3 per cent), and taking snacks (9 per cent). It was common for children of all ages to snack during the day, especially on ‘chippie’ (crackers made from flour with monosodium glutamate-MSG added). During
field work, I observed that snacks were very popular among children. A village-store 
owner said that she usually sold around a box (25 packs) each day. A pack of ‘chippie’ 
was sold for around Rp. 25 (3 Australian cents). I was told by a nutritionist who worked 
for the AIDAB project that ‘chippie’ had no nutritional value. I also often saw children 
eating ice blocks (bought from an ice vendor who regularly passed through the area). An 
observation of Al provides a fairly typical case of children’s fondness for snack foods:

Al, a 23-month-old boy, had an older sister and an older brother aged 15 
and 12 years respectively. Al was being breastfed by his mother when I 
visited him at 11.30 am sometime in August 1992. After breastfeeding, 
Al’s mother offered him a plate of warm rice served with vegetable stew, 
fish and tempe (soya bean cake). She tried to feed him but he refused the 
food; when she encouraged Al to open his mouth, he just took a few 
spoonful of rice then closed his mouth. Suddenly we heard the toot-toot 
sound of a horn pressed by an ice vendor who was passing through the 
village. Al immediately asked his mother to buy an ice block. The mother 
did not want to, but Al started crying. Eventually she asked her daughter 
to buy an ice block for Al. Al’s mother explained to me that it was very 
difficult for her to feed Al in the day time because he always wanted jajan 
(snack food from a food vendor).

The percentage of toddlers having meals or drinks was slightly higher than that of 
infants and children. Toddlers were more often inside, where they would be offered 
whatever food was available in the kitchen. By contrast, children were more likely to be 
playing outside and often did not ask for food because they were preoccupied in play.

I observed that children were fed only on demand, eating snacks frequently 
during the day. Bu Den, a 30-year-old woman, told me:

...actually I used to provide food for my child, but she refused it because 
she had already eaten at her aunt’s place. Now, I don’t ask my daughter to 
eat again because she may have eaten at my relatives’. Here it is not like 
in kota’ (town), where people don’t care for each other. Here, people are 
just like our family. Children are offered food at whatever house they 
visit.
My field work confirmed that people usually offered visitors, including children, food, even though they sometimes did not have enough for themselves. I often saw mothers feeding other children while feeding their own.

The majority of children, regardless of their ages, were observed inside their houses; however, the proportion of observations inside the house declined for older children. Around 9 per cent of observations for children were made in public places such as the river, wet-rice fields and the market. Children were often taken to these places by the mother or caregiver while she was occupied there. This was particularly the case for families who did not have someone else to look after young children, and especially during the morning when older siblings were in school. My field work took place during harvest time. I often saw children brought to the rice fields by their mothers or other caregivers if there was no-one else who could look after them.

Most caregivers (90 per cent) were near the child (within close proximity, meaning that the caregiver was able to see and hear the child and was less than two metres away) when it was observed, particularly for infants. Proximity to the child indicates the availability of the caregiver to respond to the child's needs. Infants were considered vulnerable, needing the complete attention of their caregiver. A mother or other female caregiver was usually in close proximity to children aged less than one year. For older children, the caregiver was more likely to be within hearing distance. This means that the caregiver could hear what was happening to the child, but was not always able to see the child.

The close proximity of the caregiver to the child was not necessarily an indication of close supervision, particularly if work other than caring for the child was occurring at the same time. In 60 per cent of observations of infants, caregivers were
fully attending to the infant, whereas for children the proportion was only around 30 per cent. This was perhaps because of the ability and mobility of the older children, who did not require intensive care and total supervision. For example, my field notes record that on one visit to Bu Tri, I found her watching over grain that was drying in the sun while her child Win, aged three years, played with someone else.

On another visit in 1992, my notes record that Bu Muh was delousing Bu Dar while their children, aged four years and three years, played around them. The two women were sitting on the ground. The woman whose hair was being deloused was falling asleep as it was early evening and the weather was good. Perhaps the breeze blowing in from the coast made Bu Dar feel sleepy. She woke up when one of the children cried. Her child, Sono, cried because he got sand in his eyes (kelilipan), thrown by Bu Muh’s child.

In around 15 per cent of the observations, children were left unattended by the caregiver. It was quite common to find a child crawling or toddling around a house while the caregiver was busy doing other things in the kitchen. Children were observed crawling on the floor, which was often soiled with the faeces of domestic chickens and ducks. This carried a risk of diarrhoea since faeces is a potential source of diarrhoea. When some caregivers were asked about this, they replied that it was okay for the child to toddle around the house because they had no time to fully supervise them.

The work performed by women in the study area seemed very heavy. They had to cook, clean, work in the rice field and also mind the children. In addition, collecting the fire wood for use in earthen stoves for cooking was really time consuming. The wood not only had to be fetched, but cooking took longer than if gas or other fuels were used.
The position of the children at the time of the observation indicates how they were cared for (Table 6.4). Holding or carrying is a normal component of care for infants. In around 47 per cent of the observations of infants, they were being carried, either using a sarong or on the back of the caregiver. In the study area, infants were usually carried. Not only mothers and caregivers carried infants; I often saw people holding infants belonging to others. For around 27 per cent of the observations, the infants were lying on mats or on the floor. This often occurred when the caregiver was sitting chatting with neighbours at the time of the observation. Older children were more often engaged in active play: 30 per cent of the observations of children involved active movement. Playing hide-and-seek was a common game for children in the study area.

Table 6.4: Observations by child’s position and age group, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Position</th>
<th>6 - 11 months</th>
<th>12 - 23 months</th>
<th>24 - 54 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lying down</td>
<td>27</td>
<td>22</td>
<td>16</td>
</tr>
<tr>
<td>Standing/sitting/squatting</td>
<td>19</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td>Being carried</td>
<td>47</td>
<td>31</td>
<td>9</td>
</tr>
<tr>
<td>Active movement</td>
<td>7</td>
<td>17</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>1983</td>
<td>5365</td>
<td>7052</td>
</tr>
</tbody>
</table>

Note: Totals may not always add to 100 due to rounding.

Learning to communicate with others is an important skill learned by young children. Much of this learning is based on imitation of others, especially the caregiver. Therefore, care can also be examined in terms of how the caregiver communicates with the child (Table 6.5). Mothers or other caregivers who lack support from other adults may tend to verbally communicate less often with the child because they are too busy
with domestic and other work. Table 6.5 shows that in 40 per cent of the total observations of infants, the caregiver was not communicating with the infants at all at the time of the observation. The caregiver was often busy doing other things at the time of observation. For example, an infant may have been lying down on a mat while the caregiver was busy cleaning her house. In addition, there was no communication between caregivers and infants if the infants were sleeping when they were observed. The proportion of caregivers who were actively communicating with infants at the time of observation was around 38 per cent. Most of these caregivers were ngliling (talking to) the infants. In other cases of communication, caregivers were warning their charges not to do something that could endanger them. Some caregivers seemed to spend a lot of time screaming at their toddlers who were crawling and straying far from their caregivers. Unfortunately, the data do not allow instances of positive communications such as ngliling (talking to) to be distinguished from cases of more negative communication, such as warning or yelling at the children.

Table 6.5: Observations by interaction between caregiver and the child, and age group, Purworejo, 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Interaction</th>
<th>6 - 11 months</th>
<th>12 - 23 months</th>
<th>24 - 54 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active communication</td>
<td>38</td>
<td>36</td>
<td>22</td>
</tr>
<tr>
<td>Some communication</td>
<td>22</td>
<td>31</td>
<td>42</td>
</tr>
<tr>
<td>No communication</td>
<td>40</td>
<td>33</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>1983</td>
<td>5365</td>
<td>7052</td>
</tr>
</tbody>
</table>


The caregiver was not necessarily the person with the child at the time of observation (Table 6.6). In 35 per cent of the observations, the caregiver was not the person actually with the child at that time. Only a small proportion of infants were found
with a person other than their caregiver (20 per cent). Such persons were sometimes, although not always, de facto caregivers. Infants were likely to be with siblings or other close relatives, especially when their mothers were busy doing household work. Older children were more frequently found to be in the company of someone other than the caregiver than were infants or toddlers. Older children in the study area were likely to be playing with their peers or siblings. Caregivers tended not to supervise older children so closely. They were considered to be old enough to play without adult supervision. When asked, Kas, a 30-year-old mother, explained that she never accompanied her older son (five years of age) when he dolan (played outside the home). I often saw children in the study area playing with their friends quite far away from their homes. For example, I met Sur, a five-year-old boy, who was flying a kite with his friends in a school oval around one kilometre away from his home.

Table 6.6: Observations by person accompanying the child and age group, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Person accompanying the child</th>
<th>6 - 11 months</th>
<th>12 - 23 months</th>
<th>24 - 54 months</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver</td>
<td>80</td>
<td>72</td>
<td>55</td>
<td>65</td>
</tr>
<tr>
<td>Non caregiver *</td>
<td>20</td>
<td>28</td>
<td>45</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Number of observations 1983 5365 7052 14400

Note: * including cases where the child was alone (2391 observations).
Non-caregiver does not mean substitute caregiver. He or she is a person other than the caregiver or the substitute caregiver of the child.

Most of the non-caregivers observed with the children were siblings and peers (Table 6.7). Children usually joined their peers nearby to play together as a group. I saw
children, both boys and girls, as young as five years of age helping their mothers to care for their younger siblings, especially after coming home from school:

Yan, a 10-year-old boy had two younger siblings aged five years and 18 months. Every day before going to school, he helped his mother to look after his youngest brother while his mother was doing household work. After coming home from school, he again looked after his small brother. On one occasion recorded in my field notes I met him (still wearing his uniform) carrying (nggendong) his little brother on his hip. I noted that Yan put his brother on the ground when he met his friend (apparently Yan got tired because his brother was a quite big boy). Yan played with his friend for a while, then carried his brother home.

In one per cent of the observations, the parent who was not the primary caregiver of the child was accompanying the child at the time of the observation. This was particularly the case for those migrants’ children who were primarily cared for by their grandmothers. Most of the non-caregiver parents were fathers. For example, El a one-year-old girl was cared for by neither her father nor her grandmother but by her mother’s friend (see section 6.2.1). On several observations of El she was being visited by her father who lived in another village while El’s mother was in the Middle East. In another instance, Har, a nine-month-old girl, who lived with her grandmother, was frequently observed in the company of an aunt who lived nearby. When I asked her grandmother about this, she simply answered that ‘wiwit mbiyen mpun biasa kalih nika dados mboten kemeron’ (‘Har usually stays with her aunt’). In around 50 per cent of the observations the children were alone. This was particularly the case in families without other children who could help care for younger siblings, or when the older children were in school. In addition, sleeping children were often left alone.
Table 6.7: Non-caregiver\(^a\) accompanying the child, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Person accompanying the child</th>
<th>Percentage</th>
<th>Number of observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent</td>
<td>1</td>
<td>36</td>
</tr>
<tr>
<td>Grandparent</td>
<td>2</td>
<td>78</td>
</tr>
<tr>
<td>Sibling</td>
<td>15</td>
<td>746</td>
</tr>
<tr>
<td>Peer</td>
<td>20</td>
<td>1022</td>
</tr>
<tr>
<td>Alone</td>
<td>47</td>
<td>2391</td>
</tr>
<tr>
<td>Other Relatives</td>
<td>16</td>
<td>793</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>5066</strong></td>
</tr>
</tbody>
</table>

Note: \(^a\) non-caregiver is a person other the caregiver or substitute caregiver of the child.

The total refers only to observations when the children were not with the formal caregiver.
Totals may not add to 100 due to rounding.

6.2.3 The role of non-caregiver accompanying the child

The role of the non-caregivers accompanying the child can, to some extent, be inferred from the activities of the children. Table 6.8 compares the activities of the child when accompanied by the caregiver and a non-caregiver. It shows that the formal caregiver was more likely to provide primary care such as feeding, bathing and dressing. The non-caregivers were more involved in active play than the formal caregivers for toddlers and children. Other persons were also often present when infants and toddlers were sleeping (53 per cent of observations for infants and 40 per cent for toddlers). It is not possible to distinguish between cases where the non-caregiver was engaged in de facto care and those where their presence was incidental.
Table 6.8: Observations by child’s activity and person accompanying the child, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Child activity</th>
<th>6 - 11 months</th>
<th>12 - 23 months</th>
<th>24 - 54 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caregiver</td>
<td>Non-caregiver</td>
<td>Caregiver</td>
</tr>
<tr>
<td>Sleeping</td>
<td>16</td>
<td>53</td>
<td>12</td>
</tr>
<tr>
<td>Hygiene</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Eating/drinking</td>
<td>20</td>
<td>7</td>
<td>24</td>
</tr>
<tr>
<td>Watching/idle</td>
<td>39</td>
<td>20</td>
<td>36</td>
</tr>
<tr>
<td>Active play</td>
<td>20</td>
<td>20</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Number of</td>
<td>1561</td>
<td>422</td>
<td>3861</td>
</tr>
<tr>
<td>observations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Totals may not add to 100 due to rounding

Children were also more likely to be in the company of others at certain times of the day. Around 41 per cent of the observations where the child was accompanied by someone other than the formal caregiver occurred during the morning (before 10:00 am), 33 per cent during the day (10:00 am to 3:00 pm), and only 26 per cent in the evening (3:00 to 8:00 pm). Table 6.9 shows that children were more likely to be eating or drinking when they were observed in the morning or day time and with the caregiver rather than with another person. During field work, I found that children were often fed a large meal in the morning, but later in the day, when the caregiver was likely to be doing other things, less attention was paid to feeding children. Children were more likely to be observed in hygiene activities when they were with their caregivers, and the activities occurred in the morning and evening. Older children were more often observed to actively play where they were with other persons who were not the formal caregiver. A study in Fiji also found that playful interaction was more likely when children were accompanied by non-caregivers (Katz, 1985: 277).
In Table 6.9, 14 per cent of 417 evening observations of toddlers in the company of non-caregivers indicated the toddlers were ‘idle’. These toddlers were usually just sitting, possibly watching the persons who accompanied them. For example, I often saw the toddlers aged three years and four years (Ton and Mud) being carried by their older siblings on their bikes (*diboncengke*), as they rode along the village road next to the rice fields in the evening. Both the toddlers and their older siblings were watching villagers who flew their homing pigeons at this time of day (*ngeburke dara*). The toddlers sat passively on the back of the bicycles while their brothers were more active, shouting at the pigeons. Villagers gathered to gamble (*totohan dara*) when four or more people flew their pigeons at the same time. The pigeon that reached the designated place first would be the winner, and the owner received the money put up by other participants whose pigeons were slower.

In around 50 per cent of the evening observations of older children in the company of non-caregivers, the children were playing. It was common in the study area for children to play outdoors with their friends until the late evening. This was especially the case at the time of *padang bulan* (full moon). At this time, I often saw children in the company of non-caregivers in the evening, especially when an *angguk* (traditional performance) was to be held in the village or nearby.
Table 6.9: Observations by child's activity, person accompanying the child and time of observation, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Child's activity</th>
<th>Morning</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caregiver</td>
<td>Non-caregiver</td>
<td>Caregiver</td>
<td>Non-caregiver</td>
<td>Caregiver</td>
<td>Non-caregiver</td>
<td>Caregiver</td>
<td>Non-caregiver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 - 11 months</td>
<td></td>
<td></td>
<td></td>
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<td>1</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating/drinking</td>
<td>27</td>
<td>8</td>
<td>21</td>
<td>5</td>
<td>14</td>
<td>7</td>
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</tr>
<tr>
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<td>16</td>
<td>40</td>
<td>30</td>
<td>36</td>
<td>15</td>
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<td>8</td>
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<td>15</td>
<td>33</td>
<td>14</td>
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</tr>
<tr>
<td>Active play</td>
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<td>35</td>
<td>27</td>
<td>28</td>
<td>21</td>
<td>29</td>
<td></td>
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<tr>
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<td></td>
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</tr>
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</tr>
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<td>3</td>
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<td></td>
</tr>
<tr>
<td>Eating/drinking</td>
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<td>21</td>
<td>14</td>
<td>16</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watching/idle</td>
<td>44</td>
<td>25</td>
<td>31</td>
<td>17</td>
<td>33</td>
<td>16</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Active play</td>
<td>23</td>
<td>46</td>
<td>35</td>
<td>48</td>
<td>26</td>
<td>49</td>
<td></td>
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</tr>
</tbody>
</table>

Note: Totals may not add to 100 due to rounding.
Morning (5.30 am-10.00 am), day-time (10.30 am-15.00 pm) evening (15.30 pm-20.00 pm)

The caregiver tended to remain within close proximity when attending to infants. The distance between the caregiver and the child increased for older children, who were often accompanied by others. In around 40 per cent of the morning observations of infants, they were left unattended by the caregiver, who was probably busy doing household chores. In 47 per cent of the morning observations when children were in the
company of the caregiver, the caregiver was attending to the child and also performing some other activity. My field notes, for example, record one instance where Ar, a three-year-old boy, was playing alone in the sand while his grandmother was cooking in the kitchen.

Table 6.10 shows that, in 65 per cent of the morning observations when infants were with their caregivers, the caregivers were carrying the infants. As described in Chapter 5, Javanese believe that infants are especially in need of protection and should be carried for most of their waking hours. For around 60 per cent of the observations where the infants were not with the caregiver, they were lying down. As previously noted, caregivers often left sleeping infants unattended. Toddlers were also often carried by the caregiver even though they were able to walk. Grandmothers who were caregivers were especially likely to carry toddlers using a sarong. This allowed grandmothers to do other things, because it kept the toddlers immobile while freeing the hands of the grandmother. It also saved the grandmother the trouble of chasing a mobile toddler who was able to run away. If they were sitting, toddlers were on the grandmother’s lap. During one visit, I saw, Ari a two-year-old boy, sitting in his grandmother’s lap while she peeled corn.

Regardless of the time of observation, older children were often active, particularly when they were with non-caregivers. Some children were still being carried by their caregivers, particularly in the morning (17 per cent), presumably after first waking up. Children were also sometimes carried by their caregivers when they were sick. My field notes record one instance when I met Mbah Ar carrying her grandson, Ris, a four-year-old boy. When I asked her why she was carrying Ris, she told me that he was tidak enak badan dan rewel (literally ‘not feeling well and whining’).
Table 6.10: Observations by child's position and person accompanying the child, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Child's position</th>
<th>Morning</th>
<th>Day-time</th>
<th>Evening</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caregiver</td>
<td>Not caregiver</td>
<td>Caregiver</td>
</tr>
<tr>
<td><strong>6 - 11 months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying down</td>
<td>10</td>
<td>58</td>
<td>17</td>
</tr>
<tr>
<td>Being carried</td>
<td>65</td>
<td>14</td>
<td>48</td>
</tr>
<tr>
<td>Active movement</td>
<td>7</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Standing/sitting/squatting</td>
<td>18</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>465</td>
<td>183</td>
<td>554</td>
</tr>
<tr>
<td><strong>12 - 23 months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying down</td>
<td>5</td>
<td>29</td>
<td>13</td>
</tr>
<tr>
<td>Being carried</td>
<td>46</td>
<td>8</td>
<td>35</td>
</tr>
<tr>
<td>Active movement</td>
<td>15</td>
<td>30</td>
<td>18</td>
</tr>
<tr>
<td>Standing/sitting/squatting</td>
<td>34</td>
<td>34</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>1123</td>
<td>600</td>
<td>1345</td>
</tr>
<tr>
<td><strong>24 - 54 months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying down</td>
<td>5</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Being carried</td>
<td>17</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Active movement</td>
<td>27</td>
<td>43</td>
<td>26</td>
</tr>
<tr>
<td>Standing/sitting/squatting</td>
<td>51</td>
<td>46</td>
<td>47</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>994</td>
<td>1311</td>
<td>1351</td>
</tr>
</tbody>
</table>


Note: Totals may not add to 100 due to rounding.

- Morning (5.30 am-10.00 am), day-time (10.30 am-15.00 pm) evening (15.30 pm-20.00 pm).
- * Not caregiver included both alone and with non-caregiver.

6.2.4 Differences in the care given to migrants’ and non-migrants’ children

This thesis is especially concerned with the care of the children of migrant mothers. Therefore, this section compares the care provided to the children of migrant mothers with that provided to children of resident mothers. The nature of the child's relationship with the mother and others is thought to be different (Katz, 1985: 277). To
remove the influence of the differences in the age structure between the migrants’ and non-migrants’ children, the comparison is standardised by the age distribution of the non-migrants’ children.

After standardisation by age, differences in the activity performed by the children of migrants and non-migrants virtually disappear, except for ‘watching’ and ‘eating’. Thus, the pattern of activity is similar for the children of migrants and non-migrants (Table 6.11).

Table 6.11 : Observations by child’s activity and migration status standardised by age, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Migration status</th>
<th>Activity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sleeping</td>
<td>Hygiene</td>
</tr>
<tr>
<td>Non-migrants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage</td>
<td>18</td>
<td>4</td>
</tr>
<tr>
<td>Number of</td>
<td>2169</td>
<td>527</td>
</tr>
<tr>
<td>observations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migrants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstandardised a</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Number of</td>
<td>328</td>
<td>84</td>
</tr>
<tr>
<td>observations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standardised by age b</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Number of</td>
<td>406</td>
<td>94</td>
</tr>
<tr>
<td>observations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note : Totals may not add to 100 due to rounding.
a and b are percentages.

The caregivers of both migrants’ and non-migrants’ children tended to be within close proximity of the child being cared for. In around 80 per cent of all observations, the caregivers were within close proximity of the child (Table 6.12). Slightly more caregivers of migrants’ than non-migrants’ children were out of sight of the children at
the time of observation (12 per cent compared with 10 per cent). More of the non-migrants’ caregivers were within close proximity, but most of this difference was attributable to age differences.

Table 6.12: Observations by location of caregiver and migration status standardised by age, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Migration status</th>
<th>Within close proximity</th>
<th>Location within hearing</th>
<th>Not visible</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Non-migrants</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage</td>
<td>80</td>
<td>11</td>
<td>10</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>9780</td>
<td>1289</td>
<td>1170</td>
<td>12239</td>
</tr>
<tr>
<td><em>Migrants</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstandardised</td>
<td>71</td>
<td>14</td>
<td>15</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>1543</td>
<td>302</td>
<td>316</td>
<td>2161</td>
</tr>
<tr>
<td>Standardised by age</td>
<td>77</td>
<td>11</td>
<td>12</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>1659</td>
<td>241</td>
<td>261</td>
<td>2161</td>
</tr>
</tbody>
</table>

Note: Totals may not add to 100 due to rounding.

Similarly, differences in position of the child disappeared after standardisation by age (Table 6.13). Children of migrants were observed to be engaging less in communication (Table 6.14). More caregivers of non-migrants’ children were engaged in active communication, and there was no communication for a slightly higher proportion of observations of migrants’ children. None of these remaining differences were statistically significant.
Table 6.13: Observations by position of child and migration status standardised by age, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Migration status</th>
<th>Position</th>
<th>Lying down</th>
<th>Standing/ sitting</th>
<th>Being carried</th>
<th>Active movement</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-migrants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage</td>
<td></td>
<td>20</td>
<td>35</td>
<td>24</td>
<td>21</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td></td>
<td>2466</td>
<td>4224</td>
<td>2968</td>
<td>2581</td>
<td>12239</td>
</tr>
<tr>
<td><strong>Migrants</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstandardised</td>
<td></td>
<td>17</td>
<td>42</td>
<td>11</td>
<td>29</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td></td>
<td>376</td>
<td>913</td>
<td>246</td>
<td>626</td>
<td>2161</td>
</tr>
<tr>
<td>Standardised by age</td>
<td></td>
<td>20</td>
<td>37</td>
<td>21</td>
<td>22</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td></td>
<td>441</td>
<td>791</td>
<td>459</td>
<td>470</td>
<td>2161</td>
</tr>
</tbody>
</table>

Note: Totals may not add to 100 due to rounding.

Table 6.14: Observations by communication between caregiver and the child and migration status standardised by age, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Migration status</th>
<th>Type of communication</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Active communication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sometimes respond</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No communication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td><strong>Non-migrants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage</td>
<td>30</td>
<td>34</td>
</tr>
<tr>
<td>Number of observations</td>
<td>3725</td>
<td>4211</td>
</tr>
<tr>
<td><strong>Migrants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstandardised</td>
<td>23</td>
<td>40</td>
</tr>
<tr>
<td>Number of observations</td>
<td>496</td>
<td>855</td>
</tr>
<tr>
<td>Standardised by age</td>
<td>26</td>
<td>36</td>
</tr>
<tr>
<td>Number of observations</td>
<td>571</td>
<td>779</td>
</tr>
</tbody>
</table>

Note: Totals may not add to 100 due to rounding.
Table 6.15 shows that the pattern of activity of caregivers at the time of observation was also similar for both groups of children. However, the proportion of migrants’ children who were not attended to by their caregivers was slightly higher than that of non-migrants’ children (15 per cent and 11 per cent respectively). My field observation suggested that migrants’ children were more likely to be left with relatives while their caregivers were busy in the rice fields. In addition, the caregivers of migrants’ children were often busy making palm sugar (nggeneni).

Table 6.15: Observations by caregiver's activity and migration status standardised by age, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Migration status</th>
<th>Activity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fully attending</td>
<td>Attending and doing something else</td>
</tr>
<tr>
<td>Non-migrants</td>
<td>44</td>
<td>45</td>
</tr>
<tr>
<td>Percentage</td>
<td>5375</td>
<td>5461</td>
</tr>
<tr>
<td>Number of observations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migrants</td>
<td>36</td>
<td>46</td>
</tr>
<tr>
<td>Unstandardised</td>
<td>784</td>
<td>1003</td>
</tr>
<tr>
<td>Number of observations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standardised by age</td>
<td>44</td>
<td>41</td>
</tr>
<tr>
<td>Number of observations</td>
<td>957</td>
<td>890</td>
</tr>
</tbody>
</table>

Note: Totals may not add to 100 due to rounding.

The main difference between the two groups, not surprisingly, was the identity of the person with the child at the time of observation. Among the children of migrants, grandparents accompanied the children in around 37 per cent of all observations compared to only 9 per cent among non-migrants’ children. This reflects the increased dependence of migrant families on grandparents, even when the grandparent was not the
primary caregiver (Table 6.16). The non-migrant parents accompanied the child more frequently than the caregivers of migrant mothers’ children, reflecting the fact that Javanese fathers do spend significant amounts of time with their children (52 per cent of cases where the child was accompanied only by the parents). The non-caregiver parents accompanying the migrants’ children were usually fathers where a grandmother was the usual caregiver. Migrants’ children were slightly more likely than non-migrants’ children to be left alone and much more likely to be in the company of other relatives.

Table 6.16: Observations by person accompanying the child and migration status standardised by age, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Migration status</th>
<th>Relation to child</th>
<th>Parent</th>
<th>Grandparent</th>
<th>Sibling</th>
<th>Peers</th>
<th>Alone</th>
<th>Relative</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-migrants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage</td>
<td></td>
<td>52</td>
<td>9</td>
<td>11</td>
<td>7</td>
<td>16</td>
<td>5</td>
<td>100</td>
</tr>
<tr>
<td>Number of</td>
<td></td>
<td>6361</td>
<td>1142</td>
<td>1377</td>
<td>858</td>
<td>1947</td>
<td>554</td>
<td>12239</td>
</tr>
<tr>
<td>observations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migrants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstandardised</td>
<td></td>
<td>17</td>
<td>30</td>
<td>8</td>
<td>13</td>
<td>21</td>
<td>11</td>
<td>100</td>
</tr>
<tr>
<td>Number of</td>
<td></td>
<td>360</td>
<td>656</td>
<td>173</td>
<td>285</td>
<td>448</td>
<td>239</td>
<td>2161</td>
</tr>
<tr>
<td>observations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standardised by</td>
<td></td>
<td>16</td>
<td>37</td>
<td>5</td>
<td>9</td>
<td>19</td>
<td>15</td>
<td>100</td>
</tr>
<tr>
<td>Number of</td>
<td></td>
<td>352</td>
<td>794</td>
<td>111</td>
<td>186</td>
<td>404</td>
<td>314</td>
<td>2161</td>
</tr>
<tr>
<td>observations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Totals may not add to 100 due to rounding.

6.2.5 Mother caregivers and grandmother caregivers

Because most of the children of migrant mothers were cared for by grandmothers, differences between care provided by grandmothers and that provided by mothers were also explored. Table 6.17 shows that grandmother caregivers were more often observed than mothers giving food or drinks to the child, especially during the day.
In around 30 per cent of the day-time observations when children were being cared for and were with the grandmother, they were eating or drinking compared with only 24 per cent for children cared for by mothers.

Some grandmothers encouraged the children in their care to eat snacks, using food as a reward or to comfort the child. For example:

Mbah Sar, a 70-year-old woman, took care of her granddaughter, Ti (a 20-month-old girl), whose mother worked in the Middle East. Ti had been left by her mother just a few weeks after she was weaned. Mbah Sar said that Ti did not drink milk because she had no money to buy her milk. I observed that Ti did not seem to really like jajan. In explanation Mbah Sar told me that she felt sorry for her (kasihan); therefore she always bought snacks for Ti. ‘Kulo melas Wong biyunge lungo’ (I pity her because her mother is away).

Children in the study area often drank tea or plain water with palm sugar. One elderly grandmother caregiver (Mbah Di) explained that this was to prevent the child from asking for milk:

Mbah Di, a 60-year-old woman, looked after An, a three-year-old boy, whose mother went to Saudi Arabia. An was left by his mother a week after being weaned. During the first few days when his mother left, An often cried asking for milk, which Mbah Di could not afford to buy. She gave An plain boiled water with palm sugar.

As in the previous example, the mother of the child had left for the Middle East only a few weeks after the child was weaned. Because there was not enough money to buy a milk substitute, water mixed with palm sugar was given whenever the child asked for milk. Because the palm sugar was produced locally (often by the child’s father), it was much cheaper than milk. Since the milk substitutes, particularly tea, had little nutritional value, the children probably needed to drink more in order to feel satisfied. This would explain the higher frequency of feeding for children being cared for by grandmothers.
Table 6.17: Observations by child’s activity and caregiver¹ standardised by age, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Time/caregiver</th>
<th>Sleeping</th>
<th>Hygiene</th>
<th>Eating/drinking</th>
<th>Watching/Idle</th>
<th>Active play</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Morning</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>4</td>
<td>9</td>
<td>29</td>
<td>40</td>
<td>18</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>71</td>
<td>151</td>
<td>493</td>
<td>674</td>
<td>298</td>
<td>1687</td>
</tr>
<tr>
<td>Grandmother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstandardised</td>
<td>2</td>
<td>8</td>
<td>27</td>
<td>38</td>
<td>25</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>3</td>
<td>13</td>
<td>45</td>
<td>64</td>
<td>42</td>
<td>167</td>
</tr>
<tr>
<td>Standardised by age</td>
<td>2</td>
<td>9</td>
<td>32</td>
<td>35</td>
<td>21</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>4</td>
<td>15</td>
<td>54</td>
<td>59</td>
<td>35</td>
<td>167</td>
</tr>
<tr>
<td><strong>Day-time</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>12</td>
<td>3</td>
<td>24</td>
<td>35</td>
<td>26</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>259</td>
<td>73</td>
<td>498</td>
<td>733</td>
<td>535</td>
<td>2098</td>
</tr>
<tr>
<td>Grandmother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstandardised</td>
<td>11</td>
<td>3</td>
<td>28</td>
<td>26</td>
<td>32</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>23</td>
<td>7</td>
<td>59</td>
<td>56</td>
<td>69</td>
<td>214</td>
</tr>
<tr>
<td>Standardised by age</td>
<td>10</td>
<td>2</td>
<td>32</td>
<td>24</td>
<td>31</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>22</td>
<td>5</td>
<td>69</td>
<td>52</td>
<td>66</td>
<td>214</td>
</tr>
<tr>
<td><strong>Evening</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>24</td>
<td>6</td>
<td>18</td>
<td>34</td>
<td>19</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>606</td>
<td>162</td>
<td>449</td>
<td>862</td>
<td>480</td>
<td>2559</td>
</tr>
<tr>
<td>Grandmother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstandardised</td>
<td>22</td>
<td>5</td>
<td>20</td>
<td>27</td>
<td>24</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>55</td>
<td>13</td>
<td>50</td>
<td>67</td>
<td>60</td>
<td>245</td>
</tr>
<tr>
<td>Standardised by age</td>
<td>25</td>
<td>5</td>
<td>18</td>
<td>33</td>
<td>19</td>
<td>100</td>
</tr>
<tr>
<td>Number of observations</td>
<td>60</td>
<td>13</td>
<td>45</td>
<td>80</td>
<td>47</td>
<td>245</td>
</tr>
</tbody>
</table>


Note: Totals may not add to 100 due to rounding. Mother and grandmother reported as both the formal caregiver and the person accompanying the child at the time of observation. Morning (5.30 am-10.00 am), day-time (10.30 am-15.00 am), evening (15.30-20.00 pm)
It might be expected that mothers, having competing demands on their time, would be less attentive to their children than grandmothers. This appeared to be the case during the day-time hours: grandmother caregivers were fully attentive to the children in around 65 per cent of day-time observations compared to 55 per cent for mother caregivers (Table 6.18). Grandmothers also were more often fully attentive to the children in the evening (69 per cent of observations compared with 60 per cent for mothers). As could be expected from their multiple roles, during the day time and evening mothers were more likely than grandmothers to be engaged in other activities at the same time as they attended to the child (40 and 37 per cent of observations respectively compared with 28 and 27 per cent for grandmothers). Only a small proportion of observations for both mothers and grandmothers involved the caregivers not attending to the child at all.
Table 6.18: Observations by caregivers' activities standardised by age, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Time/caregiver</th>
<th>Caregiver</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Only attending the child</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attending plus other activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not attending to the child</td>
<td></td>
</tr>
<tr>
<td><strong>Morning</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>55</td>
<td>39</td>
</tr>
<tr>
<td>Number of observations</td>
<td>926</td>
<td>654</td>
</tr>
<tr>
<td>Grandmother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstandardised</td>
<td>47</td>
<td>48</td>
</tr>
<tr>
<td>Number of observations</td>
<td>78</td>
<td>80</td>
</tr>
<tr>
<td>Standardised by age</td>
<td>57</td>
<td>40</td>
</tr>
<tr>
<td>Number of observations</td>
<td>95</td>
<td>66</td>
</tr>
<tr>
<td><strong>Day-time</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>55</td>
<td>40</td>
</tr>
<tr>
<td>Number of observations</td>
<td>1144</td>
<td>842</td>
</tr>
<tr>
<td>Grandmother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstandardised</td>
<td>55</td>
<td>36</td>
</tr>
<tr>
<td>Number of observations</td>
<td>118</td>
<td>78</td>
</tr>
<tr>
<td>Standardised by age</td>
<td>65</td>
<td>28</td>
</tr>
<tr>
<td>Number of observations</td>
<td>139</td>
<td>60</td>
</tr>
<tr>
<td><strong>Evening</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>60</td>
<td>37</td>
</tr>
<tr>
<td>Number of observations</td>
<td>1535</td>
<td>946</td>
</tr>
<tr>
<td>Grandmother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unstandardised</td>
<td>59</td>
<td>36</td>
</tr>
<tr>
<td>Number of observations</td>
<td>144</td>
<td>89</td>
</tr>
<tr>
<td>Standardised by age</td>
<td>69</td>
<td>27</td>
</tr>
<tr>
<td>Number of observations</td>
<td>170</td>
<td>65</td>
</tr>
</tbody>
</table>

Note: Totals may not add to 100 due to rounding.

Mother and grandmother reported as both the formal caregiver and the person accompanying the child at the time of observation.
Morning (5.30 am -10.00 am), day-time (10.01 am -15.00 pm), evening (15.01-20.30 pm).
6.3 Summary

The results presented in this chapter show that grandmothers were the main source of alternative caregivers for the migrants' children. Fathers, siblings and relatives were also involved in caring for children, especially when the children got older. Thus, most children were cared for by a variety of caregivers.

The study shows that the pattern of activity of caregivers at the time of observation was similar for both migrants' and non-migrants' children. However, the proportion of children attended by their caregivers was slightly higher among children of non-migrants. Migrants' children were often left with relatives when their caregivers were busy in the rice fields, or the father caregivers were busy making palm sugar.

Observations of caregivers accompanying the children declined with the increase in the age of the children. For older children, siblings and peer groups were the persons with whom the children most often engaged in activities.

Regardless of the migration status of the mother, play was the most common activity performed by children during the study period. Personal hygiene practices such as hand washing were not frequently observed among the children. Eating, which is important for child growth, was recorded in only around 20 per cent of observations.

The quantitative data do not show clear differences in the pattern of care given to migrants' and non-migrants' children (section 6.2.4). The main difference was in the identity of the caregiver. However, the absence of significant differences in the observational data does not mean that there were no real differences in actual care. That is partly because the data collected in this pioneering study were not sufficiently refined to discriminate between patterns of care. For example, as noted, the observations merely
recorded the existence of communication between the caregiver and the child. They did not identify the quality of communication, such as discriminating between negative (yelling) and positive (encouragement) communications.

Since the main quantitative difference between the two groups of children was the caregiver, the chapter compared patterns of caregiving by mother and grandmother primary caregivers.

The qualitative data suggest differences in the care given by mothers and grandmothers and for migrants' and non-migrants' children. Grandmothers were observed to feed or give drink to the children in their care more often than mothers. It was observed that grandmothers encouraged the children to eat snacks, using food as a reward or to comfort. The availability of grandmothers to attend to the children's needs was greater than that of the mothers. Grandmothers tended to position themselves within close proximity when caring for the child. Perhaps the mothers had more competing demands on their time, and this limited them in attending to the children, especially during the day-time hours. These differences will be further examined in the following chapters.
CHAPTER 7

REPORTED CHILD ILLNESS AND TREATMENT IN PURWOREJO

This chapter discusses the health status of the children as revealed by the cases of child illness and treatment reported by their caregivers. It is generally agreed that beliefs and knowledge of illness generally influence the choice of treatment (Yoder, 1989: 46; Frabrega, 1974: 24; Fox, 1988: 469; Sharp, 1982 cited in Heggenhougen, 1992: 131; Landy, 1977). Typically in developing countries, illnesses thought to be supernaturally caused are referred to indigenous practitioners, those thought to respond to common remedies are treated at home, and certain others considered caused by non-supernatural factors are referred to modern physicians (Erasmus, 1952 cited in Landy, 1977: 470). Such behavioural factors play a role in determining health status and lowering mortality levels (Caldwell, 1996: 4).

Illness treatment strategies are also affected by the household context and support structure. The role of the resource keeper may determine the treatment because she/he usually controls the information and cash needed to access treatment and thus often determines the type of diagnosis given (Castle, 1993: 140). Since women are traditionally responsible for domestic affairs, the role of women is particularly important in relation to health and sickness (Read, 1966: 62). Traditionally, women have the primary responsibility for family health within the home (Hull, 1991: 61). Thus, mothers’ actions affect the health and survival of their children (Caldwell, 1996: 4). Women, usually mothers or grandmothers, are the main health providers who diagnose and treat most common illnesses with the materials at hand (Helman, 1994: 63). A
mother's beliefs about disease origin or her conception of illness aetiology may influence her treatment-seeking behaviour (Mechanic, 1980: 146-150 cited in Rusman, 1991: 107; Singarimbun, 1984: 203). Although mothers are the main providers of informal health care for their families (Taylor et al., 1996: 55), many have to work and leave their children. In Indonesia, such children are often left in the care of older siblings, grandparents or other relatives since day-care is usually not available. Siblings may pay less attention to both nutrition and health and be less capable in childcare. Older, less educated caregivers are likely to have different attitudes to modern health services and be less aware of the importance of preventive care (Corner, 1991: 4). Thus, the identity of the caregiver may also influence health care and health outcomes.

This chapter uses the longitudinal data provided by the 1992/93 Survei Ibu to examine reported cases of child illness in the study area and how caregivers sought treatment for the illnesses suffered by their children or children in their care. These data are supplemented by qualitative data collected during the field work conducted from August 1992 to March 1993. The chapter first analyses the complaints from which the study children were reported [by the caregiver] to be suffering at the time of the survey, the symptoms noted and what was thought [by the caregiver] to have caused the illness. It investigates whether the treatment of child illness was related to the migration status of the mother or the relationship of the caregiver to the child. The chapter also discusses how treatment was sought and how different strategies were used as circumstances changed and experience accumulated. The data were gathered from focus group
discussions, in-depth interviews and personal observations conducted for this study. A village understanding of measles and its treatment is also described.

During the 1992/93 Survei Ibu, each child was visited once every three days in order to collect information on illness experienced during the previous three days. (For a detailed explanation on how the child illness data were collected see Chapter 4, Section 4.2.2). Questionnaires were administered to the caregivers of the study children, and their assessment of child illness was gathered based on questions relating to any illness suffered by the child during the three days preceding the visit. The questions focused on complaints, the symptoms the child was experiencing, and the caregiver’s ideas about the causes of the illness, what treatment they pursued and their source of information about the treatment. The sequence of this analysis follows the flow of the questions in the questionnaire.

7.1 Child illness in the study area

Because the child illnesses in these data were identified by the caregiver, not a doctor; symptoms rather than illnesses tended to be reported. The study uses the term 'illness' to refer to 'what the patient feels when he goes to the doctor' (Cassell, 1976, cited in Helman, 1994: 107) or, in this case, what the caregiver thought or observed. Thus, 'illness' reflects the patient's perspective:

Illness is the subjective response of an individual, and those around him, to his being unwell; particularly how he, and they, interpret the origin and significance of this event; how it affects his behaviour, and his relationship with other people; and the various steps he takes to remedy the situation. It not only includes his experience of ill-health, but also the meaning he gives to that experiences (Helman, 1994: 107).

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1 Informants of the focus group discussions and in-depth interviews were the caregiver of migrants' children and the substitute caregiver of migrants' children. Topics to be discussed in focus group discussions as well as questions to be asked in in-depth interviews are shown in Appendix B.
The concept of illness is related to the particular cultural and social background, which may influence health-seeking behaviour. People in the study area shared the view of the people in Rienks' (1979: 20-21) study community in Banjarnegera, Central Java, that there are two types of illness: serious illness (lara nemen) and less serious illness (lara mriang). The difference between the two is based on their ideas about illness causation. Lara nemen is believed to be caused by deviant behaviour that disturbs the relationship between people and God, whereas lara mriang or enteng is related to disturbance of the relationship between people and the biological environment (Iskandar, 1981: 46). This belief about illness causation influences the type of treatment people seek. In the study area, one example of a less serious illness was the common cold (masuk angin), which was believed to be easily cured. By contrast, a serious illness, such as high fever, was thought to be difficult to cure because the symptoms were difficult to identify. Cases of serious illness were generally taken to traditional healers or a modern health provider, whereas less serious illness was usually treated by home remedies.

One example of an illness that was considered in the study area to be serious was one where sick children were described as having had a fever, did not want to eat (aras-arasen) and were rewel (whining). Ganjar, a popular term for measles, was also considered to be a more serious illness. The illness considered most serious was where a child had a fever for many days and ndleming (literally ‘talked to himself’). Such children also did not want to eat, were lemes (weak) and inactive.

Caregivers’ perception of the severity of an illness was derived from information obtained from people surrounding the family of the sick child or from past experience. For example, Put, the mother of a four-year-old boy and a two-year-old girl, said:

My mother often tells me what I have to do if one of my family gets sick. For example, if my son gets fever, as long as there is no smell sangit that
means it is just biasa (normal). But, if he gets fever and sangit that indicates that he will nampi (literally he will receive a reward from God) [that is, measles].

People's perception of the severity of illness affected their health-seeking behaviour, as did previous experience of using either modern or traditional treatment.

In this study, the caregiver was asked to report any illness that occurred to her/his child or the child in her/his care, because it is the caregiver's perception that motivates care and treatment for children. The caregiver's strategies for treating children may be affected by knowledge of available services, and barriers or obstacles to using those services (Mitchell, 1982: 4-5 cited in Rusman, 1991: 107). The mother in non-migrant families or the grandmother in the migrant families was the immediate carer who usually first noticed child illness. The following section describes the type of complaints the children were reported to have suffered at the time of survey, the symptoms noted and what was thought to have caused the illness.

7.1.1 Type of complaints for children in the study area

The illness data collected by the 1992/93 Survei Ibu provided information on the type of complaint from which children were reported to be suffering at the time of the study. The caregiver was asked to report any illness that occurred to each child in her/his care. Detailed information on the symptoms and treatment for each illness that occurred during the three days preceding the visit was then recorded. As explained in Chapter 6, there were a total of 14,557 observations of the 278 children during the six-month period of the study. Of these, 646 were incomplete, leaving 13,911 valid observations where a child was reported as being either ill or not ill. There were 3,106 observations (22 per cent of the valid cases) where children were reported to have been ill during at least one
of the three days preceding the visit, 376 of these for migrants' children. The remaining 2,730 illness observations were for children of non-migrant mothers, representing 20 per cent of the total valid observations (ill and not ill) for these children. Because some children were reported to have had more than one complaint, there were 9,281 illness reports from the 3,106 observations when children were reported to be sick. Of the 9,281 total illness reports, 1,160 illness reports were for migrants' children.

Table 7.1 shows the types of illness from which the children suffered. The most common illnesses were classified into seven broad categories. The largest group was 'runny nose' or pilek, which accounted for approximately 70 per cent of the cases of illness reported in the period for all children. A runny nose by itself is not a disease but a symptom, frequently due to the common cold. The frequent occurrence of runny noses among children in the study area was probably because of the damp climatic conditions of the villages, particularly in the rainy season, and the occurrence of frequent flooding. The high prevalence of runny noses is probably connected to the fact that the study was carried out during the rainy season. A runny nose is also very easily identified and thus likely to be reported in a survey focusing on illness. It was commonly reported for children in all age groups.
Table 7.1: Type of illness reported for migrants’ and non-migrants’ children by age group, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Child’s age group/Type of Illness</th>
<th>Migrants</th>
<th>Non-migrants</th>
<th>All children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6 - 11 months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Runny nose</td>
<td>69</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>Fever</td>
<td>9</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Coughing</td>
<td>6</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Stomach-related illnesses (a)</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Sawan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin-related illnesses (b)</td>
<td>0</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Others (c)</td>
<td>17</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total number of observations</td>
<td>71</td>
<td>1600</td>
<td>1671</td>
</tr>
<tr>
<td><strong>12 - 23 months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Runny nose</td>
<td>71</td>
<td>74</td>
<td>74</td>
</tr>
<tr>
<td>Fever</td>
<td>3</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Coughing</td>
<td>5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Stomach-related illnesses (a)</td>
<td>9</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Sawan</strong></td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Skin-related illnesses (b)</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Others (c)</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total number of observations</td>
<td>272</td>
<td>3613</td>
<td>3885</td>
</tr>
<tr>
<td><strong>24 months and over</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Runny nose</td>
<td>66</td>
<td>71</td>
<td>70</td>
</tr>
<tr>
<td>Fever</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Coughing</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Stomach-related illnesses (a)</td>
<td>0.5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Sawan</strong></td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Skin-related illnesses (b)</td>
<td>15</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Others (c)</td>
<td>7</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total number of observations</td>
<td>817</td>
<td>2908</td>
<td>3725</td>
</tr>
</tbody>
</table>


Note: Totals may not always add to 100 due to rounding.

- a Stomach-related illnesses include stomach ache, diarrhoea, dysentery
- b Skin-related illnesses include body sores, abscesses, kutu air, biang keringat, biduren
- c Other illnesses include toothache, eye problems, headache, malaria, ear infections

Table 7.1 shows little difference in the pattern of illness suffered by migrants’ and non-migrants’ children in any of the age groups. It should be noted that as this table is concerned with daily observations of illness collected every three days, some episodes of illness are included more than once. Hence a higher percentage of observations for one group could mean more episodes or fewer episodes of longer duration, and similar
percentages could hide a real difference between children of migrants and non-migrants with a similar pattern of duration of illness. Because the duration of illness is not known, only limited conclusions about health differences between the children of migrants and non-migrants can be drawn from these data. The discussion and most of the tables presented in this chapter therefore concentrate on patterns of illness and the treatment given to sick children.

Runny nose (*pilek*) was common among both migrants’ and non-migrants’ children. The largest proportion (74 per cent) of occurrences of runny nose was found among children aged 12 - 23 months of non-migrant mothers. In the study area, there was a community myth that if a child drank too much iced or plain water, she/he would be prone to a runny nose.

Skin-related illnesses, which included impetigo (*korengen*), large boils (*bisulen*), tinea versicolour (*kadas*), ulcers (*kudis*), and rashes due to cold weather or allergy (*biduren*), ranked second in frequency. These illnesses could be caused by poor personal hygiene practices and inadequate sanitation facilities. Chapter 6, Section 6.2.2 suggested that the percentage of children observed to follow hygienic practices was very low. Lack of clean water could also contribute to the prevalence of skin-related illnesses. Many children were observed to have long dirty finger nails that could spread bacteria if they were used to scratch infected skin. During field work, I often saw a member of the Observation Team from the *Survei Ibu* cutting the finger nails of children because they were concerned about the health risk. It was also clear that soap was not widely available. Failure to use soap for cleaning was probably related to low incomes: a bar of soap sold for around Rp.300. A shortage of water also contributed to infrequent hand washing.
In Indonesia as a whole, skin-related illnesses have been noted as one of the most prevalent illnesses among children under five (Budiarso et al., 1986: 30-33 cited in Rusman, 1991: 108; Aswar, n.d: 11). According to the 1986 Indonesian Household Health Survey, 26 out of every 1000 children under age five had skin diseases (Indonesian Ministry of Health, 1994: 44). Skin disease often indicates poor environmental sanitation and hygiene, which is one of the major health problems in Indonesia (Aswar, n.d: 2).

_Sawan_ was also reported as a common complaint suffered by children in the study area, ranking third among illnesses in the study population. _Sawan_ has been described by several scholars (Geertz, 1961: 104; Iskandar, 1981: 41; Rienks, 1979: 21). It is a collective name for child illnesses that are considered very dangerous (Rienks, 1979: 21), are important in Javanese life and still regarded by some as a mystery (Iskandar, 1981: 43). In a study in rural Java, Iskandar found that _sawan_ was regarded as the cause of infant and child illness; a punishment to parents who are careless in the safety of their infants and children; related to special social events; and categorised as the cause of illnesses that are scary and related to evil (_badan alus_). _Sawanen_ is the term used for child illness, whereas for adults the terms used for similar symptoms are _kesetanan_ or _kesurupan_ (Geertz, 1961: 104-105).

Javanese believe that young children are susceptible to _sawan_ or _kemirab sawan_ (not yet free from _sawan_). Therefore, they pay close attention to young children (Iskandar, 1981: 44). Javanese believe that there is an age limit for children to be free from _sawan_, even though there is no agreement about the age. In a study in Banjarnegara, Central Java, Iskandar reported that some people considered that children aged 100 days and over could be free of _sawan_, while others said that only children aged
over five years would not be affected. In my study area, people claimed that a child would not suffer from sawan after reaching five years of age.

Many symptoms are associated with sawan. It is very difficult to categorise since each individual has her/his own description of these symptoms (Rienks, 1979: 21). High fever, diarrhoea and boils are among the symptoms often mentioned. Rienks (1979: 21) and Iskandar (1981: 47) identified the following types of sawan:

Sawan wangke (wangke means corpse): A child could suffer this sawan if its parents did not inform their children when a neighbour died, or if the parents forgot to wash the child's face when the child was brought to a funeral ceremony. The symptoms include loss of weight, pallor, loss of appetite, sleepiness and swollen eyes.

Sawan penganten (penganten: bride): A child could get this sawan if the child was brought to a wedding party but the parents did not inform the child about the aim of the party. The symptoms include sudden excessive crying, the child refusing to enter the house, the child wanting to stay in the yard, and the child's face becoming shiny like a bride (penganten).

Sawan celeng (celeng: black pig): usually affected a child who looked at someone who was preparing land for cultivation or becoming involved in the preparation. The symptoms include convulsions and stiffness. (In medical terms this could be tetanus).

Sawan klebu (klebu: dusk): is caused by the carelessness of a child who dirties its house, especially his/her bedroom, by throwing rubbish on the floor (for example, throwing banana skins under the bed). According to people in Purworejo, the symptoms include high temperature, mild cough and a bluish mark on the child's upper cheek (close to the eyes).
Rienks (1979: 22) noted many more types of sawan that could not be clearly defined, such as sawan bayi, sawan angin, sawan kere and sawan wayang. Iskandar (1981: 47) also listed a number of sawan, although he could not identify their causes. They included: sawan tangis, deleles, kupu, lugan, wawang, gedeg, buyut, menis, anti, kampret, klinting, bengok, kuning, kejer, sumeden, cecek, and ngatih. In the field, I noticed that most of the sawan mentioned by people in the study area were apparently connected with skin problems. The symptoms ranged from increased body temperature to bisulen (abscess). The sawan found in the study area were:

Sawan gromo: indicated by redness and burning in the body of the affected child. It was thought that a pregnant woman throwing a hot drink to the earth caused the child to catch this sawan. Giving the child water in which charcoal had been soaked, adas pula waras, and pepper was the common treatment for this illness. Another home remedy was to spray the body of the affected child with a mixture of chewed guava leaves and pepper.

Sawan kikir: is a type of skin infection with small scars on the body of the affected child. One treatment was to bathe the child with warm water in which a metal file (kikir) had been soaked.

Sawan lombok: the cause was unknown. The affected child usually had a cough, vomiting and fever. The treatment was either to give the child a mixture of spring onion, young popongan leaves and head lice or take her/him to the health centre.

Sawan dompo: the occurrence of rashes on the arms and legs of the affected child. The treatment was to apply a mixture of lime juice and yeast.

Sawan keong: could affect a child whose mother ate pelas tawon (a dish made of honeycomb) when she was pregnant with the child. It is indicated by an abscess as big as
a snail on the head of the affected child. Treatment included applying chalk or pounded sweet potato leaves to the affected area.

_Sawan buras:_ usually affected a child who was being breastfed if the breast-milk dropped on the child’s cheek. Symptoms included white patches appearing on the child’s cheek. A common treatment was to apply the mother’s saliva to the affected area. The sap of cucumber was also said to be commonly used to treat children with _sawan buras._

A child refusing food, having a fever for three days, having difficult breathing, a limp\(^2\) ear or losing weight was an indication of _sawan mayit._ Other _sawan_ commonly mentioned in the study area included _sawan intip, sawan kuping, serapen, sumpingen,_ and _dada’em._ Most of the _sawan_ were related to the existence of vesicles on the body of the affected child. The symptoms were often described as itchiness or abscesses.

Fever defined as a rise in body temperature, an important sign of disease (Carter and Bowen, 1991: 144), was another complaint reported for children in the study area. In the study area fever was known as _sumeng._ A child was reported to have been sick with fever if the caregiver detected that the child developed a fever. They often reported that a child had a fever even though the child’s body temperature was still within the normal range.

Coughing, which is a symptom of respiratory tract infections (Carter and Bowen, 1991: 164), was also a commonly experienced illness reported by caregivers in the study area. One contributory factor could have been smoke from cooking. Children were often kept in the kitchen when the caregivers were busy cooking nectar water to make palm sugar. The use of earthen cookware as well as the lack of ventilation may have exacerbated the problem. Some caregivers reported that coughing was probably due to

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\(^2\) By limp ear people meant that outer part of the ear was not firm, but soft to touch.
the habit of *jajan* (buying food from the food vendors), particularly fried snacks. Some people in the community believed that oily snacks could make a child cough.

Stomach-related illnesses, including diarrhoea, comprised only around 2 per cent of the total illness reports among migrants’ children. Some diarrhoea cases could be under-reported, especially if they were mild, because many people considered diarrhoea to be a sign of child development. In the study area the terms for diarrhoea were *mabjur* and *ngeprek*. A study in nearby Gunung Kidul in 1991 found that *nggebyor* (meaning watery diarrhoea that spurts out ‘like pouring water from a bucket’) and *ngenteng-entengi* (loose stools thought to be due to the process of losing weight) were not considered to be diseases or dangerous, but rather a sign of child development (Rusman, 1991: 114-115). An alternative interpretation is that the data are correct and that there were higher levels of resistance to diarrhoea among children in the study area. The 1992/93 *Survei Ibu* data collection period did not include June-July, the dry season, which is typically a period of relatively high diarrhoea prevalence (Indonesia Central Bureau of Statistics, 1992: 132).

In-depth interviews showed that diarrhoea was seen by some caregivers as a normal condition for children at certain growth stages. Such beliefs have also been found in other parts of Indonesia. In Aceh, diarrhoea episodes were regarded as a normal phase of a child’s development (Rahardjo and Corner, 1989: 8). Diarrhoea was seen as an indicator of growing cleverness. It was considered that the child with diarrhoea was *mau pandai* which means ‘trying to learn’.
7.1.2 Type of symptoms

The longitudinal data collected by the 1992/93 Survei Ibu also provided information on the symptoms experienced by children. When a child was reported to be ill, the caregiver was asked to note any symptoms the child had. Fever was the most common symptom reported, representing around 40 per cent of the total symptoms noticed. (Table 7.2).

Table 7.2: Symptoms of reported child illness for migrants’ and non-migrant’s children by age group, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Child’s age group/Type of symptoms</th>
<th>Migrants</th>
<th>Non-migrants</th>
<th>All children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6 - 11 months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General weaknesses</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>No symptom</td>
<td>34</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Fever</td>
<td>41</td>
<td>50</td>
<td>49</td>
</tr>
<tr>
<td>Coughing</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Abdominal discomfort</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Itchiness</td>
<td>0</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Others (a)</td>
<td>21</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total number of observations</td>
<td>71</td>
<td>1600</td>
<td>1671</td>
</tr>
<tr>
<td><strong>12 - 23 months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General weaknesses</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>No symptom</td>
<td>33</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td>Fever</td>
<td>45</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>Coughing</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Abdominal discomfort</td>
<td>6</td>
<td>0.5</td>
<td>1</td>
</tr>
<tr>
<td>Itchiness</td>
<td>7</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Others (a)</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total number of observations</td>
<td>272</td>
<td>3613</td>
<td>3885</td>
</tr>
<tr>
<td><strong>24 months and over</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General weaknesses</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>No symptom</td>
<td>38</td>
<td>38</td>
<td>38</td>
</tr>
<tr>
<td>Fever</td>
<td>36</td>
<td>41</td>
<td>40</td>
</tr>
<tr>
<td>Coughing</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Abdominal discomfort</td>
<td>0</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Itchiness</td>
<td>18</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Others (a)</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total number of observations</td>
<td>817</td>
<td>2908</td>
<td>3725</td>
</tr>
</tbody>
</table>


Note: Totals may not always add to 100 due to rounding.

(a) Other symptoms include excessive crying, paleness, nosebleed, lack of appetite.
Sometimes fever might not be perceived by the caregiver to be worth reporting. The case of Ar is an example:

During my fieldwork in 1992, I visited Ar, a four-year-old boy who had been looked after by Mbah Is, a 60 year-old woman. At that time, Ar was carried on the back of Mbah Is, in a piece of cloth (selendang). Ar seemed not very well because he was usually an energetic boy who always actively played with his friends. I touched Ar’s body and felt that his body temperature was above normal. When I asked Mbah Is what had happened to Ar, she said that Ar was ‘sumeng’ (had fever) and that it was common for children to be like that, particularly if he was kangen towards his mother (missed his mother very much). When I checked Ar’s questionnaire on that day, he was reported to be healthy.

In around 35 per cent of the total illness observations, no symptoms were reported by the caregivers (Table 7.2). In such cases, a sick child was reported as being able to perform normal daily activities (badan normal). The condition of the sick child was considered ‘as usual’ because the children did not show any pain or discomfort related to the particular illness.

Itchiness (gatal-gatal) ranked third as a symptom. In around 18 per cent of the total illness observations, itchiness was reported as a symptom for migrants’ children aged beyond 24 months, compared with 13 per cent for non-migrants’ children.

A particular illness might produce different symptoms. The distribution of symptoms by illnesses is presented in Table 7.3. Except in the case of runny nose, caregivers of non-migrants’ children were more likely to report no symptoms than caregivers of migrants’ children. This suggests that the caregivers of migrants’ children were quite attentive to the children in their care. Perhaps, since many were older relatives with fewer other duties, they had more time to both observe and report on the children. More migrants’ than non-migrants’ children were reported to have diarrhoea, indicating that caregivers tended to regard diarrhoea as a symptom of an illness rather
than an illness itself. Migrants' children with skin-related illnesses were also more likely to be reported as suffering itchiness, another indication of the attentiveness of the caregivers.
### Table 7.3: Symptoms reported for each type of illness and migration status of the mothers (Percentage)

<table>
<thead>
<tr>
<th>Illness group</th>
<th>Migration status</th>
<th>No symptoms</th>
<th>General weaknesses</th>
<th>Fever</th>
<th>Cough</th>
<th>Diarrhea</th>
<th>Itchy</th>
<th>Others 1</th>
<th>Total</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Runny nose</td>
<td>Migrant</td>
<td>48</td>
<td>1</td>
<td>50</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>100</td>
<td>783</td>
</tr>
<tr>
<td></td>
<td>Non-mig.</td>
<td>43</td>
<td>2</td>
<td>54</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>100</td>
<td>5867</td>
</tr>
<tr>
<td>Fever</td>
<td>Migrant</td>
<td>2</td>
<td>0</td>
<td>89</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>7</td>
<td>100</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Non-mig</td>
<td>4</td>
<td>9</td>
<td>87</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>100</td>
<td>447</td>
</tr>
<tr>
<td>Cough</td>
<td>Migrant</td>
<td>29</td>
<td>6</td>
<td>2</td>
<td>61</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>100</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Non-mig</td>
<td>36</td>
<td>1</td>
<td>2</td>
<td>53</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>100</td>
<td>218</td>
</tr>
<tr>
<td>Stomach-related</td>
<td>Migrant</td>
<td>4</td>
<td>30</td>
<td>0</td>
<td>0</td>
<td>59</td>
<td>0</td>
<td>7</td>
<td>100</td>
<td>27</td>
</tr>
<tr>
<td>illnesses</td>
<td>Non-mig</td>
<td>32</td>
<td>17</td>
<td>10</td>
<td>0</td>
<td>32</td>
<td>1</td>
<td>9</td>
<td>100</td>
<td>127</td>
</tr>
<tr>
<td>Sawan</td>
<td>Migrant</td>
<td>13</td>
<td>0</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>69</td>
<td>6</td>
<td>100</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Non-mig.</td>
<td>12</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>62</td>
<td>16</td>
<td>100</td>
<td>366</td>
</tr>
<tr>
<td>Skin-related</td>
<td>Migrant</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>87</td>
<td>4</td>
<td>100</td>
<td>137</td>
</tr>
<tr>
<td>illnesses</td>
<td>Non-mig.</td>
<td>17</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>72</td>
<td>9</td>
<td>100</td>
<td>776</td>
</tr>
<tr>
<td>Others 2</td>
<td>Migrant</td>
<td>17</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>73</td>
<td>100</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Non-mig</td>
<td>13</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>11</td>
<td>61</td>
<td>100</td>
<td>162</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>36</td>
<td>2</td>
<td>45</td>
<td>2</td>
<td>1</td>
<td>11</td>
<td>4</td>
<td>101</td>
<td>9104</td>
</tr>
</tbody>
</table>

**Source:** The 1992/93 Survei Ibu, Purworejo.

**Note:** Totals may not always add to 100 due to rounding.

1 Other symptoms include excessive crying, pale, vomiting, nosebleed
2 Other illnesses include eye problems, toothache and other minor illnesses.
7.1.3. The cause of illness

The reported cause of illness varied. More than 30 per cent of causes were reported as unknown (Table 7.4). Table 7.4 shows a higher percentage of reports of ‘unknown’ as the cause of illness for children of migrant mothers than for the children of non-migrants. The highest proportion (38 per cent) of ‘unknown’ cause of illness was for children of migrant mothers aged 12 - 23 months. ‘Food-related’, ‘weather’, and ‘tiredness’ were the next most frequent factors thought to have caused illness.

‘Food-related’ causes of illness accounted for more than 20 per cent of the total illness observations for all children in the study. In-depth interviews with caregivers revealed a belief that children eating certain raw food caused stomach ache. I also noticed that many children did not wash their hands before eating; thus an infection might have come from dirty hands rather than from the food. It is worthy of note that, although caregivers reported food as a cause of illness, they rarely made a connection between food and episodes of diarrhoea. Some people believed that eating inappropriate food could lead to stomach ache. For example, eating oranges, jackfruit and durian before having rice was believed to cause stomach upset. In addition, eggs and milk were also thought to be the cause of stomach problems. Not having food was thought to cause masuk angin (the entrance of wind to the body), the Indonesian term for what English-speakers call the ‘common cold’.
Table 7.4: Causes of reported illness for migrants’ and non-migrants’ children by age groups, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Child’s age group/ Causes of reported illness</th>
<th>Migrants</th>
<th>Non-migrants</th>
<th>All children</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 - 11 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tiredness</td>
<td>6</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Food-related</td>
<td>20</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>Unhygienic places</td>
<td>7</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Sawaan</td>
<td>0</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Weather</td>
<td>18</td>
<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Others *</td>
<td>13</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Unknown</td>
<td>37</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total number of observations</td>
<td>71</td>
<td>1600</td>
<td>1671</td>
</tr>
<tr>
<td>12 - 23 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tiredness</td>
<td>4</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Food-related</td>
<td>24</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Unhygienic places</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Sawaan</td>
<td>2</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Weather</td>
<td>16</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Others *</td>
<td>4</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Unknown</td>
<td>38</td>
<td>29</td>
<td>30</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total number of observations</td>
<td>272</td>
<td>3613</td>
<td>3885</td>
</tr>
<tr>
<td>24 months and over</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tiredness</td>
<td>5</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Food-related</td>
<td>22</td>
<td>23</td>
<td>22</td>
</tr>
<tr>
<td>Unhygienic places</td>
<td>21</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>Sawaan</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Weather</td>
<td>14</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>Others *</td>
<td>7</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Unknown</td>
<td>28</td>
<td>30</td>
<td>29</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total number of observations</td>
<td>817</td>
<td>2908</td>
<td>3725</td>
</tr>
</tbody>
</table>

Note: Totals may not always add to 100 due to rounding.
   a Other causes include falling down, drinking water when taking a bath

Weather was also thought to be a cause of child illness. (The study was carried out during the transition from dry season to rainy season). Wind and draughts are believed to be the cause of many ailments. Children were also reported to be sick because they played in unhygienic places such as drains, and stagnant water. A higher percentage of causation by unhygienic place was reported as a cause of illness among children aged 24 months and over of migrant mothers than children of non-migrants. I
also observed that children of migrants were more likely to be playing in unhygienic places, perhaps because their older caregivers had less control over their play than mothers. Playing with dirty water was also thought to cause illness. The various factors that were thought to have caused particular illnesses are shown in Table 7.5.
<table>
<thead>
<tr>
<th>Illness group</th>
<th>Migration status</th>
<th>Tiredness</th>
<th>Food-related</th>
<th>Environ</th>
<th>Sawan</th>
<th>Weather</th>
<th>Other</th>
<th>Unknown</th>
<th>Total</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Runny nose</td>
<td>Migrant</td>
<td>4</td>
<td>26</td>
<td>16</td>
<td>0</td>
<td>20</td>
<td>6</td>
<td>28</td>
<td>100</td>
<td>783</td>
</tr>
<tr>
<td></td>
<td>Non-migrant</td>
<td>8</td>
<td>28</td>
<td>11</td>
<td>2</td>
<td>18</td>
<td>6</td>
<td>27</td>
<td>100</td>
<td>5867</td>
</tr>
<tr>
<td>Fever</td>
<td>Migrant</td>
<td>36</td>
<td>11</td>
<td>16</td>
<td>2</td>
<td>0</td>
<td>9</td>
<td>27</td>
<td>100</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Non-migrant</td>
<td>35</td>
<td>8</td>
<td>7</td>
<td>8</td>
<td>7</td>
<td>8</td>
<td>27</td>
<td>100</td>
<td>447</td>
</tr>
<tr>
<td>Cough</td>
<td>Migrant</td>
<td>20</td>
<td>6</td>
<td>12</td>
<td>0</td>
<td>14</td>
<td>0</td>
<td>47</td>
<td>100</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Non-migrant</td>
<td>12</td>
<td>25</td>
<td>4</td>
<td>2</td>
<td>22</td>
<td>4</td>
<td>31</td>
<td>100</td>
<td>218</td>
</tr>
<tr>
<td>Stomach-related</td>
<td>Migrant</td>
<td>0</td>
<td>33</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>56</td>
<td>100</td>
<td>27</td>
</tr>
<tr>
<td>illnesses</td>
<td>Non-migrant</td>
<td>6</td>
<td>22</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>27</td>
<td>37</td>
<td>100</td>
<td>127</td>
</tr>
<tr>
<td>Sawan</td>
<td>Migrant</td>
<td>0</td>
<td>25</td>
<td>4</td>
<td>31</td>
<td>0</td>
<td>0</td>
<td>40</td>
<td>100</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Non-migrant</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>48</td>
<td>2</td>
<td>3</td>
<td>42</td>
<td>100</td>
<td>366</td>
</tr>
<tr>
<td>Skin-related</td>
<td>Migrant</td>
<td>0</td>
<td>14</td>
<td>37</td>
<td>4</td>
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<td>illnesses</td>
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<td>12</td>
<td>7</td>
<td>17</td>
<td>14</td>
<td>42</td>
<td>100</td>
<td>776</td>
</tr>
<tr>
<td>Others (^2)</td>
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<td>6</td>
<td>25</td>
<td>0</td>
<td>8</td>
<td>23</td>
<td>39</td>
<td>100</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Non-migrant</td>
<td>2</td>
<td>14</td>
<td>8</td>
<td>4</td>
<td>10</td>
<td>27</td>
<td>35</td>
<td>100</td>
<td>162</td>
</tr>
</tbody>
</table>

| Total          |                 | 8         | 23           | 11      | 4     | 18      | 7     | 30      | 101   | 9104|

Note: Totals may not always add to 100 due to rounding.
\(^1\) Other causes include drinking water when taking a bath, supernatural factors
\(^2\) Other illnesses include eye problems, toothache and other minor illnesses.
The table shows quite different patterns of reported cause of illness for migrants’ and non-migrants’ children for all illnesses except for runny nose. However, it is difficult to explain these differences. They may reflect the different perceptions of illness causation between older (migrant) and younger (non-migrant) caregivers.

For all children, food was believed to cause runny nose. During field work, I often heard a caregiver say that a child got a runny nose because he/she drank unboiled water while having a bath. Drinking es (a mixture of unboiled water, strong food colouring and saccharine) was also reported as the cause of a runny nose. Drinking too much was reported as another cause of a runny nose. Changing weather was also thought to cause a runny nose.

Tiredness was thought to be the commonest cause of fever suffered by children (Table 7.5). Children were reported to fall ill after playing or doing activities that required lots of physical effort. It was common to hear caregivers say that the children were ‘kecapaian’ (very tired) and therefore they got sick. One informant, a 55-year-old grandmother caregiver of a migrant’s child explained that due to excessive play that required lots of physical activity, a child would get sick very easily because her/his muscles might not be in the proper positions (bergeser).

Changing weather, cold weather, sitting in cold damp places and excessive exposure to the sun, were thought to cause cough in children. Wind and rain were also believed to cause runny nose and coughs.

Children suffering from skin-related illness were suspected of eating particular foods, unclean food, or fruit that contained sap. A high percentage of caregivers reported that it was sawan itself which caused their children to suffer from other kinds of sawan. For example, the children might have sawan penganten because they were brought to a
wedding ceremony. Sawan was also thought to be the cause of illness in young children, particularly when they became convulsive. Some people believed that sawan could cause illness in a child if the parents broke certain taboos. For example, sawan mayit (see Iskandar, 1981: 47) was believed to be due to taking a child to a funeral ceremony.

In this study the cause of illness categorised as ‘other’ included injury and kangen (missing or being missed by the mother very much). The case of Mbah Ren (approximately 60 years old, the wife of a former village headman) illustrates this:

Rendy (a four-year-old boy, Mbah Ren’s grandson) was ill for a few days after Rendy’s mother left for Saudi Arabia. He was ill with a high temperature and his hand had been burned by hot water poured from a thermos bottle. Mbah Ren reported that Rendy was sick because he was kangen and missed his mother very much.

7.2 Treatment

The response to children’s illness often depends on caregivers’ perceptions of both the illness and its cause. Sometimes people respond to symptoms arbitrarily because of the absence of some idea of causation (Maclean, 1976: 290). It also depends on the child’s reaction to illness. In the study area, if a sick child was still able to carry out her/his daily activities, the caregiver would not do anything or would just apply a remedy that was available at home. Medical care would be sought only if the child remained ill. Even then, treatment depended on access to financial resources. For poor families, lack of money sometimes prevented them from seeking medical advice. This was partly due to the fear of having to meet the cost of medicine prescribed by a doctor. The existence of a support network allowed some to meet the cost of seeking medical treatment. Caregivers sometimes obtained money for medical treatment by borrowing from neighbours or relatives. As noted by Taylor, ‘household composition, the proximity
or existence of friends and relatives and the severity of the illness episodes determined the action taken and the resources used' (Taylor et al., 1996: 54).

Table 7.6 : Treatment of reported illness for migrants’ and non-migrants’ children by age group, Purworejo 1992/93 (Percentage)

<table>
<thead>
<tr>
<th>Child’s age group/ Type of treatment</th>
<th>Migrants</th>
<th>Non-migrants</th>
<th>All children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6 - 11 months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No treatment</td>
<td>34</td>
<td>39</td>
<td>39</td>
</tr>
<tr>
<td>Self treatment</td>
<td>34</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td>Traditional healer</td>
<td>13</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Health facility or provider</td>
<td>16</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Others a</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total number of observations</td>
<td>71</td>
<td>1600</td>
<td>1671</td>
</tr>
<tr>
<td><strong>12 - 23 months</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No treatment</td>
<td>34</td>
<td>41</td>
<td>40</td>
</tr>
<tr>
<td>Self treatment</td>
<td>49</td>
<td>44</td>
<td>44</td>
</tr>
<tr>
<td>Traditional healer</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Health facility or provider</td>
<td>11</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Others a</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total number of observations</td>
<td>272</td>
<td>3613</td>
<td>3885</td>
</tr>
<tr>
<td><strong>24 months and over</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No treatment</td>
<td>46</td>
<td>47</td>
<td>47</td>
</tr>
<tr>
<td>Self treatment</td>
<td>41</td>
<td>39</td>
<td>40</td>
</tr>
<tr>
<td>Traditional healer</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Health facility or provider</td>
<td>6</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Others a</td>
<td>6</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Total number of observations</td>
<td>817</td>
<td>2908</td>
<td>3725</td>
</tr>
</tbody>
</table>

Note : Totals may not always add to 100 due to rounding.

Table 7.6 shows some variation in the treatment migrant and non-migrant caregivers sought when the child or children in their care were ill. Self-treatment, which included herbal preparations and administering drugs from the drug store, was common among all caregivers in the study area. It was also common to leave child illnesses
untreated for children of all ages. Seeking treatment from a traditional healer was not common in dealing with child illnesses.

One reason for not seeking any treatment was because it was thought that certain types of illnesses did not require treatment or were not serious. As seen in Table 7.1, the most common symptom in all children was runny nose, which was usually perceived as not serious. Field observations revealed that caregivers did not seek treatment for child illness for a variety of reasons. The fact that the child could perform as normal and the belief that tiredness was the cause of the illness were repeatedly mentioned. As long as a sick child was still able to perform normal daily activities, caregivers would not bother to seek treatment. A 50-year-old mother who had completed four years of schooling said:

> When my granddaughter, three years old, had a cough and runny nose (*batuk pilek*) last month, I did not do anything. She was normal as usual and could still play with her friends. It is not unusual for children to have *batuk pilek*. Just leave it like that. I do not worry too much. If a cough persists for a week or more, then I usually buy medicine from the village store.

> Unless children complained of pain, or when caregivers believed that the cause of child illness was tiredness, caregivers tended to leave illness untreated. A 30-year-old mother told me that if she believed that her child was sick due to tiredness, she would not seek treatment. She thought that the illness would disappear once the child had enough rest.

Self-treatment, which comprised modern and traditional home medicine, was widely used. Self-treatment included *kompres* or the use of tepid sponge to lower temperature, and *kerokan*. *Kerok* (scoring the skin with the edge of a coin) is a very common treatment for symptoms that the Javanese describe as *masuk angin* (literally,
entrance of wind into the body) (see Hull, 1979: 318). People learned of appropriate
treatment from their parents or from their previous experience of similar illnesses. Home
treatment was important, perhaps partly due to the lack of health services and because of
financial considerations. Going to the health centre or a doctor involved money and time,
since clients had to wait. Home treatment included using basic pharmaceutical drugs
provided by the village health cadre. When home treatment was not perceived to be
effective or a child’s condition deteriorated, caregivers changed the treatment. The
reasons for self-treatment are revealed in the case studies below.

Bu Is, a 30-year-old woman, said:

> When my child is sick, I use home medicines. It does not cost anything. It
> is simple because we use what we have. I use home medicine, particularly
> if my daughter gets fever. I usually use daun dadap serep to put on her
> head or if she gets masuk angin I usually kerok my child and rub in onion
> and coconut oil.

Bu Har, a 50-year-old woman told of her treatment of her granddaughter:

> When granddaughter (Tati) gets a fever, cold, cough or headache I cure
> the illness with home medicine. When she has a slight fever, I kompres
> with ice or soak a towel in cold water and put it on the child’s forehead. If
> they are not cured after giving them compress, or kerokan, I buy
> ‘Contrexyn’ in the village store. It is very cheap. One tablet costs only Rp
> 50. I try to see Pak Mantri (the local male paramedic) if they are not cured
> after using these treatments.

Mbah Ger, a 60-year-old woman, a grandmother caregiver of Agas, said:

> Usually we use home medicine to cure illness such as fever, diarrhoea and
cough. For diarrhoea we cure it by applying a mixture of kunir apu
>(turmeric mixed with chalk) on the child’s stomach. We also give it black
>coffee (kopi pahit) mixed with salt so that the child will stop having
>watery stools. And, if the child still passes the stools, we do not give any
>food to the child because otherwise the diarrhoea would not stop.
In the study area, I found that caregivers attempted to cure child illnesses by self-medication, irrespective of the age of the child. A common practice was the use of modern analgesics such as Bodrex, Panadol and Contrex. Hawkers sold medicines, particularly on market days. Such medicines were most often used to cure illnesses that were not considered life-threatening. For a few Rupiahs, people in the study area could buy drugs that were freely available in the villages. They could buy a package of medicine from the tukang obat (the drug seller) in the nearby market or the village store. It was easier to buy modern medicine from village stores or drug sellers than to visit a doctor or hospital. Modern drugs were seen as relatively cheap, effective and easy to obtain.

Seeking modern medical services was less common in both groups compared to self-medication. The proportion of caregivers using modern medical services was very low in both migrant and non-migrant families, even though the clinic fee was relatively low, only Rp.500. However, access to modern health facilities was often not easy. The travelling distance, on average, was more than two kilometres to the nearest low-cost government modern health facility. Some informants in Ngombol told me that they preferred to treat the illness using home remedies or to buy drugs in the village stores. Even though community health centres were available at low cost, people did not always seek modern medical treatment. Focus group discussions suggested that the long waiting period, as well as the inefficacy of the treatment provided by modern medical facilities, were also barriers to the caregivers’ use of the modern health services. In addition, the opening hour (in the morning) of the health clinic, was also reported as the reason for not using the facility. The participants of the focus groups said that in the morning they were still very busy (repot) with domestic work.
Economic constraints were also another important explanation for the less frequent use of modern medicine. Even though the clinic fee was only Rp.500, it was still high by village standards. This was particularly the case for people who worked as agricultural labourers, who often earned only around Rp.1,500 a day. Lack of money discouraged the use of modern health services, particularly private doctors, because they usually gave prescriptions that required money.

Although traditional healers are commonly used in rural areas of Java, only a few cases of child illness were reported to involve treatment from traditional healers. The proportion was slightly higher among children aged 6 - 11 months of migrants than among those of non-migrants. In-depth interviews showed that migrants' children were frequently taken to traditional healers to have suwuk (blessing) in order to cope with problems of temporary separation from their mothers.

The type of treatment chosen was related to the type of illness (Table 7.7). A runny nose was generally untreated. The frequent occurrence of colds among children in the study area may have led people to accept runny noses as a natural part of daily life, as was also found in Sri Lanka (Pieris, 1994: 99). However, fever was usually treated. Focus group discussions with women aged between 30 and 35 years in the study area suggested that home treatment, such as putting either dadap serep leaves or mashed spring onion mixed with cooking oil on the child's fontanelle, and sponging the sick child with warm water with salt added were among the most common practices for treating fever.
Table 7.7: Treatment reported for each type of illness by migration status of their mothers (Percentage)

<table>
<thead>
<tr>
<th>Illness group</th>
<th>Migration status</th>
<th>No treatment</th>
<th>Self treatment</th>
<th>Traditional</th>
<th>Modern b</th>
<th>Others 1</th>
<th>Total</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Runny nose</td>
<td>Migrant</td>
<td>52</td>
<td>34</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>100</td>
<td>783</td>
</tr>
<tr>
<td></td>
<td>Non-migrant</td>
<td>52</td>
<td>34</td>
<td>1</td>
<td>7</td>
<td>6</td>
<td>100</td>
<td>5867</td>
</tr>
<tr>
<td>Fever</td>
<td>Migrant</td>
<td>20</td>
<td>62</td>
<td>7</td>
<td>9</td>
<td>2</td>
<td>100</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Non-migrant</td>
<td>15</td>
<td>60</td>
<td>8</td>
<td>15</td>
<td>3</td>
<td>100</td>
<td>447</td>
</tr>
<tr>
<td>Cough</td>
<td>Migrant</td>
<td>33</td>
<td>60</td>
<td>0</td>
<td>0</td>
<td>16</td>
<td>100</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Non-migrant</td>
<td>34</td>
<td>47</td>
<td>4</td>
<td>9</td>
<td>16</td>
<td>100</td>
<td>218</td>
</tr>
<tr>
<td>Stomach-related illnesses</td>
<td>Migrant</td>
<td>26</td>
<td>33</td>
<td>7</td>
<td>30</td>
<td>4</td>
<td>100</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Non-migrant</td>
<td>31</td>
<td>39</td>
<td>18</td>
<td>11</td>
<td>1</td>
<td>100</td>
<td>127</td>
</tr>
<tr>
<td>Sawa</td>
<td>Migrant</td>
<td>23</td>
<td>60</td>
<td>13</td>
<td>4</td>
<td>0</td>
<td>100</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Non-migrant</td>
<td>15</td>
<td>58</td>
<td>7</td>
<td>18</td>
<td>1</td>
<td>100</td>
<td>366</td>
</tr>
<tr>
<td>Skin-related illnesses</td>
<td>Migrant</td>
<td>15</td>
<td>82</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>100</td>
<td>137</td>
</tr>
<tr>
<td></td>
<td>Non-migrant</td>
<td>15</td>
<td>79</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>100</td>
<td>776</td>
</tr>
<tr>
<td>Others 2</td>
<td>Migrant</td>
<td>31</td>
<td>27</td>
<td>0</td>
<td>42</td>
<td>0</td>
<td>100</td>
<td>52</td>
</tr>
<tr>
<td></td>
<td>Non-migrant</td>
<td>23</td>
<td>36</td>
<td>19</td>
<td>11</td>
<td>1</td>
<td>100</td>
<td>162</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>43</td>
<td>42</td>
<td>2</td>
<td>8</td>
<td>5</td>
<td>100</td>
<td>9104</td>
</tr>
</tbody>
</table>


Note: Totals may not always add to 100 due to rounding.

a includes home remedies and administering pharmaceutical drugs
b Includes hospital, health centre, health post, clinic, doctor, nurse
1 Other treatments include cuddling the child, not letting the child do her/his daily activities
2 Other illnesses include eye problems, toothache and other minor illnesses.
Table 7.7 suggests that there were differences in the way migrants’ and non-migrants’ children were treated. In cases of sawan, children of migrant mothers received self-treatment more often than did children of non-migrant mothers. Migrants’ children were more likely to be taken to traditional healers when they were suffering from sawan. Cases of sawan among migrants’ children were also more likely to be untreated. In the field I found that modern treatment was not sought because sawan was not considered to be serious enough to need treatment. Drinking turmeric juice mixed with egg yolk and honey and applying ointment to the body sores were repeatedly mentioned as cures for sawan. Another plausible reason mentioned earlier was that sawan in the study area was associated with skin-related illnesses, and caregivers did not seek treatment for this illness.

Most cases of fever were treated at home or received no treatment. Home treatment for fever included placing dadap serep on the child’s fontanelle, applying a kompres with warm water and salt, and applying a mixture of oil and onions. Non-migrant families relied more on modern medical treatment when their children were suffering from fever (15 per cent compared to only 9 per cent). One possible explanation may be that non-migrants’ children were cared for by their mothers who were younger, and more likely to have a better education and more exposure to the media and thus to be aware of modern treatments.

Self-treatment was common for children who complained of a stomach-related illness. This was particularly the case when the children had diarrhoea. They were given turmeric and chalk (kunir apu) or strong tea, which people in the study area believed could stop diarrhoea. Turmeric juice mixed with egg yolk and honey was also mentioned as a cure for dysentery.
Coughs among migrants' children were more likely to be treated at home (60 per cent compared to 47 per cent for non-migrants' children). No migrant's child with a cough was taken to a health facility, although 9 per cent of coughs reported for non-migrants' children were treated at a health facility. Perhaps, cough was not considered as a serious illness by the caregivers of the migrants' children.

7.3 Management of children's illness in Purwodadi and Ngombol

The management of children's illnesses depended on the caregivers' belief about the cause of illness, knowledge about treatment, and the perceived severity of the illness. People in the study area regarded an illness as severe if the sick child could not perform its normal activities. For example, if the child had fever, did not want to eat, was whining or complaining and being passive, the caregiver, usually the mother, would recognise that the child was aras-arasan (meaning 'not in good condition'). Usually no action was taken except that the child was cuddled more closely or carried with a shawl (slendang). In some cases, food was given to try to stimulate the child's appetite. For example, a mother would offer rice porridge, mixed with some meat or vegetable, to the child. In other cases, parents bought toys or something else that the children had asked for previously. These efforts were made to satisfy the child when caregivers or parents considered that the child had become aras-arasan because it did not get what it wanted. Parents paid more attention to the sick child than usual. In the case of migrant mothers' families, a sick child was often considered to be missing the mother. If so, the child was usually brought to the traditional healer to be treated (disuwukke) so that the child would not think about its mother while she was working overseas.
If the condition of the child worsened, as indicated by not being able to wake up and/or being weak, the parent would usually seek some kind of treatment. In responding to the illness, the mother usually first applied home remedies, such as putting ice or some leaves (dadap serep) on the child's fontanelle to lower its temperature. In some cases the sick child was given Panadol tablets, which could be purchased easily in the village market, or the caregiver would ask the drug-store owner what kind of medicine was suitable for the particular illness. Some parents just bought any medicine that, in their view, could cure their child's illness. The information about the medicine might be gathered from the mass media, such as the radio, or from their own experience or that of their neighbours or relatives.

Some caregivers responded very quickly to illness and others did not respond at all. It depended mainly on the caregiver's perception of whether the illness was dangerous or not. If the illness was perceived to be caused by supernatural forces, and thought to be not dangerous, caregivers would not seek treatment. If the condition of the child worsened, then they would seek treatment. Otherwise the condition was ignored. When home treatment did not help, and the child remained ill or the condition deteriorated, the patient was taken elsewhere for treatment. The mother or other caregivers would become worried after two or three days if the children showed discomfort. Children in the study area generally received prompt attention when they were really sick.

Management of child illness also depended on the availability of and accessibility to health services in providing effective medicine and a health practitioner. Those who could afford modern health facilities could take their children there.
However, poverty might have limited their ability to pay for such services for some caregivers.

Perceptions about the effectiveness of treatment sometimes varied according to the age of the patient. Some of the focus group participants believed that injections were not a good treatment because children could get polio or their feet may not function properly. In contrast, injections for adults were considered to be a good treatment; no matter what disease one suffered from. Once the doctor gave an injection, they had a strong belief that they would recover very soon.

7.3.1 The role of kin groups in illness management in the study area

Relatives of sick children often provide support, particularly in giving advice, or helping to seek treatment (Read, 1966: 9). Scholars have found a positive relationship between social support and resistance to or recovery from disease. Myntti, in a study in Jordan, found that the social network could be mobilised by mothers for the benefit of their children (Myntti, 1993: 13). This was particularly the case where the condition of sick children became worse despite treatment with home remedies or medicines bought from the village store. The members of the extended family then tried to help the children’s families to take the sick children to the hospital or to traditional healers. People helped by lending money or by providing transport.

The existence of social networks, which are usually a set of special neighbours, kin and friends, can provide support for the family of a sick person. Boyce et al. (1988: 1079) defined social support as 'the set of resources derived from interaction and exchange with the other person'. The care of a young child who is sick is usually also of
concern to the wider kin. Most families, particularly families of migrants, tended to turn immediately to their extended families.

The kin group is usually people related to the family of the sick children who live in the same household or in a nearby household. In the study area, social networks comprised of the extended family, other relatives, and members of the larger community, were very strong. The kin group was usually a part of a wider social network that enabled people to get social support and also helped the family of a sick child to seek treatment. The support given to the needy family could take the form of material or non-material assistance between family members who resided in different households. The social support network usually provided practical help in seeking treatment or financial support, particularly in the case of poor families. Such support could reduce the stress suffered by the family of a sick child. As Jaspan noted in her study site, the parents of a sick child usually listen very respectfully to the advice offered them by elders of the village (Jaspan, 1987: 24). They usually try to follow the advice given, particularly if it has a bearing on their children’s health.

In the study area, the wider kin sometimes observed the symptoms of the child before attempting to seek treatment. When the wider kin was informed that a child in their network was sick, members would come to visit the sick child. They usually discussed the cause of illness. They might suggest finding a traditional healer within the community although the data show that traditional healers were not widely used for children. If this did not work, then they looked outside the community and modern medical treatment might be sought. The father was usually involved if the illness was considered severe and involved cost. Otherwise the women took the decisions. Fathers
were generally viewed as sources of financial resources, and the persons who were responsible for financing the costs of health treatment.

It was not only the wider kin who provided support; non-kin, peers and the community at large also provided social support for the sick child's family. A neighbour, especially the next-door neighbour, was the most common non-kin member to provide assistance.

The decision to seek treatment is sometimes also a result of discussion with the extended family members:

It is clear that .......societal traditions interfere with modern medicine. The preference for consulting dukun [traditional healers] results in patients either not coming to a health centre, or coming too late....Before (a patient is) brought to a hospital there must also be lengthy consultation among members of the extended family, which further postpones going to the health centre (Hashem, 1974: 69; translation by V. Hull cited in V. Hull, 1979: 319).

Castle (1993: 137) in her study in Mali also noticed that 'household context and support structure affected illness treatment strategies'. Castle found that the relationship between women and female members of their marital families may aid or constrain effective treatment strategies and the day-to-day care of their children. This was also partly true in rural Java where the extended family members, particularly the grandparents, could become involved in decisions about seeking treatment. In the study area it was not unusual for the grandmother to take the main role in managing child illness. This was partly because the young mother's natal kin usually lived very close.

V. Hull (1979: 319) in her study of Javanese women in Ngaglik found that 'health, including childbirth, infant care, nutrition, and contraception, is a matter to be met and dealt with at home, with the advice and support of family members'. She observed that 'the one important principle underlying women's traditional approach to
health care is their attempt to deal with their environment within the very real limitations imposed by poverty and lack of medical knowledge.

The availability of a modern health-care facility in the study area allowed the people to bring their sick children for treatment. However, only around 8 per cent of cases of illness were treated by a modern health-care provider. This could be due to the cost and time involved. It could also be due to beliefs. A small proportion of caregivers were found to base their behaviour on their beliefs about the causes of illness. If the caregivers held traditional beliefs about the cause of the illnesses that occurred to their children, it was quite difficult for them seek any modern medical treatment.

People in the study area usually used home remedies first. If this treatment was not successful, modern unprescribed drugs widely available in the village store were used. Wide-spread advertisements had influenced many people in the rural areas to use modern drugs before seeking modern health treatment. Modern drugs were seen as very cheap, effective and easy to find. However, no one advised them about the danger of the side effects of the drugs, not even the drug-store owner. Sometimes modern drugs for adults were given to very young children, especially to relieve fever. The only modification was the dose: young children were usually given half a tablet.

7.4 Measles in the village: common perceptions and treatment

This section describes in more detail measles in the study villages, although there were few reports of that illness during the six-month study period. The care of children with measles will also be discussed.

Measles is one of the major preventable childhood diseases. In Indonesia, 90 per cent of children have had measles (Sutedjo, 1974; Benenson, 1975 and Morley, 1977
cited in Kasniyah, 1986: 53), and it contributes around 5 per cent of child mortality in Indonesia (Morley, 1977: 249 cited in Kasniyah, 1986: 2). Recent data from the National Household Health Survey 1992 suggested that measles, diphtheria, and pertussis are among the five major causes of child mortality in Indonesia. Diphtheria, pertussis and measles account for 9.4 per cent of the causes of child mortality (Indonesian Ministry of Health, 1994: 39). The number of persons of all ages who suffered from measles in Indonesia increased from 76,338 in 1988 to 91,645 in 1992 (Indonesian Ministry of Health, 1994: 55). Of these, the number of persons hospitalised because of measles was 2,364 in 1988 and increased to 3,142 in 1992. Unfortunately, the data were not broken down into age groups.

The Indonesian government encourages mothers to have their children immunised against measles. In 1991/92, coverage for measles immunisation was 89 per cent in Indonesia, increasing to 90 per cent in 1992/93. The coverage for Central Java remained steady, at 89 per cent in 1991/92 and 88 per cent in 1992/93. In Indonesia as a whole in 1990, 58 per cent of children aged between 12-23 months were immunised against measles. The coverage for Central Java for the same year was 65 per cent of children aged 12-23 months (Indonesian Ministry of Health, 1994: lampiran IV.C.1a).

Although immunisation against measles has been encouraged by the Indonesian government, some people are reluctant to have their children immunised. Kasniyah, in a study in Kaliangkrik, Central Java, found that measles was perceived to be a common childhood illness that was not considered to be serious (Kasniyah, 1986: 3). People in the study area also shared the view that measles was a non-serious illness that commonly occurred among young children. In the study area, measles was known as ganjar ayu (literally ‘a beautiful reward’) if the sufferer was a girl and ganjar bagus (literally ‘a
handsome reward”) if the sufferer was a boy. In Kaliangkrik, it was called bagusan (for boys) and ayuan (for girls) (Kasniyah, 1986: 55). The term ganjar ayu or bagus was used to imply the reverse condition. They believed if they said that the child looked awful because of the illness, they were afraid that it would happen. People hoped that after recovery the face of the child would be as beautiful or as handsome as before.

One 30-year-old woman explained that ‘measles is not dangerous and every child will catch it’. She told me that the symptoms of ganjar are light fever, lack of appetite, whining, and a smell of sangit (something burning). Focus group discussions confirmed that people in the study area believed measles to be a reward from God, and that parents should not worry if their children caught it. Participants mentioned that measles were usually indicated by the occurrence of a bad smell from the fontanelle of the affected child and the existence of fever and redness on the child’s body.

When a parent in the study area noticed that the child had ganjar, the child was not given any treatment. A parent would say that the child would nampi ganjar or ‘receive a reward’. If the child’s condition became worse, the parent would buy medicine from the market. They often said that the jamu seller would know the appropriate medicine for children who were suffering from ganjar. Many people also said that a child who had measles would feel hot and greges (shivering). Before the rash appears, children will not settle down. For that reason, the caregiver usually gave treatment such as egg yolk mixed with honey to make the rash appear and the child recover quickly. They thought that if the rash did not appear, it would be very dangerous and could be fatal. A study in Banyumas and Magelang, Central Java (Kasniyah, 1983: 79; Kasniyah, 1986: 50) also found that children who suffered from measles were given a liquid made from water, tamarind, and raw chicken liver, with salt and palm sugar, in
order to make the rashes come out. Another treatment was to bathe the sick child with the water which had been used to wash a chicken. They would slaughter a chicken, then wash it and pour the water used on to the body of the sick child. The chicken would then be grilled and given to the child. They avoided frying the chicken, as they believed that this would cause black scars on the child’s body.

If a mother or another substitute caregiver believed that measles was a stage of child development that could occur to any child, it would be hard to convince her to take her child to seek medical treatment. One case was found where a child suffered severely from measles. The mother believed that if she took the child to the health centre the child might become crippled because the doctor would give her an injection. She therefore kept her child at home, and also refused the medication offered by the Survei Ibu team. The case of Rapam also illustrates that measles was thought not to require treatment:

Rapam a three-year-old boy, had mild fever. He did not want to play with his friends. He also refused food offered to him. His mother did not give him anything until his temperature rose and he was shivering. Rapam just wanted to lie down and was very weak. The mother said that Rapam will nampi because she smelled sangit from his fontanelle. Rapam’s mother applied dlingo bengle (the root of a plant similar to ginger) and kunyit (turmeric) to lower Rapam’s temperature. When Rapam had a high temperature, a staff member of the 1992/93 Survei Ibu visited him to give Paracetamol but Rapam’s mother refused it and said that it would not cure the disease. Rapam would be better in the next few days. In fact, Rapam still had a high temperature and the 1992/93 Survei Ibu staff persuaded her to bring Rapam to the doctor. When I asked Rapam’s mother why she did not want to take her child to the doctor, she told me that it was because the doctor would inject Rapam and it would make his leg crippled. She put turmeric, money, and a mirror under Rapam’s pillow. She also used a new slendang to carry Rapam. When I asked her what the reason was for putting those kinds of things there, she told me that it was because Rapam was nampi ganjar (receiving rewards), therefore we should assist him.
The usual treatment for more severe cases included applying home remedies such as turmeric and tamarind (*kunir asam*), and buying snacks from the market (*jajan pasar*). Fanning the sick child was also mentioned as a treatment for measles.

### 7.5 Diarrhoea in the village: common perceptions and treatment

Diarrhoea is an infectious disease caused by agents that are invisible to the naked eye. WHO defines diarrhoea as a condition in which stools are passed more frequently and are loose or watery than usual for that person. The indication of the disease is three or more abnormally loose or watery stools in a single day. These stools usually smell strongly or pass noisily. Diarrhoea is common in young children, especially in infants who are not breastfed. Because bottles, cups or other feeding utensils can easily be infected, the chance of these babies getting diarrhoea is greater than for breastfed infants. (WHO, 1981: 100).

Diarrhoea is dangerous, especially for infants, because the diarrhoeal infections reduce the body's ability to absorb salt and water in the intestine. Serious loss of fluid from diarrhoea leads to dehydration, or drying out of the body (Jolly, 1985: 415). The water and salt have to be replaced in order to avoid dehydration. The majority of deaths from diarrhoeal dehydration can be prevented by Oral Rehydration Therapy (UNICEF, 1981: 65; Streatfield, 1989: 3). Infants and children with diarrhoea require considerable attention from parents. Infants can die because of acute diarrhoea, but parents seem to neglect the disease, and do not take action immediately when their children have diarrhoea.

Some people in the study area did not know what diarrhoea was, although their families had already had the disease. There were some special terms in the study village
to refer to the condition in which stools were abnormal, loose or watery. The terms were based on the kinds of stools that were passed. Even though infants and children passed their stools more frequently and the stools were more loose or watery than was usual, the mothers did not consider that this was diarrhoea. They used the word mansyur if the stools were very watery. Dysentery was the term for the condition in which stools were more loose and mixed with blood. If infants or children passed stools with mucus, that was called ngenteng-enthengi (this meant that bad elements were removed from their bodies). The word mabyrur was used for stools that passed noisily. In general, people used the word mencret if there were three or more abnormal loose or watery stools in a day.

In the study village, diarrhoea was considered a common disease primarily affecting infants and children. Diarrhoea was not thought of as an illness, but just a sign that the infants were going through a certain stage of development. Most mothers thought that if their babies and children passed watery stools more frequently, they would tambah pinter (become more clever). They did not worry about the illness, and thought that it did not require much attention. The condition of the infants or children would be normal a few days later.

Because diarrhoea was considered an indication of the development of infants’ brains, mothers in the study area always used home remedies. Infants were given rice diluted with clean drinking water and with added salts and sugar when they had diarrhoea. A mixture of adas pulo waras, pepper and bark of the turi tree (kulit pohon turi) was also mentioned for treating diarrhoea. In some cases, mothers who believed in spirits thought that diarrhoea was caused by sawan. If their infants and children had
diarrhoea, they would make offerings in order to ward off misfortune. They also applied a mixture of ground turmeric and chalk to the infants' stomachs.

Usually, children who had diarrhoea were also given strong tea. In some cases, they were also given a solution that was made from young leaves of the guava tree with added salt. According to the mothers, the solution could make the stools solid because the taste of the solution was bitter. Children might also be given pills (for example Enterovioform). Enterovioform was quite a common treatment for diarrhoea, because the pill could easily be purchased in the village drug stores.

Some mothers treated their infants and children with diarrhoea by starving them. They thought that if they gave food or drink to the infants and children, the disease would become more serious. They considered that if infants and children were not given food and drink, they would recover. They also thought that the more the infants and children passed stools, the better their condition because their stomachs were empty of food. As a result, the infants and children become dehydrated and their condition worsened.

However, with the availability of health-care facilities, caregivers were able to use oral rehydration therapy to relieve diarrhoea. In addition, health cadres in the study area were relatively active in providing information about caring for children with diarrhoea. As a result, some caregivers took their sick children to the community health centre or to a private doctor.

7.6 Summary

This chapter has discussed reported illnesses among children of migrants and non-migrants during the study period, and the ways in which they were treated and
managed. The illnesses suffered by the children in this study were identified by the symptoms that were reported by caregivers. The data show that both groups of children suffered similar patterns of illness. For children from both migrants’ and non-migrants’ families, runny nose was the most common reported illness. The second most common illness was skin-related diseases.

Efforts to seek treatment were influenced by people’s concepts of illness. People would seek treatment from traditional healers when they believed that the cause of illness was supernatural factors. Self-treatment was by far the most popular type of treatment used in the study area. There were many factors to explain this. One was that self treatment was not costly, and the materials were mostly available in their homes. A second was the perception that illnesses could be cured by home medicines. Self-treatment included the use of pharmaceutical drugs that could be bought in the village stores. In addition, the availability of basic medicine provided by the Survei Ibu made it easy to treat minor ailments. Lack of time might also discourage caregivers from seeking treatment for their sick children.

The proportion of caregivers who sought no treatment for both groups of children was relatively high. The explanation for this was possibly that caregivers thought that they did not need to seek treatment when their children or children in their care were sick. This was particularly likely when a child suffered from a particular illness perceived by the caregiver as a ‘normal’ illness, such as diarrhoea and measles. Treatment was often delayed until the condition of the child was serious.
CHAPTER 8

CHILD-FEEDING PRACTICES AND NUTRITIONAL STATUS

The previous chapter showed that the care given to the children was different between migrant and non-migrant families. This is likely to have an effect on the health status of the children. This chapter discusses another aspect of health status: child-feeding practices and nutritional status, comparing the children of migrants and non-migrants in Purwodadi and Ngombol. It is divided into three sections. The first section discusses community beliefs about foods and how they relate to child growth. Community beliefs about foods influence the way people feed children. People's ideas about a healthy child also influence child-feeding practices. The second section describes child-feeding practices in the study area, including the patterns of feeding. These two sections are mainly based on in-depth interviews with parents, grandparents and other caregivers. In addition, direct observation of the behaviour of mothers feeding infants and children in the study area provided data about actual situations. These qualitative data were collected during field work conducted from August 1992 to March 1993. The third section relates child nutritional status to differences in child-feeding practices. The nutritional status of both boys and girls was determined from the anthropometric indicators weight-for-age and height-for-age. The anthropometric data used in this analysis were derived from the AIDAB Women's Work and Child Welfare Project (the 1992/1993 Survei Ibu) Anthropometry File, August 1992 - March 1993.

The statistical data in this chapter are drawn from a very small sample. Thus, only limited conclusions about the nutritional status of migrants' and non-migrants'
children can be drawn. Therefore, the discussion begins with the qualitative data first and depends most heavily on the qualitative data.

8.1 Community beliefs about food

Community beliefs about particular foods are likely to influence child-feeding behaviour. The pattern of child-feeding cannot be isolated from culture (Barlow, 1985: 255). If people believe that some kinds of foods are good for children, as long as they can afford them they are likely to feed that food to their children. By contrast, if they believe that certain foods are harmful for children they may not feed their children those foods even though they may not harm the child and may even be nutritionally good and important for children. For example, some people in the study area believed that animal protein foods such as meat, fish and eggs were not good for children because they were thought to cause stomach problems or abscesses. A 60-year-old grandparent caregiver told me that Yuli, a 23-month-old boy, her grandson, had never been given fish or eggs because every time he ate fish or eggs he would suffer from ‘ponyoten’ (abscesses on his head). She therefore concluded that fish would also be ‘bad’ for him. If people hold this kind of belief, they may not feed these foods to children even though the foods are rich in the protein needed for child growth. If there is no substitute for these protein-rich foods, poor growth for children may result because their sources of protein are reduced or cut off, particularly where their parents are poor and are not able to provide other foods containing nutrients similar to the taboo foods.

Some people in the study area also believed that a healthy child is neither too fat nor too thin. A small child might be considered to be a consequence of insufficient food. If a parent had a thin child, it was likely to be assumed that the parent did not feed the
child properly. People, particularly the older caregivers, believed that as long as children grew large for their age, they were healthy. Therefore, they fed children with food that made them large, regardless of the nutritional content of the food.

Beliefs about food taboos for children seem to be influenced by age and education (Ware, 1979: 33). A focus group discussion with young mothers aged between 25 and 35 years and with some schooling conducted in the study area suggested that there were no strict food taboos for children. Perhaps, this was because the younger mothers were exposed at school to information that challenged traditional taboos. In addition, educated mothers might have more resources and thus be able to afford protein rich foods. However, when the discussion turned to whether animal-protein foods should be given to children, opinions varied. Some participants said that these kinds of food should be given to children; others said they should not. Some said that they did not give animal-protein food to their children because they could not afford it. This was not a matter of taboo, but rather a matter of choice due to their limited income which restricted consumption. Some young mothers with junior high school education said that they gave all kinds of foods, including animal-protein foods, to their children because they believed these foods were good for children. They said that the foods were bergizi (good nutritionally) and necessary for child growth. For example, Sar, 29 years old, the mother of a four-year-old girl said:

...yes, we should give ati (chicken liver) or iwak utawi daging (fish or meat) to children because they are good for them. But what restricts the caregivers is actually not the food itself, but rather the lack of money that prevents us from buying it. I think nowadays there is no taboo like in the old days. We just fear that if the children get used to eating those kinds of foods they will ask for it and if we cannot provide it they will be upset. Then 'kita ugi ingkang susah' (we too will be upset).

Before Sar had finished talking, Mbah Ko added:
...Is there any mother who will not give good food to her children if she knows that the food is important for child growth? If we are forced to buy it we can afford it but the problem is if we give it today and then we do not have enough money to buy other food tomorrow, *lebih baik memberi sekarang dan seterusnya* (it is better to give it today and forever).

Other participants agreed, saying ‘*ya pancen bener* (yes, that’s right)’. My own observations and interviews supported their interpretation. Lack of income limited their choice of food even though most mothers knew what they should give to their children. However, interviews with some older caregivers found that they did not give certain foods, especially animal-protein foods, to children, because they believed that they might cause stomach problems (*cacingan*, or ‘getting worms’). When asked what kind of food could cause stomach ache, they said *sing amis-amis* (foods with a fishy smell), particularly fish. In addition, they said that egg can also cause *ponyoten* (abscesses) on children’s heads. Mothers also said that children should not eat *nangka* (ripe jackfruit) before rice because the fruit was considered ‘hot’ and causes diarrhoea.

There was a general fear that fried foods would cause problems in children. Fried foods were considered to cause children to cough. In addition, fried chicken should not be given to a child suffering from measles. If a sick child ate fried chicken, it was thought that she or he would get permanent dark spots on the body. *Mbah Set*, an old woman aged about 60 years who looked after her grandson while the child’s mother was in the Middle East, said that she had not given fried food to her grandson when he suffered from *ganjar*, a local term for measles. However, people could not explain the reason for this. Many said that they had followed this practice over the years, learning it from their parents, kin or neighbours. It was also believed that peanuts and eggs should not be given to children with open sores because they could worsen the condition.
Older women with some years of schooling believed that child growth was indicated by gaining weight and the absence of illness. They said that gaining weight is an indicator of health. A healthy child should gain weight but she/he should not be too fat. According to them, a healthy child is neither too thin nor too fat. Older caregivers, particularly the grandmother caregivers, believed that if a child ate a lot (regardless of the nutritional content of the food eaten) she or he would grow fast and gain weight. They also felt that if children were sick their weight would drop. All food was considered healthy and good for child growth as long as it could be eaten by children and did not create stomach upsets. They also thought that foods should maregi (literally, make the stomach become 'full'). Therefore, foods given to children tended to have high carbohydrate and low protein levels. It was common to hear people say that the important thing in feeding children was ‘bocahe wareg, lemu lan sehat’, meaning ‘the child is full (of food), putting on weight and does not suffer any illness’. Some people thought that poor growth was not an indication that the child was ill, but rather that it needed a particular kind of food.

The only restrictions on consuming particular foods were directed toward pregnant or lactating women. Most participants, regardless of their age and education, believed that a pregnant woman should not eat certain fruits: specifically young pineapples or durian. If she did, it would cause miscarriage because these foods were considered to be ‘hot’. They also thought that a pregnant woman should not eat ‘twin’ bananas which dempet (stick together) because if she ate them, she would have Siamese twins. By contrast, the juice of young green coconuts (degan ijo) was considered to be very good for pregnant women because it would wash and clean the foetus. (This belief was also observed by Jaspan (1987: 4) in a study in Bantul near Yogyakarta). A lactating
mother should not eat fatty foods, which were thought to give the baby diarrhoea. If a lactating woman ate food containing coconut cream, it was thought that the child's stomach would be upset. Similarly, if the mother ate peppery foods, the child would suffer from eye problems such as 'sticky eye'. Some women also believed that lactating women should not have sexual intercourse because the semen would contaminate their breastmilk, a belief also observed by Hull (1976: 5) in Ngaglik, Yogyakarta.

8.2 Child-feeding practices

This section examines practices associated with child-feeding. The discussion covers breastfeeding, the use of supplementary foods and the availability of food within the family. The discussion of child-feeding practices is based only on information gathered from in-depth interviews, focus group discussions and personal observation. I did not observe intensively feeding practices in particular households over an extended period.

8.2.1. Breastfeeding practices

Most mothers in the study area breastfed their children. During the first month of quantitative data collection around 50 per cent of the mothers of children aged up to 24 months were still breastfeeding their children. The percentage dropped to 40 per cent for the last round of data collection, probably because some children were weaned as they grew older and the study did not enrol a replacement group of younger children.

The duration of breastfeeding varied and was largely a matter of individual preference. It seemed that age and education did not influence the duration of breastfeeding. Most mothers breastfed until their babies were 24 months old. Some breastfed until their children were three years old. Some mothers breastfed for a shorter
time because they said that the breastmilk did not flow freely and the child kept crying. They thought that the children were crying because they were still hungry, and assumed that breastfeeding alone was not enough for the child. A thirty-year-old mother, Bu Is, breastfed her daughter Is for almost three years. Bu Is told me that she had tried to wean Is, when the child reached two years of age, by applying turmeric ointment to her breast. She thought that this would discourage Is from suckling. In fact, Is cried the whole day and did not want to eat anything. Bu Is tried another method. She sent Is to her mother’s house and left her there for several nights. Again, this method failed. Some children were breastfed for less than one year. This was particularly the case for mothers who became pregnant again while they were still breastfeeding. In other cases it was because the mothers intended to work, such as those who intended to go to the Middle East to work as contract workers. As women took on new tasks associated with their decision to work in the Middle East, they decided to cease breastfeeding.

Some children were breastfed until they were three years of age. This particularly happened to children who were reported to fall ill after attempts to wean them. In such cases, mothers breastfed their children again because they could not stand to see them suffer because of weaning. One example of this involved a three-year-old child, Nur, who had been weaned at the age of 20 months because her mother went to the Middle East to work for two years. The child, who was cared for by her grandmother, became sick after the mother left. The grandmother told me that she gave her dried-up breast to Nur until she reached three years of age. In one other instance, an adopted infant whose mother worked in the Middle East was nursed by her adoptive mother. The woman’s youngest biological son was 12 years of age, but at the time she told me that her milk still flowed when her adopted daughter sucked her breast. She reported that she had
breastfed the girl for almost two years while the girl’s mother was working in the Middle East.

The real explanation for children becoming sick after weaning seemed to be not because the child wanted breastmilk again, but rather because of the lack of appropriate supplementary and weaning foods. A contributory factor was the high price of powdered milk by village standards. This was one reason why caregivers gave children other drinks, such as coklat.

As reported in earlier studies (Geertz, 1961; Jay, 1969), Javanese mothers usually offered their breasts to their children on demand. My observation during field work in 1992 confirmed these earlier studies. Young mothers carried their infants with them wherever they went and the infants were breastfed until they were satisfied. Any time a child showed signs of discomfort, the mother would offer her breast. Whenever a child cried, the mother would breastfeed the child to stop its crying. Each feeding seemed to be quite long and mothers allowed their children to suck until they fell asleep. Mothers, who seemed to prefer frequent feeds for their children, gave only one breast, usually the left breast, at feeding. They did not change to empty the other breast. When I asked the reason for this, I was told that feeding at the left breast was convenient for both the mother and the child. While the child fed at the left breast, the mother could continue other activities using her right hand, freeing her to carry out her other duties in the household. Since most mothers carried infants on their left hip, it was easy for them to breastfeed on the left. Another explanation was because of the belief that the left breast contained milk whereas the right breast contained jamu (medicine). Jaspan (1985: 14) also observed that women in her study area (Bantul) always offered their left breast to their children, and that their left breast was more fully developed than the right.
Mothers rarely refused children when they asked for the breast. Particularly for the first three months of their lives, babies were constantly close to their mothers, who offered the breast frequently. Mothers would not leave the children until they seemed to lose interest. For older children, breastfeeding often seemed to be for comfort. I noticed that children often asked for the breast for comfort before falling asleep. Children would suck their mothers' nipple for more than an hour. Mothers appeared to offer their breast continually, day and night.

Although most mothers breastfed their babies, some did not know the advantages of breastfeeding. Some thought that breastfeeding was good for babies but did not know why. Breastmilk was convenient because it was always available whenever their babies needed it. However, many said that they did not give the colostrum to their babies. They explained that the first breastmilk was not good for babies because it looked like water, dirty and yellowish in colour. Similar views have been noted elsewhere in Indonesia (see for example, Hull, 1984: 27). Some older caregivers expressed the view that if mothers gave the first milk, the babies would become ill. They said that they did not know the advantages of colostrum, which contains a large amount of protein, vitamins, and antibodies and is very healthy for the baby. Many mothers in the study area also discarded their breastmilk if they had attended a funeral or wedding. They often discarded some milk before feeding the children in order to open and clean the surface of the breast.

Certain practices, such as drinking jamu, were followed by pregnant as well as lactating women in Java in order to stimulate breastmilk production (Geertz, 1961: 90; Hull, 1979a: 8; Jaspan, 1985: 4). Jamu, usually made from various roots and herbs, can be bought in the market or prepared at home. Nowadays, jamu, including the popular
*jum bersalin* ('herbal medicine for parturition'), are produced by factories such as Nyonya Meneer and Jamu Jago.

Mothers in the study area also drank *jamu* to increase their milk supply. Some made their own *jamu*, some bought the ready-made preparations from the village market. One fairly typical example was Par, 34 years of age, the mother of a five-year-old boy and an 11-month-old girl. Par explained that she had breastfed her first child until the child was two years old. She also intended to breastfeed the second child for at least two years. She said that her breastmilk was sufficient because she usually bought *jamu uyub-uyub* (herbal medicine made particularly for lactating mothers) from the village market. Every month she spent around Rp. 500 on *jamu uyub-uyub*.

As well as drinking *jamu*, drinking large amounts of liquid before or after breastfeeding and eating green leafy vegetables were also mentioned as methods of enhancing milk production. Corn kernels stir-fried without oil (*jagung digoreng tanpa minyak*) were also considered good for women during lactation.

Weaning was usually gradual in order to avoid the children becoming 'startled'. Mothers introduced other foods such as rice or tea with sugar to their children before weaning. When the child was accustomed to foods other than breastmilk, mothers would breastfeed just occasionally until finally withdrawing the breast completely. Mothers would not wean children until they were well established on solid food. Mothers put a bitter substance on their nipples to discourage older children from breastfeeding.

Another way of weaning was to send the child to sleep with someone other than the mother for several nights. In some cases, mothers took their children to the *dukun bayi* (*disuwukke*; to get blessing) to ask for help from the dukun so that the children would not be sick or fussy when they were weaned. In addition, mothers made a small ritual meal
(among-among) on the day of the weaned children’s weton (the day the child was born according to the Javanese calender).

8.2.2 Supplementary feeding

In most parts of Indonesia, supplementary foods are first given to children from the age of two months in the form of biscuits soaked in tea or fruit, either banana, papaya, or orange juice. By the age of six months solid foods, such as rice and side dishes have been introduced, and by the age of one year children are receiving adult foods (Surbakti et al., 1989: 45). Hull (1985) also found that rural Javanese women gave supplementary feedings of mashed banana and rice paste to newborn infants. In some cases mothers gave cooked banana (steamed banana pounded to make it soft); others gave banana mixed with rice or rice porridge with palm sugar. A project on weaning practices conducted in East Java and West Nusa Tenggara by the Directorate of Nutrition, Ministry of Health, in collaboration with Manoff International (1986: 25) found that most children in both provinces regularly received small tastes of rice and banana in their first month of life, and many children in the first week of life.

Such practices were also found in the study area. As well as frequent breastfeeding, infants were given supplementary food at very early ages. Very young infants were introduced to water with palm sugar or raw legen (nectar water). Palm sugar was used mainly because many fathers in the study area worked as palm-sugar makers. Legen was available and accessible and did not cost any money. Children were also accustomed to drinking tea or plain water in which palm sugar had been dissolved.

Although WHO recommends that infants should not be given other foods until they are four to six months old, some new-born infants in the study area were given other
foods on the first day of life. It was common in the study area for young infants to be
given solid food for the first time a few days after the umbilical cord fell off. Some
mothers started giving their infants supplementary foods at five to seven days of age.
They considered that infants should be given other foods as early as possible in order to
ensure that they grew rapidly. If infants cried, although they had already been breastfed,
this was considered a sign that they were still hungry. Many thought that breastfeeding
alone was not sufficient for young children and it was common for mothers to give them
supplementary food to very young children to keep them from crying. Whenever children
cried, the first response would be to offer the breast. If they still cried after breastfeeding,
this was thought to indicate that they were still hungry and needed supplementary food.

In the study area the type of solid food varied, but was usually mashed banana
with rice or in some cases rice with palm sugar. Mothers fed ripe mashed bananas that
were soft and sweet so the infants would like them. The bananas were scraped with
teaspoons and given to the infants once a day, usually at 9 or 10 o’clock in the morning.
Some mothers fed banana to their children three times a day, in the morning, at mid-day
and in the late afternoon.

Some mothers also fed their infants rice porridge. The rice was cooked for a long
time to make it soft. If rice which was eaten by the whole family was used, then the rice
would be pounded. Occasionally, mothers who did not have enough time to make rice
porridge gave their infants rice that had been chewed to make it soft. They appeared not
to be aware of the possible side-effects such as the spread of bacteria. They thought it is
a good method of producing soft rice quickly. Some mothers believed that this method
also bound the relationship between the mothers and children, as found in West Nusa
Tenggara, Indonesia (Rusman, 1991:177). Mothers in the study area seemed do not
realise that the early introduction of solid food to their infants could be detrimental to health.

There were differences in giving supplementary food between the more and less well-to-do families. The less well-to-do families, particularly the poor from migrant families in the study area, tended to introduce adult foods to their children at earlier ages. Introducing an adult menu to young children may have a negative effect on their nutrient intake (Surbakti et al., 1989: 53) because young children are not yet physiologically ready for an adult diet. However, poor families gave adult foods to infants because their limited cash income did not allow them to buy baby food. Preparing one menu for the whole family also saved the mothers' or caregivers' time because household work in the study area was labour intensive. In the absence of electricity and with limited resources most families could not afford to buy refrigerators to store food, which might have saved time in preparing foods. Cooking one menu for the whole family was also considered a way of saving money.

For poor women in the study area, household work was particularly time consuming. Many women, particularly those from Ngombol which is close to the coast, had to fetch water from nearby wells because of the scarcity of water. They used earthenware pots on an open fire for cooking and spent a lot of time collecting wood for fuel. At the time of the field work in 1992, it was not unusual to see women from Purwodadi collecting dried leaves or sugarcane trunks from the beach near Ngombol. This was particularly the case for the women who helped their husbands to make palm sugar. One informant, Par, a 26-year-old mother, told me that if she or her husband could not find enough wood or other material to light their oven to cook *legen*, she usually bought coconut husks. In 1992, the price of 11 coconut husks was Rp. 1,000
(equivalent to 70 Australian cents), enough for one day. While their husbands *deres* (collected *legen* from the coconut trees), the wives cooked the *legen* to make sugar. When the *legen* had been collected, it had to be cooked the same day otherwise it would become *kecut* (spoiled); it could not then be used for making sugar.

Well-to-do families tended to give their young children rice porridge with vegetables, such as spinach and carrot, and meat or chicken liver. If they could not afford it, they would provide vegetable protein such as soy-bean cake (*tahu*) or fermented soy bean (*tempe*). Some better-off families used instant baby foods or infant formula; *susu* SGM (a brand of infant formula) was quite popular. Mbah Ren, an elderly informant (aged over 55 years) who looked after her grandson while her daughter worked in the Middle East reported:

> Many types of infant foods are available nowadays, as long as one can afford it. For example, there are SGM, PROMINA, SUN, NESTUM (brands of baby food products). These were not available in the ‘old times’. Nowadays if we have money we can buy the ready-made foods that we need, it is *gampang* (easy).

After a child of a more well-to-do family reached seven months of age or after the first teeth erupted, he or she would be introduced to the foods usually eaten by adults, except for hot spicy foods. The usual food was rice, which was cooked a bit softer for children, together with vegetables or soup and perhaps meat, fish or *tahu* or *tempe*.

### 8.2.3 Family food availability

Children's nutrition is strongly influenced by parents' ability to provide or purchase food and thus their socio-cultural and economic situation. Rice and some kinds of fruit and vegetables were produced in the study area. Oil and meat had to be
purchased. Meat was highly prized and purchased to add to special meals, especially for ritual meals.

Rice was the preferred staple food for all families in the study area. The soil is fairly fertile, and villagers were able to grow rice on their land. Some was grown for own consumption, and any surplus was sold for additional income. People in Purwedadi depended on their land, which was fairly fertile. They were able to grow two crops of rice per year. In addition, they were able to plant vegetables next to the paths in their rice fields.

Rice was usually served with vegetables, while tempe or tahu were the most popular sources of protein. By contrast, home-grown young jackfruit was a common food for villagers in Ngombol who lived in the coastal area. Children from this village sometimes ate fish which were caught by their parents. Children in Purwedadi ate more green leafy vegetables than those in Ngombol, mainly because their parents grew the vegetables in their gardens. The condition of the soil in Purwedadi enabled the villagers to grow green leafy vegetables and a variety of other crops. Bananas were also grown in the study area, and were usually eaten when they were ripe. Coconuts were abundant and many villagers used them in side dishes. In both villages, protein-rich foods were not eaten regularly by many children from the poorest families. Protein-rich foods had to be purchased and were expensive by village standards.

The availability of cash influences the provision of food in the household. The poor in the study area, who mostly worked as agricultural labourers for low wages, had limited resources to buy food and daily necessities. Therefore they tended to eat only those foods that they could produce in their households. Their limited cash was usually spent on rice, sugar, and tea, which were regarded as necessities, and kerosene for
lighting, rather than on protein-rich food which was relatively expensive and regarded as a luxury. The availability of protein foods was further limited whenever the price of food increased due to limited stocks or increased demand. For example, the price of meat or poultry usually increased before Idul Fitri (a celebration at the end of the Moslem fasting month). Even though the price of meat or poultry increased before Idul Fitri, people tried to eat better food at this special event as this happens only once in a year.

People’s food habits are influenced by both their capacity to buy food and its availability. Some well-to-do families were able to buy necessary supplies with cash. Ready-made or tinned food could be bought from nearby stores. However, the limited range of foodstuffs available in the market restricted their pattern of consumption. Their access to more nutritious foods was limited because the range of foods that were sold in the markets was small and did not vary. The markets only opened three days a week, and I noticed that the food being sold was always the same. On market days, there were four tempe and tahu stalls, five stalls selling vegetables, one stall selling fish, two fruit stalls and only one meat stall in the market. The meat seller bought the meat from the town market in Purworejo and therefore only sold a small amount. On one occasion, I wanted to buy beef liver in the market but it was not available.

Some villagers kept small numbers of cattle, goats, and chickens in their house compounds. Some kept the livestock for eggs and meat. Others said that they kept the livestock in case they needed immediate cash or for jaga-jaga (literally ‘in case something happens’). They needed cash particularly when family members were sick. Apart from this, they also needed cash for kelumrah (to contribute if relatives or neighbours had feasts or in the case of the death of a family member). Although eggs are a potential source of protein for children, people in the study area often sold eggs from
their poultry in order to buy other cheaper (and less nutritious) products such as tempe or rice crackers.

In some families, children were given animal protein such as meat, fish, and eggs only on special occasions, such as family feasts, Idul Fitri or a village headman selection (pemilihan lurah). Whenever there was an election for the village headman, I was told that animal protein was sure to be available. The election of the lurah was a very important event when candidates usually distributed money to villagers in order to encourage their support. The members of the Project team who had been in the field during an election confirmed that the consumption of protein was high during the lead-up to the election for the village headman. A food consumption survey conducted in the area at this time also showed a change in consumption pattern\(^1\). Overall, however, the survey indicated that the availability of cash income was the main influence on consumption patterns, especially for the less well-to-do families in the study area.

Food-exchange practices among the villagers to some extent increased the amount and variety of food available to individual families. During field work I noticed that whenever families cooked a large amount of a particular food, or if they held family rituals (selametan), they usually gave some of the food to relatives or neighbours.

A study in the South Pacific (Marshall, 1985) found that the pattern of infant feeding was also influenced by whether vegetables were grown in the households. This appeared to be true in some cases in the study area. However, sometimes the vegetables that grew in their yards were not eaten at home but were sold. Villagers grew fruit and vegetables that were needed by their children, such as papayas, bananas, snake beans and other kinds of green vegetables. However, they often had to sell them to get cash.

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\(^1\) Personal interview with a team member of a survey on Diet and Vitamin A among children of under five years of age in Purworejo (the 1992 Dietvita Survey).
Sometimes, people sold unripened fruit at a lower prices than they would have received if they had waited for it to ripen. Their need for cash was so great that they could not wait. Some children in the study area, particularly those who lived in the coastal area, benefited from having parents who worked as fishermen, because they could have fish in their diet. However, some of the children of fishermen did not eat fish because their fathers sold the fish in order to get cash to meet other basic needs. Children from more well-to-do families had a better diet because their parents were able to buy powdered milk and animal protein.

8.2.4 Post-weaning feeding practices

The practice of feeding children after weaning varied with income. Children from the more well-to-do families appeared to be at a relative advantage because their families could provide nutritious foods. Those from less well-to-do families had to be satisfied with what their families could offer. The children of poor migrant mothers were relatively disadvantaged because their mothers were away and their older caregivers often had different ideas about weaning foods and infant feeding.

Children in the study area ate whenever they wished or when they were hungry. Villagers would say ‘If children are hungry, they will come to ask for food’. When children asked for food, parents gave it to them, but if children did not ask for food, parents simply assumed that they were not hungry. Mothers would not give their children food unless the children wanted it or were willing to eat. Children were not expected to eat in any particular place. It was not common for a family to have meals together at the dining table. Mothers often fed children while they were standing or walking around and talking outside the home. The children were allowed to eat wherever they wanted as long
as it was not dangerous and they did not spill the food. It seemed that there were few rules about eating that children should follow. However, parents would rebuke children if they were noisy when they were eating (*kecap*).

It was also not customary for children in the study area to eat at the same time as other family members. Even the parents themselves seldom ate together. Rural Javanese have no custom of eating together among the members of the family. Each member of the family eats whenever he/she feels like it (Geertz, 1961; Koentjaraningrat, 1985; Jaspan, 1985: 16). Koentjaraningrat described the pattern of feeding among the rural Javanese:

For the greater part of their lives, Javanese peasants eat in an informal and irregular way, and whenever they feel like it. Food is available in the kitchen or on the table, at any time of the day any member of the family can come in and eat. There are never regular meal hours where the whole family eat together in a formal way (Koentjaraningrat, 1985: 108).

This description also applies to villagers in the study area.

**How the study area children were fed**

Feeding is an activity that is related to many factors, including physical, psychological and environmental. In Java, children were usually fed without stress or, as Jaspan (1987: 16) described it, ‘without physical or emotional strain on either mother or the child’. Studies have noted that the encouragement of those who feed children is important in determining how much the child eats. Children under five years of age are not able to affect the allocation of household resources directly themselves. Therefore, how they are fed is an important influence on their nutrition and health. Feeding children involves not only a physical but also a psychological relationship between the person
who feeds and the child. Child-feeding also provides opportunities for intense social interaction (Tietjen, 1985: 122).

In Purwodadi and Ngombok, food was usually prepared by mothers once or twice a day, depending on the availability of food. Early in the morning mothers, sometimes with the help of their daughters, cooked for the whole family. An older child in the family could help with minding the younger ones and could do some of the domestic work. Foodstuffs were bought the day before or on the same day from peddlers or the village store. In some cases, foodstuffs such as vegetables were simply picked from the garden. Several mothers cooked vegetable dishes in large quantities that could be eaten over more than one day. On the following day they just cooked rice and reheated the leftover dish. Children were often fed immediately after the food was prepared. Mothers usually served rice in the morning and at every adult meal time, afternoon or evening. When food was plentiful, it was left in the cupboard where any child could find it.

Mothers were mainly responsible for feeding children. In the case of very young children, mothers or other caregivers would sit and feed the children. If the children did not cooperate when they were being fed, they would carry them in a sling (gendong) and feed them ‘on the move’. Except for liquids and semi-solid porridges, I often saw women feeding children without using feeding utensils such as spoons and forks.

If children did not want to eat, both mothers and other caregivers appeared not to pay much attention. They mainly reacted by reducing the quantity of food given to the children. As Hull (1979b: 321) also found in her study, rural people were less likely than urban parents to seek advice on matters such as infant feeding and other aspects of childcare from modern medical practitioners. Rural people tended to depend on experience
and knowledge obtained from kin or close neighbours. Many mothers relied on the knowledge of older women in the community.

Infants were usually fed three times a day. However, as the children grew older, the frequency of feeding depended on whether they asked for food. I observed that children asked for food when they were hungry rather than their parents asking them to eat at an adult meal time. Whenever I asked parents why they did not give any food to their children at an adult meal time, they usually replied that the children would come for food when they were hungry, so why should the parents worry? I also noticed that many children wandered freely among their relatives and might go to any of them to ask for food. If a child was unwilling to eat, parents tended not to insist on them eating. If the child did not finish its food, the caregiver would eat it or simply throw it away.

Children usually ate anywhere they liked. The person feeding the children usually brought the food to the children and followed them wherever they went. This was particularly the case for toddlers. They were fed while they were playing with their friends or running around. I often saw mothers or other caregivers take a plate of food and follow their children around. Adults seemed to prefer standing or walking to sitting when they were feeding children. Sometimes, they would stand together in shady places talking to each other while they fed the children. The children would ask for a small quantity of food, run away and play, then return to ask for more food. Older children usually ate alone without adult supervision.

*When children were fed*

The times when children were fed varied. Young children who were still breastfed were fed on demand. Mothers breastfed in public. Some children ate their
breakfast early in the morning immediately after getting up; others had their breakfast at mid-morning. Many parents cooked and prepared meals for their children before they went to work in the fields but sometimes the children prepared food for themselves. When both parents were working in the fields, children were often left alone and sometimes did not eat lunch simply because they were busy playing with their friends, or because their parents were not there to give them food. When children played intently they often missed meals. In the late afternoon when their parents returned home, they were fed.

**The foods children ate**

Childhood is an important period for growth and development. Nutrition is a vital need to ensure the survival and healthy development of the child and future adult (Surbakti et al., 1989: 45). Children require considerable attention from parents to ensure that they get nutritious foods. They need breastmilk and other suitable foods. Children of weaning age in particular need appropriate supplementary and weaning foods. Protein is very important during infancy. Unfortunately, not all infants and children are adequately nourished because of the socio-cultural and economic conditions of their parents:

Young children, who require a relatively expensive high protein diet, are especially vulnerable in times of hardship when there is little money to purchase food (Adedoyin and Watts, 1989: 1333-1345).

The importance of proper infant and child nutrition has become a matter of concern to the Government of Indonesia. As early as 1972, a popular message concerning child nutrition, *empat sehat lima sempurna* (literally meaning four are healthy (eg. staple foods, protein foods, vegetables and fruits) and five are perfect (eg.
milk), was delivered through *posyandu* (health service posts). Posters describing the advantages of *empat sehat lima sempurna* adorned the walls of every *posyandu*.

Some mothers and other caregivers in the study area were familiar with the message of *empat sehat lima sempurna*. However, some poor families could not afford to follow the message. With regard to child nutrition there was a discrepancy in the study area between what people said they did and what they actually did. People knew the importance of nutrition for children and said that they gave nutritious food to their children. However, in reality, children were not given nutritious foods because of the lack of income or because of a particular belief about food. For example, some mothers did not give meat, eggs, fish and milk to their children because they could not afford these foods. Others did not give their children fish and eggs because they believed that these foods were bad-smelling and not good for children. For example:

Mbah Jum, a woman of around 60 years of age, explained that her grandson, Ger, whom she was looking after, was hospitalised for a week after eating fish. She had to pay the cost of around Rp.150,000 for treatment. For that reason, she had never given any fish again to her grandson.

The kind of food the children ate depended on their age, the time of day and the season. In Purwodadi and Ngombol, young infants were given ripe banana, rice with palm sugar or rice porridge in addition to breastmilk. The older children’s diet was the same as that of adult family members, and their food was prepared in the same ways as for the adults. Interviews suggested that some parents did not want to waste their time or money on preparing food that children might not like. I observed that some children ate rice with dried fish despite beliefs about the bad effects of fish on children. When I asked their caregivers why they gave dried-salty fish to the children every day, even
though the children had skin problems, I was told that dried fish was preferable as the main dish for some children. (In the study area, people hold a belief that eating fish would cause scabies). Dried fish was quite cheap and *nglawuhi* (tasty and does not need other accompaniments). It was easy to prepare and available in the village store or from women peddling foodstuffs from the market.

The daily meals for children did not vary much. Some mothers seemed to be afraid of introducing new foods into their children’s diet because they were concerned that the unfamiliar foods would cause diarrhoea or stomach upsets. It was believed that each serving should include rice. The daily meal began with rice and the leftover meals from the previous day. People simply reheated the leftover food to retard spoilage. Those who grew their own vegetables cooked daily or cooked larger quantities so the food could be eaten for several days. The mid-day meals depended on the availability of food and also on the activity of the mother. If the mother had time to prepare, she would cook before going to work; if she did not, the leftover food would be served again. The main meal of most of the people in the study area was quite simple, mainly rice served with vegetables and meat for those who could afford it, or *tempe* for those who could not. In the evening, the mother would serve rice again because rice was the most important food. If people were asked whether they had eaten and they had not had rice they would say ‘no’, even though they ate snacks throughout the day.

Snacking was common for children in the study area. Older children were observed to frequently snack at any time of the day. Some children were observed to snack frequently during the day instead of having two or three big meals. During field work, some mothers told me that their children spent at least Rp. 300 a day on buying snacks from food vendors. I noticed that *es* (a mixture of unboiled water, strong food
coloring and saccharine), *dawet* (a drink made from coconut milk and palm sugar), lollies, sweets, noodles, crackers, and chips were among the foods the children liked. I often heard caregivers say to children who cried: ‘*Cup meneng ngko tak pundhutke es*’ (‘Stop crying! I will buy a *es* for you’). The children usually stopped crying after the promise. One 3-year-old girl often asked her grandmother to buy a lolly when she heard the *toet-toet* sound of the horn pressed by a lolly vendor passing through the village.

Observation suggested that the quantity and variety of foods eaten by children were affected by their families’ economic conditions. *Pindang* (salty fish) was a favourite *lauk* (stew) for some families. *Pindang* was quite cheap; in 1992, three *pindang* cost only Rp. 200. Because of its strong taste (*gurih, nglawuhi*), a small amount of *pindang* was enough for the whole family. Pak Tri, a 35-year-old man and father of three children, said that his children liked eating *kering-keringan* (literally ‘dried things’). This meant that the children ate rice and *lauk*, either meat, poultry, fish or *tempe tahu* without a vegetable dish.

However, asking people about what kind of food they ate was sometimes misleading. For example, there was a tendency for rural people to lower their status by saying that they ate just with *uyah* (salt). Generally this did not mean that they ate rice with salt only (even though some people might have done so). This was because they did not want to show off (*pamer*) to other people what they actually ate. During my field work, I visited Yuli, a three-year-old boy who was looked after by his grandmother. At that time, Yuli was having lunch in the kitchen. When I asked Yuli’s grandmother what she gave to Yuli for his lunch, she simply answered that Yuli was eating rice with only salt. In fact, when I had a close look, Yuli was eating rice served with tofu and a vegetable dish.
**Who fed children**

Mothers usually prepared the foods eaten in the household and mothers also fed young children. However, in some cases mothers could not prepare food or feed their children because they had to work. Among the poorest households, women’s participation in work outside the home was often a matter of economic survival. Children in these households depended on other caregivers to feed them.

Working mothers usually prepared food for their children and left the actual feeding to another person such as an older daughter or grandmother. Other female adults in the house also often helped the working mother to prepare food for her children. However, it was also common for children aged around five years old to eat alone without adult supervision. One common reason for this was that the mother or substitute caregiver was too busy doing household chores. Sometimes it occurred because there was no other female available to substitute for the absent mother. In the absence of the mother or another female adult, young daughters, some as young as four years old, were expected to assist their mothers to feed younger siblings. In such cases, the mother usually prepared the food before she went to work. However, young children who fed their younger siblings were sometimes unable to feed a toddler appropriately:

Wati, an eight-year-old girl was asked by her mother to feed her younger brother, Sapto, a three-year-old boy with a plate of rice and a piece of *pindang* (salty fish). Wati asked Sapto to go with her. She wanted to feed her brother and watch her friends skipping. Wati did not bring a spoon to feed him but used her hand instead. After some mouthfuls, she also ate the rice. She then left her brother to join her friends playing and left the rice.

The skill of the person giving the food is important, especially for very young children. I noticed in Ngombol and Purwodadi that it was common for older children to
feed younger siblings using their fingers. While waiting for the child to finish or chew its food, the older children sometimes played with their playmates. After a while they returned to feed the younger siblings again without washing their hands.

Younger children were more dependent on the mother or mother substitute than older children. Keilman and McCord (1978 cited in Jus'at, 1991: 13) suggested that:

...the risk of death for a given nutritional status decreases with a child's age as he or she moves beyond this critical transition period. These factors, plus the child's complete dependence on the mother, make very young children particularly sensitive to the proper choice and efficient use of nutrition and health inputs.

Grandmothers as substitute caregivers in migrant mothers' families also played an important role in food preparation and feeding of children who were left behind. My own observations in the study area were that some grandmothers, who were substitute caregivers, made an effort to stimulate the children's appetite when they did not want to eat by giving them *jamu cekok* (medicine which is forcibly given to the children) made from *tempe bosok* (old fermented soy bean), *temu ireng* and young paw-paw leaves. The *jamu cekok* can be bought from the village market. One Purwodadi villager, Mbah Di, was upset when Ren, a three-year-old boy in her care did not want to eat for several days after his mother left for the Middle East. Mbah Di tried to cook foods that the child usually liked. When Ren still refused to eat, she then bought a package of *jamu cekok* from the village market. Mbah Di believed that after having the *jamu cekok* Ren would eat a lot.

An attentive person can ensure that children are adequately fed in terms of the quality and quantity of food. Perseverance on the part of the person feeding the child seems to be important to good eating habits. This is because the person feeding the child needs to encourage the children so that they will consume enough food. It was common
in the study area for children not to chew and swallow food but to keep it in their mouths for a long time, refusing to swallow (*diemu*). If the people feeding the children were not patient and threw away the food before it was finished, it is possible that the children did not eat enough.

### 8.3 Nutritional status of children

This section discusses the nutritional status of migrants’ and non-migrants’ children which is considered to be the outcome of, among other things, child-feeding practices. Child-feeding, an important part of childcare behaviour, affects children's anthropometric outcomes. Anthropometric measurement has frequently been used to determine the adequacy of infant nutrition and is a useful tool for assessing the nutritional status of children (*Paediatrics*, 1984: 729; WHO Working Group, 1986: 1). Weight, height, and arm circumference of individual children are commonly used for anthropometric measurements. These data are interpreted in relation to the age and sex of the children. Age is important because the causes of growth failure are generally age specific and the required intervention often depends on age (Beaton et al., 1990: 5; United Nations, 1990: 15).

Each child in the study was weighed, and recumbent length was measured for children under 18 months or standing height for children beyond 18 months of age. The weight of each child was measured every month, but height or length were measured once every two months. As explained in Chapter 4, the 1992/1993 *Survei Ibu* was a longitudinal study over a six-month period which yielded five rounds of anthropometric data, including five data sets on child weight and three data sets on child height. Both weight and height of the children were collected in the first round of anthropometric data.
collection. These anthropometric data then were related to age and to reference standards to obtain standard deviations below the reference median (Z-score values). The reference standard selected was the WHO/National Centre for Health Statistics/Center for Disease Control (WHO/NCHS/CDC) standard, which is recommended by WHO (WHO Working Group, 1986: 937; Waterlow, 1977: 490). Based on American children, this reference standard allows for normal variation at any age and the evaluation of child growth attainment.

The study uses less than or equal to minus two standard deviations (2 SDs) below the reference median as the cut-off point. Children with a Z-score value less than or equal to minus 2 SDs are considered to be malnourished (Dibley et al., 1987: 736). The cut-off point of minus 2 SDs below the reference median is widely used to identify cases for intervention or to assess the prevalence of poor growth attainment in developing countries (McMurray, forthcoming: 5). Of the five months' continuous records of anthropometry, only the last month has been analysed. This last record is assumed to reflect childcare practices during the six-month period of the study.

8.3.1 Child age

This section analyses the distribution of children according to their age group, sex, and the migration status of their mothers. At the beginning of the study, around 278 children aged 6-48 months were in the study sample; 54 per cent of whom were boys. Around 15 per cent (41) of the children were from families where the mothers were migrants working in the Middle East as contract workers for at least two years. However, some cases were lost from the study due to incomplete information on weight and
height. This occurred mainly because children were afraid to be measured. Since the age of children in the sample increased during the six-months’ study period, the number of children in each age group was not constant over time. Some children aged six months were enrolled to replace those who were dropped during the study. As the analysis uses only the anthropometric measurements collected during the last month, the youngest child is aged 9 months (see section 4.1.1).

Table 8.1: Children by age, sex and migration status of mother, Purworejo, 1992/1993 (Percentage)

<table>
<thead>
<tr>
<th>Age group (in months)</th>
<th>Boys</th>
<th></th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Migrants</td>
<td>N</td>
<td>Non-migrants</td>
<td>N</td>
<td>Migrants</td>
<td>N</td>
<td>Non-migrants</td>
</tr>
<tr>
<td>6 - 11</td>
<td>5</td>
<td>1</td>
<td>11</td>
<td>14</td>
<td>0</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>12 - 23</td>
<td>14</td>
<td>3</td>
<td>44</td>
<td>55</td>
<td>16</td>
<td>3</td>
<td>41</td>
</tr>
<tr>
<td>24 &amp; older</td>
<td>81</td>
<td>18</td>
<td>45</td>
<td>56</td>
<td>84</td>
<td>16</td>
<td>48</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>22</td>
<td>100</td>
<td>125</td>
<td>100</td>
<td>19</td>
<td>100</td>
</tr>
</tbody>
</table>


As can be seen from Table 8.1, 17 per cent of the 41 children of migrant mothers (seven children), were under 24 months of age. The highest percentage of children of migrant mothers was in the age group 24 months and older (83 per cent), whereas for non-migrant mothers the highest percentage was at ages below 24 months (54 per cent). Children of migrant mothers of both sexes were older than those of non-migrant mothers. There is little difference in the sex composition of children of migrants and non-migrants or in the overall study population.

Some children of migrant mothers were less than 12 months of age when their mothers left for the Middle East. Two children were left when they were only four
months old. The nutritional consequences of this can be seen in the case of An, a 2-year-old boy who was small and thin for his age. Bu Rib, aged 30 years, who was a relative of An, told me that An’s mother left him to go to the Middle East when he was seven months old, just a few days after he was weaned. An did not want to eat and kept crying for milk. Since the family could not meet his needs they simply fed An whatever they had and gave him plain water or tea to drink. Some people nearby seemed to blame the boy’s mother for leaving him when he was so young. One woman frequently said to me: ‘Look, that boy is very thin *ngeniyit!*’ (a term used to describe a child who is really thin). When I met the boy I saw that in fact he was very small and thin, and his head seemed larger than it should be for a child of that age.

8.3.2 Child growth

This section discusses the weight and height of the children relative to their age.

The weight of each child in the study sample was measured using a Salter portable baby scale which has a zero adjustment knob. The scale was always set to zero before weighing a child. This scale can weigh up to 25 kg with 100 gram increments. Zeroing and checking of the scale were carried out periodically by an expert to ensure its accuracy. To ensure the accuracy of the measurement, the anthropometric team, with support from the child’s caregiver, usually calmed the child to make sure that she/he was relaxed and did not hold anything while being weighed. This allowed the team to read the scale accurately.

The height or length of each child in the study sample was measured every two months during the six-month period of the study. Recumbent length of children less than 24 months of age, was measured using a wooden board. Children were laid down against
the board and their knees pressed firmly in order to obtain an accurate measurement. For older children, the usual measurement was standing height. It was not always easy to measure the height or recumbent length of the children. Several children were so frightened that their height or length could not be measured during the study.

Two years before this study was conducted, the Clinical Epidemiology and Biostatistics Units, Gadjah Mada University, conducted a longitudinal study (the Morvita study) on vitamin A and child morbidity in this study area. With the approval of the parents the Morvita study took blood samples from the children in the study. As mentioned in Chapter 4 some children were afraid to have their blood taken. As well as the fear of needles, there was a rumour that the blood taken from the children would be sold for the benefit of the Morvita study. This discouraged some parents from participating. In addition, I witnessed some children being told by their parents that if they did not behave well, the Morvita researchers would suntik (inject) them. Whenever the Anthropometry Team of this study (most of whom were also involved in the Morvita study) came to the villages with the wooden board to measure the children’s height, some children ran away frightened. Despite this, because of the friendly approach of the Team and their close relationship with people in the study area, the heights of around 77 per cent of 278 children were measured in the last round of the anthropometry data collection. The remaining 23 per cent could not be measured because the children refused (88 per cent), the parents did not agree (7 per cent), or for other reasons (5 per cent).

As previously explained, some children did not get anthropometric measurement for various reasons. For most children whose weight was measured, height could also be measured. However, some children were frightened to have their heights measured.
Table 8.2 shows the number of children who had complete information on the anthropometric measurement.

A value for weight alone has no meaning unless it is related to age or height (WHO Working group, 1986: 2). Therefore, it needs a combinations of measurements which are usually called indices. The indices that are used commonly for children are weight-for-age (WFA), height-for-age (HFA) and weight-for-height (WFH).

Table 8.2: Number of children measured at the first and last round of anthropometric data collection according to characteristics, Purworejo 1992/1993

<table>
<thead>
<tr>
<th>Age group</th>
<th>Both measurement</th>
<th>Weight only</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First</td>
<td>Last</td>
<td>First</td>
</tr>
<tr>
<td>6 - 11 months</td>
<td>59</td>
<td>59</td>
<td>59</td>
</tr>
<tr>
<td>12 - 23 months</td>
<td>88</td>
<td>61</td>
<td>89</td>
</tr>
<tr>
<td>24 months and older</td>
<td>100</td>
<td>81</td>
<td>103</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>133</td>
<td>112</td>
<td>134</td>
<td>121</td>
<td>15</td>
<td>26</td>
</tr>
<tr>
<td>Girls</td>
<td>114</td>
<td>89</td>
<td>117</td>
<td>112</td>
<td>12</td>
<td>29</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother’s migration status</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Migrant</td>
<td>35</td>
<td>27</td>
<td>35</td>
<td>28</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Non-migrant</td>
<td>212</td>
<td>174</td>
<td>216</td>
<td>195</td>
<td>17</td>
<td>42</td>
</tr>
</tbody>
</table>


Note: First refers to the first round of anthropometric data collection (the beginning of the study).

Last refers to the last round of anthropometric data collection (the last stage of the study).

Migrants’ and non-migrants’ children in the study sample were compared with respect to mean weight and mean height relative to age. The weight-for-age (WFA) or height-for-age (HFA) of children means that actual weight/height is compared to the reference weight/height for his/her age (Jus’at, 1991: 28). Conventional anthropometric indicators of nutritional status such as WFA, HFA and WFH were used to identify the prevalence of underweight and stunted children in the study sample. The WHO/NCHS/CDC reference is based on well-nourished American children. In this
analysis, therefore, a child’s weight and height are expressed as standard deviations from the mean for children of the same sex and age in an American reference population (Desai, 1991: 4). Poor economic conditions as well as repeated infections and inadequate nutrient intake are the cause of stunting, which is a slowing in skeletal growth (WHO Working Group, 1986: 3). The nutritional status indices of weight in relation to height or length reflect current under or over-nutrition (Beaton et al., 1990: 7).

The growth attainment of a particular child can be expressed in three ways: as centiles of reference distribution, as percentages of the reference median and as SDs, which are also known as Z-scores, from the reference median (McMurray, forthcoming: 4). Among the three indices, Z-scores are the most widely used (Dibley, 1987) because they can be used for both weight and height (WHO Working Group, 1986: 6).

The choice of cut-off point is an option. It should be chosen at the point most appropriate to suit the particular purposes or conditions. For instance, in an emergency situation where resources are restricted the cut-off point can be adjusted to identify the children in most need. However, for most group or population comparisons, where uniformity is important, the standard statistical cut-off points of ± 2SD from the mean have become widely used (WHO Working Group, 1986: 7).

The mean values of WFA of the children in the study sample, are substantially below the reference population (Table 8.3). Children in all age groups had values of mean WFA below those of the reference population, even in the youngest age group (6 - 11 months) where the mean values of WFA were more than 1 SD below the reference median. Migrants’ children had lower Z-scores than those of non-migrants’ children in all age groups except for girls of migrant mothers at ages 12 months and over. Most disadvantaged were sons of migrants in the age group 12-23 months. The difference is
greatest in the age group 12 - 23 months. Beyond 12 months of age, mean values of WFA of migrants’ girls were slightly higher than those of non-migrants’ children but this could reflect their slightly higher mean age, as mean WFA tends to improve as children approach age 5 years.

Z-score values of less than or equal to minus 2 SDs below the reference median were used for categorising the population. If the mean Z-score is <-2 then the population is categorised as very severely malnourished. Table 8.3 shows that, on average, children in the study sample had mean values of WFA below the standard; that is, the children were smaller than their expected weight for age. Children whose weight is very low for their age or below a chosen cut-off point are said to be ‘underweight’.

Table 8.3 : Mean Z-scores for weight-for-age (WFA) and mean age (months) of children aged 6-52 months by sex and migration status of mother, Purworejo, 1992/1993

<table>
<thead>
<tr>
<th>Age in months</th>
<th>WFA</th>
<th>Mean age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Migrants</td>
<td>Non-migrants</td>
</tr>
<tr>
<td>Boys</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 - 11</td>
<td>-1.44</td>
<td>-1.35</td>
</tr>
<tr>
<td>12-23</td>
<td>-2.79</td>
<td>-1.77</td>
</tr>
<tr>
<td>24 &amp; older</td>
<td>-1.73</td>
<td>-1.64</td>
</tr>
<tr>
<td>Girls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 - 11</td>
<td>-1.76</td>
<td>-1.29</td>
</tr>
<tr>
<td>12-23</td>
<td>-1.24</td>
<td>-1.59</td>
</tr>
<tr>
<td>24 &amp; older</td>
<td>-1.44</td>
<td>-1.53</td>
</tr>
</tbody>
</table>

Note : ^1 Non-migrant’s children are used as the reference group.

Studies have suggested that a large proportion of variation in body size seems to be predicted by socioeconomic factors related to the availability of food and health care, while factors such as genetic potential, environmental circumstances, and individual
variation affect growth (Martorell and Habicht, 1986 and Pelletier, 1991 cited in Desai, 1991: 13). On average, children who receive inadequate nutrition and suffer from repeated acute infectious diseases are likely to be shorter and lighter than their peers at the same age.

Table 8.4: Mean Z-scores for weight-for-age (WFA) among children aged 6-52 months according to their mother’s migration status and selected characteristics, Purworejo, 1992/1993

<table>
<thead>
<tr>
<th></th>
<th>Migrants</th>
<th>Non-migrants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Caregiver</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>-1.42</td>
<td>-1.57</td>
</tr>
<tr>
<td>Grandparent</td>
<td>-1.78</td>
<td>-1.34</td>
</tr>
<tr>
<td>Siblings</td>
<td>-</td>
<td>-1.61</td>
</tr>
<tr>
<td>Others</td>
<td>-1.67</td>
<td>-1.81</td>
</tr>
<tr>
<td><strong>Father’s education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below secondary</td>
<td>-1.97</td>
<td>-1.58</td>
</tr>
<tr>
<td>Secondary</td>
<td>-1.43</td>
<td>-1.52</td>
</tr>
<tr>
<td><strong>Mother’s education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below secondary</td>
<td>-1.65</td>
<td>-1.61</td>
</tr>
<tr>
<td>Secondary</td>
<td>-1.67</td>
<td>-1.43</td>
</tr>
<tr>
<td><strong>Father’s occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farmer</td>
<td>-1.78</td>
<td>-1.64</td>
</tr>
<tr>
<td>Others</td>
<td>-1.49</td>
<td>-1.48</td>
</tr>
<tr>
<td><strong>Number of children in the household</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>-1.69</td>
<td>-1.48</td>
</tr>
<tr>
<td>3 and more</td>
<td>-1.61</td>
<td>-1.68</td>
</tr>
<tr>
<td><strong>Number of adults in the household</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>-1.62</td>
<td>-1.63</td>
</tr>
<tr>
<td>3 and more</td>
<td>-1.69</td>
<td>-1.50</td>
</tr>
</tbody>
</table>


Children of migrants who were cared for by grandparents had a lower value of WFA compared to those of non-migrants. Similarly, migrants’ children whose fathers
have low educational levels (below secondary) and also who worked as farmers also had a lower WFA. (see Table 8.4).

In addition to the average values of the nutritional indices, the percentage of children categorised as malnourished by selected variables is also presented. Table 8.5 presents information on the proportion of low WFA among children between aged 6 and 52 months belonging to migrant and non-migrant mothers at the survey date in 1992/1993, classified according to selected characteristics of the children. As previously explained, the study uses more than two standard deviations (2 SDs) below the median as the cut-off point to identify children with low weight-for-age.

Another way of analysing the weight of children related to their age is the prevalence of low WFA. Table 8.5 shows that, overall, there is little difference in the prevalence of low WFA. The most marked difference in the proportion of children having low WFA is for children in the age group 12 - 23 months, where the proportion is higher among children of migrants than non-migrants. One possible explanation was that these children were at the weaning age. In addition, some children were left by their mothers to work in the Middle East at this age.

Table 8.5 also shows that overall, seven out of 28 children of migrants have low weight-for-age (25 per cent) compared with 59 out of 195 children of non-migrants (30 per cent). Five sons (36 per cent) of migrant mothers were underweight. Girls seem to be relatively advantaged with only two of them underweight. This might be because in the study area girls were less active in play compared to boys. In addition, older girls were more likely to help their mothers or substitute for the mothers in preparing food for their families so they were likely to be given titbits by their mothers.
Table 8.5: Prevalence of low WFA among children aged 6-52 months according to their mother's migration status, sex and age of the child, Purworejo, 1992/1993 (Percentage)

<table>
<thead>
<tr>
<th>Sex of child</th>
<th>Migrants</th>
<th>N</th>
<th>Non-migrants</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>36</td>
<td>14</td>
<td>35</td>
<td>107</td>
</tr>
<tr>
<td>Girls</td>
<td>14</td>
<td>14</td>
<td>24</td>
<td>88</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age of child in months</th>
<th>Migrants</th>
<th>N</th>
<th>Non-migrants</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 - 11 months</td>
<td>25</td>
<td>4</td>
<td>27</td>
<td>59</td>
</tr>
<tr>
<td>12 - 23 months</td>
<td>67</td>
<td>3</td>
<td>31</td>
<td>67</td>
</tr>
<tr>
<td>24 &amp; older</td>
<td>19</td>
<td>21</td>
<td>30</td>
<td>69</td>
</tr>
<tr>
<td>Overall sample</td>
<td>25</td>
<td>28</td>
<td>30</td>
<td>195</td>
</tr>
</tbody>
</table>


Note: Low weight-for-age represents children whose Z-scores of weight-for-age fall below minus 2 SDs.

Four children of migrant mothers aged 24 months and older were underweight. The proportion (19 per cent) is lower than for children of non-migrant mothers (30 per cent) at the same age. Most of the migrants' children who were classified as underweight had fathers who had not attended secondary school and who worked in the non-agricultural sector.

With the cut-off points of less than or equal to minus 2 SDs used in this study, Table 8.5 shows that the proportion of low weight for age is higher among daughters of non-migrants than those of migrants. In terms of the age group, a higher proportion of migrants' children had low weight for age at ages 12 - 23 months. One plausible explanation is that this is the age when they were left by their mothers to work overseas. In addition, this is the age at which weaning occurs, and some children were disadvantaged in nutrition due to the limited family food supply and limited quantity of high quality supplementary food. According to WHO, dietary deficiencies are common and diarrhoeal diseases more frequent at ages 12 - 23 months (WHO Working Group,
1986: 3). Beyond two years of age, four migrants’ children had low weight for age, compared with 21 (30 per cent) of non-migrants’ children. Improved household income resulting from the mother working overseas may have contributed to this. For non-migrants’ children, the prevalence of underweight among older children could be due to the limited time their mothers had available to supervise their meals. The older children might eat without adult supervision and may not have enough food. In addition, older children are more likely to snack frequently during the day rather than having main meals.

The proportion of children cared for by their parent/s who had low WFA was lower among the children of migrants than children of non-migrants. The higher percentage of underweight children of non-migrant mothers could be due to a better nutrient intake for the migrants’ children or different feeding patterns. Being children of migrant mothers, there were often many people who cared for and fed them. One example from a fairly typical case illustrates this. Kas, was 29 years old and a mother of a three-and-a-half-year-old boy and one-and-a-half-year-old girl. She also looked after the three children of her sister who worked in the Middle East. She told me:

These three kids (To, a nine-year-old boy, Pi, five-year-old girl and Su a three-year-old girl) are fortunate because even though their mother is not here, we all care for them. Even though formally I am the one who looks after them, my parents and my relatives also pay attention to them. They give them food and if they go to the market they buy snacks for them and occasionally give them some money to buy snacks from the food vendors who pass through the village. Even though their mother and father are not here, they are still ‘kopen’ (being cared for). (Kas’s neighbour explained to me that the father of To, Pi and Su was in jail, sentenced for nine months for a criminal offence while his wife was in the Middle East).

When I was in the field in 1992, I saw that migrants’ children often received money or goods from their relatives. It was also common for the children to go to a relative’s
house to ask for food. However, this could also lead to a child missing meals. I visited a migrant mother’s family and asked whether Mar, a child in the family, had had lunch. The caregiver said that Mar might have already had lunch with her aunt. When I met Mar and asked the same question, she said that she had not. She had missed lunch because she was playing with her friends.

Five migrants’ children who were cared for by their grandparents had low weight relative to their age. The qualitative study revealed that some grandmothers were engaged in household activities such as fetching water and fuel, and grain processing as well as cooking. Their additional childcare tasks tended to reduce the time available for these activities and thus the amount of food prepared. It was also observed that some children became fussy eaters. However, the proportion of low weight for age among those who were cared for by others was higher among children of non-migrant mothers. Perhaps they were the children of mothers who were relatively poor and spent most of their time earning a living.

The mean Z-score of HFA follows a similar pattern where growth had already fallen below the standard during the first year of life (Table 8.6). The mean values for boys were well below the reference population at the age group 12 - 23 months. The mean values of HFA were more than minus 1 SD below the reference population for children of 6 - 11 months. This means that they were short for their age from the beginning of their lives. Children in the study population continued to have low HFA until around two years of age, then slightly improved. The age group 12 - 23 months of migrant’ children had mean values of HFA of more than minus 2 SDs, indicating that they were short relative to their age (stunted). That could be due to malnutrition in the past together with long exposure to infections.
Table 8.6 shows that the difference in the mean HFA between children in the study sample and the reference population at the same age is greater among the sons of migrants than sons of non-migrants at age group over 12 months. Over 12 months of age, the mean values of HFA for migrants' sons were more than minus 2 SDs, indicating that the children were small for their age. The sons of migrant mothers had a mean HFA less than that of non-migrants' children in age groups over 12 months with the widest difference in age group 12 - 23 months. This could be due to long-term inadequate nutrition and long-term untreated infection.

Table 8.6: Mean Z-scores for height-for-age (HFA) and mean age (months) of children aged 6-52 months by sex and migration status of mother, Purworejo, 1993

<table>
<thead>
<tr>
<th>Age in months</th>
<th>HFA</th>
<th>Mean age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Migrants</td>
<td>Non-migrants&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Boys</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 - 11</td>
<td>-1.13</td>
<td>-1.43</td>
</tr>
<tr>
<td>12-23</td>
<td>-3.10</td>
<td>-2.06</td>
</tr>
<tr>
<td>24 &amp; older</td>
<td>-2.29</td>
<td>-1.83</td>
</tr>
<tr>
<td>Girls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 - 11</td>
<td>-1.62</td>
<td>-1.27</td>
</tr>
<tr>
<td>12-23</td>
<td>-2.32</td>
<td>-1.70</td>
</tr>
<tr>
<td>24 &amp; older</td>
<td>-1.67</td>
<td>-1.68</td>
</tr>
</tbody>
</table>

Note: <sup>1</sup> Non-migrants' children are used as the reference group.

The mean HFA of girls in the study sample is a different pattern from that of the boys, with a steady decline in Z-scores with age. At ages 24 months and over daughters of migrants are slightly better grown. In all age groups, except migrants' girls at ages 12 - 23 months, for both migrants and non-migrant daughters, the mean values of HFA were less than minus 2 SDs.
Overall, children of migrant mothers have lower value of HFA compared to those of non-migrant mothers. The marked difference is among children whose fathers have education below secondary level. As for the value of WFA, the scarcity of household income could have limited the ability of the household to provide adequate food for children, resulting in poor nutrition. Children of migrants who have 3 or more adults in their households also have a low value of height-for-age (HFA). This could be due to the need to share limited household resources.

Table 8.7: Mean Z-scores for height-for-age (HFA) among children aged 6-52 months according to their mother’s migration status and selected characteristics, Purworejo, 1992/1993.

<table>
<thead>
<tr>
<th></th>
<th>Migrants</th>
<th>Non-migrants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Caregiver</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>-1.75</td>
<td>-1.66</td>
</tr>
<tr>
<td>Grandparent</td>
<td>-2.04</td>
<td>-1.58</td>
</tr>
<tr>
<td>Siblings</td>
<td>-</td>
<td>-1.82</td>
</tr>
<tr>
<td>Others</td>
<td>-2.28</td>
<td>-2.16</td>
</tr>
<tr>
<td><strong>Father's education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below secondary</td>
<td>-2.14</td>
<td>-1.70</td>
</tr>
<tr>
<td>Secondary</td>
<td>-1.89</td>
<td>-1.66</td>
</tr>
<tr>
<td><strong>Mother's education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below secondary</td>
<td>-1.97</td>
<td>-1.75</td>
</tr>
<tr>
<td>Secondary</td>
<td>-2.02</td>
<td>-1.51</td>
</tr>
<tr>
<td><strong>Father's occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farmer</td>
<td>-2.08</td>
<td>-1.74</td>
</tr>
<tr>
<td>Others</td>
<td>-1.83</td>
<td>-1.59</td>
</tr>
<tr>
<td><strong>Number of children in the household</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>-1.99</td>
<td>-1.59</td>
</tr>
<tr>
<td>3 and more</td>
<td>-1.97</td>
<td>-1.82</td>
</tr>
<tr>
<td><strong>Number of adults in the household</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>-1.89</td>
<td>-1.65</td>
</tr>
<tr>
<td>3 and more</td>
<td>-2.07</td>
<td>-1.71</td>
</tr>
</tbody>
</table>


Height-for-age can be used as an indicator of past nutrition (Waterlow et al., 1977: 489). Children whose height is very low for their age or below a chosen cut-off
point are said to be ‘stunted’. Low HFA generally indicates long-term past malnutrition. Height deficiencies are usually related to intermittent or continued inadequate nutritional intake and/or frequent infection, especially during the first two years of life (Graitcer et al., 1981: 292).

The prevalence of stunting among migrants’ and non-migrants’ children seems to be affected by father’s education and father’s type of occupation. Children of both migrants and non-migrants whose fathers attended senior high school were less likely to be stunted than children whose father’s education was below senior high school. This may also be reflected in the father’s occupation, which is related to educational attainment.

The number of siblings seems to be associated with the prevalence of stunting among both groups of children. Children are likely to be better off when they do not have to compete with too many dependent siblings for parental support (Lloyd and Desai, 1991: 4). The study children who had more than one sibling tended to be short for their age. This could be the result of competition for the limited resources in the household. Migrants’ children who had more than one sibling had a higher chance of being stunted.

On average, children of migrants were more likely to have lower value of HFA than non-migrants’ children. Boys of migrants were found to be shorter on the HFA scale compared to boys of non-migrants. In all age groups, children of migrants had lower values of HFA than children of non-migrants, with the largest difference in the age group 12 - 23 months. Overall, relatively fewer children of non-migrants had low values of HFA. Possibly most of the migrants’ children were from poor families which may have
been unable to provide an adequate nutrient intake over a long period, resulting in retarded growth (see Table 8.8).

Table 8.8: Prevalence of low height-for-age (HFA) among children aged 6 - 52 months according to mother’s migration status, sex and age of the child, Purworejo, 1993 (Percentage)

<table>
<thead>
<tr>
<th>Sex of child</th>
<th>Migrant</th>
<th>(N)</th>
<th>Non-migrants</th>
<th>(N)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Boys</strong></td>
<td>57</td>
<td>14</td>
<td>44</td>
<td>98</td>
</tr>
<tr>
<td><strong>Girls</strong></td>
<td>31</td>
<td>13</td>
<td>24</td>
<td>76</td>
</tr>
<tr>
<td><strong>Age of child in months</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 - 11</td>
<td>25</td>
<td>4</td>
<td>18</td>
<td>55</td>
</tr>
<tr>
<td>12 - 23</td>
<td>100</td>
<td>3</td>
<td>48</td>
<td>58</td>
</tr>
<tr>
<td>24 &amp; older</td>
<td>40</td>
<td>20</td>
<td>38</td>
<td>61</td>
</tr>
<tr>
<td><strong>Overall sample</strong></td>
<td>44</td>
<td>27</td>
<td>35</td>
<td>174</td>
</tr>
</tbody>
</table>

Note: 1 Low height-for-age represents children whose Z-scores of height-for-age fall below minus 2 SDs.

Weight-for-height (WFH) is used as an indicator of the present state of nutrition (Waterlow et al., 1977: 491; WHO Working Group, 1986: 8). Children whose weight is very low for their age or below a chosen cut-off point are said to be ‘wasted’. WFH is considered the best indicator of present malnutrition, and hence is the best proxy for nutritional status. The cause of wasting is food shortage and low food intake of children (United Nations, 1990: 17; Beaton et al., 1990: 28; WHO Working Group, 1986: 3). Wasting is the condition of immediate concern because of the risk of death (Beaton et al., 1990: 27).

The mean values for WFH were only a little below the reference median (Table 8.9). The decline in WFH for boys between 6 - 11 and 12 - 23 months of age was striking, especially for sons of migrants. The difference value of weight-for-height
between children of migrants and non-migrants is very large for both boys and girls, with the girls of migrants having higher values of weight-for-height compared to non-migrants’ girls. Taking into consideration the low WFA and HFA, some children were stunted even though their values for WFH were normal. This indicates that the children were generally of adequate weight but had a past history of malnutrition. For example, some children of migrant women who were short in terms of their height relative to their age seemed to have recently gained weight because of better food. The case of Sun, a three-year-old girl, is one illustration. Sun was left by her mother who went to the Middle East when she was two years of age. She was cared for by her grandmother and her aunt. Sun’s height was quite short relative to her age. However, Sun had benefited because her grandmother and her aunt fed her with better food enabling her to put on weight.

Table 8.9: Mean Z-scores for weight-for-height (WFH) and mean age (months) of children aged 6-52 months by sex and migration status of mother, Purworejo, 1993.

<table>
<thead>
<tr>
<th>Age in months</th>
<th>WFH Z-scores</th>
<th>Mean age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Migrants</td>
<td>Non-migrants</td>
</tr>
<tr>
<td>Boys</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-11</td>
<td>-0.88</td>
<td>-0.45</td>
</tr>
<tr>
<td>12-23</td>
<td>-1.69</td>
<td>-0.96</td>
</tr>
<tr>
<td>24 &amp; older</td>
<td>-0.56</td>
<td>-0.73</td>
</tr>
<tr>
<td>Girls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-11</td>
<td>-0.90</td>
<td>-0.45</td>
</tr>
<tr>
<td>12-23</td>
<td>0.20</td>
<td>-0.89</td>
</tr>
<tr>
<td>24 &amp; older</td>
<td>-0.47</td>
<td>-0.78</td>
</tr>
</tbody>
</table>


The difference in children’s mean Z-scores for weight-for-height (WFH) between the two groups of children also seems to be related to the person who looked after them.
Migrants’ children who were cared for by grandparents had lower WFH than children of non-migrants. As for HFA, children of either migrants or non-migrants with low WFH were among those whose fathers had below secondary level of education (Table 8.10).

**Table 8.10**: Mean Z-scores for weight-for-height (WFH) among children aged 6-52 months according to mother’s migration status and selected characteristics, Purworejo, 1992/1993

<table>
<thead>
<tr>
<th></th>
<th>Migrants</th>
<th>Non-migrants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Caregiver</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>-.49</td>
<td>-.73</td>
</tr>
<tr>
<td>Grandparent</td>
<td>-.75</td>
<td>-.46</td>
</tr>
<tr>
<td>Siblings</td>
<td>-</td>
<td>-.62</td>
</tr>
<tr>
<td>Others</td>
<td>-.52</td>
<td>-1.07</td>
</tr>
<tr>
<td><strong>Father’s education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below secondary</td>
<td>-1.00</td>
<td>-.74</td>
</tr>
<tr>
<td>Secondary</td>
<td>-.38</td>
<td>-.68</td>
</tr>
<tr>
<td><strong>Mother’s education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below secondary</td>
<td>-.67</td>
<td>-.73</td>
</tr>
<tr>
<td>Secondary</td>
<td>.57</td>
<td>-.67</td>
</tr>
<tr>
<td><strong>Father’s occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farmer</td>
<td>-.76</td>
<td>-.74</td>
</tr>
<tr>
<td>Others</td>
<td>-.52</td>
<td>-.72</td>
</tr>
<tr>
<td><strong>Number of children in the household</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>-.67</td>
<td>-.71</td>
</tr>
<tr>
<td>3 and more</td>
<td>.56</td>
<td>-.73</td>
</tr>
<tr>
<td><strong>Number of adults in the household</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>-.67</td>
<td>-.83</td>
</tr>
<tr>
<td>3 and more</td>
<td>-.61</td>
<td>-.62</td>
</tr>
</tbody>
</table>


This section also discusses the prevalence of malnutrition classified by combining the HFA and WFH (Table 8.11). Two broad categories of nutritional status are used: stunting and wasting. Wasting represents children whose WFH and HFA SD
units fall below minus 2; while stunting only represents children who had HFA below minus 2 SDs but had normal weight relative to height. As can be seen from Table 8.11, stunting was prevalent among children of migrants with 41 per cent. The percentage is slightly higher compared to the result of the first anthropometric data collection (Table 8.12). The number of non-migrants' children who were chronically malnourished declined from five to two children.
Table 8.11: Children classified as undernourished by WFH and HFA for the last round of anthropometric data collection according to selected characteristics, Purworejo, 1993 (Percentage)

<table>
<thead>
<tr>
<th>Sex of child</th>
<th>Migrants' children</th>
<th>Non-migrants' children</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wasted &amp; stunted</td>
<td>Stunted</td>
<td>n</td>
</tr>
<tr>
<td>Boys</td>
<td>7</td>
<td>50</td>
<td>14</td>
</tr>
<tr>
<td>Girls</td>
<td>0</td>
<td>31</td>
<td>13</td>
</tr>
<tr>
<td>Age of child in months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 - 11</td>
<td>0</td>
<td>25</td>
<td>4</td>
</tr>
<tr>
<td>12 - 23</td>
<td>0</td>
<td>100</td>
<td>3</td>
</tr>
<tr>
<td>24 &amp; older</td>
<td>5</td>
<td>35</td>
<td>20</td>
</tr>
<tr>
<td>Caregiver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>0</td>
<td>25</td>
<td>8</td>
</tr>
<tr>
<td>Grandparent</td>
<td>7</td>
<td>40</td>
<td>15</td>
</tr>
<tr>
<td>Siblings</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>75</td>
<td>4</td>
</tr>
<tr>
<td>Father's education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below secondary</td>
<td>9</td>
<td>46</td>
<td>11</td>
</tr>
<tr>
<td>Secondary</td>
<td>0</td>
<td>27</td>
<td>11</td>
</tr>
<tr>
<td>Father's occupation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farmer</td>
<td>10</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>33</td>
<td>12</td>
</tr>
<tr>
<td>Number of children in the household</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>33</td>
<td>18</td>
</tr>
<tr>
<td>3 and more</td>
<td>0</td>
<td>56</td>
<td>9</td>
</tr>
<tr>
<td>Number of adults in the household</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>8</td>
<td>25</td>
<td>12</td>
</tr>
<tr>
<td>3 and more</td>
<td>0</td>
<td>53</td>
<td>15</td>
</tr>
<tr>
<td>Overall sample</td>
<td>4</td>
<td>41</td>
<td>27</td>
</tr>
</tbody>
</table>


Note: Wasted and stunted represents children whose Z-scores of HFA and WFH fall below minus 2 SDs.
Stunted only refers to children whose Z-scores of HFA fall below minus 2SD but WFH above minus 2 SDs.
Table 8.12: Children classified as undernourished by WFH and HFA for the first round of anthropometric data collection according to selected characteristics, Purworejo, 1993 (Percentage)

<table>
<thead>
<tr>
<th></th>
<th>Migrants' children</th>
<th>Non-migrants' children</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wasted&amp; stunted</td>
<td>Stunted</td>
</tr>
<tr>
<td>Sex of child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>0</td>
<td>33</td>
</tr>
<tr>
<td>Girls</td>
<td>7</td>
<td>36</td>
</tr>
<tr>
<td>Age of child in months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 - 11</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12 - 23</td>
<td>0</td>
<td>50</td>
</tr>
<tr>
<td>24 &amp; older</td>
<td>4</td>
<td>36</td>
</tr>
<tr>
<td>Caregiver</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>9</td>
<td>27</td>
</tr>
<tr>
<td>Grandparent</td>
<td>0</td>
<td>37</td>
</tr>
<tr>
<td>Siblings</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>Father's education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below secondary</td>
<td>6</td>
<td>38</td>
</tr>
<tr>
<td>Secondary</td>
<td>0</td>
<td>43</td>
</tr>
<tr>
<td>Father's occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farmer</td>
<td>6</td>
<td>35</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>46</td>
</tr>
<tr>
<td>Number of children in the household</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td>31</td>
</tr>
<tr>
<td>3 and more</td>
<td>0</td>
<td>44</td>
</tr>
<tr>
<td>Number of adults in the household</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>44</td>
</tr>
<tr>
<td>3 and more</td>
<td>5</td>
<td>26</td>
</tr>
<tr>
<td>Overall sample</td>
<td>3</td>
<td>34</td>
</tr>
</tbody>
</table>

Note: Stunted only refers to children whose Z-scores of HFA fall below minus 2 SDs, and whose Z-scores of WFH fall above minus 2 SDs.

8.4 Summary

This chapter has described one area of impact on child well-being, namely the nutritional status of children. The nutritional status of children of migrants and non-migrants is considered to be the outcome of child feeding practices. Anthropometric...
measurements such as weight and height which are interpreted in relation to the age and sex of the children are used to assess the children’s nutritional status.

Discussion of the nutritional status of children is limited by the small number of cases especially regarding the comparison between children of migrants and non-migrants. Therefore, the data cannot be represented with regards to the link between migration status of the mother and the nutritional status of children. Nonetheless a clear picture emerges. The pattern of child nutritional status is low regardless of the migration status.

A pattern does emerge regarding the migrants’ and non-migrants’ children. People in the study area noticed that children of migrants looked *gemuk* (fat) which they thought is a sign of health. However, the data suggest a different interpretation.

Children in the study sample had weight-for-age (WFA), height-for-age (HFA) and weight-for-height (WFH) that were substantially below those of the reference population. The average values of these indices declined with increased age. Marked declines were notable beginning at ages between six and 12 months, especially for boys. Children seemed to be moderately malnourished as evidenced by the mean values of WFA and HFA of less than or equal to minus 1.5 SDs. There was little difference between the growth attainment of children of migrants and non-migrants mothers.

Traditional food taboos appeared to play a minor role. There were few special food taboos observed for children in the study area. Most mothers or caregivers seemed to know the advantages of highly nutritious foods for child growth. However, the economic conditions and the availability of food choices for those who could afford them appeared to restrict their provision. Some mothers did not give additional foods such as meat, eggs, fish and milk to their children because of beliefs that they were
harmful or would lead to demanding eating habits. Some mothers did not give meat, which is rich in protein, for economic reasons. Limited purchasing power also did not permit some carers to buy infant formula for the infants of migrant mothers. Instead, those children were often fed sugared water.

Young children aged under 12 months were less likely to be malnourished compared to the older age groups. This could be because they were still breastfed and were still under the control of their parents or other caregivers when they were fed. Also they were fed on demand. Older children were more likely to have long-term exposure to inadequate nutrient intake. Lack of adult supervision when they were eating, to ensure that they got enough food, might also be one cause of malnutrition. In addition, children’s habit of eating snacks during the day, particularly of food bought from the food vendors who passed through the villages, might also have contributed to the prevalence of malnutrition. I noticed that children in the study area frequently ate ice blocks or dawet (a drink made from coconut milk and palm sugar) that was probably made from unboiled water, which might cause diarrhoeal disease. However, in the absence of laboratory tests, this remains conjecture.

This chapter indicates that poor growth attainment of children of both migrant and non-migrant mothers was due to a combination of limited food availability and unsound feeding practice. There was no clear indication that children of migrants were consistently disadvantaged compared with others, although sample numbers were small. Rather it appears that variations between children were more likely to be due to the behaviour of their carers and to the child’s own food seeking behaviour.

The main problem in the community was poverty. The problem of malnourished children was part of this overall problem. Poverty was the main cause of malnutrition.
among children in both groups, migrants and non-migrants. The difference in nutritional status of children in both groups was relatively minor. However, the problem was somewhat exacerbated for some of the migrant families due to the lack of purchasing power or spending patterns that gave low priority to the purchase of food.
CHAPTER 9

CONCLUSION AND POLICY IMPLICATIONS

The focus of this thesis has been to examine the childcare strategies used by Javanese families when the traditional caregiver—the mother—has temporarily migrated abroad. In Javanese family life, the mother is perceived as a more nurturing parent than the father. When the mother is absent, childcare arrangements involve other family members who may provide a different type and/or quality of care. The thesis examined the patterns of care provided by mothers and other caregivers to see whether and how the growth and health of children might be affected by substitute care.

Using data provided by the 1992/93 AIDAB-funded Women’s Work and Child Welfare Project (the 1992/93 Survei Ibu), as well as the qualitative data gathered for the study, the aspects of childcare including health and nutritional status of migrants’ and non-migrants’ children were compared by observing and recording care, and by analysing illness and anthropometry. Simple bivariate analysis was used to explore the characteristics of the pattern of care provided and the growth attainment of the children, while the qualitative data provided a greater insight into the relationship between these variables. The illness data allowed analysis of the patterns of care when children were thought by the caregiver to be ill. This concluding chapter reviews the findings and examines their policy implications in terms of:

- the overall economic and social context of Javanese mothers’ migration to the Middle East;
• the pattern of care provided to their under-five children by substitute caregivers compared with that provided by non-migrant mothers;

• the resulting patterns of reported morbidity and illness-treatment among children in migrant and non-migrant families;

• the resulting patterns of nutrition among migrant compared with non-migrant children;

• and the role of the family in providing substitute childcare for the absent mother.

9.1 The social and economic context of the women's migration

For the last few decades, women’s access to income-earning opportunities in the agricultural sector in the study area has been limited. Improved technologies have particularly tended to replace female agricultural labourers and created a shortage of jobs for women in rural areas. Thus the decline in agricultural work in rural Java has been widely reported as a reason for large numbers of rural women to migrate to other countries that offer job opportunities. Temporary female migration is increasingly seen as a viable option for families to improve their standards of living. As a result, women are moving to find a more promising future for themselves and their families. They migrate overseas seeking work to supplement their families’ incomes because they can no longer work in their villages of origin due to the limited job opportunities.

It is often assumed that Javanese families give priority to male migration. In reality, however, Javanese women make up more than half of the international labour migration movement to the Middle East. Many mothers in the study area had migrated to the Middle East to work on two-year contracts as domestic servants. Because neither
skills nor education are required for domestic servants, and the recruiting fees for women are much lower than for men, over the last 10 years many poor families have sent female household members to work in the Middle East. The higher returns for the family from women’s compared to men’s migration is what has motivated most women to become involved in international labour migration.

Remittances are the greatest attraction of international migration to both governments and individual migrants, as well as to their families and households. For the government in the migrant’s country of origin, remittances can contribute to export earnings. Scholars have argued that this is less important for Indonesia than for many other countries because remittances are not a large share of export earnings, particularly compared with the Philippines or Sri Lanka. However, at an individual level, the income a woman migrant earns may be critical as a household strategy for family maintenance or even survival. The real importance of international labour migration for Indonesia is more as a safety valve for a particular segment of the population --the poor in rural Java-- than for its impact on the economy as a whole.

In theory, the income earned by migrant mothers should enhance the household’s purchasing power. The well-being of their children should then improve as a result of improved nutrition and better access to services. In reality, however, this was frequently not the case in the study area. Often the income earned overseas by women migrants could not be used to meet immediate household needs as it was needed to repay debts and the high interest incurred in financing the mother’s migration. This was especially the case in the first year after the migration. Sometimes, remittances sent by the migrant women were used for purposes other than for the families’ daily needs, such as the purchase of motor bikes or gambling. This was partly a consequence of the different
spending patterns of women and men and the fact that the spending of remittances that the women sent home was largely in the hands of their husbands. As a result, some women returned upon the completion of their contract to find that all their remittances had been spent on consumption and nothing was left for the future support of their families.

Despite such difficulties, migration did lead to some changes in the status of the women migrants. Due to their economic contribution to their households, migrant women have become more important in their families (see Brochmann, 1993: 161). Although women in Java have always contributed to the household economy, their contributions in the form of paid and unpaid labour and subsistence output were often not recognized, even by the women themselves. By contrast, the cash contributions sent by the migrant women from the Middle East were both conspicuous and particularly significant in their households. The income they earned was much higher than could be earned in their villages for similar work, and generally much higher than their husbands could earn in Indonesia. The improvements in material wealth gained from the women’s work overseas were greatly desired by most migrants’ families. For many families, the women’s migration was the key household strategy for alleviating poverty and increasing household purchasing power and attaining a higher standard of living. Their economic importance was thus evident to all, including themselves.

However, Eelens et al., (1992: 245) in an evaluation of Sri Lankan migration, observed that any improvement in the economic situation of women overseas labour migrants could be merely temporary. This seems to have also often been the case in the study area. There is no doubt that in the short term the income earned by women labour migrants in the Middle East enabled them to improve the economic position of their
households. This was especially true of households where husbands continued working during the absence of their wives, so that the women's earnings could be saved. However, most households did not manage their improved earnings in ways that would sustain a higher income after the migrant returned home. Migrant households tended to buy luxury consumer goods with their newly found wealth. By the time the contract was over there was often little capital or savings left for the family for the future.

Women were likely to return to the Middle East for a further contract if their husbands had spent their remittances unwisely. In this case, children would be left again without a mother. A long separation from their mother, or an unhappy marriage caused by the move, may have a psychological impact on children. Eelens and Schampers (1988 cited in Brochman, 1993: 160) said that ‘very young children, in particular, seem to suffer from the long absence of their mothers’. However, the real impact remains unmeasured and largely unconsidered by policy makers. Although this study showed that migrants’ children had a higher prevalence of malnutrition, it is difficult to establish a direct causal relationship between maternal migration, child illness and malnutrition.

9.2 Patterns of childcare for migrants’ and non-migrants’ children

The study showed that there was no clear difference in the pattern of care given to children of migrant and non-migrant mothers. Regardless of the relation of caregiver to the child, slightly more caregivers of non-migrants’ children were within close proximity and able to touch the child being cared for. This could probably be attributed to age differences since the average age of migrants’ children was 34.1 months, whereas the average age of children of non-migrants was much younger (23.7 months).

A marked difference existed among both groups of children, depending on the
identity of the person with the child at the time of observation. Children of migrant women received more ‘attention’ from grandparents than children of non-migrants, probably because most of them were cared for by grandparents who had more time to devote to childcare than did the mothers of the children in the control group. Even though the grandparents were not always the primary caregivers of the migrants’ children, the migrant families tended to depend on grandparents especially grandmothers. Perhaps the grandmothers of migrants’ children had less competing demands on their time than the mothers of non-migrants’ children, thus enabling them to fully attend to children in their care.

Slightly more children of migrants were observed than non-migrants’ children to be given food or drinks when they were being cared for and were with their grandmothers. The practice by grandmother caregivers of using food as a reward or to comfort the child would explain the higher frequency of feeding among children of migrants.

The absence of significant differences in the observational data does not mean that there were no real differences in actual care. The data used for this study were not sufficiently refined to distinguish between patterns of care. For instance, data on communication between caregiver and the child were recorded only on its existence without identify its quality whether the communication was negative (yelling) or positive (encouragement).

9.3 Patterns of morbidity and treatment of illness among migrants’ and non-migrants’ children

The study revealed little difference in the pattern of illness suffered by migrants’ and non-migrants’ children in any of the age groups. However, some difficulties in
interpreting the data could conceal differences. Because the illness observations were collected every three days, some illness episodes were included more than once. Therefore, a higher percentage of observations for one group could mean more episodes or fewer episodes of longer duration, and similar percentages could hide a real difference between children of migrants and non-migrants with a similar pattern of illness duration. Because the duration of illness is not known, only limited conclusions about health differences between the children of migrants and non-migrants can be drawn from these data.

Illness in the children was reported slightly less often by the caregivers of the children of migrants, compared to those of non-migrants (see Section 7.1.1). This could be due to the difference in age distribution among the two groups, since on average the children of migrants were older than those of non-migrants. For example, the reported prevalence of runny noses, which is common among young children, was higher among the children of non-migrants (see Table 7.1).

Most of the illnesses suffered by children in the population of the study area were left untreated. However, if they were treated, the treatment that was given usually consisted of home remedies, including non-prescribed medicines. Children of migrants tended to be treated with non-prescribed drugs and traditional medicines when ill, especially for fevers, coughs, stomach-related illnesses, sawan and skin-related illnesses (see Table 7.7). The availability of basic medicine provided by the 1992/93 Survei Ibu also contributed to a larger proportion of self-medication of sick children in the study area.

The low proportion of caregivers who sought treatment for both groups of children was possibly because caregivers thought that the illnesses did not need any
treatment. This was particularly likely when a child suffered from a particular illness perceived by the caregiver as a ‘normal’ illness, such as diarrhoea and measles. Treatment was often delayed until the condition of the child was serious.

9.4 Patterns of nutrition for migrants’ and non-migrants’ children

Migrants’ children were at a relative disadvantage compared with non-migrants’ children in terms of nutritional status. In particular, migrants’ sons of weaning age (12-23 months) suffered considerably from under-weight and stunting of growth. Stunting was more prevalent among the children of migrants, reflecting long term or chronic under-nutrition. Scholars have argued (see 8.2) that stunting is partly a consequence of poverty. Chapter 2 showed that poverty was a primary factor motivating the mothers’ migration. Thus, it is possible that the growth of the children of migrant mothers was stunted because of that initial poverty, not because of the effect of their mothers’ migration.

Working overseas increased family income through remittances. Therefore, the family should theoretically have enjoyed an improved standard of living, which would have resulted in improved child nutritional status, narrowing the gap in terms of weight-for-height between migrants’ and non-migrants’ children. The proportion of wasting or acute under-nutrition was in fact lower among migrants’ children (see Table 8.12). This may have been due to the rising household incomes resulting from the migration of the mothers.

However, the impact of the migrant mothers’ absence on child feeding patterns was ambiguous. On the one hand, as part of their joint responsibility to provide support and substitute care, relatives often gave the migrants’ children food that should have
been beneficial to their growth. On the other hand, the common practice of giving snacks and sweet drinks to migrants' children that were low in nutritional value but high in calories could have contributed to the small proportion of wasting among this group.

The small number of cases, especially regarding the comparison between children of migrants and non-migrants, limits the discussion of the nutritional status of both groups of children. Therefore, only limited conclusions with regards to the link between migration status of the mother and the nutritional status of children can be drawn. Nonetheless a pattern of child nutritional status emerges that is low regardless of the migration status.

9.5 The role of the family in providing substitute childcare

The numbers of Indonesian women who have been moving to the Middle East to work on a short-term basis have increased markedly since the late 1980s. Many left in the hope that during their absence they would earn sufficient to fulfil their aspirations and those of their families. Most were married and already had young children. Under the conditions of their contracts families had to remain in Indonesia, so their children were entrusted to substitute caregivers.

The women's involvement in international migration, resulting from their search for cash income, has led to some major changes in gender roles in their families. The women have become the main breadwinners, while the importance of men in childcare has increased. In migrant households, the responsibility for childcare fell on the remaining family members. Variations in childcare arrangements occurred, depending on the nature of the family support network. Childcare of migrants' children involved both immediate and extended family members. As formal childcare centres did not exist
in the study area, women tended to rely on their relatives to look after their children. The role of members of the mother’s extended family, mainly the maternal grandmother, was often dominant. Although other family members and non-relatives were involved in care, grandmothers were found to be the main substitute for mothers in the migrants’ families.

In some cases the absence of the wife increased the husbands’ participation in domestic work and childcare. In some cases the children were left in the primary care of the father. Many fathers, usually with the assistance of older children and one of the children’s grandmothers, managed to look after their children when their wives were absent. As was often the case for non-migrant and migrant mothers alike, the presence of older children enabled mothers to delegate childcare responsibilities to them. Since school did not fully occupy children’s time, older children could look after their younger siblings in the absence of the mother (see Section 6.2.2). However, the evidence suggested that they tended to provide a different kind of care from their mothers.

Javanese men are not usually greatly involved in tasks centered around childcare and daily household work. However, the study found that a reorganisation of work roles had occurred to some extent. Some men were pleased to take on domestic chores while their wives were away in the Middle East. In other households, however, fathers were reluctant to be involved in childcare tasks while their wives were absent. In these cases, some fathers delegated their responsibility in managing their households to their mothers or female kin. Fathers, who might be expected to have more modern attitudes than the children’s grandmothers, tended to pass the responsibility for childcare to the grandmothers believing that women knew more about caring for children. Consequently, the absence of mothers imposed a greater burden on female kin, particularly grandmothers, in caring for the women migrants’ children. In some cases it also created
a situation where conflict between the father and the grandmother could arise, especially over handling and disciplining the child.

The study found that grandmothers played an important role in sharing the responsibility of childcare in all the families, but this was especially the case in the families of absentee mothers (see Section 6.2.1). Grandmothers performed the duty of childcare even though some of them complained about the heavy burden it imposed on them. Because of their age, many were unable to carry out activities that they used to be able to do when they were mothers. Being older, some grandmothers suffered from fatigue and disinterest, and may themselves have needed more care. Older caregivers were sometimes also handicapped by age or ill-health. To some extent, such physical limitations resulted in them providing a different kind of care than younger women.

Grandmothers caring for the children of migrant mothers were older, less educated, poorer, and had less modern attitudes than mothers, which may have influenced their childcare behaviour. Grandmothers, being older, were more likely to hold traditional beliefs about the nature and cause of illness. In addition, elderly caregivers might have found difficulties in communicating with health-centre staff. The grandmothers' personal experience may also affect their skills as caregivers. For example, because most grandmothers would have breast-fed their children for up to two years, they may have had little experience in, or knowledge of, substitute feeding methods for very young children. Nonetheless, grandmothers were still considered to be the main source of advice on childcare.

Although extended family members provide childcare support, this can also create problems. One aspect is the sharing of remittances among the extended family members. As described in Chapter 3, the remittances sent by the migrant women were
also shared with their wide kin networks because they were involved in taking care of the migrants’ children while the mothers were away. This could reduce the beneficial effects on the migrants’ own family and become a source of friction within the family. In many ways, a mother’s migration was a test of the solidarity of the family that she left behind.

9.6 Policy implications

The migration of women to work on contracts overseas is likely to continue for the foreseeable future. Despite the current economic downturn, in the long run the demand for domestic workers is likely to increase over time because the employment of foreign domestic servants has become a status symbol in many newly developing countries. Rising women’s labour force participation globally is also likely to contribute to increased demand. This demand, together with the expectation of higher incomes for the women who work on overseas contracts, may motivate many more poor Indonesian women to leave their villages, particularly in the current economic situation. A mother may prefer to stay at home rather than work overseas, but the search for a livelihood motivates her because the remittances to be obtained overseas could relieve her poverty whereas the meagre earnings she might obtain locally may not. Women in rural Java are no longer passive movers who migrate only to join or follow family members. Today, they move directly in search of employment for themselves.

It is very difficult to determine the economic and social costs and benefits of women’s international labour migration in order to consider appropriate policy responses. Female international labour migration involves economic, social, cultural and psychological factors. In a Muslim society like Indonesia, until recently the migration of
women to work has been generally regarded as socially unacceptable. Women's involvement in migration may create numerous problems for the migrants themselves and the families left behind, particularly for young children. In the short term, the absence of mothers may have a negative impact on children's health. Separation of mothers from young children may cause emotional deprivation in children, which may contribute to poor growth. The absence of the mother may affect the child's appetite, resulting in the child being undernourished. However, in the long term children may also benefit from the economic gains to their families. Women's migration is part of the search for a better life for themselves and their children. Financial security and material comfort seem impossible if the migrant women stay in the village.

In Indonesia, one important area of policy is that of the possibility of alleviating poverty because it is often claimed as the cause of the movement of women overseas. Scholars argue that poverty could lead to the prevalence of children being malnourished due to the absence of adequate resources to meet their minimum nutritional requirements. For this reason, policy makers should help the people to alleviate the situation by increasing the chances of success and minimising problems that might be faced by the migrant families.

Although the findings of this study suggest relatively little effect on children when their mothers migrate, policy makers should be aware of this impact. Very little has been done to provide for the children of migrants, whose mothers have contributed significantly to Indonesia's wealth. It is crucial to understand the context in order to put the research findings concerning the children of overseas contract workers in proper perspective. The children of women migrants require special attention, as do the women themselves, especially since they work in conditions that have been reported to expose
them to exploitation and violation. Job creation at home, stimulation of economic growth, as well as the development of the individual and the family as the basic economic and social unit, could be used as means to discourage women from working on overseas contracts. In the absence of such action, there is no doubt that young mothers from rural Java will continue to migrate overseas to work as domestic servants. As a result, the responsibility of care for their young children will be in the hands of other people, who may not have the same commitment to their health and welfare.

In view of the importance of the welfare of migrants and their families, the government should provide greater support to the migrants’ children who are left behind. Migrants should be assisted to make careful choices about the care of their children before the commitment is made to accept an offer of employment overseas. Support should also be provided to ensure that their children receive adequate care while their mothers are absent. It would clearly help if potential women migrants were provided with information about child-support organisations, so that the families who are responsible for caring for their children know how to get support to deal with any problems that may affect their children.

Considering that poverty is one of the factors pushing Indonesian female labourers to migrate to the Middle Eastern countries, efforts should be made to help the people to alleviate this situation. The government should also make an effort to address the needs of the family as an entire unit, particularly in relation to the increase in the chances of successful migration and minimise problems that might be faced. In addition to the provision of simple bureaucratic procedure, the prospective migrants should be well informed of the working conditions as well as be encouraged to be better prepare. This will lessen problems that might arise while the women are away.
Substitute caregivers’ characteristics may affect their willingness to utilise childcare resources. Less educated and more traditional older substitute caregivers may have different attitudes towards taking children to health clinics to be immunised or weighed. Older caregivers in the study area were sometimes reluctant to take the children to the clinic as the healthcare system in Indonesia is especially targeted towards mothers. Compared with grandmothers, mothers are younger and better educated and most will understand the official Indonesian language. Some grandmothers with lower levels of education do not speak Indonesian and others may be illiterate. Some grandmothers in the study area had difficulties in understanding the UPGK program (Usaha Perbaikan Gizi Keluarga), which addresses nutritional problems among under-five-year-olds by teaching needy families about nutrition, food budgeting, purchasing and preparation.

Alternative caregivers responsible for children should also be included in programs related to child health. Information on child-health programs should also be targeted to fathers and grandmothers as they are important substitute caregivers and key decision-makers on child-health issues, particularly in the case of migrant women’s families.

Better information on health care (preventive and curative), nutrition and other aspects of childcare should be disseminated to caregivers and potential caregivers. The study showed that some caregivers did not consider measles and diarrhoea to be illnesses that require medical treatment. As a result, measles and diarrhoea were not always treated or managed in medically appropriate ways. Given the continuing high level of mortality from these diseases, it is essential that older caregivers be educated about the nature and seriousness of measles and diarrhoea.
The qualitative data also indicate that some children experienced feeding problems. It has been suggested that less-supervised children are more likely to eat less-nutritious food (Corner, 1990: 6), and a link between the nutritional status of children and family environment has also been identified (Florencio, 1980: 29). This could possibly explain why the children of non-migrating mothers had a more adequate diet between 12 and 23 months than children of migrating mothers. As in the case of health education, better nutrition information should be disseminated to alternative caregivers, particularly older women.

The study revealed that the mother’s absence affected the quality of childcare and the general atmosphere in the family. However, the specific nature of these effects was uncertain. It was not possible to establish whether the absence of the mother was responsible for the differences in care, since the research did not cover the period before the migration of the mother. A number of intervening variables were also possible; among these, the time lag between the departure of the mother and the data collection seems to be the most obvious.

The results of this study provide a starting point for further research into this subject and for developing appropriate intervention and support systems that minimise the negative effects of migrating mothers and help families achieve the long-term benefits that they hope for. Given the lack of research on this topic and the probability that more mothers will become international labour migrants in the current economic context, this thesis can be seen as forming the basis for future research. Longitudinal studies are needed that focus on how to improve care for these at-risk children and maximise the benefits to children and families when mothers choose to migrate. Research is also needed to improve the welfare of these women whose contribution to
the national and household economies deserves more recognition.

The actions suggested above are only short-term measures. In the long-term, only socio-economic development and an enhanced status for women will prevent poorly educated women from migrating to work abroad. By improving access to education for all women and training them in practical skills the government could make an effective contribution to reducing female migration in the future.
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ABBREVIATIONS AND GLOSSARY

ABRI : (Angkatan Bersenjata Republik Indonesia) The Indonesian Armed Forces
AKAN : (Antar Kerja Antar Negara) Centre for Overseas Employment
Amben : bamboo bed
Amit-amit jabang bayi: a phrase expressing hopes that nothing happens to the unborn child
Among-among: a small family ritual on the baby’s weton
Anak membawa rejeki sendiri: each child brings its own fortune
Anda tebu : a ladder made out of sugar cane
Angguk : a traditional performance
Anting-anting : earrings
Aras-arasen : does not want to do anything
Arus : smell of blood
Ayunan : cradle
Babaran : giving birth
Badan alus : evil eye
Banyak anak banyak rejeki: the more children the more fortune
Bathok : coconut shells
Batuk-pilek : cough and runny-nose
Biasa : normal
Bobok : ointment made from rice-flour and a root similar to ginger
Brokohan : a communal feast held on the first night after the child is born
Bu dhe/Bu lik : the parent’s sister
Cacat : physical defect
Dadah walik: massage given to woman after giving birth to return the uterus to its original state
Degan ijo : green coconut
Deres : climbing palm tree to collect the nectar water
Digendong : carrying a baby using a slendang
Digenjahke : putting a child down on the ground
Dikeloni : cuddle
Dipekeh : a child's legs astride the waist of person who carries the child
Dipunumbar : free to run and play whenever one wishes
Disuwuk : getting blessing from the dukun
Ditetah : guiding a child to its first step
Dleming : talk to him/her self
Dukun : someone whose knowledge enables him/her to know about and cure illness, or someone who has special skills that are related to sorcery and healing
Dukun bayi : traditional birth attendant
Dukun pijat : a traditional masseur
Empat sehat lima sempurna: four are healthy (eg. staple foods, protein foods, vegetables and fruits) and five are perfect (eg. milk)
Gabug : infertile
Ganjar : a popular term for measles
Gemuk : fat
Gerhana bulan : the moon's eclipse
Geritan : a bamboo frame fastened to the ground by a stake with a protruding arm that pivots on the stake
Gerobak : a wooden cart
HFA : Height-for-Age
Idul Fitri : a holy day for Muslims on which they celebrate the end of the fasting month
Jajan : buying food from the food vendors
Jamu : potions made of various herbs and roots
Jamu bersalin: traditional herbal mixture used after childbirth
Jamu cekok : traditional medicine given to a child who had lost its appetite
Juadah : traditional snack made from glutinous rice
Kakang kawah adi ari-ari: afterbirth is the younger brother of the baby, and the water is the older brother
Kecapaian : tiredness
Kecut-cekutan : raw fruit with a sour taste
Kelapa gading : yellow coconut
Kelurahan : The lowest administrative division in Indonesia (equivalent level to village)
Kembang setaman: flowers, usually including rose, kenanga and kanthil
Kemben : a long wide belt
Kemirab sawan: susceptible to sawan
Kepel : a fruit, the seeds of which run in a horizontal line
Ketutrunan : descendants
Kluwih : similar to raw jack fruit
Kurungan ayam: chicken cage
Lancip : pointed
Lauk pauk : side-dishes
Legen : nectar water
Lemes : weak
Lincah : a long bamboo chair
Linuwih : literally a respectful person
Mainan : toys
Masuk angin: common cold
Mbatin : someone who has bad thoughts about other people
Mencambuk : touching a child's legs to enable the child move quickly
Mikul dhuwur mendhem jero: praise the good names of the parents and bury deeply any negative things that might affect the family
Minyak klenak : coconut oil
Momong : looking after
Mupu anak : adopt a child
Nek : nauseous
Ngalah : surrender
Ngebo : have no intense desire for particular foods during the early stages of pregnancy
Ngenyi-yi : a term to describe a child who is really thin
Ngicalaken raos kesel: banish tiredness
Ngiler : dribble a lot
Niru : be like someone else
Nitis : cooking the nectar water to make palm sugar
Nyidam : craving unusual food
Padang bulan: full moon
Panutan : a leader
PELITA : (Pembangunan Lima Tahun) Five-Year Development
Pengkar : bandy-legged
Pindang : dried salted fish
Pitonan: a ritual performed when a baby’s feet are allowed to touch the ground for the first time

Pos penimbangan: the weighing post

Posyandu: integrated health post

PPTKI: (Perusahaan Pengerah Tenaga Kerja Indonesia) Labour Recruiting Company

PJTKI: (Perusahaan Jasa Tenaga Kerja Indonesia) Labour Recruiting Company

Pranakan: uterus

Puputan: when the umbilical stump falls off

Puskesmas: community health centre

Rengeng-rengeng: sing a traditional lullaby

REPELITA: (Rencana Pembangunan Lima Tahun) Five-Year Development Plan

Rewel: whining

Rujak: a type food made of fruit salad and chilli sauce

Rukun: maintenance of social harmony

Sangit: smell like something burning

Sawan: the cause of illnesses that are scary and related to evil spirit

Selamatan: communal feasts

Sepasaran: a communal feast held on the fifth day after the child is born

Setahun ngemban: have a baby within a year of marriage

Slendang: a cloth

Tahu: soya-bean curd

Tapel: a mixture made from lime juice

Tebu: sugar cane

Telaten: patient

Tempe: fermented soya-bean cake

Tепа selira: placing oneself in the situation of the other

Tingkeban: a family ritual conducted in the seventh month of the first pregnancy

TKI: (Tenaga Kerja Indonesia) Indonesian Worker

Tukang jamu: traditional medicine seller

Tuwuuh: exist

Urab: vegetable stew

Uritan: intestines of a chicken

Uyub-uyub: herbal medicine made particularly for lactating mothers
Weton: the day on which a child is born in the Javanese calendar which coincides with the same day in the Gregorian calendar
WFA: Weight-for-Age
WFH: Weight-for-Height
WHO: World Health Organisation
APPENDIX A

DATE-OF-BIRTH CALCULATIONS

MORVITA collects several variables from which it constructs a "date of birth" with a procedure called "BACKCALC". This procedure is run after each census. It is designed to retain data on the sources used for determining the "real dob".

The variable SI090 asks for age in years. Only respondents reported to be <=6 years are asked for more age information.

For every new child in the census, the form SI asks whether the child has a birth certificate (SI210) and, if so, records the date of birth into a variable called DOB_RAW. In practice, we found reason to change several dates of birth that were originally derived from birth certificates.

If there is no birth certificate the SI asks for day, month and year of birth in three separate variables (SI231, SI232 and SI240). Even though interviewers prompt for information, sometimes it is impossible to obtain day or month and - rarely - not even the year.

BACKCALC calculates a date of birth from DOB_RAW or the day, month and year variables as described below. The results of the calculation are recorded in the DOB_CALC variable.

In the SI file, but not collected by the interviewers, is a variable called DOB. This is the "real DOB". Initially it is filled in with the same value as the DOB_CALC variable, because this is the best information we have at the time of the census. If we later obtain better information we update the DOB variable using the Change Date of Birth transaction. We never change the initial values of DOB_RAW or DOB_CALC, thus retaining potentially valuable information on the sources of each child's "date of birth".

Procedure BACKCALC

When we do not have a birth certificate we attempt to calculate the Date of Birth from the day, month and year variables according to the rules described below:

1. if only the day of birth is missing, we assign the 16th day of the month.

2. if both the day and month of birth are missing, we assign the 16th day, and assign the month to be January, then February, then .... December, then start again at January.
3. When we are missing the three - day, month and year of birth variables and SI090 indicates that the respondent is <= 6 years old, we ask the field team to investigate.

4. When we are still missing the three -- day, month and year of birth variables but SI090 indicates that the respondent is a 5 year old, we need to ensure that we have a Date of Birth which will cause us to put the child on the list of those who get Indon Govt VITA but not MORVITA VITA. This means that we want the child to be over 59 months and less than 60 months at start of the cycle. We therefor set the DOB dependent on the cycle:

** First cycle started 13NOV89. So set dob at 30OCT84.
** Second 13MAR90 28FEB85.
** Third 13JUL90 30JUN85.
** Fourth 13NOV90 30OCT85.
** Fifth 13MAR91 28FEB86.
** Sixth 13JUL91 30JUN86.
** Seventh 13NOV91 30OCT86.

SI550 is a processing indicator which records the source of DOB_CALC and DOB. The codes are:

* 0: from birth certificate
* 1: from DDMMYY variables
* 2: from MMYY variables
* 3: from YY variables
* 4: a five year old assigned date to ensure it gets RI VITA
* 6: changed via update transaction
* 7: missing value due to no data
* 8: missing value due to no data
* 9: default value during data collection. Left if SI090>6

Note that the BACKCALC procedure does not recalculate cases when SI550=6, because we assume that changes made through the Date of Birth Transaction give us better data than that collected on forms SI.

Note also that the module that calculates the anthropometric indicies calculates a "biologic age" in months, defined as ("today's date"-DOB)*12/365.25. These will differ slightly from the conventional "age in months".
APPENDIX B

Guidelines of focus group discussions and in-depth interviews

A. Topics to be discussed in focus groups discussion and questions to be asked in in-depth interviews.

1. Information on the role of parents and grandparents
   1. What is the role of father, mother, and grandparents in the family?
   2. Do fathers involve in looking after children? Why?
   3. Do siblings help the parents at home? what kind of help they do?

2. Information on migration
   1. How long has the child’s mother been away?
   2. How did the mother decide to go to the Middle East?
   3. Who do the child caretaking while its mother is absent
   4. How old was the child when the mother left her/him?
   5. What was the child’s reaction after being left by its mother?
   6. What did you do about it?
   7. Has the child’s mother send money home?
   8. How much? What was the money used for? Why?

3. General concepts associated with child health;
   1. How does one know when a child is healthy?
   2. How does one know when a child falls ill?
   3. What are the most common illnesses that children here experience?
   4. What is the most severe childhood illness here?
   5. What are the causes of the illness?
   6. What can be done about the illness?
   7. How can we prevent or protect the child from illness?

4. Beliefs about childhood diseases, knowledge and practices of health care
   1. What kind of illness does your child suffer from?
   2. What are the symptoms of the illness?
   3. How did your child get it?
   4. What did you do when your child got the illness?
   5. What kind of medicine do you usually give to the child?
   6. Where did you get such medicine?
   7. How much did it cost?
   8. What is your opinion about the causes, severity, treatment, feeding practices during the course of diarrhoea?
   9. What is your opinion about the causes, severity, treatment, feeding practices during the course of measles?
5. Beliefs and practices regarding child nutrition

1. Do you believe that a woman should adhere to food restrictions during pregnancy and breastfeeding?
2. What kind of food?, Why?
3. Have you ever heard of nutrition described as ‘four is healthy, five is complete’ (empat sehat lima sempurna)?
4. What does this mean?
5. Do you prepare the food for your child? Why?
6. Breastfeeding and infant feeding practices, type of prelacteal food, what for?
7. How do people perceive of undernourished child, what causes of undernourished, what can be done?
8. When you are breastfeeding your child, do you eat certain foods to increase the milk? Why?
9. What does the child usually have for breakfast?
10. How many time per day does the child eat?
11. Does the child usually eat at a particular time? Why?
12. Where does the child usually eat?
13. Who usually feeds the child? Why?
14. What people do in order to maintain health

C. Interviews with other sources: village and informal leaders

1. What are their opinions about the migration of mothers.
2. What are their opinions and views about the impact of maternal migration, (impact on the children left behind)
3. With regard to the involvement of migrant’s husbands, what are their opinions in the changes of role performed by the migrant’s husbands
4. What do people do if a child being upset because of the separation with its mother?