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Sumbawan Obstetrics: The Social Construction of Obstetrical Practice in Rural Indonesia

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SUMBAWAN OBSTETRICS:

THE SOCIAL CONSTRUCTION OF OBSTETRICAL PRACTICE

IN RURAL INDONESIA

By

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who taught me about so much more than reproduction and identity

and to

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beginning with Simone and ending with Lucile
who teach me every day about reproduction and identity

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Part I: Introductory Materials

Prologue: Finding my Way with Dukun Mina

My first trip to Indonesia was in 1996. I was there to conduct interviews and a demographic survey about community well-being in the villages in Kecamatan Jereweh, an area in southwestern Sumbawa. While doing this, I quickly found that when an informant could not answer my questions, they would send me to a person whom they thought would know. Within a month or so I had a short list of these people, many of whom had been mentioned repeatedly. Except for one, all of the people on the list were men, most of whom held social or professional positions that you might expect a community-elected wise person to have: mosque elder, Hindu priest, retired teacher, former mayor, etc. I visited them all and they very kindly welcomed me. In the evenings they regularly received people, mostly men, at their house to consult with them on some matter or another. Their guests were respectful, and the gatherings were somewhat formal. Although there was considerable social chatter, the people were clearly there to glean some sort of wisdom, to pay their respects, or to seek assistance with a conflict.

The one exception to this list of men was a woman named Ibu Mina. That this was a woman was highly unusual in such a patriarchal social setting. Ibu Mina was illiterate and had never attended school. I soon discovered that Ibu Mina, the wife of a farmer, was the person who people sought for advice on health, love, important

life rituals, and on how to understand the world around them that, thanks to a multi-national mining corporation moving in next door, was changing very rapidly. She was not, like the men on my short list, part of group meetings where important decisions were made regarding how the community would react to recent local problems and plan responses. In contrast, Ibu Mina helped people understand the fabric of the community around them.

Every evening when I visited her there would be a crowd of people, both men and women, sitting in the guest area outside her house. Ibu Mina's visitors were jovial and relaxed in a way that I rarely observed from the people visiting the wise men on my list. I noticed a real difference in the way that she interacted with her visitors: she touched them all, both men and women. She touched their heads, their shoulders, and their upper backs, which are areas of the body that the local people usually consider to be clean, holy, and not to be touched by other people. As she would tell me stories about the village she would wander over to the grandchild of the person she was talking about, rest her hand on an adult's head or shoulder and say "this child's grandfather…" They were all her children.

Ibu Mina was a healer that specialized in assisting women in pregnancy and childbirth. Locally she was referred to as a *dukun bayi* (which is most often translated as "shaman midwife") who had attended the majority of their deliveries. She told me that it was her responsibility to welcome each person into this world. When they were born, she had been the first to hold each of them. She had conducted the rituals that ensured safe passage from fetus to where they sat then.

She now often tended to their needs when they were sick. She was their social memory and the interpreter of the lives they all led. And for many of them Ibu Mina was now tending to their own pregnancies and the passage of their children. I was enchanted by Ibu Mina. I still have a photo of me standing next to her. Although I am a mere five feet, four inches tall, I towered over her, but I felt much smaller. This woman was big in the most important ways. I was hooked.

Over the course of many afternoons and evenings at Ibu Mina's house she introduced me to the realities and logistics of pregnanc**y** and childbirth in rural Indonesia. At the time that I was in Kecamatan Jereweh there was one government clinic (*puskesmas*) that was very difficult for women to get to because it was far from most of the hamlets where people lived. Mobile clinics (*posyandu*) arrived in each of the neighborhoods once per month and offered expanded care for pregnant women. Women reported not using these services a great deal, but many were interested in the possibility of seeing one of the government-supplied, biomedically trained midwives, a *bidan*, more frequently. I interviewed the people involved in health care in the Jereweh clinic, in the hospital in the city of Sumbawa Besar, and in several types of clinics in the capital city on the island of Lombok, Mataram. I wondered what would happen when obstetric care was accessible to all of these women in rural Sumbawa as well as the rest of Indonesia?

Upon returning to the United States I read the literature on therapy-seeking in general, and on obstetric care in particular in settings such as rural Indonesia. While I found interesting and useful ideas concerning how women (or patients in

general) created their path of therapy I wondered what was on the other side of those decisions. In reality, what were the options for those women? What did the clinic care look like in a rural setting far from the people who designed the program of care? How did the dukun bayi perceive the clinic care option? How did the clinicians and shamans actually practice? How did the presence of the bidan affect the practice of the dukun bayi? It was very clear that the clinicians hoped that their presence would gradually eradicate the dukun bayi, or at least relegate them to a merely symbolic role. It occurred to me that examining the therapies and their practitioners might offer insight that was still lacking in the therapy seeking literature. Thus I turned my focus to highlight the practitioners rather than the pregnant women.

But first, I needed a place where clinical care was accessible. The area where I had already done research, Kecamatan Jereweh, was on the precipice of becoming a very different place. The international mining company and the Indonesian government were about to open several clinics that would offer obstetric, infant, and child care. There was talk of a full-sized and jointly operated hospital being constructed. I decided that it would be better to conduct my research in a setting that would more accurately represent the experience of the bulk of rural Indonesians.

I thought it would be interesting to look at an area that had a mixed ethnic and religious population. There are many of these in Indonesia, but after reading

and talking to Indonesia scholars at SEASSI[1] I set my sights on Central Sulawesi. In 2000 I spent six weeks in May and June looking at several potential field sites as well as interviewing bidan, dukun bayi, and pregnant women to further refine my research questions. Additionally, I was concerned that perhaps Ibu Mina was an outlier. Perhaps she was a particularly charismatic person and it was not her role in the community that created her level of importance. In Central Sulawesi I interviewed seven dukun bayi in four locations. With the exception of one, they seemed to have, to varying degrees, a following of sorts made of people who respected their input and believed that their practice was important.

As I was submitting grant proposals political instability in Central Sulawesi made the area potentially too volatile for conducting research. Because I already had many good contacts in Sumbawa and Lombok I was able to change my field site back to Sumbawa and found a region that was not directly related to the mining area.

Later, when I first arrived in Lunyuk I was introduced to a bidan (a biomedically trained midwife) who took me to the clinic to meet Dr. Candra, who was the only doctor in the community, and also the person in charge of administering all of the local public health programs and facilities. I needed to formally request him to allow me to conduct research in the clinic, and I needed to deliver reams of paperwork and permits from the government that had (already) given me permission to do this research. The visit was pro-forma, but important.

[1] Southeast Asian Summer Studies Institute.

The young Javanese doctor kindly welcomed me to his clinic and asked how he could help me get started.

Dr. Candra and I talked about what it was that I intended to study in Lunyuk. After patiently listening to my research interests he looked worried and told me what many other government officials had already told me. “You might be in the wrong place,” he said. He told me that Lunyuk was not of great interest for issues of childbirth; the people here were neither completely “primitive” nor “modern.” He said that if I wanted to study people who refused to become modern in their practices concerning childbirth, who would only use the dukun bayi for perinatal care and who had high maternal and infant mortality rates, then I should go to Lombok, which is the next island to the west of Sumbawa. If I wanted to study how childbirth was dealt with in Indonesian clinics and hospitals as compared to American clinics and hospitals, then I should at least go to the hospital in the capital city of the island, Sumbawa Besar. He said, “Here, in the Lunyuk clinic, we do not have the best practices.” He used the English words “best practice”, that I later found out were commonly used in these settings, where the Indonesian form becomes, “bes praktis.” Over the time period that I was in Lunyuk the doctor, the bidan, and I had many conversations about bes praktis.

“Bes praktis” describes not only an ideal type of practices and an availability of medications and equipment necessary for biomedical treatment, but also a relationship between the patient and health care practitioner based on a common understanding of what a “modern” practice of medicine and the according treatment

of childbirth should involve. The patients were expected to respect the advice and authority of the clinic practitioner and to play the role of the good obstetric patient, which meant buying into the biomedical knowledge of the clinic. The problem, as Dr. Candra and the bidan told me, was that the clinic practitioners had to compete for authority with the indigenous practitioners, i.e. the dukun bayi. In other words there was not one source of authoritative knowledge; rather there were several sources of competing knowledge operating in Lunyuk. In the ensuing months I found that while the clinic knowledge had a certain amount of political and economic authority, the indigenous knowledge held a great deal of local social authority. The competition for patients and status between the practitioners, the dukun bayi, and the bidan, was largely an outcome of the active construction of identity and the maintenance of social relationships through the conduit of obstetrical care.

Chapter 1: Introduction

This dissertation examines the ways that the people in the village of Lunyuk, Sumbawa negotiate relationships and identity in their discussions about pregnancy and childbirth. At the center of the analysis are dueling midwives: those with biomedical training (bidan) versus those who use a local indigenous obstetrical knowledge similar to that found in much of Indonesia (dukun bayi). They compete with each other for patients, who are likewise making sense of their position in the world while juggling the pressures from national citizenship, local ethnic membership, Islam, and obstetric knowledge options. Specifically, this dissertation examines how people in this region use the two well-defined systems of obstetrical knowledge, the locally-practiced, indigenous versus the biomedical, to configure their social status and identity when confronted with the need to care for pregnancy and childbirth in a region where maternal and infant mortality is far too common.

As the two types of midwives in Lunyuk, the bidan and the dukun bayi, build practices and address the problems that they observe in the region they are in dialog with their patients, with each other, and with the larger communities. It is this dialog that shapes their practice as women decide between conflicting messages and definitions about modernization, morality, the place of ritual, and obstetrical competence. As a way of further understanding constructions of identity I will look at how the midwives of Lunyuk, in conversation with their patients, define their units of belonging and how people are classified. In this process it is especially

pertinent to look at how people define what it means to be a part of "us" as opposed to a part of "them" and how these formations of identity direct behavior associated with obstetrical care. I found that people involved in the reproductive practice spoke very consciously about their collective identity and part of how they cemented this identity was associated with choices that they made regarding reproductive care. Pregnancy and childbirth prove to be particularly rich life events for examining these subjects, as the expectant families must make a high-stakes consideration of the best route to introduce a new human being into the world.

Issues associated with reproduction were a constant concern for people in this area given the high rate at which women and babies die in childbirth or soon after, and nearly everyone in Lunyuk had experienced losing multiple people dear to them in the reproductive process.[2] People across the community thus thought in clear terms about the reproductive options that were available and about risks that they would have to confront. The local norm was to seek the majority of reproductive care from the local shaman midwives with some prenatal visits to the clinic practitioners. The actual deliveries were most often attended by the dukun bayi, with the bidan often being called to the house of a newly delivered baby to perform a post-natal examination, to provide inoculations, or to be present in the case of emergencies.

[2] The infant mortality rate (IMR) and maternal mortality ratio (MMR) in Indonesia as a whole are the highest in Southeast Asia (IMR = 38/1000; MMR = 350/100 000, WHO 2005). These number are thought to be quite inaccurate, and are in fact an underestimate, since Indonesia does not specifically collect data on maternal mortality and there is a great deal of evidence that significant numbers of infant and maternal deaths go unreported. The province that contains the district of Sumbawa is Nusa Tenggara Barat (NTB). NTB is of the five provinces with the highest MMR and IMR. See chapter three for more discussion on this matter.

In this rural region, biomedical reproductive care, albeit limited, is available locally at no charge or nearly so.[3] While people sought care from the local clinic practitioners for pregnancy and childbirth, it was through the local dukun bayi that people found a social reference point. This continued even amidst powerful government campaigns that developed and then used the clinic to "modernize" the citizenry through their obstetric practices. In the face of this, I found that the most popular of the local dukun bayi were engaged in a deliberate assessment of the capabilities of the government's biomedical system and that they actually incorporated certain aspects of the bidans' practices into their own. The local power of these dukun bayi could be seen in the fact that people sought their guidance for many issues not related to reproduction and childbirth. Even people who sought the majority of obstetric care from the bidan would consult with the dukun bayi throughout their pregnancy.

The knowledge systems of both the bidan and the dukun bayi held a great deal of explanatory power. Although both competing obstetrical knowledge sets were specific in nature, they tapped into larger cosmological paradigms. These obstetrical knowledge sets were bodies of facts or truths as described by the authorized practitioners, the bidan and the dukun bayi, and which expressed truths about the natural world as understood by their practitioners. Both of these medical systems, as they will be treated here, are finely tuned social reception systems. They are both built on and reflect social norms and truths rather than merely being

[3] There was confusion and misinformation in the public regarding the charges at the clinic.

systems that address pressing medical issues. The medical knowledge sets are graded, prioritized, and have prestige associated with them depending on the social commentator.

The following ethnographic vignette describes how these knowledge systems are graded. At the opening ceremony for the Indonesian Independence Day celebration in Lunyuk, the new district administrative head (the *camat*) was introducing the line-up of presentations. As he spoke he framed the ceremony as representative of all the parts of the community that come together to make Lunyuk a functioning and growing village. He took pains to paint Lunyuk as representative of Indonesia: heterogeneous in ethnicity and religion but working together as one to make Lunyuk, and by extension Indonesia, the best possible version of itself. He began by introducing people whom he labeled as representatives of the critical organizations and the government officials that organized and offered the services needed by all the citizens. These were people whom he sat on a raised platform on the stage. This included representatives from the clinic, specifically the bidan whom he introduced as the heroic women who bring the babies of Lunyuk into the world. He announced that the second part of the ceremony would represent the "culture" of Lunyuk.[4] The introductory performance was a group of children dancing in Sumbawan costume and to the music of Sumbawan flute and drum corps led by the primary dukun bayi whom I worked with, and by her husband who is also a *dukun* (shaman).

[4] See Pemberton 1994 for a discussion of the presentation of culture, or *kebudayaan* in Indonesian political settings. Also see chapter 8 for additional discussion of this matter.

In Lunyuk, as with any place, people organize their behaviors and categories of difference in ways that represent how they see their world and what they hope will exist in the future. People often form boundaries based on characteristics that they believe will distinguish themselves, and those like them, from those who are different, thereby establishing their sense of place in the social hierarchies. The presentation of, use of, and control over ceremonies, technical equipment, educational material, and record keeping are some of the many ways that these social organizations and categories are expressed. When the camat presented the organization of the village from a nationalist governmental perspective, he placed the people of the village into hierarchically organized categories that represented his ideas about what a modern Indonesia should look like. As he introduced the invited participants, the camat carefully placed the politically strong but socially weak clinic representative and other government-recognized community leaders on stage with him. But he only made space for the socially strong but politically weak dukun, who embody the competing traditional system of knowledge, in the minor role of cultural arts teacher and performer.

Before the performance, one of the dukun told me that the joke was on the camat. Everyone in Lunyuk knew that she and her husband were not the Sumbawan arts specialists in town. They laughingly told me that neither of them had ever been particularly proficient musicians or dancers, much less teachers. They had told the camat the names of the people who were knowledgeable about Sumbawan music and dance, but the camat had been very insistent and so they relented. They made

the point that there was never a ceremony in Lunyuk involving Sumbawan people that did not include them and the camat knew that. So even though it was silly, they were included in a role that they did not know much about, and a space had been made in the ceremony for them. Although the camat had the power to publicly place the two dukun in a category that was separate from their primary local social role—(i.e. being community elders and tending to the birth of new Sumbawans) their central position in society could not be erased, even by the camat.

I use this ethnographic vignette to illustrate how one powerful actor in this particular setting, the camat, presented his (and others') vision of a cultural future for a modern Lunyuk by carefully grading knowledge sets and placing people in categories that he thought appropriate. The camat had a vision for the "modern" future based on external, politically powerful criteria, but he clearly did not value the local social hierarchies. The socially strong dukun, who also had a vision about the future of modern Lunyuk, understood the importance of being part of a public representation of the community, even if their role in that ceremony did not reflect their actual societal position.

1.1 Research Goals

This dissertation looks at how systems of knowledge are used and circulated in the same arena by different actors. It will focus on how people define what kind of

people they are, what they look towards in developing a future, and who has the power to shape those visions for the community.

The Indonesian educational curriculum, national celebrations, print and visual media, and public service organizations include both tacit and explicit messages about what a modern Indonesian populace should look like. For both symbolic and practical reasons the state definition of the modern Indonesian is closely connected to the use of biomedicine as offered in the clinic. The government concept of producing a nation of modern Indonesians starts symbolically at birth in a clinical setting, thereby intentionally eschewing the use of prenatal and delivery care that is considered to be ethnically or locally identified. In very practical terms, the international development organizations have repeatedly used statistics like maternal mortality ratios (MMR) and infant mortality rates (IMR) to rank a country in a hierarchy of modernity. These statistics figure into the categorization of countries into "most developed" versus "least developed" nations.[5] Indonesia's placement in this hierarchy is regularly highlighted in the government training programs for their clinic midwives. At midwifery training events the opening presentation often gives graphic representation to where Indonesia is in terms of reproductive health on a global scale. Additionally, these same state and international interests strongly assert that the only way to achieve low IMRs and MMRs is through the exclusive use of the clinic for prenatal, delivery, and post-natal

[5] For example, these hierarchies could come in the form of the categorization of countries as "most developed' (MDC) versus "least developed" (LDC) countries. See http://www.unohrlls.org/en/about/ . Indonesia is classified as doing better than the LDCs but has some of the worst maternal mortality ratios of the ASEAN countries.

care. With these points in mind the use of the shaman midwives seems retrograde in the minds of reproductive health program officials and clinic technicians.

Thus it follows that the long-standing maternal and child health program initiatives in Indonesia are intricately linked to nationalist pride and global development objectives, as well as to success for Indonesia in receiving international funding. Great strides in health indices have been made in other areas that are related to maternal and infant health issues, such as family planning and child health (Hull 2005). The family planning program in Indonesia is now recognized world-wide as an example of a successful development program (Hull 2005).

Nonetheless, maternal mortality ratios and infant mortality rates remain high in Indonesia, and this causes a great deal of frustration for the development and clinic workers who address these issues. Development and clinic workers blame the high mortality rates primarily on the shaman midwives whom are the first choice for obstetric care for most rural people (Wirawan 1994). Clinic staff, government officials, and maternal health programmers frequently ask the question: why don't people come to the clinic? The pregnant women discussed in this dissertation all live within a thirty minute walk of a clinic where discounted or free reproductive health care was available. Proven biomedical solutions for the majority of the reasons why women and infants die or are disfigured in childbirth have been known for decades.

As interview data presented in this dissertation will show, clinic staff, government officials, and maternal health programmers assume that people fail to use the clinics to the extent expected, and continue to use the services of the shaman midwives because of faulty decision-making on the part of individual patients. They deride these "faulty" patient decisions in order to patronize the shaman midwives suggesting that they are lazy, naïve, uneducated, or lack exposure to modern methods and ideas. This reasoning drives program development, evaluations, and patient education, and is also reflected in the way that the clinic staff addresses patients. The message from the biomedical officials to patients is that using clinic care for a pregnancy and delivery is the only responsible choice for parents.

Little headway has been made by the biomedical officials to clearly explain why people don't come to the clinic, when distance and prices are taken out of the equation[6]. I suggest that it is equally or more important to turn the clinic and development officials' question around and to ask: why are the shaman midwives still in business? Throughout the discussion of this research it is important to understand that due to the occasionally dire outcomes, maternal mortality and infant mortality are important issues for the local people and that because of this, people consider all possible alternatives. In addition to this, both the shaman midwives and the clinic midwives actively construct midwifery practices that reflect the political, social, and religious landscape. In doing this, they respond to the practical obstetrical issues, but also to patient demand, to the criticism they face, to

[6] The primary informants discussed in this dissertation all live within a thirty minute walk of a clinic where discounted or free reproductive health care was available. Distance from the clinic clearly was not an issue.

state policy, to religious pressures, and to tradition. People use their systems of knowledge to assess the value and probable outcome of the medical care choices they have before them. The obstetrical providers, both the shaman and the biomedical midwives, will be the central figures in this the discussion, which will also include the dialogical relationships with the patients, the government officials, and the international development officials.

This dissertation makes two central points. First, a global force, biomedicine, is translated into the vernacular of a rural Indonesian village, where long-standing traditional practices exist. Ultimately the focus is on the local midwives (i.e. both biomedically-trained and shaman) who not only act as translators of these global forces, but respond to the particular demands of the local people as they negotiate competing systems of obstetrical knowledge, and social, cultural, and practical concerns about bringing a new human into this world.

Second, individuals in this particular social and cultural setting, both express and come to see themselves not only in terms of the reproductive practices they choose, but also in terms of how those practices fit within their knowledge systems. Further, the equipment that they employ, either as the health care practitioner or the patient seeking care, reflects this. Decades of Indonesian government pressure to modernize, and the more recent entrance of international and government programs into the village, have challenged the local people to re-imagine who they are and how they should live. Pregnancy and childbirth thus prove to be a

particularly rich topic for examining these subjects as the expectant families consider their best options for childbirth.

1.2 Literature Review

The issues raised in this dissertation cross three distinct bodies of literature that address social aspects of knowledge systems and claims. The first is a central concept for the anthropology of reproduction, that of "authoritative knowledge." A second body of literature is that of the social studies of science: sociology of scientific knowledge, cultural studies of science, science and technology studies. A third area is the body of literature that works to connect global health programming and local processes.

The Anthropology of Reproduction

Anthropological work on reproductive practices suggests that an important and previously over-looked place to understand social and cultural patterns is in the making of more humans (Ginsburg and Rapp 1995). Human reproductive practice and health is at the intersection of social patterns, the local visions for an ideal larger community, the ideas about risk and the fragility of life, and the ideas about the nature of humanity, control of the body, and global processes. A great deal of work has been done on the interaction between indigenous and biomedical obstetric care (Sargent and Bascope 1997, Pigg 1997, Sesia 1997). On these topics a

primary question is how do these systems interact? A great deal of research on medical pluralism and on medical issues in general shows the enormous political power that comes, as part and parcel with biomedicine. The question for the patient then becomes: from which system is the medical knowledge going to be best for my health issue? Said in another way, which medical knowledge counts in the treatment of the problem at hand?

A central concept for the anthropology of reproduction, *authoritative knowledge* is provided by Jordan ([1978] 1993) in *Birth in Four* Cultures, and is further developed by Jordan (1997) and Davis-Floyd and Sargent (1997). In short, authoritative knowledge recognizes that in most social settings multiple knowledge systems are at play but some hold more weight than others. In many ways, this is the central issue for this discussion. The way that a knowledge system can hold more weight than another is variable as much ethnographic work will show (Sesia 1997, Georges 1997, Browner and Press 1997, etc). As in the case of obstetrics in Lunyuk, biomedicine practitioners themselves expect that biomedical practice will have authority. The concept of authoritative knowledge is useful when working through the question of who has authority when multiple systems are available and biomedicine is not the primary system used.

Indeed how authority develops, remains, or is resists by different knowledge systems is at the heart of this dissertation. Many analyses of the introduction of biomedical obstetric services highlight the "multi-directional" influence acting on local practitioners (Ginsburg and Rapp 1995). These studies thereby suggest that

indigenous practitioners have significant agency in shaping their practices in response to their interactions with the global programs that introduce biomedicine. In this analysis I suggest that both the biomedical and the indigenous practitioners become "local" as we see in Lunyuk. Both practitioners are subject to pressures and restrictions that exist locally. In Lunyuk we see an extension of this multidirectionality in that the biomedical practitioners' practices change as a result of the authority of the indigenous practitioners. We will see that Dr. Candra's assertion that the clinic midwives do not have "bes praktis" is partly the result of the way that the indigenous obstetric practice has shaped biomedical practice.[7] Thus a biomedical obstetric practice has developed that is specific to the knowledge and practice alternatives that are available in Lunyuk.

This dissertation examines the negotiation, the challenge, and the production of authoritative knowledge in rural Indonesia. The authority of both the practitioners of indigenous obstetric medicine and that of the biomedical midwives is challenged in multiple ways. This analysis investigates how these bidan, who expect to have authority, reconcile the fact that they are challenged, manage to influence their patients' actions and ensure that they have sufficient authority to attract patients. The bidan and the dukun bayi do this by demonstrating that they can shape cultural truth in many ways, primarily by controlling the technology used to administer care. Ultimately, we see that the patients' obstetric choices reflect the

[7] Dr. Candra was also noting that because of structural inequalities and various political issues at the provincial and district level proper training, numbers of staff people, supplies, and facilities that were needed were not available.

internal and external ideological and cultural forces at play in their communities (Rothman 1989).

Social Studies of Science

As Margaret Lock notes in her forward to *Tibetan Medicine in the Contemporary World* (2008) medical pluralism is not only alive but also flourishing in many parts of the world. This is contrary to predictions made decades ago about the imminent demise of medical systems other than biomedicine. In their description of medical pluralism in Asian countries Leslie and Young (1992: 2) suggest that because many of the analyses have been done by "Western observers" and because the scientific basis of biomedicine is how we generally understand medical issues, our analyses of medical pluralism have the subtext of treating other medical systems as "ignorable." Surely (depending on the view point) the hegemonic force of biomedicine, or the evolutionary step to rational thought, should wipe out other systems of medical knowledge and practice. From an evolutionary modernizing perspective, biomedical knowledge is ontologically superior to local traditional knowledge, and would eventually dominate throughout the world (Leslie and Young 1992). Western observers see this as an inevitable transition; "reason and pragmatism" will trump "culture and tradition." The case of Lunyuk presented here demonstrates that medical pluralism is alive and well, and that this must be

considered, particularly when biomedical approaches are introduced into communities with strong indigenous practices.[8]

Thus this dissertation contributes ethnographic data concerning the way that obstetric care operates in a rural location such as Lunyuk. The social study of science suggests that scientific knowledge claims are made in a particular place, and thus these claims carry with them the mark of the local (Shapin 1995: 306). Obstetric care in Lunyuk comes from two different traditions: that most often labeled "biomedicine" and that often labeled "traditional medicine." Biomedicine is generally understood to be the empirically-based branch of medical science from the West (Gaines and Davis-Floyd 2004). Traditional medicine is often labeled "folk medicine," or "ethnomedicine" suggesting a system based on beliefs rather than empirical truth or natural, biological observations (Gaines and Davis-Floyd 2004; Good 1994).

To understand the obstetric options that arise from these separate knowledge systems, and to comprehend how those options are interpreted by the people of Lunyuk, it was necessary to use a perspective that does not assume the superiority of the biomedical system. Yet at the same time the social and political status of the biomedical practitioner was markedly different. Biomedical practitioners carry an elevated status because of their association with education, moneyed institutions, and a general worldliness. As we investigate the alternative system of knowledge it is important to analyze the two medical knowledge systems

[8] There are many such examples. See the volume edited by Laurent Pordie 2008 for a collection of such examples.

in much the same way that the people of Lunyuk do, as different types of *ilmu.* Ilmus is the Indonesian word that is used to describe a system of knowledge and understanding such including magic and science.

In Lunyuk the obstetrical practitioners from the biomedical and the local medical traditions compete for patients. In the study of reproductive practices, this becomes a way to work through identity, modernity, and social relationships. I found that the dueling traditional and biomedical midwives (and their patients) talked about the competing knowledge sets that informed obstetric practice in much the same way as they described ethnic knowledges, (which was often related to sorcery). As there were three ethnicities in the region, the notion of dueling knowledge sets was a common discussion. Ilmu Sumbawa, ilmu Sasak, or ilmu Bali were understood to be produced by people of that ethnicity and presumed to be most effective on people of that ethnicity. This was expressed through the discussion of its possibilities, stories, and technology. It framed the cosmology, possibilities, and nature of the world for people of that ethnicity. Thus it formed something of a descriptive paradigm. In order to understand this ethnic paradigm one must be a member, in this case of that particular ethnicity. In this way there is both an embodied connection between nature and knowledge, and a boundary delineating those who belonged from those who do not.

The Sociology of Scientific Knowledge (SSK), Science and Technology Studies (STS), and Cultural Studies of Science (CSS) all consider the content, theories, and influences of scientific knowledge. Each of these perspectives treats scientific

knowledge as a social construction, as such suggesting that these perspectives assert that there is nothing epistemologically different about scientific knowledge, as distinct from any other similarly overarching knowledge set (Pinch and Bijker 1984: 401). This type of analysis is not concerned with finding scientific "truth" and ferreting out scientific "falsehood", for it regards all knowledge as being socially constructed. So, for example and in the case of this dissertation, one could look at the interactions of two knowledge sets (such as biomedical and indigenous obstetric knowledge) without an a priori determination about the veracity of one over the other.

Science, and specifically empirical biomedical knowledge, is purported to be value-free. This scientific knowledge is powerful and prestigious. It explains natural phenomena and is thus perceived to be partially of nature. Shapin (1995: 302) reminds us that "Scientific knowledge is as secure as it is taken to be, and it is held massively on trust". It is largely invisible as a cultural system because it seamlessly follows the empirical boundaries of explanations that it itself sets.

Anthropologists who study health-related issues conduct analyses of biomedicine as cultural constructions or as sociocultural systems that reflect the norms of those who hold the system to be a most valued truth (see Gaines and Hahn 1982; Good and Del Vecchio Good 2000). Rather than understanding the biomedical sciences as a cultural truth, these analyses see biomedicine as a sociocultural system with a "consistent set of internal beliefs, rules, and practices" (Gaines and Davis-Floyd 2004: 96). This realization allows comparisons between medical systems, and

facilitates the analysis of the social norms of those who conduct and apply the obstetric knowledge systems everyday.

Certainly power relations are inherently part of any healing encounter, and scientific knowledge is not perceived equally by all members of a community. There must be some sort of trust of the practitioner by the patient. The patient must believe that the practitioner, as a representative of the knowledge system that informs her practice, has authority. Both the knowledge system and the practitioner that represents it must have authority and power; the practitioner draws on the knowledge system or their perception of truth as a source of credibility. The collective agreement of those who follow the knowledge system is that it is the knowledge system itself that imbues each individual practitioner with power.

Looking at the standards that circulate throughout the world (Shapin and Schaffer 1985) and at the technologies that embody scientific knowledge provides a picture of how power relationships develop. Certainly, as this dissertation will show, biomedical obstetric standards are discussed among the clinic practitioners in Lunyuk. That biomedicine is the standard in urban Indonesia and the industrialized world is well understood in this local setting, by practitioners and patients alike. Inaccurate and overly optimistic ideas about the potential of such a powerful *ilmu*, or knowledge set, comprising institutionalized biomedical care influence people's understandings of the limits of all the obstetrical options in Lunyuk.

No one body of scientific knowledge is understood in the same way from person to person. Different practitioners subscribe to scientific knowledge in

different manners and different localities bring diverse constructions to the knowledge-claim. Rather, science and society are intertwined and hybrid. Part of the power of scientific knowledge is that it is understood as being pure in form. The practitioners and community guard the borders of their knowledge sets by asserting what it is, who will have the power to interpret or practice, and who does not. Latour's great addition to the social study of science was to suggest that science and society really could not be seen as having pure forms, or distinct essences (Latour 1993).

In Lunyuk, we will see the assertion within the clinic body that the biomedical midwives, the bidan, are the only people who have true knowledge to oversee the care of pregnancy and childbirth. Conversely the dukun bayi and their patients assert that the dukun bayi are the only people who have the appropriate knowledge and the religious power to guide a new human to Earth. As we look at this situation, we will see that knowledge and its application is a collective process (Shapin 1995: 302), and that when the elements in a network of scientific knowledge protect the borders, then those borders are strong.

The social studies of science regard technology as being similarly socially constructed and as bearing the same social meanings as instruments of a particular scientific knowledge-claim. Interestingly, technology is seen as a manner in which knowledge travels (Shapin 1995: 307-308). There is an embodiment of scientific knowledge in the tools that are used. Additionally, there is a debate as to whether tools are created in the name of science, or whether science creates knowledge

around tools (Pinch and Bijker 1984). Fischer (2000: 283) asserts that, "Technology is not just objects plus social organization; it also is powerfully invested with fantasies, aspirations, hopes, anxieties and fears. Technological imaginaries are rich cultural fields of literary, philosophical, symbolic, and psychological production…". This dissertation analyzes the competing knowledge systems and authority by looking at the tools and technologies that one system borrows, attempts to master, or publicly uses in the quest to remain relevant or become dominant over the other.

Global Problems

As we look at these issues we will see how a global problem, such as reproductive health, is embedded in local processes. Relationships between the global and the local are a much theorized issue in the social sciences. Many of the great problems of our time, especially related to health, are not issues that can exist within finite political boundaries, but rather are global in scope (Farmer 1999; Janes 2003). The response to these transnational problems has typically been to develop global initiatives and programs, such as the Safe Motherhood Initiative as adopted by the World Health Organization. Although hard work, good minds, and a great deal of money have been directed toward finding world-wide solutions and developing programs for issues like maternal mortality, the expected changes in mortality ratios and other types of relevant data have not been observed (Graham 2002; Hay 1999; Janes and Oyuntsetseg 2004). Additionally, our assumption that we understand how to biomedically address maternal mortality and morbidity issues in

individual cases, does not mean that the same understanding and problem-solving strategies will be effective at the population-level (Graham 2002; Janes and Oyuntsetseg 2004).

This dissertation adds to the assertion made by others (e.g., Janes 2003, Hay 1999) that the key to finding solutions to global problems is based in comprehending the local social, political, cultural, and economic issues. To understand problems of health, illness, and suffering globally we must discover the proximate causes of those issues on a local level, for this is where the problems are embedded in local character. As Janes (2003) and Rak and Janes (2004) remind us, this proposition does not suggest that the problem lies in local practices, rather it is that the problem exists in a unique form in each place, so even global solutions need to allow for information gathering and flexibility as to the knowledge sets and their applications at each local site.

Practice and Identity

A primary focus of this dissertation is how people reflect on their identity in their interactions with the various forms of obstetrical care that is available. In this process people classify others and determine the necessary elements of how to bring a person into the world. Much of this analysis focuses on the use of competing systems of obstetrical knowledge, the competing midwives and the related struggles with status. The practice, or the actions, of the midwives have both intentional and unintentional social and political implications that refer to patterned and routinized

behaviors for both themselves and their patients. What complicates the matter for the people involved is that each individual inhabits a multidimensional social space that includes social forms that challenge the worldview of the individual.

The work of two practice theorists, Pierre Bourdieu and Michele Lamont, is helpful in this portion of the analysis. The manner in which Pierre Bourdieu analyzes high status symbols is particularly useful. Of particular interest is the idea that shared cultural styles are an essential element in class reproduction, which maintains hierarchies and inequalities. At the core of Bourdieu's analysis of these issues of status is the notion of habitus, which is an intermediate variable between before consciousness and reflections of the conditions of existence (Lamont 1992: 187). Bourdieu suggests that habitus is determined by the class of one's birth, current social standing, various conditions of the individual, and different access to capital (Bourdieu 1984 and 1990). Bourdieu defines habitus as "a system of lasting transposable dispositions which, integrating past experience, functions at every moment as a matrix of perceptions, appreciations, and actions and makes possible the achievement of infinitely diversified tasks, thanks to analogical transforms of schemes permitting the solution of similarly shaped problems." (Bourdieu 1977: 83). Habitus shapes a person's perception of all that is around him or her, forming the individual's ability to act in the social setting. Further, habitus is embodied in an individual in a manner that is before consciousness thus creating what seems to be the natural order of things.

Michele Lamont extends Bourdieu's theories of habitus in her analysis of symbolic boundaries (e.g. Lamont 1992). She contends that Bourdieu's formulation of habitus is too focused on proximate structural conditions such as class of birth or wealth (for example). She suggests that, "Bourdieu neglects to analyze how people's preferences are shaped by broader structural features as well as by the cultural resources that are made available to them by the society they live in" (Lamont 1992: 187). Her formulation of symbolic boundaries allow for an extension of Bourdieu's work on the relationship between habitus and social structure (specifically dispositions, taste, and sensibilities).

Michele Lamont defines symbolic boundaries as, "conceptual distinctions made by social actors to categorize objects, people, practices, and even time and space. They are tools that individuals and groups struggle over and come to agree upon as definitions of reality" (Lamont and Molnar 2002: 168). The placement of these boundaries differs depending on context and structural issues (e.g. education, ethnicity, socioeconomic status, and religion). Symbolic boundaries also create a system of rules, "that guide interaction by affecting who comes together to engage in what social acts" (Lamont 1992: 12). Lamont and Molnar (2002) assert that symbolic boundaries are a pre-condition for the construction of social boundaries. In this way Lamont suggests that symbolic boundaries help define groups but also create inequality.

Michele Lamont's formulation of symbolic boundaries breaks from Bourdieu in an important fashion, which is particularly salient in my analysis. She suggests

that while she agrees with Bourdieu that differences between social groups (Bourdieu and Lamont speak specifically about class differences) necessarily leads to hierarchalization. Lamont's work suggests that there is a great deal of variation in the strength of symbolic boundaries. I find that the moments of variation in the strength of symbolic boundaries observed by the bidan and the dukun bayi are particularly informative analytical moments. It is telling to observe which boundaries are more firmly asserted, de-emphasized, or momentarily dissolved in a particular social setting allows for a picture of the individual negotiating a multi-dimensional social space with competing worldviews at play.

1.3 Organization of the Dissertation

Chapter two provides the background context for the analytical chapters of the dissertation. This chapter presents information about the research site, which was the village of Lunyuk on the southern shore of the Indonesian island of Sumbawa. This includes a description of the geography and history of the area, the history of migration of the population into the area, and the resultant mixture of languages and religion. This chapter also provides an overview of the government and administration of the region, then discusses the immediate area of the village of Lunyuk.

Chapter three develops the background of reproductive health care in Lunyuk, first looking at global reproductive health programs, initiatives and issues,

and then introducing the traditional birthing assistant (i.e. the shaman midwife) who, as in many locations of the world, is a person regarded as having significant knowledge and social status in the community. The discussion then moves to reproductive health in rural Indonesia and more specifically in the village of Lunyuk, where the dukun bayi and the bidan are introduced, along with their roles and practices. The chapter concludes with a discussion of the etiology of dystocia as observed in Lunyuk, including attitudes about the causes of problems.

Chapter four presents the general methodology used in this research. The sample population is discussed, consisting of reproductively active women, the obstetric practitioners (i.e. dukun bayi and bidan), and the government and agency officials. The methods of data collection are then presented, including approaches to interviews, users of questionnaires, interviewing technique, participant observation, and confidentiality.

Chapters five and six look at the practices of the dukun bayi and the bidan. These discussions are organized around two objects—the umbilical cord scissors, and the shaman-produced delivery water–that emerged as emblems for the many issues that shaped the patterns of obstetric care in Lunyuk. These objects are treated in the analysis as technological representatives of the knowledge system of their origin. These two objects are seen to be inherently connected to a social milieu: each links strongly to the substance of the local society in a particular fashion. The use of each of these particular objects generates a great deal of tension concerning who is qualified to have and use these tools. These discussions highlight

the multiple tensions surrounding how people address the significant problem of maternal and infant mortality in this social setting in rural Indonesia.

These two chapters explore social tensions relating to issues of obstetrical competence, the role of ritual, and the sense of national belonging. These chapters also focus on the different players involved in providing obstetric care—the shaman midwives, clinic midwives, and government officials—as they attempt to defend their social status or challenge the social status of other types of practitioners. Each chapter describes the realms in which women's reproductive lives are acted upon, and in which they must negotiate. Neither chapter focuses directly on the pregnant women and their families, but they are central figures throughout.

Chapter five examines the dukun bayis' practices, using the social tension surrounding their use of umbilical cord scissors, which is a tool originating in biomedical obstetrical practice. This discussion provides insight as to how, under the pressure of the biomedical midwives, the dukun bayi have been able to reconfigure their identity and maintain their local status by successfully projecting themselves to the local population as a combination of obstetric practitioner, Islamic and ethnic ritual specialist, translator of biomedicine, and central figure in an ongoing definition of what modernity means in Lunyuk.

Chapter six looks at the bidan's practices by tracing the issues surrounding the use of the shaman midwife-produced medicine, delivery water, which is widely believed by the populations and practitioners alike to help speed the delivery of a baby once labor has begun. This discussion investigates the conflict that the bidan

feel in their work to improve the devastating numbers of deaths of women and babies in Lunyuk. Importantly, I discuss how, due to the local social and structural challenges, the form of the clinic midwives' biomedical practice changes substantially from what was taught to them in their formal education.

Chapter seven investigates the strong influence of Islam, the predominant religion in the community, on the formation of and acceptance of the differing practices of the biomedical and shaman midwives. This chapter addresses the role of Islam in Lunyuk, and then investigates the impact of Islamic thought on the practices of the dukun bayi and bidan. Of particular interest is how Islamic influences frame the medical choices made by the population of Lunyuk.

Chapter eight discusses the overall findings of the dissertation by synthesizing issues that face the bidan and dukun bayi. The underlying goal for all of the parties (i.e. the midwives, the population, and health care organizations alike) is similar: how to best tend to the health of mothers and infants in the birthing process. A most interesting issue that we see in this setting is that there is not a single answer to this question. Rather, there appear to be multiple competing epistemologies that are available and are routinely used by the population. A final section summarizes the major conclusions, and discusses some of the implications of this research for the future of maternal health care programs in Indonesia.

Chapter 2: The Research Site

This research could have been conducted in nearly any rural region of a developing country where clinic-based obstetric care is readily available alongside indigenous obstetric care. Along with their own distinctive aspects, Indonesia and Sumbawa also happen to have many of the characteristics that exist throughout the world. When I was looking for a research site I had the benefit of having conducted research for another project in Sumbawa and Lombok years before. Although I took an indirect path back in Sumbawa the location proved to be an ideal place to conduct this research.

In Sumbawa I found that various types of biomedical obstetrical care were readily available and that there was a rich tradition of local obstetric knowledge. The traditional practitioners, the dukun bayi, were knowledgeable not only in obstetrics but in the local flora and fauna that was the basis for their pharmacopeia. The region was not so rural or poor to limit travel between the region and more urban centers. Many people left Sumbawa and Lunyuk to receive education in the provincial capital or somewhere in Java. There was thus a constant influx of information, goods, and knowledge about a wide variety of topics. On the other hand, the region was not so wealthy that it was common to travel or receive a higher education in more urban settings.

2.1 Sumbawa

Sumbawa lies between Lombok (to the west) and Flores (to the east); and together they make up a chain of islands known as the Lesser Sunda Archipelago. The two islands of Sumbawa and Lombok comprise the province of Nusa Tenggara Barat. Lombok is the better known of the two islands and is the location of the provincial capital. Sumbawa is 275 kilometers long and 90 kilometers at the widest point and 10 kilometers at the narrowest. It is the site of an active volcano, Mt. Tambora (elevation 2755 meters), which dramatically erupted in 1815 causing global climate change for at least a year. Generally, the topography includes rough mountains, thick jungle, and dry alluvial plain along the coasts.

Figure 2.1: Map of Indonesia

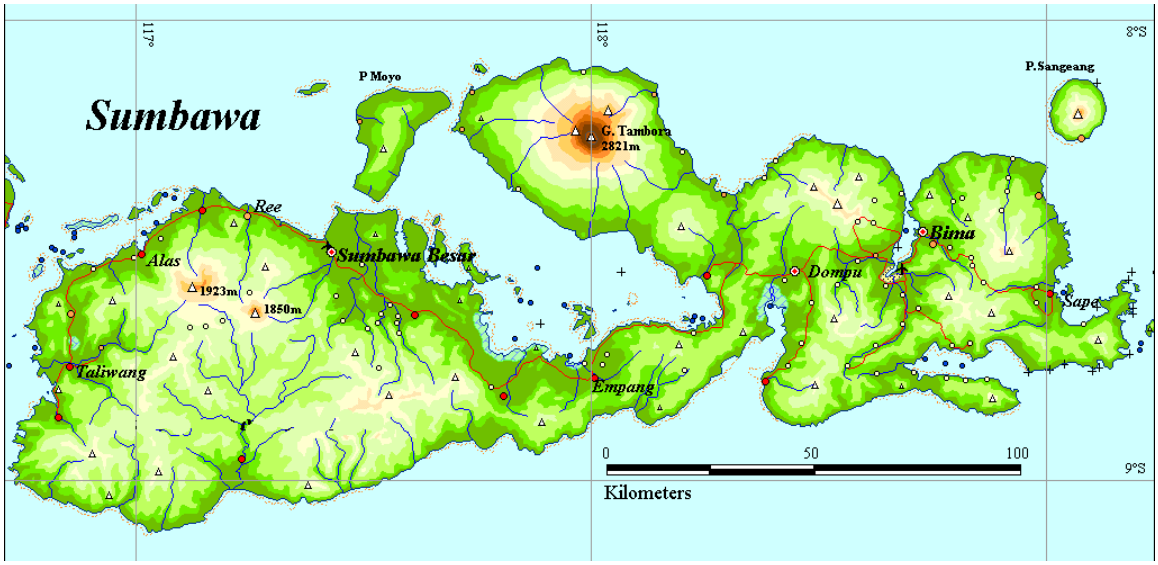

Figure 2.2: Map of Sumbawa

The island of Sumbawa is considered a transitional area between Western and Eastern Indonesia (Just 1986; Brewer 1979). This is perhaps why Sumbawa is not often mentioned in the Indonesian studies literature: it is not quite one area or the other. Just (1986: 21) and Brewer (1979: 2) suggest that Sumbawa has often been passed over because it was not interesting to people who were looking for an Indonesian-ness, and is not similar to the other Eastern Indonesian islands in a religious sense as the island is almost exclusively Muslim.

There has been comparatively little ethnographic research done on the island compared to adjacent regions that more closely fit the mold of either Eastern or Western Indonesia. Some primary works (e.g., F.A.E van Wouden (1968) and those from the Leiden school) devoted most of their attention to the people of Sumba, Flores, Timor, and other islands in Eastern Indonesia. Since World War II, research has included Goethals (1961; 1967), concerning Tau Semawa social organization

and village politics; Brewer (1979); Hitchcock (1996); Chambert-Loir (1980); and Just (1984, 1990, 2001).

Until recently the island did not have one coherent identity. Neither of the primary languages spoken on the island, Sumbawan or Bimanese, had words for the island as a whole, but only for the part that they inhabited (Just 1986). It was not until European cartographers assigned "Sumbawa" to the area that the island had one name (Just 1986). This fact is telling about the diversity and isolation of its inhabitants, its geography, and its history.

Sumbawa is rich in natural resources. Long before the Dutch arrival Sumbawa was engaged with the Makassarese traders. Sumbawan products that were of interest to those outside of the island were sappanwood, edible swallow's nest, bees wax, honey, horses, and horse milk. The bird nests, honey, and horse milk were all traded for medicinal purposes. Today there remains a great demand for these products throughout Asia. Sumbawa also has copper and gold deposits, so it historically has received attention from the Japanese, Dutch, and Makassar Empire. Currently there is a large internationally run gold and copper mine in operation in the southwest-most region of the island.[9] Mining operations have been aided by the fact that Sumbawa has five natural deep bays: Saleh, Bima, Cemi, Wawordad, and Benete.

[9] Marina Welker (2009) has written about the operations of this mine in Southwest Sumbawa.

Sumbawa is situated between the Wallace and the Weber Lines in the region that zoologists refer to as Wallacea.[10] Indigenous mammals are small (e.g., deer, civet cats, mice). Non-indigenous mammals (e.g., the grey macaque) are imports from the western islands. The wild pigs are rumored to be the descendants of domesticated pigs. There are a wide variety of snakes and monitor lizards and occasionally a Komodo dragon appears in the region as well. The small but famously strong Sumbawan horses are found all over the region. Local people say that the horses arrived when a Portuguese ship sank near the coast of Sumbawa and the horses made it to the island on their own.

For a long time Sumbawa was long part of the Majapahit empire. As a part of this empire, there were original sultanates of Sumbawa that were of a Hindu influence. Later, the merchants and sailors of Makassar brought Islam in the 1600's when the island became part of the Makassar empire (Cedderoth 1981; Just 1986). The ancestors of the Sultan are still in Sumbawa today. Presently there are disagreements as to who is the rightful heir to the Sultanate. While there is, in fact, a man in Sumbawa Besar who is recognized by some as the Sultan, the people of Lunyuk assert that the rightful heir actually lives in Lunyuk Rea. Several versions of a common Indonesian story about inheritance and sultanates tell of a feud between brothers who were sons of the Sultan.

[10] The Wallace line refers to the research conducted by Alfred Russell Wallace. He placed the line marking a shift from Asian to Australian flora and fauna between Bali and Lombok. Max Carl Wilhelm Weber placed a similar line closer to Australia to mark a region were the mammalian fauna are exclusively of Australian origin. The region between the two lines is referred to as "Wallacea."

The Dutch, in the form of the VOC (Vereenldge Oost-Indische Compagnie, Dutch Mercantile Trading Company) arrived in 1605 but had a very small presence until 1674 when a contract for supplies was extracted from the Sultan of Western Sumbawa. In 1910 the Dutch built the trans-island road across Lombok and Sumbawa, which is still one of the only major well-maintained roads on the island. The Dutch became more interested in Sumbawa when the Japanese began asserting authority before World War II.

Languages and Religion

The Island of Sumbawa is divided into three regions: Sumbawa, Sanggar, and Bima (Fig 2.2). Sanggar is the central portion of the island that surrounds Mt. Tambora and is primarily populated with Bimanese people from the eastern end of the island. Today the region is very sparsely populated (Dove 1984: 113); however, before the eruption of Mt. Tambora (April 5, 1815) it was home to three separate kingdoms with distinct languages.

Bima is the eastern and most densely populated portion of Sumbawa. The dominant ethnolinguistic group is the Dou Mbojo, or Bimanese, or in Indonesia *orang Bima* (Hitchcock 1996; Just 1986). Most people speak Bimanese, or Nggahi Mbojo. The Bimanese language is considered closer in origin to the languages of Eastern Indonesian, specifically those found in Flores or Sumba. Probably because of its proximity to Sumba and Flores, a great deal more people follow a Christian faith in the region, although Islam is still the dominant religion.

The western portion of Sumbawa is primarily inhabited by the *Tau Semawa*, or in Indonesian *orang Sumbawa*, who are people who speak *Basa Semawa* (referred to here as Sumbawan). Sumbawan is a language categorized by Esser (1938, found in and reaffirmed by Adelaar 2005) as part of the Bali-Sasak language group, which is closer in origin to Malay than Javanese. This area of Sumbawa includes regions that have spent long periods of each year isolated due to poor road conditions. Thus distinct dialects of the language have developed. People often in any one area of Sumbawa claim that they cannot understand both the vocabulary and accent of a person from another region.

In general the Sumbawan people consider themselves to be particularly pious. Like Just found in Bima (1986: 45), Sumbawans often proudly commented to me that the people in Sumbawa are "*fanatik*" (or fanatical Muslims). At the time of my research there was a good deal of activity from extremist Islamic groups with ties to global terrorist networks. People quickly made the distinction between the local type of fanatik, in which they meant pious, and a brand of fanaticism exhibited by terrorist groups that the local people found scary and largely abhorrent. Privately people told stories of recent boar hunts and the exceptional taste of the Sumbawan boar, despite the consumption of boar meat being forbidden by Muslim practice. The justification for this consumption of a forbidden meat was that the practice of Islam had only recently become "fanatik." It was the norm for people to pray five times per day. A common assessment of whether another person was of good

character or not depended on their attendance at the mosque, or *masjid*. In 2002 there were 17 people who travelled to Mecca for the *haj* from Lunyuk (BPS 2002).

2.2 Government

The province of Nusa Tenggara Barat is divided into six regencies (*kabupaten*): West Lombok, Central Lombok, East Lombok, Sumbawa, Bima, and Dompu. The three regencies on Sumbawa more or less reflect the old sultanates that existed under Dutch rule. The capital of the Island is Sumbawa Besar, which lies on the north coast. The administrative leader of the regency is the *bupati*, or regent. The kabupaten legislature, the Dewan Perwakilan Rakyat Tingkat II (DPRD II) creates a list of potential bupati. The governor of the province then selects one from the list to become bupati. From independence until Suharto's overturn it was accepted that the decision about who would be bupati was really from the central government. Indeed the governor is appointed by the president. However since there has been a move toward local autonomy (*otonomi daerah)* in 2001 under Habibie's presidency, there has been a move to follow the suggestions of the DPRD II more closely and to appoint bupati who represent the predominant ethnicity of the region. The term of the bupati is five years; they can serve only two terms.

The move to local autonomy meant that the national government ceded control over the health, education, labor, social, trade, and natural resource departments to the regional government. The people in the area say they had hoped

that with the move to local autonomy, the people of Sumbawa would see less corruption as a Sumbawan Bupati would have a greater vested interest in his region and its people. However, people now complain that this is not the case and that they feel as though there is even more corruption than before. Several suggested to me that because the Bupati is Sumbawan he knows how to steal money and goods from the local people even better than the Javanese Bupati. The people in the clinics found that they are more often undersupplied than they were before local autonomy. Because of this, many people longingly refer to Suharto's New Order government as a time with less corruption.

The kabupaten Sumbawa is broken into twenty sub-districts (*kecamatan*). The kecamatan are broken into the *desa* and then *dusun*. Desa is unfortunately translated into English as village even though most rural desa do not represent anything even close to a village, rather a desa is a division of space that has multiple smaller areas that look like the definition of village. Dusun is translated into English as a hamlet. It is more along the lines of what an English speaking person envisions when he or she uses the word "village" (a grouping of households that are affiliated with administrative and social ties). This translation error appears to lead to troubles in administering public health programming. Funding for projects is targeted at the desa level but the administrative design is something that would work for the dusun level.

2.3 Lunyuk

Kecamatan Lunyuk is located 96 kilometers south of Sumbawa Besar on the southern coast of the island. There are several daily buses between Lunyuk and Sumbawa Besar. A trip on the bus takes around five hours, including stops in other villages, but this can be extended considerably by delays, mechanical problems, or "rest-breaks" along the road. As is typical in this area of Indonesia, the villages between Sumbawan Besar and Lunyuk tend to be strung along the road rather than clumped together. Until 2000 this road was impassable for months at a time, but in 2002 the last portions of the road were finished between Lunyuk and Sumbawa Besar, so it is now rare that traffic is completely stopped.

The majority of the people in Kecamatan Lunyuk live in the lowland plain and river valley near the south coast of the island where several desa meet (Lunyuk Ode, Lunyuk Rea, Pada Suka, and Suka Maju). The total population of Kecamatan Lunyuk was given as 18,766 (Kecamatan Lunyuk dalam Angka). The population of the four desa in the study area was given as 13,485, with four village populations consisting of Lunyuk Rea (2344), Lunyuk Ode (3466), Pada Suka (4956), and Suka Maju (2719). The study area is in a river valley making it an unusually fertile place for the otherwise dry Sumbawan climate. It is for this reason that Kecamatan Lunyuk became a site to receive transmigrants from Java, Bali, and Lombok.

Twenty-four hour electrification of the villages was completed in 2001. At the time of the research there was not enough electricity generated for all the

villages to have power at night so there was a regular schedule of outages. There was no phone service at the time of this research.

The primary industry in the Lunyuk valley is agriculture. Lunyuk is often considered the most fertile agricultural area in Sumbawa. The Sumbawans were primarily herders of cows and agriculturalists with a loose sense of property ownership. The Balinese arrived with a long tradition of complex systems of wet rice agriculture and well-defined notions of personal property ownership. There are many legal cases being tried in local courts to negotiate disputes based on these differences in understandings about what it means to "own" or "sell" land. As the Sumbawan people noticed that the Balinese, and to some extent the Sasak, people have become successful in irrigation methods of agriculture the Sumbawans have become increasingly interested in the land that was exchanged years ago. This is especially true after a large Government of Indonesia and Japanese sponsored construction of a dam intended for irrigating the Lunyuk valley.

A regular part of the telling of the history of Lunyuk by the inhabitants includes the story of how all three groups have adopted elements of each other's methods of making a living in the rather harsh Sumbawan environment.[11] Balinese and Sumbawan people alike report that the Sumbawan agricultural practices have become increasingly intensive in the manner that the Balinese have made so famous (Geertz 1963; Lansing 1991). The Sasak and the Balinese people now report having

[11] Rampant ethnic stereotyping are often used in the story telling but the stories essentially tell the same tale. A Balinese might say that the Sumbawans were lazy and only watched their cows wander while harvesting whatever the forest had to offer. The Sumbawan tale might include references to the Balinese being singularly focused on crops to a fault, noting that it is not wise to invest in only one source of livelihood in the unpredictable Sumbawan environment.

larger herds of cattle after seeing the way that a herd of cattle can effectively act as a family savings account and a diversification in their investment. Disputes still erupt that boil down to notions of how land should be used. The Sumbawan methods of releasing cows to roam freely often do not sit well with the stricter notions of land boundaries of the Balinese people. Sumbawans and Balinese both complain that the Sasak have little sense of an object being owned if the owner is not present.

There are small villages scattered in the mountain areas under the jurisdiction of kecamatan Lunyuk. In the best of conditions this area can only be reached by four-wheel drive truck, foot, or horse. For months at a time during the rainy season many of these areas are isolated due to road conditions. During this time there no trucks can pass the roads, any movement of people between the mountain villages to the lowland or the city is done by horse or foot. According to clinic workers in Lunyuk, the people who live in these areas primarily speak Sumbawan, are generally less educated than the people of river-valley Lunyuk, many are illiterate, very poor, may be malnourished because of lack of access to food for extended periods of time, and have an otherwise very low health status. Although not a representative sample, I interviewed 32 pregnant women in these areas. The highest educational level was third grade. Twenty-seven of these women had experienced one or more miscarriages, still-births, or the death of infants. Twenty-five of the women already had between two and four live births. In these areas, there are few sporadically staffed sub-clinics, a couple of elementary schools

that lack basic educational supplies and often teachers, and there are often extreme drought situations and serious lack of food.

There is no regular market in Lunyuk. There are several smaller open-air stores (*warung*) where people would sell some produce and occasionally shrimp. There was one supply store, owned by a Sumbawan-Chinese woman, where nearly anything could be ordered. Large trucks with buyers representing agricultural companies would drive through the Lunyuk valley at harvest time to buy various products. The sellers in Lunyuk often reported feeling bullied into low prices because the location was so remote and there were no other options to sell their products.

The majority of inhabitants of the Lunyuk river valley were at one time or another transmigrants. The transmigration program began in Indonesia in 1905 under the Dutch colonial rule to address problems with population density and unavailability of land for farming people in the "inner" Indonesian islands (Java, Bali, Lombok)[12]. The newly formed Indonesian government reinstated the program in the 1950's (Sutjaja 1996). People in these areas volunteered, or were volunteered, to move to another region in "outer" Indonesia that was less populated. Transmigrants were admitted to the program if they were married, "of good character," and had farming experience. The "spontaneous" transmigrants moved at their own expense but received government assistance in finding land in the new area. Those who joined a government "sponsored" move were given assistance with

[12] World Bank. 1988. Indonesia: The Transmigration Program in Perspective. Washington D.C.: A World Bank Country Study

the move, a small house on .25 hectares of land, one hectare of farming land, and assistance with food, health care, small livestock, and agricultural supplies in the new area. Settlements were expected to become self-sufficient at the end of five years (World Bank 1988).

Sumbawa is one of the islands that has received transmigrants for decades. There was a wave of transmigrants from Java in the early 1900s. These people intermarried with the local Sumbawans and consider themselves to be Sumbawan. They do not speak Javanese. Most of the transmigrants living in the Lunyuk river valley were moved from Bali or Lombok[13] in between 1950 and 1970. As Sutjaja (1996) reports of Bali, and Sasak settlers confirm as true of Lombok there were great troubles with poverty after Indonesia gained independence. The rural landless were particularly susceptible to this downturn in the standard of living. The majority of the Balinese transmigrants came from Nusa Penida off the east coast of Bali in what is called a "spontaneous" transmigration program. This means that they transmigrated on their own accord and were not offered government support, but did receive assistance in purchasing land.

People came to Lunyuk looking for affordable land and a fresh start. There are many different stories about how a particular family became part of the transmigration programs. For most it was simply a desire to own their own land instead of working others' land for wages or food. For some they were escaping

[13] The majority of Sasak people came from eastern Lombok.

potential social and legal problems of some sort. Others reported answering the call of dreams or visions.

The Balinese live primarily in Suka Maju, but also in Lunyuk Ode. They primarily speak Indonesian and the Nusa Penida dialect of Balinese. The Sasak, which is the ethnicity found on Lombok, mostly live in Pada Suka. The majority of the Sasak people in the region were part of a government sponsored transmigration program. They primarily speak Sasak and Indonesian. I found that it is rare that people do not speak some of all four languages. The schooling is entirely in Indonesian and it is difficult to live a life completely isolated in this community. Most people in the village, particularly the young, and as a result of schooling, speak Bahasa Indonesia, the national language. Many of the children and young adults speak Indonesian much better than they speak the language of their ethnic origin. Everyone shares the same river, schools, and clinics, and like frontier communities across the world they desperately needed each other in the early years to survive.

One of the reasons that Lunyuk was such an interesting place to conduct this research was precisely the mixed ethnic context. The government-sponsored maternal and child health programs were meant to meet the needs of all the people in Indonesia. The national motto, often printed on maternal health program materials, is "unity in diversity" or "*bhinneka tunggal ika*." In the setting of the clinic there is little attention paid to the specifics of ethnic difference as "Indonesian" people are supposed to come to the clinic rather than "Sumbawans" or "Balinese" (Li 1999). The clinic of Lunyuk serves multiple ethnicities rather than just a single

ethnicity as is common in other rural areas. Although this study does not systematically analyze ethnicity it does allow room for issues to ethnicity to arise naturalistically, which might be helpful in future research.

For example, when a woman became pregnant and eventually made her way to the clinic she was given a record book (*Buku Kesehatan Ibu dan Anak* – Health Book, Woman and Child) that detailed her exams and the eventual care of the child. The development agencies that created the book attempted to personalize the cover of the book to show a woman and child dressed in what the government categorized as the traditional dress for the ethnic majority of the region. In the case of the province of Nusa Tenggara Barat, which includes the islands of Lombok and Sumbawa, the books had a woman and child in either Sasak, Balinese, or Sumbawan dress on the cover. For the government to represent an ethnicity through specific dress is something that all Indonesian people are accustomed to, even though this representation was fabricated by the government in at least several cases. There were only two models for the three books (representing three ethnicities) for the area. The models were women involved in reproductive health in Sumbawa so the Lunyuk bidan knew them. One of the women was pictured with her child once in Sumbawan dress and once in Sasak dress.

Out of curiosity, on research trips to Bali and Lombok I was able to acquire these same books with Balinese or Sasak women on the front cover. Curious to see if it made a difference to people what ethnicity was represented on the cover, I gave these books (specifically 20 Balinese and 15 Sasak) to the clinics in the Balinese and

Sasak villages, respectively. The bidan in the villages reported that the books were gone very quickly; some went to a few newly pregnant women, but within a few days women with more mature pregnancies came to the clinic under the guise of coming in for an exam but it became clear that they wanted a new book that represented their ethnicity.

Chapter 3: Reproductive Health Problems

3.1 Global Reproductive Health

Maternal and infant health is a significant social and public health problem worldwide. It is theorized that the physical well-being of a population is related to the overall health of women. Childbirth and pregnancy are of the riskiest times of a woman's life and antenatal care is shown to improve the life chances for a woman and her child. Additionally, household without a mother tend to correlate to lower health statuses and life chances for any children in those households. Thus reproductive health is considered sufficiently important for it to be one of the Millennium Development Goals.

Worldwide, 25% of deaths of women between the ages of 20 and 30 are due to maternal deaths (Walsh et al. 1994). The United Nations reports that in the year 2000 there were 529,000 women who died worldwide due to complications associated with pregnancy and delivery (UNICEF 2009, WHO 2005). A startling 99% of these deaths occurred in developing countries (Walraven et al 2000). Further, among women of reproductive age (15-44 years) from poor countries (Tinker and Koblinsky 1993), death and disability associated with obstetric complications comprise 18% of the disease burden that is figured into the disability-adjusted life year (or DALY). In 1985 the major international aid agencies, governments, and

NGOs held a Safe Motherhood Initiative in Nairobi, Kenya. At this time the Safe Motherhood Initiative (SMI) was developed.[14] Maternal mortality ratios vary widely world-wide, with Africa and South Asian reporting the highest numbers (1000-1500/100,000), and the industrialized countries of East Asia, Europe, and North American (4-10/100,00) reporting the lowest (Koblinsky 1995).

While maternal mortality ratios[15] and infant mortality rates[16] that are collected reflect the vast inequality of worldwide resources in general it is theorized that they under represent a great deal of the reproduction-related devastation that exists. First, these figures are widely believed to under-represent the actual suffering of women, their families, and their communities as they do not report obstetrically-related morbidity and the social problems (AbouZhar and Wardlaw 2001, Janes et al 2004, Koblinsky 1995; Kwast 1998). Maternal deaths represent a fraction of the actual disease burden associated with reproductive events. It is estimated that 20 million women suffer obstetric related morbidity yearly (WHO/UNICEF 1996). Said in another way, up to 15% of the world population of women will experience complications related to pregnancy that may have life-altering results (e.g. Prual et al 2000; Stewart et al 1996). A great number of these conditions become chronic conditions such as vesico-vaginal fistulas, infection, uterine prolapse, and severe anemia (Say et al 2004; Wall 2006).

[14] See Nicole Berry 2005 for an extensive discussion on the SMI.

[15] Maternal mortality is "the death of a woman while pregnant or within 42 days of termination of pregnancy, from any cause related to, or aggravated by, the pregnancy or its management, but not from accidental or incidental causes." (WHO 1992). Maternal mortality is represented by a ratio of a number of deaths per 100,000 live births.

[16] Infant mortality rate is the number of deaths of infants under one year of age in a given year per 1000 live births.

Second, there is a great deal of evidence that suggests that many maternal and child deaths go uncounted (AbouZhar and Wardlaw 2001). These statistics, especially maternal mortality, are exceptionally difficult to calculate (Rosenfield 1989; Barnes 1991; Graham et al 1989; Graham and Campbell 1992). Maternal deaths are often recorded as death by another cause. Infant deaths often go unrecorded (Scheper-Hughes 1992**;** Haraway 1997). UNICEF reports that approximately 60% of the living children under five do not have birth certificates or formal identification of any kind. The logical extension of this finding is that the babies who die are not recorded.

Prodigious international resources have been directed toward maternal health yet there has been disappointing levels of reduction of these statistics (Maine and Rosenfield 1999). Addressing maternal mortality and morbidity is an exceptionally complex problem. The biomedical treatment and prevention of maternal mortality is well understood and practiced (Harrison 1989) as the causes for maternal mortality are remarkably similar in developed and developing countries (Maine and Rosenfield 1999).

Although the global health apparatus has great inefficiencies and failures (see Ferguson 1999; Escobar, 1995) infant and child health programs have historically been more successful (Maine and Rosenfield 1999). Why there is a difference in the success level of child and infant health programs versus maternal mortality programs is theorized to be a difference in the specificity of the initiative suggestions (Maine and Rosenfield 1999). While the child and infant programs had

designated four major activities needed to improve the life chances (i.e. growth monitoring, oral rehydration treatment for diarrhea, breast feeding, and immunization) the SMI initiative had broad goals largely with out specific suggestions about how to reach those goals.

A good deal of the lack of focus of the SMI goals is due to misunderstanding and lack of information about how maternal mortality actually happens. What is more complicated and not well understood are the social factors associated with maternal mortality and morbidity. McCarthy and Maine (1992) refer to this as "distant determinants of socioeconomic status and cultural factors."

Most of the development work for improved perinatal outcomes has been in three areas: 1) training of the "traditional birthing attendant" (TBA); 2) perinatal risk screening; and 3) the presence of a "skilled birthing attendant" (i.e. biomedically trained) at all perinatal events. An additional thrust is ensuring that there is skilled emergency obstetrical care available (Maine and Rosenfield 1999; Miller et al 2003). For years the assumption was that a general change in the socioeconomic status, associated with what was termed as "modernization" in the literature[17] would eventually lead to women choosing the care of a "trained maternal health professional" rather than a TBA. Examination of these issues in this fertile environment is the central theme of the research effort presented herein.

[17] For example Harrison 1989, suggested that the building blocks of "modernization," such formal education, improvements in social status and nutrition, would lead to changes in behavior.

3.2 The TBA and Global Reproductive Health Programs

Although there are exceptions, most places in the non-industrialized world have a local inhabitant, usually a woman, who acts as a birthing expert of some sort (Trevathan 1997; Van Hollen, 2003). The reproductive health literature calls this person a traditional birthing assistant or TBA. It has been noted by anthropologists (notably Stacy Pigg 1997) that the category of TBA in the global reproductive health discourse does not represent the great diversity of how these women and sometimes men practice. For example, it is equally as likely that this person is considered a non-professional as it is for this person to be a professional. An example of the former case is a woman of the older generation who has delivered children herself and has been identified as being able to help other women in the difficult situation. In the field of reproductive health these people are referred to as traditional birthing attendants or TBAs.

For several decades the policy was to train these indigenous birthing experts in the basics of biomedical obstetrics (Goodburn et al 2000). TBA training was then a major component of reproductive health programs (Goodburn et al 2000). In countries of limited resources where maternal and infant mortality are high most deliveries are attended by TBAs. This was considered the easiest way to implement interventions immediately, with the goal of gradually weaning patients off the TBAs and onto biomedical services. The majority of this training focused on the practice of sterile methods, discouraging the use of traditional therapies that could be harmful,

improving nutrition, and recognizing high risk pregnancies or warning signs of troubles in delivery that should be triaged to a clinic or hospital if available. This knowledge set, as currently taught in TBA programs is very similar to that which was taught in the Dutch colonial times in Indonesia (see Stein 2005; 2007).

Beginning in 1997, the international safe motherhood movement changed the policy to focus on ensuring the attendance of a "skilled birthing attendant" for perinatal care rather than train TBAs (van Roosmalen et al 2005). The argument against the TBA training programs was that development agencies, governments, and NGOs spent a great deal of time and money in TBA training without seeing an impact on pregnancy outcome (Goodburn et al 2000; Smith et al 2000). There was little that TBAs could do in the case of obstructed labor, hemorrhage, eclampsia, breech deliveries or other complications that rely on an operative or drug intensive solution[18]. Additionally, there was a concern that training the TBAs delayed the change of the patient use patterns from the TBA to the skilled birthing attendant. After all, the TBA training programs were meant to be a stopgap measure before facilities with skilled birthing attendants could be accessible for all women (Smith et al 2000).

It is evident that in many areas of the world there simply were not enough skilled birthing attendants available for the numbers of reproducing women (Sibley et al 2004). Additionally, even if there were sufficient numbers of skilled birthing attendants the reproducing women still might seek the care of the TBA (Sibley et al

[18] This is still the case. However the bidan in rural areas are also not able to do very much in these situations as their training, facilities, and supplies are limited and people largely refuse to take the long journey to the hospital where there is also little assurance of an effective solution.

2004). For this reason evaluative studies were conducted on the effectiveness of TBAs in birth activities (e.g., see van Roosmalen et al 2005; Sibley et al 2004; Goodburn et al 2000; Smith et al 2000). A range of outcomes are reported on the effectiveness of TBA training programs from negative to partially positive. The positive evaluations report small decreases in some types of mortality but question whether the programs are cost effective for the agencies, governments, and NGOs (Sibley et al 2004). Extensive and reliable evaluations of the TBA programs are difficult to conduct as there is little baseline data to use for comparison. Additionally it is very difficult to observe the behaviors in which the evaluators are most interested.

Currently there is an uneven return to the policy of training TBAs. There is some evidence that the continual emotional support offered by TBAs is effective in improving the outcomes of labor (van Roosmalen et al 2005, Hodnett 2002). There have also been experiments in teaching even illiterate TBAs to administer misoprostol for the prevention of postpartum hemorrhage (Walraven 2003; van Roosmalen 2005)

3.3 Reproductive Health in Indonesia

Since 1990 family planning programs have been very successful in decreasing the fertility rate. There has not been a similar improvement in reproductive health (Bennett 2005). The most obvious indicator of poor

reproductive health is a high incidence of maternal mortality. Compared to other Southeast Asian countries Indonesia's health indicators are quite poor. The United Nations Children's Fund (UNICEF) reports that Indonesia's maternal mortality ratio is somewhere between 310[19] and 420[20] deaths per 100 000 live births.[21]

Estimates of maternal mortality and morbidity vary widely by region within Indonesia for other reasons beyond calculation issues. Part of this is due to a great diversity of all aspects of building reproductive health status including social, structural, and physiological issues. For example, middle class and wealthy Javanese or Balinese people have access to excellent reproductive health care and live in a world that is nothing short of the opposite from that of poor villagers in remote areas. Questions about the sample from which these health statistics are derived are important and are generally not answered. This includes how the statistics are collected (Geefhuysen 1999; Iskandar et al 1996: 10**;** Mboi 1995: 183). My observations of how these numbers were collected at the village level were soundly validated by other reports (Geefhuysen 1999). The numbers of prenatal visits, births attended and outcome would be collected at a monthly meeting of the bidan. Each bidan would mentally tabulate her activities and report them, generally in numbers rounded to the nearest five. These figures would be compiled and posted on the

[19] Based on reported numbers for the period of 2000-2007.
[20] Based on adjusted figures for 2005. The adjusted figure is based on a new approach of figuring the ratio developed by JH-PIEGO, WHO, and UNICEF. This method uses all the information that is available: vital registration data, household surveys, sisterhood surveys, and reproductive age mortality surveys.
[21] http://www.unicef.org/infobycountry/indonesia_statistics.html

many recording boards on the walls of the clinic and eventually sent to the Department of Health in Sumbawa Besar.

Not included in these numbers were the births attended by the dukun bayi. The dukun bayi had been trained to record their birthing activities and to submit them to the clinic on a monthly basis. Although these women were largely illiterate most of them very carefully recorded the births that they attended. Each book that I saw were carefully ruled in columns and rows with neat handwriting that was different for most entries. There were no fatalities of either infants or women listed. Long ago the dukun bayi stopped submitting their record books to the clinic because they were not treated well when they arrived at the clinic and their books were lost. When I asked at the clinic about these books the bidan said that they could not count on the veracity of the records and that they were able to collect those statistics in other ways.

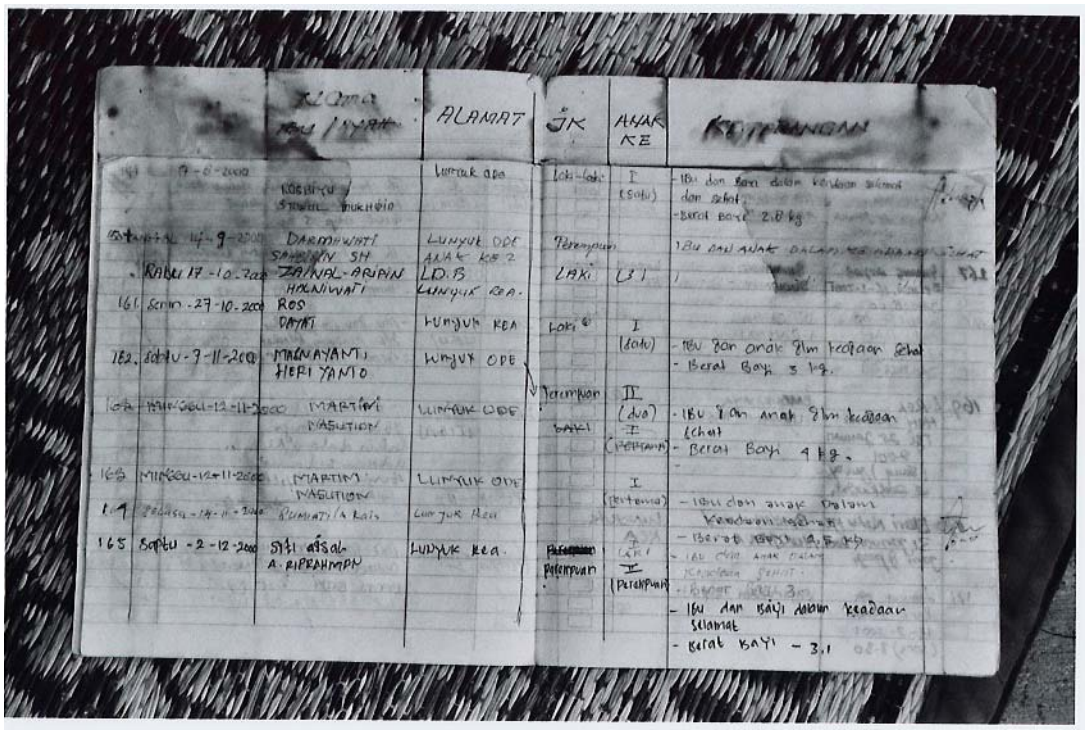

Figure 3.1: Record book of births maintained by a dukun bayi terlati (clinic trained shaman midwife)

UNICEF estimates that 72% of births between 2000 and 2007 in all of Indonesia were assisted by "skilled birthing attendants" or bidan.[22] This figure probably something that is closer to a reality in urban areas with high density populations. Shefner-Rogers and Sood (2004) report that bidan assist with about 34% of rural deliveries, and that Indonesian women seek prenatal care from bidan, but rely on the dukun bayi to assist in the delivery. They also report that between 65–75% of all rural birth deliveries are assisted by dukun bayi (Shefner-Rogers and Sood 2004). These statistics are in agreement with the findings of Thind and Banerjee (2004: 286) who report that 80% of deliveries in rural Indonesia happen at home. My small sample reflects these statistics as well.

[22] http://www.unicef.org/infobycountry/indonesia_statistics.html

The three most common causes of maternal death in Indonesia are: hemorrhage, sepsis, pre-eclampsia/eclampsia. Hemmorrhage with retained placenta is thought to be the cause of over 50% of the deaths. Other causes include dystocia, complications related to abortion, prolonged labor, and underlying conditions (e.g. diabetes) (Achadi et al, 2000, IDHS 1997). The factors that contribute to these deaths connect to the "Three Delays": 1) delays in deciding to seek care, 2) delays in getting to the care facility, 3) delays in receiving care once the patient has arrived (Thaddeus and Maine, 1994; Achadi et al, 2000).

Given these problems with reproductive health and the global attention to such issues Indonesia has developed extensive reproductive health programs. Here maternal and child health is rolled into one program called *Kesehatan Ibu Anak*, or Health of Women and Children. The international programs tend to separate maternal and child health following the scheme of the Millennium Development Goals. In 1986 the government of Indonesia established a new community-based program that was designed to place biomedically trained midwives in closer contact with the people who needed their services. At this time it was believed that the reason that people chose to continue using the services of the TBAs was that they had to travel too far to get to a local clinic. In order to decentralize the services from the main clinic the *pustu* (sub-clinic center) and the *posyandu* (integrated health post) were developed. In 1989 the government began to train a new sort of midwife, the *bidan di desa* (midwife of the village), who were to work self-sufficiently and largely independently from the puskesmas facility, only calling the puskesmas when

there were complications. These bidan di desa were intended to replace the existing dukun bayi. This new development in the Indonesian health program was supported by numerous global health care organizations (PATH; US-AID; WHO).

The Dukun Bayi

The *dukun bayi*, are the primary maternal health care providers throughout Indonesia, especially in the rural areas. The presently troubled position of the TBA in global reproductive programs has continued, unabated, from the Dutch colonial times until now. For decades the TBAs have been both revered and despised: revered by those who request their services or see them as the glue binding the community; despised by those who wish to modernize the populace or who are involved in the work of biomedicine.

Throughout Indonesia, many people speak in terms of respect for the dukun bayi. The dukun bayi is a person who holds a great deal of the authentic (*asli*) and ritual knowledge of life events for the community. Along with this type of connection with the community is the storage of historical knowledge of the local area. The dukun bayi are important guests at most major life events beyond the birth of a person, and are often called to help with community or individual problems. Throughout the pregnancy and the lifecycle of the individual there are many stages and rituals that must be observed where the dukun bayi's presence and often participation is required. Thus develops a long involvement between the

individual, the family, the community, and the dukun bayi. The nature of the involvement of the dukun bayi in the event of birth is thus intensive and intimate.

The colonial era administration and medical services did not look so favorably on the practice of the dukun bayi. Eric Stein's archival research on colonial era medical endeavors in Indonesia (2005) reveals that the dukun bayi were despised by the colonial modernizing elements, much in the same terms as they are now. Stein reports that many medical officers in the military suggested banning the dukun bayi from working in the colony. No ban was ever implemented. At the time the colonial government did not have the staff to offer an alternative birthing attendant. Additionally, there are many reports that the biomedical practitioners did not have the credibility to engage in the realm of birthing in Java and elsewhere (Stein 2005). This is true today as well. In Lunyuk there are rituals and ceremonies that are considered of utmost importance to the well-being of the new person. Early colonial efforts were made to train the dukun bayi in biomedical techniques, primarily with respect to sanitation. These efforts were not perceived by the colonial medical officers to have any great effect.[23]

After Indonesia gained its independence, the Republic of Indonesia Health Services (*Dinas Kesehatan RI*) continued to train dukun bayi. Historical documents from the Indonesia Department of Health report that there was even limited success in bringing dukun bayi into the training courses (Departamen Kesehatan RI, 1980). The dukun bayi training programs were kept in place throughout Sukarno and

[23] See Stein 2005 and 2007 for a more extensive description of the history of the interaction between indigenous practitioners and Dutch colonial medical officers.

Suharto's presidencies. Dukun Bayi who refused to attend training courses at the local clinic were classified as "wild dukun" (*dukun liar*) rather than the more prestigious "trained dukun" (*dukun terlati*).

The Bidan

Although critiques can be found of the traditional birthing attendants (TBAs) from the colonial times on, most global medical efforts, as in Indonesia, have been focused on eradicating infectious disease. It was not until the development policies of Suharto's presidency that the bidan came to the fore in the Indonesian reproductive health scheme. In the early years of his presidency, Suharto sought to ally with the international community. One of the ways of doing this was to embrace the global development efforts of the 1960s and 1970s. Consequently, since the 1980s there has been an enormous increase in the number of bidan available to women in rural areas. The goal of Indonesian Health Services (the *Dinas Kesehatan*) was to station a bidan in every village throughout the country. 1988 President Suharto instituted the Safe Motherhood Initiative in Indonesia with the goal of reducing maternal mortality by 50% by the year 2000. The Suharto administration set upon a course of development policies to reflect the global family planning agendas. Indeed, showing the Suharto administration's ability to document the success of their development programs was a key factor in receiving continued funding (Piet 2003). Suharto's development policies prioritized curbing overpopulation in the Indonesian archipelago as a way to boost economic growth as

part of the effort to modernize the nation (Hull 2003; Lubis 2003). One of the primary jobs of the state midwife, or the bidan, was to administer, regulate, and carry out surveillance for birth control for the Indonesian National Family Planning Coordination Board (BKKBN). Many anthropological analyses have been written on the coercive nature of the Indonesian family planning program (Hull 1991).

In 1989 the pressure within Indonesia to expand the family planning program, coupled with the increased focus on reproductive health worldwide, culminated in a change in domestic policy that sought to have a bidan stationed in every village (Hull et al, 1998). It was hoped that simply having access to a bidan would change expectations of the family for obstetric care, from solely depending on the dukun bayi; people would now have options.

In 1991 the Indonesian National Family Planning Coordinating Board (BKKBN) introduced the Health and Prosperous Mother Movement. This was a community-based program that targeted four interventions: antenatal care, nutrition, tetanus vaccination, and importantly the provision of maternal health care by "skilled birth attendants" or "trained midwives." It was determined that a village midwife, *bidan di desa*, should be placed in every village in Indonesia, a number expected to amount to 65,000 midwives.

The role of the *bidan di desa* was to provide reproductive health care to the members of the community. This included antenatal care, deliveries, post-partum visits, and family planning. Many of the bidan di desa also became de facto primary care providers. Many nursing academies began to specialize in midwifery in order to

train this new army of bidan (Frankenberg and Thomas, 2000). The bidan received three years of midwifery-focused training, and then were required to work in a village of the government's choosing for three years. About 56,000 women were placed in the contract positions, and it was hoped that after the three years the women would stay in the villages where they were assigned as bidan with private practices (Hull et al 1998).

Since the 1990s the rate of maternal mortality has not declined in the way that was expected (Frankenberg and Thomas 2000). While Indonesia's GDP was higher than the other Southeast Asian countries, the maternal mortality rates remained higher. In 1996 President Suharto introduced a new program to try and improve maternal mortality. This program was called *Gerakan Sayang Ibu*, or Mother Friendly Movement. This program was sponsored by NGOs, international donor agencies, and the Ministry of Women's Empowerment, which was called the Indonesian Ministry for the Role of Women at the time (Cholil, Iskandar and Sciortino 1998). The objectives of the Gerakan Sayang Ibu program included a component founded on information, education, and communication, which was based on the "Three phases of delay" introduced by Thaddeaus and Maine (1994).

Addressing Problems in Pregnancy

In my ethnographic research it became evident that when deliveries become complicated, the primary decision-making concerning the course of care typically moved from the woman herself to a larger group of people, primarily her husband

and family members. The reproductive health care literature has focused on this in terms of patriarchal societies and the role that men play in the health care decision making for women. While much of the literature is probably more reflective of patterns of patriarchal societies that exist in the rest of the world, there is some amount of male leadership in decision making, particularly in more difficult situations.

One of the major programs operating at the time of the research was the Suami Siaga (Alert Husband) program run by JH-PIEGO. In evaluating this program, Shefner-Rogers and Sood (2004) states (Shefner-Rogers 2004: 237),

> …yet while men play a key role in decision-making about when their wives should seek obstetric care, especially in emergency obstetric care, they often lack specific knowledge about why such care is necessary. This lack of knowledge is potentially dangerous since it may cause husbands to downplay their wife's need for timely care, especially when financial resources are unavailable to the family. Men need to be enabled with information about (1) antenatal care, (2) when and where to seek obstetric care, especially emergency obstetric care, (3) available community resources for example, transportation to reach a healthcare facility, and (5) the cost of emergency obstetric care.

Both my research experience and other literature indicate that men typically do not interact with the reproductive health care providers in cases of normal delivery, whether it is the bidan or the dukun bayi. This is considered to be of the women's domain. The qualitative data from the Suami Siaga program support this. Cholil et al (1998) observe that "'No this [pregnancy] is a women's secret. This is not a man's job.' Service providers (who are almost entirely women) are oriented to interacting with their female clients, overlooking the need to address men about their wives' reproductive health." (JHU/CCP, 1999)

The Etiology of Dystocia in Lunyuk

As there is a direct relationship between etiology and treatment choice I will briefly review some of the perceptions encountered in Lunyuk concerning difficulties in labor and delivery. Both the dukun bayi and the general population had many explanations for difficulties in fertility, pregnancy, delivery, and for difficulties in the post-natal health of the child. A difficult delivery is a particularly frightening turn of events as problems can often not be predicted. If the mother has a difficult delivery there is a high likelihood that the infant or the mother will suffer ill-effects or die.[24] My observations were that if problems developed there would be extended discussions in which people explored the possible causes of the difficulty. Many people considered that factors that may have caused problems with fertility and pregnancy may then cause problems with the delivery and the health of the woman and child after birth. The local rationale for the causes of difficult labor and delivery generally fell into one of four categories: individual behavior, the will of God, natural human issues (similar to a biological explanation), or problems with spirits. Since opinions abounded, each of these only be briefly discussed.

When people in Lunyuk talk about a problem with individual behavior, they generally mean the behavior of the mother, but the behavior of the father is also considered. There is a great deal of discussion among family members and

[24] Operative delivery methods are not available in Lunyuk. If the problem is diagnosed soon enough, and the patient is able to travel five hours to the one hospital in Sumbawa Besar there is only a possibility that operative delivery methods might actually be available. This is dependent on both the obstetrician being in town and the necessary equipment being available.

neighbors about how a couple behaves during the woman's pregnancy. The woman and the man are both expected to behave like upstanding local citizens and proper partners to each other. Any deviation from that definition could be seen as detrimental to the pregnancy, the delivery, and possibly the character of the child. The woman is expected to focus ample attention to the child in-utero. What that means exactly is defined in different terms. This belief might prompt a woman with closely spaced pregnancies to hand the care of an infant to another family member so that she can focus on the pregnancy. A woman and man are expected to work hard. A man must work especially hard to provide for the family and often provide for the desires of the pregnant woman, which are often seen as a request from the fetus.[25] A woman is supposed to guard her strength while also demonstrating that she is able to take on the work of an adult woman (i.e. provider/ mother/wife), so she must find a balance between working hard and not working too hard. The rumored manner of conception is of great interest both along moral and spiritual lines. This is particularly true when the couple in question was not married at the time of conception, or decided to not marry even though there is a pregnancy. Other possible reasons based on individual behavior could be the inappropriate consumption of foods or drinks or types of physical activity. If the behavior of the parents is deemed inappropriate there will be great concern about the delivery of the child. Likewise, if there is a problem in delivery a great deal of analysis of the couple's behavior will occur by the family and neighbors.

[25] There are many stories of a man travelling for days on a bus at the expense of a family's economic well-being to purchase a particular food item that his pregnant wife is craving.

There are times when the assessment of a death due to difficult delivery or pregnancy will be attributed to simply the "will of God." These tend to be cases where a socially respected couple was perceived to have done everything in their power to have a healthy child and there was still a death or a permanent disability.

Discussions of the human body are common as well. Often the physical state or build of the woman or man is discussed. Individuals who were considered to have sickly or weak constitutions or builds are often feared to have trouble in delivery or to pass along weak traits to the baby. For example, women with small breasts or people who are comparably short are generally considered to be physically weak and less able to both carry a fetus to term and deliver a healthy baby.

Pregnancy and childbirth are times that Balinese, Sasak, and Sumbawan understand as being particularly susceptible to the problems associated with attraction to spirits. This is found throughout the Indonesian archipelago (Laderman 1983, 1987; Newland 2001). The dangers associated with spirits are possible for many reasons, many of which are the same as reasons why any non-pregnant person might have trouble with spirit issues. Spirits are particularly attracted to the pregnant state for a number of reasons: the power of producing a human body; the close spiritual proximity of the pregnant body to life, death, and the afterlife; and the general attraction of spirits to the pregnant body, the fetus, blood, and bodily fluids associated with reproduction. Similar findings of a danger to the individual at pregnancy are found all over Indonesia and Southeast Asia (e.g., Hart in the Philippines; Rajadhon in Thailand; Coughlin in Vietnam).

There are also social reasons that a pregnant woman might have troubles with malevolent spirits. Another person might have sent the spirits out of social jealousy or anger. Or the afflicted person might have slighted the spirits in some way or another causing anger of the spirits to be directed at her. Evil spirits are believed to enter the body or to send agents into the body to cause pain and difficulty of all sorts. The more general purpose of the delivery water is to address the problems of malevolent spirits in the body at the time of pregnancy and childbirth.

Often the reason for a problem delivery or concerns about a possible problem delivery will be associated with more than one of these categories. Often non-spiritual reasons for difficulties were factors that were thought to make an individual more susceptible to spiritual problems. For example, one infant death was associated with a woman who was considered to be very lazy and too proud. In her laziness she could not offer sufficient energy to the fetus or summon the strength to deliver the baby in a timely manner. She was also considered boastful and tended to say unkind things to those around her. It was suspected that someone directed a malevolent spirit to her, which caused additional problems. In another example, an unmarried woman became pregnant. After the rushed wedding ceremony and the pregnancy were publically revealed, people started to discuss problems that could occur with the delivery and possibly the life of the child. It was rumored that the baby was conceived in a Hindu temple on the outskirts of town. This was a lesser used temple that was also known for many other strange events

related to spirits and odd spirit haunting. The factors that were thought to be a problem were the woman's promiscuity (incidentally, there was no discussion of her boyfriend's promiscuity), the time of the year on the Hindu calendar, possible angering of the spirits thought to be lurking in the area, and the fact that an act (i.e., sexual intercourse) that is generally considered one of the dirty human traits, was committed in a holy space.[26]

There were a couple of reports made to me about dukun bayi that were so powerful and had such powerful treatments that the delivery of an infant was completely painless. No dukun bayi that I worked with thought that this was true. All believed that the story was exaggerated, the dukun bayi was boasting (something that by local figuring would eventually bring harm to her and her patients), or that the dukun bayi was dabbling in black magic. Dukun Papin explained that just with any kind of difficult physical exertion some amount of discomfort and fatigue is expected in the delivery of a baby. She gave the example that planting rice or gathering wood causes sore muscles and fatigue. She suggested that it was through this hard work that humans learned to appreciate the outcome. If Allah had intended for us to live a pain-free life, we would live that way. She reasoned that this was one of the reasons that she knew that the stories of a painless birth were false or a sign of deviating from a faithful path. Her job was to assist the women with her skills and treatments so that delivery was no more painful than it must be.

[26] Even given this concern it was widely known as a place where many unmarried girls became pregnant. I was told to stay away from this area.

Chapter 4: Research Methods and Description of the Sample Population

My goal in this research, put very simply, was to understand the fabric of obstetric care in Lunyuk. This study was designed to elucidate the following issues: First, the social value of being treated by the various obstetrical practitioners; second, and related to the first, the manner in which people use reproductive choice as a part of defining units of belonging; third, the extent to which local and national political agendas are reflected in treatment choice; fourth, the various ways that people treat pregnancies and the post-partum period; and finally, the practical considerations of health and survival.

Thus the methodology of the study did the following. First, by asking direct questions, I discovered how people represented their treatment of obstetric issues in the past and the present. Second, I observed and talked with all people involved in reproductive issues about how they formulated ideas about obstetric needs, goals, concerns, and ideals. This elucidated the individual's reasons for particular actions, theories that supported their courses of action. Third, it developed, by observing and asking further questions, a more finely differentiated sense of what the women involved in reproductive activities actually do in their daily practice and life to care for pregnancy. This allowed me to note any discordance between what they did and what they said that they did. These objectives were met primarily by conducting ethnographic research (i.e. participant observation, structured and unstructured interviews), but also included a reproductive health survey.

4.1 Research Location

This research was conducted over eighteen months primarily in the central villages of Kecamatan Lunyuk (district level), Kabupaten Sumbawa (regency level), in the province of Nusa Tenggara Barat. My research covered the villages (*desa*) of Suka Maju, Pada Suka, Lunyuk Ode, and Lunyuk Rea. I did not include the villages of Kelawis, Jamu, and Mungkin in the central part of the study due to their inaccessibility from the others and the clinic. However I did interviews in these areas when I accompanied the touring clinic (*Puskesmas Keliling*) officials to these far-away areas. I conducted research in the regency capital of Sumbawa Besar at the local hospital and Office of Public Health (Kantor Dinas Kesehatan).

As I was also interested in the interaction between the bidan, the training staff, and the people who developed the reproductive health programs I attended training seminars, conferences, and conducted interviews in program offices in Sumbawa Besar, several villages in Western Lombok, the provincial capitals of Mataram and Denpasar, and the Indonesian capital, Jakarta. While I was in the other locations I visited local clinics and hospitals (government and private) as well as met with dukun bayi.

Lunyuk fit the profile that I was looking for nicely. It had a well-staffed clinic with the level of equipment and supplies that is normal, or even better than normal,

for a rural area.[27] Lunyuk had a wealth of active dukun bayi, some of whom were well known and influential far beyond Lunyuk. The nearest hospital was five hours away by truck. The hospital was accessible but a person had to be determined that this was a necessary step to receive hospital care; going to the hospital was not something a person could do on a whim. The people of Lunyuk were relatively prosperous for the region. Although there had been famines in 1971 and 1980[28] and there was a diversity of socio-economic status, most people felt as though they had a reasonable diet and that they could seek basic health care of their choice.[29]

4.2 Sample Population

I conducted the research among three populations of people: formerly and currently reproductively active women, obstetric practitioners (bidan and dukun bayi), and reproductive health program agents. As described above, Lunyuk has an ethnically, religiously, and economically diverse population. The majority of the population practices Islam (84%) (BPS 2002). There is a sizable population of Hindu people (15%), all of whom are Balinese (BPS 2002). There is a small group of ethnically Balinese people who practice Islam. There were two families who

[27] The clinic was able to address basic illness and injury needs of the local people. There were regular problems with the clinic running out of supplies but this was a normal problem for the clinics throughout Indonesia. I made a habit of visiting local clinics wherever I went in Sumbawa, Lombok, Bali, and Java. All of the staff members complained that they often ran low or ran out of basic supplies and wished that they had more extensive services to meet the needs of people who felt as though they could not go or did not want to go to the hospital.

[28] This was reported to me by several reliable local residents, although there is no mention of food shortages in government reports for the region.

[29] This information is based on data I collected in the reproductive health care survey.

practiced a Christian faith (both were teachers assigned to Lunyuk by the government) and one clinic worker who was Catholic.[30] In the following sections I will describe the sample population in more detail.

Formerly and Currently Reproductively Active Women

I spent a good deal of time with the pregnant women, reproductively active women who were not currently pregnant, and the formerly reproductively active women. Generally as soon as a woman was married she would attempt to become pregnant. Because there has been an active family planning program in Indonesia for several decades, people tended to report using birth control between children. Birth control was offered at low prices at the government clinic and the private clinics.[31] It was widely known that the government family planning program encouraged people to have only two children with a five year gap between them. Thus there were many women who were certainly pre-menopausal but who considered themselves finished with having children. These women are lumped into the same category as formerly reproductively active women along with the post-menopausal women because they consider themselves as being finished with having children.

As in many places in the world many women in Lunyuk keep their pregnancies a secret until it becomes obvious. There are concerns about sorcery and keeping the baby and woman safe. Even when a woman is obviously pregnant a

[30] In Indonesia the Protestant and Catholics faiths are considered related but separate religions.
[31] Until just before the time of this study most birth control was free.

family will not want to draw attention to her as it is considered a vulnerable state for many reasons. As people do not advertise their pregnancies in the household it became evident that I would need to accept any pregnant women that I came across into my sample so that I could eventually develop relationships with enough women who could become primary informants. In short I was afraid that if I did not accept women on the basis of a certain set of criteria I would not end up with a reasonable sample size. Thus I accepted all women hoping that a sizable portion of them would result in an extensive research relationship (i.e. multiple interviews throughout their pregnancy and delivery). At the completion of this research there were 48 primary informants out of the 252 pregnant or hoping to become pregnant women that I was able to interview at least once.

All 48 of the women completed multiple interviews and the reproductive history survey. With this group of 48 women I conducted a series of interviews that began with a reproductive history survey, then proceeded with a series of interviews that included informal interviewing, as well as structured and semi-structured interviews, plus participant observations that were accomplished as I accompanied the bidan or dukun bayi on visits to the women. Often the first interview with a woman who did not know me already was difficult. Many of the women were very young and many had not ever interacted with a person from outside of Lunyuk, much less a person of European descent.

All of the 48 women were pregnant at the time of the initial interview. The average age of the informants was 26.25. The ranged in age from 17 to 45. All of the

48 women were married throughout the entire time of my research period. The average age of marriage was 18.37. The average age of first marriage for women of the province of Nusa Tenggara Barat (NTB) is 18.7 (ORC Macro 2003). Only one of the women had been married once before. The average age of the women at their first pregnancy was 20.1. The average age of women at their first pregnancy for NTB is 20.4 (ORC Macro 2003). This sample population conforms to the national average in terms of age at first marriage and pregnancy.

All but four of the women had attended school for at least one year. Most of the women had only attended some amount of elementary school (31 of the 48), five women had attended middle school, five women had attended high school, and three women had college-level teaching degrees. Two of those women with teaching degrees were currently employed as teachers. Eleven women reported that they were "housewives." Thirty-one women reported that they were farmers. One woman worked in the mayor's office and two women reported that they were in private business.

As reported above, except for a handful of people, all of these residents of Lunyuk are either Muslim (84%) or Hindu (15%) (BPA 2000). My sample over-represents people of the Hindu faith (20.8% were Hindu and 79.1% were Muslim). The majority of the people in Lunyuk classified themselves as being Sumbawan (52%), followed by Sasak (23%), and Balinese (19%). My sample includes 70.8% Sumbawan people, 1% Sasak people, and 29% Balinese people.

Clearly this distribution does not represent that of the entire district of Lunyuk. This occurred for three reasons. This research has shortcomings regarding ethnicity, especially since ethnicity is inherently part of identity in Indonesia. There was not equal representation of the ethnic groups. If I had research assistants working on this project doing interviews independent from me this could have been possible. However this could have introduced problems of its own because of a whole host of reasons associated with the research assistant's local identity and social status. Thus I decided that what I lost in terms of equal ethnic representation would be gained by the consistency of the identity of the interviewer (with whatever influences on interview or behavior response that had). The end result is that I do not feel that this dissertation can answer extensive questions about how the Sasak, Sumbawan, or Balinese ethnicities address one issue differently or the same than another. Rather the data presented here can suggest points at which ethnicity is general becomes an issue.

The majority of the women (39 out of the 48) already had at least one child at the time of the first interview. Thirty-two of the women already had one living child at the time of the first interview. At time of my departure from Lunyuk, 45 women had at least one child. Three of the women who were in my sample of 48 had not yet given birth at the time of my departure. At the end of my research period in Lunyuk 45 women had delivered 105 times total (para), the majority of those deliveries occurred before my arrival in Lunyuk. The total number of pregnancies for all of the women (gravida) was 129. Nine women reported having miscarriages (abortus).

The 47 women who had children by the time that I left Lunyuk had an average of 2.23 children each. Twenty-four women reported having children who died. Nineteen of those children died before the age of one. I do not have reliable information about how many of those infants were stillborn and how many of those infants made it past the first 42 days of life. At the time of my departure from Lunyuk there were 81 living children among the 48 women.

Infant mortality in the province of Nusa Tenggara Barat (NTB) is relatively high, 74 deaths per 1000 live births, which is about double the national average of 35 deaths per 1000 live births (ORC Macro 2003). This is at a level comparable to the highest IMR nations in Southeast Asia (Timor-Leste 88 per 1000; Laos 70 per 1000; Myanmar 70 per 1000; and Cambodia 67 per 1000) (http://www.prb.org). Of the provinces in Indonesia only Gorontolo in Sulawesi has an IMR higher than NTB (77 live births per 1000 deaths) (ORC Macro 2003). Although there is not a published figure of IMR for Lunyuk the fact that 24 of the 48 women have experienced an infant death suggests that the IMR for Lunyuk is relatively high as well. The relatively high IMR is quite interesting given the relatively low fertility rate of 2.4.

Of the 105 deliveries experienced by the 48 women in the sample, 95 of the deliveries occurred at the woman's home or a home of one of her family members. Ten of the deliveries occurred at a clinic or a hospital (only 2 of the deliveries). Of those 105 deliveries, 69 (65%) of them were assisted by the dukun bayi for the birth, 36 (34%) were assisted by a bidan, and two women (2%) gave birth without

assistance from anyone. UNICEF reports that in the period between 2000 and 2007 the percentage of births attended by a "skilled birthing attendant" (most often a bidan) is 72% for all of Indonesia. The Indonesian Demographic and Health Survey for 2002 – 2003 (ORC Macro 2003) reports that in rural areas of Indonesia, such as Lunyuk, 55.2% of women delivered with the assistance of a "skilled birthing attendant" and 41.6% gave birth with the assistance of a dukun bayi or "TBA."

It is noted in the IDHS (ORC Macro 2003) that if more than one birthing attendant was reported by the respondent the "most qualified person" was tabulated in the report. While this result tabulates that number of people who met the goal of the reproductive health programs for the final outcome of a skilled birthing attendant at birth, this does not reveal the preferred birthing attendant, which I think is an important factor as well. In Lunyuk, seventeen, or 16% of the total number of deliveries first started with a dukun and then ended with assistance by a bidan. At some point in that delivery it was decided that it would be best to call a bidan, most often because there was concern about the progress of the delivery.

Through the interviews and participant observation I looked for themes that revealed the underlying theories or goals that guided and brought the individual and her family to a particular obstetric caregiver. These themes included the following: what did the woman consider as "best practice" for the care of pregnancy; what social relations the family had to the individual practitioners; how the family was connected to government activities; and perceptions of what makes a person modern or traditional.

I did my best to follow the pregnant women from the time of contact to 40 days after the pregnancy in order to establish actual behaviors of seeking treatment, sources of advice from social contacts, participation in government programs and groups, as well as cultural and religious rituals observed. After a birth, a miscarriage, a death, or for many regular treatments I interviewed women about the event.

The Obstetric Practitioners: Bidan and Dukun Bayi

My other major activity involved a considerable amount of unstructured time and participant observation as I acted as an apprentice to the obstetric practitioners in the community. In the role as a researcher who was present to learn what they did by acting as an apprentice, I was able to observe their activities and interactions with their clients, to attend their training and seminars, and to interview all the providers following each reproductive event.

There were thirteen dukun bayi and seven bidan in the District of Lunyuk. Of the thirteen dukun bayi, nine had received training in the clinic and were dukun bayi terlati. During the course of study, I had contact with most of these individuals, and regularly worked with three, of which two were Muslims and one was Hindu. I had contact with most of the seven bidan in Lunyuk, and regularly worked with three individuals. Of the seven bidan who were operating at the time of my research one was Hindu, one was formerly Hindu but converted to Islam when she married a Sumbawan man, and the remaining five were Muslims. Two of the bidan were

ethnically Balinese, one of the women was Sasak, and the remaining four were Sumbawan.

In order to treat the dukun bayi and bidan with as equal weight as possible in my research, I used the same research protocol with each of them. Each of the practitioners was interviewed on subjects such as: how and when they received their initial and on-going training (i.e. both biomedical and traditional); what treatments the birthing expert perceived as most important, as well as those that are most requested; social connections to the community; their interactions with different ethnic identities; their participation in various women's or government groups; and their goals as a birthing expert.

I did a considerable amount of participant observation with these women as they visited and received their patients for prenatal care and births. By doing this I was able to collect data on how they used medical and non-medical information from various sources to treat their patients; how social, political and religious factors influenced their treatment of patients; and interactions with other birthing experts, government and local community organizations. I attended all training seminars with the birthing experts and I attended every delivery possible. These observations entailed doing research in the homes of individuals, the various clinic buildings, and in the one hospital on the island.

Initially, I had intended to start the research with the dukun bayi. I did not want to become overly identified in the community with the clinic, for fear that this would shape the way that people would interact with me, what they would be

willing to talk to me about, and most importantly that identification with the clinic would harm my ability to work effectively with the dukun bayi. Unfortunately, due to their position and status in the community, and my lack of community contacts, this proved to be impossible. I found that since I didn't know anyone in this community, no one could vouch for me. Later, as I got to know more people in Lunyuk and in other communities I was able to get introduced to local dukun bayi with the assistance of people who could personally vouch for me. In the end, beginning with the clinic did create some obstacles to meeting the dukun bayi and then in establishing relationships with them. It also made it difficult at the start, to interview pregnant women. Fortunately, those obstacles proved to be surmountable.

Reproductive Health Program Officers

Through attending every training session that I could and traveling to government agencies and meetings in Sumbawa Besar, Mataram, Denpasar and Jakarta, I was able to develop a broad set of contacts from the various agencies involved in reproductive health programs. I interviewed every reproductive health agent that I came into contact with. To determine the goals and methods of communication of the government maternal health policy, I interviewed officials in the public health system and collected the training and instructional materials that had been developed for both the obstetrical practitioners and for the women of Indonesia as they sought care for their pregnancies.

4.3 Methods of Data Collection

The most revealing of the data came from intensive interviewing and participant observation with various informants. Data for this study were gathered using key informant interviews of various types, reproductive health questionnaires, and participant observation. In order to ensure that my interview guides or questions or even interviewing techniques were locally understandable, appropriate, and revealing of what I actually wanted to find out, I often discussed research methods, vocabulary, manners, social cues, and interview techniques with local people who became trusted advisors. Some of these people were formally educated. Some were not in Lunyuk but were familiar with or originated from the region. Some were local people who were particularly reflective or observant. And some were the informants themselves. For example, if I was having trouble getting to a specific topic with an informant once we were able to talk about that which I was hoping to cover, and after apologizing for speaking so clumsily, I would ask the informant, how I might ask the question so that it was more understandable. Often these clarifications in themselves were revealing.

For example, I kept asking the dukun bayi if they were training younger people to help them and so that one day they would take over as an apprentice. I kept getting the answer 'no' but I saw younger family members assisting their elders and heard stories from the dukun bayi detailing how they did the same for their

grandmother who were dukun bayi. In asking an observer for assistance with that question she pointed out that it was not believed that a person could "train" to become a dukun bayi. The power to be a dukun bayi was a gift from God.

These interview guides were created based on information gathered from informal and unstructured interviews. I then tested the interview guides, made the necessary changes, often pointed out to me by the informant or a person present, and then I re-tested the interview guide.

Survey and Interviews with Reproductively Active Women.

As reproductively active women were identified by the survey of Lunyuk women, I began to conduct separate semi-structured interviews, informal interviews, and participant observation with this group. These women were surveyed every month from the time of contact until the end of the pregnancy period. Informal contact with these women was ongoing. The people in the Lunyuk region recognize a pregnancy lasting until forty days after the birth of the baby. The interview questions covered the following: concerns and expectations about becoming pregnant, the pregnancy and delivery itself, and possible problems and their causes; understandings about the reproductive operations of the body; symbolism, ritual, and tradition associated with birth; and changes in her daily activities as a result of the pregnancy.

These included questions concerning the timing and recognition of symptoms, the perceived cause of the problem, the expected course of the

pregnancy, and the treatment plan that the woman will follow. Additionally, questions were asked concerning choice of birthing expert, patterns of use of the birthing experts, and who else was consulted about pregnancy related issues. Questions were specifically asked about what influence men had in decisions about pregnancy. Special attention was paid to how women cared for problem pregnancies, including the following: how do women make the decisions to seek the help of biomedical practitioners or traditional birthing experts, how do their social contacts (including kin and friends) influence this decision, and who are the influential people in the individual woman's decisions? Women were also asked questions about their perceptions of the government health clinic, their participation in the government family planning program, and interactions with government programs in general. The data from these interviews will further answer the general research questions by clarifying how pregnancy-related health concerns are addressed, what social interactions are associated with the pregnancy, and how political views or participation in government programs may influence prenatal care.

Reproductive Health Questionnaire

The first time that I would interview a pregnant woman, a bidan, a dukun bayi, a hospital staff member, or a program officer I would conduct a semi-structured interview. I had an interview guide, which I called an intake interview, for each research population. Most of the questions on these research guides had to

do with the person's relevant history and their current activities. I also had interview guides for different related topics; for example, on the causes of a particular obstetric difficulty, or what ritual was necessary for a healthy pregnancy.

I found that the reproductive health questionnarie was a particularly useful way to meet an informant. Often the pregnant women and the dukun bayi would be hesitant to talk to me in a first meeting. Many of the women and dukun bayi had never talked to a foreigner before or even someone who came from outside of Sumbawa, Lombok, or Bali. It gave the women a chance to interact with me in a comfortable manner. Additionally they were familiar with this style of interaction with a person they did not know and the questions that I asked them were largely considered public information. Indeed it was often the listening neighbor who would answer a question rather than the intended interviewee.

Informal Interviews

Often the best information or insights came when sitting down with a group of women at the end of a day, after a semi-structured interview with a particular person, after or during a birth, during what was initially intended as a social visit, etc. I always had a notebook with me and most often a camera. I found that these types of interviews were often times where information that I would never have thought of or have known to ask about, but were the most important in the end, came up. People would naturally come to topics or frame an idea in a certain way that was quite revealing. After these types of interviews I would get to my computer

as soon as possible to write about the events of the interview. Often I would drop in to talk to one or more of those who became my informants to clarify information or ideas that surfaced. This would often lead to more important discussion and an unstructured interview. Often, but not always, these informal interviews were conducted with multiple people present.

Unstructured Interviews

Unstructured interviews are what I set out to do most of the time. These interviews were sometimes scheduled or sometimes loosely scheduled. The conversational nature of these interviews was important. As Bowen (2007: 5) suggests this manner of interviewing allows for people to frame a topic in a way that reveals how the interviewee thinks about things. Sometimes what is not discussed by the interviewee is as important as what is mentioned. This naturalistic manner of interview allows room for topics to be dismissed by the interviewee.

I would ask people during more public interviews if I could drop by later to talk to her or him about a particular subject that had emerged but there was not time to explore. Often when I arrived to conduct the interview I found that the person had thought about the subject and was particularly insightful or thoughtful about his or her responses to my questions. Sometimes a person would give me a critique of what other people had said in the more public informal interview setting. Often these unstructured interviews were with informants that I interviewed many times over the course of the research. Some of them were particularly reflective and

would bring up topics that we had discussed in previous conversations to let me know that they had rethought something, or that they thought that I should meet a particular person, or even to tell me that they thought that I was asking the wrong question.

Many times I was re-directed in ways that were particularly fruitful to my research. One such example was a redirection that was given to me by a teacher who had been present for many of my early interviews. He noted that there was a point in the reproductive health survey where the same point of confusion arrived every time he witnessed the interview (and indeed it happened when he was not present as well). He said that it occurred to him when I was interviewing his wife that I was asking the wrong question. He and I had talked enough times about what it was that I was interested in for the overall research. He made suggestions, which then led to the two of us writing through another interview guide related to the spiritual dangers inherent in pregnancy and delivery.

During these interviews I would take copious handwritten notes. In oder to ensure accuracy I would read back the important portions of the conversation or get a direct quote from someone to make sure that what I recorded was accurate. I found that this was a good way to allow an informant to reflect on what he or she said and often it began other fruitful conversations.

Participant Observation

Basic ethnography was carried out throughout the entire research period. Participant observation is necessary to observe the various social influences imparted by family, neighbors, and attending birthing experts, as well as to witness behavior surrounding the pregnancy, and to understand the larger social setting in which these events take place. It is in being witness to the casual conversations, activities, discussions, and realities of everyday life that I was able to develop a more complete understanding of the setting in which women seek care. This was especially important, given the unscheduled nature of pregnancy and delivery.

When developing the survey instruments and interview questions I relied on information gathered during participant observation. The participant observation in turn verified the statements made by the informants with behavior that I could observe. Using all three of these methods I was able to elicit information about different beliefs, opinions, occurrences, and relationships from different points of view. Additionally, the more flexible form of participant observation will allow me to fully explore the differences of opinion that emerged in each setting.

It is necessary to be continually present in the community to observe both the various social influences imparted by family and neighbors, and by the attending birthing experts. Participant observation served a number of critical functions in this research. At the most basic level, the participant observation allowed me to spend non-structured time with individuals in the study and it allowed me to build rapport with the local communities that I would not have otherwise had, even as a

regular visitor. This made it more likely that people would be willing to discuss sensitive information concerning successful and unsuccessful pregnancies, as well as various factors that influence the care of the pregnancy.

Additionally, the participant observation allowed me to observe and interact with women in a wider setting, frequently in surroundings that were comfortable for them, where they would talk about many things other than pregnancy. In this social space I was able to see both the subtle and the direct messages from various sources that influence the behavior of reproductively active women.

A third aspect of the participant observation was the opportunity it provided to validate information obtained in the more structured forms of data gathering, for as social conversation proceeded during participant observation, we re-visited many of the subjects of the more structured forms of data gathering.

On the occasion that I was speaking to a person or sometimes two people without an audience, I would always assure them that what they said to me was confidential. I kept my interview notebooks in a locked wardrobe and used codes for people's names. I made a practice of never passing along information, even not related to research, from one person to another unless specifically asked to do so.

Apprenticeship

The people whom I interviewed were very curious as to why I, a young American woman, was in Lunyuk asking people about pregnancy, childbirth, and infant health. The assumption was that I worked for an NGO or international agency

and was there to teach people how to be "more modern" (on the part of the pregnant women) or to evaluate their abilities (on the part of the bidan and dukun bayi). It took a great deal of time and explaining to convince people otherwise. I repeatedly asserted that I was there to learn about what they do; that the people in Lunyuk were teaching me; that my work was not intended to change what they do; and that my work would not result in a new program that would be available to them in the near future. I told people that I could only hope that my work would somehow, at sometime in the future, help the problem of women and children dying needless deaths. I often received answers to my questions that were clearly repeating what they assumed that an agent of a reproductive health care program would hope to hear.[32]

After my first month in Lunyuk I decided that I should re-frame my role from "researcher" to research and an apprentice to the local practitioners. This seemed to be well-received. Of course, I was not actually treated like an apprentice. I am an outsider and everyone knew that at some point I would return to my home, but it seemed to frame my level of interest in such a way that made more sense. First, it suggested that I was truly interested in learning from the people engaged in reproduction rather than teaching them. Second, I hoped that it suggested that I valued the knowledge that people had. Third, it helped with the question of what to do with me during the clinical encounter where everyone needs a role. I was able to become an assistant rather than merely an observer, which was a much more

[32] Russell Bernard (1994: 231) calls this the "deference effect."

comfortable way to interact for everyone. Additionally by taking on the role of assistant the person had to teach me at a greater level of detail.

Part II: Ethnographic Data

Prologue

Just before I left for my final and extended research trip to Sumbawa I met with John Bowen hoping to for some last minute wisdom about anything having to do with doing fieldwork, Indonesia, or being an anthropologist. Although he had many good suggestions one that is particularly memorable was that I should be particularly observant when I first arrived. His reasoning was that I would notice many details that would soon fade into normalcy. I found that that this was particularly good advice. I thought about this manner of looking around me a great deal in the first few months that I was in Indonesia and found that it was very useful in getting to know a new setting and indeed what was "normal" and what was not.

For example, in the first week in Indonesia I was at a government office starting the long process of getting a research visa. I noticed that near the entrance of the building, next to a sign suggesting that polite dress and appearance was appropriate in the building, there was a comb attached to the side of a mirror for any person to use. Having just arrived I thought that it was quite funny. All American children are taught not to share brushes and combs because of the danger of transmitting lice. Of course lice are transmitted in American elementary schools anyway so the intervention, while probably helpful, is not completely the answer to the problem of lice. Certainly head lice is an underlying communicable health

problem in Indonesia too, but clearly, as demonstrated by the public comb, sharing grooming implements was not considered to be a public health risk. Six months later when I returned to the same office I only registered the fact that the comb was there because I had noted its existence and possible meaning when I had first arrived.

Indeed as more time passed, more became "normal" and not so obvious to my eyes. Instead I took the kernel of John Bowen's advice and continually noted what was "normal" in a setting and what seemed "out-of-place." I found that these out-of-place events, people, or objects (for example) tended to be revealing of some sort of social tension; a tension that often deserved a great deal more attention.

What follows in this section are analyses that center on points of tension: umbilical cord scissors, delivery water, and moral issues associated with Islam and childbirth. These chapters describe and analyze the ethnographic data that are at the heart of this dissertation. The chapter on umbilical cord scissors focuses on the dukun bayi and the chapter on the delivery water focuses on the bidan. The chapter on religion and obstetrics equally focuses on people seeking care, bidan, and dukun bayi.

In order to assist the reader through the many ethnographic vignettes with different people I standardized some terms of address in ways that are not found in the local setting. When referring to a bidan I use the title "Bidan" and the bidan's pseudonym. Rarely do people call the bidan "Bidan Wati," for example, rather people usually use the title of address "Ibu," meaning mother in Indonesian. The same is true of the dukun bayi. Rarely are these women referred to as "Dukun

Madu," for example. Rather people tend to call them "grandmother" in one of the local languages (dadong, nini, inaq, papin). I include the titles of "Ibu" (mother) and "Pak" (father) to note to the reader that I am referring to a non-midwife woman or man.

Chapter 5:
Umbilical Cord Scissors:
The Conflicting Influences that Shape the Practice of the Dukun Bayi

Much to the dismay of the infant and maternal health care officials, there remains a great demand for the services of the dukun bayi even though there is currently a clinic within easy reach of the people in my study area. In situations where a family has decided to use the care from the bidan or at the clinic, people often hire the dukun bayi to accompany them. As they do this, the people in Lunyuk are negotiating competing knowledge systems concerning birth and pregnancy as well as social and political factors. The local people have social, cultural, and serious practical concerns about bringing a new human into this world.

The local people, the bidan, and the dukun bayi each draw differentially from the same domains of meaning to create symbolic boundaries that assert their individual hierarchy and authority in their competing epistemologies. Thus the bidan construct their authority and status within the same domains as the dukun bayi, but the way that they invoke those categories is different. Likewise, discussions of these cultural categories, or domains, are included in the critiques that the general community members make of the practitioners when determining which practitioner to see. These domains fall into issues of birthing, religion (most often Islam), ritual and the importance of local ethnic identity, and nationalism.

These issues were highlighted for me one day as I observed one of the dukun bayi, named Dukun Papin, assisting a local birth. Except for the sounds of extreme exertion from the laboring woman, the crowded room was silent with an air of both

relief and fear as two full days of difficult labor were about to come to an end. There had been discussion among the twenty family members and neighbors present about whether or not the laboring woman, their daughter, sister, cousin, or friend, should be moved to the clinic or even to the hospital in Sumbawa Besar. The prevailing opinion, although not without dissent, was that the woman was better off here in the capable, trained, and proven hands of Dukun Papin.

Finally the delivery of this baby progressed sufficiently for the head to crown. After a few more contractions, tired pushes, and some gentle tugging from Dukun Papin, the baby silently made its way out of its mother and into the waiting sarong. Family members poked their head into the room from the doorway to catch a glimpse of what was happening, and then reported back to the crowd outside. The baby's translucent skin was tinged with a frightening blue and it was far too still. While whispering prayers, Dukun Papin went to work quickly tying the umbilical cord in two places about three inches apart to restrict the blood flow. She placed her umbilical cord scissors around the umbilical cord, between the two ties, and made two cutting motions (without actually cutting the cord) while, in a louder voice, reciting a prayer asking God to bless these two children (the baby and the placenta) as they separated. Then she took a waiting razor blade and cut the still uncut umbilical cord separating the baby from the undelivered placenta.

With a concerned look on her face, Dukun Papin set the baby down on the bed and quickly swept her fingers in and out of the mouth of the infant. She placed her mouth first over the nose and then over the mouth of the baby, gently sucking

fluids from the baby and spitting them onto the dirt floor. She rolled the baby on its side and softly hit the baby on the back between shoulder blades while she blew on the same area. After Dukun Papin assessed that the baby was breathing, she paused for a few seconds, seeming to take her own breath of relief. She recited a prayer to God in thanks for the gift of life, swaddled the baby in a clean sarong, handed it to the waiting arms of the new grandmother, and proceeded to tend to the new mother as she delivered the placenta.

I saw Dukun Papin and the other dukun bayi perform this same ritual "cutting" with the umbilical scissors many times. The first time that I saw this I thought that Dukun Papin had just discovered that the scissors could no longer cut the tough umbilical cord. Then, as I observed several other dukun bayi, as well as Dukun Papin, repeat the same behavior I began to see the deliberate nature with which the act of cutting was performed. Surely Dukun Papin (and the others) had not simply forgotten that the umbilical scissors would not cut. So why use these scissors at all if they knew that they were not sharp enough to cut the umbilical cord? And especially, why take this extra step at a moment when there is often no time to spare? Lives are often at stake. Surely these scissors held meaning, in this situation, beyond that of a simple cutting instrument.

When I asked Dukun Papin and the other dukun bayi about the use of the seemingly non-functioning umbilical scissors they described their actions and the ownership of the tool in terms that clearly revealed weighty meaning that reached

far beyond that of a mere cutting implement. First, Dukun Papin noted that the use of such tools was one of the hallmarks of her practice and her position at the intersection of the "modern world" and the "primitive" (*persimpangan dunia moderen dan dunia primitif*), andthere was demand from her patients. They expected her to use equipment provided from the clinic in her training as a government certified partner practitioner (*dukun bayi terlati*). Second, she told me about how the use of the umbilical scissors, a rare commodity on the rural island of Sumbawa, and even more so in the remote region of Lunyuk, was their right as a clinic-trained dukun bayi and partner of the clinic (dukun bayi terlati). They were legitimately trained in techniques of the clinic so they needed the tools to practice what they were taught. Third, she reminded me of the importance of ritual for a successful outcome and the acquisition of goals.

Women and their families are confronted with a very real concern for their lives and those of their babies when they become pregnant. The infant mortality rate and the maternal mortality ratio are very high in this region, and hence, the likelihood of losing either mother or child or both feels real to the woman and her family. For this reason many local people think carefully about caring for pregnancy and delivery (when most problems occur). As people do all over the world, a newly pregnant woman and her family in Lunyuk construct a plan that they believe to produce the greatest likelihood of a healthy mother and child. This is especially true when a family has experienced the loss of a woman or a baby in childbirth.

The dukun bayi, and the bidan for that matter, also feel the reality of infant and maternal mortality. Both groups of obstetric practitioners often speak in terms of their efficacy and ability to solve life-threatening problems that might arise. However, like their patients the midwives see themselves in a particular light depending on the variety of reproductive practices, knowledge systems, and equipment that they employ.

5.1 Goals and Organization of the Chapter

This chapter addresses some of the major points of the dissertation. These will include addressing how the dukun bayi acts as a mediator for the local people as they synthesize a wide range of theories, materials, and practices from both inside and outside of Lunyuk. Although I want to avoid setting up an overly simplified dichotomous relationship of inside and outside, I do want to recognize the local categories of native or authentic (*asli*) and foreign (*asing*). The umbilical cord scissors, which are a tool from the biomedical tradition, are translated into the vernacular of the dukun bayi in Lunyuk. They incorporate certain public elements of biomedicine into their practice that they learned through their training years ago at the clinic.

This chapter will also address how both the dukun bayi and the patients evaluate elements of their life and ideals for their children in the choices that they make concerning obstetric care. Local people have felt pressure to "become

modern" (*menjadi moderern*) and "to progress" (*maju*), as defined by the nationalist sentiment of the institutions of government or aid since their inception, since the independence of Indonesia. Lunyuk, being on an outlying island that many people in Jakarta have never heard of[33], and in an area that is not deemed of strategic interest, did not have many government clinic facilities or organizations until recently. The recent availability of these biomedical options has challenged the local people to re-imagine who they are and how they should live. Pregnancy and childbirth prove to be a particularly rich topic for examining these subjects as the expectant families carefully consider the best route to introduce a new human being into the world.

Finally, the chapter will address how the dukun bayi of Lunyuk make public use of the umbilical cord scissors as a part of negotiating their identity and maintaining their status as medical care providers. In doing so the dukun bayi terlati circumvent the mission of the current international and government reproductive health programs that would effectively eradicate their practice. In doing this they are able to assert their relevance and negotiate status through the public ownership of this tool. I discuss how the symbolic boundaries that delineate group status and membership are alternately reinforced and challenged through the use of a tool, the umbilical cord scissors, which is publicly recognized as being specific to a practice associated with the clinic, specifically the clinic midwife.

The chapter traces the social-political history of the umbilical cord scissors from the time that the government clinic opened to the present. This is important,

[33] While in Jakarta I would continually have to explain to taxi drivers, people in the market, etc where Sumbawa was and that I really did mean "Sumbawa" not the better-known island named "Sumba."

for it creates the historical context in which the maternal healthcare providers and community presently form their identities. The chapter will investigate the historical development of the relationship between the clinic staff and the dukun bayi as they tacitly negotiated, years ago, a treaty of an unequal but agreeable partnership. It was this partnership that put the scissors in the hands of the dukun bayi. The chapter will then trace the introduction of biomedically trained midwives to the clinic, and how this, plus the shift in international and national health care policy, changed the relationship of the dukun bayi to the clinic staff and restricted their access to the clinic, thereby making umbilical cord scissors a rare commodity in rural Lunyuk. The chapter will then discuss how the umbilical cord scissors came to have meaning for the dukun bayi terlati[34] in their unique usage of the tool. This will include their negotiation of status, authoritative knowledge, biopower, modernity, ritual events, and response to the criticisms that they perceive are levied against them. Finally, the chapter will examine this from the perspective of clinic trained midwives (*bidan*) and the understanding of the practices by the people of Lunyuk.

5.2 Technology Transfer and the Dukun Bayi's Kit

When I started talking to the clinic-certified dukun bayi about the scissors, I asked a question that I thought had a rather obvious answer, but I thought that I

[34] The dukun bayi terlati ("trained") were dukun bayi who had received some limited training during the early days of the government clinic program.

should ask it anyway since there seemed to be a uniform use of dull scissors: "Would they prefer to have scissors that would actually cut the umbilical cord?" The answer was, as one would expect, always "yes." The problem was that the people at the clinic would no longer give scissors to them. I was able to piece together a history of the umbilical cord scissors in Lunyuk with the help of these women, various staff people at the Lunyuk clinic, several pharmacists in Sumbawa Besar, a doctor who was stationed in the district twenty years ago, and an international aid worker familiar with the region, in addition to some archival work.

Before the clinic or the training programs existed, the dukun bayi used their own birthing kit made mostly of locally derived ingredients. Their tools consisted of a variety devices and techniques: a bamboo knife, a razor blade, or in some cases a knife with magical power; locally derived poultices, potions, and pills; other medications based on the Indonesian medical system; protective mantras; massage; spiritual channeling. Many dukun bayi possessed blades of various sorts produced either locally or elsewhere (usually in Makassar, Bali, Java, or Lombok) that had purported magical powers, as described in stories of the important deeds of each particular knife.[35] These knives (bamboo or otherwise) are still used among a few remaining non-terlati dukun bayi to cut umbilical cords as well as in some male and female circumcision ceremonies.

[35] This is similar to the stories told about *kris*, or daggers, some of which are thought to have great power.

Figure 5.1: A dukun bayi's tool kit for childbirth. Included are medicinal treatment that she made, the umbilical cord scissors (just out of view), and latex gloves (never used) all housed in the aluminum container that she got at the clinic training over 20 years before.

If viewed as a borrowed technology then it makes sense to briefly compare the umbilical cord scissors to other technologies that have been shared and adopted in this ethnically diverse region. Dukun Papinsin, a local shaman and husband to my primary dukun bayi informant, explained that the adoption of various types of technology has been an important part of life in Lunyuk for centuries. Dukun Papinsin was a descendent of the original people to settle in Lunyuk who were from the descendants of the Sultan of Makassar. They were there to expand the trading network of the Makassarese. Because there were at that time so few people in this area of the Indonesian archipelago, in order to survive they had to learn from the ways of the people who already lived in Sumbawa. Sumbawa quickly became a site

for all sorts of migrations even until the present time. Dukun Papinsin said that people who learned from each other and successfully adopted technology from other groups survived, and those who did not left or failed[36]. To make the point that adopting the tools of the clinic, such as the umbilical cord scissors, was a natural progression, Dukun Papinsin described the way that the people of Lunyuk appreciated the various types of magic that exist. He described to me, as did others on many occasions, the way that Sumbawan magic is the best for certain situations, while Sasak magic is for other situations, and Balinese for a different set of situations. While many of these practices were secret, elements of these practices were shared by the dukun with people of different ethnicities and are still practiced today.

Even if technology transfer is recognized as normal to the Lunyuk existence[37], the question still remains, why not use an effective cutting instrument that is either readily available and inexpensive (such as razor blades) or locally produced and with symbolic significance (like a special knife)? What is the benefit to using the dull umbilical cord scissors that fit in neither of those categories?

When the bidan first arrived in Lunyuk, many of the dukun bayi welcomed the biomedical programs. As they became familiar with the biomedical programs, they adopted some techniques and equipment from their training[38]. They did this

[36] Dukun Papinsin used the Indonesian word "gagal" or "fail." By this he meant that they were not able to develop a life-sustaining farming practice. Some of these people died while some of them became dependent on working other people's fields, or were absorbed by other households.
[37] E.g. shared physical technology relating to tools, agriculture, etc.
[38] Although not developed herein, as I interviewed dukun bayi in various locations in the region, I came to feel there was a clear correlation between the distance to the local clinic, and their interest in the government training programs.

because of several clear benefits: they developed a new level of authority from knowing something about the outside, it addressed their sense of nationalist duty, and it addressed their basic concerns about doing a good job.

In Lunyuk there is long history of trading technologies and knowledge systems about all kinds of things. Whenthe Sasak and Balinese, which are ethnic groups that primarily rely on intensive agricultural techniques for subsistence, were moved by the government transmigration program into the area, they met with the Sumbawan people- For centuries, the Sumbawans primarily raised cow herds, and their agricultural experience was limited to small kitchen gardens. As a result of living in the same region and seeing the benefits of the other's methods they all adopted some techniques of the other. The Balinese and Sasak men carry the Sumbawan machete and herd cows, and the Sumbawan families practice a more intensive form of agriculture than they did before, although still not like what is found on Bali. This is also the case with general dukun practices. Often I would be told that particular types of conditions are best treated by a person who practices a certain type of shamanism, that "type" would be attached to an ethnic group. So the idea of actively sharing and adopting knowledge systems is very common on all fronts of life in Lunyuk.

5.3 The Status of the Dukun Bayi in Lunyuk

Historically, a great deal of status was accorded to the dukun bayi by the community. Birth is one of the three community events (besides marriage and death) of great significance that required the help of others. The community has traditionally considered these events to be shared social events, rather than being individual experiences as in biomedical births. Literally hundreds of people may gather for the birth of a baby. Birth is an event that requires the presence of others for the purposes of both assistance and as a community welcome. Delivery is a risky event with the real possibility of death for both mother and child. It is also the first opportunity to welcome a person into local community in the corporal world. The course of and requirements concerning these events is described in detail by both local custom and religion.

The dukun bayi's great community status is derived from both the material and the spiritual world (i.e., chosen by God). To become a midwife the dukun bayi must learn a great deal about the ritual and practical aspects of pregnancy, delivery, and post-partum care. She must also have spiritual power that is a gift (i.e.,not something that she sought) but that was assigned to her. It is this spiritual power that ensures her great success. She credits her prowess as a midwife to her spiritual power to and not to the practical aspects of birthing that can be taught to anyone. This gift is not considered hers necessarily. It is often considered a borrowed trait that could be taken away at any time. She is loaned the ability to care for obstetrical

issues and it is expected that she will in turn pass along those loaned abilities to others. If she is not willing to offer her services, or she assigns a fee, then this is considered morally wrong. In fact, this was often a critique of the bidan by the dukun bayi, and in some cases other dukun bayi.[39]

The dukun bayi did not traditionally take payment for her work, for their work was regarded as a service to be offered not to be sold; it was a social duty to be offered to community members in need by the one who knows or has the gift. The dukun bayi does not see payment as something given due to any sort of contractual agreement, but rather it is a gift in appreciation for the great power of the dukun bayi. In some cases, this has changed as the bidan have arrived with definite fee schedules and talk of professionalism. I found that several of the dukun bayi had fee schedules, although often in terms other than currency. In the dukun bayi terlati training (i.e. training at the government clinic) the women were taught that they must charge for their services. In practice most of the dukun bayi did not charge a set fee, although they all told me when I first met them that they "followed the fees of the clinic" (*ikut harganya puskesmas*). The idea is that to sell these skills, to see this as a "service," is to be disrespectful of the relationship that each person has within the community. Additionally, it would be disrespectful to think of a time when pain is experienced and the potential for death is great, as a time to profit.

The dukun bayi are socially obligated to never refuse service. Their first priority is the health of the baby. The baby has not yet sinned, while the life of the

[39] Bernstein 1997; Hay 1999

mother is in the hands of God. Should she die in childbirth both Islam and Bali/Hinduism confer great status to the woman. It is as a result of the importance and status of birth and of her great commitment to the community that the dukun bayi has a very high social status. Often she is the first person to cut the child's hair; or in the case of Muslim people usually she will recite the adzan in the right ear of the child just after birth; she will make arrangements for the first ceremonies and ritual burial of the placenta. The baby is in her care until the umbilical cord stump falls off. If there are any problems, such as death, deformity, or sickness, it is possible that there will be a commensurate fall in her social status, or public opinion of her ability and power. She might ultimately be deemed incompetent or thought to have lost the spiritual powers that she did have. The power that was given to dukun bayi can be withdrawn as she is channeling power. When something goes wrong she will carry out a ceremony of redemption. This had happened in recent history. The one male dukun bayi in the region had made what were considered some horrible errors in ritual performance. The child and the mother died. It was told that the male dukun bayi was both so distraught over having lost his spiritual ability and so mortified that he had done harm that he finally committed suicide.[40]

[40] Iman Budhi Santosa 1999; Bernstein 1997; Laderman 1983; Connor 2001; and many others describe similar aspects of practice and status of dukun bayi, or dukun bayi, in Indonesian and Malaysian society.

5.4 A Socio-political History of Umbilical Cord Scissors

When the Lunyuk clinic was first built in 1984 the staff consisted of several nurses (all male) and a doctor who was to visit several times weekly. There were no clinic midwives stationed at the clinic and there would not be any for quite some time. Initially the government clinic doctors recreated a synthetic approach of treatment in developing a local biomedical program. This had been the standard in the general public health system in Indonesia since the early days of the Rockefeller hygiene programs (see Stein 2005). The clinic staff developed relationships that accommodated local social and hierarchical structures as well as an open combination of the biomedical with the authentic (*asli*) in terms of religious traditions, the herbal with pharmaceutical medicines, and local healing practitioners with biomedical care. As Stein finds in his study of the public health programs in early 20th century Java, these elements of the *asli* were allowed to coexist as long as they did not interfere with the mission of the clinic. In fact, as Stein notes, "Although elements of 'authentic' (*asli*) culture were often subordinate to biomedicine, the remaining incommensurabilities continue to destabilize and limit the process of medicalization into the present" (Stein, 2005: 6). Thus, the local dukun bayi were treated as integral members of the functioning clinic after they went through the clinic training to become dukun bayi terlati. This was, after all, part of the mandate of the early public health systems: to forge relationships with the local dukun bayi to help them "progress" (k*emajuan*), or "develop" (p*embangunan*, *perkembangen*). In

the past the Indonesian government realized the power of these women and hoped that by affiliating with them they could use the status of the dukun bayi to the benefit of the biomedical program, thereby promoting the use of the clinic and specifically the family planning and the maternal and infant health programs (KIA).

At that time the dukun bayi were given free access to the clinic tools that were included in the training. This was, in fact, part of the reward to the dukun bayi for agreeing to take the clinic training program. Their certification would make them official partners of the clinic with a continual supply of equipment not available locally. While the clinic was then, and continues to be, poorly-supplied (largely due to corruption and outright theft) the clinic staff were happy to hand over any of the supplies that they had. Additionally, the inexperienced, understaffed and male health care practitioners of the early clinic were anxious to hand over the job of actually dealing with childbirth to someone else(i.e. the traditional specialists), even if they were not technically biomedically trained.

When the dukun bayi agreed to be trained and become official members of the clinic, some argued that the Dukun Bayi had lost their spiritual power or that it was only those who had weak powers or no power who agreed to take the training; in other words, they needed the connection to the clinic because their power was not very strong. Thus, the dukun bayi lost some of their supporters by affiliating with the clinic.

Yet these women were still not full members of the biomedical clinic. It left them in a awkward place and open to strident criticism from all sides. But

eventually, these women became the health care practitioners with the most extensive practices in all of Lunyuk. They eventually were able to hold onto their Lunyuk-style, shaman-based healing methods while also using some of the methods that they learned in their clinic training.

As a result of these factors the supplies that were then offered to the dukun bayi terlati were fairly extensive and included umbilical cord scissors. Scissors are presently not included in the generic dukun bayi kit that is distributed in Indonesia and world-wide. Normally, razor blades are included in the dukun bayi kit, which are much cheaper (i.e. $0.10 per blade vs. $11 for scissors), are much more widely available, and are meant to be used only once so as to reduce the spread of infection. Additionally, except for ease of use and durability, there is no benefit to having scissors in the practical sense of cutting an umbilical cord.

Figure 5.2: The biomedical tools that were given to the dukun bayi terlati in the TBA training program and the record books that she purchased (to the left). Everything was unused except for the umbilical cord scissors.

In the early 1990s the first biomedically trained midwives, the bidan, started joining the staff of the clinic in Lunyuk. They implemented family reproductive health programs designed by global health care organizations and the national ministry of health. Beyond their duties as biomedical professionals, they were expected to help the local populations "progress" and "modernize," in the words of national development health care program officials. It was hoped that the local populations would choose to seek the services offered by the clinic staff rather than from the dukun bayi. These global and national reproductive health care programs conflate ideas about moral superiority, modernity, and the exclusive use of the

biomedical services that are available through the clinic. Indeed, ideas about modernity and a challenge to local hierarchies are integral to understanding the shifting identities of the dukun bayi. Like Cecelia Van Hollen's work in India (2003), a very important element of this research is to understand how ideas about "becoming modern," and explicit goals of the Indonesian nationalist maternal health care programs, impact the behaviors and practices surrounding childbirth.

The process of helping the Indonesian populations to modernize was expected to erase the dukun bayi's position of local importance. These maternal health care programs still constitute one of the few regular channels between global programs and the local environment in this isolated area. As a result, access to the resources offered by these programs became a source of power and social status for the local biomedically trained midwives.

Also occurring at this time was a shift in international and Indonesian national program policy to the use of "skilled attendants," as it was assumed that there was a sufficiently complete coverage of the entire country. This was, and is part of a global paradigm of development that expects an "evolution" toward "progress." Additionally, the continued funding for these programs depends on attaining some of these goals. It was assumed that the natural evolution of these reproductive health programs would mean that the bidan would, at some point, take over the entire business of childbirth in the village. The move of the global donor organizations in the last twenty years, led by the International Confederation of Midwives, has been to cancel programs training Traditional Birthing Attendants (in

Indonesia called dukun bayi) with the logic that people would slowly but surely use the clinic services as they became available and people saw that they had much more to offer than the traditional services.

One of the many effects of the changes in these programs is that the umbilical cord scissors have become much harder for the dukun bayi to find. In Lunyuk the clinic midwife program began in the mid 1990s, the dukun bayi were no longer welcomed at the clinic and were certainly not welcomed to ask for supplies. Bidan Dewi noted that because the clinic staff had trouble maintaining their stock of supplies they were not likely to share them with the dukun bayi. Further, this was one of the many examples that the bidan used when they framed the dukun bayi as bothersome both professionally and socially. Other than from the clinic, the umbilical scissors are very difficult to find. The only present alternative source is by special order from one pharmacy in the capital city, Sumbawa Besar, five hours away by bus.

5.5 Criticisms of the Dukun Bayi

Ginsburg and Rapp (1995:5) suggest that, "the control and distribution of knowledge and practice concerning reproduction are contested in every society". In this Sumbawan village, tradition holds that the older dukun bayi are those who dispense the knowledge and practice related to fertility and childbirth. The state health care program policy introduces an alternate, biomedical and non-Sumbawan

hierarchy to the area that openly criticizes the dukun bayi and their practices on which their long-standing traditional authority rests. There is an explicit moral imperative to this criticism (Anagnost 1995). They are labeled using Indonesianized forms of the English words "primitive" as opposed to "modern," and "not wanting to progress," (*tidak mau maju*). It is as a result of this challenge, and bolstered by the fact that there is continued great demand for their services (see discussion below), that dukun bayi feel the need to recreate their public image.

The dukun bayi are not only responding to the biomedical messages, as conveyed through the state apparatus, but they are also responding to the demands of the birthing women. These include how the birthing women conceptualize birth, how they understand the relationship between modern and primitive, and how they view the competing practices.

Although there was an increasing number of government reproductive health care services available in the region[41], there was not a corresponding decrease in the demand for Sumbawan ritual and traditional health treatments[42]. Additionally, the recent political shifts in Indonesia towards greater autonomy have increased the popular interest and discussion about what it means to be "Sumbawan." Due to a variety of factors, there has also been an increase in demand for the care available from the clinic practitioners, including both doctors and bidan.

[41] As already noted, since the 1990s Lunyuk went from having no government skilled birthing attendants to having seven available to assist people throughout Lunyuk.

[42] No figures are officially kept on demand for the services of the dukun bayi in Sumbawa. There are estimates of the numbers of bidan or dukun bayi who attend the births and offer prenatal care. The dukun bayi reported no change in demand for obstetrical care since the arrival of the bidan. Instead they suggest that women who do receive care from the bidan just added more prenatal visits instead of changing their care from dukun bayi to bidan.

This may result from persistent calls, from the government and from religious groups, for Indonesians to leave the "primitive" behind and become "modern."

Shaman midwives have capitalized on this, transforming their public identities to become people who scale multiple planes. They can offer a little of everything to their patients. In this way they are able to respond to the challenge to their place at the top of the hierarchy. Evidence that they are at least somewhat successful in this bid to hang onto their authority is the shift in the practice of the bidan to adopting obstetrical practices that fall squarely in the purview of the dukun bayi (as will be discussed in the next chapter concerning delivery water). In *Conceiving the New World Order*, Ginsburg and Rapp (1995) demonstrate that although the imposition of ideas and practices through global reproductive health care programs does occur, the power to shape reproductive practice, using local cultural logic and social relations, is multidirectional. The dukun bayi recast their public image in response to criticisms from reproductive health care programs, modernist Islamic groups, and government agencies. In fact, their successful recasting of their public image is based on drawing connections to the very institutions that criticize them.

5.6 Symbolic Boundaries and being "Modern"

Although many of the dukun bayi see themselves as having progressed and modernized per national requirements, many also remain nationalists and point to what they feel was the Golden Era of Indonesia the middle 1900s. They remember this era as being a time when Indonesia was a new country of diverse people working together for the betterment of themselves and their neighbors. They took their mandate with the clinic in the 1980's seriously. Moreover they see themselves as something superior to the "modern," (*moderen*) and far from being "primitive" (*primitif*). The construction of the category modern has its roots in nationalist ideology and the work of development programmers. It is a word that means that a person displays a certain list of characteristics.

But what the dukun bayi are talking about is "modern" in a temporal sense that embraces Sumbawan-ness, Balinese-ness, Sasak-ness, Indonesian-ness, and even a connection to the larger world. It doesn't fix the Sumbawan identity in Sumbawa. Ironically, for many people the dukun bayi embodies an element of this modern-ness. The dukun bayi assert that the charge that they are *primitif* is misplaced. They argue that while they might not be as formally educated as the bidan and might "get lost if I ever entered Jakarta," they are experts in not only all aspects of pregnancy, fertility, delivery, and post-natal care, but also in assisting their people with the strain associated with the contemporary world. They argue that the few dukun bayi that practice, but who do not have clinic training, are the

ones who are primitive. “They live with their backs to the road, they don’t want to see what is new that comes to Lunyuk.” They described their job as to act as a guide of sorts. However, those dukun bayi who chose not to get the training (*dukun bayi liar*) claimed that the trained dukun bayi (*dukun bayi terlati*), those who are central to this dissertation, needed the training because their magical skills are lacking or non-existent.

As we look at the criteria that the dukun bayi use to associate themselves with this elite status and authority in their community, it is convenient to use Lamont’s formulation of the symbolic boundaries to help identify these criteria. Symbolic boundaries are, “conceptual distinctions made by social actors to categorize objects, people, practices, and even time and space. They are tools that individuals and groups struggle over and come to agree upon definitions of reality” (Lamont and Molnar 2002: 168). Through these criteria the dukun bayi hold themselves as a distinct group from the other obstetrical practitioners, primarily the bidan, but also the few dukun bayi who have not received clinic training. These criteria become evident when examining the symbolic boundaries or “the types of lines that individuals draw when they categorize people” (Lamont 1992: 1-2). The maintenance of these symbolic boundaries both defines the group and responds to criticism from those who would like to see that very group abolished. The dukun bayi made use of the umbilical cord scissors as they developed their symbolic boundaries, including: the use, maintenance, and incorporation of ritual into the birth practice; the demonstration of a high level of obstetric competence; an active

engagement with religion, and asserting a position of religious authority; and making an effort to participate in the nationalist project.

Lamont's work with the process of boundary making, is about how groups create elite status. They make themselves superior by using these boundaries. While this is an important part of this discussion, I extend Lamont's argument by exploring how people create status based on the same, but overlapping symbolic boundaries. Throughout the population in Lunyuk, different groups of people use the same set of symbolic boundaries to determine the worth of others. However, these symbolic boundaries are interpreted and weighted differently between groups. The placement of these boundaries is different depending on context and structural issues (education, ethnicity, socioeconomic status, and religion). Thus later I will discuss how the bidan use a similar, overlapping set of symbolic boundaries to distinguish themselves from the dukun bayi and emphasize their elite status. As Lamont points out, this highlights the relative salience of different types of high status symbols. My study revealed that the shaman midwife made a very self-conscious assessment of their position vis-à-vis the bidan, a careful inventory of their skills and resources, and what services the local people are interested in seeking.

During several weeks of working with dukun bayi Dukun Papin I kept asking her about what part of her work was ritual and what part of her work was what she learned from the clinic. After I finally figured out that I was asking her the question in the wrong way she explained to me that the process of creating a healthy

pregnancy and birth was ritual. She explained that every aspect of it is ritualized, and she did not separate the ritual from practical aspects of the process. The elements of the dukun bayi's practice that were incorporated from their training in the clinic were incorporated into the ritual. Thus, using the umbilical cord scissors was part of the ritual of delivery. The dukun bayi saw themselves as the only practitioners who could perform ritual.

These aspects of the development of ritual as a part of their symbolic boundary are consistent with other examples. Rosaldo and Atkinson extend Levi-Strauss' work with *bricoleur* in their discussion of "redundant metaphors" (Rosaldo and Atkinson 1975: 45). "By combining what once was separate, by saying the 'same thing' in a variety of symbolic forms, *bricoleur* creates a context in which new meanings are realized, and the experienced world is re-ordered in terms of unique orientation or goal. In magical spells, for example, practitioners typically call on a wide range of objects" (Rosaldo and Atkinson 1975: 45).

Similarly, Pigg (1997) found that in Nepal when the shaman midwives receive training in the biomedical clinics it required them to "fragment their practices" and distinguish between the biomedical, the traditional or the religious elements of what they do. I found that this was not true in Lunyuk, simply because the dukun bayi were able to absorb elements of the biomedical practice into their routine. They recognized an overlap between their practice and the practice of the bidan. They saw that part of their job was, in fact, to counter the fragmentation of the bidan, for whom there was great fragmentation between their personal versus

professional lives (see next chapter). The dukun bayi enveloped the practice and tools that were offered to them, to become a general practitioner of sorts, who occasionally sent a woman and her family to a biomedical specialist. The dukun bayi had powerfully absorbed and shaped the elements of biomedical practice to fit their needs.

As Sumbawan ritual specialists the shaman midwives were are thought to be uniquely able to address certain issues. As in many areas of Indonesia, magic and certain maladies were assumed to be branded to a particular ethnicity. So, some illnesses, curses, powers or states of being are thought to be specific to Sumbawan people. Non-Sumbawans can be affected by these, but they are most dangerous or important to Sumbawan people. Additionally all illnesses or curses thought to be Sumbawan in nature must be addressed or shielded by a person able to conduct Sumbawan magic. In the case of pregnancy this would be the Sumbawan shaman midwife. These women, and sometimes men, use massage and a vast knowledge of plant remedies in their practices.

There are certain maladies that are regarded as being the result of uniquely Sumbawan spirits. The only way to address these maladies is to have a Sumbawan shaman address the problem. This would be a dukun bayi if it is related to fertility, pregnancy, or delivery. Protection is also an issue. By using a Sumbawan midwife who is also tied to the mosque, some of the modernist-leaning members of the community are able to find a way to legitimize their consultation with the dukun bayi while not engaging in what might be seen as hypocritical behavior. The dukun

bayi is able to convince or cajole harmful spirits to leave the patient alone. These powers are explained to have been given to her or him by God, an Islamic God. Dukun Papin describes these powers as given to her by an Islamic God and God intends for her to use them. It is widely believed that should she, or others like her, not heed the signs (i.e. that she does not use her powers) then bad can fall on her and those around her. It is in fact dangerous for her to not practice a God-given gift (Bernstein (1997) and Atkinson (1987) and Laderman (1983) have similar findings).

The most active and influential of the shaman midwives point to the training that they received in the clinic before there were clinic midwives as an indicator that they are versed in the "modern" biomedical techniques of the clinic. This training is the basis on which they publicly present themselves as able to synthesize multiple modes of health and understanding.

The dukun bayi are portrayed as medically incompetent by government reproductive health programs. This becomes a topic of open contestation and competition between the bidan and the dukun bayi as they engage in a struggle for who is "modern" and who is "primitive." Dukun bayi are described as being so steeped in tradition that they are not able to know, master or practice the most basic of skills that are needed to conduct a "modern," here meaning biomedical, and healthy reproductive care practice.

Officially, the power arbiters associated with contemporary Indonesian nationalism reject the idea that the dukun bayi are legitimate obstetrical

practitioners. Many government and clinic officials define the current use of the shamanic practice in terms that communicate a level of abhorrence and politely describe the dukun bayi themselves as being like *antik* (antiques), borrowing the English word. Like the craft market's use of the word *antik,* this description allows for a shred of remaining worth, good enough for the days of the past, worthy of a place in history, but better to be replaced by more effective models.

At nearly every official ceremony in Lunyuk there is a "cultural performance." As there is a fragile balance of three ethnicities in this area often there is a performance, or some sort of representation of "culture" (*kebudayaan*) from all three. For example, these performances might involve Sumbawan drumming, Sasak stick fighting, and Balinese dance, or a fashion show representing the costumes of the three ethnicities present in Lunyuk. It is the dukun bayi who is asked by the government official to oversee the production of the "cultural performance." These performances are where the dukun bayi (and other dukun) are at their most public. They choreograph, select, and practice with the performers often in the name of cultural education. They become an important signal of involvement and participation with the nationalist project. These performances offer public displays of involvement and participation in the nationalist project. The dukun bayi are asked to publicly present their skills and knowledge, that for which they are normally criticized, by those who normally criticize them. This is a situation where those who criticize, then come to need the skills and knowledge set of the dukun bayi because of the compulsory performance of the political construction of culture

and tradition (*kebudayaan*). It can equally be said that this is an attempt to find an appropriate slot in which to place these people.[43]

The dukun bayi all reported that, decades ago, they were motivated to join the clinic training because of their identification with and approval of nationalist ideology. Indeed, the fact that the dukun bayi have the umbilical cord scissors is a public signal that they were involved in the nationally mandated program. Government officials requested that they follow the clinic training to become a dukun bayi *terlati*, or "trained" traditional midwives, and partners to the government clinic to help build the nation by improving the health outcomes related to antenatal and postnatal care. This allegiance and certification not only met their desire to be involved in a national improvement project but differentiated them from the other dukun bayi who chose not to join. The government clinics desperately needed the help of the dukun bayi at the time. As the bidan program grew and more clinics were staffed with bidan, the dukun bayi began to be seen as an annoyance and an unwanted vestige of the old Indonesia (Stein, 2005), or to be more specific, the old Sumbawa. Since the change of policy and cancellation of the terlati programs, the government officials designing a nationalist project did not promote the identity of the dukun bayi, rather they opposed it by rejecting the dukun bayi as legitimate obstetrical practitioners (Jaffrelot 2003).

In general, the government program and education officials describe the practice of the dukun bayi, and those who seek her care, to be backwards and

[43] See Bowen 1986; Pemberton 1994; Rutherford 1996; Spyer 1996; or Keane 1997 for more extensive discussions of this matter.

recalcitrant to the national project of becoming a modern and prosperous Indonesia. They point to the dukun bayi and the people seeking their practice as holding Indonesia back from becoming a modern, prosperous county[44]. This critique is also tied to the rationale that there are now clinics in the village so local people should automatically begin to use the clinic as their sole source of medical care. These are people who ultimately create the definition of the category "modern" (*moderen*). This word, used in this context, implies a specific range of behaviors and importantly the rejection of certain practices, such as seeking the care of a dukun bayi in fertility and pregnancy-related issues.

Even though the dukun bayi are aware of this critique by the government officials they maintain their desire to have a connection to the national Indonesian project. They point to the era leading to national independence and the early years of nationhood as a Golden Age. This was a time when (although not yet in Lunyuk) the dukun bayi were called to help. They remember those decades as a time when everybody, people from all regions and stations, was *bermasyarakat* (with the people), working together with a single goal of the betterment of the people of Indonesia. In their recollection, all people from all different places were appreciated and honored. That village structure was to be the model for the national structure. In the mind of the dukun bayi, it followed that this placed the dukun bayi in an honored place in the national structure as well. At that time, when Indonesia needed them the most, these women came to the fore to help women survive pregnancy and

[44] Reproductive health care officials often expressed a great deal of frustration over what they saw as the people who needed the most care and had the least resources "wasting" their money on the services of the dukun bayi.

delivery healthy babies. Dukun Madu remembers this history as mixed with the pro-natalist sentiments of the Sukarno era, and the problems of women and children dying at high rates. She described this era as a fundamental element that shaped her ideas about where she believed that she fit in to the community.

The dukun bayi generally counter the critiques of their work (and existence), as something to be left behind, by defining themselves as those who are critical to usher in the Indonesian people to the modern ideal envisioned during the Golden Era. Generally the dukun bayi countered that a healthy modern Indonesian is one that cherishes and incorporates the old traditions. They maintain that they embody the beginning of this modern Indonesian reproductive practice as their talents and abilities are layered with the multiple histories of Indonesia.

These symbolic boundaries work in tandem to define what it is to be the ideal, worthy, and good. The dukun bayi hold on to their connection by being the official keepers of ethnic tradition and they refute the criticism of being obsolete by describing themselves as being a modern dukun bayi.

The dukun bayi's reasoning is also seen in a wider population. Many people, who fall into the category of "modern" (i.e. educated, employed in salaried jobs, and living in homes with modern amenities) talked to me about valuing what is seen as "asli." Among many young intellectuals this return to an "asli" forms a new elitism. Often, central to this is a relationship with a dukun bayi, such as the example of the Sumbawan Bupati's educated, urban daughter-in-law who was rumored to have received care from a Sumbawan dukun bayi throughout her pregnancy.

In the following discussion two individuals, Pak Safar and Pak Syafruddin, talk about how the people in Lunyuk reflect on the symbolic boundaries concerning their interactions with the dukun bayi.

Pak Safar, a Sumbawan engineer employed in Jakarta, described this elite status as an ability to recognize that which exists in "original" village life, understanding all the other options and being able to make an educated choice about the best course of action. He felt that as an informed person, and not someone who is "*masih bodoh*" (still naïve), he could choose to honor the traditional village ways and rituals while embracing the best out there.

Pak Syafruddin, a high school teacher in Lunyuk, who was from Sumbawa Besar, but educated in Java, mirrored the sentiments of Pak Safar. He had conflicted thinking regarding what he feels is good, worthy and the ideal, what is modern, what is traditional, and what is prescribed by his religion, Islam, and as a part of this, he sought the care of the dukun bayi for their fertility and pregnancy issues. His wife, also a teacher and a native of Lunyuk wears a head scarf. She is the only teacher at the high school to do so. They went to college together. Pak Syafruddin notes that Islam says don't worship false spirits or those who promote them (i.e. the dukun bayi and other more general dukun). He and his wife consult with Dukun Papin and Pak Abdul frequently. Pak Syafruddin and his wife are recognized as good Muslims, and are very active with mosque activities and are faithful, pious people (*rajin berdoa*). Pak Syafruddin points out that Pak Abdul and Dukun Papin are good Muslims too, they are also widely recognized as pious people and regular attendees

of all Muslim events, yet they represent exactly that which the good modernist Muslim is told to avoid. He says that he has seen the 'modern life' outside of Lunyuk (i.e. Java and Lombok where he got his college education and had his first teaching jobs) and he said that not only did he not like modern life, he thought that it wasn't very Muslim. He says that he wants to be Sumbawan, but also a modern Sumbawan, which means something different than a modern Indonesian. He wants to live with the values that he grew up with in Sumbawa, such as hard work and a focus on the community. He is there in his wife's hometown to help the people of Lunyuk (including all ethnicities) move-up and progress (*bermaju*). He points to Dukun Papin in particular and says that she and her husband are like the central supporting post in the Sumbawan house. They are what it means to be Sumbawan. They have educated themselves in techniques that help the local people (*terlati* training). They take care to learn about the world outside of Lunyuk and Sumbawa while maintaining a focus on the Sumbawan identity. He said that maybe they don't look modern and in many ways they are not, but young educated people need to return to them to learn what it means to be a good person, a good Muslim, and a good Sumbawan. He pointed to the fact that he prayed next to Pak Abdul regularly at the Mosque, and he joked that Pak Abdul must be there all the time because he never shows up without Pak Abdul being there. He says that his wife has had trouble both conceiving and maintaining a pregnancy. They tried using the services at the clinic and even traveled to Sumbawa Besar and to Lombok to see if anything could be done. So far they were not successful. So they were consulting with Dukun Papin.

They felt that this might be the key. He equated this to the fact that there was an essence of being Sumbawan, and that they might need specifically Sumbawan help.

5.7 Conclusions

The dukun bayi understand the world to be fragmented, and understand that this fragmentation is hard for people to deal with. Their job is to help people through pregnancy, childbirth, and other difficult times, to help them find their place, to help them understand and feel comfortable. They understand that pregnancy and childbirth is a particularly vulnerable time on many levels for the baby, the mother, the family, and the community. Their particular wide-ranging expertise is unique in the community in the way that they can help people with this.

The dukun bayi are attempting to maintain an elite status and community authority; they use the same symbolic boundaries as others but draw on a different interpretation of the same boundaries, and their construction of the symbolic boundaries is different because they also use them as a defense against the major criticism levied against them.

Dukun bayi Dukun Papin commented to me that people go away for education and then they come back to her as modern Sumbawans for reproductive issues. She points to many other cases like that. As an example, she said she knew the dukun bayi who performed fertility rituals and cared for the pregnancy of the

Bupati of Sumbawa's daughter-in-law, who lives in Jakarta, where she and her husband were employed by an international mining corporation.

At one point, I had been very sick with "Dengue Fever." Dukun Papin diagnosed this as a general fever sickness but was more interested in the cause. She said that I was so sick because my stomach was inside-out (*perut terbalik*). As she was performing several therapeutic treatments she asked me if I would do some translating for her. Her grandson had recently brought her a DVD with all of the videos from the Swedish band "Aqua" that was popular in Indonesia at the time. For nearly two hours I translated the words into Indonesian and explained many of the concepts, such as what a Barbie doll was, both as an object, and in the context of the Western feminist critique of Barbie, which then later turned into an interesting conversation as well. Dukun Papin and Pak Abdul had many questions that afternoon and then again the following morning.

I had similar discussions with them many times before. I asked them why they were interested in these videos. They told me that this is part of what they needed to do to be up to date on what their patients and children were exposed to in their life. Their treatments addressed the whole person. They reminded me that they, unlike the clinic practitioners, don't just look at the physical problem and address a body part. They used me as an example. Dukun Papin repeated her diagnosis of my illness with added social commentary. She said the body was sick and that my stomach had turned inside out and spilled the dirty contents into my body because of what she diagnosed as a major fragmentation. She said that I was

experiencing emotional and intellectual upheaval in my life by having a life in Indonesia and a life in the United States. She further noted that even my Indonesian life was fragmented as I had just returned to rural Lunyuk from spending a month in Jakarta. She perceived that I was very sad that I was completing my research in Lunyuk and that I would be leaving the people I had come to love, yet I was also happy to return to those who I love in the United States. She was quite certain that this was why I was sick rather than the cause being the victim of black magic or poisoning. Her focus was on the cause of the illness state that I was experiencing rather than the disease. Yes, maybe this was called Dengue by some, but, she pointed out, why did I contract this now and I've never had a problem with this before? There are swarms of mosquitoes around me everyday. Why now? She explained that I was weak because of the fragmentation that I was experiencing[45].

The dukun bayi believe that they are Sumbawa, they are Indonesia, they are of the world. Their relevance has a greater scope than just a specific geographical location. They are a resource for people to negotiate their identities and their place in the world. They see the work of the bidan as fragmented, while they are whole. Bu Dewi explained to me that a person is not one thing, they are many, and they must come to terms with that fact. This is the same explanation that Dukun Papin and Pak Abdul had for my dengue fever.

[45] During my stay in Lunyuk there was constant speculation among the medical personnel (shamanic-based and biomedically-based) about whether I was able to be harmed by Balinese, Sasak, or Sumbawan magic. Until I got dengue fever I had only suffered from minor respiratory or digestive illnesses that were not recognized as anything out of the ordinary—and I rarely suffered from those. While many people attributed this strength to immunity from magical issues, I always suggested that it was because I had never been malnourished. Nobody ever thought much of that explanation.

Chapter 6:

Delivery Water:

The Conflicting Influences that Shape the Practice of the Bidan

This chapter traces the social tension surrounding the bidan's use of delivery water, a medicine produced by the dukun bayi that is believed to help speed the delivery of a baby once labor has begun. The use of delivery water by the bidan highlights a number of the social interactions at play as the bidan offers reproductive medical care in a rural Indonesian village and addresses the problems that arise in pregnancy and delivery. Although the bidan build their elite pan-Indonesian social status based on their association with the government reproductive health care programs and their commensurate economic status, the conflicting pressures and critiques that the bidan feel bring more pressure to bear on the way they practice than any other allegiance. Their use of the delivery water reveals the tension that they feel while trying to improve the conditions of reproductive health, as they try to draw patients to their practice, and as they resolve their own feelings about the more popular traditional treatments.

The use of the delivery water is particularly interesting because unlike other treatments that the bidan use, it is locally understood to be imbued with both a power of its own and with the powerful prayer of the dukun bayi. Unlike offering massage, using oils, and applying pastes, in order for the bidan to obtain the delivery water they need to purchase or trade it from the dukun bayi. The bidan, as a matter

of Indonesian reproductive health policy and daily habit, publicly maintain that the dukun bayi have practices that are harmful to the health of pregnant women and babies.[46] Yet here they are using practices that are identified by all as those originating from the dukun bayi, and they are working hard to maintain a relationship with a dukun bayi so as to have access to this treatment modality. It is therefore instructive to look at the conflicts relating to the use of delivery water by the bidan, and at other social issues relating the bidan in the community. These social issues relate to conflicts that the bidan and others feel: they are seen as elite persons who have different backgrounds and training than others in the community, and they are not as integrated into the community as others may be.

This chapter will examine these issues, first using an ethnographic vignette centered on the difficult birth of Ariana's baby, then examining the shaman origins and the use of delivery water by the bidan, then considering the bidans' view of themselves in bringing modern practices to the community and the conflicts this creates, and then considering criticism of the bidan by the government program officials and by others in the community.

[46] In consultations with patients and in reproductive health education sessions the bidan regularly point out to the patients damage or harm that can be done by the dukun bayi. Most often they point to rough massage or infection.

6.1 An Ethnographic Vignette

On a quiet afternoon, while everyone else was napping, I sat with Bidan Marta outside of one of the Lunyuk sub-clinics (*pustu*) as she explained what had been for me a confusing turn of events just before the delivery of a healthy baby boy the day before. I had just completed four months of careful tutelage from the clinic bidan, learning the details of the prenatal treatment and delivery protocols as instructed by the government and international reproductive health care programs. During this time I had witnessed Bidan Marta regularly refer to the use of what I'll call delivery water, a dukun bayi produced medication, in deliveries that were stalled or had stopped. This was confusing as the use of any kind of treatment that fell under the purview of the dukun bayi is on many levels antithetical to the expressed mission of the reproductive health programs. The bidan were expressly trained and deployed to serve as agents of biomedical modernization in the reproductive process. Briefly put, Bidan Marta's use of the dukun bayi produced delivery water was heretical to everything that she and the other bidan had taught me thus far. Further, on this afternoon she told me that it was a completely normal course of behavior.

The delivery the day before had been especially difficult. It was the first difficult delivery that I had attended while in Lunyuk. Ariana, who was barely nineteen, and newly married, had been in labor for two and a half days already when she was brought to the sub-clinic in the late afternoon. When she originally

went into labor her mother-in-law called for Dukun Madu, the dukun bayi who lived near their house. Ariana had received prenatal treatments from Dukun Madu but had never chosen to seek care from Bidan Dewi who lived close by. Like most women who lived in this area, Ariana wanted to give birth at home with the help of the Dukun Madu who had assisted her mother in the delivery of Ariana herself.

When Ariana's delivery started taking longer than Dukun Madu and her parents thought that it should they called for Bidan Dewi.[47] I was with her when she received the call as we had just returned from visiting a remote community to implement a vaccination and vitamin A supplementation program. Bidan Dewi was immediately annoyed. She noted that Ariana had never stopped by her local sub-clinic or the village clinic even though Bidan Dewi had stopped by her house a couple of times and told her that she needed to come in for appointments. Bidan Dewi commented to me that this was what normally happened: people sent for the dukun bayi when they went into labor. If a problem developed they sent for the bidan and if something bad happened, then the bidan received the blame for the negative result.

I accompanied Bidan Dewi to Ariana's house to check on her. We found Ariana looking tired but comfortable in one of the central houses of the family's compound. She sat on a bed that had been moved to the center of a room and was surrounded by family members and a few friends. She rested and chatted with people as they came and went from the room. Ariana's husband came in and out of

[47] Ariana's husband was also nineteen. He was not a vocal presence during the delivery. The older family members were clearly acting in an advisory role.

the room where Ariana was but spent most of his time getting teased by male relatives outside. Dukun Madu left the house when we came in but stayed with the group of people waiting outside. Bidan Dewi listened to the history of the labor, did an exam, and offered her assessment that Ariana should be moved to the one sub-clinic that had a gynecological examination table and the intravenous equipment.

Outside of the small building where Ariana was laboring was a group of family and neighbors. They were concerned about the lack of progress and were talking about what to do. The options for care in the village are very few. The dukun bayi and the bidan both have medications and treatments to help with normal delivery but any sort of assisted delivery (e.g. those requiring vacuum or forceps extraction or a c-section) are only available in the hospital, a rough drive by car or truck five hours away over several mountain ranges. Protracted deliveries, such as this one, could possibly end in the death or severe injury of a mother or a baby or both. There is no doubt that the people waiting while Ariana labored had experience with relatives, friends, or infants who had died in childbirth. The concern among the crowd of people was very real.

A stalled labor is something that the dukun bayi and bidan alike see as a problem. Although the dukun bayi have many possible reasons for a stall or a cessation in the progression of labor, they do share with the bidan the belief in at least three possible causal factors: a woman who is under 20, or who is experiencing her first delivery, or who is well under the local average height (officially under 145

cm tall). Ariana was all three. At the time I did not talk to Dukun Madu about her ideas about why the birth was stalled as I had only just met her.

The decision was finally made to move Ariana to the sub-clinic. The same group of about 20 people who were at Ariana's house arrived with her and found places to sit outside of the clinic. Upon arrival, Ariana's contractions nearly disappeared. She appeared shaken and she was silent. The other village bidan gathered as they often did to help each other and keep each other company.

At the clinic, Ariana was required to lie on a narrow and very tall examination table. Only one family member was allowed in the small room with her. Every once in a while another family member would squeeze their way into the room, and then another. All of the village bidan sat in the room too, mostly scrutinizing a shoe catalogue and putting together a group order. Every once in a while the family members were told that a few of them had to leave because the room was too crowded. The large open window in the room became a place where family members and friends would check on Ariana. Dukun Madu made several visual assessments from the window as well. Each time Dukun Madu came to the window one of the female relatives in the room would then go outside and consult with her. Every once in a while one of the bidan would go over to the window and close it. Eventually the room would become too hot and the window would be opened again. Ultimately, it was a process where Ariana was left alone in a room full of women she didn't know and who largely didn't interact with her.

Through the evening Ariana continued to labor. Her contractions came and went but they were rarely regular. The bidan had regular conversations amongs themselves regarding her progress. Ariana became visibly weaker and tired as time went on. Eventually the bidan decided that the clinic doctor needed to be consulted. The young male Javanese doctor arrived with great fanfare in his new Honda sedan, which was the only car in the district. He did a hurried examination of Ariana and assessed that she indeed seemed to be stalled at five centimeter dilation. After examining her, he loudly told me that people in Lunyuk don't want to hear about the possibilities of care at the clinic or the hospital for prenatal care and delivery. While sitting on the end of the examination table where Ariana lay, he used Ariana as an example. He commented that Ariana was very short and that if she had come to the clinic for prenatal care they would have told her that she needed to go to the hospital in Sumbawa Besar for her delivery. He said, "But these village people…I think that you say in English…[switching to English] 'in one ear and out the other' …they don't understand. We can talk for days and they will not listen." He commented, as Bidan Dewi had, that people choose to call the bidan only when there is a problem. After leaving the examination room, he left to talk to the husband about moving Ariana to the hospital in Sumbawa Besar and then left for the evening. Outside the examination room the gathered family and friends discussed the possibility of moving Ariana to the hospital but it was decided to remain here for the time being.

As night came people filtered home, but a small group made up of family members were allowed to stay with Ariana overnight. The bidan and I found places to sleep on mats on the floor in the next room. Ariana, and everyone else, slept fitfully. Before the sun came up the next morning more people gathered outside to sit and wait to see what would happen with Ariana's delivery. A large crowd had formed by the time mid-morning arrived. By this time people were quite worried. Ariana was not looking well. She had still made very little progress.

In the morning the bidan continued with the only intervention available for them to offer, which was another intravenous drip of oxytocin to bring stronger and more frequent contractions. There had been a slight improvement at this point but not what had been hoped for over a nearly eight hour period. Ariana was getting more and more tired. At this point all the bidan were there, the doctor came, and Dukun Madu was being less secretive in her visits. While the bidan were trying to convince the family to send Ariana to the hospital Dukun Madu came into the exam room. Only Ariana's aunt, mother-in-law, and I were present. She felt Ariana's swollen abdomen and gently looked at her eyes, her hands, and prayed while holding her head. Then she left before the bidan returned. At this point Ariana had been in labor for three days, almost 24 hours of those had been in the sub-clinic. As there had been little demonstrable change in Ariana's progress the clinic staff were now pushing as hard as they could to send Ariana to the city hospital. They explained to the family that this meant that she would probably have a C-section and a hospital stay in Sumbawa Besar. This would surely result in a large payment to the

hospital that their family would have difficulty paying. The clinic staff guessed that it could total up to $500 with transport and paying for family members to stay with Ariana in Sumbawa Besar.

At this point a large crowd had gathered outside the clinic. Discussion became quite heated concerning what Ariana's family should do. People were concerned that Ariana would die. I was concerned that she would die as well. People also considered the fact that the family was poor. They only had four cows. Each cow was worth about $500 in a good selling season but in this season they would only get about $400 for it. Plus they needed this cow. It was the savings account for the entire extended family. Finally, Ariana's family of marriage decided to keep Ariana in Lunyuk. The clinic staff had her husband sign a piece of paper stating that he understood the risks.

Bidan Marta was checking Ariana's blood pressure because she had recently begun another bag of saline laced with pitocin through Ariana's IV. Ariana's mother-in-law came in the delivery room with a glass of water after being gone for a while. She walked quickly to Ariana's side and with great force splashed the water all over Ariana's belly and pelvic region. Bidan Marta, whose back was turned, was splashed by the water and shouted angrily at the mother-in-law asking her what it was that she had done and why she was making a mess and getting everyone wet. Her anger subsided very quickly when the mother-in-law explained that it was a water medication (variably referred to as *medo* [Sumbawan], or *obat keluarkan* [Indonesian], or *aik/air persalinan*) that Dukun Madu had given her. This

medication, or delivery water as I call it here, was a treatment imbued with spiritual power commonly produced by dukun bayi that was thought to aid in the delivery of the baby by increasing contractions, lubricating the birth canal, and offering sustenance to the baby for strength. Bidan Marta responded by asking who had made the delivery water and said calmly, "Ah. Dukun Ina's is more effective. I've used it many times." At that, she left to find towels to clean the water off of the floor. After the floor was cleaned, everyone noticed that Ariana seemed to turn a corner. Her contractions became regular, strong, and quick. Within forty-five minutes the baby was beginning to crown and in another twenty minutes he was fully delivered and swaddled in a sarong. Except for an oddly shaped head (which had disappeared by the time I went to talk to Ariana six weeks later) the baby was alert and Ariana was exhausted but largely fine.

The birth of Ariana's baby was the first difficult delivery that I'd witnessed since I arrived in Lunyuk five months earlier. I was shocked when I witnessed Bidan Marta's response to the use of the delivery water. This revelation was directly opposed to everything that I'd seen and learned from the bidan thus far. As I sat with Bidan Marta outside the pustu [subclinic] she described this practice as common. Furthermore, she noted that the bidan often used other treatments in both prenatal and delivery care that were specifically forbidden by the reproductive program officials. These treatments included: massage during pregnancy intended to place organs and the fetus in a favorable and comfortable position; the use of

locally produced oils in the birth canal to lubricate the baby's descent; and pastes for the mother for various ailments.

As the months passed and I attended more prenatal exams and births, those that were problematic and those that were without complication, I would come to find that this was, although not universal, quite common in situations where the bidan were running out of answers from their limited biomedical tool kit. Additionally the bidan contended that the inclusion of the practices would draw more patients to their practice. This was perplexing. These were the very types of practices that the bidan were trained to teach against and were supposed to be supplanting with biomedical practices.

6.2 Delivery Water

Delivery water (*medo*, *obat keluarkan*, *air/aik persalinan*) is a shaman-produced treatment that was believed to help speed the delivery of a baby in the case of a difficult birth. The actual substance of delivery water is part of a treatment to remove evil spirits from a woman's body. As noted above, there are many causal factors that are locally associated with difficult deliveries. The treatment of delivery water is used by the dukun bayi in almost all of these circumstances.

It is a long process to produce delivery water and each dukun bayi has a unique recipe and production technique. I was never part of the direct production of delivery water; however, I did assist in the collection and processing of ingredients

that would be used to make delivery water along with other medications. What follows is Dukun Papin's description of the important aspects of what makes delivery water.

Figure 6.1: Ingredients used to make a variety of shamanic remedies

The delivery water is made of herbs, flowers, chilies, oil, and in some cases, water. It can be made with different combinations of ingredients if some or all of them are limited. Generally, the herbs, flowers, and chili peppers are made into a poultice and then boiled for quite a long time. At this point some of the ingredients

are discarded and others kept. After the ingredients have been properly pounded, boiled, and sorted they are mixed with the oil in a manner that was never revealed to me. After the delivery water is made it must be stored properly in an appropriate vessel and in an appropriate position in the house or compound. Some of the dukun bayi had a special vessel to store the delivery water that was itself thought to hold power. Most others kept the delivery water in a dark-colored glass bottle. Most often the vessel was kept in a high place, far from human waste, and often only accessible to the dukun bayi. In the Sumbawan households this often meant that the delivery water, as well as other medications, was kept in the household granary.[48]

Figure 6.2: Sumbawan household granary

[48] In Sumbawan households the granary is a sacred space. Only the matriarch of the household and chosen helpers may enter.

In the end, the oil is largely translucent. The oil can then be used in its full strength or it can be mixed with water from various sources. An oil-only preparation was used for massages or sometimes to lubricate the birth canal in preparation for birth. A water preparation was used when it was deemed appropriate to cover the body, as was the case with Ariana.

The water used is always from a special or powerful source. The water sources that I knew about where from springs that were considered sacred or pure, and could possibly come from sources both locally and from great distances. Dukun Papin, and other dukun bayi, often requested that family members who were travelling bring her plastic bags of water from sacred sources.

Figure 6.3: A dukun bayi repacking her childbirth kit

The process of making the delivery water also included a great deal of prayer during which the dukun bayi would draw on their spiritual powers. Dukun Papin and others noted the importance of honoring God while making the delivery water by being properly clean both physically and ritually, saying the appropriate prayers, behaving properly, and performing the relevant rituals for that particular day in the ritual and religious cycle.

Making DeliveryWater: Source of Knowledge

The majority of the dukun bayi report that they came to know how to make the delivery water in a similar manner; they were given the knowledge by God (either Allah, or by *tuhannya Hindu*). Over the course of my study with Dukun Papin she reported this same source of knowledge came from Allah but she also regularly credited her long years of assisting her grandmother (also a dukun bayi) with her extraordinary knowledge of the medicinal uses of Sumbawan flora. It was often said to me that spiritual ability is passed from generation to generation. Many of the other dukun bayi were also children or grandchildren of dukun of various sorts. Dukun Papin made the point to me many times that in this, like all matters of the spirit or God's work, a recipe is just a recipe. It is the unexplainable spiritual gift that gives delivery water and all her treatments power. She said that she did not fear others knowing of the substances that went into the delivery water because only she could imbue the substance with the power that has been demonstrated over many decades and witnessed by many people.

This is the critical difference between the delivery water and the other traditional treatments that the bidan used. The bidan are not dukun bayi. None of the bidan claimed to have spiritual power and no one saw them as having such power. Even if they knew the recipe for the delivery water they could not produce it by themselves. They accepted this fact that was also held by the general population of Lunyuk. This was true of many other substances produced by dukun bayi and

dukun in general. Thus the bidan needed to have a publically credible source to both obtain and substantiate the power of the delivery water.

Application of Delivery Water

The dukun bayi applied the delivery water in a number of different manners based on the perceived etiology of the difficult labor. Treatment most often involved a massage of some sort. The method in which the delivery water was applied varied by dukun bayi. Dukun Papin preferred to massage the head or the temples of all women that she was treating as a preventative measure. During early labor massage with a strong rubbing and with a hand motion that first would look to the observer as if she was wiping something off the body or pulling something out of the skin and then flinging a sticky substance off her hands with a quick motion that often makes a snapping sound. She would give a full body massage if she suspected trouble with spirits and when a malevolent force of some sort needed to be extracted. Often in this massage she would also attempt to repair bodily damage that was done by malevolent spiritual forces (for example, a turned uterus, a closed uterus, or a narrowing of the umbilical cord or cervix). The delivery water, in the form of oil, would be inserted into the birth canal to lubricate and introduce an extractive force.

The most dramatic of the treatments was similar to that which Ariana received at the hands of her mother-in-law, with the instruction of Dukun Madu. The delivery water (the oil mixed with water) is splashed with great force all over pelvis

and abdomen. This is perceived by many to be one of the most effective routes to assisting in a stalled labor. In this case it is often perceived that there is a blockage.

6.3 The Mission of the Bidan: Encouraging Modernity

For the five months that I had been in Lunyuk before Ariana's delivery I'd spent most of my time with the bidan and other clinic staff. Each of the bidan had carefully been training me in the methods that they themselves were trained in through the government midwifery schools and continuing education programs. At that point I had also accompanied several clinic members to various training seminars for bidan in the capital city of the regency, Sumbawa Besar. From the beginning of the programs, the bidan's mission explicitly was to implement family reproductive health programs designed by global health care organizations and by the Indonesian Ministry of Health (Stein, 2005). One of the primary duties for the bidan, as biomedical professionals and national employees was, in the words of Indonesian development program officials, to help the local population "progress" and "modernize." The program developers and clinic professionals involved in this modernization process expected the availability of clinic services, offered at nearly no charge, to erase the local importance of the dukun bayi. An important part of this program was to discourage the patient demand for the treatments that the dukun bayi offered, and through a patient education program, to create demand for

biomedical obstetric prenatal care, treatments, and techniques. To the consternation of the clinic officials the dukun bayi remained solidly in business.

In an isolated area, such as Lunyuk, these maternal health care programs remain one of the few regular channels between global programs and the local environment. The importance of these programs is additionally reinforced by state rhetoric valorizing an identity of being a modern Indonesia. This definition of modernity is partially defined as being part of using biomedical services and identifying with a unified Indonesian nation. The bidan are presented to the local people as officers of the state whose mission is to help in the modernization process and to encourage a nationally defined identity rather than that based on local ethnicity and cultural norms.

The bidan consider themselves to be elite and socially separate themselves from the rest of the local population. Although the bidan do not figure prominently in locally-based social hierarchies, the local people do recognize a class difference based on criteria that are unfamiliar to them, but are recognizable as socially elite and Jakarta-centric. These issues result in a variety of ambiguous feelings, by the bidan and the community alike, about the bidan and their roles in the community and as health care providers.

In the eyes of the developers of Indonesia's reproductive health program an important indicator of a "modern" population, and thus success of the bidan, is having a high number of women who seek prenatal care and who deliver with the assistance of clinic staff, rather than seeking the services of the dukun bayi. These

global and national reproductive health care programs explicitly conflate ideas about moral superiority, modernity, and the exclusive use of the biomedical services that are available through the clinic. The clinic staff, bidan and doctors, all expressed frustration that they had not been able to affect more change in their time in Lunyuk. The number of infants and women they saw die, or experience permanent disability, were dishearteningly high and tugged at their conscience. The clinic staff were passionate about their charge to help the people of the village live a healthy life, but in this situation, they just did not know what to do. The doctor at the clinic told me, "…we do not know what to do with these women…they are not modern but they are not traditional either. They are…different." This reasoning resonated through the descriptions from the clinic bidan of their attempts to attract a larger patient load.

Making Social Space for the Construction of a Modern Identity: The Behavior of the Bidan at the Clinic

The bidan prioritize being modern and maintaining their elite class status, and they actively use several criteria to define themselves as part of an elite group. This section will address how this social status is created, the recognition and understanding of this elite status by the local women, and how their public performance of status consciousness creates an unwelcome environment for the village women, and ultimately contributes to a low acceptance rate of the bidan and the maternal health programs. The discussion will particularly address how the class relations and the social divisions between the elite and non-elite contribute to

the low caseload of the clinic bidan, and how this encourages the bidan to adopt, or perhaps return to the traditional local treatments for pregnancy and birth. Here, it is useful to employ the concept of symbolic boundaries as an analytical tool for determining how people in Lunyuk think and talk about the differences between groups, and how they determine who is an insider and who is an outsider.

Symbolic boundaries offer insight into the cultural underpinnings of social inequality (Stuber 2006) and allow for a sense of relationality. Michele Lamont defines symbolic boundaries as, "conceptual distinctions made by social actors to categorize objects, people, practices, and even time and space. They are tools that individuals and groups struggle over and come to agree upon as definitions of reality" (Lamont and Molnar 2002: 168). The placement of these boundaries differs depending on context and structural issues (e.g. education, ethnicity, socioeconomic status, and religion). Symbolic boundaries also create a system of rules, "that guide interaction by affecting who comes together to engage in what social acts" (Lamont 1992: 12). Lamont and Molnar (2002) suggest that symbolic boundaries are a pre-condition for the construction of social boundaries. In this way Lamont suggests that symbolic boundaries help define groups but also create inequality. Through "boundary work" members of this elite group of bidan draw a line between those who are "worthy" and those who are not. In rejecting others, or creating the other, the individual or the self emerges (Goffman 1961: 320). Michele Lamont's formulation of symbolic boundaries is particularly helpful in developing an understanding of how the players negotiate the relative salience of the various

symbolic boundaries. What differences are ignored, what differences are brought to the fore, and what differences are despised becomes clear in the public performance of these boundaries. Two ethnographic examples that do not include discussions of delivery water will highlight the ways that symbolic boundaries are constructed and used among social groups to define those who are included, those who are excluded, and what characteristics are weighted more heavily. This will reinforce the idea of how social boundaries are used in defining the identities of midwives in Lunyuk. The first example, that of the bidan usurping patient treatment time in favor of doing a Tae Bo exercise for their personal benefit at the clinic, highlights how the public performance of important signals of symbolic boundaries distinguish the elite from the non-elite. The second example, that of the gathering of the women and children in a village neighborhood for the *posyandu*, or mobile clinic, demonstrates how the criteria of elite status, and how the relative salience of the various signals of the symbolic boundaries, are negotiated. In reviewing these examples it is interesting to note how on one hand the bidan make use of their power and status to maintain their sense of elite modernity, while on the other hand they feel isolated and are forced to adopt traditional health care methods in order to keep the clients coming.

Performing Elite Signals: Tae Bo, Appearance, and National Duty

The clinic staff are instructed by the government that on each Friday morning, they should do fifteen minutes of calisthenics and a flag raising ceremony.

Well before my arrival in Lunyuk the fifteen minutes of calisthenics, previously lead by a male member of the clinic, had been replaced by exercise videos. These videos were often discussed in the Javanese-based women's magazines that were voraciously read by all the clinic women. As the character of the Friday morning exercise sessions at the Lunyuk clinic evolved, the favored routine became a morning long session of video Tae Bo[49] instruction and socializing.

Bidan Wati said that the change from calisthenics to exercise video occurred after she attended the last midwife training conference in the provincial capital about a year before the event described below. So every Friday morning they tried a new exercise video rather than the prescribed calisthenics. Bidan Wati explained that the Indonesian Midwifery Association (Ikatan Bidan Indonesia, IBI) official leading the training considered it to be more important to keep people interested in exercise and in a healthy lifestyle than to follow an outdated calisthenics routine. She thought that if the clinic staff was interested in doing weekly exercise it would be a good example for the local people.[50] The clinic staff happily eschewed calisthenics in favor of the exercise videos. Bidan Marta commented that this was part of the need to keep up to date on health issues and new theories about maintaining health.

[49] Tae Bo is an exercise form developed in the United States by Billy Blanks. It combines moves from martial arts, boxing, and dancing. The video that they watched was made in Jakarta based on the videos that feature Billy Blanks.

[50] This is one of the many examples of how the elites who are creating public health programs are so focused on the vision of what they hope the Indonesian populace would look like, that in some cases they have lost sight of the reality of the life of most people in rural Indonesia. The idea that a person in Lunyuk needs to exercise to maintain health is preposterous. Most people in Lunyuk perform heavy labor everyday.

These exercise videos, purchased when staff members traveled to other more urban islands, featured prominent Jakartan celebrities, in exercise outfits that one might find in an American gym. Although the video featured the American exercise form of Tae Bo, which incorporates martial arts, boxing, and dance, it was presented by a famous Jakartan sinetron[51] star who had now dedicated herself to educating Indonesian women on health and fitness. The video was sponsored by one of the major Indonesian women's magazines, which had funding from the government health ministry. By doing Tae Bo, the clinic women were still fulfilling their mandate to exercise as a model of healthy behavior while also performing their desire to emulate celebrities who embodied the national Indonesian ideal woman, rather that the ethnic Sumbawan, Sasak, or Balinese woman.

On this day, before the Tae Bo session began, the female clinic staff (i.e. the bidan and nurses) stood in the open-air patient waiting area while the men moved the furniture out of the way to create a space for the exercise participants and the television. The people who were waiting to see a clinic staff member were moved to the periphery of the room or voluntarily left the clinic. The clinic women loudly joked with each other as conversation shifted from their exercise outfits, to wondering if they would be as sore after the upcoming exercise as they were after the last time that they did Tae Bo.

The women of the clinic affected an urbane look, rare in rural Sumbawa, in their exercise clothing, jewelry, and shoes, all of which were expensive by local

[51] The Indonesian "*Sinetron*" is an acronym for "sinema elektronik." It is the equivalent to the American soap opera or the Mexican telenovela.

standards. A critical distinction here was that not only did they own new, specialized clothing and shoes, but that they needed to make time for exercise instead of living a life that required heavy physical labor. Their make-up was carefully applied and their hair was cut and styled in a fashion that could be seen on the Indonesian, Western, or Korean sit-coms that were popular in the region. The majority of this apparel could not be purchased anywhere on the island of Sumbawa: rather it was evidence that they, or someone they knew, had the financial resources to travel beyond the confines of the island. Not only did the women have the financial ability to buy these items, but they also knew how to put together an exercise outfit and they had the courage to wear it in a public place.

The waiting patients, who had scattered when the furniture was being moved, quietly peeked in the waiting room to catch a glimpse of what was happening. One of the bidan was still tending a pregnant woman in the exam room, but as she saw that the rest of the clinic staff had assembled she hurried to finish the prenatal exam and rushed out to join the others. Her patient remained in the exam room confused as to whether the exam was over and if she needed to pay. Not wanting to disturb the bidan and nurses doing their exercise, the patient decided to sit in the room and wait. There the patient sat, for about thirty minutes, until she got the nerve to ask a non-participating clinic worker if she needed to pay for her appointment. The patient then joined the crowd of people watching at the sidelines.

Ibu Ratna was a local woman who was hired to clean the clinic building. To the clinic women's amusement, Ibu Ratna accepted their offer to participate in the

exercise session for this Friday. She had been present for the previous Tae Bo sessions so she knew that the women wore special clothing for the exercise and that the various kicks and lunges would not be possible in the sarong that she normally wore. She appeared on Friday dressed in her closest approximation of the exercise wear as previously represented in the clinic. She laughed and expressed embarrassment as she wore what she described as "men's clothing." She was barefoot, her hair was wrapped in the normal village hairstyle of a loose bun at the nape of her neck, she wore a large t-shirt and some pants that clearly belonged to a male family member that had been cut short so that they ended just above her ankles, like the exercise pants of the clinic women. The effect was a stark contrast between Ibu Ratna and the clinic women. Although the exercise clothing that the clinic women wore was very modest, it was radically different than anything that the non-elite women of Lunyuk would wear. As the Tae Bo video was started she found a place behind the clinic women and did her best to emulate what they were doing. Before long, her hair fell out of the bun, an event that she used as an exit cue from an activity where she did not fit. She then joined with the observing village women, all of whom teased her.

As time went on, the crowd of patients waiting for maternal and child health consultations grew. When confronted with this Tae Bo spectacle they were visibly uncomfortable and confused about what they should do. Should they return home and come back later? Should they sit quietly outside? Or could they watch this kicking and boxing? Later in the week I visited women who had witnessed the Tae

Bo exercise session. One woman told me that she felt "confused" (*bingung*) when she saw the women exercising in that way and another told me she was "ashamed" (*malu*) because she felt that this was further proof that she did not understand what happened at the clinic.

Ibu Nurma was one of the women who witnessed the Tae Bo event at the clinic. She asserted that she would be ashamed to wear such clothing or spend time in frivolous activity that accomplished nothing for the welfare of her family. She thought that it was wasteful to spend money on such clothes that were "only for sweating." She said, "These women are already rich. They already have formal clothes. Now they have clothes to sweat in too!" She recognized that the clinic women looked like the women on television. Ibu Nurma said that these elite women (she used the term *kaya*, meaning wealthy) are different than she is and that she felt ashamed if she went to the clinic.

Technically this Tae Bo event was not mere vanity. Although eschewing the calisthenics recommended by the national Ministry of Health, the clinic women were fulfilling their mandate as government workers to participate in healthy living activities. However, they were doing so by explicitly practicing an exercise program that references the Indonesian elite, Java, and even further, the world. The clinic workers are explicitly linked to the central aspects of the Indonesian nationalist project. In their training exercises they are told to act as model Indonesian citizens: they are to perform as the ideal citizen would, as referenced in the public health

programs in Indonesia. In their actions they were demonstrating an element of how one belongs to the larger body politic.

The village women recognize the boundaries which give the bidan power. The bidan have knowledge about much outside of Lunyuk, and they have the socioeconomic ability to enact that knowledge. That these signals of symbolic boundaries are recognized and agreed upon, renders them powerful, thus constraining entrance to their elite group (Lamont and Molnar 2002). Even if the village women do not aspire to be like them, they still feel in some ways inferior, which gives the bidan power.

In the clinic space, where the bidan uniquely and publicly belong to the nationalist project, they performed an activity that excluded all others on multiple levels. They exercised, something a farmer would never need to or dream of doing, in expensive clothing, using a technique that references elite Jakartan activities (a place the Lunyuk women will never see), prioritizing this group activity over treating or interacting with the women and families who do not belong to this social group. Ironically, the women who were not being treated at the clinic were doing just as the bidan would hope that they would: come to the clinic for treatment. Yet when they were at the clinic the bidan were essentially ignoring them in favor of Tae Bo.

The clinic staff, specifically the bidan, exhibited their elite status in three ways: first, by taking much time beyond the officially allotted time for their Friday morning exercise and at the expense of patient treatment time; second, by

exercising in a way that demonstrates their knowledge of elite Jakartan culture, with a hint of international flavor; and third, by wearing specialized exercise clothing that both demonstrates their financial ability to buy luxury goods and their ability to buy items not available in the region. This event emphasizes the differences between the Lunyuk elite and non-elite knowledge of consumer goods, financial ability to obtain those goods, employment status, and connections to the Indonesian national and worldwide projects. The patients recognize these boundaries between the elite clinic staff and themselves, and they are at once uncomfortable, repulsed, intrigued, and entertained by the spectacle.

Observations at the Posyandu and the Relative Salience of Markers of Status

The second ethnographic example centers on a gathering of the neighborhood women and children for the mobile health clinic, called the *posyandu*.[52] This example highlights how the relative salience of symbolic boundaries, on which elite and non-elite status is derived, is negotiated as the bidan assess the modernization and development of the village women. In the terms of Lamont (1992) we see what is at the center of the bidan's map of perception as positive developments and those that are noted but are not given as much weight. The most important criteria in the bidan's assessment are what they define as a moral issue: do the village women demonstrate that they want to progress and be

[52] "Posyandu" is an acronym for "Pos Pelayanan Terpadu," or "Integrated Service Post." It is a joint effort of several Indonesian agencies including the National Family Planning Coordinating Board (BKKBN), the Ministry of Health, and the Ministry of Home Affairs. The Posyandu program has been in existence for nearly thirty years.

modern? The answer to this question comes in the form of their actions: do they seek prenatal care from the clinic, participate in a family planning program, and take their children to clinic events for regular pediatric care? Women who clearly are making an attempt to follow the suggestions of the clinic and national programs are considered more worthy than village women who do not participate.

The posyandu is a government run, community based, mobile clinic developed to improve child survival and development, as well as a place to dispense basic information for women's health. The mission of the posyandu is to ensure that the most basic health care (i.e. the care most highly prioritized by the Indonesian government and world public health organizations) is readily accessible for all women and children. This care includes: free vaccinations, basic pediatric developmental assessments, contraceptive information and basic children's health information. The posyandu is considered one of the most important ties between the government development programs that fall under an umbrella goal of the *keluarga sejahtera* or "prosperous family" program. The posyandu is held in the open air gathering structures that exist in each neighborhood. This is considered one of the crowning gems of the Indonesian health systems and was the brainchild of several cooperating international aid agencies. As a result of these programs great strides have been made in children's vaccination coverage.

Within each community there is a *posyandu kader*, or a group of local women, charged with organizing and administering the event. An important part of their task is also to identify women and children who clinic officials would define as

particularly in need of health assistance and going door-to-door to remind the neighborhood women of the importance of participating in the program for the sake of their children's health and future.[53] This applies direct social pressure to attend, in the name of promoting a healthy family. The kader women are generally wives of locally-based contract workers in the government office or neighbors of a clinic staff member who has been identified as particularly exceptional "modern" village women by clinic staff. Ibu Yanti told me that she was honored to be asked by Bidan Marta to be a kader member. "I was surprised/confused (*bingung*) when Bidan Marta chose me for the job." Ibu Yanti told me that in her training she was taught that the kader members were a critical link between the national programs, national progress, and the people of the village.[54] Because the posyandu program is based in the community, it was her job, along with the other kader members, to find the women in her neighborhood who were pregnant or already had children, encourage them to at least attend the posyandu, or better yet see one of the bidan at the clinic for health services.

Although Ibu Yanti expressed pride in being a kader member she noted that she felt a certain level of anxiety about her ability to meet the expectations of the position. The clinic staff especially emphasized that the women were chosen as kader members because they already exhibited characteristics of model Indonesian

[53] Their duties are carefully detailed and involve several steps: 1. Three days before the posyandu meet to target specific people who need assistance. 2. Two days before the posyandu go door-to-door to let people know that the posyandu was scheduled to occur. 3. One day before the posyandu, check the equipment necessary for the event. 4. On the day of the posyandu arrive early to arrange the tables and chairs. 5. After the posyandu meet with the kader and bidan to evaluate the successes and failures, as well as prepare the data for the official report. However, I did not see this procedure followed. (Hamijoyo and Chauls 1995)
[54] Linda Newland (2001) likewise finds that these programs, specifically those concerning women's reproductive health, are conflated with the well-being of the larger family and the nation.

village women and that they should try even harder to become a more perfect community model. Bidan Dewi noted that the kader women were chosen because they were particularly diligent (*rajin*) and that they demonstrated a real desire to progress, as indicated primarily by their attendance of clinic sponsored events and that they had all sought the assistance of the bidan for their prenatal care.

Even though the kader women were told that they were a select group of people, many of them felt under-prepared and even unsure of their commitment to the posyandu. Ibu Yanti told me that the expectations of her made her anxious because it meant that she needed to be *rajin* in all her behaviors in everyday life, not just in health care issues. She felt that it was up to her to help the people of the village progress (*bermaju*). However she said that she did not feel equipped to be a model like the bidan as she was not educated past junior high, she described her family as being poor, and she was not modern in dress like the bidan. Ibu Herwati, another kader member, told me that she was often a little bit nervous when the monthly posyandu in her neighborhood was about to happen. She felt that it was particularly important to have a neat and put together look that she said was too much for the village setting ("*itu terlalu rapi untuk kampungnya"*). She was concerned that the other village women would think that she was self-important (*sombong*). Even so, Ibu Herwati said that she was always careful to have her best skirt clean and ready to wear for the posyandu and when the second hand clothing merchant came to town she chose clothing with the posyandu in mind. Both women expressed embarrassment that they were women who worked in their house as

opposed to being accomplished career women (*wanita karier*) like the bidan. They felt as though the clinic bidan were very successful and important people, while they were just mere village women (*hanya orang desa*). Ultimately the kader women expressed happiness as a result of being chosen to help those around her to live a better, healthier, and cleaner life (*hidup yang bersih dan sehat*).

Without fail, the posyandu events always began with the kader members arriving early, often with a few local women in tow. They would set up the tables and chairs for the event. The bidan would arrive soon afterward to oversee the distribution of the vaccination equipment to the kader members and the installation of the scales as well as to dispense last minute instructions. More neighborhood women and children would arrive and sit together, interacting neither with the kader members nor the bidan until their names were called. With the help of the bidan the kader members would then register women and their children, weigh the children, record the weight of the children into the individually held health booklets, dispense information on childhood health and contraception, and dispense immunization and contraception.

The social anxiety felt by the kader women is felt even more acutely by the village women. Many of these women communicated to me that they avoided attending the posyandu. They reported feeling pestered into attending and said they came only to please their neighbor kader member, or they found a reason to be away from the house at the time of the posyandu. Much has been written about the coercive nature of contraceptive programs in Indonesia and elsewhere (e.g.

Chapman 1996, Hull 1991, Robinson 1989). However, in the time that I was in Lunyuk, and in the history that was reported to me, there were no reported incidents of various rights being withheld from a family who refused to follow a contraceptive program.

Certainly there were women who made a practice of not attending the posyandu. Ibu Kursi, one such woman, said that she felt like the posyandu was more a venue for women and children to wear their best clothes than it was a place for health and wellness. Indeed at the posyandu event children were freshly washed, dressed, and groomed. The women wore their best sarong, blouse, or better a dress, for the event, although the effect was very different than the well-put-together bidan in her custom tailored clinic uniform. Ibu Kursi said that she could not afford to buy her children things like athletic shoes or new clothes and she certainly could not buy new clothes for herself. "It is better if I do not go. I do not want to be embarrassed (*malu*)." However Ibu Kursi added that she was concerned about getting the vaccinations for her children and that she would rather go to the posyandu than to the clinic. Ibu Epi, and many others, agreed with this sentiment. She said that she felt too ashamed to go to the clinic but she occasionally went to the posyandu because she could mostly interact with the kader members, and her family and her neighbors would be there with her. In this way she felt that she was able to mostly avoid the perceived scrutiny of the bidan.

Generally the bidan also do not like going to the posyandu. Even though at the posyandu the bidan was in her home neighborhood where she was best known,

it was evident how socially isolated she was from her neighbors. Her primary social connections were with the other bidan, the clinic staff, and teachers. The bidan seemed shy when at the posyandu, keeping their eyes down and their interactions to a minimum. The village women only approached the bidan when their name was called to the recording table or to the scale. The bidan complained that the people forgot their health record books, the patients were loud and smelly and they had to re-train the kader members to give injections and use the scale. The bidan all commented that it was better for the women to come to the clinic or to their private clinics at their houses[55] instead of the posyandu because they had their full compliment of equipment and medications.

Even though all present were wearing their best clothing there was a stark difference in the appearance of the bidan compared to the kader women, and further compared to the Lunyuk women. However the comments made among the bidan as the posyandu finished for that month made it clear, once again, that the bidan saw it as more important to seek clinic care than to dress as a "modern" woman. The bidan would mention the individual women's attendance records and comment favorably or ask why a certain person had not some in for quite a while. The women who arrived at the posyandu, whether dragged or not, were always noted as being cooperative and making an effort to progress and better themselves, as opposed to those who were not present at all.

[55] In addition to their work at the community clinic and the posyandu, many if not most of the bidan ran private clinics at their homes as a side activity.

The bidan link morality and modernity to participation in the government programs.[56] In the eyes of the bidan the people who participate are better than the others. Village women who willingly participated in the activities of the clinic were seen as superior to those who did not. The differences of their level of refinement and sense of the cosmopolitan began to pale when the more heavily valued criteria of activities of national development and clinic participation began to show.

The Bidan's Frustration

The bidan have significant frustration in their work and in the local social setting, and they realize that they have had little success in drawing people away from the services of the dukun bayi and into biomedical reproductive practice. They feel a great deal of frustration in dealing with what they consider to be the backwards behavior of the village women and the dukun bayi. They sincerely desire to effect positive change in the reproductive health in the village and they feel devastated in those unfortunate occurrences when they are not able to do anything to help the woman and child before them, resulting in numbers of women and infants who died, or were injured in childbirth. They understood the scope of biomedical life saving procedures available elsewhere in Indonesia and in the industrialized world. They felt great sorrow, and often a little anger, when they could do nothing for many infants and women who died unnecessarily in the village,

[56] Anagnost (1995) has a similar finding.

but might not have if hospital-level services were available to them locally, or if the patient would consent to going to the hospital.

In the following example, we will look at a bidan's analysis of what type of person chooses to receive the majority of her prenatal care from the dukun bayi rather than from the bidan. This is intended to highlight an elite insider's assessment of what it means to be an elite group member. Bidan Dewi describes the social, economic, and moral differences between the local elite and non-elite of Lunyuk. She also emphasizes a moral responsibility that she feels as a result of coming from an elite background. Bidan Dewi explains that because she has been fortunate in her life it is her duty to help others to progress, to become modern, and most of all, to do something to change the devastating numbers of women and babies who die in rural Indonesia. She explains that the elite and non-elite women of Lunyuk have different world views and centers of influence: the non-elite being focused on Lunyuk and the elite being focused on cosmopolitan areas, where she feels new solutions to problems come from. In describing the importance of her work, she draws connections to nation-building, her role in the larger world reproductive health programs, and her role in helping the Indonesian populace become healthier and more modern.

One afternoon, I was sitting in the kitchen at Bidan Dewi's house, helping her prepare food for a religious ceremony. On the day before, I had accompanied her to the house of a pregnant woman named Salma where she assisted in the delivery of Salma's baby. The baby had died before he was delivered. Like Ariana, Salma had

received all of her prenatal care from a dukun bayi, Dukun Madu. For the months before her delivery, Salma walked directly by Bidan Dewi's private clinic to get to the dukun bayi's house for prenatal treatments. When Salma went into labor she called the same dukun bayi to help her with the delivery. After many hours of labor, with little progress, Salma's parents-in-law called Bidan Dewi to assist in the ill-fated delivery of the baby. Just as in the case with Ariana's delivery, Bidan Dewi pointed out that bidan are often called as a last act of desperation. Bidan Dewi, like the doctor, argued that because they see the more difficult cases their success rate is lower and then their local esteem decreases or can never grow in the eyes of the people in the community.

On this day, the day after Salma's delivery, Bidan Dewi was feeling particularly disturbed by the death of the baby. She believed, based on reports of Salma's difficult pregnancy from the in-laws and the portion of the delivery that she attended, that any clinic bidan would have sent Salma, before she went into labor, to the regional hospital where they are equipped to perform a surgical delivery. The question would have then become, as it did in the case of Ariana, whether or not Salma's parents would have accepted this advice and sent her to the hospital. In short, her conclusion was that the death of the baby was especially tragic because she felt confident that the baby would have lived if Salma had sought care at the clinic from the beginning. Additionally, while Salma's husband and parents-in-law did not blame her, Bidan Dewi knew that the death of the baby would just be added to her public association as a midwife who assists in deliveries that often result in

death. Bidan Dewi had not used delivery water in this delivery. In fact, she was one of the few bidan that did not regularly use this particular treatment.

While we sat alone, I took this opportunity to ask Bidan Dewi why, after fifteen years of being in the community and even though she is well liked, people would walk right by her clinic and go to the dukun bayi that lives near-by. Her answer to this question centered on a lengthy description of how she believed that "they," meaning the non-elite, were different from "us," meaning the elite. She said that it was part of her job to help the women of Lunyuk become more modern, or more like her, in as many ways as possible. She said that although she could not change their education level or their economic well-being, she saw it as her job to show the women that there is good to be found outside of Lunyuk and it could save their lives.

In Bidan Dewi's explanation she highlighted differences in cultural factors, economic factors, and understandings about morality between the elite and the non-elite that directed the women of Lunyuk to seek the majority of their prenatal care from the dukun bayi. Bidan Dewi noted that you could see the inward rural focus of the non-elite people (she used the term *orang desa*, or village people) in their appearance and manners. She asserted that she could immediately determine how "modern" a woman was simply by looking at her. As an example, she noted that village women would have long hair wrapped into a bun. She noted that, "modern women do not wear their hair long like village women. It is old-fashioned. It shows that they do not care about new ideas. If they have long village hair they will get

their care from the dukun bayi unless there is a big problem…then they'll call too late" She said that women in Lunyuk would wear a sarong rather than pants, a skirt, or a dress that could be more practical attire for their agricultural work. She noted that a sarong is the same price as a skirt or dress from the local second hand clothing merchant. She considered these choices in hair style and clothing to be associated with disinterest in progress and anything outside of the village.

Additionally, Bidan Dewi told me that because local non-elite women were poorly educated and unaccustomed to assimilating new information they were actually not capable of understanding many things, even if she explained it to them many times. As an example she pointed to her troubles in getting village women to follow basic ideas about health, cleanliness, and nutrition in pregnancy and childbirth. She noted that women like her did not need to be told to not use jamu (locally made medications) on newborn's umbilical stumps, or the importance of eating a balanced meal during pregnancy, or to wash their hands. She added that when she gave medical advice to women who she classified as "like her" they would follow it and ask for more information.

Bidan Dewi felt that all of these traits formed women's levels of interest in and value of new ideas that come from outside of Lunyuk. She described the local women as not being interested in anything beyond the scope of Lunyuk and generally uninterested in new information or ideas that might make their life better. She felt that as a result of this inward focus the women of Lunyuk prefer going to the dukun bayi and do not understand that there is much to be gained from new ideas

(*teori baru*) that might solve old problems. As a result, women and their families do not see the value in the *teori baru* of the bidan and only seek their care when they are desperate: essentially when they are in need of magic that does not exist in the Lunyuk medicine cabinet.

Bidan Dewi felt that the sum of these categorical differences resulted in the most important distinction between the elite and the non-elite: the importance of making connections to the larger world outside of Lunyuk. Bidan Dewi said that the "modern" women will try to learn new things. She suggested that it was a result of her education and the fact that she was raised in an educated family that she learned to appreciate the possibility that there might be a better way to do things, including maternal health care. She learned to seek the latest innovation, which then translates to all parts of her life like her choices about how to treat her own children when they are sick, which television programs she watches, the clothes that she chooses, and what she thinks is funny. She said that she is careful to watch the new trends in fashion. Even if she cannot afford new clothes, she will choose clothes from the second hand clothing merchant that resemble the clothes in the magazines. Bidan Dewi felt that her status, education, and specialized training gave her access to what she felt were sophisticated ideas and knowledge in which the village women were largely uninterested.

Bidan Dewi was most emphatic about her role as an agent of modernization, health educator, and assistant in bringing healthy babies into the world. She felt that her privilege and unique training gave her an elite social position, and with it a

moral imperative to help those who were, in her eyes, less than she. She felt that the great differences between people "like her" and people in the village are reflected on a larger scale in the differences between Indonesia and other countries. She said that people in the village are so busy with activities like paying for and preparing for ceremonies to have a healthy child that they did not work in the field enough to produce healthy food for the family and products to sell in the market that might later pay for school or medicine for a sick child. She likened this inward focus to the operations of Indonesia as a whole. She felt that Indonesia is so busy fixing problems in the country that it cannot sell its own products on the world market. She noted that "Japanese and American companies come to take our gold to sell. We do not profit from it. Newmont[57] is here taking our gold and putting poison in our river. Why don't we mine the gold and sell it?[58] Then we could be modern and rich too." Bidan Dewi suggested that the women and their families were not concerned about the welfare of Indonesia, but only about themselves and the people in Lunyuk. She conflated a sense of superior morality and the importance of participating in the nationalist project.

Moreover, Bidan Dewi felt that the position of bidan allowed her to draw connections between herself and the world outside of the village, the province, the nation, and to other countries. She felt that this connection afforded her a certain

[57] The American company, Newmont Mining Corporation, with investment from the Japanese company Sumitomo, operates the Batu Hijau mine in the same southwest region of the island as Lunyuk.
[58] Among the elite inhabitants of Lunyuk there was an interesting discourse about the fate of the former colonies worldwide. They connected the current socio-economic success of some former colonies with who the original colonizer was and discussed post-colonial life in ways that are reflected in academic treatments of the subject.

level of sophistication that was met by only a few other people in the community. She noted that her work, and that of the other bidan, had special importance not only for the nation, but also for the world. This was indicated by the fact that not only did she have connections to the national programs and resources, but there was a great deal of involvement from international aid organizations. She felt that there was a cosmopolitan and humanistic nature to her work. She pointed to the fact that connections (such as that of the Indonesian Ministry of Health and the international Safe Motherhood Initiative) to the larger world are what will help Indonesia advance to a level on par with other countries. She was deeply disturbed by the loss of the babies and women in Lunyuk and noted that other countries do not have the problems with infant mortality and maternal mortality that Indonesia does. She felt proud to be a part of something that was simultaneously good for the village community and the global community.

Criticism of the Bidan

The bidan feel criticism from all sides. The Safe Motherhood Initiative (SMI) agents do not like them, and they are criticized by and feel abandoned by the government health services. The bidan see both the government heath services and the SMI people as being out of touch with the structural and cultural issues on the ground in the village. The bidan feel because of the lack of equipment, training, facilities and sufficient numbers of clinic staff the bidan are not able to carry out the reproductive programs as they as they are designed.

Critique of the Bidan by the Safe Motherhood Initiative Program

The goals of the international and government reproductive health programs are, simply put, to improve the reproductive health in Indonesia. These goals include a belief that a pure course of the proven biomedical obstetrical treatment programs would be most effective in changing mortality and morbidity outcomes for both women and children. The SMI officials who visit the village are Indonesia Ministry of Health officers, *Ikatan Bidan Indonesia* (Indonesian Midwives Association) workers, and development organization workers. With these officials, the bidan share a strong commitment to the basic goals of the SMI mission. Even so, there is a great deal of tension between the bidan and SMI workers based on perceived deficiencies on both sides, and one of the most serious critiques felt by the bidan is levied against them by the Safe Motherhood Initiative (SMI) program officers; exactly those people who send them out on their mission of obstetrical modernization.

The program officers generally operate with the theory that if a good biomedical maternal health care program is put into place, people will naturally gravitate towards it. These programs are created by officials based on their perceptions of the needs and the problems that exist in areas with high maternal mortality and morbidity. Generally they define these needs as: improving access to obstetric care, improving the quality of care offered in the clinics, and addressing the inability to pay for services. The program officers view the clinic bidan as delivering poor

quality care that the program officers derisively grade as being only marginally better than the obstetrical services offered by dukun bayi.

The SMI program officials believe that part of the reason for the low adoption rate of clinic services is the result of the poor work of the bidan. Several people who have worked in reproductive health in multiple places in the world suggest that part of the reason that the clinics have not been more successful in attracting patients is that the care that is available in the rural clinics is of poor quality. This connects to Dr. Candra's assessment of Lunyuk as not having "bes praktis." The bidan feel this critique and retort that there is a much greater complexity involved in the women's care seeking patterns than the SMI officials realize. Thus, both sides see the other as being somewhat naïve regarding the needs and perspective of the local population.

There is tension between the bidan and the SMI officials, and also between the program officers and the bidan relating to their divergent understandings of what is most needed in these rural areas, and how to best make a positive change in the maternal and infant mortality rates. This is underscored by ethnographic data from interviews with SMI program officials in their central offices, as well as a group interview with the bidan as they assess the value of a new training video for the bidan called *Asuhan Persalinan Normal* (or normal delivery care).

I spent a week interviewing officials at the maternal and infant health care program offices of WHO, US-AID, JHPIEGO, CARE, UN, AUS-AID and other organizations in Jakarta. In commenting on the cause for weaknesses in the reproductive health care programs in rural Indonesia, one official told me:

> I'll tell you the real problem…the reason all of these programs are failing in Indonesia is because of the abysmal quality of care that the bidan are able to provide! They are horrible! That is the real problem. No one wants to talk about it. And the real kicker is that they are *un-trainable*. You should see them at training exercises—they don't listen and are completely uninvolved in the very information that they need! [59]

The program officers who I interviewed believed that if the quality of care that the bidan offered was better, then people would be much more likely to abandon the care of the dukun bayi. The program officials primarily perceived, "a complete disregard for sterile practice," "poor technique," and "harmful practices in emergency situations that should have been triaged to the regional hospital anyway."

Generally, the program officers did not even see that the bidan had knowledge of the goal of improving the life chances of women and infants in the reproductive process. While they had patience for similar complaints that they had heard concerning the indigenous midwives, they were particularly frustrated with the bidan because they were the official representatives of the biomedical reproductive health programs. However the program officials had little knowledge about how the bidan actually did practice. Certainly, since the midwifery training is brief, the training sessions are few, and there is nearly no oversight of the actual midwifery practice in the bidan program, there is a great deal of variability in skill, interest and dedication amongst the bidan. But there was also a great deal of lack of understanding on the part of the SMI officials about the issues that the bidan actually face at their work site.

[59] Quote used with an agreement of anonymity.

Clearly the bidan are the frontline operators for the entire reproductive health care system. Thus, their failure, as perceived by the program officers, was an enormous problem that much hard work had gone into rectifying. Re-training programs had been developed for the bidan. One of these programs was a video called *Asuhan Persalinan Normal* (or normal delivery care). This video was produced by *Ikatan Bidan Indonesia* (the Indonesian Midwives Association) and funded by the World Health Organization, and US-AID. The video featured a bidan modeling care for the labor and delivery of a healthy child born from a healthy mother who had a pregnancy with no complications. In the video the bidan interacted lovingly with the woman and her husband while demonstrating an ideal brand of care. Throughout the story of the labor and delivery the specifics of the bidan's duties were featured with close-ups and bulleted summations. The duties included: sanitizing of tools, maintaining a sterile field, properly interacting with the birthing woman and the father, patient education, and post-delivery care including determining whether sutures were necessary and if so how to administer them. One of the program officials, a nurse midwife who was closely involved with the design of this video commented that if this was the standard of care that was offered in the clinic many of their problems would be solved.

How the Bidan View Themselves

The bidan in Lunyuk expressed a great deal of frustration with the maternal and infant health care program trainers, and the people who developed the

programs. They understood the criticisms of their work, and realized that their first-hand knowledge of the shape of reproductive health in the rural village was not recognized. The bidan had their own severe critique of the authoritative knowledge of the reproductive health program designers and trainers. Over the period of my research it was clearly demonstrated to me that the bidan were dedicated to the basic goals of the Safe Motherhood Initiative Programs.

Several months after my interviews with program officers in Jakarta, I attended a rare on-site training in the village clinic. A team of Indonesian reproductive health trainers from the provincial capital were presenting the aforementioned video *Asuhan Persalinan Normal* (Normal Delivery Care) followed by leading a discussion of the importance of following these procedures. As the video reviewed procedures that the bidan, for the most part, routinely performed, their attention wandered and a great deal of whispering with each other ensued. The scene did look exactly like what was described to me by the program officer whom I interviewed. However, he had missed the fact that the bidan were offering irritated critical commentary about the irrelevance of the video, given their local structural constraints.

The next day when I interviewed the bidan as a group about the events of the training video they very nicely summarized the subject of their whispering. Bidan Dewi noted:

> They have no idea what we need or what the people here need. Yesterday was an example of what is normal…they arrive in the morning in their new, clean

> *Kijang*[60], they get out at the clinic, they do their assessment without leaving the neighborhood. They leave some training materials that we just have to stuff in a drawer. And then they leave in time to get back to the city because it is too rough for them here.

Bidan Maria later said:

> They show us videos that instruct us to use equipment and supplies that we have never had here. We have to be inventive in the small village. They have no appreciation for that.

Bidan Wati said,

> Why do they show us a video about how to address normal delivery? We know how to do that. We need to know how to deal with emergencies.

Bidan Maria added:

> If we mention the need to deal with emergencies here they just scold us like children and tell us to send the patient to the hospital. You can't make someone go to the hospital. We have to deal with what we get.

The bidan depicted the trainers and program officials in general as stuffy researchers and bureaucrats who had little idea what the reality of obstetric care was in rural Indonesia, had little interest in knowing, and looked down upon the only people who did know (i.e. the bidan). The bidan understood their expected role as primary reproductive care workers in the Indonesian reproductive health program and that they were expected to send anything but the most normal of cases to the regional hospital. However, they argued that there was a great deal of educating and convincing women to even use the clinic services, and why would any woman consent to an expensive and arduous five hour trip to the regional hospital

[60] A model of four-wheel drive Toyota for sale in Indonesia.

when no problems in the pregnancy had presented themselves before labor, or even when problems did appear while the woman was in labor.

The critique felt by the bidan also comes from the women in the community and from the dukun bayi. On a social level the bidan are clearly not welcomed by the village women and in turn do not welcome the village women in to their spaces. They realize that they are considered outsiders and except for one another they are generally friendless in this isolated village. They clearly see that their practice has not had the revolutionary effect that was set out for them as their mission. Yet they believe in their moral rightness and their vision of modernity. As has already been detailed, the village women see the bidan as being socially slightly absurd, yet also frightening. Although the village women are willing to dabble in many types of the biomedical obstetric care offered at the clinic, their social connections are with the dukun bayi and the larger community, and those interactions are more important at the time of delivery.

Why the Bidan use Delivery Water

Bidan Marta explained to me, on the same afternoon, while sitting outside of the *pustu*, how it was that she began using Dukun Ina's delivery water. Bidan Marta had family roots in Lunyuk. She was raised in Sumbawa Besar, the island capital city, but had visited often when she was a child. Her husband was sent to Lunyuk for a government job decades ago and she eventually got a position at the puskesmas. Her family had social ties to the dukun bayi, in particular Dukun Ina, so when Bidan

Marta arrived she visited Dukun Ina to pay her respects (since the dukun bayi are also socially important people). Dukun Ina had assisted in the delivery of many of Bidan Marta's relatives, although Bidan Marta's mother had obstetrical care from a bidan. Dukun Ina gifted her with a vial of delivery water and told Bidan Marta that for years she knew that Marta would be a healer of some sort so she was not surprised at all when she became a bidan. Bidan Marta said that she accepted the gift, but didn't know what to do with it. She knew exactly what it was, but this was exactly what she had been very specifically trained not to use.

For a great deal of time the vial sat in a locked cupboard in Bidan Marta's house. As treatments such as this were part of her heritage she did not see this as something that she could just dispose of; it was a gift and it was laden with magical power. Yet she did not intend to use it. She was trained in the biomedical version of midwifery and made an effort to keep her practice as purely biomedical as possible. As Bidan Marta worked in Lunyuk over the years she became increasingly frustrated with the low flow of patients to her midwifery clinic and to the puskesmas, seeing patients only in times of emergency, and she became increasingly frustrated by her inability to help when the situation was dire.

Bidan Marta recounted to me how she first began using Dukun Ina's vial of delivery water. One day after a month of difficult deliveries she was cleaning out the cupboard and came across the vial of delivery water. Bidan Marta said that when she saw the vial she felt so frustrated because it represented what she saw as the reason that she could not get women to follow the designated plan for prenatal care

and delivery. She took the vial out of the cupboard with the intention of destroying it in some way. Still hesitant to dispose of a powerful object she let the vial sit on the shelf next to the television telling her children that they were absolutely not to touch or go near it. A few days later she was called to visit a woman who had been in labor for a couple of days already with the assistance of one of the primary dukun bayi in the village. Given the information that the messenger delivered to her she knew that the woman was in trouble, grumbled in frustration, and as she readied herself to leave the house she put the vial in her bag. She described that all of a sudden in her frustration she felt free. She could not tolerate any more deaths.

Bidan Marta arrived at the woman's house. She examined her to find that the woman was dehydrated, fatigued to the point of being nearly unconscious, and not fully dilated. Still feeling free Bidan Marta splashed the contents of the delivery water on the woman in front of a room full of people. Bidan Marta said that as soon as she did that she felt panic. What had she done? Was this a magical effect of the delivery water on her? She was concerned that she had introduced bacteria into the birthing canal and to the fetus or that she would be reported to the clinic as a heretical bidan. Bidan Marta says that she does not remember how much time passed because she felt like she was in shock. Soon she realized that the birthing woman's situation was changing and before long a healthy baby was born.

Bidan Marta went home tired and scared. She was sure that the clinic workers would find out that she had dabbled in sorcery and she would be shamed or lose her job. Instead, over the next few weeks Bidan Marta found that no one at

the clinic said anything to her. But she did notice that she had a few more patients at her home clinic. Little by little she became braver in her use of the delivery water.

Bidan Marta told me that upon reflection the success of the delivery water made a great deal of sense to her. She noted that she knew that Sumbawan magical knowledge (*ilmu*) was particularly good at some things. For example, she explained that there were several dukun in the area who were believed to be able to transport goods or people from one place to another in an instant. She understood that biomedicine was particularly good with other issues. She gave the example that in the case of many of her patients if they had had a caesarean available to them, then their child would have lived, and they would not suffer some complication that resulted. She posed the question to me why could it not be that Sumbawan (or Balinese or Sask) ilmu was able to help a woman deliver a healthy infant? I asked her if she was aware of the biomedical concept of placebo, which she was.[61]

I also spoke with Bidan Dewi concerning the use of delivery oil in the birth canal and also about applying paste to the head of an infant whose mother, Herwati, was concerned about the head being too soft. Bidan Dewi gave me essentially the same explanation that Bidan Marta had used; she also pointed out that she massaged the abdomen of Herwati to help her expel the normal post-birth fluids (*kotoran*, meaning dirty*)*. Apparently these aspects of her maternal care were

[61] The conversation was much more extensive than this. I didn't know the Indonesian word for "placebo." In a rather clumsy fashion I explained to her what the placebo effect was and asked her if she had heard of it without using the word "placebo." She said to me, "o ya Vanessa, itu namanya efek plasebo." They essentially use the English word.

acceptable, and Herwati chose to have Bidan Dewi assist with the birth of her next child.

Critiques of the Bidan from the Dukun Bayi and the Women of Lunyuk

Generally the dukun bayi see the bidan as something of a nuisance. Dukun Ina summed up the general feeling about the bidan when she told me that if the bidan had spiritual ability then they would not need to use the clinic medicine. The dukun bayi say that the bidan are just not good healers, they were not chosen by God so the births that they tend are more painful, they forget to honor God, they do not honor spirits, they don't know how to remove evil spirits before birth, they do know how to address some of the mortal human things, and that all that they know is a method. That being said, both the dukun bayi and the women of Lunyuk saw that there was potential in the biomedical method used at the clinic.

I spoke to several women concerning why they chose to use bidan for their births rather than the dukun bayi. Herwati said that she knew Bidan Dewi now and saw that she knew many things. Kursi said that she had problems before and she thought that there were more *ilmu* with Dewi. She still consulted with Dukun Bayi Dukun Madu but she liked it that Bidan Dewi had many *ilmu* at her disposal. She thought it was easier to have the Bidan and also consult with the dukun bayi, but it was harder to do the opposite because the bidan would find out and scold her.

6.4 Discussion

It is clear that the bidan live and work in a highly conflicted situation. On one hand and for a lot of reasons, they live a socially separate life from the women of the village. Many of them are not from the village, but more importantly, they all have knowledge, training, behaviors and practices that are different than those of the village women. Furthermore, due to their training and official guidance, they work to displace the local shaman midwives, the dukun bayi and their traditional midwifery methods, with the methods that they, as biomedically trained midwives, believe are safer and more effective.

Given all this, it might seem inconceivable that the bidan choose also to adopt some of the methods of the dukun bayi. One might suspect that instead, they would work to erase the existence of the dukun bayi. Based on the criticism of bidan by the SMI and other government/international maternal health care officials, one could easily assume that this was the hope and expectation of those officials.

However, while the bidan may voice this point of view, they are also under enormous pressure from multiple directions. These include the criticism they receive from officials and local people, the failures they experience in their most difficult obstetric cases, the continued public acceptance of the role of the dukun bayi, plus their isolated social status in the community. As a result of these multiple pressures, the bidan feel themselves not to be succeeding at a level that is satisfying to themselves, let alone to the government/SMI officials. They particularly express

frustration with the SMI program and its officials for failing to recognize the issues that make their mission and charge extremely difficult to achieve. This is amplified by being provided with training material that is too simple for then, covering things they know well such as normal routine birth delivery procedures, while not providing training on issues that would be of use to them such as procedures to deal with problematic deliveries.

As a result of these conflicting pressures the bidan have adjusted their practices in several regards. Since they are not fully successful in dealing with the more difficult health problems they encounter, they feel ambiguity concerning the effectiveness of treatments, both theirs and those of the dukun bayi. As a result they return to their roots in search for answers, and since their roots are similar to those of the local people, they have adapted some of the indigenous approaches, such as the shaman-supplied delivery water, oils and pastes, plus massages into their practices. There are many subtle suggestions that the bidan hold some belief in the shamanic methods, even if slight. All the bidan would at some time or another make comments along the lines that how can one really know what made a patient, like Ariana, turn the corner and what makes some patients suffer at the end of what had been a completely unproblematic pregnancy and delivery. All the bidan at some time or another mentioned the use of use of shamanic treat in their own households. Although the use of a treatment for other reasons other than addressing reproductive issues the root theory is the same.

The bidan also offer rationalizations for the use of indigenous treatments. They suggest that if they use these indigenous treatments, they can administer them more safely than the dukun bayi. They have the hope that by adapting some of these methods, they can enlarge the size of their practices. Further, they feel that if these approaches succeed, then perhaps more people will respect them, and perhaps with more respect their patient base will increase meaning that perhaps even the SMI officials will respect and listen to them.

Aside from the negative feedback from the SMI officials, there appeared no reason that would effectively counter this choice by the bidan to use the delivery water,and other dukun bayi practices. During this study, there were no observed cases in which a bad result occurred as a result of the bidan's use of dukun bayi practices that would not have most likely happened anyway, given the level of care that the bidan were able to provide.

In turn, for several reasons the dukun bayi generally appeared not to be all that alienated by the bidan. While the dukun bayi expressed their criticism of the bidan, they were also willing to supply their delivery water and other treatment products to the bidan. In this, there actually were several positive benefits to the dukun bayi for cooperating with the bidan, including an elevation in status and power for the dukun bayi as a source of knowledge and products used by the bidan, plus the interest the dukun bayi had in obtaining resources and recognition from the clinic.

The use of the delivery water is particularly interesting because it is locally understood to be imbued with the powerful prayer of the dukun bayi. Unlike offering massage, using oils, and applying pastes, in order for the bidan to obtain the delivery water they needed to personally request the water from the dukun bayi: the figure whose social traction they are explicitly charged to erase. The bidan, as a matter of daily habit, publicly maintain that the dukun bayi have practices that are harmful to the health of pregnant women and babies, yet here they are using these same practices that are identified by all as those originating with the dukun bayi.

6.5 Conclusions

Major issues affecting the role and functioning of the bidan in the community include their identity and social status, their failure to meet the full expectations for health care outcomes, their level of acceptance by the community and by government officials, and by the consequent need to have larger practices. While identity and social status prove to be a paramount motivation for public behavior among the bidan they feel strongly disparate pulls from their training / government expectations versus the social situation and status issues of the community. As a result, they exhibit several incongruous behaviors that reveal serious internal conflicts. On one hand, their social status as community elite is connected to sophisticate external centers and this works to shape their public behavior and their identity as agents of modernity. Yet at the same time, they note that they fall short of expectations and feel pressure from multiple sources, including: the government

institution from which they draw their elite status; their honest and deep desire to help improve the situation of women and babies; and their understanding that they have to some extent failed to inspire the confidence and appreciation of the local people seeking care.

As a result, many of the bidan use a number of the techniques used by the dukun bayi. The adoption of the techniques of the dukun bayi can occur out of desperation, or out of ambivalent feelings the bidan may have concerning the biomedical dismissal of local explanations and cures, or in an attempt to draw in more patients in order to increase their numbers to be successful in the government's eyes. Consequently, the bidan believe that they will see an increase in their patient load if they offer these services, but worry that they are bringing in more patients in a manner not condoned by the government or development programs. They also can tell that they are on to something: this may be their best catchment route to get people into the system. Yet at the same time, this is a route that would never be acceptable to the development programs, because it allows practices that are not considered acceptable.

Nevertheless, the adoption of those practices by the bidan does have clear benefits; it humanizes the experience women have with the bidan, and it allows for treatment with which the women are much more accustomed. Further, because the bidan tended to offer the treatments for often associated with the dukun bayi in one of the home environments the women reported being more comfortable with the bidan. Ibu Yoharia told me, "Bidan Wati is arrogant at the clinic with the other bidan.

At home she is in her *daster* (house dress) and peaceful." The women typically do not want to go to the clinic where the standardized biomedical care is given and the bidan are all together. If the bidan are all together then they are more likely to assume the social elite role that makes the women really uncomfortable. When the bidan are in their own home they treat their patients in clothing that more closely resembles the clothing of the patients.

In using the delivery water, the bidan are drawn into conflict as they attempt to improve the reproductive health situation in Lunyuk. They have been charged with a task that they do not have the equipment, facilities, training, or staff to carry out successfully. While the dukun bayi do accomplish exactly what is social expected of them and what they promise to do (in most cases) the accomplishments of the bidan often fall short from what they have promised to the community and what is expected of them from their superiors in Jakarta.

Concerning the use of delivery water in the case of Ariana's birth, the bidan told me that Ariana was lucky. She could have died, or even more likely her child would have died. The bidan did not bring up the delivery water until I mentioned it again. I don't know if it was the dukun's water or not. Bidan Marta was not sure what made that birth succeed while others that follow the same course do not. She thought through potential causes. It could be that the oxytocin was the critical factor in finally helping Ariana delivery her baby. It could have been Ariana's fate; she was to struggle in childbirth but live. It could have been that the delivery water was powerful and effective; either as a placebo or as a spiritually powerful substance.

Bidan Marta reasoned that at least Ariana did come to the clinic in the end, saying that more could be done there and it was clean, and rationalized that at the clinic they could be sure that the dukun bayi does not do things that will make the situation worse.[62] When I talked to Ariana about her experience, she said:

> I am happy. It was all fine in the end. I'm glad that I didn't have to go to the hospital. That might have made my relationship with my [new] family difficult. I would have felt bad if they spent all this money on the hospital. What if something bad happened there? I would have been scared at the hospital.

A number of factors elevate some clear symbolic boundaries between the bidan and the women of the community into fairly major social and symbolic boundaries which then reduce the willingness of the village to use the clinic. Women are socially uncomfortable at the clinic and with the bidan. The bidan do little to make the women feel comfortable or welcome, doing things such as attaching moral superiority to being modern, and associating the frequency that women use the clinic to their assessment of a woman's modernity. In turn the women of Lunyuk avoid the clinic and the bidan for they feel they are going to be judged, mostly on the basis of their dress, education and worldly sophistication. These behaviors continue in spite of the ever-present specter created by the high numbers of women and babies that die at various points in the reproductive process. The net effect is that these symbolic boundaries, many of which are created by the actions and the attitudes of the bidan, have created strong social boundaries that keep women from

[62] There were some horrible and gruesome stories about methods of extracting babies from women when a normal vaginal delivery was not working.

going to the clinic for reasons other than disbelief in the efficacy in biomedicine. This, in turn, contributes to the bidan's low caseload.

Chapter 7: Islam and Obstetrical Practice

Islam provides central organizing guidance for the life of a majority of the people in Sumbawa. No matter what the educational background, the ethnicity, or the manner of making a living, about 96% of the people in Sumbawa meet at the Mosque at various times during the year where all are considered equal under the eyes of God (BPS 2002). I found that when one person described another a comment is often inserted as to their religious adherence. For example, one evening as I visited with a teacher and his wife, a neighbor called Dylan (nick-named after a character on the American television show 90210), came by to visit. Dylan was a man in his early twenties whom the local community thought to be irresponsible and in need of guidance. After Dylan left, my friends told me of his various escapades, the problems that he was causing in the neighborhood, but as the discussion concluded that said they thought that he would eventually grow up to be a good person. Their justification for this was that through all of Dylan's misdeeds, some of them quite serious, he was observed to be very diligent in prayer and was often seen at the neighborhood mosque. Because of his religious observance they thought that there was hope for him; that through the behavior that they deemed to be quite bad, there must be good if he was seeking refuge in God.

This chapter takes a look at how the midwives, the dukun bayi and the bidan, exist within this framework. Specifically I suggest that the obstetrical practitioners' relationships with Islam are connected to the way they see their mission in practice. Their relationship with Islam, and more generally with religion (for a few non-

Muslims), forms one of the bases for the critique of their practice made by their patients and by each other. These criticisms reveal the importance of Islamic and religious thought and principles in negotiating identity in Lunyuk.

7.1 Obstetrical Practitioners and Islam

Although both the bidan and the dukun bayi would describe caring for pregnant women, their families, and infants as the primary focus of their practices, the shape of their practices is very different from each other. Dukun Papin believed that one of her primary roles was to serve as a Muslim specialist in all matters related to birth. It was her job to call the new person to the faith and ensure that proper ritual was performed, and that the basic prescriptions of Islam were observed.

"I am always thinking about God," Dukun Papin told me when I asked her what she did when a baby was born. She went on to tell me that because God made us and made the world around us, and because God gave her the ability to help people in childbirth, she must always think of God. This was the way that she began a description of how she welcomed a baby to the outside world. She emphasized the natural order of her relationship to Islam and her practice of midwifery as she drew connection to Sumbawan life and what she presented as scripture-based knowledge. She used this connection to religion to differentiate herself from the practice of the

bidan, to respond to the critique of her authority in the realm of obstetrics and as a Muslim specialist.

The manner in which Dukun Papin and the other dukun bayi presented their obstetrical practice was one that would seemingly make the modernist Muslim critic of her practice happy. Dukun Papin told me that her work, whether prenatal treatment, delivery, or postnatal treatment began with prayer. It was in prayer that she learned that she was meant to be a midwife, and so in prayer that she must do her work. As she deftly massaged a patient she would quietly, and in deep concentration, pray. She would then blow these prayers across the body, especially on the nape of the neck and across the abdomen. She said that it was preferred that she, and not the father of the child, was the one to whisper the adzan (summons to prayer) into the ear of the baby. She said that through the prenatal treatments the child was already learning from her about Islam and about its relationship to God while it would be on earth. It was important that she performed the adzan because it is her voice that the baby heard praying in utero. She explained that if this was the first thing that the baby heard it would help him or her become a devout and faithful follower of Islam.[63] She must give the baby her first lesson and call him or her to prayer. She noted that this had always been the practice of the Sumbawan people, and it was clearly stated in the Qur'an. Clearly the two were meant to be together. Further she noted, scripture also said that the child should immediately have something sweet in its mouth to ensure a sweet life and to ease the difficult

[63] Geertz describes a similar belief in *The Religion of Java* (1976).

transition into this world. God gave the Sumbawan people honey that is so incredibly delicious and is thought to have fortifying and healing powers, that it is known throughout Indonesia. God also gave her the ability to find and harvest a more abundant supply of honey than anyone else. What is in scripture, she said, is what she lives.

Dukun Papin cast her practice as a Muslim, as a Submawan midwife, and as of the natural order. She makes her case in response to the modernist critique that she does not follow a scripturally based Islam. Similarly, when Dukun Sahara treated a pregnant woman who had a miscarriage that had been diagnosed to be the result of the interference of jinn, she told the woman that we all must take refuge (*perlindungan*) in God and pray. Prayer to God will protect her from the jinn. Dukun Sahara explained the treatments that she performed to rid her patient of the attention from the jinn were derived from deep prayer and her knowledge of Sumbawan-specific jinn. Mirroring the viewpoint of Dukun Papin, Dukun Sahara noted the natural connection between the people of Sumbawa and Islam, saying that Sumbawan knowledge derived through prayer was completely permissible; and that it was a moral imperative for her to help woman with the gift that was given to her by God.

One of the treatments that had connections to both ethnicity and scripture was the delivery water. In making the delivery water many of the dukun often left a piece of paper inscribed with what they presented as religious texts and prayers. Dukun Papin said that one of the early indicators that she had been chosen to be a

healer were the drawings that she would create as a child. They came from her dreams and prayers. Although Dukun Papin was largely illiterate, she made verbal connections between the drawings and scripture. Occasionally these papers were given to the patient to keep on their body, perhaps pinned to their clothing or in a pocket. These papers were most often left in the oil or in the oil-laced water. The water would then either be used in massage, delivery, or sometimes drunk by the patient. This was a common treatment for troubles with jinn, and it was believed that this method of treatment was directly from the Qur'an.

In contrast to Dukun Papin's practice that she positions as being close to God, the bidan keep religious matters as part of their personal life. They see their primary goal as bringing the superior biomedical system of obstetrics to people. They see that being a faithful follower of a monotheistic religion as part of being a good person. In particular they see their work as part of being a morally sound Muslim citizen.

The clinic staff operated in a way that minimized religious and ethnic boundaries. They saw it as their mission to treat any and all Indonesian people, without regard to background. In this way the bidan of the Lunyuk region tended to separate themselves from a great deal of discussion about religion. The clinic was an ethnically and religiously diverse place. Beyond the representation from the local ethnicities there were several people from various areas of Java, and Flores. Except for this handful of people from outside of NTB and Bali, the proportions of ethnic and religious groups of the clinic reflected the diversity of the larger community of

Lunyuk. People of the minority religious (Hindu) and ethnic groups (Balinese, Sasak) held positions of authority within the clinic hierarchy. The Lunyuk clinic operated very peacefully and toward a common mission of offering modern biomedical health care to Indonesian people.

Since the last few years of the Suharto presidency there has been a rise in Islamic orthodoxy across Indonesia that can be seen at the level of behavior in the state offices such as the clinic. For example, women are now free to wear the *jilbab* (Muslim head scarf that is tied under the chin) in the clinic or in state offices while they were not allowed to do so before the mid 1990s. While in other regions this was more common, in Lunyuk only one bidan wore a jilbab. This began near the end of my research, and she only did so under intense familial pressure. The diverse population of Lunyuk tended to have a moderating influence on religious practice in the settings, such as government offices, where this heterogeneity was part of the fabric of the institution.

Except for recognition of important holy days, which would keep a person from their duties at work, there was little discussion about religious or ethnic issues, either between clinic practitioners or about other clinic practitioners. Frustration did occur quite a bit on the part of the clinic practitioners when they perceived that religious practice kept patients away from them or kept them from treating patients. The bidan uniformly expressed a great deal of frustration about the focus on maintaining the ethnic and religious practices that they saw as getting in the way of bringing the best possible biomedical obstetrical practice to the families of Lunyuk.

After one delivery I was talking to Bidan Dewi about the handling of a placenta. It was a difficult delivery that had necessitated resuscitating the infant. Bidan Dewi continued to tend to the infant after it became obvious that it would live. The mother delivered the placenta and somehow, in the jostling of many people moving around in a cramped space, the placenta slid onto the floor. The family was aghast and to the bidan they seemed more focused on the placenta than on the fact that the infant was alive.

Bidan Dewi was incensed. She reiterated to me that her job was to help people deliver babies in a manner that was healthy to the woman and the child, and not to tend to religious and ethnic practices. Further she noted that she, in her personal life, did not see much sense in these "primitive" practices. She said, "if it were up to me I would have thrown my children's placenta in the ocean. Perhaps then they would have floated to America and my children would live rich, educated lives like Americans." Of course her intention was to tell me that she did not think much of burying placentas as an important religious and ethnic practice. But her statement revealed that she did see a connection between the preparation and disposal of the placenta and life outcomes.

7.2 Islam in Practice

The practice of Islam in Lunyuk could be characterized into three groups. The first was a moderate *traditionalist* Islam that was practiced in way that had existed

for centuries. For these people local ethnic practices, reasoning, and understanding, or *adat,* were melded with the practice of Islam. This reasoning or problem solving pointed to scripture in some places and at other places pointed to the history of the ethnic group. Where people described their reasoning in terms of scripture they often used general terms rather than actually quoting the Qur'an or hadith, often in a way that highlighted a rich cultural history that was intertwined with Islam. Adat was not completely separate from Islamic reasoning and understandings of Islam were couched in terms of the village rather than a global Islam. When pushed to describe the meaning behind certain arguments or ways of doing things it was not uncommon to hear a person say, "ah, that is *adat Sumbawa*." But for the most part the idea of "we as Muslim people" was inseparable from "we as Sumbawan," or Sasak, or Balinese, people. Most of the people of Lunyuk would characterize themselves in this way.

The second form of practice was of the *modernist*-leaning Muslims. These people saw themselves as members of a global Islam *and* as Sumbawans, or Sasaks, or Balinese. People of a modernist Islam were more likely to be educated; many of them held government positions of some sort and had spent a considerable amount of time outside of Lunyuk before settling into their current position. This group was quite vocal about the need to practice an Islam that was "pure," or scripture-based, especially during Ramadan. They asserted that the scripture of the Qur'an is clear and must be followed closely; there was no room for variation in practice. Friday evening religious study groups were well attended by this population of people.

Ethnic identity was also clearly important to this group of people. Several of the study groups discussed issues of interest locally that were not specifically about scripture or learning about the life of the Prophet. Study groups might address building a community where Islam had greater centrality in daily life or at other times they discussed issues of interest locally that were not specifically about religion. This population was concerned about strengthening the community in which they lived, which included several religions and ethnicities. This in itself was seen as a good deed, something that the members were compelled to do as good Muslims.

The third form was of the more *orthodox* Muslim community. They also were similarly focused outside of Indonesia, with people of this group adopting Islamic practices with a goal of "purifying" the religion, and looking to the Arab world for their interpretation of the practice of Islam. The people of this group prioritized an Islamic way of reasoning or knowing the world over other explanatory or regulatory systems. There were frequent references to *fiqh* and *shari'a* (in Indonesia often seen as *syariah*) that did not exist to the same extent among the previous two groups.

Most of the people of Lunyuk call people of this group "*fanatik*". These orthodox Islamists typically kept themselves unusually separate from other people in this rural community, whereas the common behavior across the rest of the community included interactions across practices, religions, and ethnicities. Sumbawan people often describe themselves as "*fanatik*" in reference to religious practice. In these cases the use of the term fanatik was meant to impart that Islam

was an important part of the daily life of the Sumbawan people. In the case of describing the people of the segregated fundamentalist community, people used the term to impart a level of irregularity that made people feel uncomfortable.

The orthodox Islamist group insisted upon having their own mosque and was known to not allow other local Muslims access to their facilities because of suspicion that they were not following Islamic law.[64] Their fear was that in this diverse religious setting the practice of some of the people who called themselves Muslim might be polluted, for example, by the fact that they have Balinese neighbors who roast pork for a ceremony. These people were less well educated and generally had a lower economic status than the other two groups.

Ethnically this group was very diverse, the common factor for this group being their focus on Islam in their lives over all other things. One man, Pak Ham, told me that their community was an ideal that Indonesia could work towards. After pointing to people of several different ethnicities in the room he suggested that this was "unity in diversity" (*bhinneka tunggal ika*) in action, using national motto for the Republic of Indonesia. He described his community has having become one through Islam.[65]

[64] The fear mostly revolved around questions about Muslim community members resolve to resist temptation. Their fear was that in this diverse religious setting the practice of some of the people who called themselves Muslim might be polluted, for example, by the fact that they have Balinese neighbors who roast pork for a ceremony. The smell of the roasting pork might become pleasant to the Muslim neighbors and eventually they might start eating when guests at their neighbor's house. Or perhaps the Muslim neighbors would feel pressure to join the Hindu ceremonies to keep peace with their neighbors.
[65] Pak Ham's use of Unity in Diversity is expressly contrary to the negotiated intent of the phrase that President Sukarno initially intended. Douglas Ramage (1995: 12) reviews the way that the idea of religious diversity was central to this unity. Although at the time there was a push to develop an Islamic state it was deliberately designed to mean ethnic diversity and religious diversity as long as those religions were

7.3 Concerns of the Orthodox Community

In a discussion that spanned several weeks[66], with seven men and women from the more orthodox Muslim community, I learned about the way that people of this community prioritized an "Islamic thinking" (*pemikiran Islam*) that shaped how people thought about the issue of taking care of pregnancy and delivery. Pak Mohammad, a well respected Islamic study teacher for children and adults in this community, described to me the importance of maintaining bodily modesty during exams and delivery; observing fiqh related to pregnancy and delivery, mostly related to blood and bodily fluids; and having relationships with people who were morally correct.

Modesty

Pak Mohammad explained to me that while he was sure that there were interventions that were very powerful at the clinic, it was not possible that a woman's modesty could be ensured in such an environment. He pointed to the fact that there were windows all around the exam room. A gust of wind could move the

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monotheistic. The concept was *ketuhanan yang maha* esa or belief in God. In that way Indonesia was not to be a secular state, but at the same time it was not to be an Islamic state.

[66] For only five days over a six week period was I able to do intensive interviews of people in this community (although I met many of these people at other times and elsewhere). The political situation in the world and in Indonesia was such that an American was not particularly welcome into their homes (immediately post 9-11, invasion of Iraq, the Bali bombing, the first bombing of the Marriot in Jakarta). But with an introduction and an escort to vouch for me (a friend who was a teacher from the local pesantren and his wife) of my own I was warmly received.

curtains aside and let any person in the waiting room or outside see a delivery in the examination room. He noted that this was true of the private clinics as well. He went on to explain to me the ways that bodily modesty was a core principle of women's morality among Muslim people. The idea that genitalia might be exposed to people outside of the exam room was not acceptable. He went on to add that even within the exam room there was concern about exposure of the genitalia to the clinic practitioners, whose morality was considered suspect, or even to the male clinic doctor[67]. There was concern that the clinic practitioners might even discuss the genitals of one of their patients. The genitals were considered something that was private and only for the woman and her husband.

This concept of great privacy and modesty concerning the genitals is not foreign to the people of Lunyuk, or even Indonesia. The general word for genitals is *kemaluan*, or in English "ashamed." The dukun bayi observe this issue of modesty in their practice with great care. Rarely do they look at a woman's genitals during prenatal examinations or even during delivery. Great attention was paid to making sure that clothes are covering a woman's lower half during the entire laboring, delivery, and post natal process.

Fiqh

Pak Mohammad also noted that he was concerned with the proper observance of cleaning and dealing with the blood and bodily fluids (*nifas*) involved

[67] The clinic doctor was Muslim.

in pregnancy and delivery. Pak Mohammad said that the answers to this were found in the *fiqh* related to *darah perempuan*, or fiqh of women's blood. Very generally, fiqh or Islamic jurisprudence is a method for discovering the truth from the Qur'an. As Bowen (2003) points out, "Far from being an immutable system of rules, Islamic jurisprudence (*fiqh*) is best characterized as a human effort to resolve disputes by drawing of scripture, logic, the public interest, local custom, and the consensus of the community." Thus the fiqh are of particular interest as they are representations of how to be an observant Muslim regarding issues of childbirth while incorporating local understandings and structural constraints. Through discussions of what fiqh exist and how they are enacted, knowledge is transmitted to followers about what is most important in the process of delivering a child.

Islamic knowledge categorizes women's blood in the following manner: menstrual blood (*haid*), post-partum bleeding (*darah nifas*), and vaginal bleeding related to a sickness or disorder (*istihadah*). All of these types of blood are considered to be polluting, causing a person to be ritually impure. In the case of childbirth this impurity is considered so severe that it is dangerous for anyone to come into contact with the blood and is a dangerous state for the woman, child, and husband. It is uniformly understood that women who are emitting such blood are not to pray, handle the Qur'an, enter a mosque, not to fast, and not to have sexual relations with their husband. A purifying bath (*ghusl* or *mandi*) is considered obligatory (rather than just recommended or encouraged) to purify the woman after being in a state of emitting haid or darah nifas. There is disagreement among Islamic

religious officials about the specifics of the fiqh related to haid or darah nifas; for example, how many days is menstrual bleeding haid and at what point it becomes istihadah. These issues were handled by local practices that were accepted by the population (Douglas, 1966, 1984).

The issue here was that while it was understood that there were a great deal of fiqh regarding the blood related to reproductive processes, there was little explicitly written about how the people who often dealt with women's blood, that is obstetrical practitioners or health care workers in general, were supposed to maintain ritual cleanliness or about questions concerning possible pollution if one interacted with a ritually impure obstetrical practitioner.

Both Pak Mohammad and Pak Ham did not know of any specifics in the scripture of the Qur'an to lead the way. Pak Mohammad said that the closest was fiqh related to handling of dead bodies. However, it had been decided that it was probably best for a midwife to follow the same ritual cleansing bath, or ghusl, as a woman who was cleansing herself after leaving one of these states.

Moral Correctness

It is with the orthodox Islamic practices of the third group that the bidan struggled most. Likewise, the people of this group struggled the most with the medical practices of the bidan in terms of their religious beliefs. Women from the fundamentalist Muslim community would typically come to the clinic for only one or two examinations during a pregnancy. These women would be accompanied by a

male relative and all potentially exposed skin would be covered either with a combination of jilbab and many layers of clothing including socks or with a burqa or chador.[68]

The tension between these populations was first introduced to me when I observed that it was common that there would be some negative comments about the orthodox women upon their arrival. An often heard expression would be, "a ghost wants to be examined" (*ada hantu yang mau diperika*). Afterwards the bidan would complain that they could not examine the women because of all of her clothing and being observed by the husband made the bidan nervous. They would also complain that women from this community rarely sought the bidan for their delivery and were not diligent in their prenatal check-ups.

The issue of bodily modesty was of great annoyance to the bidan. Although they did their best to keep curtains closed and keep the exam or delivery room available only to the personnel who they thought necessary, their focus was on putting biomedicine to practice and on the outcome of the delivery. Bidan Wati, who was Muslim, and who was one of the two bidan most likely to tend to the women of this community, said that she did not like to care for the women of this community, mostly because of the husbands. She felt as though they would watch her suspiciously and tell her "enough" when she examined a woman who was

[68] There is a thriving market for women's clothing from the Arab world in Sumbawa Besar. Women's clothing is also a popular gift to bring home from people who participate in a work program in one of the Arab countries.

laboring.[69] She noted that by the time she saw laboring women they were usually in trouble for one reason or another so she needed to do complete pelvic examinations to help diagnose the problem and develop a plan of action. Further she noted that it was nearly impossible to get the woman to uncover her body sufficiently to be examined. She said that it was much easier if the husband was not there.

Pak Mohammad suggested to me that if a bidan was not an observant Muslim it might not be possible for an Islamically-concerned patient to know that the proper purification was performed after assisting a delivery. Further, if the bidan was not Muslim, then it was sure that the practitioner was ritually impure. This was not the way to bring a new human into the world.

Thus there was a great deal of concern about the morality of the bidan. People regarded the bidan as an unusual group of women. As women, they were out of the house tending to births at odd hours, often at night. They had professional practices that had no other parallel in the level of autonomy in their mobility, authority, and command of specialized knowledge in the community except for those held by men. While there is little that they did that would have been unusual for an urban Indonesian woman, much of this behavior was unusual for Lunyuk. For example, when there was a difficult labor that the bidan were tending to at the clinic, several bidan would gather to assist one another, often spending a night or several nights at the clinic. The clinic was technically not the house of any man. The

[69] I was never present for a delivery of a woman from the strict Islamist community, only prenatal exams. I am not sure how it would happen that a husband would be observing the bidan during a delivery as it was normal for them to be outside of the room being used for delivery and not to enter the room until well after the delivery of the baby.

women were spending the night outside of the physical authority of their husbands. Certainly, difficult births became public events where many people sat in vigil for the life or death that was to happen. All in the community could see who came and went at the birthing location, but there was no patriarchical control over the location, except for the occasional presence of the unmarried male doctor.

While there was communal understanding that the female bidan were engaged in important activities that necessitated them being out of the home, these activities placed the bidan outside of the sphere of familial male protection and thus in a position of possible inappropriate behavior or infidelity. Pak Ham described the importance of bringing up a child in a morally-correct Muslim environment. If there was doubt about the moral principles of a practitioner, why not avoid that?

The bidan felt that this judgment was one of the barriers to their work. The bidan saw that it was most important to get good treatment to women, not whether or not a bidan was a good Muslim. Being Muslim herself, Bidan Ayu pointed to the fact that scripture was very clear about the fact that part of being a good Muslim was serving the community. She pointed out that there are few more important things that she could do then to help women and children survive in childbirth. Bidan Nur, who was in charge of some of the far reaching nursing posts (*pustu*) and was regularly required to travel long distances on her own in the name of her work, said that the people in this area were not used to *wantia karier*, or working women. She pointed to the fact that she was known to be disciplined in her worship (*rajin berdoa*) yet she knew that people of the orthodox community looked askance at her

as she travelled far from home and away from her husband and children. Generally, the bidan complained that an over-zealous fanaticism was one of the reasons that people sought the care of the dukun bayi over the properly trained bidan.

7.4 The Islamic Community and the Dukun Bayi

The orthodox Muslim community found comfort in the practice of the dukun bayi. They felt as though the dukun bayi shared a focus on what they termed Islamic thinking and Muslim practices in general. Pak Mohammad and others explained that although the modern biomedical techniques were seen as potentially having a medically superior explanatory and diagnostic knowledge set, Islamic propriety had greater value. When I talked to women in this community they often would explain that they felt better seeking care from Dukun Hadjar or Dukun Hapsa, the dukun bayi closest to them, because they were also Muslim.

The modernist community in the area felt that Islamic law is meant to free the faithful followers of Islam from idolatrous behavior and superstition that is harmful to both the soul and in practical life. The act of communicating with the jinn is the much cited example that the people of the modernist Muslim community use in Lunyuk. In general, contact with the dukun bayi is discouraged as they are thought of as backwards and occasionally idolatrous.

Pak Syaiful, who was involved with modernist Islamic groups in the province, described the work of the shaman as somewhat dangerous. He felt as though people

were foolish to keep participating in Sumbawan ceremonies concerning pregnancy that are not described in the Qur'an. He was worried that people spent their time and resources on these ceremonies instead of performing the daily worship that are part of the basic duties of a Muslim, and seeking advice from scholars of the Qur'an. Further, he suggested that people might actually be harming their chances of having a healthy child both by dabbling with magic and "primitive" medicine.

Pak Syaiful held a position of social and political power in the community. He told me that he actively encouraged people to only use the clinic services. Indeed, all of his children were born in the local clinic or in the only hospital in the region, five hours away. This was quite unusual. He continually encouraged me to interview religious scholars on the matters of pregnancy and birth and to stay away the dukun bayi. The ironic thing is that it was his wife who had provided me with the formal introduction to Dukun Papin whom she knew well.

Although a vocal and powerful force, this modernist Muslim sentiment does not describe everyone in the area. Most people I talked to about this matter felt that as long as the practice was not prohibited by the Qur'an or if it was in the spirit of Muslim teachings then there was no reason to worry. The dukun describe all of their prayer, chanting, singing and other ritual speech forms as Islamic in nature while also being important and uniquely Sumbawan in character.

The modernist Muslim community is troubled by the fact that the dukun bayi spend any time in communication with the spirit world. Islam does recognize the existence of black magic, and a great deal black magic is perceived to be present in

Lunyuk by the local inhabitants. The Sumbawan, Sasak, and Balinese knowledges are all thought to have very powerful black magic. The modernist Muslim community posits that it is only in the name of God and practices prescribed in the Qur'an that a person can rid themselves of black magic. Pak Syaiful's concern was that a person cannot really know if the dukun bayi has only used knowledge from the Qur'an and not something from local spiritual knowledge in their practice. His point was echoed by many. The dukun bayi hold that all of their knowledge is of the Qur'an and God meaning that there is no separation between their practice and Islam.

These diverse categories of Muslim practice do not have clean boundaries when the human practitioners of Islam in Lunyuk are added to the formula. While the bidan themselves were more aligned with a modernist globally-focused Islam, consistent with their more global or Jakarta-centric focus in general, there was diversity in the importance that the bidan placed on religious practice in their own lives. Similarly, the bidan often blamed the continued success of the dukun bayi on an overly ethnic and religious focus of their patients.

Part 3: Discussion

Chapter 8: Discussion and Conclusions

In the introduction of the dissertation I described how the Camat (the sub-district head) of Lunyuk who, physically several local public figures into the the Indonesian Independence Day celebration, using his opinion of their status in the community to determine their roles in the celebration. The bidan sat on the stage along with the mayors, the visiting official from the Bupati's office (district head), the local religious leaders, the principals of the schools, and representatives from the Army and Police. The dukun, who had no expertise in Sumbawan arts, sat with the group of children whom they had been charged to teach and direct for several Sumbawan cultural performances.

The Camat's demonstration illustrated John Pemberton's discussion of the *warisan kebudayaan*, or "cultural inheritance" nicely (1994: 10). Although the New Order government of Pemberton's analysis is no longer relevant, the idea of the use of tradition in creating a common cultural identity, which would then parlay into a common trajectory, holds well. This political event attempted to draw on social connections to suggest a genealogical lineage from the authentic Lunyuk, a shared experience of Subawan, Sasak, and Balinese ethnicities, to the present political power structure. As Pemberton suggests, the use of "traditional culture," or *kebudayaan tradisional*, is not meant as direct social control, but rather is a means of refocusing attention on the overall project led or supported by those in political

power. It momentarily strips away issues of class and power and instead reframes the situation in a way that states "this is where we all came from and this is where we are going." The public demonstration of a shared experience is powerful. Here the demonstration helped to illustrate the idea that the people of Lunyuk have had a shared and unique journey and thus should have a common goal as presented on stage.

The two dukun who were part of this Independence Day celebration offered an alternative narration for this event. Although the camat had mixed local categories and placed the two dukun in the specious role of artistic directors, the dukun were there because they were strong social representations of what a modern Lunyuk looked like.

As Webb Keane points out balancing nationalist drive with the "rich cultural heritage with deep histories" has a tendency to threaten the project with divisiveness (1997: 38)[70]. As Keane suggests, the presentation of a modern Indonesian identity is tricky when the audience of the message is highly diverse both in experience and in their contemporary reality.

This dissertation, at the most general level, is about how people define who they are. In the daily assertion of identity people constantly assess what group or groups they belong to, what it means to belong to a particular group of people, and which people do and do not belong to their group; in short, who is "us" and who is "them." In doing, this people connect and refer to a body of knowledge that

[70] Here Keane cited Anderson 1978; R. Fox 1990; Geertz 1973 as those who have written about the same point before him.

represents part of what is their Truth. This truth informs the way that they live and the decisions that they make.

Although these questions could be explored in many ways, this dissertation used as a case study the way that people involved themselves in obstetric care in rural Indonesia to explore this subject. Here people negotiated conflicting messages about the proper way to bring a person into the world. The Western science-based biomedical and the indigenous humoral-based systems of obstetric knowledge operated as two divergent guiding bodies of knowledge that explained essential truths to those who subscribe to those systems. As a trusted and respected person is necessary for maintaining a system of knowledge (Shapin 1995: 302; Hay 1999), this study focused primarily on the obstetric practitioners of the dueling knowledge traditions, the bidan and the dukun bayi.

This dissertation explored the manner in which competing knowledge systems related to pregnancy and childbirth, and absorbed and organized into the local practice of obstetrics among both biomedical and shaman-based practitioners. I argued that although the bidan attempted to purify their local obstetric practice to reflect biomedical scientific methods they were constantly undermined by the hybridity inherent in local life. In order for them to develop a clinic practice and attract patients, they had to translate their services and in the end adopt some local shamanic practices. After all, how can they see themselves as a success if they have no patients? Additionally, this dissertation demonstrated that the biomedical practitioners felt some ambivalence about entirely extracting indigenous medical

knowledge from the practice of obstetrics. In most cases, even if only distantly, the bidan had personal connections to indigenous medical practices and knowledge. When five of the seven bidan were born their mothers were tended to by the dukun bayi. All seven of them have sought the help of dukun in their lives, a few of them regularly.

As the global force of biomedicine translated into the vernacular of a rural Indonesian village it encountered long-standing traditional practices. The local midwives, both the bidan and the dukun bayi, acted as translators for these global forces, responding to the demands of the local people as they negotiated competing knowledge systems, and the social, cultural, and practical concerns about bringing a new human into this world. In the social and cultural setting of Lunyuk, people expressed and came to see themselves in terms of the knowledge systems and reproductive practices that they employed, either as the health care practitioner or as the patient seeking care. Decades of Indonesian government pressure to modernize, and the more recent entrance of international and government programs in the village have challenged the local people to re-imagine who they are and how they should live. Pregnancy and childbirth thus proved to be a particularly rich site for examining these subjects as the expectant families were considering their best options for introducing a new human being into the world.

Rather than grounding this dissertation in anthropological (or sociological) works in medical pluralism or more specifically the anthropology of knowledge, I

used the social studies of science[71] to look at the knowledge-claims in question and its variability depending on a complex genealogy of the practitioner. The knowledge in place, informing local obstetrical practice, was powerful and understood as monoliths of Truth; this body of knowledge was nearly invisible to the practitioner as it clouded even the possibility of other ways of knowing. Here I assumed that local obstetrical knowledge had the same power of forming Truth as did biomedical care. In fact I think that this is the crux of the problem with the question of the reproductive health programs: they underestimate the ineffable strength of the local "medical" knowledge.

The social studies of science challenges this taken-for-granted-truth. This analytical structure suggests that scientific knowledge is in fact "constitutively" social, in that it challenges that which is taken for granted. In rural areas of Indonesia for example, where biomedical and shaman-based obstetric practices operate simultaneously, there is not a clear domination of either knowledge system. Because most patients seek care from midwives of both forms of obstetrical knowledge, practitioners find themselves competing for patients and defending their system of medical knowledge. The weight or value of the various systems of knowledge are variable and depend on the setting and the actors involved. Ultimately, both types of practitioners see their system of knowledge as one of their culture's most highly valued sources of "truth" (i.e. the basic treatments and procedures that sustain and develop human life). The ironic result of this

[71] I have mostly used the work in the fields called the sociology of scientific knowledge (also known as SSK, e.g. Shapin, 1988, 1994, 1995) and science and technology studies (also know as STS; e.g. Latour, 1988, 1993; Haraway 1991)

competition for patients is that both types of midwives adopted certain aspects of the competing practices in their bids to elevate their own system of knowledge.

One way to look at how the scientific knowledge systems have clashed in this setting has been to look at the areas of tension in obstetric practice: areas where the people involved have consistently and explicitly argued about what was right and what was wrong. These arguments centered on four specific areas of tension: morality (often in terms of religious observance), obstetrical competence, the place of ritual and how people prioritized their communities of belonging. In each case, people's opinions about these points were connected closely to the bodies of the scientific knowledge that they most adhered to.

Two specific objects, delivery water and umbilical cord scissors, were used to examine the tension between the competing knowledge systems. These objects are technological artifacts of the two knowledge systems in which they originated. Each object, used in the hands of the practitioner of the competing obstetrical knowledge system, was imbued with the essence of the other. Each object was not just a tool made from a particular social system, rather it was a tool that was richly laden with the "cultural fields of literary, philosophical, symbolic, and psychological production" (Fischer 2000: 283). The discussion focused on these objects as a means of examining how the players involved in providing obstetric care, the shaman midwives, clinic midwives, and government officials, operated as they worked through defending or challenging status. Physical objects carry with them an embodied physical knowledge. Shapin (1995: 308) gives the example of the

thermometer. Rejecting the use of and results of the thermometer as a tool would mean instigating a struggle of understanding on many levels, not just on the reading of the tool. It is similar for the delivery water and the umbilical cord scissors.

Although this discussion did not focus on the pregnant women and their families, they are central figures throughout, for they provide a sense of the woman's experience as she negotiates the various realms of obstetric care through pregnancy, pregnancy loss, delivery, post-natal care, and the loss of children, A few of the same women were followed throughout the three chapters, although input from many other women is also included.

The Bidan

Every official action on the part of the clinic midwives, or bidan, was meant to strengthen the hold of biomedical obstetrics in the region. The bidan attempted to put forward a single theory of practice, of biomedicine, that encompassed obstetrics, but also gave instruction for modernity. They believed that the knowledge set that includes biomedical science would create a path for the Indonesian people from the life of people of a poor nation to an educated and modern populace. Bidan Dewi noted that her goal was to change her practice so that all women came to the clinic. The bidan believe they were meant to create a "pure" obstetrical practice, in a sense, that would not be polluted with the practices of the dukun bayi.

The bidan repeatedly described that they were meant to be missionaries, of sorts, for what they called a "modern" way of life, railing against what they termed

the “ancient” obstetrical treatment practiced by the dukun bayi. Implicit in the introduction and expected acceptance of biomedical obstetrics was the assumption that other elements of “modern” life would then be accepted by the local populace as well. The bidan assumed that the western scientific basis for biomedical obstetrics would trump, what they called, “primitive cultural practice.”

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systems that are, in most cases, indigenous to their life experience, even if only distantly.

An important part of the Bidan's duty is to erase the practice of the shaman midwife. This is a change that is not happening. At the same time, the bidan feel desperate to help the women and infants around them. They describe themselves as being somewhat helpless in this regard because of what they perceive as the local women's refusal to change, coupled with the lack of a full complement of biomedical obstetric resources. Because the clinic midwives have not been able to affect a great change in the obstetric care seeking patterns in the local population they perceive a severe critique from both the government and the local people. Likewise, they feel as though their status is challenged by the shaman midwives and by the local women.

While the clinic midwives are desperate for anything that would help them keep mothers and infants alive, they are also ambivalent about their official dismissal of shamanic practices, and they want to attract patients to legitimate their authority, practice, and status. For this reason they incorporate local medicinal remedies, massage, and most dramatically delivery water into their treatments.

The Dukun Bayi

The dukun bayi similarly held that their services were critical in this changing era. They contended that it was through their work that a changing Indonesia could be translated into terms understandable for the rural Sumbawan

people. The dukun bayi could not conceive of the possibility of birth of a Sumbawan without the proper ministration for the body and the soul. The people demonstrated their support of this view through their continued use of the services of the dukun bayi, in preference to or in addition to the readily available bidan,.

The social tension surrounding the use of umbilical cord scissors provides insight into how the shaman midwives reconfigure their identity and maintain their local status as central figures in the construction and maintenance of a local Lunyuk identity. I argue that the shaman midwives are able to circumvent the mission of the reproductive health programs to eradicate their practice by successfully framing themselves to the local population as a combination of obstetric practitioner, translator of biomedicine, and as central figures in the ongoing definition of Lunyuk modernity. The umbilical cord scissors are part of the shaman midwives' ability to assert their relevance and re-frame their high social status. The use of the umbilical cord scissors, plus other tools, accomplishes several goals: a strategic public use of a tool that is branded with biomedical modernity; it asserts the right awarded to them as certified traditional birthing attendants by the nationally and internationally-designed maternal health programs years ago; and it challenges the clinic staff, who openly attempt to threaten their practices and their influence with the local people.

The shaman midwives were seen to have effectively responded to the challenges to their long-standing authority by the newer biomedical system. In order to maintain their relevance and power in the community the shaman midwives regularly pointed to their connections to the very policies and programs

that attempted to strip them of their authority. It was through these programs that these shaman midwives were given their limited biomedical training, including some of the procedures that they follow and some of the tools that they advertise using. These issues became sites of open contestation and competition between the clinic and shaman midwives as they engage in a struggle for whom, using their words borrowed from English, is "moderern" and who is "antik."

Obstetric Practice in Lunyuk

After several decades of work in the region, the biomedical obstetric system has not had the ascendancy that was expected. The bidan, in their association with national and international programs and their modern look and feel, have a political strength, but little local social traction. Both the program officials and the bidan note that rural Indonesian women continued to seek the majority of care for pregnancy and delivery from the dukun bayi and consult the bidan only at a few points throughout the pregnancy and post-partum period. For years the bidan only saw patients in situations of emergency and for postpartum vaccination. The bidan continually noticed and worried about the fact that the dukun bayi have much more active practices.

What the dukun bayi lacked in political strength they more than made up for in social power. They still had extremely busy practices. In the early 1980s, before the arrival of the bidan, the dukun bayi were encouraged to come to the clinic to learn some basic biomedical obstetric practices in sterile methods. With this

training they received a few pieces of equipment that are locally emblematic of modern biomedical practice. While the dukun bayi will generally describe that they use very little of what they learned in their current practice, they do very publicly use some of the clinic equipment: a midwifery bag, umbilical cord scissors, and a plastic apron, among other items.

The dukun bayi Dukun Papin explained to me that it was her job to remain up to date on what is happening in Indonesia and over at the clinic. It was up to her to help the local inhabitants deal with new "ilmu" she called it, or knowledge. Dukun Papin asserted that she must adapt so that she can help her patients adapt. But she also noted that part of her job was to help them remain rooted in their Sumbawan and Muslim identities. She said to me, "If we do not retain our Sumbawa ritual then what are we?" Sumbawan obstetrical knowledge, she explained, is the corner stone of creating a Sumbawan human. But also, perhaps in recognition of the various pressures on their patients and themselves, the dukun bayi were willing to serve as translators, both for the community, and for me as I observed their practices.

The bidan, in noticing that their patient load was lacking and understanding that part of the measure of success was having patients, took some lessons from the dukun bayi. Slowly, and to varying degrees, the bidan began to use some of the shamanic treatments. Bidan Dewi said, "I keep trying to teach the women that the dukun bayi are dirty. They do not know the newest obstetrical theory [*teori baru kebidanan*]. But if I don't put my hands on them and give them a massage they will go back to the dukun bayi."

The women in rural Sumbawa live amidst the flux of the various ilmu, or knowledge sets, that Dukun Papin the other dukun bayi mentioned. During an evening chat with my pregnant neighbor, she articulated what many reproductively active women already had said to me: "Why not use all the knowledge? Indonesia changes all the time. First, the nation was most important. Now it is regional autonomy. How am I supposed to know what to do? I choose what I know and I choose other options also. It is mixed."

Indeed Latour (1993: 2) reminds us that, "all of culture and all of nature gets churned up again everyday". Latour's work offers guidance in understanding the boundaries of the knowledge set that the bidan initially presented and how this applies to their claims of being "modern." He suggests that in order to be modern there must be a "break" in time, where the antiquated are separated from the new form: here the antiquated being the practice of the dukun bayi and the modern being the practice of the bidan. The antiquated then becomes, "an archaic and stable past" (1993: 10). The bidan found that the Sumbawan body of knowledge that they placed themselves in opposition to was not, in fact, archaic or stable in the ways that they thought. Rather they found a shamanic obstetric practice that, while steeped in history, tradition, and ritual, was dynamic and explicitly seeking to respond to the needs of the patients.

Latour hypothesizes that the more that we attempt to separate, or "purify" boundaries of knowledge, the more these separations enable the work of "translation" (1993: 12). Indeed, the dukun bayi were translating an obstetric

biomedical practice by using biomedically developed tools. The bidan found that in order to draw patients they also needed to translate and use some of the shamanic practices. Latour suggests that translation then forms impure alliances and makes boundaries fuzzy; in our case, combining the biomedical and shamanic obstetrical treatments. In this translation we find categories that defy distinctions of "modern" or "ancient" and the creation of the type of hybridity that exists in the lived experience.

The bidan and the dukun bayi both find that they could not erase the existence of the other. Maintaining a pure practice that does not reference the other weakens their existence and their hold on their target patient population. Instead, they both gain power in associating with the other knowledge system. Like Margaret Weiner's (2003) analysis of the meeting of science and religion in colonial Indonesia, the efforts at purification of the biomedical knowledge system are undermined by the natural hybridity of everyday life.

Thus it follows that the long-standing maternal and child health program initiatives in Indonesia are intricately linked to nationalist pride and global development objectives, as well as tosuccess for Indonesia in receiving international funding. Great strides in health indices have been made in other areas that are related to maternal and infant health issues, such as family planning and child health. The family planning program in Indonesia is now recognized world-wide as an example of a successful development program.

Nonetheless, maternal mortality ratios and infant mortality rates remain high in Indonesia and this causes a great deal of frustration for the development and clinic workers who address these issues. Development and clinic workers see the primary reason for high mortality rates as being due to the fact that the shaman midwives remain the first choice for obstetric care for most people in rural areas. Clinic staff, government officials, and maternal health programmers frequently ask the question: why don't people come to the clinic? The pregnant women discussed in this dissertation all live within a thirty minute walk of a clinic where discounted or free reproductive health care was available. Solutions for the majority of reasons that women and infants die or are disfigured in childbirth have been known for decades. While maintaining ethnic and local identities is important, all parties agree that it is a most laudable goal to reduce the number of women or children who die or are disfigured in childbirth.

Clinic staff, government officials, and maternal health programmers assume that the reasons why people are not using the clinics to the extent expected, instead continuing to use the services of the shaman midwives, is the result of faulty decision-making on the part of the individual patients. They blame these "faulty" patient decisions to patronize the shaman midwives on laziness, naïveté, lack of education, or lack of exposure to modern methods and ideas. This reasoning drives program development, evaluations, and patient education and also is reflected in the way that the clinic staff addresses patients. The message from the biomedical

officials to patients is that using clinic care for a pregnancy and delivery is the only responsible choice for parents, community members, and citizens.

Little headway has been made by the biomedical officials in explaining why people do not come to the clinic, when distance and prices are taken out of the equations[72]. As noted earlier, I suggest that it is important to turn the clinic and development official's question around and to ask: why are the shaman midwives still in business? The high rates of maternal and infant mortality and morbidity are clearly of great concern to the local people. For this reason people do consider all the options that are available to them and make calculated decisions about how to treat pregnancy, delivery, and the post partum period. These decisions are based on local understandings of obstetric possibilities, cosmologies, and social ties. Because of this, both the shaman midwives and the clinic midwives actively construct midwifery practices that reflect the political, social, and religious landscape. In doing this, the midwives respond to the practical obstetrical issues, but also to demand, to criticism, to state policy, to religious pressures, and to tradition. The obstetrical providers, both the shaman and the biomedical midwives, become the central figures to the discussion while also including the dialogical relationship with the patients, the government officials, and the international development officials.

So what happens to the new hybrid system of obstetrical practice used by the bidan? Largely the bidan keep their forays into the shamanic practice hidden. They are already heavily criticized by their reproductive health administrators as lacking

[72] The primary informants discussed in this dissertation all live within a thirty minute walk of a clinic where discounted or free reproductive health care was available. Distance from the clinic clearly was not an issue.

critical skill, being inefficient, and of not being dedicated to the program. The administrators partly blame the bidan for the program's inability to change the patterns of obstetrical care across Indonesia. Thus, the bidan of rural Sumbawa outwardly maintain their stance that the obstetric treatment that patients receive should be purified to only include biomedical procedures and interventions rather than including a mixture of the biomedical and indigenous. Steven Shapin (1995) suggests that great offense is taken when a culture's highly valued system of knowledge is challenged. The idea of making biomedical obstetrical practice hybrid, while understandable at the local level, is detestable to the reproductive health care program administrators, and on some levels to the bidan as well.

Shapin, likewise suggests that scientific knowledge flows along patterns of cultural success and power. Along with these flows, the context for this obstetric knowledge is shaped, developed, and standardized (1995: 308). Locally, the bidan are some of the sole members of the rural community that have access, and moreover the mandate from the Indonesian government and the aid organizations. The bidan have all the trappings of economic and political power that come along with association with the clinic in a small rural Indonesian community, yet they find they must adjust to the local reality of scientific knowledge and practice.

Here, Haraway's (1991: Chapter 9) concept of situated knowledge is useful. The bodies of knowledge used by the bidan and dukun bayi are situated; they are categories that structure how they understand and experience the world. In the hybrid world of rural Sumbawa, the boundaries between the systems of knowledge

become fuzzy. There is a great deal of difference in the power that each medical system holds and the way that it holds it. But without adopting elements of the other system there would be a lack of clients. The bidan must pollute or adjust their knowledge set in order to maintain or gain patients who live a hybrid life. In conclusion I agree with Bruno Latour and suggest that what the bidan are negotiating is "what exactly, is the substance of society" (1993: 4).

The result is an obstetric practice that has a look specific to Lunyuk. As Steve Shapin reminds us, knowledge sets, here, obstetric knowledge, is made in a particular context. Thus obstetric practice in Lunyuk, both for the dukun bayi and the bidan, is shaped by the demands of the customer, and the sense of having to compete for customers, the very fact that there is another competing knowledge system (Shapin 1995: 306; Shapin 1988).

In the larger analysis, it seems that the bidan and their roles and conflicts may be the place to look in reshaping the SMI programs locally to fit social, cultural, and structural aspects of local reproductive health understanding. In this way international reproductive health care programs officers might refocus their perspective and programs development to better serve the local population, including the provision of services that the population will accept and adopt. It seems that a key to addressing global health problems, such as maternal mortality, is in the local settings. I follow Janes (2003) in asserting that to understand the global problems of health, illness, and suffering, we must understand the proximate causes of those issues on a local level, as the problems are embedded in local

character. This suggestion does not assign blame to local practices; rather it seeks to understand the local character in relation to a global problem. I suggest that a possible and partial solution comes from this route as well. This is that the bidan who reshape their practices to reflect the more popular local obstetric traditions, are on to a potentially powerful solution to getting basic, simple, and potentially life-saving care to pregnant women. The goal of the SMI program is to convince more women to seek the services of the skilled birthing attendant. Here in rural Indonesia the local bidan have reshaped their practice to reflect local realities, structural issues, and beliefs while still implementing the basic care that they can.

Global maternal health programs under the Safe Motherhood Initiative umbrella follow an outline of reproductive health care procedures. These programs are piloted in a few areas and then implemented elsewhere, with a premium placed on generalizability. While there certainly is an argument to developing a global standard of care, homogenous solutions have not improved the level of maternal health. Brigitte Jordan suggested that the only way to bring effective care to women is to have a system that allows for the "mutual accommodation of indigenous and biomedical systems of birth, based on respect for women's bodies and women's biosocial needs." (Davis-Floyd and Sargent 1997: 16). Certainly this is the more difficult route to implementing reproductive health care programs as it entails incorporating local specificity; but this is just what might make global reproductive health programs work.

There is a great danger in program level perception of patients and practitioners as being outside of, or refusing to, participate in a system of health care. This is especially true when this system of health care, specifically biomedical obstetrics, is well-proven to have dramatic results of decreasing mortality and morbidity in a population. The patient or the practitioner who does not act in the expected role then becomes perceived of as irrational and is eventually written off as a lost cause as I saw when I visited many international offices for reproductive health programs.

This dissertation is a call to rethink the actions of those who do not come to the clinic. As a great deal of anthropological work and this dissertation has suggested pregnancy and childbirth are tightly wound with identity formation and utopic ideals of what a new generation could be. We have seen that the dueling midwives (the bidan and the dukun bayi) as well as the pregnant women and their families were negotiating their relationship to their position in the broader universe through obstetric care. They all operated using a logic based on the resources and knowledge accessible to them. We see that symbolic boundaries related to social, cultural, and moral ideals shapes practitioners' and patients' interaction with available obstetric care. In Lunyuk obstetric care indeed became unique to the setting.

Appendix 1:

Finding a Dukun Bayi in Lunyuk.

Finally I had a meeting with a dukun bayi at her own house. It had taken me months to arrange and I was beginning to wonder if I would ever gain more than passing access to a dukun bayi in Lunyuk. This was a person who was supposed to be a key element to my research project, and I could not get in. Up to this date, every time I'd been introduced to a dukun bayi it was at a birth where, obviously, I was with bidan and no good conversation would be had. Or the dukun bayi would mysteriously disappear when I arrived at her house. This had not been the experience I had when I interviewed dukun bayi in many places in Central Sulawesi and in another districts in Sumbawa. But here in Lunyuk, I suspected that I was having trouble because up to this point I had been solely associated with the clinic staff. Later I found that this was absolutely true. I needed to break into another social realm and it had been very difficult.

People did not want to introduce a foreign researcher to a dukun bayi for many reasons. One first reason, I learned later, was out of embarrassment. People assumed that there was no such thing as a shaman midwife in the United States, and that I would have a disapproving opinion about her existence, her practice, and about those who seek her services. Some people also did not want to introduce me to a dukun bayi because they themselves disapproved of the practice, despite the fact that the same people see dukun for reasons other than childbirth or pregnancy.

These people believe that the dukun bayi was something that should be hidden from foreign researchers, the existence of the dukun bayi would serve as evidence of Indonesia and the Indonesian people as a backwards, poor and uneducated. Some of these people would go as far as to tell me that there were no practicing dukun bayi in the area (a great falsehood). I also was aware that the clinic staff with whom I'd been working to this point, thought that this was the wrong direction for my research, because in their minds most people were choosing to be treated by the puskesmas staff rather than dukun bayi, so why would I waste time with the old woman. And also, people were concerned about my well-being. Would I be able to recognize black magic and because it was assumed that I was especially naïve about black magic would I be particularly susceptible? People are generally cautious about which dukun of any sort they consult.

Some dukun deal more in black magic than others. It was assumed that all know a bit of black magic – "I must know some of the black magic so I can cure ailments caused by it or protect people from it" Dukun Papin would later tell me. In particular, the family with whom I lived was very concerned that I might become involved with a dukun bayi who might harm me. They worried that because I didn't know anything about black magic or about dukun, and that I wouldn't be able to recognize the signs that I was in danger. Several times a member of my hosting family was even assigned to thwart my attempts at finding or meeting with a dukun bayi, or stood nervously by as I tried to make contact with a woman. Later I learned

from Dukun Papin and from some others that she was concerned that I would tell people at the clinic about her practice and about what an "antique" person she was.

As I got to know her and other dukun bayi, I found that many of them were initially shy with strangers. They are all older women who had little or no direct contact with someone from outside their community, much less someone of European descent. None of them spoke Indonesian very well; some of them not at all. In the end, it was necessary for me to be in the community, and to become somewhat known by enough people that I could make contact with a dukun bayi in a meaningful way. Dukun Papin saw me at many births before I ever met her. In fact I was much less aware of her presence at the births that we both attended early on as I only remember her being there a couple times. Later, after I knew her well I saw why; she would slip in and out of a room where a woman was attended by a bidan without much notice. She would interact with a few key people in the large group in attendance and maybe have a quick interaction with the laboring woman if the clinic staff was out of the room for a bit. Often the bidan had no idea that she had been there.

After months of trying to develop a relationship with the dukun bay, a friend of mine said she knew of a dukun bayi who might talk to me. This friend had known from the early days of my stay in Lunyuk that I needed to do research with a dukun bayi, but up to this day had not offered to introduce me to anyone. One day when we were alone as I was helping her cut green beans for dinner, she offered to help me. The next day she took me to a house that I had visited several times, including just

the day before with a bidan. The young woman there had given birth with the assistance of a dukun bayi, and the bidan had come over at the request of the family because she was still bleeding. As post-partum hemorrhage is the most common reason for maternal death in the area, the family was concerned and called a bidan. When my friend and I arrived at the house the dukun bayi was there giving the woman a massage, applying medication and attaching a charm to stop the bleeding. I was invited to watch the massage. This had never happened before. After the massage was over we chatted for a while and agreed that I would come to her house the next day for an interview and a medicinal massage (I was recovering from an intestinal infection). Later I learned that it was not by chance that we met at the house where the woman was recovering from birth, rather it had been by the dukun's request and as they already knew me, the woman's family offered to have the meeting at their house.

So there I was off to meet with the dukun bayi who I would later call Papin, or "grandma" in Sumbawan. I'd been instructed to find her house from a "small road" in front of the puskesmas—I would be able to see the house from the road. After looking for the entrance to her family compound for about half an hour, on a wild and last guess I squeezed my motorcycle through a bush-covered trail that in my eyes looked more like wild animals used it as a path to a water hole than a "small road", and I could see no houses from the road. I found that I had entered a compound and directed my little motorcycle to the house a woman pointed to when she popped her head out the window to see who had entered. At the house I was

politely greeted by Papin's husband (Pak Abdul), a cousin (Ibu Siti) and her granddaughter named An, who had a seven month old baby.

Although they remembered that I was scheduled to come they seemed surprised that I had made it there. I was told that Dukun Papin was giving a massage and would be out any minute. A few minutes later she emerged from a room with her patient and sat on the mat with us. Dukun Papin had a soft and comfortable feel about her. She was well under five feet tall and very thin. The wore a kein and kebaya[73] everyday. Some days her hair was covered in a knit cap. I never saw her wear a jilbab although I know that she has one as it was a gift given to her by a grandchild in my presence. Dukun Papin kept her hair uncut and pulled up into a bun in the style of many Indonesian women that miraculously (to me) stays in place with no pin, rubber band or any other kind of hair holder.

After visiting for a while they asked me many questions about what I was doing in Lunyuk and about my home. I told them a bit about my research and that it was very important for me to interview everyone involved in pregnancy including the pregnant women, the bidan, and the dukun. I wanted to know all about how Dukun Papin helped women through pregnancy and childbirth.

On this first visit most of the answers came from Dukun Papin's cousin Ibu Siti and Dukun Papin's husband, Pak Abdul. Dukun Papin is the mother in the household and of the compound. Dukun Papin told me that she was 73 years old, but I'm not sure that this is a really accurate number now that I know all kinds of other

[73] Indonesian women's clothing.

dates that exist in her life including her own reproductive history, the reproductive history of her children and grandchildren, her certification from the clinic and her recollection of historical events. Her granddaughter An, was helpful in communicating with all of the older women because at that point the thick Sumbawan accent was difficult for me to understand, my knowledge of Sumbawan medical terms was extremely limited, and my accent was odd to them. Bu An, who had lived in several other locations in Indonesia, and I were able to speak to each with no problems so she was able to explain to me what her grandmothers were saying sometimes and explain to them what I was saying when we were crossing paths. As time went on it became easy to communicate with each other.

During our discussion on that first visit to her house Dukun Papin told me about her training at the clinic years before. She joined the first training program offered for dukun bayi in 1985. This was before there was a bidan in Lunyuk and just after the clinic was built. At this time she had already been a practicing dukun bayi for three years. She told me that she had notebooks documenting every birth that she has attended since her clinic training (a real shock!) and got the books for me. Her first, dog-eared book indeed starts in 1985. Dukun Papin said that this was the first thing that they learned how to do in the training. They must keep records like the clinic staff and then submit the record sheets monthly. She told me that she did not read or write so after each birth she had someone complete the entry in her record book. She had hundreds of entries in her books. There were no deaths of infants or mothers recorded. She also kept a log book of women who were pregnant

and had been to see her but she obviously did not tend to this book the way that she did the other book.

Dukun Papin told me that every so often she takes the books to the clinic or to Bidan Marta to report her data as she was instructed. However she told me that she no longer leaves the books with them because they lost one, made no attempt to find it, and were very rude to her. Dukun Papin was quite upset that one of her carefully kept books was missing. She said that she had gone over there several times to see if they found the book. Dukun Papin told me that the bidan brushed her off saying that it was lost, the data was already reported so why did she need it now anyway. Later I asked everyone at the puskesmas if they knew where the book was. No one remembered anything about the book. I do believe that Dukun Papin submitted it as she has so carefully preserved her records for nearly 20 years: the books are clearly important to her.

When I asked Dukun Papin if she would mind showing me the kit that she used when she went to laboring woman's houses she brought a pristine government-issued dukun terlati kit. She told me about the contents of each bottle (still sealed), the type of bandages and what they were for, a plastic apron and each piece of equipment (needles, mucous extractor, gloves, and stainless steel containers). Dukun Papin said that she also had scissors but they were with some other equipment. She told me that she needed new umbilical cord scissors but they wouldn't give them to her at the puskesmas. The whole collection fit into a metal box. It was interesting that she showed me these unused supplies. I asked her

several time if these were all the supplies that she used, where there any more? She said no.

After talking for quite a while, I asked Dukun Papin if she still had time to give me the massage. I thought this was probably the best way to start finding out what these massages were about without asking too many questions during someone else's massage. I thought that this might go somewhere in convincing her that I really wanted to know what she did and not what the clinic told her to do. Additionally I'd had a some sort of infection so if this helped I would be grateful. The cousin Bu Siti Sindaya came in the room with us. She told me that she was coming in for "administrasi."

Dukun Papin gave me a massage in exactly the same manner that she gave the post-partum woman the day before. The only difference was that she spent a different amount of time in various places. She eventually finished the massage with a prayer over my belly button accompanied by some gentle blowing onto my abdominal region. Then Dukun Papin climbed up a 10 foot bamboo ladder to get some medicine that she kept in the rafters with the agility many 25 year old Americans would have trouble exhibiting. On her way down she instructed me to take a mandi (bath), but to be careful not to wipe off all of the obat (medicine). She handed me a piece of bark that was stored in the space to which she had climbed and showed me how to use the bark like one might use a bar of soap.

Appendix 2:

Descriptive Statistics of Kecamatan Lunyuk and Kabupaten Sumbawa

Religions present in the sub-district (kecamatan) of Lunyuk and the regency (Kabupaten) of Sumbawa for the year 2002

Religion	**Kecamatan Lunyuk Total (% of total)**	**Kabupaten Sumbawa Total (% of total)**
Islam	15788 (84)	428852 (96)
Catholic	18 (.09)	2218 (.4)
Protestant	12 (.06)	1895 (.42)
Hindu	2871 (15)	10885 (2.4)
Buddhist	0 (0)	0 (0)
Other	0 (0)	0 (0)
Total	18689	444277

(Source: BPS 2002)

Ethnicities present the sub-district (kecamatan) of Lunyuk and the regency (Kabupaten) of Sumbawa for the year 2002

Ethnicity	**Kecamatan Lunyuk Total (% of total)**	**Kabupaten Sumbawa Total (% of total)**
Sasak	4374 (23)	61148 (13)
Sumbawa	9750 (52)	305040 (68)
Dompu	0 (0)	596 (.1)
Bima	78 (.4)	12360 (2.7)
Bali	3653 (19)	11979 (2.6)
Java	180 (.9)	14490 (3.2)
Sunda	23 (.12)	844 (.2)
Bugis	0 (0)	14375 (3.2)
Other	631 (3)	23445 (5.2)
Total	18689	444277

(Source: BPS 2002)

Population of the sub-district (kecamatan) of Lunyuk for the year 2000

Village (Desa)	**Population**
Lunyuk Rea	2344
Lunyuk Ode	3466
Pada Suka	4956
Suka Maju	2719
Jamu	1089
Mungkin	1052
Kelawis	2041
Senawang	1100
Total	18766

(Source: BPS 2000)

Appendix 3:

Selected Vocabulary Used in the Text

Adat	Custom
Antik	Antique
Asing	Alien, foreign, strange
Asli	Authentic
Asuhan Persalinan Normal	A video training exercise to train bidan in safe delivery techniques
Bes praktis	Best practice
Bidan	Biomedically trained midwife
Bhinneka tunggal ika	Unity in Diversity – the Indonesian government motto
Bidan di desa	Midwife of the village. The name of the position created by the Government of Indonesia program to place "skilled birthing attendants" in rural areas who could act somewhat autonomously
Bupati	The administrative head of the kabupaten (district)
Camat	The administrative head of the kecamatan (sub-dsitrict)
Desa	Village
Dewan Perwakilan Rakyat Tingkat II	The legislature of the kabupaten
Dukun	Shaman
Dukun bayi	Shaman midwife. In Lunyuk the term dukun beranak was used more often than dukun bayi. Dukun bayi is more commonly used throughout Indonesia
Dukun bayi liar	A dukun bayi who has not taken the government training program
Dukun bayi terlati	A dukun bayi who has taken the government training program
Dusun	Hamlet
Gerakan Sayang Ibu	Mother Friendly Movement – a program of reproductive health developed in the Suharto era, around 1996
Ilmu	Specialize knowledge set. Used to describe magic or science
IMR	Infant mortality rate
Kabupaten	The regency or district, i.e. Sumbawa
Kebudayaan	Culture – most often used in the sense of culture used for political pageantry
Kecamatan	The subdistrict, i.e. Lunyuk
KIA	Kesehatan Ibu Anak – the reproductive program of the government of Indonesia public health system
Obat persalinan	Delivery water
Otonomi daerah	Regional autonomy – After the Suharto regime lost

	power there was a shift to give provinces more autonomy from the central governement
Maju / kemajuan	Progress – used as development terminology
MMR	Maternal Mortality Ratio
Moderen	Modern
Pembangunan	Development
Polindes	Bidan sub-clinic
Posyandu	Integrated health post – a mobile clinic that arrives in neighborhoods to give vaccinations and encourage women to receive prenatal care
Posyandu Kader	Group of women charged to help run the posyandu
Primitif	Primitive
Puskesmas	Government clinic – An acronym from Pusat Kesehatan Masyarakat
Puskesmas kelining	
Pustu	Sub-clinic
SMI	Safe Motherhood Initiative – International reproductive health initiative that is the guiding body for reproductive health programs in Indonesia
Suami Siaga	Alert Husband – a reproductive health program developed to involve husbands in caring for their pregnant wives
TBA	Traditional birthing attendant
Warung	

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