At Home or in a Clinic: An Ethnography of Trust Construction and Risk Calculation in Indonesia's Maternal and Neonatal Development*

Arryman Fellowship Paper
May 2017

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Abstract

This paper explains the gaps inherent in a maternal and neonatal health intervention program in the eastern part of Indonesia, East Nusa Tenggara. A foreign-funded program, called Revolusi KIA, focused on women using a professional health care provider in a facility rather than continuing to use a traditional birthing attendant (*dukun*) to deliver their babies. In practice, some women preferred to give birth at home with help from *dukun* even though the government uses fines and punishments for every birth occurring outside the clinic. This paper argues that the government's approach focuses on reducing risks to mothers and babies, while pregnant mothers are focused on delivering their babies under conditions that they know and trust. The government's framework, in fact, neglects significant aspects of historical intervention programs, perpetuates health risks, and disrupts the established socio-cultural relationship among women, frontline health apparatuses, and *dukun* in the local community.

Keywords: *maternal and neonatal health, trust, risk, development, Indonesia*

* This paper is a preliminary draft of an Arryman Fellowship – EDGS working paper. Parts of this paper, general background of Revolusi KIA's design and programs, constitute the final paper for a class on "Reproduction and its Regulation Across Time and Space" at Northwestern University. Historical contexts, argument, and analysis of trust and risk within the development program are new. This work was conducted under the auspices of an Arryman Fellow award from the Indonesian Scholarship and Research Support Foundation (ISRSF) and its benefactors: PT AKR Corporindo, PT Adaro, PT Bank Central Asia, PT Djarum, the Ford Foundation, the Rajawali Foundation, and the William Soeryadjaya Foundation. The research opportunity would not have been available without support from Australian Indonesian Partnership for Maternal and Neonatal Health (AIPMNH), and the research team for the study of "Perceptions and Expectations of Maternal and Neonatal Care: Views from Patients and Providers in Indonesia."

INTRODUCTION

Giving birth is potentially dangerous for both infants and mothers. Even if we assume that pregnant women are in the best health condition or have a high quality of care, they are still at risk of dying from the childbearing process. Globally, the Neonatal Mortality Rate (NMR) in 2015 was 19 per 1000 live births, while the Maternal Mortality Rate (MMR) was 216 per 100,000 live births.[1] Indonesia's performance in maternal health care has been improving during the last quarter century. In Indonesia, the national averages in 2015 were an NMR of 23 and an MMR of 126.[2] In the eastern part of the country, known as East Nusa Tenggara, the story is similar. In this poor and rural region, the average NMR is 11 and the average MMR is 133.[3] This paper will examine the strategies of the Indonesian government to address this problem in East Nusa Tenggara and explain why those strategies are failing.

The central argument of this study has two related dimensions. The first is that the government's approach to addressing infant and maternal mortality focuses on the notion of reducing *risks* to mothers and babies by trying to push pregnant mothers to use modern clinics rather than traditional (semi-mystical) healers known as *dukun*, while pregnant mothers themselves are focused on delivering their babies under conditions that they know and *trust*. This gap in understanding on the part of the state, between notions of risk and trust, has deadly consequences for thousands of babies and mothers in poor areas of Indonesia every year. The second dimension is that the state's approach is technocratic and *institutionalized* (and thus impersonal), while the mothers' rely in times of threat and crises on *personal networks*. The government's approach to

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[1] https://data.unicef.org/topic/maternal-health/maternal-mortality/ Accessed Wednesday April 26, 2017 at 11:13 am.

[2] http://data.worldbank.org/indicator/SH.STA.MMRT?locations=ID Accessed Wednesday April 26, 2017 at 11:59 am.

[3] http://www.depkes.go.id/resources/download/profil/PROFIL_KES_PROVINSI_2015/19_NTT_2015.pdf Accessed Tuesday March 17, 2017 at 11:43 pm.

saving mothers' and infants' lives is a matter not just of urging or even forcing women to go to modern clinics, but of getting them to shift from personal networks to impersonal institutions. I am not interested in prescribing solutions to this development problem; what I intend is to present the problems of development itself that intervene in women's social lives by asking about how and why they make the choices they do in potentially dangerous moments like childbirth.

The state-initiated project named *Revolusi Kesehatan Ibu dan Anak* (Maternal and Neonatal Health Revolution: Revolusi KIA) was formally in existence from 2009 to 2015 but various practices are on-going. The program advocated a modern and biomedical approach to reducing maternal and infant mortality by redirecting women in 14 districts in East Nusa Tenggara to use a health care facility to give birth (AIPMNH 2014; Department of Health Nusa Tenggara 2009). The program received financial support from the government of Australia and operated with assistance from the Australia Indonesia Partnership for Maternal and Neonatal Health (AIPMNH).[4] The implementation of the program was protected by the enactment of the Governor's Regulation No. 42 year 2009.

Revolusi KIA provided women with incentives to persuades to give birth at a clinic. At the same time, it punished both mothers and *dukun* who violated the governor's rule by continuing home-birth practice. The on-going fine for mothers is 1.000.000 IDR or 76 USD; it is 500.000 IDR or 38 USD for traditional birthing attendants who help the process at the mother's home. This fine is beyond the means of most poor people in Indonesia who live on barely for 2 USD a day (Pisani et al. 2016:2). While the government interpreted women's continuing to give birth at home as resistance, I contend that it reflected problems in the program. While, development programs are

[4] https://www.oecd.org/derec/australia/48473777.pdf Accessed Tuesday March 17, 2017 at 12:24 pm.

often viewed as the ultimate strategy, to overcome problems of inequality, women's response to Revolusi KIA belies the notion that universally technical solutions are always effective.

My involvement in the issues of maternal and neonatal came from my previous role as an independent research consultant in a study aimed at understanding both patients' and providers' perceptions and expectations of maternal and neonatal care in 2015. I conducted research in Sumba Barat and Manggarai, two regencies in East Nusa Tenggara that are part of AIPMNH areas of intervention. I stayed in four villages: two in Manggarai District, Posamo and Tandima[5]; and the other two in Sumba Barat District, Lolimo and Lokomi. Every two villages represent a coverage area of service from one *Pusat Kesehatan Masyarakat (*Primary Health Clinic; *Puskesmas).* The ethical clearance of the study was granted from Australian Indonesian Partnership from Decentralization (AIPD) codes of conduct. My previous role was what in this paper I refer to as the so-called "expert" or technocrat, which is part of a broader category of development agents in general. The research occurred over 110 days, including writing the final report. The ethnographic process took much longer, however, in line with my changing positionality.

This paper consists of five sections. The first section provides historical and contextual background for the arguments I will develop. It begins by tracing historical projects in East Nusa Tenggara. Later, using the definition of access proposed by Penchansky and Thomas (1981), I challenge the claim that Revolusi KIA provided better access for women to use health care facilities. Their definition, which includes availability, accessibility, accommodation, affordability, and acceptability, has been widely used to design modern health care policy (McLaughlin and Wyszewianski 2002). I come a conclusion that it is problematic to consider Revolusi KIA as an effort of providing access to health care for rural women in the province.

[5] Names of interlocutors and villages in this paper are under pseudonyms to protect their identities.

Section two presents the theoretical foundation of the paper which draws upon and expands the concepts of trust and risk in the setting of a development project. I examine trust as a dialectic between *trust as a category* (Mythen 2004) and *trust as a process* (Khodyakov 2007). From this perspective, trust performs its utilitarian effects to bind social relationship and is shaped by people's creative construction in understanding social and cultural change in their surroundings. Development brings different perspectives, in a reshaping of trust, toward a modern institution. Furthermore, the notion of risk in development programs differs from that of women in precarious health situation. Programs see risks as biomedical requiring the application of rigid system of clinical knowledge. Women in contrast see it in a broader social and economic context. *Clinical governance* (Brown and Calnan 2009) explains the bureaucratization of technical suggestions such as rules, guidelines, and strategies proposed by experts.

The main argument in section three derives from understanding that women's trust in *dukun* (traditional birthing attendants) is not only situated in a social network but also is a by-product of an historical trace from various preexisting development projects in the province. Although this trust can be challenged by a new intervention program like Revolusi KIA, the quotidian relationship among women, *dukun*, and frontline health personnel still contributes to women's decision-making of how and where to giving birth.

In section four, the inherent objective of Revolusi KIA is revealed as a broader target of a development agenda than maternal health care provision alone. I argue that bureaucratic and technocratic procedures in Revolusi KIA—which neglect factors that are immeasurable but very significant for both women and midwives (*bidan*)—are in fact a mechanism through which technocrats and development agents try to protect the program. My argument unravels the purpose of the state's risk calculation, showing that its goal is not aimed precisely toward overcoming

maternal and infant deaths. I support this argument through examining the impacts of delayed funding; particularly by creating medical equipment shortages and postponed salary for health care providers. In the end, such limitations perpetuate trust in *dukun* as a reliable resource, *bidan's* dependency on *dukun* for support in their jobs, and the use of informal payments as a way to receive basic care from the state. Lastly, in section five I provide my initial conclusions and suggestions for future research to develop and expand my preliminary findings and arguments.

I. BACKGROUND AND CONTEXT

This background describes the history of intervention programs in East Nusa Tenggara. It provides an understanding of the ways in which local community including the desire to improve the local condition, is always related to global political issues. I refute the presumption of tradition as a bounded category. Although, we tend to think that tradition is the fundamental basis for women to trust *dukun*, we should consider historical traces of preexisting events. In the second part of this background, I examine Revolusi KIA claims of providing women with access to health care. I utilize the framework of access defined by Penchansky and Thomas (1981) that has been widely used as a standard for proposing health policy.

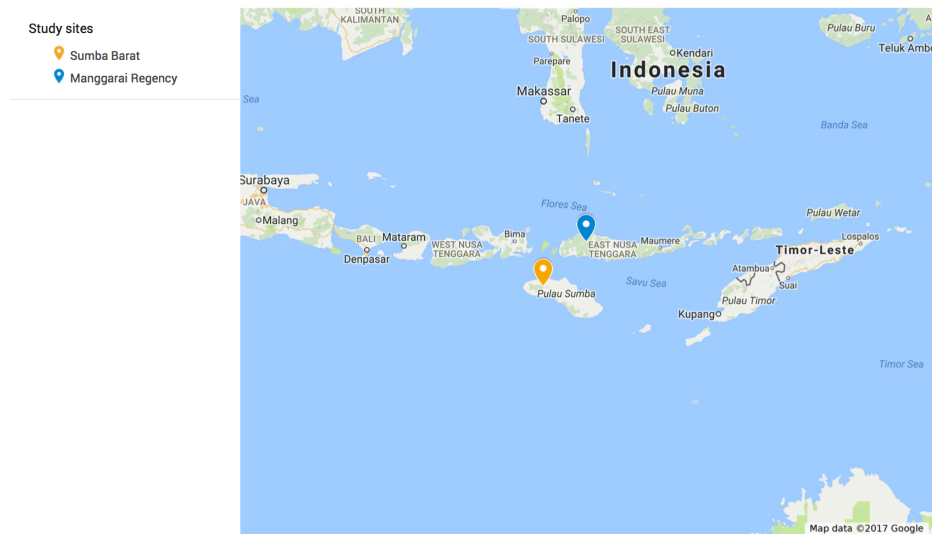
I. A. Historical Assemblages of Development Programs in East Nusa Tenggara

The province of East Nusa Tenggara is located on an outer island of Indonesia. Many people identify the province with social issues including poverty, health, and education. That public assumption is not new; in fact, association between East Nusa Tenggara and the so-called problems of development has existed since the country's independence (Webb 1989). Van Klinken and Aspinall (2014) offer three main factors that they believe explain these social condition. First, infrastructural development is concentrated in the central island of Java, leading to the eastern region of Indonesia (including East Nusa Tenggara) to have "a less developed transport hierarchy" (2014:6). Second, only few people have the material power to be able to exert much influence in the heartlands, and few institutions connect eastern politicians with Java's central powerful actors. Third, different cultural elements such as language, religion, and lifestyle contribute to the eastern region's unawareness of "the world on the other side" (ibid.:9-10).

During the late colonial period (late 1940s), the central government of the Netherlands East Indies left the island of Timor in East Nusa Tenggara underdeveloped and neglected (Webb 1989:152). Immediately after the World War II, the first intervention programs were largely church-run efforts, initiated by the Bishop of Larantuka, focusing on “village socio-economic development projects”, as a response to a long crisis from periodic local famine (*zaman lapar)* (Ibid:154). The Catholic church felt it necessary to participate "in a sustained and planned socio-economic development, under which agricultural advisers and experts, hygiene supervisors, builders, teachers, education advisers and economists, together with financial aid from more affluent Europe, would all work within a framework designed to raise the economic expectations of subsistence farmers in N.T.T [East Nusa Tenggara]" (Ibid). This historical background provides a broader landscape of various intervention initiatives in the province that appear as a common mechanism to engineer the social relation of the society.

1. Map of Indonesia

East Nusa Tenggara



Source: google maps

The impacts from social engineering programs that started in the early colonial era were influential in providing the people of East Nusa Tenggara with public services that were unavailable from their own livelihoods. Further, it accustomed them to the presence of development apparatuses in every aspect of their lives. The assemblage of knowledge and practices introduced to the society has relied on the same mechanism, which is to restore community through the reconstruction of the social relation in the village (see Li 2007:230). For instance, the 1954 Flores-Timor Plan intervention, a German funded program for agricultural development, provided knowledge and techniques for modern agriculture (Webb 1989), followed by a Catholic credit union. The assemblage of knowledge and practice about modern agriculture was designed not only to change agricultural practices, but also to reshape the social relation into a new form. To move the community from subsistence into a modern farming system meant changing the habits of the farmers regarding where and how the new techniques would be used. Such a change, was thought would substantially transform the interactions of the farmers with the people from whom they got seeds, the irrigation manager, and the consumer of their produced goods. The development

program was inadequate because farmers preferred to continue raising the cattle of local Chinese businessmen rather than starting a modern permanent agricultural system on land not inherently rich in nutrients (Webb 1989:161). Local communities have been accustomed with the existence of social engineering programs. Thus, people's traditions and habits have been coalesced with modern values imbricated through the long history of development projects in their environments. Assessing Revolusi KIA, I contend, requires the awareness of this enduring entanglement with the development projects.

I. B. Revolusi KIA: Providing Access to Health Care?

This section will point to the logic underlying the goals of Revolusi KIA for rural women in East Nusa Tenggara. This background is crucial for understanding if the state's concept of access meets women's needs. According to Penchansky and Thomas (1981:128), five factors that are included in access are: availability, accessibility, accommodation, affordability, and acceptability. The concept of access is ill-defined, although it is indeed important to understand access as an operational idea to measure the 1) utilization of service; 2) clients' satisfaction; and 3) providers' practice patterns (Ibid:130). In this chapter, I attempt to illustrate how the purpose of Revolusi KIA was to give access to maternal health eliminate the social, political, and historical contingencies in women's lives.

The fact that many people suffer and die even when health care services exist in a community is common in developing countries (Biehl 2013; Heggenhougen 2009; Wildman 2004). In reproductive health, less than half of pregnant women in South Asia receive an antenatal care check-up and only one-fifth of births are assisted by medical professionals (O'Donnell 2007:2821). Providing health care is not the same as making access available. Therefore, I assess

Revolusi KIA using the five dimensions of access provided by Penchansky and Thomas (1981). I argue that the existence of the program supports the idea of providing health care for women. Yet, that health care is still inaccessible because the services fail to facilitate their use, let alone to consider women's satisfaction or to provide a devoted health care professional.

According to a report published in 2012 by the United Nations International Children's Emergency Fund (UNICEF) Indonesia, the neonatal mortality rate in East Nusa Tenggara is the fourth highest among provinces.[6] Because the rate failed to decline significantly after massive intervention in 1989, the assumption has been made that deliveries happened with help from the *dukun* outside of clinics (Health Department of Nusa Tenggara 2009). Therefore, the guideline of Revolusi KIA declared that the province needed revolutionary and extraordinary efforts to develop a 24-hour walk-in clinic as well as the availability of trained midwives (Ibid). Trainings on essential obstetric and neonatal services for health care providers would define whether a primary clinic held the status of PONED or PONEK for a hospital.[7]

In 1989, the government of Indonesia started an intervention program for maternal and neonatal health by focusing on the provision of health workers at the village level (Titaley 2010:2). One of the target goals was to distribute at least 50,000 midwives in villages all around Indonesia by 1996 (Geefhuysen 1999). Although efforts at improving access to health care were massive, disproportion in midwife distribution and shortages in health personnel were a large problem (Makowiecka et al. 2008:68). Therefore, trainings to comprehend the health providers' skills and knowledge are embedded in Revolusi KIA. However, the distribution of health care professionals

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[6] https://www.unicef.org/indonesia/id/A5_-_B_Ringkasan_Kajian_Kesehatan_REV.pdf Accessed Friday March 24, 2017 at 4:54 pm.

[7] PONED stands for *Pelayanan Obstetrik Neonatus Essensial* Dasar (Primary Obstetric and Neonatal Services). PONEK stands for *Pelayanan Obstetrik Neonatus Emergensi Komprehensif* (Comprehensive Obstetric and Neonatal Emergency Service).

remains imbalanced among villages. According to Penchansky and Thomas (1981:128) the first taxonomy in defining access is to consider the element of *availability* which deals with both health personnel and the facility. Generally speaking, Revolusi KIA provides access as the *availability* of both health personnel and the facility for maternal care.

Second, access must be assessed from its *accessibility* (ibid) which considers the location of a facility, travel time, and patients' resources for transportation. Revolusi KIA provides ambulances to transports mothers from their homes to the primary level clinic (*Pusat Kesehatan Masyarakat*: Puskesmas). In Puskesmas Malata, the funding from AIPMNH gave the clinic one additional new ambulances to enhance their performance in helping women to go to the clinic. Ambulance services are covered for people who are under the insurance of *Jaminan Kesehatan National* (National Health Insurance: JKN).[8] In this sense, poor communities receive free ambulance service as part of their state-funded services (Mclaughlin and Schun 2015:18).

Despite the existence of ambulance services, the ambulance is not available 24 hours a day and gasoline is not always available. Women from the village can reach Puskemas by public transportation but that also is not available 24 hours a day. In some cases, a husband must rent a motorcycle to get his wife to the clinic through a bumpy road in their neighborhood. In Posamo, the village head helps to arrange a rented car owned by one of his people. The cost for renting this car is about 250,000 IDR or about 20 USD. Lena, a mother from Tandima Village, told me that she was lifted by her relatives onto a palanquin to go to the clinic.

Accommodation relates to how long a patient receives care by health care professionals (Penchansky and Thomas 1981:129 see also Simon et al. 1979). During the delivery process, women spend more than one day in the clinic. This is in line with the World Health Organization

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[8] JKN is a single-payer insurance under the management of a state-enterprise body, *Badan Penyelenggara Jaminan Social* (Social Insurance Body; BPJS). (Pisani et al. 2016:6)

(WHO) guideline that says at least three postnatal examinations are crucial to save both mother's and baby's lives (WHO 2013).[9] The first examination is during the first six hours after birth, the second is between days 4 and 18, and the last is within 42 days of the birth (McLaughlin and Schun 2015:42).

Because it is important to conduct a health examination during the first six hours after birth. Revolusi KIA built maternal waiting houses for relatives who accompany mothers before, during, and post-natal periods. The maternity waiting houses were built to support the implementation of the 2H2 system, which requires women to stay at a primary health clinic for two days both before the due date and after childbirth. By providing the maternity waiting houses, the program acknowledges the importance of accommodation for women to be able to deliver a baby at a facility.

Further, financial support for health care has complemented the maternal health program since 2005. As part of the national program, poor families can access health care services free of charge through a tax-funded insurance program (International Labor Organization 2013).[10] Since 2014, the JKN has been providing free service for pregnant mothers on the poverty lists; JKN also sets delivery costs for public patients. Primary clinics in Manggarai regency charge 600,000 IDR (50 USD); primary clinics in Sumba Barat charge 350,000 IDR (30 USD) (McLaughlin and Schun 2015:54). These delivery costs are, in fact, far higher than the routine household expenditures for the majority (38.35%) of families in East Nusa Tenggara which are only around 300,000-499,000 IDR (23-38 USD) per month (East Nusa Tenggara Statistics Bureau 2016).[11] The *affordability* of

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[9] http://apps.who.int/iris/bitstream/10665/97603/1/9789241506649_eng.pdf Accessed Saturday, April 29 2017 at 11:16 am.

[10] http://www.ilo.org/dyn/ilossi/ssimain.viewScheme?p_lang=en&p_scheme_id=3146&p_geoaid=360 Accessed Thursday, November 17 2016 at 08:04pm.

[11] http://ntt.bps.go.id/backend1812/pdf_publikasi/Provinsi-Nusa-Tenggara-Timur-Dalam-Angka-2016.pdf Accessed Saturday, April 29 2017 at 12:03 am.

the health care service is acknowledged by Revolusi KIA as important in making it desirable for women to give birth at a clinic.

In addition to these government subsidies, the Health Department, according to officials I interviewed, provides an incentive of as much as 250,000 IDR (20 USD) per delivery to support a family in buying their newborn baby essential needs such as clothing, soap, and blankets. This additional aid is designed to attract women to give birth at a clinic, although none of mothers I interviewed had heard about this money. This situation reflects that information is also essential for women to have access to health care, but the state has failed to address this type of access when they designed Revolusi KIA.

Lastly, *acceptability* describes the patients-health providers' relationship regarding attitudes toward "provider personal characteristics" and "other characteristics of the provider's practice" (Penchansky and Thomas 1981:130). This dimension of access is the one which makes this study about Revolusi KIA particularly interesting. Revolusi KIA contains no mention of the relationship between service providers and mothers. Thus in designing Revolusi KIA, the state touches all the operational idea of access mentioned by Penchansky and Thomas (1981) except for acceptability.

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Government claims that Revolusi KIA provides access to maternal health care are inconsistent with Penchansky and Thomas' definition of access. In the setting of a development program, availability, accessibility, accommodation, affordability, and acceptability serve an important function in making women willing to utilize the service. As Penchanksy and Thomas (1981:131) note in their fundamental explanation about access in public health services, patient satisfaction is the key to measure if the health care is truly accessible. The lack of *acceptability* suggests that Revolusi KIA does not provide women with full access to health care.

II. THEORETICAL FRAMEWORK

II. A. Trust as Historical, Social, and Economic Construction

To understand women's decisions regarding where and from whom they desire to get assistance for giving birth, I draw attention to the notions of trust and risk. Trust can be understood in at least two ways: as a category (Mythen 2004) and as a process (Khodyakov 2007). For the purpose of my argument, I examine trust as a system of cognition that incorporates social, cultural, and historical conditions as a resource for human action. As a category, trust entails a particular series of factors that include "authority, perceived ability to act, previous competence and informational credibility" (Mythen 2004:152). Understanding trust as a category means, according to Khodyakov, to perceive the concept in a utilitarian form as a "medium" or "glue" that binds both social relationships and societies. Also, considering trust as a process allows me to understand its underlying fundamental elements (Khodyakov 2007:125). Further, he proposes

> "[t]rust is a process of constant imaginative anticipation of the reliability of the other party's actions based on (1) the reputation of the partners and the actors, (2) the evaluation of current circumstances of action, (3) assumptions about the partner's actions, and (4) the belief in the honesty and morality of the other side" (Khodyakov 2007:126).

I consider trust in my study as an interrelated category and process. On the one hand, it holds together social relationships between women and *dukun*. On the other hand, it explains the foundation that produces it—such as historical contingencies, personal agency, and infrastructural conditions surrounding women's lives—as a process of constant imaginative anticipation of the reliability of *dukun*. This dialectical relationship between the utilitarian and the process of trust is beneficial not only for examining the process of reasoning by which women trust *dukun* but also for providing a perspective on the affects historical programs and the political economy of East Nusa Tenggara.

Trust is not merely an autonomous system of cognition (see Fukuyama 2001).[12] Trust is always attached to the social, economic, political, and historical contingencies surrounding the lives of the pregnant women. Trust functions to direct human beings' conduct in circumventing problems beyond their capacity to overcome yet requiring the confidence to leave solutions to others' capacity. For women to trust another person's capacity to overcome their uncertain condition they must understand the person's ability and credibility, an understanding gained from the women's personal contacts.

Trust is not a given state; it is actively reconstructed by both internal and external factors. For Simmelian, the notion of trust stems from human "experience" towards the interpretation of the life-world (Möllering 2001:412). Since experience shapes trust, Möllering (Ibid.:414) explores the element of suspension discussed by Giddens (1991) as "…the mechanism that brackets out uncertainty and ignorance…." The suspension is pivotal to making an "interpretative knowledge momentarily certain" that can enable "the leap to favourable (or unfavourable) expectation" (Ibid). When women trust *dukun,* their decision is processed through their interpretation of both their direct and their indirect experience such as from their relatives and neighbors. Unknown future danger related to giving birth at home is bracketed out, and therefore women feel confident to put their lives in the hands of *dukun. In* addition, according to Luhmann, "individual trust takes into account both past experience and the associated risk involved in the decision to trust…" (in Meyer et al. 2007:181). Thus, when a woman decides to give birth at home, she relates to her past experience with *dukun* and pushes out uncertainty about all the sanctions declared by Revolusi KIA.

[12] In Fukuyama's (2001:479) conference paper on trusting, he argues (as do other scholars) that trust "is a psychological state that is epiphenomenal to the more basic concept of social capital."

Furthermore, the relation between trust and experience is linked to a "particular cultural and historical condition" (Mythen 2004:151). An ethnographic study by Vanessa Hildebrand (2012) found that the existence since 1984 of village clinics on Sumbawa Island, West Nusa Tenggara was inadequate in serving people through biomedical system of health care. Her ethnography suggests that the limited availability of the clinical health care system made possible "relationships that accommodated local social and hierarchical structures as well as an open combination of the biomedical with the local folk medicine in terms of religious traditions, the herbal with pharmaceutical medicines, and local healing practitioners with biomedical care" (Ibid.:560). Historical inclusion, since the 1980s, of *dukun* in the development discourse regarding Indonesia's health care system (Stein 2007:63) is imbricated with tradition and trust for their power and capacity to help women to deliver their babies. The underlying argument in favor of the historical context I have mentioned illuminates that trust on *dukun* is part of social reconstruction rooted in previous development programs.

Studies have analyzed the concept of trust in both interpersonal and institutional domains (Lee and Lin 2011; Brown and Calnan 2009; van der Schee et al. 2007). As I have explained earlier, women's trust in *dukun* is situated within social relationships. *Dukun's* roles and status are interwoven in social and cultural relationships. Their reliability as traditional health care providers cannot be separated from the fact that women face socio-economic struggles. In the government's effort trying to achieve a modern system of health care, women face several obstacles. These barriers include additional informal payments in accessing services in the clinics that are beyond what most families can afford, geographical distance which makes travelling during labor dangerous, and health care professionals who are overworked and set aside the importance of meaningful contact with their patients. These intricate uncertainties for sets of medical clinics

promote precarious life in the public services. In this kind of precarious condition, women's perception about pregnancy risk—according to biomedical standards—is expendable. *Dukun*, because they are part of the community (sometime they have familial ties) understand these condition, and to help women in this kind of situation is sometimes part of "the calling" for their God's gift.

The following sub-section explains the conceptual framework behind the process of moving interpersonal trust in *dukun* to institutional trust in clinics and health professionals. The government and development agents design sets of rules based on their calculation of risk. A characteristic of development practice is that the authority of experts allows them to define risk and propose preventive action accordingly. My framework proposes that risk calculation is done not to avoid pregnancy risk for the mother but instead to secure Revolusi KIA as a development institution.

II. B. Institutional Trust and Risk in Clinical Governance

The aim of Revolusi KIA to make all pregnant mother to use a clinic reflects an effort to transform interpersonal trust in *dukun* into "public trust" (van der Schee et al. 2007) or "institutional trust" (Meyer et al. 2008). This transformation, according to Giddens (1991 in Meyer et al. 2008:181) represents broader phenomena in which trust becomes a fundamental "medium of interaction between modern society's systems and the representatives of those systems." Revolusi KIA in this sense can be understood as a modernization process in which the state apparatuses try to shift women's trust from *dukun* to the health care system. Efforts to make women trust *bidan* is a challenge to women existing trust in *dukun.*

In order to gain women's trust for a modern health care system, the utilization of "expert rationales" (Li 2007:16) is crucial. Deborah Lupton (1999:59-60) explains that a pregnant mother carries "a complex network of discourse and practices directed at the surveillance and regulation of her body…she is rendered the subject of others' appraisal and advice." In Revolusi KIA, trust in the medical system is determined based on a risk calculation by the expert. Advanced techniques to assess reproductive health risk emphasize an element of uncertainty that is limited to two types of risk knowledge: "clinical risk and epidemiological risk" (Ibid:63). Allowing pregnancy risk to be defined by these restricted biomedical perspectives means the mother's ascribing knowledge about being pregnant to a few people who act as the experts. The experts search for reasons behind the risk-taking action and then dictate rules and actions that need to be taken in order to avoid negative impacts for the baby and the mother.

The experts indeed possess qualification, credibility, and legitimacy vis-à-vis the knowledge being imposed, based on their training.[13] But the adverse effects of following experts' suggestions in the context of rural Indonesia include women's becoming detached from their significant social, cultural, and historical relationships in their communities. Although some experts are fully aware of these factors, their professional role mandates them to propose solutions according to their expertise.[14] In that sense, when development experts address pregnancy risk,

[13] I make a connection between a few people that I call the experts in my ethnography with Scott's argument (1998:269). He argues that an implication of following prescriptions from a few individuals who are considered reliable to overcome social problems is a tendency to direct action into a mere simplified solution. However, this point implies the existence of a "complete" solution that might help to overcome problems of development. My argument goes beyond this examination. Based on my observation, what happened in Revolusi KIA shows that the solution provided by the expert's rules is often very different from what the women consider the problem. This fundamental difference in viewpoints leads to an inability to reach consensus. Thus, the expected transformation becomes significantly costly, it requires either violent conduct or political maneuvering to justify that a further strategy is needed to achieve the experts' suggestion.

[14] Mitchell (2002:41-42) argues that experts' intervention in development has led to the emergence of "new politics based on technical expertise" in neoliberal Egypt. First experts propose technical knowledge based on pilot projects, then reformulate the design of their previous solutions, and finally set aside fundamental difficulties or represent them as "the improper implementation of the plans."

they simultaneously eliminate particular elements in women's lives that they consider (wrongly) to have no relation with pregnancy risks (see Li 2007:17). Similarly, reproductive health risk generally identifies women as "a single, universal 'risk group,' defined by reproductive biology epidemiology, [that] seems to ignore…social realities of gender [that] manifest themselves in women's bodies" (van der Kwaak and Dasgupta 2006:22). The experts' narrowly defined pregnancy risks treat pregnancy as "calculable and governable" (Lupton 1999:63); in fact, this paradigm approaches maternal and neonatal health care as impersonal and institutionalized required actions.

In maternal and neonatal health intervention, social ties that help pregnant women overcome feelings of uncertainty become meaningless. Yet Bledsoe's (2002:25) study among rural woman in Gambia found that "the success with which a woman can prevent or contain future bodily harm depends on her investing broadly and deeply in social relations." By neglecting women's socially invested relationships, Revolusi KIA appears to be very problematic. The shift is not simply moving women to a new system of health care that is probably safer, cleaner, and nicer—from the development perspective—but is instead positioning them against the socio-culturally normative conditions they usually count on for help. In general, Revolusi KIA tends to render irrelevant the personal relationship between woman and *dukun* as a significant element in women's risk-taking behavior that may, however, explain their decision to give birth at home.

Literature focusing on trust note the relationship between trust and risk (Samimian-Darash and Rabinow 2015; O'Malley 2015; Mythen 2004: Beck 1994; Giddens 1994). Meyer argues, "[r]isk is an important aspect of trust because it adds another aspect to partial understanding" (Meyer et al. 2007:181). To be able to trust health care professionals as a modern biomedical apparatus, women need to be exposed to notions of pregnancy risks that from their experience

appear strange, and thus in the modern domain, there is always an infinite partial understanding regarding pregnancy risks.

Further, Lupton (1999:61) argues, "[t]o be designated 'at high risk' compared with others is to be singled out as requiring expert advice, surveillance and self-regulation." The concept of 'high-risk' in Revolusi KIA focuses on where the birth is done as the main pregnancy risk. Furthermore, risk calculation of defining pregnancy risks becomes a terrain for development agents to propose room for intervention. That is what Tania Li (2007:123) describes as "rendering technical": explaining a direct relation between the solution and the problems it will solve. In this sense, the mechanism to find what type of problems in development should be addressed is tied up with the available pragmatic solutions that the expert can suggest. The utilization of a risk paradigm then guides the whole approach to overcoming possible threats attached to the pregnant body. Women's feelings of precariousness and their social network in the community which influence their decision to give birth at home are considered realms outside maternal and neonatal health care.

The adverse results from rendering technical appear to be important in analyzing the relationship between women and health care professionals. As I have explained earlier, the existence of health care professionals is in fact not enough to make a pregnant mother trust the modern clinical system. Echoing Giddens, Meyer and colleagues argue that trust in health care institutions is determined by trust in health care providers as a representation of the institution (Meyer et al. 2007:181). Even when women encounter a health care professional monthly for antenatal care, the relationship is disrupted by providers' perceptions regarding "people's failure to understand what is good for them" (Li 2007:16). The government and development agents (including *bidan)* are characterized as parties who always know what is best for women, and the

health care professional will see a woman's failure to comply with Revolusi KIA's agenda as a matter of non-compliant actions.

In addition, development projects like Revolusi KIA are inherently vulnerable to creating their own sustainability. Therefore, "risk is applied as a basis of governance due to its apparent incontrovertibility and probabilistic acknowledgment of the potential for failure…" By defining the notion of pregnancy risk, government and development agents find their basis to govern women's conduct for self-regulating and following suggestions on risk avoidance. Failure to make women follow the rules can be considered failure to govern. This perspective is in line with Rothstein's argument that the logic inherent in risk regulation is directed toward "the minimization of risk" for the institution serving the people rather than the people themselves (in Brown and Calnan 2009:15). Therefore, to cultivate trust in the modern health care system, Revolusi KIA mandates women to act in accordance with risk-avoidance that inherently is directed not to assist the women but instead to secure the sustainability of the program and its success.

III. UNDERSTANDING WOMEN'S DECISIONS FOR THEIR MATERNAL HEALTH

III. 1. Background

The historical trajectories of development programs in East Nusa Tenggara, I argue, contribute to the construction of the trust of the role of *dukun* within the rural community. I base my logic on Li's argument that, according to her findings, various development initiatives have "left traces on livelihoods, landscapes, and ways of thinking" although one can barely find any program that successfully shaped people's behavior in correspondence with the program objectives (Li 2007:228). She argues, in addition, that the forms of agency expressed by the people are also shaped by the traces of preexisting assemblages of development programs (Ibid). In the ethnography analysis in this section, I will propose a way of understanding women's trust in *dukun* that is beyond tradition as a bounded category (see Wolf 2010). In fact, tradition in this ethnography rests on the apprehension of historical trajectories of global development programs that were introduced by state engineering interventions.

Later, I examine how maternal and neonatal health interventions contradict the existing social condition of rural women in Indonesia. The gap between the interventions and the social condition is shown through the everyday challenges that do not fit with the design of the program. I present the role of *dukun* vis-à-vis health care providers for women in East Nusa Tenggara, including the personal and horizontal relationship between mothers and the *dukun* that characterizes the existing community-based relationship. In contrast, I show how women's personal experience with an impersonal institution reflects a hierarchical relationship between mothers and the service providers. The scope of this study limits my analysis to Revolusi KIA although I will draw some historical explanations related to prior maternal health interventions.

III. 2. Traces of Historical Intervention Programs in East Nusa Tenggara

Maternal health care has been one of prominent targets for social engineering programs. Soon after Suharto's New Order regime began ruling Indonesia in 1965, development programs began to massively utilize modern discourse to conduct state development projects (Barkin and Hildebrand 2014:1109). The "modern way of life" interventions in maternal health programs has been mainstreamed since 1980; at that time, main basic health care for rural people was *puskesmas* (clinics), consisting of male nurses and a doctor who came only once in a while to the clinic (Hildebrand 2012:560). Therefore, in 1991, the Ministry of Health decided to focus on a *bidan desa* (village midwives) program (Barkin and Hildebrand 2014:1109). Due to the difficult of access to the remote *puskesmas,* one of the responsibilities of *bidan desa* was to build a partnership with *dukun* who were community members. At that time, the approach was reasonable because *bidan desa* had only limited power to provide services for all mothers in a village. Up to this day, *bidan desa* cover not only maternal care; in various areas they are, in fact, the main health care provider for all health problems.

In her ethnography, Hildebrand (2009; 2012) found that *dukun* have been central to village life. Without formal educational training, they were regarded as receiving their skills from God, thus carrying a great sense of the authentic (*asli)* and ritual knowledge of life events for the community (Hildebrand 2012:561). After *bidan desa* were stationed in the Tandima health post in 1991, a *dukun* named Bet took up medical training at Cancar Hospital[15] in 1992. As she proudly told me, "I was trained by Doctor Bachtiar, *Bidan* Aga, and *Bidan* Deta. They were all from Java, they were sent here just to train some *dukun* like me. It was thirty of us, we got scissors and boxes of handscoons [sterile gloves]."

[15] Private hospital located in Manggarai Regency with a range of service that includes Tandima village.

From Bet's experience, we learn that there was huge sense of necessity on the part of the state to incorporate biomedical discourse into the existing traditional performance of *dukun.* This incorporation, reported by Hildebrand (2012:561), signifies the shifting moment when *dukun* who formerly were known as people carrying a mythical power were transformed into a quasi-state apparatus as a medically-trained provider, or *dukun bayi terlatih*, involved in the "national duty" to help pregnant mothers.

After the early 1990s, *dukun bayi* and *bidan desa* started to develop partnerships to strategically help each other with their responsibilities. The role of *bidan* for reproductive health in rural areas of Indonesia, however, can be traced further back, to the early years of the New Order regime. With neo-Malthusian discourses spreading around developing countries globally, in 1968 Suharto, who was mostly enthusiastic toward the country's economic development, started to implement a national family planning program focused mainly on population control (Lubis and Niehof 2003). *Bidan* became the image of frontline health services for the family planning program which women considered to be *bidan's* specialty. *Bidan* held a highly critical role for assuring lowered fertility rates that would firmly support the agenda of the anti-natalist state: putting in IUDs and other semi-permanent contraception in women soon after a baby was born (Stein 2007:56).

The history of family planning in Indonesia, however, cannot be simplified to the successive birth control intervention per se. Critiques of family planning confront the narrow-minded goal of controlling population without an interest in providing sufficient health services and educational information (Sen 1997). Greenhalgh's (2010) study of China's tough one child - per couple policy documents a series of harsh enforcement methods backed by military support, involving forced abortion and contraception insertion in women's bodies. Similarly, in the 1970s,

in the national family planning program in Indonesia, state apparatuses were forcing the use of IUDs in order to achieve family planning targets. As one researcher has described, "[In] the presence of civilian, military, and police leaders, women were taken to a house in which IUDs were being inserted. They were asked to go in one door and put under very strong pressure to accept an IUD before they could leave by another door" (Warwick 1986:470). *Bidan*'s later conduct binds easily with this antecedent of aggressive reproductive policies and coercive practices in Indonesia's family planning program.

One day I met Ega, a forty-eight-year-old mother living in Tandima, who told me her experience related to contraceptive use. "Now we have *bidan* so we can get contraception practices, don't ask too many question. She is a fierce lady. Well only one *bidan* as I far as I can recall was truly a nice person, *Bidan* Dewi, she is not here anymore." This is an interesting reflection from Ega, as it not only tells about the character of *bidan* in responding to women's needs but also presents a division of labor in which the services women can get from *bidan* are not available from *dukun.* This division stems from women's understanding their changing social environment with the existence of *bidan* as service provider in their village. Because knowledge of *bidan* is dominated by their roles in family planning which is widely known as regularly incorporating violence in its practices—*bidan* are often associated with being terrible people who hold the power to control women's reproduction.

III. 3. Women's Encounters with *Dukun* and *Bidan*

In this sub-section, I explain women's relation with *dukun*. First, I illustrate the moment of trust-building that happens based on interaction in everyday life experience. Contrasting to the women-*dukun* relationship is women's experience when they encounter impersonal interaction

with *bidan*, particularly in events which are always situated specifically around clinical problems. The second analysis of this sub-section concerns patients' disappointment based on *bidan*'s attitudes and how it raises question in them about the capacity of health care.

III.3. A. When Women Choose to Give Birth at Home

Especially since the implementation of Revolusi KIA in 2009, *dukun* in East Nusa Tenggara pay careful attention to the limit of services they can provide for pregnant women. Bet realizes that helping the mother give birth at home may cause problems for both the couple and herself. However, she also realizes that her duty to help a mother is as a gift from God, and she would be a sinner if she denied the request of a mother.

Before various maternal health interventions came to East Nusa Tenggara, Bet's role was limited to assisting a mother to give birth at home and/or to give women prenatal massages. At that time, as a *dukun bayi terlatih,* her role as a birthing attendant was compensated by the government because she was part of the previous global health care program. Now that Revolusi KIA has a "*kemitraan bidan dan dukun"* (*bidan* and *dukun* partnership) she is not acknowledged as part of this new program. Once the program changed, systems that had penetrated within the society crumbled. Bet is aware that the system now being used in the state development project forbids her to assist a pregnant mother in the childbearing process because of Revolusi KIA. But to betray her responsibility is not her preference. "It really is depending on the mother's decision. I will get her with me to the village post clinic. It would be a sin if I could help (accompany women) but I didn't go. But if it is late at night and she can't hold to travel and she asks my hand to help, I can't refuse. I will help," Bet told me. Bet also admitted that she cannot reject the request of a mother who asks her help to assist the child bearing process at home.

When a woman gives birth at home, she may have a greater risk of postpartum hemorrhage and eclampsia (McLaughlin and Schun 2015), and data point to untreatable postpartum hemorrhage and eclampsia as key factors in maternal mortality in East Nusa Tenggara (Department of Health East Nusa Tenggara 2015). According to Revolusi KIA, a house is an insufficient setting for treating these severe conditions. A clinic is the safer place because oxytocin and magnesium sulfate (MgSO4) are more likely to be available, although in practice, health care professionals as well as the medicines are often only inconsistently available.

In Posamo village, Romi and Violina told me how desperate they were, waiting for about sixteen years to be able to have children in their marriage. When Violina was about to give birth to their first child, they went to Cancar Hospital. Romi and Violina decided to go to the hospital because the road to access *Puskesmas* Nanu was so bad. Their travel to Cancar Hospital is actually farther than to *puskemas,* but the road condition was much better for a pregnant mother. Although the couple had to pay more in this private hospital, at that time Romi thought it was the best decision they could make. Fortunately, when Violina had two later pregnancies, both these daughters were born at home. "My wife felt her tummy hurt, so we guessed it was about the time. I knew that I have to tell *bidan* in Puskesmas Nanu because we aren't allowed to get assistance from *dukun.* We waited quite a long time, none of them [*bidan*] showed up. So my second daughter was born in the hand of a *dukun*," said Romi. Despite their second daughter's birth at home with a *dukun*, their third daughter was born at home with help from *Bidan* Erlita—the village *bidan* stationed in the village health post.

Romi's and Violina's second and third daughters received different treatment from the state although both were born at home. Even though Romi went to *Puskesmas* Nanu to pick up one of *bidan,* the fact that the second daughter's birth was not assisted by a health care professional meant

she lost her right to receive a birth declaration letter which is required for obtaining a birth certificate. Because their third daughter was born with assistance from *a bidan,* she could receive the birth declaration letter from *bidan* who helped. Romi's and Violina's third daughter who was born at home with *bidan* could receive a birth declaration letter because *bidan* are the ones who hold the authority to issue it. *Bidan* did not punish the couple because both sides were "mutually noncompliant"[16] with Revolusi KIA rules.

Similarly, in the evening of April 8, 2015, my co-worker and I talked to two pregnant women in Tandima village. Winona and Yosefin are family connected. Neither has finished her third level of education (high school) and only Winona finished junior high school. Both are housewives who also work as subsistence farmers. Tandima village were chosen as our site because of the good reputation of its health post that we heard about both from the Health Department officer and the head of *Puskesmas* Nanu*.* There, *Bidan* Yana, twenty-six-years-old, had been working for four years in the village health post in Tandima village. Winona was eight months pregnant when we met. "I will deliver my baby in village health post with *Bidan* Yana, but if I have to go to *puskesmas*, just let me give birth here with my mama." Winona told us that her mother is also a *dukun*. Listening to Winona's make her point about her birth plan, Yosefin added, "here [in the village] we have difficulty if we are in labor in the middle of the night because there will be no midwife. She [*Bidan* Yana] told me, 'after 3 pm I won't be in the post,' that's that." In these situations, both Winona and Yosefin experienced feelings of uncertain because *bidan* is not always available in their critical moment of need.

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[16] This concept was presented in John James Kennedy 's talk, April 14, 2017, in the EDGS Speaker Series: "Society and Politics in the Asia-Pacific." Kennedy's talk was titled "Social Stability and Mutual Noncompliance: Cadre-Villager Bargaining at the Local Level." http://planitpurple.northwestern.edu/event/506503

Although the village health post originally was built to support the optimization of *puskesmas* which are mostly located far from people's neighborhood, in practice, people perceive the health post as the main health services available for them. The idea of shifting people's trust from traditional health practice to a modern system needs "…a process of constant imaginative anticipation of the reliability of the other party's action…" (Khodyakov 2007:126). Following Khodyakov's argument, I argue that the uncertainty of the availability of *bidan* in the village disrupts the trust-building process for the modern system. Even when *Bidan* Yana is considered a reliable person (according to Winona's opinion, for instance), the fact that she is not always available in the clinic leads to the services of the modern health system's being conceived as unreliable.

Moreover, Yosefin told us that all of her children were born at home with assistance from *dukun*. Her first and second experiences of giving birth at home, however, did not make trying the new health care system from *bidan* undesirable. In one of her routine antenatal check-ups, Yosefin was told she would be in labor on Sunday, October 25, 2014. She also knew Revolusi KIA guideline to go to the clinic two days before the due date (see section 1). "Two days before the due date I went to the village health post. I had a vaginal discharge at that day too, so I thought I needed to be in the health post due to birth symptom I had," she told us in our conversation. *Bidan* Yana asked her to go home because her visit was not for childbearing. Before Yosefin went home, *Bidan* Yana told her that unfortunately she would not be in the health post after 3 pm on October 25. Yosefin was confused because *Bidan* Yana did not mention when she would be available in the health post again. She knew that *Bidan* Yana always stayed at her parents' house in Manggarai city every weekend. "I had packed my stuff to prepare for my date of giving birth, but since she said that she won't be available, I finally thought that it would be better to give birth at home,"

Yosefin explained. Yosefin told us that when she and *Bidan* Yana met again, after the birth, for a monthly health checkup and immunization, at first *Bidan* Yana refused to give the immunization and contraception to her. Yosefin defended her rights by saying, "I was there and ready to give birth at the health post but you [*Bidan* Yana] said that you will be gone to the city by 3 pm." According to Yosefin, *Bidan* Yana was no longer mad at her after she explained the situation. Yosefin impersonated *Bidan* Yana's response, saying "Sister, it was a long weekend holiday (*tanggal merah*) when you gave birth."

Ethnographic details I have presented so far are in line with Pinto's findings in her study about maternal health development in India. In India, "[t]emporality is key to the health equation…" which means "…services, personnel, and reliability come and go," although hospitals may exist over a long-term period (Pinto 2012:17). As the frontline health provider, *Bidan* Yana is the only state apparatus representing the quality of health care who lives close to the society. But as a worker, she has rights to a day off and to enjoy her holiday with her two children. Although doctors who are stationed at the *Puskesmas* Malata and Nanu rarely fulfill their working schedule and prefer instead to spend most of their time in the city, *bidan desa* cannot have access to that privilege and must be at the clinics at least six full days. Moreover, since *bidan* Yana is the only service provider in that health post, she can barely close the clinic, except for holiday and during the weekend. Ironically, since she also has to fulfill her bureaucratic responsibility as part of being a state apparatus, the Department of Health demands that she to go to the city to submit her monthly report and to join a workshop or a training. Those times require the clinic to be closed because nobody can replace *Bidan* Yana.

III. 3. B. Disappointment and Bargaining of Trust

Coming from a well-off family in their village, twenty-four year old Julio, a public health-graduate, works on the administrative staff in *Puskesmas* Malata. His wife Ana began working as non-official staff at a sub- district office soon after she graduated from a private college, majoring in management information systems. Based on their story, Ana was experiencing a long labor. She arrived at *puskesmas* at nine in the evening, and every three hours, Julio called *bidan* to see if it was the time for delivery. Julio told me, “I am so disappointed with all of *bidan* in here. When Ana stayed in *puskesmas* and felt an extreme pain, I called them to visit and see my wife. But they did nothing. “They didn’t see my wife, they just stood in from the door and said that it wasn’t the time. They didn’t touch her! I really wanted to cry. Anna added, “*Bidan* always said it wasn’t the time, until at 6.30 am. *Bidan* panicked and told me to push or otherwise my baby will die. After I heard that my blood pressure increased, it was so intense.”.

After a long labor with placenta left in her womb, Ana was referred to Waikabubak Hospital in the city. From the beginning of the childbirth process, the couple was accompanied by a *dukun*. According to Julio, although he works at *puskesmas* he cannot trust *bidan’s* capacity to help pregnant women. Such judgement was based on his experience witnessing her wife’s suffering from receiving services from *bidan* who were his own co-workers. “They were not supposed to cut the umbilical cord if the placenta didn’t come out together with the baby. It means they cut the baby’s breath. *Dukun* knows such things, but *bidan* don’t,” said Julio, expressing his disappointment.

Their decision to bring *dukun* to the *puskesmas* was part of their reasoning to prevent bad things from happening. Especially since Ana always felt unfortunate when she had her monthly check-ups as part of her antenatal care. “One day she [*bidan*] told me that I would have twins, and

I felt so happy about that. At the next checkup she told me that my fetus was not growing well, the baby has no head they said!" Ana complained. Her mother in-law sent her to meet a *dukun* named Nandayo who told Ana that her baby was okay. These experiences taught the couple that *bidan* cannot provide reliable services and information. Therefore, the presence of *dukun* was to give this couple a sense of safety. *Bidan*'s failure to provide comfort during prenatal care contributed to convincing them of the legitimacy of *dukun's* power and capacity.

In contrast with Julio and Ana who felt indebted and fully trusting in *dukun* even though their baby was born in the modern health care system, Teri, a twenty-eight-year-old with four children gave birth at home. *Bidan* Erlita told me that Teri is one of the pregnant women in Posama village who are never absent from their three antenatal care visits. At that time, *Bidan* Erlita was sure that Teri would give birth at the village health post. Teri said, "It was four in the afternoon and I was alone because my husband worked at Labuan Bajo.[17] At that time, when I felt the pain, I just knew that I was about to give birth. I asked my relative to run and get *dukun* here. She is my relative so I did not need to worry about giving her stuff right away. At five pm my baby was born." For Teri, attending antenatal care is one of the ways she can receive vitamins and food supplements for free. During her pregnancy, when her husband worked far from their village, being active in routine prenatal check-ups helped her to monitor and maintain her health condition. Without her husband and since they live in *virilocal*[18] residence, she was hesitant to ask for more than to call a *dukun*. "I was alone. I didn't want to be troublesome by asking for too many things. I don't have enough money to pay for transportation. To go to a village health post, you need

[17] It takes about three and a half hours to travel from Labuan Bajo to Manggarai Regency.
[18] Patrilocal residence or patrilocality.

money to pay for motorcycle taxi, need money to pay medicines. No, it is better to stay at home," Teri told me.

In Tandima, I made an appointment to Mariana whose sister in-law died two weeks before. Mariana is one of the integrated health post cadres, and she agreed to meet me in her parents' house. While she held her baby, Mariana told us the story.

> "She (the mother) did not want to go to the health clinic (to give birth). 'I will just do it at home,' she said. My brother told me that. We found out that she was in labor only after her husband called us. Blood was all over her body when we arrived. We tried to send her to the clinic, but we were too late. She could not talk anymore…she died." (Mariana, 48-years old, Posamo Village, East Nusa Tenggara, Indonesia, in-depth interview, April 11, 2015).

The fragment above cannot explain why the woman did not seek even a *dukun* to assist her in giving birth. Mariana and her family lived in a very remote area, even from the village office of Tandima. A shortcut is available, but only a healthy man or a woman can access it on the sloping side of a hill. Despite how challenging accessing health care services for rural women is, I argue that they understand very well that the modern health care system provides better technology for reducing pregnancy risks. From Teri's experience, we learn that even trust in *dukun* that is situated in a personal, egalitarian, and embedded social network, is in fact transactional. As not all women have familial ties with *dukun*, people exchange *ikat* fabric and/or a rooster for the services *dukun* provide. People know that in the modern health care system, the so-called free service does not exist because nobody will take care their children while they are gone and unexpected cost during childbearing process. Even if the maternal health development program has designed a set of rules based on a risk calculation paradigm, there are too many intricate nexuses that are beyond state's power to accommodate.

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From the ethnographic stories in this chapter, I propose that women's trust in *dukun,* is to some extent tied to historical trajectories of various development programs in East Nusa Tenggara. Similarly, *bidan's* roles and characteristics are attached to previous coercive programs, particularly family planning initiatives. These intricate nexuses influence women's relationships with both *dukun* and *bidan* which lie in social network, infrastructural conditions, provider's willingness to stay in the clinic, shortages and imbalance of distribution of health care professionals, and women's political economic condition.

IV. DYNAMICS OF HEALTH CARE SERVICES: CHALLENGES AND STRATEGIES

IV. 1. Background

Revolusi KIA's main objective is to shift from "home-based to facility-based delivery" in order to reduce maternal and infant mortality rates to meet the progressive target of the Millennium Development Goals (MDGs).[19] In section three, I presented women's relationships with both *dukun* and *bidan* in various interactions. The stories show that the development intervention indeed influences the dynamics of social relationship in the local context. Revolusi KIA leads both women and *dukun* to adjust to the transformation initiated by the state-engineered program. Each tries to situate her roles and responsibilities in accordance with the state's desired plan, although many fail to comply.

Some women want to give birth at a facility. According to O'Donnell (2007:2826), the modern health care system can raise their desire to utilize it if it can be invested with their trust in its service professionals. Similarly, women's interactions with *bidan* may allow them to use services available in *puskesmas.* But because the state's approach to overcoming maternal health problems is produced in a technocratic way, it renders invisible notions of uncertainty which, along with other factors, are "immeasurable aspects but nonetheless important for patients" (Brown and Calnan 2010:15) that stem from the outsider's perspective of public health.

My argument in this section is that Revolusi KIA does not simply move women's trust from personal and traditional health care services to impersonal modern services, but more broadly, it produces an impact by reconstructing social relation and tradition. The changing relationship causes disruption and challenges in women's personal lives, and these outcomes become easily translated by development agents as forms of resistance toward state intervention

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[19] The MDGs began in 2000 and ended in 2015 and have guided Indonesia's public policies to fit more specifically the eight targeted goals. http://www.unmillenniumproject.org/goals/ Accessed in Thursday 8, 2016 at 8:00 am.

power. Based on my ethnography, I argue that both *bidan* as frontline health apparatuses and the people are adjusting to and modifying the conditions they face every day because of the state project's enforcing inadequate health services. The ethnographic examples in this section pay attention to the repercussion of the "audit culture" (Ibid.:14) discourse that is an inherent part of Revolusi KIA's development procedures.

IV. 2. Fixing Social Practices with Revolusi KIA

I examine broader implications of the implementation of Revolusi KIA, which is the reconstructing of social relation through reshaping individuals' capacity and communities' responsibility. For example, while the transaction between women and *dukun* was previously accommodated through *ikat* fabric and/or a rooster, through Revolusia KIA, every household in East Nusa Tenggara must be able to provide cash as the system of exchange in maternal health service. This factor, to a great extent, contributes to reproducing the new habits and practices for the majority of the women to adjust to this changing configuration. For another example, women are introduced to *tabungan ibu bersalin* (maternity collective savings: *tabulin*); this new program utilizes experts' assumptions about a local community that "…are said to have the secret to the good life (equitable, sustainable, authentic, democratic—however the good is being defined), yet the experts must intervene to secure that goodness and enhance it" (Li 2007:232). In the *tabulin,* the experts propose a form of collective sharing which they believe is part of community "natural goodness." While the notion of collective sharing may be morally good, they are not aware that the majority of women in East Nusa Tenggara rely mostly on subsistence farming to fulfill their needs. Even if some women could save some money collectively, usually around 2,000 IDR (15

cent) per month, the amount they could gather would still be insufficient to fund their maternity expenses.

Revolusi KIA reflects what Brown and Calnan (2010:14) call clinical governance. It concentrates on risk calculation as the means of holding practitioners accountable for their clinical work. In order to do so, Revolusi KIA assigns sets of technical and economic parameters to create a manageable scientific bureaucratic approach. These parameters are monitored, evaluated, and later modified in order to achieve the main objective of Revolusi KIA. But "…bureaucratised medicine is a poorer, reductive, least-worst quality of medicine, in that aspects which are immeasurable, but are nonetheless exceedingly important to patient experience, are neglected," argue Brown and Calnan (Ibid.:15). In the context of development projects, I argue, because risk management tends to maintain faulty practices by neglecting meaningful elements in women's lives, development programs become obsessed with fixing that kind of technical and bureaucratic problems. As a consequence, development projects like Revolusi KIA, reproduce distance between the program and the people whose lives they intend to improve.

IV. 2. A "In Limitation We Work" – Bidan Erlita

When I was conducting my research, rules and guidelines that were intended to be used for the JKN health insurance system had not yet been circulated. At that time, an approved operational health budget submitted to the central government had not yet been received by district health officials in the Department of Health. As a result, a program called *Pos Pelayanan Terpadu* (Integrated Health Post: *Posyandu*) which had become the common setting for antenatal check-ups had to stop operating. In addition, essential basic medicines distributed by the Ministry of Health arrived late. On the provider side, service providers' salaries, which were basically earned

from their providing services, had not been paid by *Badan Penyelenggara Jaminan Social* (Social Insurance Body; BPJS). These financial disruptions significantly affected the availability of services for the rural women of East Nusa Tenggara. In this kind of situation, *bidan, dukun,* and the people themselves had to create strategies to cope with health problems.

Bidan Yana treated a woman with eclampsia in 2012. She told me that she was trained to inject MgSO4[20] using a 10 mm syringe size twice, but the only size available from *puskesmas* was 5 mm. In that situation, she diluted the MgSO4 with distilled water and injected it four times, using the 5 mm syringe. She noted to me also that both *puskesmas* and village health posts had only expired MgSO4. The situation is very ironic: these are the place where the health care priority is to fight against maternal and infant deaths, and thus effective MgSO4 is crucial. In all *puskesmas* I visited, in both Manggarai and Sumba Barat regencies, MgSO4 was lacking although *Bidan* Yana noted that at one time there had been a surplus. “I rarely have a patient with eclampsia. Usually I just refer the potentially high-risk women to *puskesmas* or a hospital, but if we think in case of emergency, I am nervous,” *Bidan* Yana told me.

The problems were not limited to the scarcity of important medicines to treat eclampsia. In the middle of a night in April 2015, four men knocked on the door of the Posamo’s community health post where I lived during my research there. They asked *Bidan* Erlita and Nurse Maria, the only two health providers in the village, to help a sick person but were refused. Even after the men came back with a village elder, both *Bidan* Erlita and Nurse Maria rejected their request for medical assistance. Three women came and finally explained, “I believe this girl is pregnant and about to give birth, please help…please…please,” the lady was asking in desperation. *Bidan* Erlita and Nurse Maria were shocked. While they walked hurriedly to respond to this last call, they

[20] A prominent medicine for treating eclampsia, the primary cause of maternal death.

complained that the first group of men had not told them earlier that there was a pregnant girl who was about to give birth.

While *Bidan* Erlita accompanied the girl to *puskesmas, Dukun* Magdalena arrived at the village post with another woman who came to deliver her baby. Magdalena was breathing heavily; she knocked on the door in a hurry. Only Nurse Maria's husband Stefanus was there. He told *Dukun* Magdalena that both his wife and *Bidan* Erlita were going to the *puskesmas. Dukun* Magdalena cried out, "Dear Lord, this woman is about to give birth!". *Dukun* Magdalena assisted the woman to lie on the bed in a maternity room. Nurse Maria's husband tried to call his wife, but he reported with huge disappointment that both *Nurse* Maria and *Bidan* Erlita would not come back soon as they were heading to the hospital. At six in the morning, *Dukun* Magdalena was preparing hot water and blankets for the woman she had brought from her home. Soon, I heard the sound of a baby crying. *Bidan* Erlita and Nurse Maria came about ten minutes later, after the *dukun* had assisted the woman's giving birth; they then took over care of the baby and mother.

This story reflects the volatility of delivery, with limited human resources at the remote health care service. This finding is consistent with other studies that found that *dukun* "…have developed practices that synthetically incorporated elements of the biomedical into their local obstetrical knowledge" (Hildebrand 2012:562; Davis-Floyd 2001; Daviss 1997). In a context where human resources to support the function of modern health care services are limited, *bidan* are in a position of finding that they need *dukun* more than *dukun* need them. This relationship, however, is missing from Revolusi KIA's evaluation plan suggested by development agents.

IV. 4. Informal Payments as Financial Resources

According to Stringhini and colleagues (2009:2) "[t]here is growing evidence that informal payments are, in many low- and middle-income countries, the main source of health care financing" (see also Ensor and Witter 2001). They define informal payments as "unreported or unregistered illegal payments that have been received, in cash or in kind, in exchange for the provision of a service (or of a faster or better service) that is officially free" (Stringhini et al. 2009:2). However, this additional cost has led patients to "deter access and reduce their demand for care" (Mæstad and Mwisongo 2011:108). My arguments in this sub-section are directed to the need for service providers to come up with ideas for how to make services run, including how to substitute their salary.

In Tandima, women from Babosa hamlet complained about *Bidan* Yana. "We here in this hamlet are marginalized. If we come to the village health post, we pay 10,000 IDR (less than a dollar), if not she does not want to give us her service," said one woman to me. In another hamlet, Ema told us that she prefers to go to the village health post in the morning. According to her, the village health post gives free service for those who have JKN, but those who do not have JKN must pay a small fee of 5,000 IDR (less than fifty cents) for the morning service. Ema does not like to access health care in the afternoon, noting "…the post [health post] closed, it will open again at 1 pm, but we need to pay higher. If it is not an emergency, I would rather wait until the next morning." In this village, informal payments frankly become one aspect of evaluating *Bidan* Yana's quality. Although in Babosa hamlet, a number of people felt disappointed with *Bidan* Yana, I found no other persons complaining about this extra payment.

Bidan Yana told me that since she started working in this village health post in 2011, a cleaning package with chlorine, soaps, and even a mop has been supplied only one time, in 2013,

by *puskesmas.* She no longer receives disposable goods. “It should be in the budget [health budget] but we did not have an oxygen tank until last year, let alone soap and disinfectant. I use my own soap and buy my own gloves. I do not want to beg for those things. Those are my personal protection so I bought my own. Sometime I took money from the village health post’s petty cash to buy some of it,” she explained.

Similarly, in Posamo, I was surprised that the village health post was not equipped with electricity. I personally had to pay the man who ran a generator service to get electricity to recharge my laptop and my phone. The generator worked daily from 7-9 pm only. “We always prayed that I could give birth during the day, otherwise I needed to pay extra for gasoline to run the generator,” noted Arora, a mother of three in Posamo. One day when we were sitting and enjoying our coffee, Stefanus told me that he wished that soon the village health post in Posamo would be able to get access to electricity. “It is so difficult for Erlita and Maria if they have to work at night. Well it is of course hard for the poor couple too, because it will be an expense of the patient to pay for the generator. I am always honest to them: we do not have electricity here, if you want, we can ask an old guy who has a generator to send the light here, but it costs 250,000 IDR (20 USD) for the whole night.”

Other than electricity, informal payment in Posamo village includes an extra service from Nurse Maria for older citizens who cannot come to the health post. Maria would walk to the sloping hill to reach her patients and give them medicines and vitamins. She charges a small fee for her services, but because of her services, Posamo’s health post always receives positive credit from the people. “Erlita is a non-official *bidan.* Her salary has been postponed for six months now. I share my money with her because she cannot travel and give services to older people here. Her role is limited to maternity care only,” Maria told me about her co-worker’s financial situation.

The topographic condition in East Nusa Tenggara has always been challenging for driving, and ambulance service is not always available for reaching some places due to poor road conditions. On New Year's Eve 2015, Madia feel a huge pain in her stomach. Her water broke soon, and she knew that she was about to give birth. Her husband Toni called the ambulance driver to pick up his wife. "It was New Year's Eve and Tadi (the driver) was having his day off to visit his parents in a different village. So I searched for another car from Lolimo village. I paid 150,000 IDR (12 USD)," Toni told us about his experience. Madia, who was holding her baby, added, "the hardest part is if we rural people do not have money, what can we do? I prefer to just stay at home and give birth here." Thus, another factor which contributes to women's decision to give birth at home is the topographic condition and the absence of reliable transportation. As I mentioned in section 2, Revolusi KIA has considered these issues, as shown by the availability of ambulances in all *puskesmas* throughout East Nusa Tenggara. In practice, however, this solution is challenged by uncertain situations (such as holidays) which are always difficult to capture in a technical solution provided by the experts.

Bidan Yana and Nurse Maria stories told us that informal payments are indeed part of the coping mechanism that they have developed under conditions of job dissatisfaction and minimum wages (Stringhini et al. 2009:2). But my ethnographic findings suggest that informal payment is inherently embedded within the health care development project. To some extent it helps providers to perform "better than nothing" service, rather than their relying on money from the central government, the reliability of which is always in question due to long and complicated financial bureaucratic procedures.

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Revolusi KIA is not just trying to seek solutions for maternal and infant deaths per se. Instead, it endorses a broader social transformation to modernized social structures and practices. In doing so, the program in fact is challenged by the most fundamental obstacle for common development programs in any poor country: the flow of funding. As a consequence, services designed to provide “better” health services for people is disrupted. Informal payments, although most likely making supposedly free services as expensive as paid services, contribute to maintaining the availability of minimum health care in some rural areas in East Nusa Tenggara. My analytical point in this section is that although informal payments may hamper people from accessing health care services, based on the quotidian narratives provided in this chapter, informal payment is one of the strategies that frontline health providers can utilize. They do so in order to sustain basic health services that have been diffracted by the existence of health care development initiatives intervening in every aspect of a rural community’s life.

V. Concluding Remarks and Further Research

The aim of this study is to answer how and why women make the choices they do in potentially dangerous moments like childbirth. This ethnography explains that women's relation with both *dukun* and health professional is tied up with the historical practices of various program interventions in this province. The relation is a by-product of historical development actions that situate *dukun* as trustable care providers and *bidan* as outsiders from the socially embedded practices followed by women in their maternal care. In general, the findings suggest that the role of *dukun* today cannot be separated from the historical assemblage of development programs that have been introduced in the region.

The implementation of Revolusi KIA reflects the changing modes of relation caused by experts' proposals for addressing development problems. Revolusi KIA intervened to make a major transformation to the role of tradition: displacement of trust in *dukun* and reappropriation of the trust to a modern institution represented by *bidan.* Many actions designated to protect women and assure a safer pregnancy experience concentrated only on development guidelines. But since the framework for maternal health, rules, and guidelines were rendered technical, other aspects of women's lives that do not appear directly related to maternal health become invisible. For example, when Revolusi KIA rendered access to health care technical, professional midwives were stationed at village level clinics. The program did not consider, however, if electricity, water, and medicines were fully available at those clinics. The risk calculation paradigm, in addition to addressing problems merely in a very technical approach, also transformed maternal and neonatal health issues to the terrain of bureaucratic governance. Surveillance and interventions proposed to reduce risk did not directly approach maternal and neonatal health; rather, they functioned exclusively to minimize the risk of the Revolusi KIA program and secure it.

Nevertheless, as the current findings suggest, *bidan*, *dukun,* and women have their own mechanisms for enduring the state's limitation in the development framework. Tracing social, class, and cultural transformation as impacts of development, as well as paying attention to the politics of expertise, is worthy of future investigation and analysis through affect theory. This is the direction I would like to pursue in order to understand the chain of events influenced by the proliferation of global health political discourses and practices. ***

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