

Chapter VII

"Normal" Infants and the Politics of Health Care

Children everywhere have long been part of the discourse of formal politics. As active members of a community, children are directly affected by population policies and population controls often targeted specifically at them (see Wee 1995; Greenhalgh 1995; Ginsburg and Rapp 1995; Hartmann 1987; Anagnost 1995). A few of the overt policies commonly used are state regulation of infanticide, birth control, and family size. However, more subtle links between children and political structures also exist in most contemporary nation-states; indeed, some nation-wide policies that focus attention on other concerns, indirectly attempt to monitor or manipulate reproduction and quality of family life. Even so, children, parents, and families hold a central symbolic position in the presentation of the goals of many nation-states and have done so consistently since the mid-19th century (e.g. Fildes et al. 1992; Miyaji & Lock 1994; Shiraishi 1995; Stephens 1995; Thomas 1994; van de Walle & van de Walle 1989; Wee 1995).

This and the following chapter explore the origins and implications of the relationship between infants and the nation-state in Indonesia, with particular attention to the provision of health care in indigenous communities. Any exploration of relations between nation and child needs to be grounded in the fact that assimilation of culturally diverse citizens into a single cohesive nation has been a key goal of the Indonesian nation-state for the past 50 years (Anderson 1983, 1987). In other words, health care in Indonesia cannot be understood free from Indonesian notions of development and nationalism. Indonesia adheres to a conservative understanding of development, one grounded in economic constructs of growth. Development policy is grounded in a modernist model that sees financial prosperity as a rational indicator of social progress (Tirtosudarmo, 1990). "Development" as it is used in everyday discourse in Indonesia,

however, tends to mean the application and impact of the intersection between economic growth and nationalism at a local level. Health care in the Baliem valley, for example, is taken as a sign of *pembangunan* (development), but the nature of this health care links it directly to Indonesian constructs of nationalism as well as to national targets for economic growth.

Across the nation, control over population growth is seen as the first prerequisite to economic development and national prosperity (Tirtosudarmo 1990). There are 200 million people in Indonesia and most of them are concentrated in the densely populated central islands of Java and Bali. A core policy, and one seen as key to national prosperity overall, is to institute control over the family; over whether or not families produce infants, how many, and of what caliber.

Within a broad state propensity to intervene in family life, reproduction receives a significant amount of attention (Government of Indonesia & UNICEF 1988). In the Baliem valley, there are more services aimed at controlling reproduction and at improving infant well-being than services targeted for other health measures. At present, government-run health clinics and affiliated agencies offer *KB* (*Keluarga Berencana* or Family Planning), training of midwives or traditional birth attendants, pre- and post-natal maternal care, early childhood immunizations, infant weight gain measurements, food supplements, nutrition training for mothers, and vitamin supplements for mother and child.⁵⁹ The extent of efforts to draw infants into nationally-approved health policies is such that it questions the seeming benevolence of health policies that aim to improve the lives of children. Widely-available and widely-touted policies such as early childhood immunization seem to be less an overall positive contribution to health in the Baliem valley than a focused attempt to draw infants and their families into the modernizing goals of the nation. In other words, health care is politics by other means (Das 1989;

⁵⁹In contrast, there are no programmes aimed at reducing sexually-transmitted diseases, aimed at the health of children over the age of five, or aimed at the health of non-lactating women.

Morgan 1993; Foster 1987). These two chapters explore the extent to which health care provided to infants in the Baliem valley functions as a coercive tool which serves to maximize the control of the nation-state over the actions of individuals.

Health care is a highly effective means of drawing peoples on the margins, such as government designated *suku terasing* (most isolated tribal peoples), into having a greater participation in the state. Making indigenous people part of Indonesia is a concept with an emotional legitimacy tied to the history of the nation (Anderson 1983), but in practice, life on these margins does not always resemble the abstract political ideal of benevolent inclusion. As Atkinson (1995) shows for the Wana of upland Sulawesi, neither the Wana nor the government care to make government health systems part of that remote community, whereas in the administrative center of the Baliem valley, a terrain of historical conflict and of considerable importance in the present day, the quantity of health services is consonant with national models. There the government clinic symbolically accompanies schools, flags, and photographs of President Suharto as key nationalist icons made to resonate at the local level.

Health services are tightly enmeshed in Indonesia with the nation-state and with the organizations, activities, and cultural processes of civil society (Budiman 1990:5). Indonesian state goals of "assimilation, homogenization and conformity within a fairly narrow ethnic and political range" (Nagengast 1994:109) are achieved through tight associations at all levels of society with government creeds. As van Langenberg (1990:138) proposes, "very few areas of private and public realms in Indonesia remain in any sense autonomous of the continual interaction between state-system and civil society," and health care is no exception (see also Vatikiotis 1993:96; Foulcher 1990; Suryakusama 1991). By health care I mean all of the institutions that provide services, including missionary, church, and non-profit services. Non-profit organizations that subsidize state responsibilities for health must each fit, in both spirit and observable practice, within policies tightly defined by a government dominant in all arenas of social

life (Eldridge 1989; Vatikiotis 1993). In the early 1990s, for example, missionary nurses working in remote regions of Irian Jaya who had exceeded the bounds of policy simply lost their visas; those who remain now tend to work closely with government objectives, in essence subsidizing official health programmes.⁶⁰

Chapters 7 and 8 delineate the specific techniques of *how* infants in Irian Jaya are made to become subjects and objects of the nation. I argue that inclusion of Irian Jaya into the "imagined community" that is Indonesia is vital to nationalist political sentiments (Anderson 1983). The political importance of Irian Jaya in nationalist sentiments means that services offered to the rest of the country are reproduced without change in Irian Jaya, although quality of services vary widely. While it is possible for Indonesians from outside the province to imagine Irianese in "quasi-logo form: 'negroid' features, penis sheaths" (Anderson 1983:178), it is not possible to sustain an image of a cohesive national community by providing province-specific or culturally-grounded health services to those culturally distinct Irianese. Health services reinforce and validate nationalist political objectives of assimilation, even though the services themselves appear to be resolutely non-partisan. In this chapter, I first show how biomedical knowledge about infants enables rather than challenges these political strategies of control. Constructs of the infant--specifically those of the "normal" infant prominent in biomedicine--make interventions regarding infant well-being legitimate. I then summarize healing resorts that the Dani use, focusing on the government-employed *mantri* as a key player in the transmission of information about nation-wide health institutions.

The role of the indigenous, biomedically-trained health worker deserves special attention for it shows ways that politics of the nation permeate relationships between

⁶⁰Collaborative relationships between missionary and ruling powers have been well-documented. Both Young (1989) and Thomas (1994) document invasive missionary health care under British colonial authority in Melanesia in the past century, wherein missionary health care for children furthered colonial goals even as they satisfied missionary objectives of cleanliness, family order, and appropriate parental responsibility.

healer and patient. These *mantri* (health worker) translate biomedical constructs of the "normal" infant into treatment strategies. As an indigenous member of the community, the *mantri* communicates information and provides services; but as a government civil servant, the *mantri* is also accountable for the levels of participation of women and children in government programmes. *Mantri* have power as both healers and bureaucrats. I focus on the diagnostic tactics the *mantri* use, calling them the "*mantri's* secret," which is to provide no diagnostic information whatsoever. This tactic allows the *mantri* to enjoy status but it also allows him⁶¹ to successfully cajole and sometimes coerce patients into participating in programmes aimed at controlling reproduction and its outcomes. As Young (1993:117) has suggested, institutions exist wherein people are controlled "through surveillance, coercion, and rewards, and ideologies are not needed to convince people to behave correctly." Health care in contemporary Indonesia is one such institution. Thus my exploration of both indigenous health care workers who provide on-the-ground care (in this chapter) and non-indigenous workers who occupy positions at clinics, as medical doctors, birth control specialists, or data compilers (chapter 8), gives rise to the argument that their use of different healing tactics work under constraints brought about by the close link between health care and formal political power.

The following chapter extends the analysis of relations between the Indonesian nation-state and infants by examining the use of the infant as national symbol and as specific target of health policy. A national culture bound by passive models of familism shapes the provision of care and legitimizes interventions into the family. Both chapters show that control over indigenous populations is imperative to political stability and that one way this is being effected is through small-scale techniques that act directly on the bodies and in the social lives of infants in the Baliem valley.

⁶¹The vast majority of Dani *mantri* are men. Only three of the approximately 30 Dani *mantri* and clinic staff that I met were women.

Biomedicine and Infants in Indonesia

Since 1949, when Indonesia attained independence from Dutch colonizers, the country has relied on health systems established during the colonial period as the foundation for contemporary care. In 1926, the Dutch government joined forces with the Rockefeller foundation to begin training the first *mantri* (village health workers) to provide basic services to people of similar linguistic and cultural backgrounds at village clinics (now called *puskesmas*). Also during this earlier era, a pattern of giving tacit support to efforts to set up efficient health systems in rural areas ended up being dominated by real patterns of expenditure that to this day direct funds disproportionately to urban health establishments (Hull 1989; van de Walle 1995). Since the 1970s, however, Indonesia has been a staunch supporter of primary health care endeavours, defined as "essential health care made accessible to everyone at a cost the country and community can afford, using methods that are practical, scientifically sound, and socially acceptable in Indonesia" (Yahya and Roesin 1990:134).

As a newly-industrializing country, Indonesia has been on the receiving end of what Rubenstein and Lane term international health, "the flow of advice, health professionals, and health technology from the wealthier nations to the poor" (Rubenstein and Lane 1990: 368). While the ministry of health sets in-country policies of childhood immunization, family planning, health service standards and their distribution, for example, they do so in long-standing consultation with international agencies who reflect the values and assumptions of the wealthier nations (Cohen and Purcal 1989). The focus on primary health care that dominates current health interventions derives from international health policies, and has had some impact on redirecting money and planning energies to non-urban areas although the benefits have yet to be measured conclusively (Deolakikar 1995; van de Walle 1995).

In Indonesian state ideology, improvement in health is seen as an investment in human capital that allows the nation to develop rapidly and effectively. Healthy and prosperous families, in the words of one public law, will allow Indonesians to "become valuable human resources for national development and resilience" (Government of Indonesia 1992:3). The link between development objectives and control over population growth is frequently stated through explicit links to a strong, healthy body. For instance, the law concerning "Population Development and the Development of Prosperous and Happy Families states that:

Population Development shall be directed towards controlling the size of the population, development of population quality as well as guiding population mobility as human resources potentials so that they will become strengths of national development and national resilience as well as being able to provide the optimal benefit to the population and to raise the human dignity in all dimensions of the population. Development of happy and prosperous families shall be directed towards the development of family quality through family planning efforts in the framework of inculcating the norm of the small, happy and prosperous family. (Government of Indonesia 1992:10-11)

The terms "population quality" and "the conditions of the population" (Government of Indonesia 1992:10-11) are criteria determined by country-specific development concerns about family size, infant mortality, and infant health (see Kardjati 1990; Government of Indonesia & UNICEF 1988). They are also terms that flatten out differences between ethnic minorities in Indonesia in the interest of inculcating national norms. Thus health policies pay little regard to the cultural diversity and the range of knowledge about infants present in the country when formulating policy but place demographic issues instead at the forefront of national policies of intervention.

Population control is a key means to monitoring and controlling demographic processes in this nation of 200 million people. So successful has Indonesia been at population control that Suharto and the *PKK* (Civil Servant's Wives Association) were given the 1989 United Nations Population Award, and their family planning initiatives have been imitated throughout the world (Smyth 1991; Singarimbun 1988). Although

called family planning, *KB* (*Keluarga Berencana*, or Family Planning) is in essence a policy of birth control. Thus earliest efforts in the 1960s to reduce population growth were targeted at Java and Bali, the most densely populated of Indonesia's islands. Less populated areas were served by so-called "safaris;" "rapid visits to outlying areas which have the express aim of signing up as many 'acceptors' as possible within a short time" (Smyth 1991:787). Today in Irian Jaya, *KB* (family planning) services mix the "safari" model with village-run distribution centres, where community leaders, religious groups, and volunteers promote and monitor birth control at the level of the community. Smyth (1991) has argued that the perspective, needs, and wishes of women and families take second place to decisions based in demographics. As Smyth astutely argues, the healthy prosperous family is a constructed, normative ideal masking the real goal of reduced crude birth rates.

Puskesmas (health clinics) also carry out the directives of encouraging small, healthy families because they place infant care high on their list of priorities. Since the 1970s, health care in rural areas has been structured around the *puskesmas* (major health centers).⁶² These large centers are intended to provide preventive and curative services and have a doctor, paramedics, nurses, and a midwife. About fifteen staff work at Javanese *puskesmas*, but in Irian Jaya the average number of staff is a fraction of that. Clinic subcenters called *puskesmas pembantu*, or *pos pengobatan*, are run by *mantri*, and offer curative and maternal and child health care. In the Baliem valley, two full-service *puskesmas* operate in Wamena; the remaining clinics all fall under the category subcenter. To avoid unnecessary terminological obfuscation, I retain the word *puskesmas* for all clinics.

In addition to these *puskesmas*, a score of *posyandu* (integrated health and family planning posts) dot the valley. These posts, informal and makeshift, are supervised and

⁶²*Puskesmas* is an acronym, drawing the first three letters of "center", "health", and "people" to build a word that translates approximately into "people's health center". *Posyandu* has a similar word origin, and translates as "people's helping post."

run by *puskesmas* staff and offer monthly preventive services to children under five and pregnant women. *Posyandu* expansion has been one of the main objectives of the national and international health organizations over the past 20 years. The government, in conjunction with international health agencies, aims for immunization targets of 95% of all children, the implementation of maternal and child health policies, the promotion of breast-feeding, and use of birth control, all provided through *posyandu* (World Bank 1990, 1991; Government of Indonesia & UNICEF 1988). *Posyandu* growth has been exceptionally rapid in the past decade, going from 34,000 *posyandu* in 1985 to 200,000 posts across the country by 1989. At present, *posyandu* claim to serve an estimated 85% of Indonesia's children. Although the majority of villages have access to *posyandu*, overall other services remain sparse in rural areas (van de Walle 1995).

The impressive level of growth and systematic organization that characterize Indonesia's health care system has its particular local character in the Baliem valley. On paper, all systems conform to public policy. The district of Jayawijaya has a municipal health office, based in Wamena. The two full-service *puskesmas* in Wamena are staffed by doctors; all other *puskesmas* in the valley are run by trained *mantri*. Staff recruit and encourage *kader* (volunteers) to assist in motivating potential clients and to help with the daily operations of the clinic. The many new *posyandu* are up and running, and each offers immunizations, prenatal information, child-weighing services, and birth control promotion. In reality, however, systems operate within a number of constraints and reflect problems in the country overall, where the "quality [of health care] is often lower in poorer, more isolated regions, taking the form of inadequate and unreliable drug supplies, a lower range of services, and fewer and less-qualified staff" (Van de Walle 1995:230). In the Baliem valley, *puskesmas* regularly lack medicine, many services are not available, and staff frequently disappear for months on end. *Posyandu* often take place on paper only, and nutrition seminars or talks about birth control take place some of the time in some health posts, and not at all in others. Some *mantri* are highly skilled;

others, relegated to rarely-used isolated health posts, have almost no training whatsoever. Even skilled *mantri* often leave their clinics and delegate the task of diagnosis and treatment to their volunteer *kader*, who have had no formal training. The pressure to submit monthly reports appears more pressing than quality of care for many *mantri*, who overall provide the vast majority of health services to Baliem valley Dani.

Before reviewing *mantri* healing strategies, it is crucial to note that services offered to infants at *posyandu* fit national models but they do not help improve infant health status in the Baliem valley. There are four basic health interventions offered at *posyandu* throughout the nation: immunizations; oral rehydration therapy; growth monitoring; and the promotion of breastfeeding. Of these four interventions, none is effective on the ground in the Baliem valley. First, immunizations have been and continue to be unnecessary as none of the childhood diseases targeted by early childhood immunizations are present in the population (diphtheria, polio, pertussis, measles, and tetanus). Tuberculosis has been diagnosed only recently. With the introduction of cattle over the past decade, it is expected that tetanus will become a problem, but no cases had been diagnosed by 1995. Thus, while the preventive possibilities of immunizations are as great as they are for any other population, and government clinics promote vaccinations assiduously in the present, the shots are not to curb diseases which currently kill. Similarly, Oral Rehydration Therapy (ORT) for childhood diarrhea is widely available and widely promoted through posters and in seminars but is seldom used. Local perceptions of ORT are that it is cosmetic medicine that has little value as a healing tool. Growth monitoring, exacting measurements, carries no demonstrable health benefit for indigenous peoples. The function is primarily statistical (see chapter 8). Finally, the promotion of prolonged breastfeeding, already a local cultural practice, is unnecessary. Indeed, health employees, who offer motivational seminars at immunization clinics, regularly breastfeed their children less time than do indigenous women. A very few women, smitten with the potentials of *pembangunan* (development), have taken to

imitating Indonesian practices, restricting breastfeeding to infants under eighteen months of age. Overall, basic health services for infants do not contribute in any significant way to improving the well-being of infants.

The job of the indigenous *mantri* is to apply these national health policies at village clinics. As the person employed by the government that indigenous people usually come into contact with the most, the *mantri* has, first, to execute infant health mandates from within the complex health care system outlined above and, second, to translate them into workable practice at the village level. His work requires that he carry out population control mandates. He is asked to promote birth control, even though many Dani women have less than two live children. He is expected to promote immunizations and attendance at *posyandu*, even though these services contradict many Dani beliefs about infant care, and are not effective. Finally, he is asked to understand infants in profoundly different ways. "Government medicine" supports a biomedical view of the world which contains a distinct model of the infant, discussed in the following section. Biomedicine portrays infant health as dependent on the social and environmental world in which she lives; it portrays indigenous infants as "small" and "unhealthy." Biomedical views of the body, constructed through definitions of the "normal," are the models then made legitimate in population and in the *Puskesmas* system; it is this framework that the *mantri* is expected to use when he heals.

The Construct of the "Normal" Infant

Every time the *mantri* makes one of his silent diagnoses, he processes, at the least, ideas taught him by mission nuns, government schoolbooks, or government-sanctioned seminars on nutrition, diagnosis or treatment. The knowledge he has absorbed about infants has a particular flavour to it. Overall, it reflects a EuroAmerican understanding of the person as made up of two distinct components, body and mind. In

addition, medical discourse about the infant operates within a constructed space I call that of the "normal" infant. Understandings about the infant are grounded in notions of the "normal" which legitimate forms of medical intervention to improve the lives of children deemed not "normal." This section briefly reviews the focus on normalcy in understanding infant illness and growth in order to show what forms of knowledge the *mantri* and other health providers contend with when promoting indigenous children in Irian Jaya as "abnormal" in their growth patterns.

Overall, biomedicine sustains a vision of the contemporary child as "a passive recipient of culture rather than a cognitively competent social actor" (Ginsburg and Rapp 1991:324). Euroamerican ideas about infant health have been grounded in beliefs that infants are biologically consistent persons. Passive, biologically immature, and limited in their abilities, babies have been defined primarily through physiological status. In contemporary Euroamerican constructs, the paradigmatic understanding that has dulled creative thinking about infants is that of "normal" growth and development (Armstrong 1983). Nutrition, size, and weight have become physiological barometers for measuring arbitrary goals of normal growth, and infant growth is being used increasingly as an overall indicator of the health of a given population (Dettwyler & Fishman 1992; but see Pelto & Pelto 1989; Messer 1989; Cassidy 1982 for partial critiques of biomedical constructs).

The notion of "normal" infant growth is a construct of fairly recent invention. According to the philosopher, Ian Hacking, the term "normal" evolved in a modern, medical context. The "normal" has come to encompass understandings of infant growth because the "normal" has infused the sphere of almost everything: "the word became indispensable because it created a way to be 'objective' about human beings" (Hacking 1990:160). Measures of "normal" infants currently pertain more to the social world from which the child comes than from scientifically established criteria: "We have regularly used 'normal' to close the gap between 'is' and 'ought'," argues Hacking, and this

"conflation of the average with the ideal makes the benign and sterile-sounding word normal... one of the most powerful ideological tools of the twentieth century" (Hacking 1990:169). Thus "normal," because it invokes comparison, is simultaneously about actual and potential states of being, about how to transform a malnourished child, for instance, into a normal, well-nourished one.

One of the most pernicious outcomes of the notion of a passive, mindless infant is the construction of a series of assumptions about physiological growth that falls under "normal." Through increasing processes of monitoring and regulating infant physiology in the nineteenth and twentieth centuries,⁶³ medical research began a process of creating infants as a separate medical category, with special sicknesses, growth patterns, and problems. Medical discourse, fueled by colonial constraints on social relations, the rise of statistics, changing relations of production, and the solidification of the germ theory of disease, increasingly focused attention on the infant, previously under-scrutinized (e.g. Imhof 1985; Armstrong 1986; Stoler 1995).

Medical discourse, colonial constraints on social relations, and the rise of statistics in constructing normal growth, over the past century, have all played important roles in fashioning current understandings of child health in an international context. At the turn of the 20th century, a new vocabulary evolved in Europe and North America that "created babyhood as a medical object" (Wright 1988:301). This discourse reflects a central feature of 20th century medicine, which has been to constitute and monitor the space of relations between bodies. In other words, having explored the anatomical regularities of infants and adults in the 19th century, researchers during the late colonial era began to investigate relations between infants and their mothers, families, and their broader social and economic environment. This focus on social relations was partly grounded in demographic changes that occurred up to the 1930s when infant mortality

⁶³Foucault (1980: 166-183) pushes this regulation back a century or more, but there is little evidence in social history texts to support his argument.

rates began to drop precipitously. As babies thrived as never before, infancy became a time of life and growth, and "a terrain in which death was an obscene intrusion" (Wright 1988: 306). The medicalization of the infant's social world allowed for an unprecedented extension of power that extended both to and beyond the family. These new ideas divided families according to how they cared for their children, a distinction van de Walle and van de Walle (1989) signal as that of the "private," coddled bourgeois child, "precious and irreplaceable," versus the "public" child. The latter was unloved, was surrounded by growing degeneracy and lacking adequate care and nurturing. Families that had less access to life-giving resources such as clean water regularly found themselves early targets of class-driven health interventions aimed to improve the welfare of the "public" child.

Statistical measurements of infants were able to validate the class distinction intimated in the "public" child. De Certeau (1986) reminds us that the technology of counting, humanitarian in its origins, became a means by which realities could be created. For example, during an era of rapid industrialization in the late nineteenth century, European and American governments produced different pamphlets on infant care for different social classes because statistics had demonstrated that working class families had higher infant mortality rates (Condran & Preston 1994). The implicit comparison with the lower death rates of bourgeois families strengthened the notion that the working classes needed to improve mortality rates by emulating normal bourgeois practices, a comparison that was echoed in relations between colonizers and the colonized in British, French, and Dutch territories (Condran & Preston 1994; van de Walle & van de Walle 1989; Stoler 1995, 1996; Thomas 1994). Thus statistics legitimated class distinctions even as they were also used to push responsibility for controlling the child's well-being onto the biological mother (Ginsburg & Rapp 1991:314; see also Donzelot 1979; Dye & Smith 1986; Fildes et al. 1992; Stoler 1995). Within the family it was the mother who was to stay at home, nurture the child, and

protect her from various noxious influences. The point is that as babies came to be understood as medical objects, in both colonies and in countries of origin, they were accompanied by their mothers. Linking infants to mothers through formal policies was a crucial step in the process that tied infant well-being to the social context in which the baby lived.

Throughout these medical, political, and policy shifts, an increasingly detailed notion of what constitutes normal has remained central. As Armstrong astutely argues, this century's concern with social relations between bodies, to use his terms, entails a concern with the normal. Examining relations between people involved the approximation and comparison of each body with "normal" social environments and then a search for "normal variability" (Armstrong 1983:43). Since the end of the Second World War, the discourse on normalcy has so invaded our perceptions, measurements and understanding that worrying about growth has come to seem, well, normal. Normal good health is a taken-for-granted assumption that practically reproduces itself in countless health interventions throughout the developing world. A recent critic labeled international health discourse and practice "normalizing" (Bibeau 1997; see also Escobar 1995; Rubenstein & Lane 1990), and this is particularly apt for describing the treatment of infants in the present day.

If scrutiny of infants depends on models of the "normal," then children in remote areas of Indonesia, described as smaller, shorter, and more likely to die than their "normal" urban counterparts, fall far short of the ideal. Thus, improving the health of the most disadvantaged to bring them up to "normal" standards sits at the core of Indonesian development projects aimed at infants (WATCH & Dinas Kesehatan Jayawijaya 1994; Escobar 1995). Non-profit organizations must conform to government objectives if they wish to have an impact in the country, and consequently the groups involved in health education in the Baliem valley reiterate and enact state policy, whether or not individuals agree with the intent. Thus, both government and non-profit organization begin with the

presumption that infant health in the Baliem valley falls far short of "normal" (See Handali et al. 1994 for summary position).

Using the discourse of biomedicine, the Indonesian state has created an atmosphere of emergency around the health status of mothers and children among the poor and among designated *suku terasing* (most isolated tribes) in the country's outer islands, such as in Irian Jaya. Statistics of mortality and growth become an effective way to distinguish *suku terasing* from communities more integrated into the nation's prosperity by showing how the growth of infants is "delayed" in less than ideal nurturing conditions, that is, in regions not fully integrated into the nation. Specifically, interventions target children whose height and weight have been measured as less than the national average (Frankenburg 1995). In one instance, a government-supervised 1988 study done in a poor, rural village showed that "growth faltering starts as early as four months" (Kusin 1990:21), and that "the onset of growth faltering can be attributed to inadequate amounts of additional foods, given to infants" (Kardjati 1990:vii). By the age of three years children seem to have adapted to the unhygienic environment, "but at a cost. They are stunted and wasted" (Kusin 1990:21). And "small/stunted infants become small/stunted adult[s]. Short mothers are known to give birth to smaller babies" (Kusin 1990:23).

While all children in low-income and rural areas in Indonesia are thus "at risk" of "abnormal" growth patterns, children from Irian Jaya deviate even more from the desired norm. The "public child" surfaces in descriptions of indigenous infants: by the age of six months, "relatively gross dietary deficiency" has taken place because parents do not feed their children enough protein. This is reflected in a "retardation of growth" associated with "the failure of breast milk to provide the total calories required: protein deficiency exists at all ages" (citations from Malcolm 1970: 19, 21,46; see also Handali et al.

1994).⁶⁴ Breast milk provides important calories and nutrients in an environment of dietary deficiency, where "food intake tends to be irregular and of high bulk" (Shaw 1986: 209, 214). Social conditions are the cause of poor infant health: the living environment of indigenous people is described as "toxic," a source of "burns," "mite populations," "smoke," and "carbon monoxide." Shaw adds, "the degree of crowding in houses [is] positively correlated with the prevalence of coughing among newborns to four-year olds and the incidence of skin disease at all ages" (Shaw 1986:211).

Measurements, in short, spotlight local causes for so-called abnormal growth and legitimize interventions to improve them.

Mantri, who are all Dani, learn to look at children in their community using these types of categories. While learning is idiosyncratic and while not all schools teach the same things or in the same ways, I argue that basic premises of concern about growth, disinterest in embodiment, or notions of personhood in healing techniques, and a perceived need to improve the "abnormally" poor patterns of child health are all transmitted unequivocally in formal schooling materials. The *mantri* is trained, if not to understand biomedicine, at least to reproduce its broad outlines in processes of diagnosis and treatment, actively communicating information about a different cosmology of disease causation whenever he receives a patient in his dusty village clinic. These categories are also passed on to *mantri* by their non-indigenous supervisors in a number of ways, some of which I discuss in the following chapter. They include requirements to measure infants, to promote growth-oriented programmes such as nutrition classes, and to use infant growth as a criteria for assessing the status of the family who cares for him. In addition, *mantri* are expected to organize women to attend seminars on birth control,

⁶⁴I have drawn quotations from the work of Malcolm (1970) in Papua New Guinea because there is little work available on children's health in Irian Jaya. In addition, non-profit organizations that advise the government health agencies use material drawn from the work of Dr. Malcolm. Thus while not formally part of the discourse used on health in Irian Jaya, it is an example of discourse that is unproblematically accepted by health care providers in the province.

PKK activities (Civil Servant's Wives Association), church seminars and more, and each of these transmit the same message: bring infant health up to "normal" standards.

The *Mantri*'s Secret: Techniques for Applying Biomedicine

"*Puskesmas* [government clinic] medicine is just play medicine, not really important at all, just pills. *Puskesmas* medicine is a test to see whether a sickness is really *adat* or not, not a real treatment resource at all"

Lina Matuan

Mantri hold positions in the community as paid government employees in *Puskesmas*. However, they also can have roles as political leaders and claim the status that accrues to successful healers. I had originally sought out *mantri* because of their potential leadership role in the community. As the providers of "government medicine," *mantri* are healers who challenge the prevailing cosmologies of sickness beliefs. As LiPuma (1989:307) shows among the Maring of Papua New Guinea, support for biomedicine is mixed up with other material goods, such as prospects of a trade store or a hospital. Important men "take on medicine" because of the status accorded to clinical staff; as he puts it, they "submit to it in order to make use of it." In the Baliem valley, clinic workers may become power brokers because they possess an alternate form of knowledge: "the coexistence and validity of two forms of medicine is itself revolutionary. It inclines [people] to perceive the indigenous order as arbitrary, as one possible order among others and hence open to question" (LiPuma 1989:307). The power of biomedicine to cast in doubt indigenous ideas is one of the most important implications of the *mantri*'s role in Dani communities.

While it is true that *mantri* possess political power because of their specialized knowledge, they are also civil servants and state bureaucrats of a minor sort. Employed, secure, educated, and powerful, *mantri* are responsible to the local health board. They

must tally monthly reports on service use, medicines dispensed, births, and deaths in the village as well as individual participation in government initiatives in immunization, weighing, and birth control. They must contend with shortages of medicine, a community much inclined to gossip about their healing powers and the possibility of being shunned if they do not heal someone under their care. As Crandon-Malamud (1991) says in regard to Bolivia, those who use the services reflect the politics within the community, its wealth, class, and status. Thus while Dani use health services, they do not do so merely within the framework of syncretic beliefs about healing; they also react to factors such as status, power, and politics when they consider whether or not they want to spend money and time to go to a government clinic (see also Frankel and Lewis 1989).

Most of the *puskesmas* in the valley are accessible by motorbike or taxi, which makes it convenient for immunization staff from Wamena to visit clinics as well as convenient for the *mantri* to avail himself of the town's services and to pick up his wages. Posts in the valley are coveted and overall tend to attract, one supervisor said, the highest caliber of *mantri* in Jayawijaya district. Indeed, in interviews I found that several health workers had been mission-trained, and had over 15 years of experience treating patients, whereas more remote posts tend to be staffed by poorly-trained and inexperienced employees.

In total, I interviewed nine *mantri* from *puskesmas* in the valley out of a total of eleven. Apart from two *mantri* I was never able to track down, all were willing to work with me. My interviews included a series of talks with three experienced *mantri*, all Baliem valley Dani, highly-regarded by their supervisors in Wamena. A score of informants, including the nine *mantri*, described a range of healing options which a sick person can pursue, either for himself or on behalf of his child:

Table 10. Healing Resorts

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1. No action: Watching, waiting, worrying.
 2. Use herbal remedies. Cuts, burns, old age disease, and fever can be treated. Men and women can treat themselves or others. Cinnamon bark is used as a preventive against colds, and many women nibble on bark regularly.
 3. Consult local person who has a known ability to heal specific ailments. This person holds no special status otherwise but may be known as able to heal infant coughs, or to facilitate childbirth. The person uses a combination of herbs, chants and poultices to effect healing.
 4. Consult *dukun di dalam* (healer from within the clan). The man who sits at the rear of *adat* pig dividing ceremonies is called the *wesagun* and has the power to heal. The *wesagun* can execute four types of *adat* healing:
 - a. blowing on the head of the sick person. Elders can heal clan members through this technique as well, but the *wesagun* has greater power to heal through blowing.
 - b. confessing misdeeds to a third party who can then communicate the acts and the act of confession to the aggrieved party. A sick person may confess; alternately husband or affines may confess to an act that caused a sickness. The confession fits within *adat* but no special ceremony is required.
 - c. killing a rat or other small animal and providing diagnosis through examining the animal's innards for any sickness. If the rat has an abscessed stomach, for example, the afflicted person will have the same problem. Ideally, *wesagun* should carry out the diagnosis, but elders and less important people will sometimes try it out.
 - d. eating special *adat* pig. When a person's life is perceived as under threat, family and clan will kill a small pig, cut off the tail, ears, and side piece and spread pig blood over the body of the sick. The pig becomes an *adat* pig by virtue of this ceremony, and, if the sickness warrants it, the ceremony actors will smear pig's blood all over the head, torso, and thighs of the sick person. The sick person eats a piece of the *adat* pig. If the ceremony is for an infant and the child is too small to eat the pig, the mother does it for the child, as the child will take in the healing properties of the pig through her mother's breast milk.
 - e. wearing the tail of the pig around the sick person's neck. The tail, usually very small and coated in grease, is tied around the infant or sick person's neck and left there to protect the *etaiegen* (soul) from invasion by spirits. Infants often have two or three pig tails tied around their neck.
 5. Go to *Puskesmas*
 6. Consult *dukun di luar* (healer from outside the clan). There are only three healers in the Baliem valley who have achieved the status of being able to heal outside of their clan. They employ the above techniques, and the most famous healer also

has a reputation of being able to extract bundles of sickness from the afflicted person's body.

7. Participate in preventive medical programmes. Immunizations, weigh-baby *posyandu*, birth control, church-run seminars on nutrition, and volunteer health worker training programmes (*kader*).
 8. Pray and consult religious leaders
-

Mantri have stiff competition in the arena of healing. Most Dani see some symptoms as potentially responsive to medical care, but a few symptoms--uncontrollable seizures, *panas dalam* (inner heat, indicated by fever, pulsing forehead), and *suangi* babies (babies who have "pointed heads and cannot sit up or talk")--cannot be cured at clinics. Equally, however, most symptoms will also respond to *adat* healing techniques. Seizures and *panas dalam* can be cured through *adat* sometimes, as can pneumonia, scabies, malaria and other common diseases.

Mantri are all adept at manipulating the *mantri's* secret in order to keep patients happy. The *mantri's* secret is simple: "never tell a patient that you know he believes in *adat*. Never tell them what disease they have. Just give them the medicine." Throughout the valley, all *mantri* stressed that they adopted this approach to providing care, hiding what they know about what the patient knows, while they simultaneously hide from the patient what they know about biomedicine.

Mantri employ their strategy of secrecy because *adat* beliefs prevail. Jacob, a highly popular *mantri* for the busy clinic of Hitigima, analyses responses: "around here maybe 50% call themselves Christians, and 50% believe in *adat*. But when it comes to sickness, everyone looks to *adat* first. People who come to see me have already made their diagnosis." The other *mantri* who come from the valley agree that most Dani ground etiologies in *adat*, that is, in the belief that actions of oneself or others can cause illness, that ancestors are primarily responsible, but that sorcery and malicious spirits can also

play a part. Some Dani may resort to religion immediately, but more often than not, *adat* precedes resort to biomedicine, and prayer generally takes second place in term of its healing power to all other options. For example, Christians resort to prayer more quickly, but these incantations often remain at the level of lip service, and in at least one case I observed, a "devout" Christian immediately sought help from a local person and from a *dukun di dalam* for her child's fever, only resorting to prayer once the child was significantly better. Along with *adat*, many people will also pray or go to the clinic. Depending on whether or not the person gets well, a common pattern of alternating *adat* with *puskesmas* care can bounce back and forth for some time. Thus the *mantri* who wishes to heal with penicillin or another pharmaceutical needs discretion to avoid offense.

In the following portraits of three popular Dani health care workers, I show how these men negotiate a prominent role within the dizzyingly pluralistic approach to healing that I have outlined above. Without aligning themselves resolutely with the biomedical services available at the clinic, the health workers nonetheless end up by expanding the influence of government health services, ironically primarily through the culturally-grounded stoic silences and secrecy they maintain around diagnosis and treatment of the patients they see.

Jacob and the "*Mantri's* Secret"

At the Hitigima clinic in late November, as the rainy season was beginning, a woman brought her young girl of about ten months for Jacob to treat. The girl was thin, wan, and racked with horrible coughs. Every few minutes she would have a coughing fit and spit up mucus uncontrollably for about twenty seconds, and then would go limp, while her mother tried to catch the mucus and wipe it up, as she crooned and rocked her weak little girl. As Jacob ran through the patients in order of their arrival, he cringed

every time the girl coughed. When it came to her turn, Jacob asked the mother: "How long has she been sick?," and the mother replied "a long time," to which Jacob retorted "then why didn't you bring her in before?" and the mother answered, "I was busy in the garden." On the basis of this conversation, Jacob gave the little girl an injection of penicillin and told her to come back in a few days for another injection. After everyone had left, I asked his opinion on this particular case. He grimaced, as if both he and I could still hear the sound of the child's cough in our ears. He replied,

That baby might die because she waited so long to bring her in. When the mother answered that she had been busy, I knew that she had done *adat* and brought the baby in only when it was clear the baby might die; that the *adat* wasn't working... I don't tell her these things, don't tell her that the baby might die, I just give her the medicine. People are obsessed with death. If I tell them what I think I'll make them worry, so I just give out medicine, which is helpful sometimes because if I run out of medicine I just give out something else, without explaining, then they don't know if it's the best medicine or not.

The next week, the woman brought the child back for a second shot, and the week after that she returned for a third shot with her child who had improved somewhat, and had gained a little lost weight back, but was still coughing. The mother and I had a brief interview, in which the first thing she told me she was that she was a Protestant and so was her husband, and that they didn't do *adat* ceremonies anymore because the church forbade it. Then she went on to explain that this was the first time any of her children had gotten this disease: "There is no traditional medicine for this disease, you have to pray to God, and not do *adat*, and so I prayed and prayed. But prayer doesn't work, so we did *adat* and under *adat* the baby got just a little bit better. Then when she didn't get better, I prayed some more; then I brought her to see Jacob." A few weeks later, Jacob told me that the baby had died. Her mother had not brought her back to the clinic after the third visit when I interviewed her. He presumed she had noted the child's improving health and had chosen not to continue with treatment, saying "If she didn't come back when the baby

got sick again either she was embarrassed or she was more concerned with fixing up *adat*. It's too bad, I could have saved that baby."

Cheerful, joking, and amiable, Jacob is a highly popular *mantri*. Patients, notably women with children, will walk several hours to seek treatment with him rather than with two other *mantri* who practice at posts nearby who have bad reputations (see Figure 20). Jacob's good reputation derives partly from his willingness to go out of his way to help people. He will walk for hours to help a sick person if that person cannot walk. He does it for money or barter, but other *mantri* often refuse to take these additional measures to help, payment or not.

Jacob has been practicing for almost twenty years. He was selected by missionaries and taught basic anatomy, diagnosis and treatment through, as he puts it, "doing, not just learning." Through rote and repetition of bodily actions, Jacob gained exceptionally high levels of confidence in his skills: "once knowledge is in me it can't be forgotten" he said, and he feels the mission trained him well, better, in fact, than training at any of the short government-run seminars he has attended since: "they talk and talk and want us to listen and listen. We don't learn anything." His mission training was a factor in his becoming a Christian, and he is the only adult man I met throughout my year in the Baliem valley who does not raise an *adat* pig for the big pig festival. However, he is intimately familiar with all the permutations of healing that take place outside his clinic.

Because of Jacob's popularity, he enjoys good relations with the Wamena health office. As well as showing consistently high use rates by the local population, he always submits his monthly reports on time, uses his medical allotment carefully, and encourages women to participate in government programmes including birth control, immunizations, and weigh clinics. Perhaps because of his conformity to bureaucratic expectations, Jacob receives a fairly good assortment of medicine, better, it seems, than other *mantri*, although it was difficult to determine whether he was more careful in

meting out coveted medicine such as penicillin or whether he simply received more of it than other *mantri*. Certainly, the supervising doctor at the Wamena clinic wished there were more *mantri* like Jacob, and cited him as a model employee, with his carefully documented medication statistics and his ability to motivate women to participate in government initiatives.

Jacob's popularity comes not from his knowledge, from his religious status, or from his jovial personality, but mostly from his ability to hold his tongue: he was the most assiduous practitioner of the *mantri*'s secret in the valley, never referring to *adat*, to death, or to the act of diagnosis in any of his interactions with patients. By bringing in five or six patients to the examining room at a time, by sustaining a high level of gossip and banter, and by moving fast and efficiently, Jacob could be highly personable without revealing any of his treatment strategies. Overall, Jacob has adopted the biomedical model of child health over ones grounded in local knowledge. His patients do not know this, however, and this space between knowledge and practice that secrecy allows is a space that allows him to promote immunizations, birth control, and the use of weigh clinics without challenging local knowledge and practice.

Simeon the Strategist

Simeon, a *mantri* now for twenty-five years, was trained by missionaries and has been diagnosing and treating illnesses in the Baliem valley since 1971. A jovial, portly man, he supervises three staff at Sogokma, the southernmost clinic in the valley. He retains control over the amounts of medicine his staff use, because he says health staff are wont to steal drugs and sell them privately. He therefore does most of the diagnosis, leaving the administration of medicine and weigh clinic activities to other staff. In this fairly rigid control over the clinic's division of labour, Simeon gives himself the status

job of making a diagnosis, and employs a vibrant actor's persona to communicate his inviolable skill to patients. Simeon claims to know immediately who has done *adat* and who has not; in fact he claims to know the diagnosis before the person has even sat down, which makes all the "hmmms" and nods he gives while people are explaining what is the matter with them part of an impressive acting role, in contrast to his more reserved private persona. When someone comes in with a sick child, he asks them "why did you wait so long?" and they answer "we had no money, we were busy" which tells him they did *adat*, and that he must keep it a secret, a secret he claims he already knew. As he says, "I know the people in Sogokma so well, I know they'll be needing my services even before they know it themselves. But I don't tell them anything, they have to come on their own." *Adat* has to be a secret if it's to work, he argues, because if you tell anyone that you are carrying out *adat*, you run the risk of retribution from the ancestors or of jealous revenge from enemies.

Simeon grounds his healing firmly in both *adat* and biomedicine. He participates in alliance rituals, is a minor leader in his own clan, and keeps many pigs, including the *adat* pig for the *epe ago* feast. In cases where patients are reticent to talk but haven't gotten better after several injections, Simeon might say something euphemistic such as, "maybe there is a problem?" and the patient might reply "there is" which allows them both to know what it is they are talking about, namely *adat*:

We must be discreet about what we know. A person will come in with a very sick baby and it's obvious to me that they have tried *adat* before coming in and so I don't say anything, because *adat* is a big secret. If a baby gets sick, you can't talk about it, he'll just get sicker, so a family does *adat* in secret, partly so the elders or other gossips won't find out about it and give their opinion and make trouble for the family that is already busy enough worrying about their baby. All *mantri* know they have to keep secrets. *Mantri* never give out the diagnosis, only the medicine, they never bring up *adat*. They might talk about God a little bit to distract the parents, try and inflate God's role in the scheme of things rather than get angry at the parents for doing *adat* and taking so long to bring the baby in. Patients want reassurance, not explanations.

Simeon enjoys the art of diagnosis, especially if he has the appropriate medicine on hand, but access to medicine does not mean that the patient will necessarily get better. "Medicine," he says, "is a component of *adat* healing, but it comes after, not in conjunction with all the rituals of pig killing and eating." Simeon uses biomedicine as a tool to diagnose sorcery efficiently: "you give a diagnosis and only later do you learn it is sorcery because the person doesn't get better. I try and give the medicine that will heal, when we've got it of course and that isn't always. Sorcery, *adat*, careless behaviour, whatever, the most important thing for me is to keep my reputation," he said one day and chuckled, "I'm the *mantri* who is famous for *satu suntik dan sembuh* (one injection and fully healed)! That's why we're closing tomorrow. I've run out of penicillin, and I don't want to have to give out useless medicine; it wouldn't do my reputation any good."

Albert's Ambitions

Albert has been the *mantri* for Kuliama for six years. A firm believer in *adat*, as well as a devoted churchgoer, Albert is conscientious, quiet, and very ambitious. In our time together, he complained at length to me how hard it was for him to do a good job of providing medical care. Albert uses the *mantri*'s secret--no discussion of diagnosis, no explanations--because he has to cope with acute shortages of key medicines. For example, when I interviewed him in September, he told me that they had had no antalgin for six months, no ampicillin for three months, no tetracycline for two months. He showed me how the requests for medicine he submits often have nothing to do with the medicine he receives: he'll ask for 100 vials of ampicillin for infections, for example, and instead get 10,000 sachets of Oralit, rehydrating powder for diarrhea primarily intended for infants and young children. He opened a large unlocked cupboard and showed me that it contained at least 100,000 sachets of unused Oralit: "We have so much Oralit we don't know where to put it all, and for what? Nobody ever uses it, we never give it out." Thus,

when he opens his clinic doors in Kuliama he uses silence and secrecy as a way to get around the fact that he is limited in what quality of care he can provide. If someone comes to him with a case of *salah jalan* ["dirty walking" or gonorrhea] what he would like to do would be to give the patient some trisulfate, but since none is on hand Albert probes the patient for more details on how serious the condition is. If the patient says his urine has blood in it, then Albert will hunt up his special stash of trisulfate and give it to the patient; if not, then he holds back on the correct medication and sends the patient home with disinfectant soap especially made for sexually transmitted diseases, and with injunctions to wash frequently. Of course, he says, the treatment does not work, and the patients end up back at the clinic, and if Albert still does not have the medicine then he must play the game all over again.

Albert also uses the *mantri*'s secret because, after eight years of work, he knows the futility of talking about *adat* in a clinical setting. *Adat* healing is supposed to be a secret, thus patients are unlikely to talk to him about their healing attempts. Albert believes in *adat*, because "it was the only truth when I was growing up," he said, and he knows what is going on when people show up at his clinic and have been using *adat* healing strategies. Sometimes if he has been trying to heal a patient for a long time he will break the silence and ask if they "have put everything to right." He tells the patient to go away until they have performed the necessary rituals and then when they come back the medicine will work: "The injection is what cures, but *adat* has to be made right before it can work. Fixing *adat* makes the injection effective."

When one of the wives of a prominent alliance leader fell sick, for example, Albert used clinic medicine in conjunction with her husband's *adat*. Lesina Hilapok, the third wife of Otober Kossay, fell deathly ill in the fall of 1994. Because her symptoms were considered serious -- a high fever, shaking, and loss of consciousness -- the alliance leader let little time pass before conducting a series of *adat* ceremonies, first a confession (the secret contents of which were the source of much debate), then feeding Lesina a

piece of *adat* pig, killing a pig and smearing the blood on her. This latter ceremony was repeated five or six times. Lesina's co-wives decided to pray, although Otober did not, and the Pastor came to visit and prayed with her as well, leaving a crucifix and a Bible in the doorway of the woman's house to ward off ancestor spirits and sorcerers. Almost simultaneously, her husband called on Albert who gave Lesina pills and then an injection of penicillin. When those didn't work, Albert came to visit her once or twice a week and gave her injections at every visit. Albert never offered a diagnosis throughout this time but tried out a range of pharmaceutical combinations though in his mind it was clear that the problem lay with unresolved grievances and sorcery that were targeted at Lesina's husband. When the medicine failed, Otober called for the renowned shaman from the west of the valley who came for a day and conducted a healing ceremony in which he established the diagnosis as sorcery, and claimed to have cured her. As Lesina rallied a bit, *mantri* Albert claimed success. When I interviewed Lesina during this time, she told me someone caused her sickness. She also thought she was sick because she was sad about her eldest son's departure to the coast. An "imbalance" in social relations was causing her sickness. But Albert told her not to think like that, not to blame herself, but to continue taking his medicine, "a little bit of everything," he said, "phenobarbitol, vitamins, tetracycline." Throughout this time, Otober brought rice, noodles and the occasional tin of sardines back from Wamena for his sick wife, and was considered by many as highly solicitous.

Lesina eventually died, some five months after her original collapse. Dani from the entire region stopped their work to attend the funeral, to bring a pig if they could afford it, sweet potatoes and netbags if not, and to cry, and mourn over her in the year following her death by smearing mud on arms and faces, by wearing old and ugly clothes, or by returning to traditional attire; a penis gourd for men, a *yokal* for women. Throughout the eight months of mourning, people mulled over reasons for Lesina's death. While some insisted that it came about because Otober mixed Christianity and *adat* in

attempts to heal--none opposed the mixing of clinic medicine and *adat* --most agreed that she died of sorcery, ultimately coming down in judgment on a minor tribal chief from the hills west of Kuliama, traditional enemy of the valley floor Dani, who had poisoned Lesina deliberately by feeding her a piece of stolen pig at a festival the previous year. One of the key factors cited in the pro-sorcery argument was the fact that the injections that Albert gave Lesina did not work. As Albert put it, "if it hadn't been sorcery, she would have gotten better. You can tell if a disease is caused by sorcery or *adat* if it doesn't get better the way it is supposed to under regular medication." Medicine provides a means to test out the validity of local diagnoses.

Most of the time Albert is fairly confident he can heal sickness, as long as the person's *adat* is "under control," as he says. Albert has used this knowledge in a coercive manner in order to further his career goals, notably to sustain high attendance at the monthly weigh clinics for which he is responsible. Albert speaks out at church and harangues his employees at smaller posts in the hills to send people to him for medicine, but mostly to go to monthly weigh and immunization clinics for babies. He admits to coercing families on occasion, "but mostly they don't listen." For example, a man from nearby brought his baby in to the clinic one day with an advanced case of upper respiratory infection. As Albert tells the story:

I asked him, 'Have you ever been to the Posyandu?', and he said 'No, never.' 'And you live where?' I knew the answer but I asked so he would have to face the issue that he lived close by. 'Near', he said, and I replied 'Near? Don't you hear me at church say to bring your child to the clinic for shots?' 'I'm busy in the garden.' 'What's more important, the garden or the kid?' I replied. 'They're both important.' 'Well, who do you make the garden for?' 'For my child.' 'Then, is the garden important or is your child important?' And then I told him, 'Ah, you make your garden for your child but you don't want to look after your child. Go back home with your child, I won't treat her here.' Then I stayed inside the clinic and after an hour I saw he was still waiting with his baby outside underneath the tree, and so I treated the baby. Now that baby has had all her shots.

Albert has strong links to the community and is well aware of the hierarchies and issues that prevent or promote participation in health or other development activities.

Albert's high community status, his regular pay cheques, and his good reputation at the Wamena health office as competent and reliable gives him power and an obligation to promote the health office, in particular to promote immunizations at the *posyandu*. In other words, he is placed in a position in which he uses biomedical knowledge about infants as a means to justify aggressively promoting health services. Key to the process is the way Albert manipulates information to retain his prominent position in a pluralistic healing system.

Commentary

The above three accounts highlight *mantri*'s concern with the act of healing and their pride in the work that they do. They try and control relationships within healing in order to maintain both their standards and their reputation when medication supplies are inconsistent and when the quality of drugs is poor. But masking a lack of supplies is not the full story. Even in Jacob's and Simeon's time, under the support of missionaries, when medical supplies were sufficient and reliable, both *mantri* used silence and secrecy as an efficient way to treat their patients.⁶⁵ Secrecy derives from *adat* beliefs but it masks two issues: the personal power of the *mantri* and the transmission of biomedical knowledge and practice. Not only does the *mantri* manipulate the symbols that offer solace, or at least appear to do so, in order to heighten his personal power, but he simultaneously legitimates the bureaucratic presence of *puskesmas* and *posyandu*.

First, *mantri* gain power through providing medical care. Biomedical knowledge gives *mantri* status because when the service they offer is effective the institution of

⁶⁵ This successful approach contrasts with another *mantri* I interviewed who openly attempted to connect allopathic medicine with *adat*: "I try and find out right away if it's sorcery, ancestors, or just sickness. If it's *adat*, I can ask them why they are sick and I'll tell them they have to go and make retribution and once they've done that to come back to me for treatment." By transgressing the privacy of *adat* healing decisions, and by refusing to engage in relations of secrecy, this *mantri* has lost patients and has a sorry reputation.

"government medicine" is validated. As long as new knowledge is filtered into the acceptable form of "*mantri's* secret" and as long as diagnoses and treatments conform to locally acceptable notions of disease and their outcomes (Young 1982), *mantri* gain the power that accompanies the ability to heal. A monthly wage and the chance to work alongside other powerful men can also increase *mantri's* social status. For example, Albert is a church leader, a financial partner of the government village chief, and the director of a soon-to-be-enlarged Kuliama clinic which he will oversee.

Dani patients respond to these recognizable cues of status and power. Responses to *mantri* healing are also grounded in time and space. Dani responses are also highly pragmatic, in a pattern already well-recognized in studies of responses to health care in Melanesia (Frankel 1986; Frankel & Lewis 1989; Lewis 1975; Romanucci-Ross 1975; Welsch 1983). In the current move towards a rapidly modernizing valley, Dani re-evaluate local values and practices in light of the influx of new ideas contained in *pembangunan* (development). Many Dani make explicit links between *pembangunan* and "government medicine." Pigg (1995) has suggested that from this reassessment of relationships between healing and modernization comes a specific "social symbolism," to use her term, that specifically accrues to healing personnel. In other words, because *mantri* are affiliated with government medical services, because they draw a monthly wage, and because they adopt a strategy of healing through secrecy, they sustain meanings different than those accorded to *adat* healers. The *mantri* personifies a certain type of modernization wherein form matters, wherein participating in health initiatives such as birth control connotes "progress," and wherein calling oneself "developed" invariably requires adopting "government medicine," in name if not in practice. Thus more than just a healer, the *mantri* is intimately connected to other forms of governance in the valley.

As well, the *mantri's* secret works to transmit knowledge. *Mantri* transmit the healing model offered in their textbooks and teachings in the ways they treat others. They

encourage women to bring their children to clinics for immunizations, even though Albert, at least, was vocal in saying that unnecessary shots go against cultural ideas of what is good for infants. *Mantri* promote the use of penicillin to treat upper respiratory infections because they know their medicine works, moreover because they *want* it to work. Perhaps most importantly, *mantri* implicitly reinforce the notion that Dani babies are abnormally small: By promoting monthly weigh and immunization posts, they force a comparison between Dani and other Indonesian babies that show the Dani babies to be deficient according to established norms; by promoting pre-natal care and by encouraging people to attend talks on birth control and nutrition they extend key objectives of the nation-state down to the level of everyday indigenous experience (see chapter 8 for a full treatment of this issue). Where they are given room to offer new technology and ideas, *mantri* do so. The treatment of diarrhea, for example, fails not because *mantri* are unwilling to promote Oralit rehydration therapy, but because Dani caregivers are not interested in using it. Overall, while each *mantri* expresses different levels of commitment to biomedical knowledge, and uses it in an idiosyncratic way, they by and large transmit intact the practice of what villagers call "government medicine."

Performing *adat* legitimizes the biomedical perspective and policies of the nation. In its emphasis on secrecy and silence, *adat* essentially prevents *mantri* like Jacob from saying anything about healing at all. Through this silence *mantri* transmit some features of biomedical knowledge. Whether or not the Dani make use of these services is one important aspect of this situation of medical pluralism (cf. Last 1981). What I suggest matters more, however, is the way the *mantri* legitimize the presence of "government medicine." *Mantri* may not transmit the specifics of biomedical knowledge systems, particularly disease etiologies and anatomical understandings, but they enhance the legitimacy of a relationship between biomedicine and the rule of a nation.

Conclusion

The delivery of medicine in the Baliem valley is inseparable from broader state attempts to promote change, understood locally as *pembangunan*, and the prominent role of the government in all arenas of social life (Azis 1996). *Mantri* communicate ideas about biomedicine at the same time as they communicate ideas about the relationship between biomedicine and the Indonesian state. Both connote progress and change. Undeniably, though, the goal of the nation-state is to make conformist health practices part of national agendas that promote the prosperity and health of families. Likely, *mantri* will come under increasing pressure to become more actively involved in the arts of persuading, particularly given the increase in programmes geared specifically towards infants (UNICEF n.d.). On the basis of observations in the field, I argue that this is already happening. *Mantri* like Jacob and Albert are lauded and promoted; others, more lax in ensuring participation in, for example, family planning outreach, are slowly being transferred out of positions of power.

The techniques of power employed in the realm of health care have only been touched upon in this chapter. In the following chapter I broaden discussion of the impact of health care services offered to infants. I show how the production of statistics about infant health, a near-obsession with infant growth, and the attitudes of non-indigenous workers are all processes that solidify relations to promote conformity to national health goals. Strategies of statistical manipulation and racial practice draw from a "national culture" that reveres children, that sustains a racist attitude towards indigenous people of the Irian Jaya highlands, and that defers knowledge and power to government authorities, such that the search for the "normal" infant becomes a model for and a means to legitimate coercive health measures against the Dani.