

Chapter VIII

The Indigenous Infant and the Body Politic

"All members of society, even those who seem to be incapable of participating, have significant roles [to play] in development"

H. Sayono, Indonesian State Minister for Population (1996:119)

One day, I asked a family that happened to be visiting Wamena from Kuliama one afternoon to pose beneath a large poster promoting *KB*, or family planning, that was situated in the busy marketplace. The husband Franciscus, a man who I had been working with for some months, looked up at the poster and grinned knowingly. He stood stiffly in the center of the billboard, flanked on both sides by his two wives, both of whom carried an infant under one year. Three other children aligned themselves on either side of him, and smiled happily at the camera. While my photograph shows the ideal family according to at least one Dani man, the billboard shows the Indonesian family ideal: a woman dressed in batik cradling her plump infant, standing with a man holding the shoulder of a five-year old boy dressed in a school uniform. The billboard proclaimed "Two is Enough." On another occasion, a monogamous family from Kuliama asked me to take a "family picture" of them. Pelesina, mother of four children including a newborn, changed into her best dress and stood awkwardly alongside her husband who put his arm around her and their children and posed for the camera. Awkward about touching in public, Pelesina and her husband split apart immediately after the picture was taken. Pelesina said to me, "it is right to take a family picture now because we have had the all the children we need. Four is enough."

This chapter is about the nation-wide models of the family to which Pelesina and Franciscus are reacting. Franciscus offers a comfortable response to ideal government

models of a two-child nuclear family. Pelesina, more inclined to want to emulate Wamena families, struggles in a too tight dress and accepts her husband's embrace as a means to confirm her affiliation with the *pendatang* (newcomers) she meets in Wamena. While there are a range of responses similar to those of Franciscus and Pelesina, this chapter is concerned to document the processes by which they and other Dani in the Baliem valley are confronted with powerful and recurring formal policies to reshape the family. This chapter describes the model ideal family and documents the techniques by which the model is communicated. I argue that nation-wide ideals of the family are especially prominent in the arena of infant health care. In attending *posyandu* (infant weigh clinics) or in seeking pre- and post-natal care of any kind, infants receive medical care that is tightly bound to a "national culture" that places familism at the forefront of desired social behaviour. That culture of familism, in turn, turns on hegemonic institutional relations such that notions of the ideal family are present in policies, specific practices, and attitudes of valley *pendatang* (newcomer) in both health care and in valley relations in general. In nation-wide models of the family, the infant and young child hold a particularly prominent place. Children symbolize the merits of government; they are the beneficiary of a positive vision of the future, and they validate themes of prosperous growth and family values that the nation offers. The very young child is both the target and a tool of policy, a key communicative device by which national goals gain legitimacy among the heterogeneous Indonesian citizenry.

This chapter extends from Chapter 7's focus on the extent to which state and civil society complement one another in Indonesia, for example, in the *mantri*'s role as mediator between for health programmes, to a focus on the features of the Indonesian health bureaucracy that promote assimilation. I examine non-Dani health worker practice and the operations of *posyandu* as key places wherein the goals of the nation-state are further institutionalized in local thinking and action. Gupta (1995) has argued that minor bureaucrats such as *mantri* supervisors and clinic and agency heads (all non-indigenous

immigrants to the region) transmit goals of the state, adding that they do so in a manner constrained by social and cultural norms of a given place. As an "outer island" province, the easternmost province of "underdeveloped Eastern Indonesia" and the home of many of the nation's *suku terasing* (most isolated tribal peoples), Irian Jaya is on the receiving end of recent state attempts to integrate the province more fully into the nation (Azis 1996). The bureaucracy of health care at the local level is firmly ensconced in the nation's broad efforts "to construct images and ideals of unitary identity" (Foster 1995:2; see also Foulcher 1990; van Langenberg 1990).

While a more usual approach within anthropology would be to review Dani responses to this bureaucracy, I argue it is more relevant to document the impact of nation-wide images and practices on indigenous families and infants. This is not because Dani response is unimportant but because the institutions that provide health care in the Baliem valley are more tightly controlled than they first appear to be, and because health practices are more bound by hegemonic goals of the nation-state than by goals that are simply humanitarian. Health measures that at first appear benevolent and unproblematic, such as immunizations and weighing, can also be seen as part of a political process of naturalizing connections between a national culture and a heterogeneous citizenry that make up its members (Gupta & Ferguson 1992). This chapter explores ways that the nation-state creates and accumulates knowledge about its citizens by rendering minorities within as knowable subjects: "subjects counted and classified in censuses; registered on birth certificates; issued with draft cards; and so forth. Moral regulation, in this sense is all about the establishment of categorical identities" (Foster 1995:17). Identities need not necessarily be ones of inclusion, however, and it is a goal of this chapter to document ways that the Dani are created as Other more than as welcome citizens.

This chapter begins with a review of the ways children function as a symbol in Indonesia to support development goals and paternalistic models of nation-citizen relations pervasive in the contemporary nation-state. Next, I describe *posyandu* (child

weigh clinics) as exemplary of the tightly-meshed relationship between national cultural models and local implementation of seemingly neutral health measures. The production of statistics at child weigh clinics, the recording systems, and the child immunization records all reinforce a broad policy of assimilation. Statistics are manufactured and manipulated to emphasize infants in indigenous communities as "small" and "unhealthy" and therefore in need of intervention. Finally, I scrutinize the types of ethnic discrimination that pervade the health bureaucracy by examining the response of a non-profit agency head to a Dani woman's childcare strategies. In denying validity to Dani practices, health care providers promote ubiquitous and powerful state models of citizenship even as they deny the Dani a significant role within the nation.

The Child within the Indonesian Nation-State

Family in the modern sense--a unit bounded, biologically as well as legally defined, associated with property, self-sufficiency, with affect and a space 'inside' the home--is something that emerges not in Stone Age caves but in complex state-governed social forms.

(Collier et al. 1993:155)

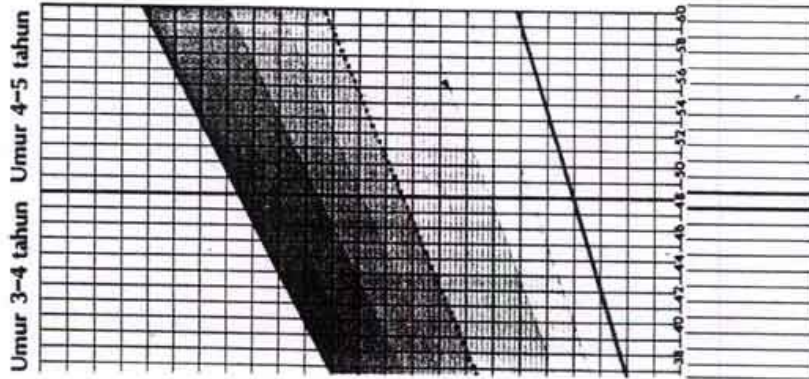
Children play a prominent role in Indonesian government propaganda and in the country's "national culture." The idea of a national culture is central to the Indonesian nation-state's search for ideological legitimacy: in fact, it is written in the country's constitution (Foulcher 1990). Ideally, national cultural values combine a healthy dose of "tradition" with such elements of modernization as are seen as positive. Aragon has termed this "the internal politics of culture" and recognizes the efficacy of the strategy for containing ethnic difference (Aragon 1994; see also Hughes-Freeland 1989; Kipp 1993; Liddle 1985; Pemberton 1994; Spyer 1996). Regional arts, dance, and spectacle are welcome as long as those cultural values and forms do not serve alternate political interests or promote alternative foci of allegiance and identity: "systems of belief which

once constituted an all-embracing moral order have become like an etiquette; what counts as *adat* is only what can be displayed or performed" (Acciaioli 1985:161; Aragon 1994).

Within national culture imagery, children have several roles to play. The first identifies the child's political role as a key member of a domestic family unit, the "household." The household is an ideal type: "the authoritative, all-knowing father; the ever-giving, never-angry, and also all-knowing mother, who is in charge of family life; and obedient children" (Shiraishi 1995:170). Grounded in concerns of the nationalist movement in the 1930s, which were in turn fomented by interventions into families in the Dutch colonial era (Stoler 1995, 1996), discourse of the family saturates official language in Indonesia. Soeharto is *Bapak*, "father" of the nation; elders and bosses are addressed as "mother" and "father"; and obedient adults are equated with children who know their duty (Shiraishi 1995). A "family principle" conceives of the state explicitly as family: "Paternalism infuses Indonesian social organization and relationships, with President Suharto as the ultimate *bapak*, or father figure" (Suryakusama 1996:95) or, in the words of the nation-wide civil servants organization's constitution: "the family household is the smallest unit of a nation" (Suryakusama 1996:97). In another example, ideologies of paternalism were used in a 1974 pamphlet airdrop in the warring border region between Irian Jaya and New Guinea, where the army referred to itself as *Bapak Tentara* (Father Army) to discourage rebel forces (Gietzelt 1989).

The woman's role in this imagined family community is to nurture her children. Sears shows how the *Garis-Garis Besar Haluan Negara* (Principal Outlines for State Policy) clearly describes the role of women as, at the very least, "a wife and associate of her husband, an educator and cultivator of the younger generation, a controller/regulator of the household" (Sears 1996:19). Above all, the family is part of a larger socio-political order: "the family is the smallest unit of society consisting of husband and wife, or husband and wife and their children" (Government of Indonesia 1992:7). Shiraishi (1995)

Figure 22. KMS - Front



Bawalah KMS setiap kali berkunjung ke Posyandu dan Sarana Pelayanan Kesehatan.

Boleh di cetak dengan se-izin Dep.Kes.

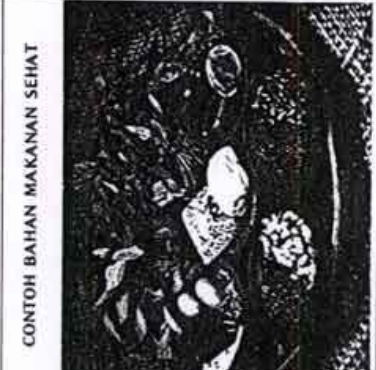
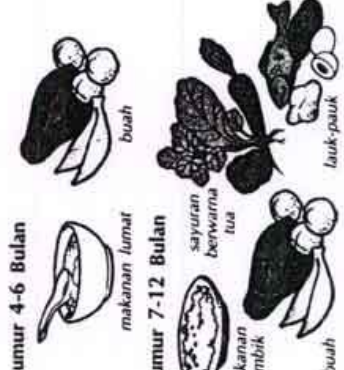
Jenis Imunisasi	Tgl. diberikan Imunisasi		
	I	II	III
B.C.G.			
D.P.T.			
Polio			
Campak			

- Mintakan imunisasi untuk bayi sejak umur 2 bulan.
- Imunisasi harus lengkap sebelum bayi berumur 1 tahun agar bayi terlindung dari penyakit berbahaya.
- Penyakit ringan seperti panas, batuk, pilek dan mencret bukan halangan bagi bayi untuk memperoleh imunisasi.

KAPSUL VITAMIN A-DOSIS TINGGI:
(Diberikan hanya kepada anak balita kecuali bayi sampai umur 1 tahun, satu kapsul setiap 6 bulan).

Tanggal diberikan ke 1:
ke 2:
ke 3:
ke 4:
ke 5:
ke 6:
ke 7:
ke 8:

**PETUNJUK
PEMBERIAN MAKANAN YANG SEHAT**



TIDAK DIPERDAGANGKAN

KMS

KARTU MENUJU SEHAT

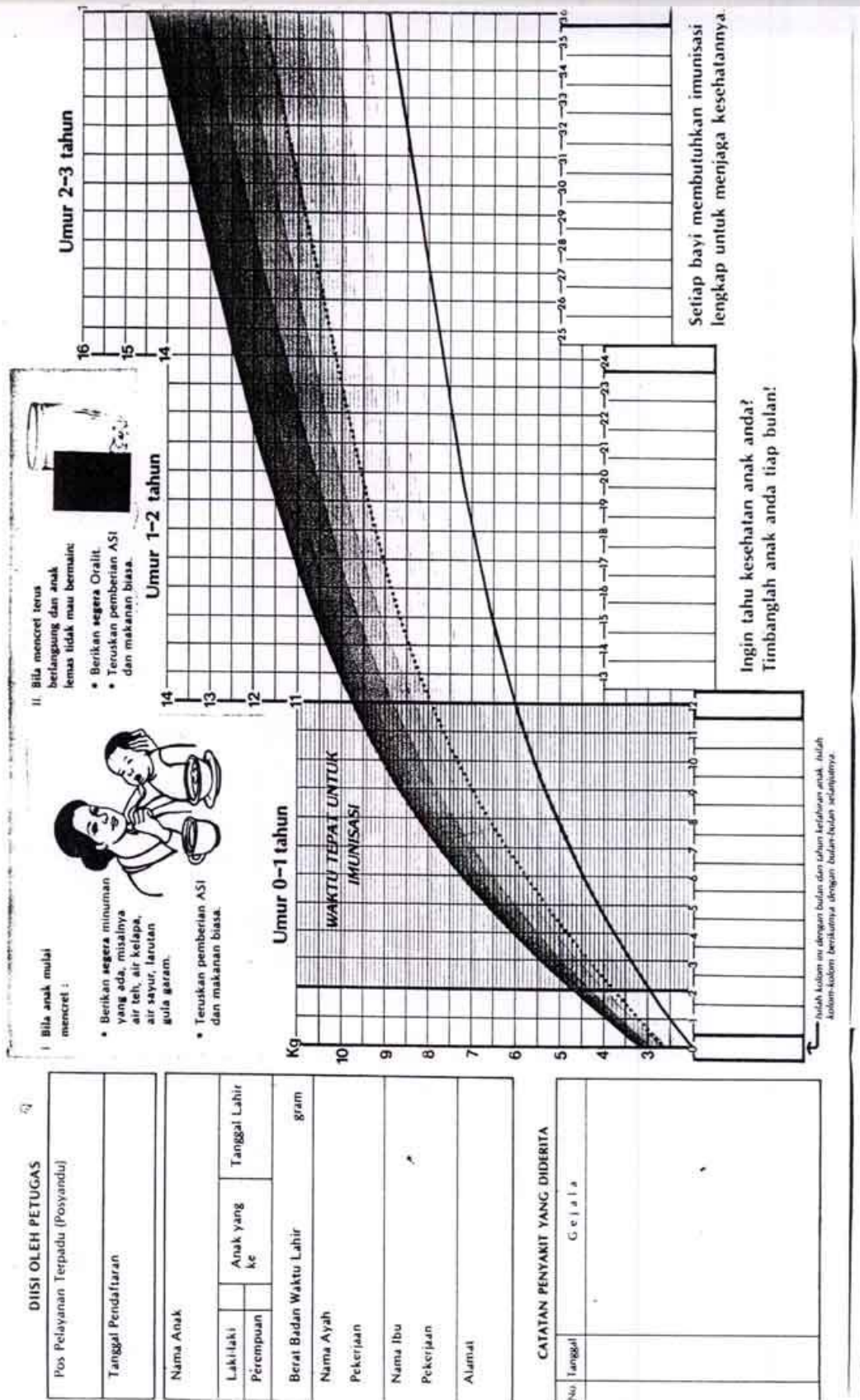
Nama Anak: No. Pendaftaran:



AIR SUSU IBU
makanan bayi terbaik

Dibuat oleh
Departemen Kesehatan Republik Indonesia
dalam rangka kerjasama dengan UNICEF
1982

Figure 23. KMS - Back



has demonstrated the ubiquity of images of a docile female domestic regulator in popular children's literature in Indonesia, in which a currently popular political ideology of *tut wuri handayani* (guiding from behind) also underlies most children's literature.

Wondering why family relations in children's literature is depicted as so highly and consistently laden with political messages, Shiraishi suggests that "guiding from behind" draws its roots in the history of the country and reflects a conservatism and obedience ultimately grounded in fear of political reprisal. As Pemberton (1994) and Tanter (1990) posit, violence during the 1966 revolution and other political battles remain part of people's memories:

In Indonesia today the terror which matters most is not what is manifest in day-to-day social relations for the majority, and which is uneven, diffuse and low-level in its affectivity. It is the memory of having suffered horribly in the recent past.
(Tanter 1990:269)

These memories give impetus to Javanese models of reticence and obedience to political authority, models that guide contemporary Indonesian politics across the nation (Vatikiotis 1993) and that transform obedience into everyday practice such that in Indonesia, "terror becomes culture" (Pemberton 1994).

The second role the child plays is to make "national culture" accessible. If "ritual idiom" can make imperial authority "manifest and compelling" (Comaroff & Comaroff 1993:xvii), then children dressed up, marching in file, and singing their *adat* songs symbolizes the need to make the concerns of the next generation a national priority. Extremely young children dress up as adults and perform on national public television; children often act as the heroes of state-sponsored television programmes; children dance and display finery in parades in the community, at school, in print media and on television, and in spectacular costumes, singing and dancing for every major religious holiday (Sears 1996). While this focus on child-oriented public performances may draw from roots in Javanese cultural values, the extent to which Javanese values have pervaded models of national culture mean that even Wamena children and youth, well-entrenched

in nationalist education and ritual display, have adopted the notion that culture is spectacle, and that spectacle is linked to the nation's prosperity and to the country's motto, "Unity in Diversity" (Kipp 1993; Langenberg 1990; Anderson 1990; Foulcher 1990).

In much of Irian Jaya children must wear uniforms if they wish to go to school. Every morning students assemble in file to salute the flag and sing the national anthem. In Wamena, at major Christian and Islamic religious holidays, at independence day, and for school holidays, children dress up in the cultural costumes of their homeland or that of their parents and parade in orderly units throughout the streets of the town. They sing songs from their homeland and some try out dances they have been taught. New notions of modesty mean that Dani girls wear t-shirts and strap netbags across their breasts instead of hanging down their back, and boys paint their faces and bodies but wear shorts instead of a penis gourd. All children are technically welcome to participate but invariably the parade leaders, in the costumes most admired from the parade watchers, represent families from central Indonesia.

The third arena where the child has influence is in linking families to healthy practices. An assumption that underlies the Happy Families Law and family planning policies outlined in the previous chapter is that if Indonesian families have healthy children, they will in turn want smaller families (World Bank 1990; Government of Indonesia & UNICEF 1988). Smaller families help keep population growth under control. And as many Indonesians told me, smaller families mean that you can look after your children better, providing them with the opportunities, for example, to attend parades in quality costumes. The small family ideal has pervaded everyday life and, notably in discussions I held with Indonesian women in 1993 in Java, most families have internalized the two-child family logic and have given it a personal interpretation that makes it meaningful to them (cf. Hull & Jones 1994).

The notion of an ideal family is a construct made legitimate through state policy, through national cultural values, and through a broadly consensual intense affection for children. However, national family values also find their way into health practice. The ideal family model is promoted in indigenous communities whose practices differ drastically from this constructed norm primarily through interventions in the arena of early childhood health. In the following section I describe monthly weigh clinics in some detail to show how health care employees and bureaucrats reproduce the family values outlined above. In the bureaucratic practice of the actual clinical event, in the production of statistics, and in the forms used the message about family, conformity is reinforced.

Infant Weigh Clinics: The Production and Manipulation of Statistics and Families

One of the most ubiquitous features of Baliem valley health care is the baby weigh scale. *Posyandu* (monthly weigh clinics) are held every month at *puskesmas* and at established posts across the valley. They are free and target pregnant women and children from birth to five years of age. *Mantri* and *kader* (village volunteer health workers) are expected to visit the farthest corners of their villages, to encourage women to attend, and to have their baby registered, weighed, and immunized on the same day of every month. Response to this service is varied: of the ten *posyandu* at which I conducted structured observations, two had zero attendance, two had less than five attend, four had from between five and 20 children, and two had more than 20 in attendance. While I hesitate to assign the term "normal" to a summary description of weigh clinics, in the main, less well-attended clinics were held in the mountainous valley borders, where the immunization truck could not travel. The better-attended clinics were held in easily-accessible valley posts, and drew participants if a *mantri* influential within the

community, such as Jacob, advertised the *posyandu* well ahead of time and got *kader* to remind women and to round them up the morning of the clinic.

I observed a well-attended *posyandu* in Kuliama about six weeks into my field research and noted a high level of bureaucracy: At this *posyandu*, a total of ten paid and volunteer staff attended to weighing and immunizing children, starting about eight a.m. One of the volunteer *kader* was charged with tracing the names of the children attending, Albert and his wife Berta, paid and trained clinic staff, wrote down the names of the children, what they had received in the way of shots, and how much they weighed. They wrote this information down three times: once in the weigh cards mothers have to bring with them each time they go to the clinic (*Kartu Menuju Sehat* or *KMS*); once in the daily book of health records; and once in the official monthly statistics book that Albert works from when he completes his monthly statements of service use. They processed a total of 35 children that day, an unusually high number.

These procedures were well under way when the truck from Wamena drew up about nine a.m. with the two regular staff, two training nurses, vaccines, and a standard bathroom weigh scale. The two paid staff had specific tasks. Ibu Norma weighed the children and yelled the numbers over the din to Berta, who wrote them down (see Figures 17-19). Pak Dasinapa, a 20-year veteran of health services, gave immunizations to children in the minuscule back room using a sterile, reusable metal needle, which set the babies to wailing. The women, all illiterate, and many with minimal skill in the Indonesian language, sat outside or on the crowded bench inside the inoculation room and waited for their child's name to be called. Whether the child was a newborn or a toddler, the staff from Wamena asked the mother to take the child out of the *noken* and weigh herself, standing on the bathroom scale, both holding and not holding the baby. Staff wrote the information on the child's card, and the mother was then sent to the back with the baby and card where the child received injections and the *kader* wrote this information down on the card.

In order to process people faster, Norma called on several women at a time to come forward and be weighed as they waited for their shots, with the result that there were always 15 to 20 people in the tiny clinic at any time. Confusion grew as Norma handed a baby back to the wrong mother; as one woman refused to take her child out of her netbag and have her weighed by someone else; as women unfamiliar with the routine came forward without being called, and others didn't come when called. One woman came only to have her baby weighed, and everybody yelled and laughed at her; meanwhile the nurses in training were given the task of popping vitamin A capsules into the mouths of older children. Within the space of two hours, all the children had been processed, and mothers were ushered out, card in hand, with a thoroughly frightened child, and told neither to lose the card nor to forget to return the following month for their next set of shots.

In contrast, I experienced a no-show *posyandu* the following week when, accompanied by Jacob, I left the small Hitigima *puskesmas* to take a monthly hike up the mountain to give immunizations to the babies of the village of Air Garam, an hour's walk away (see Figure 21). He explained confidently,

These people are Christian, they all come for their immunizations because they are modern, not full of *adat* beliefs like the people in the valley below. At least fifty percent of Air Garam residents have abandoned *adat*. If they don't follow *adat* then they come to me right away if their children get sick.

Yet when we arrived at Air Garam, nobody showed up for immunizations, not even the woman who had promised just two days before that she would be there. Jacob was visibly disappointed, not least because the poor showing might undermine his claims to effective healing throughout the mountain region, but also because he was concerned that his excellent reputation with the director of health services in Wamena was overly-grounded in his ability to get women to follow government programmes such as these.

Actual *posyandu* attendance is low in the valley. Albert targets an immunization rate of 60% for valley children. Of this target he estimates he reaches half, or 30%, of the

area's children. Of this 30%, half come for only one or two shots and never return. Thus, about 15% of valley children are fully vaccinated. Albert's breakdown holds only for valley children: at *posyandu* in the surrounding hills where Wamena staff travel less frequently and where *mantri* are less involved in providing health care, attendance rates are lower. Thus, when I asked Albert what rates of full compliance he estimated for the entire region under his jurisdiction, both mountain and valley floor, he suggested that less than 3% of children were fully immunized.⁶⁶

While it is clear that *posyandu* have a strong bureaucratic presence in the valley, the current effectiveness of their stated initiatives is less obvious. However, in other parts of the province *posyandu* have become well-entrenched, and given some of the measures used to encourage attendance, there is no reason to expect that numbers will not increase in the future in the Baliem valley as well. The following sections describes some of the ways the bureaucracy of health care helps remake people into families consistent with values of good citizenship. In particular, the production of statistics and the use of cards to record weight promote impressions of poor health among indigenous people, a health status that can be improved if they adopt the health-giving measures offered by the nation-state.

The Production of "Abnormal" Infants

In Irian Jaya, as elsewhere in the country, governing bodies expend significant amounts of energy compiling statistics about people. Statistical discourse, however, almost always depends on "accepted beliefs about the nature of social reality" (Starr 1987:40), and these beliefs can often provide justification for the policies of a state. Like any other situation where statistics are considered important, decisions about what to

⁶⁶In contrast, government statistics state that 60% of children in Jayawijaya have been immunized (Kantor Statistik 1993). It is possible that the majority of relocated Indonesians have been immunized, and that mission-run posts in rural areas are also successful in immunizing indigenous children, but observations at mission-posts do not support such a likelihood.

measure in the arena of infant health belong to a world of political image-making as well as more pragmatic but no less political concerns about measuring acknowledged indicators of growth or change. Using Urla's insightful definition of statistics as a "technology of truth production" (Urla 1993), I argue that given the political past and present of Irian Jaya it behooves the nation-state to make health policies appear to be effective through the judicious use of statistics.

I suggest that in Irian Jaya two goals of statistical production exist: the first is to show the health of indigenous Irianese as lacking in some way, as needing intervention so as to "catch up" to the rest of the country; the second is to show health standards as improving, with rates of health achievements presented as solid and impressive. Statistics of mortality and growth then become an effective way to distinguish *suku terasing* from communities more integrated into the nation's prosperity, by showing how the growth of indigenous infants is "delayed" in less than ideal nurturing conditions. For example, by monitoring weight and growth, interventions can and do target children whose growth is recorded as not "normal," that is, whose height and weight is less than the national average (Frankenburg 1995). In this section I demonstrate that statistics produced about infant health in Irian Jaya are false on both counts.

Statistical reports about some of the most isolated regions of Irian Jaya sustain the "is" and the "ought" of "normal" infant development and growth. For example, height for age scores suggest that from 50 to 86% of children aged zero to four years in remote Jayawijaya test regions have "below average" scores (Handali et al. 1994). These are the statistics that show "the ways things are." Only 14% of children in one village, for example, achieved "normal" height for age scores. In another statistical report, only 7% of all children weighed at 36 months had weights over the desired average of 11 kilograms (WATCH & Dinas Kesehatan Jayawijaya 1995). The Director of Health Services for the region (who is of Javanese origin), has stated that Indonesian health measurements are tailored to country norms, not international ones. Consequently, an

infant who is "delayed" is so defined within constructed Indonesian norms. Situating health objectives in achievable terms is not an uncommon strategy but it emphasizes that biomedical knowledge and statistical recording facilitate development goals, rather than the other way around. This point was driven home to me at a talk in which the Director for Health Services explicitly stated: "indigenous people here don't know methods of eating, they have food, but food does not accord with what is necessary, and the result is children have less nutrition. *Children from Jayawijaya are shorter and lighter than children anywhere in the world.*"⁶⁷

The second statistical strategy employed is to show how health is improving. Jayawijaya children may be the smallest in the world, but they are growing bigger! Statistics routinely show sharp drops in infant mortality rates following the provision of care. This is "the way things should be" of "normal" growth. In keeping with Suharto's nation-wide anti-poverty crusade, infant mortality in Irian Jaya is seen to drop as the number of villages in the province tagged as "poor" also drops (UNICEF n.d.). Thus measuring infants can be said to be a means of measuring to what extent Irianese children conform to artificially constructed national goals of how fast and how big children *should* grow, presenting the ideal as the real and mandating interventions through this technique.

These indigenous infants, supposedly the smallest in the world, supposedly deprived of their basic needs because of their cultural environment, appeared to me when I was conducting fieldwork in Irian Jaya in 1994 and 1995 to be nurtured, loved, and growing children. They appeared to me to be at least as big and as strong as the infants of Indonesians living in Wamena. Challenged by the differences between official accounts and my observations, I focused attention on how statistics were gathered. I complemented these observations and interviews by conducting a small-scale census

⁶⁷This statement is highly problematic. In some parts of Jayawijaya, living conditions are arduous and children are "stunted" and do grow to be among the shortest in the world. However, Baliem valley Dani, for example, are robust and healthy people, and regularly outsize relocated Indonesians. Of the adults at the meeting where Dr. Hakim spoke, he was among the shortest adults present, and the few Dani were among the tallest.

where I tallied occurrences of morbidity and mortality, and by observing child care practices. My data challenge the official records, and suggest that five facets of numerical assessments within the health bureaucracy aid in constructing and legitimizing the idea of "abnormal" indigenous infants. First, bureaucrats compile false statistics to produce mortality rates that fluctuate wildly depending on the purposes to which they are put. Second, Irianese infants are not the smallest in the world but are made to seem so by government officials. Third, the Ministry of Health does not gather data about cultural identity which can clarify patterns of well-being as culturally or environmentally shaped. Fourth, official weigh cards communicate to women that their children are unhealthy. Fifth, the health of infants is made to be a household problem, and mothers the focused target of attempts to alter practice. I briefly discuss each of these strategies below.

1. *The Decline in infant mortality rates is fabricated.*

While unable to confirm rates across the province, tallies from the village in which I worked show overall infant mortality rates of 280 deaths per 1,000 live children, or a rate some 250% higher than the claims of the provincial government. Data collected by missionaries in isolated outposts suggest that rates of between 200 and 400 deaths per 1,000 are standard for the region. Thus the precipitous decline in rates attributed to the success of Indonesia's particular version of development does not appear to have a solid basis in the village-level demographic processes (see Table 11) I was able to observe.⁶⁸

⁶⁸I recognize the problems with small surveys that attempt to estimate mortality or sex ratios (cf. Stannard 1991). However, reports tallied by missionaries and small non-profit organizations across the mountainous core of the island offer similar ratios, which lends credibility to my census data.

Table 11. Irian Jaya Infant Mortality Rates per 1,000 live births in 1985, by Source

<u>Source</u>	<u>Mortality Rate per 1,000 births</u>	<u>Reference</u>
World Bank	38	World Bank, 1990
Government of Indonesia	74	Gov't of Indonesia/ UNICEF, 1988
Ministry of Health	133	Kantor Statistik, 1993
District Government	24	Kantor Statistik, 1993
District Government	106	Kantor Statistik, 1993
Health Center Records	100	WATCH & Dinas, 1995
Mission Records	300	Handali et al., 1994

Are mortality rates 38 deaths per 1,000 live births, or do 300 infants die for every 1,000 live births? This extraordinary variation in official figures suggests that statistics validate existing practices more than they measure the actual merits of health care. In my research, I could find no perceptible long-term positive impact of health policy on life expectancy of infants. Statistics beget changes and allow for realignments of policy, validating claims to improved mortality by showing concomitant decreases in malnutrition rates, maternal mortality rates, and low birth weight infants (World Bank 1991). For example, between 87 to 98% of women recently measured for nutritional status were classified as moderately-to-severely malnourished (Handali et al. 1994). What this measurement does is give impetus to a new policy focus upon maternal nutrition and increased prenatal care; in other words, the numbers validate the policy, even if the numbers have been made up and even if the measurements are clearly inappropriate for understanding women's health in that particular local context.

The outright invention of statistics occurs throughout the health bureaucracy. Indigenous volunteer and paid health workers have to conform to the goals set out for them to keep their jobs. For various reasons, trained indigenous area health workers produce the "right" numbers rather than accurate ones. For example, compilers of data look in frustration upon a list of birth weights tallied in which every infant weighed three kilograms at birth or upon annual reports from large villages listing not a single infant death. An administrator at a non-profit organization expressed frustration at his agency's attempts to get adequate baseline data for financial backers:

Indigenous people don't know numbers, they don't think in numbers and yet top-down bureaucrats from funding sources want baseline data. They want numbers. So much energy is spent trying to get *kader* (volunteer health workers) to learn how to use numbers and it never works. They do what they have to do--fake numbers--because that's what they are expected to do. They produce the "right" fake numbers because they learn fast what "should" be written down and so avoid problems and think they are doing a good job if they write down the "average" desirable activity.

Health workers I interviewed understood that providing numbers, preferably non-controversial ones, was a key component of their jobs. For example, six of the *mantri* I interviewed said they submit statements about birth, death, and disease that have no basis in reality whatsoever. *Mantri* are supposed to record a death (which rarely happens) and submit it to the clinic head. One *mantri* told me he tabulates mortality rates: "from gossip and from tales I pick up at the clinic. If someone died of witchcraft, I wouldn't write it down. I would make up something else instead, but if I know what killed the person then I usually write it down. I only write down deaths of older people, age two and up."

Supervisors who collate data from health centers expressed frustration with the inadequacy of record-keeping; "the reporting is either fabricated or impossible," said one staff member. Given that managers know both that the data are false and that they need to produce numbers that appear "reliable enough," they pass the falsehood on by massaging and submitting the impossibly conformist numbers they receive so that they appear more "real." Even the district health officer knows that the reports she sends to the provincial

capital are essentially fabrications. Administrators and bureaucrats allow the fabrication to remain, or "tidy up" numbers to look closer to what is expected. These numerical flights of fancy ultimately compound the fabrication of undersize tribal infants, for the statistical creations are hence less bound to legitimately measured and verifiable measurements of difference. Thus it is easy to show, as government reports do, that infant mortality rates have been on a steady decline in Irian Jaya for the past fifteen years⁶⁹ (see Mboi 1996 for recent example).

2. *Comparative measurements about "the smallest infants in the world" are also fabricated.* Some Irianese infants from the Highlands may be smaller than other Indonesian children who have benefited from diets richer in protein, and who have greater access to smoke-free housing and clean water. However, even if it is measurable, the difference in infant size appears to have been until recently nonexistent. In reliable studies of infant size at one year of age, for example, infants from the Indonesian island of Java have been measured as overall smaller and shorter than infants from New Guinea. Measurements at birth and at eight years of age showed negligible differences in growth patterns as well (Government of Indonesia & UNICEF 1988; Malcolm 1970; Meredith 1981).⁷⁰ On the contrary, size differences between infants of different indigenous groups from different environmental zones from within Irian Jaya are much greater than are the same kinds of differences between provinces. If the measurements are more or less artificial, and height and weight scores between Irianese and other Indonesian children

⁶⁹In tandem with this reduction in mortality rates, statistics are also showing extraordinarily rapid movement of Irian Jaya villages out of poverty. Ways in which statistics from Irian Jaya are manipulated suggests that the province is a malleable tool because few Indonesians have ever visited the province and it would be almost impossible to verify the data. Thus Irian Jaya can easily become the place where numbers are manipulated to bring down (or up) national level averages. I conjecture that this is the reason for the low statistics in the World Bank example from Table 12.

⁷⁰Length at one year: Javanese, Java: 67.6 cm; Bundi, New Guinea: 67.9 cm. Weight at One year: Javanese, Java: 7.52 kg; Bundi, New Guinea: 7.71 kg. In comparison, a Dutch study conducted at a similar time showed average length of 76.2 cm and weight of 10.23 kg. for Dutch children at age one year (Meredith 1981:281).

are little different, then constructing measurements so that indigenous children come out on the bottom is a political message, not a statistical fact.

3. *Measurements can be fabricated because characteristics of the person are omitted.*⁷¹

Officials do not record details about the individual child in monthly reports. Albert and his peers work diligently for days every month compiling statistics about patterns of all attendees. Nevertheless, sociological data are omitted. Information about ethnic identity, birth order, or a correlation between, for example, weight of child and number of immunizations, is not a normal accounting procedure. Thus, trained health workers at *posyandu* submit reports that detail the number of children whose weight was below nine kilograms at 36 months or below six kilograms at 12 months. They report on the numbers of vaccines distributed and numbers of those who attend immunization clinics. When Albert totals the number of incidents of upper respiratory infection diagnosed by his staff over the course of a month, he does not distinguish between those who arrive for a first visit and those who are returning for follow-up medication. Thus there may have been only five infants with pneumonia who visited the clinic, and these may all have been children of newcomers, but if each came four times, Albert records monthly totals of twenty cases of upper respiratory infection. At the level of bureaucracy, the gap in participation goes unnoticed. Records will show high attendance and high rates of immunization. Mantri may not try to rectify these gaps in reporting partially because the rewards gained from having a full house are the only criteria by which mantri performance is measured.

Omission of data about the person is significant for the following reasons. If newly-resident women bring their infants to immunization clinics, but indigenous women

⁷¹This strategy of omitting sociological information about persons is used across the country. The Household Health Survey does not collect data on ethnic identity, nor does the national Contraceptive Survey. Nationwide birth control prescriptive goals leave ethnicity and beliefs out of the picture entirely, and even the national identity card, which lists religion as a key sociological fact, does not ask for ethnic identification.

do not, this important pattern of service is not recorded in monthly reports. Staff record numbers of children who attend, their age and the types of vaccines they received, but nothing about the actual people who attend. Thus, in one instance I saw a well-attended village immunization clinic without a single indigenous woman in attendance. In another instance, women flocked to a nutrition demonstration program showing indigenous women how to cook tofu, vegetables and rice, but all attendees were indigenous women from other regions who had recently relocated to the Baliem valley. Local women and their infants fall through the wide cracks between services offered at health posts. Services appear to be well-attended and attendance is taken as a measure of success. The omission of sociological data about who uses what service allows the health ministry to continue to proclaim the success of its programs by enumerating attendees, even as these "successful" programs exclude the very women and children who may be in most need of its benefits.

4. The infant is made to appear abnormally small.

Each child who attends an immunization clinic, and who is weighed or vaccinated receives a card, the *Kartu Menuju Sehat* (Health Goal Card or *KMS*), designed by UNICEF and the Indonesian Department of Health). On this card, staff record the child's weight on a large, colorful chart, and the mother takes home and keeps this highly graphic card (see Figures 21 and 22). A chart showing the child's growth takes up most of the space. Indigenous mothers who are not literate understand well that a mark below the bottom red line means that the child is abnormally "small." On the back of the card health workers inscribe the child's name, her birth order and her parents' names, and the dates on which she received immunizations and Vitamin A capsules (see Figure 22). The remaining space is filled with pictures of nutritional foods that help children grow: rice, tofu, vegetables, and grains.

Little on the *KMS* card resonates with indigenous experience. Indigenous peoples eat the highly nutritious sweet potato tuber; they do not eat any the foods promoted on the card (excepting the rare special occasion), nor do they resemble the women who are used as models. Their concerns with infant growth occur mostly in the first six months of a child's life, not through to his fifth year. These cards promote conformity to an Indonesian ideal. Most Baliem valley Dani know that this is what they are *supposed* to aim for: Indonesian style food, Indonesian style clothing and attributes, and reliable, recorded attendance at monthly weigh clinics. These cards also stress the importance of weighing children. They are thus a reminder, in the home, of the importance of watching where their child sits in the lines. These cards simply stress the importance of weighing children and of knowing how their infant compares to national "norms." Even those women most dedicated to development goals and who strive to offer their children the best food, medicine and affection they can give find that their child lags in the bottom half of the chart, hovering a square or two above the brightly colored red line that demarcates the lowest limit of acceptable growth rates. Women become acutely embarrassed as non-indigenous staff berate them for the low weight of their older children. Thus the card continually reminds them that the weight of their child is a public affair.

In other words, parents possess a document in their home which intimates that sociological information about infants is important and that infants have legitimate status as a person. Yet in practice, there are no official records of individual persons. The goal of weigh cards is simply to infer that these parents' childrearing abilities are inadequate. Intra-provincial differences are fabricated and emphasized through statistics on weight. Mothers take home visual reminders of this marginality, read it to infer inferiority, and read in the visual reminders of a plump and prospering child a symbol of cultural conformity.

5. *Posyandu* "make a family" out of a birth

Finally, the nation-state acts on people through infant health provisions through making a family out of a birth. Within this attempt to reformulate relations to make nuclear families out of extended kin relations, I suggest a single goal dominates: "to assign certain functions to groupings of kin by making them legally responsible for these functions" (Collier et al 1993:157). As reviewed in Chapter 7, biological mothers historically have been the prime target of attempts to shape and control family practice. In addition, emphasis is placed on biological fathers and mothers becoming primary caregivers. Finally, numbers of children also become the responsibility of the biological parents.

The nuclear, biologically-related family is assumed at all *posyandu* events. For example, the *KMS* has the names of both father and mother inscribed on the card. These remain, and thus the child's biological parents are formally expected to take precedence over any household restructuring that might occur. Second, the child's birth order is noted in both the *KMS* and in the clinic's monthly records. Reports on the number of families with more than two children are compiled into annual statistics. Third, information on birth control at a *posyandu* stresses that a woman cannot receive birth control without her husband's consent. A single, sexually active woman cannot receive birth control; a woman who has run away from her husband cannot receive birth control; and a woman whose husband does not support regulating fertility cannot access birth control. Married couples are urged to take birth control as soon as their children are born so as to ensure adequate spacing between children. What these policies do is push together couples who would not normally be expected to act in concert on these types of decisions. The restructuring of knowledge and practices surrounding sex and responsibilities for nurturing children literally requires reshaping thinking to focus on one type of relationship and one aspect of reproduction as somehow more important than all the others.

The role of woman as mother is also emphasized. Only mothers may bring their children to *posyandu* for injections (Yahya and Roesin 1990). Fathers are sent home, and caregivers who are not mothers receive no formal recognition. This policy aims to maximize learning through contact between the primary caregiver (deemed the mother) and health personnel. Thus, if the woman whose job is to weigh children at the *posyandu* tells a woman to cut her son's nails, she wants to be sure she is talking to the primary caregiver.

Clinics reduce women's role to that of primary nurturer. In health department posters adorning the walls of all of the valley's clinics, the mother is the person seen to diagnose fever; treat diarrhea; prepare nutritious food; attend pre-natal checkups; seek treatment for scabies, leprosy, and yaws for her children. Demonstrations for nutritional supplements take place on *posyandu* days, when only mothers are present. Policies to shape the mother's role in the nuclear family unit are pervasive. In the Birth Control Bureau (BKKBN), the agency responsible for all promotion surrounding birth control and family prosperity at *posyandu* and clinics, 11 goals shape a current policy named KISS [*Kampanya Ibu Sehat Sejahtera* - Campaign for Happy and Prosperous Mothers], to which all staff who offer advice and information must conform:

K.I.S.S.

1. Be 18 years of age before marriage
2. Be educated about healthy reproduction
3. Participate in pre- and post-natal care
4. Service contraception
5. Immunize self and children
6. Breastfeed children
7. Prevent diarrhea in infants
8. Nurture children under five
9. Try and increase nutrition in family
10. Learn skills of motherhood
11. Remember to practice birth control

(Government of Indonesia-BKKBN:1995)

With the possible exception of six, seven and eight, each of these policies requires a substantial transformation of practice. Most obviously, such policies deny culturally

different ways of practicing childrearing or health maintenance. However, these rules also situate women only where their first priority is to mother their children through dedicated nurturing. Ultimately, women are seen as the receptive vehicle through which to implement health transitions, an idea which has a long history, but whose use here reflects a particularly pernicious view of maternal conformity as crucial to improving the "quality of families" (Government of Indonesia 1992:5).

Culture and the Health Bureaucracy

In the previous section, I examined statistical production, denial of identity, emphasis on "normal" infant growth, and reformulations of the family within *posyandu* as key techniques through which the nation-state transmits idealized forms of the family and through them, assimilation into the culture of the nation. However, in Irian Jaya people of Melanesian ancestry differ so forcefully from other citizens that many Indonesians consider effective assimilation impossible (Anderson 1987; Vatikiotis 1993). Thus while health services promote conformity and obedience to government policies, in observations I conducted of health care services, highly racist attitudes of relocated Indonesians providing this care tells the Dani that in this nation they will be on the bottom rungs of status and class. Thus, health care sends a double-barreled message, one of conformity and assimilation and one that simultaneously denies the possibility. Indonesians use cultural difference to demonstrate that intervention is necessary while in the same breath they query whether interventions can ever possibly have any impact.

In the main, indigenous people are seen to have no culture. Polygyny, food choices, eating habits, childrearing practices, housing preferences and form of dress are invoked as proof of the backwardness of indigenous people throughout the province. When the phrases "lazy," "they don't know anything," "primitive," "dirty," "stupid,"

"backward," and "simple" are used to describe indigenous Irianese by relocated Indonesians, as they are frequently in everyday discourse (see also Gietzelt 1989), what the speakers are saying is that acceptable citizens are those who participate fully in the production and maintenance of national culture. For example, a book extolling the accomplishments of LIPI (Indonesian Institute of Sciences) in Wamena, produced by long-term Wamena staff, presents images of Dani men either in full tribal war costume (photographs taken at the government sponsored War Festival) or clothed, contented, and working on an agricultural project or building a "healthy house" (Kusnowo & Nazif 1992). While LIPI may be justifiably proud of their accomplishments in Wamena, the images and information they present suggests that LIPI's understanding of Dani culture is superficial and is bound by the simplistic, but popular, imagery of the penis-sheathed Dani warrior. Newcomers and visitors use the primitivism and perceived lack of culture of indigenous peoples as an excuse for having almost no social interaction with the Dani. Outsiders are expected to dislike having to travel to "posts" outside of town, and a medical anthropology consultant brought in for a project, for example, flatly refused to conduct interviews with Dani unless they were held in her hotel room in the center of Wamena. Even long-term residents who claim to enjoy life in rural Irian Jaya tend to separate their private life from their more public interaction with indigenous people, and I only met two Indonesians living in Wamena who regularly entertained and enjoyed the company of indigenous highland Irianese.

In order to show how Indonesians in Wamena can interpret cultural practice as ignorance, I describe two types of interaction. First, I discuss results from interviews with non-Dani health care staff on how they interact with the Dani, and explain why they shout at their patients, demean them, and attempt to circumscribe Dani behaviour. Second, I tell the story of Pelesina's childcare techniques and how they were interpreted by a non-profit agency director in a way that reinforces stereotypes of incompetence and ignorance in Dani populations. I argue that the essentialist attitudes of newcomers reveals

more about the constraints of nationwide policy and the artificially-constructed "national culture" of familism than it does about personal values. Official discourse translated and mingled with personal beliefs is still official discourse.

Health Care Workers and the "Primitive" Patient

An association commonly made by health staff is that between "primitivism" and underdevelopment. Since Dani are *belum bangun* (not yet developed), they need to be treated as children and need to be disciplined and taught how to behave. As I reviewed my fieldnotes, I observed that the word I used most frequently to describe non-Dani health care workers' treatment of Dani patients was "rude." While I am ambivalent about lumping together all relocated Indonesians, I suggest that most, although not all, Indonesian health workers often treat Dani like children, assuming they know little about why they are seeking help and also assuming that the only way to get through to them is to yell and threaten them. For example, the Wamena supervisor of the *BKIA* Office (Woman and Child Health Office) who relocated to Wamena from the coast a decade ago summarizes her work duties:

We supervise about 10 births a month through the BKIA office, but almost all of them are from Wamena. The indigenous women who bring their children for weighing or immunization or who are pregnant are scheduled for Monday because the Indonesian women don't want to be examined on the same table as the indigenous women. These women are primitive and they trail in lots of dirt... Pre-natal care for indigenous women only sort of works. Lots of women wander in when they are in town for the market and want to be weighed. I'll yell at them because I want them to come regularly and to make sure they are clean when they come. I'll tell them if they don't come all clean then they can't come back. So they come back clean. That way they'll understand that it's good for the baby and mother to be clean...The difference between people on the coast and people in Wamena is how they treat their babies. There is drinking and fighting but people look after their babies, give them three meals a day, and respond quickly when they are sick. Here people are lazy about bathing, feeding, and taking the baby to the clinic.

In the Wamena health woman and child health office, the majority of customers are relocated Indonesians. However, indigenous women who live in Wamena as well as women selling wares at the market come to the office inquiring about birth control. They are only allowed to visit this free, public service one day a week. Whether long-time Wamena residents or women from the valley outskirts who speak little Indonesian, Dani women are all treated the same. When I observed events at the office, an indigenous woman came in on the wrong day and was shunned by the other customers and sent home by the supervisor. The supervisor is consistently soft-spoken and friendly with Indonesian women, and consistently loud, harsh, and physically forceful with indigenous women.

Another supervisor, newly relocated from Java, also offers segregated services at her clinic located on the outskirts of Wamena. She is responsible for training new *mantri*, and the following fieldnotes excerpt summarizes her conversation:

Dr. Meli reviewed a new Dani health worker's monthly reports. She chided him for extravagant orders for medicine - 'don't request so much penicillin,' she said, 'only give it to kids who can't take any other kind of medicine. Tell adults to try other medicines first.' Then she turned to face me and said in a loud voice: 'people here only like shots, not pills. *Mantri* shouldn't listen to the people. What do they know? A woman who think she has syphilis or AIDS doesn't know what she is talking about' and then she turned back to the *mantri* and repeated; "*jangan dengar masyarakat* ' [don't listen to the people].

In a third interview with a *pendatang* employee who has been in Wamena for five years, the fieldworker for *BKKBN* (Birth Control Bureau) said,

I see that *adat* here is not so strong. It's still strong but people can learn here. When I go to the *posyandu* I tell people with young babies that they have to use birth control [*harus ikut KB*] and I use the motivation of regular relations with their husbands and child spacing as the key that they can understand. You have to be angry and rude with indigenous women otherwise they don't hear you. And they do respond when I am rude.

The inoculations supervisor for the region has a long-standing policy,

A *mantri* will yell "why did you wait so long?" instead of saying "is it *adat*?" I know people will try and heal the baby on their own and bring it to me when it's

half dead, and they will say they were "busy with the garden". We try and teach them about the welfare of their children. We yell and shout because that way they hear us.

There were numerous other occasions where I observed what I considered to be demeaning and discriminatory medical treatment. When I took my friend Pelesina to the clinic to test if she was pregnant, the worker first yelled at her then ignored her, assumed she knew nothing about reproduction and treated her brusquely,⁷² even as the same worker claimed in a separate interview with me that it was crucial for her to increase the numbers of pregnant women participating in the programme. On another occasion, I was so incensed at the treatment I observed that I found myself yelling at a health worker to have some respect for the people she was treating, to which she replied "I have no time for respect, I'm too busy trying to get these women to do what they have to do!"⁷³

Culture and Control - Pelesina Bathes her Baby

Racial overtones and deprecating comments about cultural difference pervade the administration of non-profit agencies as well as government offices. Culture practice is seen as *the* barrier to successful implementation of innovative health programmes. For example, the hotel-bound medical anthropology consultant brought in to conduct analysis of cultural practice had concluded after a week of interviews that since the traditional healing system in all of Irian Jaya is "soft, not strong, simplistic" that intervention to change will be easy, "you just need to be direct and forceful and change will occur because there is nothing in place to stop it." The agency that hired the anthropologist rejected her analysis; yet this same set of staff see culture as the cause for backwardness.

⁷²Once this worker found out that I accompanied Pelesina to the office and that I was her friend, the quality of her interaction with Pelesina improved dramatically.

⁷³Such attitudes, of course, do not go unnoticed by Dani women. About an equal number of women I asked said they were interested in birth control but were afraid to go and find out more about it because the woman at the clinic had a terrible reputation. Others were comfortable with the treatment they received.

In an example that drives home the ubiquity of essentialist thinking, staff from one flagship non-profit agency claimed that culture grounds their project goals. Yet the following tale shows that even though their mandate is based in notions of cultural sensitivity, staff still reify Dani and other indigenous people's social life as static and view culture as a negative trait that is aligned with primitivism. I observed the type of cultural translation summarized below many times over the course of my fieldwork, but this case offers an excellent example of the way observations and experiences of the processes of Dani cultural practice become simplified and transformed into an ethos of difference grounded in an essentialist view of culture.

My friend Pelesina from Kuliama gave birth to her fourth child in March 1995. She wanted to be "modern" and to that end she learned a great deal about contemporary ideas of child care through attending various non-profit agency educational meetings, *PKK* events (civil servants' wives association), and Catholic church outreach programmes. In Jayawijaya, the *PKK* is particularly active under the energetic leadership of the mayor's wife, known locally as Ibu Bupati [mayor's wife]. For the last three years, Ibu Bupati has been leading volunteer *PKK* expeditions, frequently in the Baliem valley, to teach indigenous women about nutrition. At a public forum on nutrition, Ibu Bupati clarified how *PKK* teachings aim to restructure social practice:

[Indigenous women] do not know how to cook food that they already have...Infant weaning foods are terribly unhealthy, the infants need vegetables, vegetables, and some rice too...Nutrition problems arise because women work too hard, they are too slow to give weaning food to infants and food is too low in nutrition.

Women need to take three months off after the baby is born; they must rest for those three months. The husband must increase his work load because at the root of it, gender is not working and must be transformed into good conditions. After three months, babies should receive peanut oil, flour porridge, sweet potato, and women should return to the garden after three months and men should stay home and feed the baby (WATCH & Dinas Kesehatan 1995:24).

Ibu Bupati's imaginative solution is one commonly expressed among non-Dani health workers. Ibu Bupati, like many other *PKK* and civil servants, is Javanese/Malay in origin

and her advice about nutrition is peppered with child-rearing knowledge she learned while growing up. Thus, when Ibu Bupati, dressed in her immaculate pink *PKK* uniform, visits community groups like the short-lived woman's group in Kuliama, she is insistent that women learn "proper" infant care--a daily bath is essential as is a warm baby. Mothers must drink only warm liquids to keep breast milk warm, and eat only "warm" foods for the same reason. One of the many Javanese/Malay beliefs Pelesina has absorbed is that babies must be kept warm at all times in order to stimulate growth. It is proper, she was told, to bathe your child and to place the child in the direct sunlight for an hour in the early morning, before 9 a.m., to counteract the cooling effects of the bath and to keep your child warm. It is also important to cover the child with Malay oils to keep the skin moist and to protect the body from cold.

These suggestions directly contradict Dani beliefs. Dani believe that an infant up to the age of about three months should be kept as quiet as possible, in a cool and dark netbag slung over the mother's back or hung on a hook inside a cookhouse, especially during the hot daytime hours. Consequently, Pelesina faced a conundrum every time she wanted to bathe her newborn baby. Putting a child in the sun is a highly risky act, tradition says, but local child care experts tell her that putting the child in the sun will help the child grow big and strong. Pelesina's husband did not want Pelesina to expose the baby to the sun because of the dangerous diseases that can come from "overheating" or from entry of the body by spirits. He therefore told her not to do it at all. This is how Pelesina dealt with the problem. As she had learned, she bathed her child every day. She also covered his body with generous amounts of skin oil purchased at great expense. However, she increasingly put the water on to heat later and later in the morning, so that when the time came to bathe the child it was closer to noon when the sun was at its hottest. "Will you put the child out to dry in the sun today?" I asked Pelesina. "Oh no," she replied, "it is far too hot outside now to do that."

In effect, Pelesina made a choice. She kept what she liked from what she had learned--bathing and slathering the baby with oil--and rejected what she didn't like or what didn't fit in with what she believed. She also negotiated her choice extremely tactfully, in a way that was designed neither to offend nor to deny the value of what she had been told was the best thing for her child. It is good to put the child in the sun, she is certain, she just isn't able to carry out that task.

I liked this story and told it to staff at a non-profit agency. Everyone laughed and the story was much repeated by staff over the next week or so. However, it was reshaped to be more in line with expectations about Dani ability, that is, that the Dani are gullible and unreflective. For example, this is how the project manager retold the event to an audience of Indonesian bureaucrats at a health policy meeting that we both attended several days later:

A woman had heard from us that it was important to give your baby a bath and dry the baby in the early morning sun. One woman listened to what she had learned but she didn't listen well and so put her baby in the sun to dry for an hour at noon, when the sun is too strong! We have to be careful about what we teach because they will interpret it wrong. They are very simple people; they have very little intelligence. They need to be told what to do.

Although workers from this agency have received some information and training about beliefs concerning illness, such as the power of ancestor spirits, they do not appear to apply their knowledge to understanding how people learn and make choices. Thus the director of the project supports women leaving their infants in netbags for the first months of life because the seclusion prevents sickness. However, whenever he analyzes cultural practice as detrimental to health, he advocates intervention. Thus he condemns indigenous weaning practices, early introduction of foods, hygiene practices, household smoke and dust levels, and marriage patterns for fomenting poor health. In addition, he does not consider the iatrogenic impact of introduced health measures to be a significant problem. Surprisingly, in contrast with government employees and most other non-profit agency workers, this project director is known as highly culturally-sensitive, with

employees who reflect a similar token awareness of cultural patterns. As one of his employees, also known as intelligent and sensitive, said to me:

I had no idea that the Dani actually had any ideas about their bodies, or how babies are born, or that they might have ideas about how to keep a baby healthy. I thought the Dani had empty bodies, no content.

While this worker knew that many Dani link sickness to spirit ancestors, he tended to keep this knowledge separate from Pelesina's everyday pragmatism. In other words, the health worker compartmentalized beliefs about healing so his client's beliefs were easily separated from her life experiences. He saw culture as something, ultimately, that needed to be defused and replaced. Filling up the empty body with correct information might be the metaphor that best describes his perspective on what he does for a living.

Discussion

Workers at non-profit agencies and government offices share a broadly essentialist set of assumptions about the Dani. Although couched in a slightly different discourse, both groups define indigenous people in contrast to a national model of the ideal family. This prevailing belief system draws to some extent from policies of the nation-state, particularly from the policy regarding local application of normative family models. As Foulcher (1990:302) argues, the "state has engaged in a vigorous and successful construction of 'Indonesian values and traditions,' defined in relation to a negatively-perceived 'other.'" Defining indigenous people as full of "primordial" instincts is one means by which *pendatang* distinguish themselves from those they perceive as stuck in custom-bound forms of thought (Foulcher 1990). Thus the head of the non-profit agency rejects indigenous practice in favour of biomedical models of the "normal" and advocates intervention ground in notions of "toxic" social environments, because these constructions validate perceptions of difference between him and his clients.

Mantri and bureaucrats have a lot in common. The apparent freedom of the *mantri* to manipulate secrets for his own gain, just like the apparent freedom of health employees in government offices to sustain racist imaginings of Dani abilities, where both say and think what they want, as long as they submit monthly records, suggests that this apparent freedom in fact denotes a distinct lack of it. To reiterate Young's (1993) argument from Chapter 7, the institution of health care in this context does not need to engage in the production of ideologies in order to ensure that staff conform to the goals of the organization. Or, to use de Certeau's (1986) terms, *mantri* and bureaucrats employ *tactics* of healing that are contained by nation-wide *strategies* such as maintaining a high degree of military supervision, promoting rights of the community over rights of the person, and promoting national development ideologies.

The construction of difference between Dani and *pendatang* operates within essentialized models of culture also defined at the level of the nation-state. Irianese might once have been perceived as on the same footing as those more involved in the production of national culture, Anderson (1987) argues, but the volatile history of opposition to inclusion in Indonesia as well as underlying racial attitudes made many "civilian and military officials [begin] to think and even speak of the Irianese less as unfortunate brothers and sisters than as racial and cultural inferiors" (Anderson 1987:76). In the decade since Anderson's comments, the increased normalization under Suharto of "national culture" draws out even further the cultural differences between groups such as the Dani, who continually thwart expectations, and the bureaucrats and agency staff whose job it is to show them how to conform.⁷⁴

Acting on these essentialized models of culture allows bureaucrats to do their jobs. The mayor of Jayawijaya district, who claims to be a great friend of "the people," proposed that his development goals are culturally sensitive because they include certain

⁷⁴See Pemberton (1994) for an argument about how the reproduction and manipulation of national culture as a political tool has increased dramatically since the early 1980s under Suharto.

"positive" features found in all indigenous Irianese: "environmentalism" and "cooperation." He also suggests that his health policies eliminate the "negative" in indigenous culture, that is, "warfare" and "primordialism" (Waenas in Suara Pembaruan 1996), which is a term used to describe any cultural group that places its own local interests above state policies (Jakarta Post 1995).

Data from chapters 7 and 8 ironically suggest that creating a demarcated group of people, isolated tribal people, is central to the goals of the nation-state even though assimilation dominates health policy mandates (World Bank representative, personal communication). We can note this process in the cavalier use of statistics, where emphasis lies in creating links between categories of persons and health practices, *not* on creating individual identities. Thus what Foster terms "possessive individualism"--a subject "constituted through capitalist economic practices and rhetoric on the one hand, and the state-subject relationship of 'citizenship' on the other" (Foster 1995:19)--is not a key feature of state-subject relations in the arena of the very young in Indonesia. Information about indigenous infants is assiduously maintained only as these reinforce the need to sustain national targets. As Anagnost (1994:139) argues for China but also applicable for Indonesia, the state produces "docile bodies and transform[s] these bodies into signifiers that figure in a master narrative of progress." Compliant indigenous infants as Other validate broader national goals. Hence fabricated statistics, aggressive outreach programmes, reproductive control, and invasive policies about rearing and caring for an infant have as much to do with the fabrication of meaningful symbols as they do with the subjection of parents, perhaps infantilizing *them* through paternalistic judgments grounded in a national culture from which they are then consistently excluded.

Conclusion

Indonesia has recently released a stamp commemorating the birth of its 200 millionth citizen.⁷⁵ On it, President Suharto--*Bapak Suharto*--cradles an infant and gazes intently into the child's eyes. The infant sleeps serenely. The infant, swaddled in bleached white cloth, has light brown skin, brown eyes, and straight black hair. The baby is plump, is already about three months old, and looks pleased to be Indonesia's newest citizen. This is the "normal" child as things should be, an infant pleased to be in the guiding arms of the benevolent father of the nation, trusting her leader, passive, uncomplaining, and who as a result, is healthy and will prosper.

The stamp builds on a simplified and idealized notion of parent-child relations. Chapters 7 and 8 have shown that state power depends both directly and indirectly on defining "normal" families, particularly as "the way things should be," and in controlling the quality of their offspring. Events at *posyandu* demonstrate that the policies of population regulation found in post-birth medical care depend in defining the "normal" as a passive, quiescent, and powerless infant. The infant's new place at the center of health care attention, however, suggests that economic goals are pressing. Greenhalgh (1994) has argued that state attempts to monitor reproductive practice are at their most invasive when target-driven, and this is the case for Irian Jaya. National development targets aim to reduce infant mortality in Irian Jaya to levels similar to the rest of the country, to focus on Eastern Indonesia as a target for development, and to bring service levels in the eastern provinces to levels similar to those in western Indonesia (Azis 1996). All of these goals may lend a sense of urgency to health plans and may legitimize even further the

⁷⁵The history of Indonesia's health and development agendas are well-recorded in stamps. For example, in 1969, a stamp was issued with the motto "Family planning leads to national development and prosperity". In 1973, with the introduction of primary health care, a stamp was issued with the motto "Health begins at home."

forceful attitudes taken by employees who must aim to meet targets as part of their jobs (Barlow and Hardjono 1996; Mboi 1996).

For the Dani, the price of citizenship under *Bapak Suharto* is high. Many Dani, for personal, financial and perhaps political reasons, continue to avoid health care outreach for children, refuse to take birth control, refuse to move into "healthy houses" (the official term for tin-roofed homes with bedrooms for parents and children), do not send their children to school, or buy them expensive school uniforms. Dani ambivalence about full participation in the local trappings of nationalism makes them the target of the scorn of bureaucratic and non-profit agency staff, who sigh and call the Dani "*susa*" (difficult, as in stubborn, childlike) for retaining cultural practices deemed counterproductive. The Dani are not so much "difficult" as merely disinterested. As one educated Dani man said:

We have incredible wealth. We are big and strong. The *pendatang* who move here are jealous. They are not as big as we are and they covet all our wealth. We have enough money to give away hundreds of pigs at a time, and they come here and struggle so hard to buy a T.V., on credit, and we have so much and so they are jealous....*Pendatang* come to our pig feasts and stuff all the pork they can into their pockets and don't even wipe the grease off their hands before shaking our hands and disappearing. And yet they never invite us to one of their parties, they never can repay us all that we are able to give them. And then they tell us we do everything backwards...It is hard to take those *pendatang* seriously sometimes.

An attitude such as this is rarely spoken, and it perhaps oversimplifies complex relationships, but it does suggest that some Dani (notably educated men or clan and alliance leaders) are acutely aware of the sophisticated nature of political relationships between *pendatang* and themselves. On three separate occasions, Dani men described the push towards family planning on the part of the government as a strategy to eliminate Dani and other tribal groups from the nation. Dani women do not produce enough children as it now stands to ensure the population continues to grow, and enforcing birth control in light of this demographic situation is, in the words of one particularly vocal critic, "genocidal." Again, while this may put too bold a stripe on Baliem valley relations,

the issue remains that exceptionally high local infant mortality rates are treated with nation-wide infant health strategies that are irrelevant to the Baliem valley situation, and exceptionally low female fertility rates are treated with family planning seminars. The cost of assimilation is high.