

Appendix

Health Care Recommendations

On the basis of infant mortality rates of 280 deaths per 1000 live births recorded in a village some 11 kilometers from Wamena, and on the basis of an analysis of health care services provided for infants in the Baliem valley overall, this dissertation concludes with a series of broad recommendations that suggests the need to improve the effectiveness of the health care system already in place. This section lists ways that health care providers can reevaluate how they serve indigenous people and how they can improve their use of limited resources.

1) Health officials need to improve the reliability of data about birth and death rates. Data about infant mortality can be more reliable if aggregate data were complemented by reliable small-scale community censuses. Acknowledge that small-scale censuses suggest that most communities in the highlands have infant mortality rates over 200 deaths per 1000 live births. If, as seems to be the case, mortality rates fluctuate between communities, even where distances between them are small, investigate the breadth of factors that might contribute to infant mortality.

2) Health officials need to encourage external funding agencies to conduct their own rapid baseline data survey before funding non-profit agency projects on the basis of national-level statistical reports. This precautionary data gathering might reduce the likelihood of introducing irrelevant health technology because inaccurate statistics demonstrate a need for it.

3) Health officials need to recognize that weighing and immunizing infants, while important preventive measures, steer energies away from more life-saving preventive measures such as ensuring clean water and assessing development projects for their impact on access to land and water. Few attempts are made to integrate the impact of immigration and modernization in government-run development work. Health workers can promote the non-iatrogenic use of new technologies such as knives, spoons, and introduced foods. For example, some women have begun to use spoons to feed their children, but do not use the same care when cleaning the spoon as they do when cleaning their hands. Or, some caregivers feed their children new Indonesian foods, using cooking methods that do not render food sterile. Services need to focus less on justifying existing health policy, and more towards providing services relevant to the specific region.

4) Health officials need to recognize the impact of volunteers, health care workers and policy makers on the kinds of decisions that get made about how health care information is communicated. Health officers and volunteers from the corps of civil servants' wives carry their own cultural baggage and transmit knowledge that does not improve health through direct instruction or through emulation. Health staff show women how to replace sweet potato with foods that offer less protein, vitamins, and calories than the sweet potato. Staff do not teach ways to clean spoons and bowls even as they promote food that can only be eaten with a spoon and a bowl.

Staff also transmit knowledge about child care that reflects their own experiences. This knowledge is of dubious benefit to the Dani. Of the many cases that I observed, some of the values transmitted include: an emphasis on daily bathing, which contradicts local beliefs and can expose the child to dirty water; switching infants from netbags to cloth slings, which greatly increases the chance of the infant getting scabies; and emphasizing the use of oils to cover the baby's skin, a costly practice that increases the likelihood of scabies.

5) Health officials need to design health policy to reflect the impact of modernization. Dani have voiced concern to me about sexually transmitted diseases, AIDS, and glue-sniffing. Yet there are no *preventive* measures in place for any of these potential problems. Women should be learning that their children who live may learn about the joys of glue-sniffing, not about the fact that their weights at infancy are a kilogram or two shy of an artificially constructed desired average.

6) Health officials need to design health care that begins by accepting the worth of indigenous concepts and practice. Denying that Dani know and understand their infants in terms of ideas about embodiment, personhood, politics, and the inseparability of these from the pragmatics of daily care and routine, makes it impossible to provide acceptable care. Direct coercion remains high if understanding is low. Women in particular are pressured to bring their child to immunization posts, to conform to nation-wide ideologies of nutritious food consumption, and to put up with racism and rudeness. These all occur because those who provide care and those who design it have very little idea of indigenous ideas about healing and even less idea of why Dani respond the way they do to the services offered.

Glossary

Terms followed by (I) are Indonesian words.

adat (I): Custom, tradition, culture. Used by Indonesians to mean material culture and ritual and dance displays. Used by the Dani to indicate belief and rituals geared to ancestors.

aloak: Tail and tailbone region of pig, used in *adat* ceremonies but also a term used for position of *adat* leader who offers counsel.

apisan: Head of pig, usually section of an ear, used in *adat* ceremonies and used as term to designate clan or alliance head.

bapak (I): Father, a term of respect used for officials, supervisors, and elder male kin in most of Indonesia.

dukun (I): Shaman, traditional healer.

epe: Body.

epe ago: The big pig feast held every five years or so.

etai-egen: Organ situated behind the breastbone that is the seat of emotions, well-being, and generosity.

ima wusan: Purification ritual for incest transgressors.

hukum (I): Legal decision.

je: Smooth stones decorated with fronds used in *kaneke* and other *adat* ceremonies.

kabupaten (I): Regency. Jayawijaya is one of 8 kabupaten in Irian Jaya.

kader (I): Health care volunteer operating at a village level as recruiter and assistant.

kaneke: Ritual affirming solidarity within the clan; first of three rituals culminating in the big pig feast (*epe ago*).

KB (I): Family Planning acronym used to mean "birth control" in everyday discourse.

KMS (I): Infant weigh card.

mantri (I): Paid government health worker.

noken: String netbag used by women to carry food, goods, and children.

omolo: Side of pig, used in *adat* ceremonies and used as term to designate person of action within alliance.

opase: Placenta.

OPM (I): Organisasi Papua Merdeka, the Free Papua Movement.

PKK (I): Civil Servant's Wives Association.

pembangunan (I): Economic and national development, employed in everyday discourse to mean government sponsored local change.

pendatang (I): Newcomers, a term used by the Dani to describe relocated Indonesians who now live in the Baliem valley.

posyandu (I): Integrated health posts.

puskesmas (I): Clinic.

silimo: Men's house.

su: Special netbags used in clan and alliance rituals.

suangi (I): Sorcerer.

suku terasing (I): Most isolated tribal peoples, an official government designation.

waya: One of two moieties that underlies clan and alliance formations.

wesagun: Healer from within the clan who also has status within the alliance.

weta: One of two moieties that underlies clan and alliance formation.

yerak: Long band of fibre onto which shells are sewn. Used in clan and alliance rituals.

yokal: Women's fibre skirt.