

MORAL LANDSCAPES OF HEALTH GOVERNANCE IN WEST JAVA, INDONESIA

by

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¹ All photographs by Priscilla Magrath with consent of those depicted, except Plate 2 taken by Pk Leo.

Glossary of Acronyms and Government Terms

APBN	Anggaran Pendapatan Belanja Negara (State Income-Expenditure Budget)
Askes	Health insurance for civil servants
BKKBN	Badan Koordinasi Keluarga Berencana Indonesia (Indonesia Family Planning Coordinating Body)
BLUD	Badan Layanan Umum Daerah (Regional Public Service Body, a self-managed body distinguished from UPTD by its greater autonomy. Since 2010 district hospitals have BLUD status)
BOK	Bantuan Operasional Kesehatan (Health Operational Fund, a fund from central government for puskesmas)
DPRD	Dewan Perwakilan Rakyat Daerah (Regional Parliament)
Jamkesda	Jamiman Kesehatan Daerah or District health insurance for the poor
Jamkesmas	Jamiman Kesehatan Masyarakat or National health insurance for the poor
Jampersal	Jaminan Persalinan or National health insurance for childbirth
Lansia	Usia lanjut (elderly; community health post for those over 45)
PAD	Pendapatan Asli Daerah (Locally sourced government income)
PAUD	Pendidikan Anak Usia Dini (Government pre-school education)
Pendopo	Residential and office complex of the Bupati (head of kabupaten).
PHBS	Perilaku Hidup Bersih dan Sehat (Clean and Healthy Behaviors)
PKK	Pembinaan Kesejahteraan Keluarga (Support for Prosperous Families, the national housewives association).
PLKB	Pelayan Lapangan Keluarga Berencana (Family Planning fieldworker)
PMD	Pemberdayaan masyarakat desa (Village Empowerment Committee)
PNS	Pegawai Negeri Sipil (Permanent Civil Servant)
PTT	Pegawai Tidak Tetap, Contract Civil Servant
PONED	Puskesmas Pelayanan Obsterik Neonatal Emergensi Dasar (Basic Emergency Obstetric Neonatal Services)
Puskesmas	Pusat Kesehatan Masyarakat (Community Health Center)
Tabulin	Tabungan Ibu Bersalin (Saving for Maternity)
UPTD	Unit Pelaksana Teknis Daerah (Regional Implementation Unit)

Terms of Address

Pk (Bapak)	Father, used as a term of respect to refer to a man older than the speaker
Ibu	Mother, used as a term of respect for a woman older than the speaker
Drg	Dentist
Bidan	Medically trained midwife
Kader	Cadre or Volunteer
Ma	Paraji (traditional birth attendant in West Java)

Phrases

Cocok	Fitting, suitable
Dana abadi	Endowment fund
Dukun anak	Indonesian term for traditional birth attendant
Gotong Royong	Mutual assistance
Mandiri	Independent or self-sufficient
Masyarakat	Community, public
Musyawaharah	Consultation and deliberation aimed at reaching a consensus
Orang kecil	Little people, term used until recently for the common people
Orang miskin	Poor people
Swadaya	Self-sufficient
Swasembada	Self-managed

Note on the Use of Terms

I use Indonesian terms for: puskesmas (community health center), posyandu (community health post), bidan (medical midwife), kader (health volunteer) and paraji (traditional birth attendant in West Java) because these are distinctive Indonesian institutions and their uniqueness may be lost through translation. I use Indonesian terms for: kabupaten (regency or district) and kecamatan (district or sub-district) because they are translated differently in different works². All of these Indonesian terms denote both singular and plural.

² See Figure 1 for the Hierarchy of Government Administration.

Abstract

The democratic decentralization of government administration in Indonesia from 1999 represents the most dramatic shift in governance in that country for decades. In this dissertation I explore how health managers in one kabupaten (regency) are responding to the new political environment. Kabupaten health managers experience decentralization as incomplete, pointing to the tendency of central government to retain control of certain health programs and budgets. At the same time they face competing demands for autonomy from puskesmas (health center) heads. Building on Scott's (1985) idea of a "moral economy" I delve beneath the political tensions of competing autonomies to describe a moral landscape of underlying beliefs about how government ought to behave in the health sector. Through this analysis certain failures and contradictions in the decentralization process emerge, complicating the literature that presents decentralization as a move in the direction of "good governance" (Mitchell and Bossert 2010, Rondinelli and Cheema 2007, Manor 1999).

Decentralization brings to the fore the internal divisions within government, yet health workers present a united front in their engagements with the public. Under increasing pressure to achieve global public health goals such as the Millennium Development Goals, health managers engage in multiple translations in converting global health discourses into national and local health policies and in framing these policies in ways that are comprehensible and compelling to the general public. Using the lens of a "cultural theory of state" (Corrigan and Sayer 1985) I describe how health professionals and volunteers draw on local cultural forms in order to render global frameworks compatible with local moralities. I introduce the term "moral pluralism" to describe how individual health workers interrelate several moral frameworks in their health promotion work, including Islam, evidence based medicine and right to health. My conclusion is that kabupaten health managers are engaging in two balancing acts. The first is between decentralization and (re)centralization and deals with the proper way to manage health programming. The second is between global health discourses and local cultural forms and concerns the most effective way to convey public health messages in order to bring about behavior change in line with national and global public health goals. This is the first anthropological study of how government officials at different levels negotiate the process of health decentralization in the face of increasing international pressure to achieve global public health goals.

Chapter 1: Introduction

In this Chapter I explain how I came to be studying health governance in Indonesia and the perspectives and theoretical frameworks I bring to my analysis. I show how I interacted with my informants and the roles we assigned for each other, and I describe my methods and analysis. I begin with an ethnographic vignette intended to capture the atmosphere of the kabupaten³ health office, my core research site, and how it feels to work there. In this scene the foundational values of the Indonesian civil service bureaucracy are on display, including discipline, adherence to regulations, respect for hierarchy, and an Islamic commitment to service. But immediately after the morning roll call civil servants revert to informal horizontal networking characteristic of the new decentralized government structure. I suggest that there are two bureaucratic ethics at work here, a centralization ethic emphasizing hierarchy and standardization and a decentralization ethic focused on autonomy and “bottom up planning”. One of my goals in this dissertation is to tease out what has changed and what has endured following the dramatic shift in 1998 from the centralized New Order government of President Suharto to democratic decentralization. I explore how civil servants navigate the new democratic environment and how centralization always seems to creep back into decentralized programming. Within the complex co-existence of decentralization and (re)centralization, I seek to identify the shared values that enable teamwork, the “grease in the machine” that allows the bureaucracy to function.

³ See Figure 1 Hierarchy of Government Administration. The kabupaten is the third tier in the government administration under the central government province levels. It is translated into English as regency or district. To avoid confusion I use the Indonesian term throughout.

Since my object of analysis is a state bureaucracy I then explain how I understand “the state” and which theoretical traditions I draw on. I depart from many anthropologists in my focus on middle management at the kabupaten level rather than on citizens at the periphery of state power. Rather than viewing the state as monolithic, this enables me to explore different perspectives within government and how these are expressed and negotiated. I then explore theoretical influences on my work from anthropology of development and anthropology of public health. Whereas scholarship in the anthropology of development has focused on international transfers of ideas and resources, I focus on “development” as a project of the state I regard public health as a component of this project. Public health represents a “ticket to modernity” requiring multiple interventions in peoples’ lives in order to transform them into modern healthy citizens.

In the following section I position myself as a development practitioner with over five years’ experience working as an applied anthropologist in Indonesia. I describe how this background affected my approach to fieldwork and how I was received in the offices and communities where I worked. I go on to explain how I selected my field sites and my informants and how I used participant observation, interviews and focus group discussions to gather information.

1.1 A Brief Scenario: The Kabupaten Health Office⁴

It is almost 8:00 am on a Friday morning. At the kabupaten health office in Lahanbesar the large courtyard is bustling with staff, greeting each other and making their way to their positions for apel pagi (morning roll call). The Master of Ceremonies, Pk Rahmat⁵, tests the loud speaker system and urges staff to form rows, each person carefully lined up with someone behind and in front, men and women mixed but roughly aligned in height order. Someone motions for me to join the front row, where I quickly find my place between a man and a woman roughly my height. Meanwhile the heads of Departments are forming a single line to one side. Friday is batik day and everyone is decked out in vibrant batik outfits, the women's headscarves attached with colorful broaches, the men's shirts just as bright as the women's blouses. A silence descends on the assembled employees as the Master of Ceremony asks those in the front row to call out their number from one end to the other. I have to concentrate hard so as not to miss my number. Pk Rahmat rapidly counts the number of rows just as the head of the kabupaten health office approaches, exquisitely dressed in matching green and yellow headscarf and blouse, and takes up her position close to the microphone. "58 staff ready for work" barks Pk Rahmat, while saluting his boss, along with the assembled crowd, each raising their right hand, military style to the right hand side of their forehead. She salutes back then drops her hand, signaling that her staff may also drop their hands, which they swing behind their backs, left hand grasping right elbow as they

⁴ See Figure 2 for an organogram of the Kabupaten Health Office.

⁵ I have used pseudonyms for all names of people and places throughout this dissertation.

stand to attention. This formal pose is maintained throughout the rest of the morning roll call, a process that can take up to half an hour.



Plate 1: Apel Pagi (morning roll call) at the kabupaten health office

After a short prayer delivered by the Master of Ceremony, the head, Dr. Nia, takes the microphone, greets everyone and launches into a persuasive speech, designed to motivate and inspire her staff. Her rhetoric is intended to transform her staff from the tired citizens who rose from their beds earlier that morning into proud representatives of the state dedicated to achieving targets. I attended many morning roll calls like this one and the themes were familiar to me, even more so to the rest of the audience. Discipline, the importance of following regulations, the urgent need to fulfill targets and

issue reports, the value of team work and avoidance of “egoism” all shrouded in a veil of Islamic duty, sometimes including admonishments for those who failed to attend early morning prayers at the “pendopo” (home and residential complex of the Bupati, the head of the kabupaten).

When I asked staff after morning roll call they rarely remembered any of the details of the speech. The specific content was less important than the general form of the speech. Sometimes the traffic noise was so loud that we couldn’t hear the words. Nevertheless, participation in the morning roll call involved an enactment of discipline and team work that reinforced the verbal messages, heard or unheard, that Dr. Nia uttered.

All government offices are obliged to carry out morning roll call every morning, but Dr. Nia managed to transform it into something quite special and worth participating in. Friday morning roll call is particularly significant. At the kabupaten health office it was the only day when staff from the four separate office locations gathered together for morning roll call followed by Islamic teaching given by an invited speaker and held in a large hall. On at least one occasion the speaker was asked by Dr. Nia to address the issue of discipline in his Islamic address, which he duly did, urging staff to carry over the discipline of praying five times a day into the workplace.

I came to Indonesia in 2012 to find out what had changed and what had remained the same within the culture of the bureaucracy, following dramatic political reform and structural changes to government that began immediately after the resignation of President Suharto in 1998. Having lived and worked in Indonesia in 1990 and then again

in 2000, I had experienced the bureaucracy of the New Order government, steeped in obedience and upward accountability. I was now keen to investigate how such a bureaucracy would adapt to horizontal accountability under a decentralized government structure that devolved authority and decision making power from the center to the kabupaten. Would the hierarchical values of Javanese culture that Suharto explicitly drew on (Pemberton 1994) be transformed along with the shifts in government structure and rhetoric? Judging by the morning roll call, apparently not. The only feature that had changed seemed to be the more explicit focus on Islam as a source of motivation and discipline. President Suharto had distanced himself from Islamic politics, promoting a secular Indonesian citizenship, undivided by religious or ethnic identities (Kingsbury 2002). In the post-Suharto era religion has become a powerful mode for reinforcing motivational and disciplinary messages now that the authoritarian style of discipline was no longer acceptable or possible.

But a hint of other changes became apparent as soon as the morning roll call was over. Staff immediately assumed a relaxed stance, and broke into small groups, sharing gossip as they headed towards their various offices. Departmental and section heads have their own offices, generally with a reception area for visitors and an inner office for desk work. Other staff work in open plan offices, desks haphazardly arranged, windows and doors always open, visitors streaming in and out. By contrast with the Suharto era, computers and laptops are everywhere, and printers churn out reports, statistical charts and letters that accumulate on the desks, sometimes competing for space with snacks, boxes of tissues and photos of families.

As I follow Pk Yudi, head of Health Promotion, to his office I notice there is already a visitor waiting. He is from the planning office of the kabupaten government, and Pk Yudi suggests he joins our conversation about changes that have occurred with decentralization. In all of my visits to Pk Yudi's office I only once encountered supervisory staff from the central Ministry of Health in Jakarta. The majority of Pk Yudi's communications and those of his colleagues were with the various kabupaten government offices. Telephone calls that occurred while I was present in the various offices were nearly always to other branches of kabupaten government, very rarely to officials from Jakarta. This was the first change that I observed in the culture of the bureaucracy following democratic decentralization. While maintaining a respect for hierarchy, these kabupaten government officials were horizontally networked, along decentralized lines of accountability. They were, in fact, accountable to kabupaten government and submitted an annual accountability report to the local parliament. They received health policy from the central government but were no longer legally obliged to follow it.

A second major shift in bureaucratic culture and the exercise of power under decentralized government lies in the ways in which civil servants relate to the public. Pk Yudi, along with some of his colleagues, receives a regular stream of visitors from the press, from local non-government organizations and directly from the general public. He prides himself in the way in which he deals with these various guests, guiding them in the direction of more information, appeasing those with complaints, displaying NGO posters on his walls. He claims his predecessor during the New Order government was

afraid of such visits, but he regards them as part of his investment in an ever expanding social network, that includes local politicians and businesses as well as other civil servants. It is all part of his role in promoting health under the new democratic and decentralized framework that involves him in lobbying for health within the kabupaten parliament. In his words health services have become a “komoditi politik” (political commodity) valuable for legitimizing government but also a liability as increased transparency opens the way for bad publicity as well as good. As a result, Pk Yudi is careful in dealing with the increasing number of queries and complaints from the public. One message that I heard repeatedly from health managers was that the general public were now “berani” brave enough to speak out, to complain and to demand. This was certainly not encouraged under the New Order regime where criticizing government could lose a civil servant their job and a citizen their access to basic government services (Antlov 2003, Magrath 2010).

It was not only the public who were more brazen in their engagements with government. I was quite taken aback when Pk Yudi openly criticized central government during my interviews. His persona as a self-proclaimed critic seemed to be an integral part of his career development strategy as a promoter of decentralization and autonomous local government.

The co-existence of the military style morning roll call, the informal horizontal networking and the open criticism of government reflect the ongoing co-existence of centralization and decentralization in the contemporary era. Democratic

decentralization has brought about many significant changes in how government is done, yet it sometimes feels as though nothing has changed at all.

1.2 Theoretical Frameworks

My goal in this dissertation is to tease out what has changed and what has endured in the ways in which governance is done in Indonesia. I use health as a lens to reveal pervasive shifts in the rhetoric and style of government. I look for these shifts in the reflections of government officials and in my observations of the social relations of governance. I examine both relations among government officials and between representatives of the government and citizens.

Anthropologists have drawn on several theoretical sources from outside of anthropology in analyzing government by “the state”. Prior to the 1960s political anthropologists focused on local politics (Radcliffe-Brown 1948, Barth 1959) or how social order was maintained in the absence of the state (Colsen 1974). Whether following the British tradition of structural-functionalism or the American Boasian tradition of cultural relativity, their objects of analysis were small scale societies and how they operated according to their own internal logic. Analysis of the state was therefore not considered relevant (Radcliffe Brown 1948), even though many of these studies were undertaken under the auspices of colonial states (Fortes and Evans-Pritchard 1940, Colsen 1974). From the 1960s, under the influence of Marxism, anthropologists started to examine relations between the local people who continued to be the focus of their analysis and the state, regarded as a remote but important

influence on the everyday lives of citizens. For example, Hart (1986) argues that local labor relations in the Indonesian village she studied could only be understood by reference to the state's interest in controlling the rural sector, while Hefner (1990) reveals how the colonial and post-colonial state framed capitalist development in upland Java. In these studies anthropologists examined "the state" from the perspective of people located far from the centers of power, often in remote or marginal locations. I contend that viewing the state only through the eyes of the marginal contributed to a tendency, already present in Marxist theory, to demonize the state. According to Marx (1978 [1848]), Engels (1970) and others, the state arose historically out of a process of class formation, as an organ of the capitalist, property owning class, with the function of containing the property less working class. Since, according to this view, the state represents the interests of a small elite against the majority it is founded on conflictive relationships. The anthropologists' emphasis on the powerless and the marginal reinforces this tendency to regard the state in terms of conflicts of interest between governors and the governed (see for example Tsing 1993, Ferguson 1999, Roitman 2004).

Foucault (2008:75) cautioned against "state phobia" arguing that the state should be examined not as a subject with its own intentions but in terms of what it does, the everyday practices that are employed to regulate human behavior and how these practices are framed within particular rationalities and related discourses. These practices include what Foucault referred to as "technologies of government" including the use of statistics, record keeping and laws and regulations. These technologies

categorize each individual according to various “dividing practices”: the good citizen and the bad, the sick and the well, the rich and the poor. At the same time they are totalizing since they address the “public good” always seeking to align the interests of the individual with that of the state (Foucault 1983). Foucault has been very influential among anthropologists, including scholars of Indonesia (Stoler 2009, Newberry 2006, Li 2007).

I acknowledge that the state achieves its effects through everyday regulatory practices including the enforcement of laws governing almost every aspect of the lives of citizens from childbirth to education to traffic control (Painter 2006); ‘paper trails’ that track individual citizens (Secor 2007, Verdery 1996); and plans, indicators and targets for government programs (Scott 1998, Mulligan 2010). But rather than focusing on the practices themselves I focus on the social relations in which these practices are embedded. These social relations are not restricted to the formal regulatory process but include informal mechanisms that are equally essential in order for the state to function (George 2009, Gupta 2012). These informal mechanisms involve judgments made in order to overcome inconsistencies, contradictions and failures in the way in which the state is supposed to operate (Mountz 2010). I regard both the formal and informal mechanisms as embedded in every social interaction in which at least one party claims to be representing the state. These agents of the state bring their own interpretations and personal style to each engagement, leading to unpredictable, but not necessarily negative “state effects” (Mosse 2005, Gupta 2012).

This approach to understanding the state through the multiple interactions between agents of the state and citizens aligns well with recent approaches to studying “everyday state formation” (Painter 2006, Corrigan and Sayer 1985, Newberry 2006). According to this approach state formation is not a historical event but rather an ongoing process. Government officials and citizens together reproduce the state through their daily enactments of state regulations and practices. Rather than regarding citizens as objects who are acted on by the state, in this approach citizens are themselves part of the state. Several anthropologists have documented how citizens claim this status of subjects rather than objects of the state both through ideological (Tsing 1993) and practical (Chatterjee 2004) strategies. Tsing (1993) describes how people from a marginalized ethnic group in Kalimantan engage positively with state officials who dismiss them as primitive and backward. They comply with the demands of the officials in the hope that, by performing the role of good citizens, they will acquire some of the power emanating from the state. One female leader rationalizes their claim to be treated as respectable citizens by framing local “adat” (customs) as more authentic than the national law, since it is rooted in the ancient Majapahit Empire that pre-dates the current state government. Chatterjee (2004) explores how slum dwellers who lack full citizenship rights in India nevertheless make effective claims on the state for basic services. Recognizing the proactive strategies adopted by people in relation to the state does not mean adopting the naïve position that government employees and citizens have a similar relationship to the state or that they are acting within a level playing field. Typically there is an enactment of power in which the government

employee claims to act in the best interests of the citizen while the citizen may have limited choice in the matter. Their views may not be taken into account except perhaps as barriers to overcome in the implementation of government policy. Nevertheless I argue that they play an important part in the everyday reproduction of the state through their adherence to and contestation of state regulatory practices.

Corrigan and Sayer (1985) draw attention to cultural aspects of everyday state formation. Although they offer no formal definition of culture, I take culture to refer to everyday social practices that are meaningful because they are based on shared values⁶. Corrigan and Sayer see the routines and rituals of the state as cultural forms that confer moral authority on the state that effects moral regulation both of the rulers and the ruled. Corrigan and Sayer (1985:2) point to the cultural content of state institutions and behavior, and the regulation of cultural forms by the state as mechanisms through which consent is manufactured. In their analysis Corrigan and Sayer draw on Durkheim's vision of the state as "the organ of moral discipline." They point to Durkheim's depiction of the state as "parasitic" on the wider "collective conscience" of society. According to this view the state draws on cultural forms that resonate within society and uses them for its own ends. This "cultural theory of state" seems pertinent in Indonesia where state rituals of rule are taken very seriously, as suggested by the ethnographic vignette of the morning roll call that was presented at the beginning of this chapter.

⁶ Geertz has done much to elaborate an anthropological understanding of culture, often using case studies from Indonesia to develop his arguments (Geertz, 1973, 1980). I find his definition of culture too focused on the realm of ideas as distinct from social relations and practices that he regarded, following the Parsonian fashion of the day, as a separate field of analysis. I regard social practices as cultural ways of doing things even where participants hold divergent interpretations (Beatty 1996) or where they do not know or feel the need to know why they are participating.

Several anthropologists have studied the ways in which the Indonesian state draws on cultural forms believed to resonate widely with the Indonesian people in order to build legitimacy and encourage compliance with state programs (Pemberton 1994, Bowen 1986, Bebbington et al. 2004, Newberry 2006). For example, Pemberton (1994) describes how President Suharto arranged his daughter's wedding in the style of the Javanese aristocracy. By presenting himself as akin to a Javanese King he aimed to confer legitimacy on his rule. Bowen (1986) offers an example of the development of a supposedly indigenous cultural form to enroll people in government programs. He describes how the state frames unpaid labor contributions on state development projects as "gotong royong" a term evocative of local forms of mutual assistance. Each of these cases illustrates how the state not only draws on culture but also modifies cultural forms. Suharto performed the ideal Javanese wedding but his government also elaborated rules for how ordinary people should conduct weddings, rules that were so complicated that a professional was required to guide participants through the ceremony to make sure things were done properly (Pemberton 1994). According to Bowen (1986) the government also formalized "gotong royong" documenting local forms of reciprocity as variations of "gotong royong" even where local people used different terms. In other cases state formation involves the creation of new cultural forms that gradually become part of everyday life. Examples include the PKK⁷ organizations studied by Newberry (2006) and the related "posyandu" community

⁷ Pembinaan Kesejahteraan Keluarga (Support for the Prosperous Family) the national housewives association to which all married women automatically belong whether or not they are active members.

health posts that I examine in Chapter 5. In all of these cases there is a two way relationship between state formation and cultural formation.

As Corrigan and Sayer (1985:6) note, however, state processes of cultural appropriation and moral regulation are not always successful as citizens may interpret cultural forms differently from those in power, and use them for their own ends. Bowen (1986) points out that the government strategy to frame labor contributions to state projects as “gotong royong” was rejected in areas such as Aceh, with no history of corvee labor. In these cases village heads would regard the money intended for construction projects as a village subsidy and would distribute it as they saw fit. Newberry (2006) provides another example. She describes how some women in Yogyakarta, Indonesia engage with the PKK (national housewives association) not primarily in order to further the interests of the state but rather to enhance their own reputations within local moral frameworks. The PKK seeks to mold mothers into an ideal that combines the domestic housewife with the community volunteer in the service of national development. Women participating in the program interpret this government rhetoric through the lens of local Sundanese culture. Newberry argues that this moral regulation of government entwines with neighborhood (kampung) morality and that women draw on both in their attempts to generate moral accounts of themselves and to build social reputations. This relationship between citizens and the state could be described as one of mutual exploitation.

I build on the work of Bowen (1986), Newberry (2006) and others in emphasizing the ways in which people use their engagements with state policy for their own ends, to forge social reputations and build moral identities⁸.

Newberry's work on the relationship between local and state moral frameworks contrasts with the depictions of moral economies portrayed by Scott (1976, 1998, 2009), Ferguson (2006), Roitman (2004) and others. In these works citizens are positioned in opposition to the government and are considered to have a distinct moral framework that is in conflict with that of the state. For example, Ferguson (2006) argues that African populations judge the government according to whether it is "feeding the people" or "eating the people". Meanwhile, the official discourse of the state, under the influence of the International Monetary Fund's (IMF) loan conditionalities known as Structural Adjustment Programs, defines "good governance" in terms of efficiency, accountability and transparency. Ferguson describes the rationality of the IMF as "scientific capitalism," an attempt to frame economics as technical rather than moral. He argues that African governments pressurized into adopting this economistic approach cannot gain legitimacy among populations following a different moral economic logic. Thus, the introduction of IMF policies in Zambia gave rise to food riots that ultimately toppled the government. Roitman (2004) studied a similar context in the Congo where the government followed IMF policies of privatization and contracting out that violated popular understanding of the role of the government. She found that

⁸ Building a moral identity involves presenting oneself as a good person through social behaviors and speech acts. What constitutes a good person will depend on the social and cultural context. For my respondents in a kabupaten health office building a moral identity might involve presenting oneself as a good civil servant, a good Muslim and a good health professional.

illegal traders operating at the border argued that the government was now behaving like a private company rather than fulfilling its obligations in governing the state.

Consequently, their own behavior was, in their view, less immoral than that of the government that had relinquished its responsibilities towards its citizens.

Newberry's (2006) treatment of the moral frameworks she encountered in Indonesia is quite different. She recognizes that the moral frameworks of the government sometimes interact in positive ways with those of the Kampung, suggesting a process of syncretism that has often been noted in the Indonesian context (Hefner 2000, Beatty 1996, Newland 2001).

Another recent ethnography of Indonesia that points to alignment between the moral frameworks of citizens and the state is Rudnyckyj's (2010) insightful study of a state company anticipating privatization. Following the Asian economic crisis in the late 1990s the government of Indonesia agreed to IMF loan conditionalities that included privatization of state companies. Rudnyckyj describes how managers at Krakatau Steel Mill seek to align American management techniques with a brand of evangelical Islam in their attempts to increase worker productivity. Workers are encouraged to regard the new policies not as an imposition from the state but as a sign that God is calling them to raise themselves up to new levels of productivity. In this way, the moral values of Islam that are shared across the manager-employee divide are aligned with the state policy of privatization. Through its syncretism with Islam, privatization is not regarded as negative

or immoral but rather as part of a new moral world in which Islam can assist Indonesia in gaining a foothold in global markets.

I follow Newberry (2006) and Rudnyckyj (2010) in exploring how citizens and state employees forge moral identities through their engagements with state policies. There is another commonality between Newberry's and Rudnyckyj's studies. Both focus on state policies that seek to transform people into modern Indonesian citizens. In Newberry's case this is through the domestication of Indonesian mothers following an American cultural ideal of the domestic housewife. In Rudnyckyj's study the contemporary iteration of modernization involves privatization of state companies. The project of "development" towards a modern Indonesia has dominated state policies in Indonesia since Independence when intellectuals and policy makers sought to define an Indonesian modernity distinct from that of the West (Lubis 1964). This particular state project has taken on various forms by successive government as described in more detail in Chapter 2.

In my focus on the state project of development I also draw on the growing literature of "development anthropology". But I find one drawback in relying on this literature. Development anthropology tends to focus on international transfers of resources and ideas from "developed" to "developing" nations rather than recognizing "development" as a state project in which many so-called "developing" nations are engaged (examples include Cornwall 2007, Quarles van Ufford and Giri 2003, Eyben 2006). One consequence of this focus on international transfers is that it tends to exaggerate the

impact of foreign aid projects. Indeed one sometimes gains the impression that “development” would not happen in a “developing” country without foreign assistance, a point made by Ben Jones (2009). This applies both to “critical” analyses of development that point to the negative impacts of aid (Escobar 1991, Rogers 1980, Williams 1994) and to “instrumental” reviews aimed at improving development policy (Chambers 1983).

Departing from this trend, I focus on “development” as a state project aimed at transforming people into “modern” citizens based on global and local norms of “modernity”. I regard “development” in both its global and national aspects as a form of governance based on what Tania Li (2007:4) has termed the “will to improve”. She argues that the “will to improve” dates back to colonial times and involves what she terms “trustees”, people who act on the basis that they know what is best for others. Both international and state development projects involve diverse goals that may be contradictory⁹, and various means including the transfer of technology and educating populations to ensure that they use the technology correctly. The transformation of citizens is undertaken “in the public interest” and is often presented as being in the interest of the individual as well, but citizens do not always respond as intended perhaps because they have no interest in being modern or have different ideas about what it means to be modern. Thus, as Li (2007) points out, “development” as a form of governance involves transforming desires, and I would add also transforming peoples’ sense of obligation, what they feel they “ought” to do. In this sense it represents an

⁹ As when industrial development undermines environmental and population health

example of what Corrigan and Sayer refer to as “cultural revolution” by the state. State development projects are attempts at cultural and moral regulation in line with the state’s vision of modernity. State officials need to work constantly to align state and individual ideas about what it means to be a modern citizen. This may involve paternalistic approaches to guiding citizens in the “correct” direction. But although the state aims to transform citizens into something new it may draw on “traditional” cultural forms and rituals as well as on global “key words” to persuade and enroll citizens in the project of national development (Bowen 1986, Ferzacca 2002, Cornwall and Brock 2005.) For example, in Newberry’s (2006) study the traditional cultural ideals of “community” and “gotong royong” (mutual assistance) are fused with the modern idea of the domestic mother, whereas in Rudnyckij’s study Islam, albeit a modern form of it, is fused with modern approaches to management.

Public health is a good illustration of the “will to improve” and of efforts to manufacture “modern” populations through cultural and moral regulation. Since its inception in the early 18th century public health has been an important component of states’ efforts to improve populations through moral regulation of everyday life. Medicine helped develop the idea of a normal body. Deviations from this norm were then defined as sick and requiring interventions from medicine and/or the state (Lock and Nguyen 2010). This standardization of the body and appropriate interventions represents one aspect of the rationalization and bureaucratization of life (Weber 1999, Lock and Nguyen 2010). Public health developed in Western Europe and also Japan and China and was then exported to South East Asia and elsewhere through colonial governments that sought to

“protect the colonizers and civilize the colonized” (Lock and Nguyen 2010:69). Thus, in the colonies as in the countries of origin public health was inexorably linked with projects of modernization. Schemes to improve citizens’ health behaviors have included campaigns to vaccinate populations against infectious disease, encourage hygienic behavior (Stein 2009) and control reproduction through family planning (Lock and Nguyen 2010). During colonial times these took on a quasi-military style that has been repeated by some post-colonial governments especially for family planning (Hartman 2011). Collective social memories of such campaigns endure in some areas and affect popular responses to public health initiatives such as contemporary polio vaccine campaigns (Obadare 2005, Dugger and McNeil 2006).

But many post-colonial states have followed the lead of global health agencies such as the World Health Organization (WHO) in framing public health programs as something that the public are entitled to, as their “right to health” (Gruskin 2004, Halabi 2009, Biehl and Petryna 2011, 2013). For example, in Indonesia giving birth at a health facility is currently framed as a “right to health” rather than a form of moral regulation. Similarly, adopting clean and healthy behaviors and having “small prosperous families” is framed as being in the interests of the individual but also for the good of the community and the nation. Consequently citizens are placed under moral pressure to adopt such behaviors as a matter of good health citizenship. These issues will be explored in greater detail in Chapter 7. At the national level public health governance

including pandemic control and achievement of the Millennium Development Goals¹⁰ is regarded as central to gaining global health citizenship (Fidler 2004, 2008). Thus public health from the village to the global level operates as a ticket to modernity.

In this dissertation I explore how Indonesian government officials and citizens engage with contemporary public health policies. Building on Corrigan and Sayer's (1985) conception of a cultural theory of the state, I focus in particular on the cultural forms and moral frameworks used to justify policies, motivate workers and enroll citizens in public health programs and policies. I draw attention to how these strategies have evolved in the era of democratic decentralization, even though the underlying public health goals remain similar. I identify transformations in the rhetorical devices and "key words" needed to align "old" public health goals with the new political climate.

In seeking to understand how public health programs work to frame individual behaviors I draw on Foucault's analysis of the "arts of government." Following Foucault (1991, 2007), Li (2007) and Newberry (2006), I regard public health programs in Indonesia as mechanisms for extending a government rationality of "development" to the household and individual level. I use this lens in Chapter 5 where I describe various projects that seek to govern through community.

Foucault appears to have been less interested in how particular individuals engage with and respond to government. In my analysis of how health managers and practitioners

¹⁰ The eight Millennium Development Goals were agreed by member nations of the UN and international organizations in 2000. For each goal global numerical targets were to be achieved by 2015. For example, under Goal 5 to improve maternal health the target was to "reduce by three quarters, between 1990 and 2015, the maternal mortality ratio." Source: <http://www.un.org/millenniumgoals/maternal.shtml>

reflect critically on government policies and on their role in the systems in which they operate I turn to Weber. Weber was interested in understanding social action from the point of view of the individual engaging in such action. He identified four ideal types of motivation for human action: instrumental rationality, value oriented rationality, traditional action and affective action (Weber 2013:63, 1376). According to Weber's sociological method, categorization into these ideal types helped in identifying patterns in human behavior although a particular social action might involve a combination of these different forms. This framework is fitting for Indonesia where rational frameworks of medicine, science and technology are readily embraced yet moral values and ideas about tradition and community remain salient and continue to influence policy making processes and health promotion efforts. In the kabupaten health office where I spent much of my time both evidence based medicine and Islam permeated office life and both were used to motivate and discipline staff. In Chapter 7 I describe how these frameworks, along with the idea of a "right to health," are used in health promotion work at the village level. I argue that health promotion involves a form of "moral pluralism"¹¹ in which a combination of rational and moral arguments and frameworks are deployed to encourage adherence to government health policies.

The balancing act between rational and moral is reflected in Weber's analysis of the bureaucracy (Weber 2013:956). Although he saw the bureaucracy as reflecting increased rationalization of society he argued that it also involved a moral code or

¹¹ My use of the term differs from its use in moral philosophy where it refers to a multiplicity of values that may form the foundation for morality (Mason 2015, Honderich 2005). I use the term to refer to a form of governance, as elaborated in Chapter 7.

bureaucratic ethos. In Chapter 6 I explore what is happening to the bureaucratic ethos in Indonesia in the age of decentralization.

Drawing on these various theoretical frameworks, my work lies at the intersections of anthropology of the state, anthropology of development and anthropology of public health. In combining all of these sources I make connections that are often missed.

When development anthropologists talk of the rhetorical devices and “buzz words” used to enroll support for development policies they are providing an example of the use of culture to further governance aims (Cornwall 2007, Apthorpe 1997, Mosse 2004).

This is the stuff of a “cultural theory of state” but even though the development agencies that form the sites for this research are often state agencies the connection with state theory is not always made. International development is somehow regarded as a separate activity requiring its own body of theory. I hope to bridge this gap through using the lens of a “cultural theory of everyday state formation” while also drawing on “anthropology of development” in my examination of the Indonesian state project of development under democratic decentralization.

1.3 Fieldwork approach

My perspective draws on over twenty years’ experience working as an applied anthropologist in international development. Development has been described as anthropology’s “evil twin” (Ferguson 1997) but I have argued elsewhere (Magrath 2010) that the insights of development practitioners can make important contributions to anthropological theory. My development experience also framed my approach to

fieldwork.



Plate 2: Author sharing a meal with kader, Desalindah village, West Java, Indonesia

It was as a development practitioner that I first encountered Indonesia. From 1989-91 I worked in a large government bureaucracy in Jakarta, BULOG (Badan Urusan Logistik or Food Logistics Agency), as socio-economist for a British Aid funded project. I was responsible for running a research project to understand the private rice market in Indonesia at that time. A decade later I worked as a consultant to the World Bank on a pilot project for decentralized health care, the Provincial Health Project (PHP1). I conducted field research in Lahanbesar kabupaten together with a well-known local

doctor and researcher on people's experiences with the health services, with a focus on public accountability issues.

In many anthropological analyses of power and the state information is gathered about citizens' personal experiences with the state. From these personal stories the anthropologist infers insights about the system as a whole. Examples include Roitman (2004), Li (2007) and Ferguson (1999). Few anthropologists engage their respondents in theoretical arguments about the systems in which they live.

In my case, treating my respondents as co-analysts seemed an obvious approach to me. As a development practitioner, government officials and citizens were my co-researchers, trainees or co-workers. Against this background I was less likely to fall into the twin traps of "state phobia" and a failure to recognize the reflexive agency of government officials and the people they sought to govern. Moving beyond the citizen-state dichotomy central to many analyses of the state, my experience of working on development projects allowed me to see the government system as multi-layered. I was aware of the multiplicity of perspectives both within and outside of government, and I knew that people at all levels in the system regularly reflected on their roles and on the wider systems in which they operated. Having worked on participatory development programs that evolved in line with the concerns of intended beneficiaries (Rhoades 1984, Magrath et al. 1997) I readily adopted what Rudnyckyj (2010:15) has described as "para-ethnography". According to this approach informants are treated as co-researchers whose interests and concerns are allowed to influence the direction of

research. As an example, in response to the priorities and concerns of my informants I included a focus on Islam, the right to health, maternal health and health insurance none of which were evident in my original research proposals.

Many of my informants within government had Masters degrees in government or public health. Some would have liked to be doing PhDs if they had had the time. They were comfortable discussing theories of development and interpreting statistics. I regarded them as expert analysts of the systems in which they operated. In this dissertation I present their analyses as a first step in seeking to understand how things operate. I then add my own interpretations.

If I regarded my informants as co-researchers, how did they regard me? One clue to this question lies in an experience I had towards the end of my fieldwork when Pk Yudi, head of Health Promotion, invited me to a staff meeting at which he introduced me, with a chuckle, as one of his “staf ahli” (expert staff). I worked hard to establish relationships of trust with my informants on the basis that, as ethnographers, that is really all we have to validate our results. Ethnographies consist of the anthropologist’s interpretations of what people say and what we observe them doing. We cannot rely on statistical manipulations and our credibility depends on convincing the reader that we developed relationships of trust with the people we live and work with who are our sources of information. In past decades anthropologists have been experimenting with fieldwork sites and styles of writing (Clifford and Marcus 1986, Marcus 1998), but the importance of “gaining entry” and “building rapport” have remained as a constant foundation for

ethnographic work. A particularly revealing example of this is given by Stoller (1987) in his ethnography of sorcery in West Africa. Stoller decided to start by using a questionnaire to collect information about the linguistic abilities of the people he was staying with. During the final interview his respondent asked him how many languages the penultimate respondent had claimed to know. When Stoller told him three, the respondent laughed heartily and denied the claim saying he only spoke one language. Stoller ran back to the man and confirmed this distressing piece of information. He then determined to check the information from all of the other respondents and he found to his dismay that they had all lied to him. When he asked them why, they answered “what difference does it make?” Evans-Pritchard’s (1969) Nuer informants were even more frank and asked “why are you asking us our name and our lineage?” In these cases the informants chosen by the anthropologist reveal to them the importance of building trust before you can ask questions. The challenge is learning what it takes to build trust in a particular context.

I came to realize early on that the important thing for my gaining entry in Indonesia/West Java was that people could place me in some category that made sense to them. I introduced myself as an anthropologist who was studying the culture of the bureaucracy. In the village I was introduced as a student doing my practical training, a familiar figure in village Indonesia.

The official letters that I carried with me everywhere played a crucial role in conferring legitimacy in any government office. It took me a full month to obtain the foundational

letters, with initial visits to local offices of Immigration, Police and Law, followed by trips to the capital city Jakarta, to obtain my research letter from the Ministry of Research, then another letter from the Ministry of Interior. Finally I had to visit the kabupaten capital, several hours from my residence. Armed with these official letters I then approached the head of the kabupaten health office, Dr. Nia. She welcomed my research and agreed to write a letter instructing all of her staff to cooperate with me. The importance of this letter was brought home to me during my first visit to the head of Information. I explained to her that I had been sent by her boss, and that I would soon obtain a permission letter from her instructing all staff to cooperate. She replied that she would not be able to share any information until she had actually received the letter. A few days later I was able to hand her the letter, and she readily agreed to share all of the data she had available. The promise of the letter was not enough, only its physical presence would suffice. This attitude towards official letters reflects something about how Indonesian civil servants regard the bureaucracy. No amount of explanation on my part could have built trust as quickly as producing the correct letter. Fear of the disciplinary consequences of not following protocol may be part of the reason but I think it also signifies a trust in bureaucratic processes, and a sense of security conferred by knowing that things have been done properly. Pemberton (1994) may be referring to something similar when he talks of the anxiety Indonesians experience around the performance of cultural rituals, an anxiety played upon by the New Order regime that regulated cultural practices such as weddings to ensure that they were conducted properly, according to “tradition”.

This attitude towards the bureaucracy contrasts with that described both by Herzfeld (1992) and by Du Gay (2000) for “western bureaucracies”. They point to the tendency for people in “the West” to complain about the bureaucracy and its “red tapism”. Herzfeld regards this as a cultural practice and points to “conventions that govern talk about bureaucracy” and its “predictable image of malfunction” (Herzfeld 1992:3). He argues that both citizens and bureaucrats are engaged in a common symbolic struggle to exonerate their own behavior against a backdrop of a bureaucracy that fails to live up to its own lofty ideals of “good governance”. My informants were ready to criticize “the government” in relation to particular policies and practices, as will be revealed in the following chapters, but they did not critique the underlying functioning of the bureaucracy and its reliance on regulations, procedures and record keeping with all of its consequent paperwork.

Outside of the office environment my official letters were not of interest, but I always carried consent forms. I had anticipated that people might be intimidated by official letters and fearful of signing papers so I had permission from the IRB (Institutional Review Board¹²) for waiving the requirement for signatures. To my surprise I found that people liked to be given an official looking letter, perhaps as a memento of our meeting, or to show family members and neighbors. In cases where I did ask for signatures for permission to use photographs, no-one minded. The vast majority of people were happy to talk to me and for me to write down what they said. Most were comfortable with me recording their voice. Only a couple of people did not want me to write down what they

¹² The IRB is the body that gives permission for a researcher to work with human subjects.

said, or said I should not use it in my writing. Only one person wished to remain anonymous, even though I explained that real names would not be used in my writing.



Plate 3: People reading my letter of consent before I interviewed them.

Building my identity as a researcher was necessary but not sufficient for gaining acceptance within the social milieu of the kabupaten health office, puskesmas¹³ (health center) or village. My second step was establishing my language skills. Having worked in Indonesia previously I already spoke Bahasa Indonesia, the official national language, quite fluently and my first few weeks of participant observation at the kabupaten health office helped bring me back to speed. The only remaining language barrier was my

¹³ The puskesmas (pusat kesehatan masyarakat) will be described in detail in Chapter 3.

inability to speak Sundanese, the West Java language spoken in the villages. But elderly women were the only people who could not also speak Indonesian, so there were usually plenty of people to translate.

Having my family with me also helped people to make sense of me as a person. On my first day at the kabupaten health office I brought my two children, aged 11 and 13, and we happened upon a festive staff lunch to mark the start of “bulan puasa,” the Muslim fasting month. The assembled midwives and doctors were delighted when my son accepted more of the spicy “sambal”, indicating that he could tolerate “pedas” (hot) local food. Joining meals with office staff, volunteers and people in my case study villages continued to play an important role in building relationships throughout my fieldwork. I also brought my family along to events such as National Health Day where we met many of the personnel whom I subsequently visited and interviewed at their puskesmas.

Having a religious identity provided the final pillar in gaining acceptance. Under the government philosophy of Pancasila, described in more detail in Chapter 2, belief in God is one of the founding principles. Six religions are recognized: Islam, the majority faith of almost 90% of Indonesians, Catholicism, Protestantism (these two are seen as distinct religions), Judaism, Buddhism and Hinduism. If a stranger can be placed in one of these categories they are accepted as worshipping the same God. If not, suspicions are likely to arise as to whether the stranger is a moral person, or whether they might be a communist. I felt comfortable identifying as Catholic, having been raised in a catholic

family. I attended a Catholic church in the kabupaten capital and was immediately struck by the bare heads of the women – there was not a headscarf in sight. I remembered Catholic churches I had attended in Europe and the US, where the wearing of some kind of headgear would be quite normal, especially for older women who might wear a hat or even a veil. In this Indonesian context, it seemed, the bare head operated as part of a Levi-Straussian binary opposition to the headscarves worn by Muslim women. A bare head marked more than simply the absence of a Muslim identity, it marked out these women as Catholic.

The meaning of the headscarf was again brought home to me at the kabupaten health office. Despite my Catholic identity, I tried to follow the Muslim dress code that was also the office dress code.¹⁴ I consulted the head of the kabupaten health office who informed me that, to show respect for the Muslim dress code, my shirt sleeves must reach my wrist and my skirt or trousers my ankles. Her staff additionally wore socks to cover their feet and most wore headscarves to cover their hair, ears and neck, leaving only their face visible¹⁵, but these were not obligatory for non-Muslim staff.

Nevertheless I did initially try wearing a headscarf, to the delight of my co-workers who exclaimed that I looked much prettier when wearing it. They took pains to show me how to fold the scarf and attach it with a broach so that it didn't slip off. Headscarves are regarded as a necessary component of office dress, although not actually obligatory¹⁶,

¹⁴ Out of the 300 or so staff of the kabupaten health office there was one Protestant and one Catholic. All of the other staff identified as Muslim.

¹⁵ The full black Burqua common in other Islamic cultures is rarely found in Indonesia, except among Muslims who come from these cultures.

¹⁶ Only one Muslim woman staff member chose not to wear a headscarf.

but they are also treated as a fashion item and women take great care to select headscarves that match their outfits and spend much time arranging them so that they are positioned just right. I was told that while Saudi Arabia was the center for Islamic theology, Indonesia, and particularly Bandung, the capital of West Java, was the center for Islamic fashion. At the kabupaten health office all staff, male and female, were expected to wear a brown office uniform on Mondays, and a green office uniform on Tuesdays and Wednesdays. Thursdays and Fridays they were encouraged to wear Batik to demonstrate appreciation for local culture. On the 17th of the month they were supposed to wear a blue Batik civil service uniform, along with all government employees, in commemoration of Indonesian independence on September 17 1945. Consequently the women's headscarves always matched whatever happened to be the day's uniform.

I stopped wearing the headscarf when several people, seeing me in the headscarf, asked if I had converted to Islam. This made me feel that wearing the headscarf, rather than indicating my respect for local culture, was actually misleading. This was something of a relief because I found that I was not very good at keeping the scarf in place, despite the advice of my friends in the office.

The wearing of headscarves in government offices was less prevalent during the Suharto era. Suharto sought to emphasize an Indonesian identity over any religious or ethnic identity. I heard that it was during the presidency of Abdurrahman Wahid, a Muslim cleric popularly known as Gus Dur (1999-2001) that the wearing of the headscarf by civil

servants was encouraged. West Java appears to have taken it up more enthusiastically than other Provinces, reflecting a relatively conservative and widespread commitment to Islam in this Province.

If my research letters, language skills, family and religious identity facilitated my entry into my research community, there were a number of distinct events that marked my acceptance. In my first week I was welcomed by the office secretary who gave me a place to sit where I could watch office life go by, chat with her and take notes. She became an important informant about office events and personnel and I drew on her social network and support when arranging interviews and focus group discussions. But it was Pk Yudi, head of Health Promotion, who offered himself as my research sponsor. He took a great interest in the topic of my research, offered himself as an expert, and introduced me firstly to his own staff and then to the heads of the puskesmas I had selected for my research. He continued to provide support throughout my fieldwork, and frequently invited me to meetings, events and meals with his staff. But I really felt I had passed my rite of passage when one of his staff, Bu Erna, head of Health Insurance Section, invited me to join a field trip to the south of the kabupaten to evaluate the health insurance program for childbirth, Jampersal. Much to my surprise, on arrival at a remote puskesmas, I was handed some forms and sent off to a village to interview the mothers myself, with a local escort transporting me on his motor-cycle and locating the families to be visited. My role as one of Bu Erna's staff continued as I was asked to help out in the documentation and distribution of the new insurance cards that arrived in December 2012. I followed these insurance cards from the kabupaten health office to,

one of my case study villages, where I accompanied a kader (health volunteer) who distributed them to individual households¹⁷.

In the villages it was the kader who provided me with a way in to the lives of ordinary people. Indeed the village heads would not allow me to visit homes unaccompanied by a kader. I stuck to this guidance for the first couple of days. Then, one morning I woke up in the village and simply wandered out and started talking to the neighbors. They were able to associate me with the kader, and this placed me in a comprehensible category, but without the physical presence of the volunteers they were more open and relaxed. I always felt welcomed by people, most were happy to be interviewed, and several asked me to stay in their homes on my next visit

Bu Erna became a good friend and on my return trip in September 2013, when I travelled without my family, she invited me to stay in her home. I was able to observe her private bidan practice that she operated from a front room in her house early in the morning and again after she returned from the office. I also got a lift into the office with her each morning. Robert Hefner (1990) has pointed out that on a return visit to a research site people are often more open and informal, and one learns more of the background politics and gossip. This certainly applied to my return visit. In the six months since I had left there had been several changes in personnel, most notably, the head of the kabupaten health office had been replaced, as had the village head in Desalindah village. In both cases I was treated to detailed interpretations of the politics of these replacements, leaving me with a stronger impression of the political

¹⁷ Insurance programs are the subject of Chapter 5

maneuverings that were no doubt also going on during my main period of fieldwork when I was given more official versions of events.

Not everyone welcomed me with equal enthusiasm. It was only after repeated attempts that I managed to meet up with some of the Heads of Departments, perhaps because they were too busy, or waiting for confirmation of my trustworthiness or value as a confidante. One puskesmas head initially said I could attend one of his monthly meetings, then sent me a text message (the usual mode of communication for office staff and volunteers) to say that I could not attend because the content was confidential.

But the majority of my informants seemed to welcome the opportunity that my interviews offered to reflect on their work, on the role of government in the health sector and on the policies that they were embroiled in in their daily activities.

Interviews also allowed them to present themselves as thoughtful and moral individuals, trying to be good civil servants and good Muslims in the workplace. I responded by treating them as co-researchers and taking their concerns seriously enough that I allowed them to guide the direction of my research. I wondered what else they hoped to obtain. For some I was a friend and a guest to be entertained. As a white foreigner, perhaps I represented a connection to other worlds, as well as a source of new ideas or perspectives. There were very few white people in the kabupaten and association with me may have conferred some symbolic capital (Bourdieu 1986). Perhaps some hoped for something more concrete, such as a future project, training or other opportunity. I

emphasized that I could not guarantee any specific outcome, but that I did hope for continued engagement with their country if not their kabupaten. I believe my friendships were also based on shared priorities, such as the desire to “help the poor” that is rooted both in Islam and Christianity. The overlap in values was brought home to me one time when Pk Yudi invited me to lunch with his staff at a restaurant. On the way Pk Yudi, who was driving, mentioned that I wasn’t like other foreigners, I seemed genuinely interested in them. I answered that, as an anthropologist I thought it most important to respect everyone and take seriously others’ point of view. “Not just anthropologists Bu Pris,” he answered, “human beings!”

Indonesia is not an easy place to do fieldwork. As I remembered from my first time working in Indonesia in the late 1980s, one is never quite sure what is going on, or what people mean. It seems as though every utterance has several layers of meaning. The surface always looks good, but what, one wonders, is hidden from the perspective of the naïve foreigner? Laine Berman (1998) captures the complexity of linguistic interpretation on Java in her book *Speaking through the Silence*. Based on her interpretations of conversations in Javanese among urban women in Yogyakarta, Central Java, she argues that the marking and consequent reinforcement of social relations and social status among those participating in the conversation is more important than the content or literal truthfulness of the statements. This can result in people stating opinions they do not hold simply in order to avoid contradicting their superior. I found similar processes operating at the many meetings that I attended where contributions were often carefully framed in order to avoid openly contradicting

or offending other participants. At these meetings, seating arrangements often signaled the status of the participants as well, with higher status people separated from others by tables. While this might also occur in a Western context, it is adhered to more diligently in Indonesia.

In individual interviews displays of deference were less noticeable, but I had to take account of other cultural tendencies. As Berman (1998) and other anthropologists have pointed out, in their “presentation of self” Sundanese and Javanese in particular place a great deal of importance on controlling one’s emotions and not showing anger or impatience. I had to remember this while conducting interviews that sometimes lasted several hours. My informants were not going to tell me that I was taking too long and it was up to me to discern that they had had enough. One reason why interviews tended to be lengthy is that it is sometimes difficult to obtain direct answers. People are liable to frame their critiques in a roundabout way, hinting at things rather than saying them outright. They are generally reluctant to speak openly about other people, especially about people holding official positions, or to criticize official policy, although political dialogue is more relaxed than during the Suharto era. For example, Drg Saipudin would not criticize the head of the kabupaten directly, even though he found the rapid staff rotations that the head implemented very frustrating (see Chapter 4). Within the kabupaten health office people showed loyalty to the head and never criticized her in front of me. They also showed support and respect for regulations and paperwork. These things were sometimes critiqued but never ridiculed, as they might be in Western settings. I found my informants to be sincere and not cynical. But I had to maneuver

carefully in order to get people's thoughtful critiques without putting them in the uncomfortable position of having to display a lack of loyalty or personal self-control. Nevertheless, I found most people to be surprisingly frank compared with my previous visits in 1989 and 1999. At that time I found people reluctant to speak out for fear of losing access to benefits or services. This time I found that fear had been replaced by caution, as reputations remained important but did not determine one's life chances to such a degree as previously.

1.3.1 Site Selection

Anthropologists have long recognized the need to account for connections between "their" community of focus and the wider world, particularly as the subjects of anthropological analysis have broadened to include trans local processes such as globalization, development or technological change. Marcus (1998) has advanced the practice of multi-sited ethnography as one means of addressing this challenge. However, there remains a tension between the need to incorporate breadth of analysis and achieving the in-depth understanding that is the hallmark of the anthropological approach. Ultimately the decision must be related to the objectives of the research and the object of analysis. My goal is to examine health governance under decentralization. The object of analysis is a process that varies both vertically, with the level of government, from the center in Jakarta to provinces, kabupaten, kecamatan¹⁸ and villages, and horizontally. Indeed the geographical diversity within Indonesia is one of

¹⁸ Kecamatan are the government administrative unit between the kabupaten and the village. See Figure 1 for Hierarchy of Government Administration.

the main arguments given for the need for decentralized government. I chose to adopt a multi-sited approach within a single kabupaten in Indonesia. Within the kabupaten I focused on two puskesmas (community health centers) and two villages. This allowed me to explore relationships between the kabupaten health office, puskesmas and villages while allowing me to develop good relationships, and often friendships with informants at each level. I gained some sense of the geographical diversity of health governance styles under decentralization when I attended a national Public Health conference in September 2013, during a brief return trip to Indonesia.

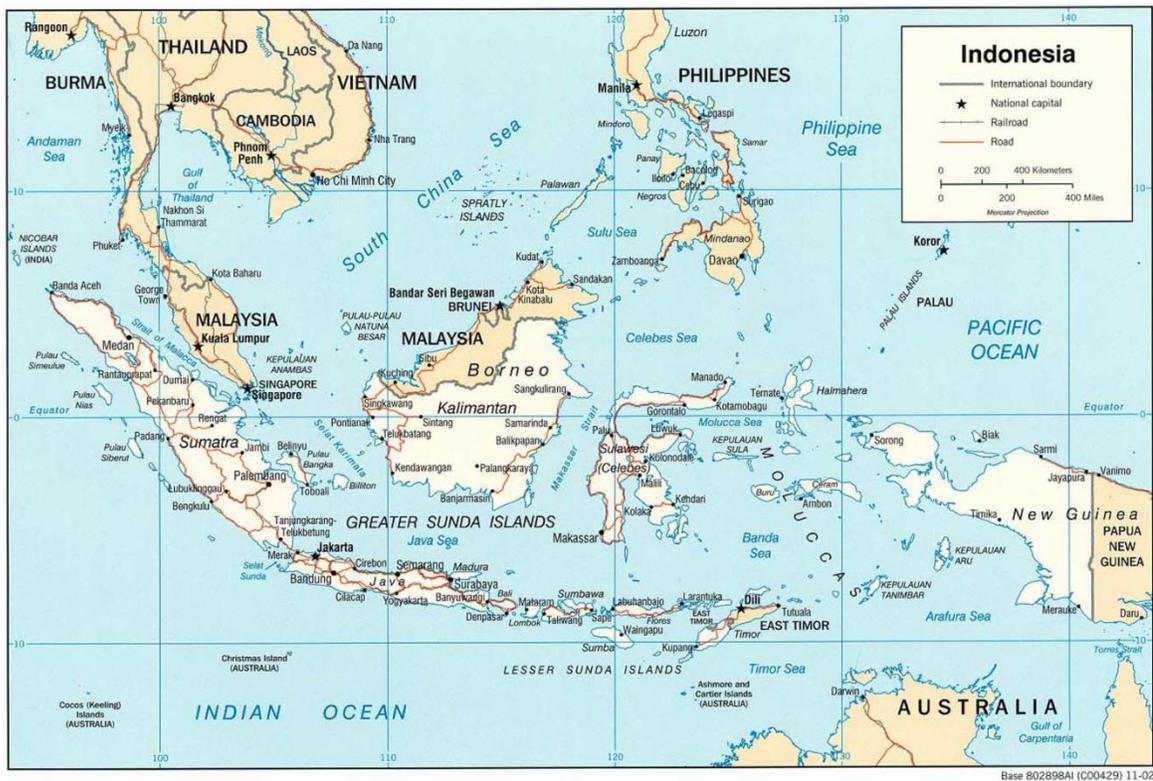


Plate 4: Map of Indonesia.

(Source: Perry Castanada Map Collection on-line)

This confirmed my sense that even if I had included two or three kabupaten I would not have been able to capture the range of variation, and I would certainly have lost much of the depth of understanding that I sought.

I selected Lahanbesar kabupaten in West Java because I had already done research in the kabupaten under the auspices of a World Bank project 12 years earlier. At that time West Java was selected for research on public accountability issues in health services delivery because of the relatively high incidence of maternal mortality (Mize et al. 2010). This was partly attributed to the strong Sundanese cultural practices that continued to influence health seeking behavior, including use of traditional birth attendants known locally as “paraji”. The Sundanese people who comprise 80% of the population of West Java speak a different language and follow different cultural traditions from the Javanese people of Central and East Java. West Java is the most densely populated province in Indonesia with a population of 46.3 million inhabiting 37,000 km²¹⁹. The percentage of the population following the Islamic faith is 97% compared with 90% for the nation as a whole.

Lahanbesar kabupaten was selected from among West Java’s 18 kabupaten because my research counterpart for the World Bank study was from Lahanbesar. She was well respected in the locality having been a puskesmas head, then head of another kabupaten health office. Following her retirement from government service she worked as a consultant for UNICEF and also ran a popular private practice in Lahanbesar town. Consequently she knew many of the people we interacted with for the research that we

¹⁹ About the size of Belgium

did together in 2000. This enabled us to carry out qualitative research on sensitive issues in several puskesmas and villages within a short time framework, since villagers and health staff alike readily trusted her. Furthermore she was able to negotiate the culture of the health bureaucracy and interpret what was going on.

Choosing the same kabupaten for my dissertation research had two advantages. Firstly it facilitated my gaining entry and building rapport. Even though many of the people I had worked with had moved on, I felt comfortable in Lahanbesar and my previous research helped build credibility. Returning to the same location also offered the potential for capturing a longitudinal perspective on people's perceptions of and relationships with their health services.

Selecting a single kabupaten still presented a challenge for multi-sited research. "My" kabupaten had a population of 2.34 million people²⁰ inhabiting 363 villages and covered by 58 puskesmas. Luckily for me, there was only one kabupaten health office, although it turned out to be spread over four different locations. I decided that this would be my research base because the kabupaten government, including its health offices, had been the focus of the decentralization process that I intended to investigate (see Chapter 2 for details of the decentralization laws). I then selected my puskesmas and villages based on a combination of factors including my previous research, advice from kabupaten office staff and logistical concerns.

²⁰ According to the 2010 census.

When discussing site selection with local health personnel I was told that there were marked differences between the south and the north of the kabupaten. Health facilities were less accessible to people in the more remote south of the kabupaten where livelihoods were more focused on agriculture. The north of the kabupaten was divided by the main road that linked Jakarta to the West and Bandung, capital of West Java, to the East. Villages were more urbanized and many people worked in the factories that peppered the main roads and generated notorious traffic jams. In the end both of my selected puskesmas were located in the north of the kabupaten. I chose Koratanah, a relatively rural puskesmas covering six villages, because this was one of the three puskesmas I had studied during my previous research. I hoped that some of the staff there would remember my earlier work and provide some continuity. My second puskesmas, Pariwisata, was located close to a Lahanbesar city and was the nearest puskesmas to the village where I was living with my family. Being a peri-urban puskesmas it provided a good contrast while being logistically easier for me to cover. I could reach Pariwisata puskesmas in 10 minutes using a local mini-bus. This compared with journeys of half an hour or so to the kabupaten health offices and a two hour trip to Koratanah, involving a public mini-bus and a motor-bike taxi.

For each puskesmas I selected one village for intensive study. I consulted the head of Koratanah puskesmas and he suggested Desalindah because the village head was committed to health issues and supported villagers in accessing health facilities and dealing with the administration involved in using health insurance. To get to Desalindah I needed to take a minibus or motor-bike taxi from Koratanah puskesmas. For Pariwisata

I selected the village where I lived, Mendekati Kota. Mendekati Kota happened to have an assistant puskesmas located very close to my house, as well as a private voluntary health clinic in my local mosque, run by the puskesmas staff on a Saturday morning. I was able to walk to all of these sites from my house.

Villages on the island of Java tend to be large with little space between them so that one sometimes has the impression, while driving along the main roads that one is passing through a single, seemingly endless, semi-urban village. Based on data available at the village offices, Mendekati Kota has a population of about 12,686 while Desalindah has 5,218. With such large villages there is inevitably quite a lot of variation within the village in terms of access to health and other facilities.

1.3.2 Interviews

The kabupaten health office is divided into four departments, Human Resources, Infectious Disease Control, Health Services and Health Promotion. Each of these departments has three sections. In addition there are three positions at the same level as department head, namely Personnel, Finance and Planning. I held in-depth interviews with all department level staff and several section heads. My first interview focused on their views on decentralization. In many cases I followed up with up to twelve further interviews related to their professional area of work, what was happening on a day to day basis and discussions around my findings. Towards the end of my fieldwork I held three focus group discussions with all of the department heads and section heads at which I presented material I had gathered at the puskesmas and villages. These group

discussions focused on the dilemmas faced by government health workers and how they negotiated these dilemmas. I also interviewed junior staff. In total, I interviewed 33 out of the 300 or so staff of the kabupaten health office.

In addition to interviews I attended about 30 public health related meetings at the kabupaten health office, puskesmas and other meeting locations including hotels. I made a one day visit to the main kabupaten hospital and interviewed several staff there.

At the puskesmas level I interviewed fifty-nine people including six puskesmas heads, three puskesmas office managers, several nurses and numerous midwives. In the case study villages I talked to forty-three kader and over one hundred other people. Some of these conversations took place at puskesmas or at the posyandu (village monthly community health post) while others took place in people's homes. At home, people were more relaxed and could speak more openly about their health seeking behavior and experiences without feeling that they had to be seen to be following government policy. For example, I held a discussion with several women comparing birth with a "paraji" (traditional birth attendant) and birth with a medically trained midwife known locally by the Indonesian term "bidan". In the presence of a bidan they would have felt constrained since the official government policy is that all births should be attended by a bidan.

In order to obtain the perspective of non-governmental health providers I interviewed five private providers, five paraji, one acupuncturist and one unlicensed nurse²¹. I also talked to government officials outside of the health sector at village, kecamatan, kabupaten and central government level as well as to several people from NGOs and universities.

Participant observation at the kabupaten health office, puskesmas and villages was crucial in helping me to make sense of the information gathered in the interviews. I learnt how a posyandu was run, what it felt like to go to a puskesmas and how things got done at the kabupaten health office.

1.3.3 Writing Up

My data consisted of my notes on my observations, notes and recordings of interviews and focus groups and written documents. I collected much of this material in electronic format, since very few people objected to my using a netbook computer in their office or home. I then entered most of my material into MAXQDA, a qualitative data analysis program, coding as I went along. The coding process helped me develop my key arguments and design an outline. In my writing I seek a balance between giving voice to my informants and articulating my own arguments. I regard myself neither as a ventriloquist simply providing an outlet for local voices (Hefner 2000) nor as a puppeteer directing the action. I aim for an accurate representation of my informants' perspective.

²¹ Whereas doctors and midwives are allowed to run independent private practices nurses are supposed to work only under the direction of a doctor (Sciortino 1995, Heywood et al. 2011)

In Chapters 2 and 3 I provide necessary background information on Indonesia to assist the reader in understanding what follows. Chapter 2 describes the history of state formation in Indonesia, and the recent political history that led to the transformation of government with the introduction of democracy and decentralization from 1999.

Chapter 3 gives a brief outline of government involvement in the health sector, the structure of health services and community views on government and private health services.

In Chapter 4 I present local interpretations of decentralization to identify what this policy framework means for those charged with implementing it, how it differs from the previous centralized regime and how elements of centralization endure within the decentralized framework. Informants from the kabupaten health office and puskesmas have mixed responses to decentralization. Most are supporters yet they have concerns and criticisms about certain aspects of the decentralization process.

In the process of outlining how decentralization is imagined, implemented and rendered successful I hope to achieve two things. Firstly, I provide a rich narrative of how decentralization is rolling out at the kabupaten level, told from the perspective of those most intimately involved in the process, the government health officials and volunteers who implement government health policies. I describe how these protagonists navigate the ongoing co-existence of centralization within decentralization policies and how they understand the strengths, failures and contradictions of these policies. At the same time I build up a picture of the moral identity of government health workers in one

kabupaten of West Java, Indonesia and of the institutions in which they work. The narratives of these health program managers reveal the priorities and concerns that drive their everyday decisions and their strategies for achieving personal, career and public service goals. They show what it means in contemporary Indonesia to be a good civil servant, a good citizen and a good Muslim and how Islamic conceptions of the common good infuse their interpretation of government policy. The moral identity of the state official is often absent from anthropological analyses of the state, international development or public health. I argue that the moral frameworks and values of state officials and citizens influence how policies take effect. Documents, laws and policies don't have effects until they are taken up by people who do things with them. Thus, their effects are always mediated by the state officials and others charged with implementing them. The moral identity of these workers and the collective moral identity of the offices in which they work affects how they translate policies to people. Thus, an understanding of these underlying moral values and ideals enriches our comprehension of how governance works.

In Chapters 5 and 6 I turn to the implementation of decentralization policies. Each chapter investigates a particular project selected by my informants as epitomizing what decentralization is all about. I argue that the meaning of decentralization has shifted over time. The project discussed in Chapter 5 is characteristic of the early years of decentralization, immediately after the passage of the first laws on decentralization in 1999. The project aimed to strengthen village level autonomy through village management of public health. Chapter 6 captures the spirit of decentralization in the

period after the amendments passed in 2004 that introduced a degree of re-centralization. This project demonstrated kabupaten autonomy through a supplementary kabupaten health insurance program that operated alongside a centralized insurance program. The kabupaten health insurance program illustrates a decentralization ethic that includes commitment to local autonomy “bottom up” planning, reliance on local knowledge, and problem solving orientation. In the narratives of my informants this is contrasted with centralization that relies on standardized solutions that often miss the target. Yet in each of these two projects centralization tends to creep back in to the decentralized project. In Chapter 7 I explore how government health officials go about enrolling people into public health programs. I identify the moral frameworks and rhetorical devices used to justify policies, motivate junior staff and encourage citizens to adopt government policies. I develop the term “moral pluralism” to refer to the ways in which health workers combine moral frameworks in their efforts to encourage people to shift behaviors in line with government health policies.

Chapter 2: Background on Indonesia

2.1 Introduction

In this Chapter I offer a brief history of state formation in Indonesia to help illuminate contemporary forms of governance. Following anthropologists Newberry (2006), Siegel (1998) and Pemberton (1994) I use a cultural theory of state in order to understand how successive governments have used cultural forms to bolster state legitimacy and regulate populations (Corrigan and Sayer 1985).

I begin with the pre-colonial era of “mandala states” as described by Scott (2009), that differ from Western conceptions of the nation state in that borders were not fixed and zones of influence tended to fluctuate over time. I then move on to the Dutch colonial era from 1800-1948, initially characterized by indirect rule with the goal of resource extraction to the mother country, and subsequently by increasingly elaborate bureaucratic administration reaching down to the village level. Following a brief period of Japanese colonization during the Second World War Indonesia gained independence in 1945, although the Dutch did not relinquish sovereignty fully until 1948. At independence, Indonesia sought to define its own political philosophy of Pancasila democracy, distinct from Western political ideology and founded on indigenous values. Each of Indonesia’s first two presidents, President Sukarno, who ruled for twenty years from 1945-1965 and President Suharto, who ruled for 32 years from 1965-1998, interpreted Pancasila democracy differently, in line with their own distinct styles of government. Drawing on the indigenous values of “musyawarah” (deliberative

consultation) and “gotong royong” (mutual support), President Sukarno developed a form of consensus politics he termed “Guided Democracy”. By contrast, President Suharto focused on planned economic development, drawing on the same value of “gotong royong” to enroll people into large scale development projects.

Under Suharto’s watch political expression was stifled and political power and economic resources were increasingly concentrated in the national capital, Jakarta. The Asian economic crisis exposed the fragility of Suharto’s model of state led development leading to a political crisis culminating in the resignation of President Suharto in 1998. There followed a period of political reform including democratic decentralization.

In the second part of the chapter I describe the decentralization process that provides the backdrop for my analysis of contemporary health governance in Indonesia. Although regarded by international observers as a necessary process to ensure “good governance” decentralization remains politically contested in Indonesia and elements of centralization persist. The co-existence of centralization and decentralization is described and analyzed in the subsequent chapters.

2.2 State formation and “Asian values” in Indonesia

When the first Dutch traders arrived in what became known as the Dutch West Indies in the 17th century they encountered a very different political system from the one they had left in Europe. Scott (2009) has described the pre-colonial state in Indonesia, as in Asia more generally, as a “mandala” state, comprising a circular sphere of influence with an “exemplary centre” from which power was thought to emanate outwards. The power

of the state became more diffuse as the distance from the center increased until one eventually entered the sphere of another “mandala” state. These circular spheres of influence waxed and waned over time as successful exemplary centres conquered and absorbed neighbouring territories, only to lose their grip once more at a later time (Andersen 1972). While some areas, including Central and East Java developed centralized kingdoms and elaborate aristocratic court cultures, other areas including West Java remained decentralized with Bupati (kabupaten heads) governing independently (Antlov 1998). Geertz (1980) describes similar processes of centralization and decentralization in pre-colonial Bali. He argues that struggles between the nobles of the plains and those in the hills revolved around control over people rather than over land, and that territorial borders were not considered important. In this respect, the “mandala” state contrasts with the idea of the nation state established in Europe at the Treaty of Westphalia in 1648, defined in terms of co-existing sovereign states with fixed borders with supposedly uniform exercise of power up to the border.

The mandala state system was also associated with distinct ideas about how to maintain political order in society. According to Geertz (1980), within the classic Indic state from the 5th to the 15th century, the royal court or Negara sought to emulate the cosmic order of the universe. Its performance of perfect order provided a pattern for the conduct of life in the surrounding society. While everyday administrative matters were left to the Desa (local government) the Negara or Theatre state, as Geertz termed it, focused on maintaining its status as an exemplary center that would shape the world around it.

The idea of the exemplary center as a mode of governance is based on a particular understanding of power and how it operates. Andersen (1972) describes the Javanese concept of power as a concrete form of energy in the universe that manifests in various ways. Whereas in Western thought there are different sources of power such as social status, wealth or military superiority, in the Javanese concept as described by Andersen there is only one universal source of power, and there is a fixed amount of power in the universe. This power is evident in the natural world and can also be concentrated in a person through ascetic practices. Political influence and wealth are merely consequences of a person having power, rather than a means for attaining power, as in Western thought. Once power has been acquired it is only temporary. A person may lose power at any time. It will be evident when a person has lost power because they will no longer be able to command authority. Again this appears as a reversal of Western ideas of power where capacity to command authority actually confers power rather than being a sign that the person already has it. This Javanese understanding of power gives rise to a particular attitude towards political leadership in Indonesia. Just as power in the mandala state is concentrated in the geographical center, so political power is also understood to be concentrated in the political leader positioned at the exemplary center. Thus, the leader is ideally supposed to embody both the state and the people.

Dutch interests in what is now Indonesia began early in the 17th century with the Dutch East India Company, the VOC,²² that extracted profits via local leaders through various systems of tax collection, forced labour, usury and trading monopolies. The Dutch crown took over from the VOC in 1800, initially continuing the pattern of indirect rule using local leaders to collect taxes and labour contributions. Kartodirdjo (1998) describes how the Dutch administration relied on the patrimonial bureaucracy of the Bupatis (heads of kabupaten) and inadvertently reinforced their aristocratic feudal practices. For example, under the cultivation system established by Dutch governor Van den Bosch from 1830-1870, Bupati were enrolled in mobilizing Javanese farmers to allocate “spare” land and labour to sugar production in the valleys or coffee production in the hills in order to pay taxes to the Dutch colonial government. This entrenched the position of the Bupati as mediators between the Dutch and the general population.

This form of “state sponsored capitalism” (Li 2007:41) allowed Javanese farmers to continue cultivating rice for home consumption rather than becoming plantation labourers, but it placed pressure on the household economy and family welfare as well as on hillside ecology (Hefner 1990). As a consequence of the Dutch demand for labour there was a rapid increase in population on Java and some of the other islands, and this exacerbated poverty and health issues. The welfare of the indigenous people was not a priority of Dutch during the 19th century. Only the elite from the indigenous population were offered education (Soeroto 1986) while health care was oriented to the needs of the colonial staff (Stein 2009). Some Dutch observers both at home and in the colony

²² Vereenigde Oost-Indische Compagnie

registered concern about the deteriorating living conditions and health of the indigenous peoples, while others blamed the low standards of living on indigenous “culture”. Towards the end of the 19th century, in an attempt to respond to these concerns as well as to maintain their authority in the region the Dutch administration shifted from a purely extractive model to a form of government that sought to improve the population through addressing welfare and environmental issues. From 1905-1930 an “ethical” policy was adopted that recognized the need for welfare support for indigenous peoples. This involved the penetration of an increasingly elaborate bureaucracy down to the level of the village, an administrative unit that was formalized by the Dutch. But according to Li (2007), despite its apparently benevolent objectives the welfare of ordinary people only continued to deteriorate during this period as taxes rose to pay for the expanded bureaucracy.

In addition to their welfare programs the Dutch boosted their legitimacy through association with the local aristocracy and its elaborate court culture. Pemberton (1994) documents how the VOC defeated the Javanese royalty as early as 1743 and how various royal families responded to their loss of formal political authority through an elaboration of court ritual in an attempt to assert cultural authority. No longer allowed to wage wars, the Javanese royalty used weddings as the key means for displaying their authority and rank. This process of cultural elaboration was encouraged by successive Dutch administrators some of whom engaged in competitions with the kings for rank, thereby reinforcing an association between Javanese culture, hierarchy and order. By transforming what were once emblems of political power into forms of cultural

authority the Dutch allowed the Javanese aristocracy to retain some dignity while legitimizing their own rule through their association with it.

During the Second World War the Japanese occupied Indonesia and imposed even more draconian methods of extraction in order to finance the war effort. Livestock were commandeered, leading many to slaughter their animals pre-emptively, and agricultural schemes were extended from the valleys to the mountains leading to ecological damage (Hefner 1990). Nevertheless it was during the harsh rule of the Japanese that the Independence movement gained momentum. Indonesia wrested independence from Japan at the end of the war in 1945. However, the Dutch did not recognize Indonesian independence until 1948 when they finally relinquished their last stronghold in Maluku.

Following their bitter struggle for independence, the new political leaders sought to avoid imitating Western political models, instead defining a distinct political philosophy drawing on local values and styles of government (Pemberton 1994). The development of an ethic of government based on supposedly traditional values was deemed necessary in order to protect Indonesian citizens from corruption by Western values.

Although Indonesian leaders wanted the “goods” of modernity, including industrial technology, economic development and medicine, they promoted traditional values as a bulwark against cultural contamination (Lubis 1964, Ferzacca 2002).

In this respect Indonesia followed a pattern that has been described for other post-colonial governments in South-East Asia. A number of scholars have drawn attention to the efforts by political leaders and policy makers of Indonesia, Malaysia, Singapore,

Thailand, China and Japan to define a set of Asian values foundational to state formation in the region (Tonnesson and Antlov 1996, Antlov and Ngo 2000). According to this philosophy of “Asian values” Western democracy with its emphasis on individualism, competition, opposition and pluralism is not appropriate for their populations. Government rationalities are instead constructed on Asian values of community, consensus and hierarchy. Some have argued that such “Asian values” have been used in practice to justify paternalistic leadership and strong centralized governments (Antlov 2000).

In the case of Indonesia, Asian values translated into a political philosophy termed Pancasila democracy (Antlov 2000, Kingsbury 2002). Pancasila refers to five principles of government agreed by the Indonesian parliament in 1945 along with the constitution. The five principles are: monotheism, humanitarianism, nationalism, consensus-democracy and justice. Each are open to different interpretations and indeed have been framed differently by successive Presidents, yet Pancasila has endured as the state ideology and is regarded as being not only distinctly Indonesian but also more or less beyond criticism even today.

Cutting across all five principles of Pancasila was the traditional Indonesian value of “gotong royong” or mutual cooperation. President Sukarno, Indonesia’s first president from 1945-1965, declared that he intended to establish a “gotong royong” state, characterized by “mutual cooperation between classes and political parties, not on competition and opposition” (Antlov 2000:204). Nationalism was to be achieved by

bringing together divergent political forces into a single unity, giving rise to the national motto “unity in diversity”. Reflecting the ideas of power described above (Andersen 1972), the unity of this diverse new nation was embodied in the President who regarded himself as the father of the nation (Siegel 1998). In the latter part of his rule (1957-65) Sukarno developed his political philosophy based on the principle of consensus politics into a system of government he termed “Guided Democracy”.

Faced with the economic aftermath of the Second World War combined with diverse political expressions that emerged as colonial power receded, Sukarno struggled to establish an effective bureaucracy and his period of rule was characterized by economic chaos and periodic bouts of famine in parts of the archipelago. Despite his charismatic personality and visionary ideas he failed to achieve the unity he sought between the three major political forces of the time: nationalism, Islam and communism. In 1965 a military coup was instigated in response to the mysterious assassination of four generals. In the ensuing chaos that involved a bloody massacre of up to half a million people accused of being communists, Suharto, one of the military commanders involved in the coup, assumed power (Kingsbury 2002, Pemberton 1994, Antlov 1998).

In an effort to avoid a repetition of Sukarno’s mistakes while containing and suppressing the violence that had been unleashed by the coup and communist massacre President Suharto imposed an authoritarian style of government he termed the New Order. The term is evocative of the Javanese cultural valuation of social order as reflecting the divine order of the cosmos. It also marked a decisive break with the “old order” of

President Sukarno and with the violence associated with the transition to new leadership. Andersen (1972:34) argues that Javanese peoples' intuitive sense of the historical process, drawing on Indic cosmology, involves periodic oscillations between times of order when power is concentrated in a strong leader and times of disorder when power is diffuse and unity is lost. President Suharto was able to draw on this conception and related anxieties associated with chaos expressed in the Malay term "amok" by implying that Sukarno's rule had been a period of disorder while his own rule marked the instigation of a new period of order (Kingsbury 2002).

Under the New Order a complex machinery of government was established, extending from the center in Jakarta to the village and even the individual household. At the same time a monopoly of political power was attempted through suppression of political parties and non-government organization and enrolment of all forms of leadership into the New Order government (Antlov 2003). These draconian measures were justified as necessary in order to achieve the twin goals of political stability and economic development. Regarding poverty as a fuel for communist support, Suharto committed his government to safeguarding the three basic needs of food, clothing and shelter for all Indonesians and established a system of five year development plans²³, drawing on the expertise of economists trained in the US (Li 2007:57). National development programs such as the rice intensification and transmigration programs were implemented in a top down fashion reminiscent of the Dutch agricultural schemes (Hefner 1990, Li 2007).

²³ Rencana Pembangunan Lima Tahun or Repelita

A monopoly on politics was achieved through the institution of a single government political party, Golkar²⁴. In a periodic show of democracy political activity was allowed in the run-up to elections held every five years (Pemberton 1994). But only two political parties other than Golkar were allowed to participate in these so-called “festivals of democracy”, the Islamic PPP and the Christian democratic PDI, and their activities were strictly controlled (Antlov and Cederroth 1998). Between elections political activity was restricted through Law 3 1975 that banned activities of political organizations below the kabupaten level on the grounds that people would be diverted from contributing to national development. Thus anyone who wished to advance was obliged to do so through the Golkar mechanism.

All government employees in the rapidly expanding civil service²⁵ were automatically members of Golkar, and any prospective village head who did not support Golkar had very little chance of being approved by the government appointed Bupati, which was a requirement for assuming their position. Although they continued to be popularly elected, the reputation of village heads was now based on their ability to enrol citizens into government development programs such as BIMAS, the rice intensification program (Antlov 1998, 2003). They were thereby transformed from representatives of the people into agents of the state, accountable to their superiors at higher levels in the government hierarchy.

²⁴ Golkar stands for Partai Golongan Karya or Party of Functional Groups. Golkar was established in 1964 by Sukarno as part of his Guided Democracy system. Suharto converted Golkar into a political party which he subsequently dominated. Golkar was the ruling party from 1973-1999.

²⁵ According to Achmad (1999) the number of civil servants increased from 50,000 before World War II to more than four million by the end of Suharto's rule in 1998.

Extending government down to the village and household level involved not only an expansion of the civil service but also the mass enrolment of citizens in a proliferation of unpaid semi-official roles, including development officers, security guards and volunteers (Antlov 1995, 2003). In this way the distinction between “government” and “citizen” was blurred since many citizens who were not formally employed by the state were nevertheless directly involved in implementing government policies and programs. The implications of this citizen-state continuum will be explored in later chapters. Antlov (1998: 73) summarized the structure of government under the New Order as follows: “The most conspicuous features of the Indonesian state, and the most important consequence of the advent of the New Order, are its presence in almost all spheres of everyday life and its domestication of political ambitions at all levels.”

While departing from Sukarno’s style of government, Suharto’s New Order continued to draw explicitly on the same traditional principles of Pancasila democracy and the gotong royong state. The metaphor of the family was used to describe how individuals should cooperate through “gotong royong” mutual support and how decisions should be made based on “musyawarah” mutual deliberation leading to consensus. The supposedly shared value of “gotong royong” was used to enrol citizens in labour intensive government projects for national development (Bowen 1986, Li 2007, Newberry 2006) while “musyawarah” was invoked to legitimize the process of village development planning²⁶.

²⁶ See Chapter 5 for a description of “musyawarah” in the planning process

It is important to note that these “shared values” may not have the same connotation for citizens as they do for state officials. “Gotong royong” mutual assistance is widely regarded as a venerable Indonesian tradition that is practised on a daily basis among neighbors (Dasgupta and Beard 2007). Despite government attempts to capture “gotong royong” citizens continue to use this cultural form for their own purposes and may be sceptical of its use in government programs. Nevertheless, its power as a mobilizing concept draws on its simultaneous existence in other spheres of people’s lives (Newberry 2006).

In order to justify his monopoly of power under “Pancasila democracy” Suharto also drew on the values of hierarchy, harmony and order that had been associated with the Javanese aristocracy, to argue that political pluralism was conflictive. “Harmony” was now re-interpreted to mean obedience to the New Order regime presented as the only avenue for achieving “development” from which the community, and indeed the whole nation would benefit (Antlov 1998, Pemberton, 1994, Mulder 1998). Since individual and state interests were perfectly aligned there was no need for special measures to protect individual human rights (Antlov 2000,). Individual rights were interpreted in terms of obligations to the common good (Mulder 1998)²⁷. Citizens were encouraged to sacrifice personal goals to the needs of the community and the state. According to Mulder (1998: 58): “The thought is elaborated in the idea that, if the common good is fulfilled all individual goals are also reached, while it is not certain at all that the fulfilment of private interests means that the common good has been served too.”

²⁷ An interpretation has endured to some extent as discussed in Chapter 7.

This New Order government rationality was reinforced through political indoctrination in schools and other institutions. From 1981-1998 all civil servants and community leaders were given obligatory training in the Pancasila Promotion Programme, while school children had to pass an annual exam in Pancasila moral education (Mulder 1998).

Suharto's institution of a comprehensive political structure extending to the level of the household, an almost complete monopoly of power and a persuasive political philosophy, all reinforced by violent suppression of political opposition, appears to have been remarkably successful. But it should be remembered that the New Order government had two further advantages: support from Western governments and from international financial institutions that regarded the regime as a bulwark against communism during the Cold War, and state revenues from the national oil industry that expanded rapidly under Suharto's watch. Together these sources of income financed the grand national development schemes such as the rice intensification, transmigration and family planning programs. Suharto's "top down" style of government ensured that all citizens were enrolled in these programs "for their own good".

A combination of factors eventually led to the demise of the New Order regime. The Asian economic crisis of 1997-8 that involved a dramatic fall in the value of the Indonesian rupiah and escalation in the price of staple foods, particularly rice, exposed the fragility of "state led development" (Rudnyckyj 2010). Poverty is estimated to have doubled during the crisis period from around 10% of the population or 20 million people to between 14% and 20% of the population leading to widespread

concern including among international donors (World Bank 1999:5, Suryahadi and Soemarto 2000)²⁸. The crisis prompted open public critique both within Indonesia and internationally of the autocratic style of government that disproportionately enriched Suharto's inner circle of family and friends (Znoj 2007). Popular accusations of "KKN" (kolusi, korupsi, nepotisme or corruption, collusion and nepotism), and calls for "reformasi" became increasingly vocal. The final tipping point came with the shooting dead of four unarmed students from Tri Sakti University in Jakarta while they were protesting on the streets on May 12, 1998. President Suharto resigned on May 21 1998.

2.3 The Process of Decentralization in Indonesia

In response to this political crisis, President Habibie, Suharto's Vice President and immediate successor (May-October 1999), moved rapidly to implement a series of bold reforms in order to re-establish the legitimacy of a government that had become "empty of value" (Good and Good, 2008). These reforms laid the foundation for regional autonomy, decentralization and democracy. They included direct elections for the President and increased accountability for political leaders. Political parties, non-government organizations and the media were given greater freedom to operate. These reforms were a response both to domestic demands (Damuri and Amri 2004, Ahmad and Mansoor 2002) and to international pressure (Znoj 2007).

²⁸ Based on a review of multiple data sources, Suryahadi and Soemarto estimated a poverty index according to which "by the second half of 1998 (the poverty index) was more than two and a half times the estimated pre-crisis low in mid-1997." Poverty then declined as the rupiah recovered and rice prices fell, but it remained higher than pre-crisis levels.

International agencies including GTZ, the World Bank and ADB supported decentralization as a means of strengthening “good governance” and improving public service delivery (Lieberman 2000, Turner et al. 2003, Ahmad and Mansoor 2002). Nevertheless, Turner et al. (2003:21) describe the decentralization process in Indonesia as “authentically Indonesian in its genesis and design” although they point out that there was “no widespread organized lobby for decentralization” as there was for democracy. They identify a combination of three groups responsible for moving the process forward: political leaders from the regions who demanded both greater autonomy and a fairer share of resources; international agencies some of which had attempted pilot decentralization projects since 1992; and a small group of influential but not always well coordinated policy makers operating within the Ministry of Home Affairs and the Ministry of Finance.

Two laws laid the foundation for decentralization: Law 22/1999 on Regional Administration and Law 25/1999 on Financial Balance²⁹. The Law on Regional Administration defines decentralization as: “the delegation of authority of administration by the (central) government to an autonomous region in the framework of the Unitary State of Indonesia.” (Law 22, 1999 Article 1 e). This matches standard definitions of decentralization as devolution of power and authority to lower levels of government (Rondinelli and Cheema 2007, Manor 1999)³⁰. Provinces and kabupaten are

²⁹ See the following link for a translation of the law: http://www.embassyofindonesia.org/ina-usa/economy/pdf/laws/Law_on_Regional_Administration.pdf

³⁰ The Indonesian laws on decentralization do not refer to privatization or delegation of government services to parastatal organizations. These processes of contracting out are sometimes referred to in the literature as decentralization (Manor 1999:4) but they are not relevant to my discussion here.

both defined as autonomous regions. In terms of their specific responsibilities, kabupaten and municipalities are charged with providing most government services, including health services, while provinces are given the relatively minor role of addressing issues that cut across kabupaten/municipalities.

The reference to the 'unitary state of Indonesia' in the definition of decentralization reflects anxiety that decentralization would encourage independence movements in certain provinces. This also explains why decentralization devolves authority to kabupaten, essentially by-passing provinces. It was thought that kabupaten would be too small a political unit to present any such threat (Fane 2003:160). Under the law, the maintenance of Indonesia as a unitary state is reinforced through the retention of certain key functions by central government including foreign policy, defense and security, judicial, monetary and fiscal policy, national planning and development.

The Law on Regional Administration also specifies how democratic elections are to occur and outlines new lines of accountability. The regional parliament (DPRD)³¹ at provincial level is given the power to elect the governor and vice governor of a province, while the kabupaten or kota (municipality) parliament elects the bupati or walikota (mayor) and vice bupati or vice walikota (Article 18). The governor, bupati and walikota are described as being accountable to their respective parliaments (Articles 31 and 32)³².

³¹ Dewan Perwakilan Rakyat Daerah

³² Under the previous New Order government provincial governors were appointed by the President while heads of kabupaten and municipalities were nominated by their respective parliaments, but then needed

Law 25 1999 on Financial Balance established new systems for resource distribution among provinces. Under the New Order natural and human resources were increasingly concentrated in the capital city, Jakarta. Law 25 1999 redefined the distribution of income from natural resources such as oil and forest products so that producing provinces were allowed to retain a much higher percentage of the income generated by these resources³³. Regional governments' demand for a fairer share of locally sourced income had been one of the forces for decentralization. In practice, however, the capacity for provinces, kabupaten and municipalities to generate such income varies widely. Law 25 1999 included a "fiscal gap formula" according to which general allocation grants from central government would be distributed to regional governments according to need. If implemented this would have given lower grants to regional governments with high revenues from natural resources, thus having an equalizing effect. Resource rich regions successfully campaigned against the fiscal gap formula and the actual formula did little to address regional inequalities in income (Fane 2003). Turner et al. (2003) estimated that, in 2001, the 10% of regional governments with the highest natural resource revenues had more than six times the per capita income of the 10% with the lowest revenues³⁴. They argue that regional inequalities increased with decentralization.

to be proposed to the Ministry of Home Affairs by the appointed provincial governors (Turner et al 2003:66).

³³ Onshore oil producing provinces retained 15%, gas producing provinces 30%. Of this, 1/5 was retained by the province, 2/5 was allocated to the producing kabupaten and 2/5 was distributed among remaining regencies (Ahmad and Mansoor 2002).

³⁴ The particular figures and resulting degree of inequality will vary from one year to another.

A second potential source of income for regional governments to fund the increased responsibilities acquired under decentralization is taxation. But the central government retained control of all major taxes including property and income taxes, leaving only minor taxes under the control of local governments as specified in Law 34 2000. As a result, most regional governments rely heavily on direct financial transfers from central government in the form of general allocation grants and special allocation (ear-marked) grants³⁵.

Grant funding from central government to the kabupaten level doubled from 2000 – 2006 (Heywood and Harahap 2009a) yet the decision space for regional governments to allocate this funding did not increase substantially. Although general allocation grants are supposed to be used at the discretion of regional governments in practice some 50% are needed to cover the salaries of permanent civil servants hired by the central government. Much of the remainder is needed to finance services that local governments are obliged to provide (Fane 2003). Only locally generated resources are entirely under the control of local governments. Heywood and Heywood (2009a) estimate that regional governments on Java, with no significant natural resource revenues, only had discretion over about 10% of their income in 2006.

The wide variation in locally generated income resulting from the decentralization laws thus leads to a double inequality. Not only do resource rich provinces have more public

³⁵ General allocation grants are termed DAU (Dana Alokasi Umum) and special allocation grants DAK (Dana Alokasi Khusus).

funding available per capita (Turner et al. 2003:40) they can also exercise discretion over a higher proportion of their funding (Heywood and Harahap 2009a).

The limited discretion that kabupaten and municipality governments have over spending has led some to question whether decentralization in Indonesia is meaningful. For example, FITRA³⁶, an Indonesian NGO, argues that since kabupaten only have discretion over about 10% of their income this does not constitute decentralization (personal communication, head of FITRA, Lahanbesar 9 27 2012). This assumes that fiscal decentralization is an adequate measure of the decentralization process, an assumption questioned by Bossert (2014). Bossert argues that even though fiscal decentralization is often used as an indicator of decentralization because it is easier to measure, this misses political and administrative dimensions (Bossert 2014:82). This observation is pertinent to Indonesia. By comparison with the New Order structures of government the decentralization laws introduced radical changes to the administrative and political landscape. So much so that the World Bank has described the early years of decentralization in Indonesia as a “Big Bang”, referring to the rapid passage and implementation of the original laws in 1999. This involved the transfer of some 2.4 million civil servants from Jakarta to the regions by the end of 2000 representing some 70% of the central government workforce (Hofman and Kaiser 2002, Turner et al. 2003, Heywood and Harahap 2009b).

Despite this initial momentum, technical implementation has been gradual and phased, and in 2004 the original decentralization laws were amended, weakening some aspects

³⁶ Forum Indonesia Untuk Transparansi Anggaran (Indonesia Forum for Budget Transparency).

of decentralization. For example, under Law 22, 1999 autonomous regions are described as independent, with no hierarchical relationship between them (Article 4 (2)). The amendment to this law, Law 32, 2004 strengthens the role of the center and re-introduces a hierarchical relationship between the center and the regions. Specifically, the center is given the role of “coordinating administration among the government structures” (Article 217), and “supervis(ing) the running of regional governments” (Article 218).

Scholars of Indonesian decentralization offer various reasons for the slow implementation of decentralization and for the amendments. Firstly, the original Law 22, 1999 on Regional Administration left the relationship between the center, province and kabupaten or kota ambiguous, leading to perceptions of a lack of coordination and confusion (Trisnantoro 2007, Legowo and Djadijono 2007). Secondly, regulations specifying how Law 22 was to be implemented were delayed. A number of regional governments chose not to wait of these regulations and developed their own policies that were often not in line with existing central policies. Thirdly, a large number of local parliaments were found to be engaged in corruption cases (Legowo and Djadijono 2007). Finally, it has been suggested that top level government support for decentralization was lacking (Turner et al. 2003, Trisnantoro 2007). For example, decentralization units that were established in certain government agencies, including health, had limited authority (Trisnantoro personal communication, 12/28/2012). Thus, the 2004 amendments represented an attempt by central government in Jakarta to claw back some of the power and control that had been lost. This suggests that

decentralization in Indonesia is a politically contested process, where the battle is waged through regulations. The kabupaten regulates to exercise its autonomy, and in response, the center regulates to maintain its authority.

Trisnantoro (2009) uses the idea of a pendulum to describe how Indonesia moved rapidly towards decentralization in the early years from 1999, then swung back towards (re)centralization from 2004. In his view it continues to swing back and forth depending on the strength of particular policies and political factions. The pendulum metaphor captures the ongoing tension between centralization and decentralization, the pulling back and forth depending on the political climate of the day. I take from Trisnantoro the insight that government is never entirely centralized or entirely decentralized but is a mix of the two. Moving beyond the linear image of a pendulum, with centralization at one end and decentralization at the other, I see elements of centralization and decentralization existing alongside one-another even within the same program³⁷. The tensions and dilemmas that arise from the co-existence of centralization and decentralization underlie my analysis in the following chapters.

2.3.1 Decentralization and Neoliberalism

In this section I discuss whether decentralization in Indonesia is “neoliberal”, taking neoliberal to mean the application of market mechanisms within new domains of government (Foucault 2008)³⁸. I am prompted to do this for two reasons. Firstly,

³⁷ I discuss examples of this in Chapters 4 and 5

³⁸ I acknowledge that the term “neoliberalism” has been used, more or less precisely, to refer to different phenomena (Ferguson 2009). Ferguson distinguishes between neoliberalism as a macro-economic policy

decentralization is often associated with broader reform agendas that include increased use of modes of economic calculation within the government bureaucracy. For example, Bossert and Beauvais (2002:14) observe that decentralization policies often “introduce competition and cost-consciousness into the public sector” (Bossert and Beauvais 2002:14). Secondly, several observers of contemporary Indonesia have found the term applicable arguing that an economic rationality is being extended into new domains of government and the family (Rudnyckyj, 2010, Newberry 2010).

Rudnyckyj (2010) detected neoliberalism at play at Krakatau Steel, a parastatal company where he analyzed how managers engaged with globalization. Following IMF imposed loan conditions Krakatau Steel was to be privatized. This prompted an attempt to transform employees into workers capable of competing on world markets. Neoliberal modes of economic calculation were combined in novel ways with a form of evangelical Islam to encourage workers to improve their productivity. Rudnyckyj notes that the term neoliberalism is not commonly used in Indonesia, but he nevertheless finds it to be a useful analytical term for describing governmental techniques that he observed within the parastatal company.

The use of market mechanisms within a company, albeit a parastatal, is perhaps unsurprising. But Rudnyckyj regards the experience of Krakatau Steel as representative of a broader shift in Indonesia. He argues that the state-led development model followed by President Suharto and his New Order government had failed, and had been

pursued by the IMF through its structural adjustment programs in Africa, and as a more general approach to government followed by governments wishing to reform welfare states in Europe and the US. My use of neoliberalism is closer to this second interpretation.

replaced by the “afterlife” of development. According to Rudnyckyj (2010:4) “The afterlife of development is neoliberal because it entails the introduction of economic rationality and calculative reason into domains from which they were previously limited or excluded. Thus the afterlife of development captures the shift from modernization supported through state investment in the space of the nation to a market based system that caters to private, transnational capital.”

From my perspective based in a kabupaten health office, however, I witnessed continuities with the New Order that make me cautious in concluding that the government of Indonesia is neoliberal. Far from regarding individuals as enterprises they were regarded as moral beings, striving to do the right thing but often ignorant and misled, or, as they put it “belum sadar” (not yet aware), and therefore in need of guidance from government. Rather than a faith in markets the health workers I accompanied had great faith in an older set of government practices including educating the public about government policy through speeches, trainings and one on one consultations; government through community organizations such as the PKK and posyandu; and if necessary, regulation³⁹. These practices date from previous government regimes but have endured into the era of democratic decentralization. Based on these observations of continuity I maintain that the government rationality remains one of “state-led development”, meaning that the government is still regarded (at least by government employees) as the key player in national development. As such it seeks to enroll citizens in an expanding array of programs for their improvement (Li

³⁹ These practices are examined in detail in Chapters 5-7.

2007) while extending an ever wider safety net to protect the population from extreme poverty and enable citizens to participate in the national economy (Aspinall 2014). In this sense it resembles a welfare state more than a neoliberal one⁴⁰.

Even though I do not regard the government as neoliberal in its general orientation, I did notice practices that are often associated with neoliberalism. For example, decentralization placed increased pressure on lower levels of government to become more financially self-sufficient⁴¹. This may reflect the influence of international agencies such as the IMF and the World Bank. Policy staff at the World Bank regarded decentralization as an opportunity to improve the performance of puskesmas and hospitals through allowing them to become self-managing and financially self-sufficient so that they could take their own initiatives and be more responsive to local demand (Lieberman 2000). Some observers of the early years of decentralization found evidence that financial self-sufficiency had in fact occurred, only they framed it in negative terms. For example, Kristiansen and Santoso (2006), in a study of four kabupaten in four different provinces found that puskesmas were turned into profit centers, rendering them unaffordable to the general population. They argued that preventive health was being neglected and that transparency and accountability had fallen. Whether or not this was so in the early years of decentralization, my research, undertaken nine years later, does not support these findings. Regulations implemented since 2004 severely limit the capacity for puskesmas to make independent decisions and

⁴⁰ This argument is elaborated in Chapter 5.

⁴¹ Discussed in Chapter 5

to generate income through setting their own prices, much to the disappointment of some puskesmas, as we shall see in Chapter 5. Health center charges are set by the kabupaten, typically at less than US\$0.50 per patient, while medicines are supplied in kind from the kabupaten warehouse. Although the kabupaten might be tempted to set high charges to generate revenue for the kabupaten coffers, a national policy implemented in 2012 mandates that 100% of puskesmas charges be returned to the puskesmas. Aside from financial and in-kind subsidies from the kabupaten government and the low fees they charge to patients, puskesmas can develop public-private partnerships, but this is not as an alternative to government support but rather in addition to it. It does not represent a neoliberal withdrawal of government but rather a way of increasing the scope for puskesmas to exercise the decision making autonomy they expected to gain under decentralization.

A second phenomenon that might be considered an effect of neoliberal policies is the pressure on kabupaten health officials to lobby for health within the kabupaten parliament that now sets the health budget⁴². Again, this lobbying is occurring within government and could be interpreted simply as a transfer of a political bargaining process from the central government to the kabupaten government. It is not that lobbying did not occur before decentralization, but rather that it has been multiplied from a single process at the center to a process that has to take place within every kabupaten, town and province.

⁴² Discussed in Chapter 4

These efforts to achieve financial self-sufficiency and to lobby for health, rather than revealing a neoliberal government rationality, could reflect experimentation with techniques pioneered by governments, with very different agendas, to achieve the goals of state led development. After all, as Foucault (2008) points out any government following any rationality will likely seek to reduce the costs of achieving their goals. Several authors have observed similar combinations between apparently neoliberal techniques and other government rationalities. Sharma (2008) describes the articulation of neoliberal techniques of “empowerment” with the welfare state in India as well as with older understandings of empowerment rooted in feminist, Gandian and Freirian philosophies. Ferguson talks of “neoliberal moves” within social policies aimed at poverty alleviation in South Africa. These examples demonstrate how techniques of government migrate from one government rationality to another, undergoing transformations that open up new and unpredictable possibilities (Ferguson 2010, Storeng and Behague 2014). Within the government bureaucracy where I worked neoliberal attitudes and techniques were marginal. The hint of neoliberalism that I witnessed may presage a more neoliberal future. But a review of regulations implemented since decentralization suggest that the government is cautious about moving in this direction.

Chapter 3: The Government of Health in Indonesia

3.1 Introduction

In this chapter I turn to the evolution of a public health infrastructure in Indonesia.

Although health in general has not been a political priority certain aspects of health, such as family planning, have been prioritized as security issues or as important for economic development (Achmad 1999). I describe how a comprehensive public health infrastructure has been established for the delivery of public health programs even if the quality and consistency of such programs is highly variable across the archipelago, an attribute exacerbated by decentralization (Heywood and Harahap 2009a and b).

Western medicine was brought to some of the islands that now comprise Indonesia by the Dutch East India Company in the 17th century. At that time European understandings of disease etiology were based on the “miasmatic” theory that disease was spread by “bad air”. But by the end of the 19th century microorganisms had been identified as causing infectious diseases including those that prevailed in the Dutch East Indies. The Dutch administration carried out small pox and other vaccinations, but the main purpose was to protect the health of the Dutch colonists (Stein 2009). Medical services were concentrated in urban areas and physicians took little interest in the health of local populations, the majority of whom inhabited rural areas, even though it was recognized that public health could play an important role in “civilizing” native populations (Li 2007). Rural populations continued to rely on various types of non-biomedical healers, including Islamic healers, bone setters, masseurs and traditional

birth attendants. It was not until after the First World War, under the impetus of the US based Rockefeller Foundation that the Dutch administration addressed the issue of rural health through vaccination programs and sanitation and hygiene (Stein 2009). These programs provided a foundation for the public health programs of national governments after independence (Stein 2009).

3.2 Indonesian Public Health Policy

Public health was not a priority for Indonesia's first President Sukarno and medical services continued to reflect the legacy of the Dutch administration. There were public and private hospitals in urban areas and a limited number of public treatment clinics and mother and child centers used in cases of emergency. In 1951, however, a new system of public health was piloted in Bandung. The Bandung Plan involved building and staffing community health facilities at the local level (Heywood and Choi 2010). The puskesmas (pusat kesehatan masyarakat or community health center) was to be located at the kecamatan level and was to be supported by a kabupaten level public hospital.

This system was extended under President Suharto's New Order government from the late 1960s and became a cornerstone of its public health administration. A key goal during the early years of the New Order was that every kecamatan should have a puskesmas that would ensure access to basic medical services for the entire population. Anticipating the Primary Health Care movement launched by the World Health Organization at Alma Ata, Kazakhstan in 1978, puskesmas were envisaged as more than rural clinics. Rather they were to be centers for public health outreach activities that

would stimulate community participation in their own health. The posyandu (integrated community health post) was conceived as a focal point for puskesmas outreach activities (Kollman and van Veggel 1996). Posyandu were established in every village. Kader were trained to hold the posyandu once a month and to encourage attendance by mothers (or other guardians) of all children under five years old, so that they could be weighed and administered vaccinations. Pregnant mothers were also to attend for pre-natal check-ups. Control of infectious disease remained a key focus along with child survival and maternal health. Although it was clearly a government initiative, the posyandu was presented as “community led” for the benefit of the community⁴³.

By the mid-1970s there were more than 7,000 puskesmas each serving an average population of 30,000. Both the puskesmas puskesmas and kabupaten hospitals were staffed through obligatory service of all graduate doctors, nurses and midwives (Heywood and Choi 2010). These staff were recruited and deployed by the central Ministry of Health and supervised through Ministry sub-offices termed kanwil at provincial and kabupaten level. In addition there were health offices of the provincial and kabupaten governments, termed dinas kesehatan (health office) under the supervision of the Kanwil offices. The Kanwil were supposed to ensure that the Dinas followed national policy and that they focused on preventive as well as curative services through the network of puskesmas and hospitals under their administration. Within this highly centralized system virtually no decisions were left to the health facilities and even

⁴³ The rhetoric surrounding the posyandu will be explored in more detail in Chapter 5.

the dinas and kanwil offices simply followed orders from the central government in Jakarta (Achmad 1999, Heywood and Choi 2010, Heywood and Harahap 2009 a and b).

Throughout the duration of the New Order government the public health infrastructure gradually became more elaborate with the addition of assistant puskesmas in some villages, and the extension of an ever-expanding portfolio of outreach programs to schools, boys and girls scouts, businesses and so on. In this way public health became an important component of the New Order's extension of government down to the household level. Just as Newberry (2006) describes for the women's empowerment program, PKK, so the puskesmas outreach programs such as the posyandu⁴⁴, were in effect a form of governmentality that enrolled everyone into government public health programs. These programs not only extended the benefits of modern medicine to the population they also facilitated the formation of citizens in line with the goals of national development. Just as the PKK sought to create "domestic" housewives according to an American ideal (Newberry 2006), so the posyandu and other public health outreach transformed people into "clean and healthy" citizens according to global norms of development and modernity.

The ambitions of government public health programs to penetrate everyday life were brought home to me during research I undertook in 2000 while working for the World Bank (Magrath 2010). A bidan explained to me the concept of the puskesmas "working area" (wilayah kerja).

⁴⁴ Posyandu often used the same volunteers as the PKK

Aside from the services in the puskesmas (health center), we are supposed to monitor the health of the population in our administrative area. This is the 'wilayah kerja'⁴⁵ concept. Even if someone never uses our services, we are considered responsible if something goes wrong in our kabupaten. The posyandu is a good opportunity. When the posyandu is over, we ask the kader, are there any pregnant woman around their houses? Has any woman missed her period? Anyone feeling nausea? If she hasn't visited the posyandu, we have to visit her at her house.

This attitude epitomizes the ideal relationship between government and the governed as conceived under the New Order: health staff should know when a woman misses her period, and women should attend the posyandu monthly check-up. In this way, women will benefit from the health services, and the government will benefit from improved health statistics on infant and maternal mortality and on family planning. Individual and state interests are perfectly aligned.

Despite the rhetorical emphasis on "participation" public health under the New Order regime was delivered in a "top down" fashion. Programs were devised by the Ministry of Health and guidelines, funding and materials were passed down the administrative structure to the kabupaten and puskesmas, while lines of reporting and accountability passed back up to the center. There was no scope for local initiatives or genuine community participation (Achmad 1999). Programs considered to be of importance to national development, such as family planning, were not even handled by the Ministry

⁴⁵ Literally, "working area," but the meaning is closer to "area of responsibility" or "administrative area".

of Health but rather by the Ministry of the Interior. Family planning had its own special body, the BKKBN⁴⁶, with their own staff responsible for promotion but they used Ministry of Health professionals to administer family planning at puskesmas and posyandu. The program was administered with efficiency and rigor, with staff under extreme pressure to achieve targets. Funding allocations followed political priorities with family planning relatively well funded while other public health programs received limited funding and relied heavily on unpaid volunteers, following a model established by the Rockefeller sanitation programs of the late colonial period (Stein 2009).

3.2.1 The Private Health Sector

The private sector operates alongside the public sector and is always described as being “complementary”. This complementarity takes various forms. Firstly, doctors, dentists and midwives employed by the government at hospitals or puskesmas are allowed to practice privately out of government hours. Most in fact do this, running practices from their homes or at private clinics in the early morning from 6:00 am – 7:30 am then again from 4:00 pm to 7:00 or 8:00 pm. This “dual practice” dates from at least the 1970s when the government started to hire doctors to staff its puskesmas. At that time all graduate doctors, nurses and midwives had to provide government service at a puskesmas for at least three years before they could specialize or leave government

⁴⁶ BKKBN = Badan Koordinasi Keluarga Berencana Indonesia or Coordinating Body for Family Planning in Indonesia

service. The promise of a private practice for doctors and midwives⁴⁷ was thought to make the obligatory government service more attractive while enabling the government to pay low salaries for public service work. In practice, doctors sent to remote locations had little prospect of establishing profitable private practices as local people could not afford the fees. But once promoted to more central locations the running of a private practice out of hours became the norm, providing additional income as well as profitable employment after retirement from the civil service.

In the early years graduates were taken on as permanent civil servants (PNS or Pegawai Negeri Sipil) with their job guaranteed until retirement with a pension. From the mid-1990s this system was deemed unaffordable and a system of contract workers was introduced. Graduating doctors, nurses and midwives were henceforth hired on various types of contract including three year renewable contracts from the central Ministry of Health (PTT or Pegawai Tidak Tetap) or three year or one year contracts from provincial or kabupaten health offices (Heywood and Harahap 2009b). In 2007 the Ministry of Health offered the majority of these contract workers the option of transferring to permanent civil service status. At the same time provincial and kabupaten governments were strongly discouraged from taking on any more contract staff on the assumption that these staff would eventually expect to be taken on permanently as well. This severely limited the discretionary powers of regional health offices to match staffing levels to local requirements (Heywood et al. 2011).

⁴⁷ Nurses are not allowed to run independent private practices, although many in fact do so (Heywood and Harahap 2009b, Heywood et al 2011). They are allowed to practice privately under the supervision of a doctor at a private practice or hospital.

At the time of my fieldwork in 2012 puskesmas were trying to meet requirements through taking on recent graduates on a volunteer basis, paying small stipends from the limited funding available to puskesmas⁴⁸. At the same time the obligatory service for graduating doctors was reduced to a period of one year, with a six month internship at a puskesmas and another six months at a kabupaten hospital. After this period they were allowed to practice in the private sector. The reduced opportunities to work in the public sector have fuelled the expansion of the private sector. But while the demand for private practice doctors remains strong especially in urban areas, graduates from the expanding number of nurse and bidan private training academies are finding it hard to find work. They are currently providing a pool of volunteer labor for the puskesmas and public hospitals.

A second form of complementarity is that private practices are expected to support government health programs. For example, a private clinic or hospital might support local posyandu with visits or supplies. Private practitioners interviewed for the research all emphasized the complementary role between public and private practices.

Nevertheless, I heard accusations of practitioners encouraging public patients to visit them at their private practice or using public medications at their private clinics.

Needless to say, practitioners vehemently denied this.

In addition to licensed government and private medical providers there are numerous other alternatives for health care. These include “mantri” who may be un-licensed

⁴⁸ This was not a new practice. Several health workers described how they started out as volunteers in the 1970s before eventually being taken on as contract or permanent staff.

nurses running their own private practices or people with no formal medical training who nevertheless offer certain biomedical services, Ustad offering Islamic spiritual healing and various other forms of “dukun” (traditional healers) including, “bengkel tulang” (bone setters), “dukun pijit” (masseurs), acupuncturists and others. As Ferzacca (1996, 2001) describes, some “traditional” or unlicensed providers offer hybrid services that combine biomedical and “traditional” approaches. Thus, health seeking in Indonesia occurs in a context of vibrant medical pluralism (Geertz 1960, Ferzacca 1996).

Although the private sector has been expanding in the past two decades and the use of “traditional” healers also seems to be on the increase (Ferzacca 1996, Rokx et al. 2010) government health workers still regard the government as playing a dominant role, particularly for the poor. This view is supported to some extent by available data. For example, according to Rokx et al. (2010) based on analysis of the Indonesian Family Life Survey, a national sample survey, utilization of government puskesmas declined between 1997 and 2007, but the puskesmas remained the preferred provider for 40% of patients in the lowest socio-economic quintile and was used more often by them than any other type of provider. Better off patients tended to use private providers including private midwives as well as doctors.

3.3 A Day in the Life of a Health Center

At the time of my fieldwork in 2012 the public health structure established during the New Order regime remained intact. In “my” kabupaten in West Java there were 58 puskesmas each covering about 6 villages and employing a staff of between 15 – 35,

including at least one doctor⁴⁹, several bidan under the supervision of a bidan coordinator⁵⁰, several nurses and other technicians. The head of the puskesmas is typically trained in public health and/or is a doctor, dentist, bidan or nurse. In addition to clinical services, each staff is responsible for one or more of six basic and nine “development” public health programs that each puskesmas must implement. The “basic six” are mother and child health, nutrition, infectious disease control, environmental health, health promotion and clinical services. “Development” programs include dental services, mobile health, elderly health, school health, mental health, surveillance, health counseling and so on. Although puskesmas are supposed to implement all of the development programs they may focus on a selected few. For example, some pay greater attention to elderly health than do other puskesmas. While each puskesmas is supposed to have a mobile health mini-van that makes monthly rounds, in practice this depends on the human resources available. Ten of the 58 puskesmas include 24 hour obstetric care.⁵¹

At the village level each village has at least one puskesmas staff resident in the village, typically a bidan, sometimes a nurse. 118 of the 347 villages in the kabupaten had assistant puskesmas where these village staff worked. Other villages have more informal “village health posts” providing services once a week or “village obstetric care rooms”. Each village has about a dozen monthly community health posts (posyandu), giving a

⁴⁹ Several puskesmas had no doctor at the time of my research, but were seeking to employ one.

⁵⁰ The majority of these midwives are posted in the villages where they are supposed to reside, although they also have duties and attend meetings at the puskesmas.

⁵¹ Obstetric care units, named PONED, were started in 2006. Additional units were under construction during fieldwork

total of 3281 for the kabupaten. A new program starting in 2008 is “community health posts for the elderly” (posbindu) for those aged over 45. Attendants are weighed and basic check-ups and treatments are offered by a nurse and/or pharmacist. Not all villages had these by 2013. Whereas payments for the posyandu services are voluntary, some posbindu charge for medications.

The following description of one of my visits to Koratanah puskesmas is intended to give an impression of the day to day operation of puskesmas services in Indonesia.

Koratanah, one of two puskesmas selected as case studies for this research⁵², was described to me as a typical rural puskesmas located in the north of Lahanbesar kabupaten. It covers six villages, three of which have assistant puskesmas, and 67 posyandu.

To get to Koratanah I left Lahanbesar city around 6:00 am and boarded a crowded “kol” Colt mini-bus headed west along the main road towards Jakarta. After a one hour drive covering about 20 miles, alternately crawling in traffic jams or hurtling along the busy main road dodging other “kol”, smaller local mini-buses, huge trucks and private cars we arrived at a bus station from where I took a small mini-bus to Koratanah. Leaving the main road, we took a steep road through lush secondary forest, and then passed extensive rice paddies until we reached Koratanah Utara, a village of over 10,000 inhabitants, where the puskesmas is located.

⁵² For details of site selection see Chapter 1



Plate 5: Patients wait to register at Koratanah Puskesmas

Koratanah puskesmas is nested within a large compound set away from the road. There is a wide verandah at the front where patients wait for clinical services. The clinical rooms face this verandah, while administrative offices are located behind. At the back is a courtyard where training sessions in health promotion are held, and behind this are the TB treatment offices and one large in-patient room with several beds. There is a “poned”⁵³ 24 hour obstetric services unit in a separate building behind the main compound. To the left of the compound are separate buildings for mother and child

⁵³ Poned is an abbreviation of Puskesmas Pelayanan Obsterik Neonatal Emergensi Dasar or Health Center Basic Emergency Obstetric and Neonatal Center

health clinics, held every Monday and Thursday mornings, and to the right, a little behind the compound is a mosque where men retire for Friday prayers.

Koratanah puskesmas has a staff of 34 including the head (who is a doctor⁵⁴), Office Manager, three more doctors, a dentist, six nurses, twelve bidan, a dental nurse, a nutritionist, a pharmacist, a dispenser, a lab technician, a treasurer and four office staff. Twenty six of these are permanent civil servants while the remaining eight are on annual or three year government contracts.

According to national law government puskesmas are open from 8:00 am – 2:00 pm Monday – Thursday and 8:00 – 11:00 am on Friday. Patients are seen before 12:00 whereas the last two hours from 12:00 to 2:00 pm are for meetings and administrative work. Arriving at 7:30 am I join several patients sitting on the wooden benches under the verandah, waiting for the puskesmas to open. Several elderly people are there, along with parents of small children. One mother has brought her son who has had a fever for the past three days. She often comes to the puskesmas. She has a Jamkesmas health insurance card⁵⁵ but forgot to bring it. A man has come because of a toothache. He has brought his health insurance card, which he once used at the kabupaten hospital, as well as his registration ticket for the puskesmas.

⁵⁴ A puskesmas with a Poned must be headed by a doctor. Many other puskesmas are headed by people trained in Public Health or in other medical professions such as dentists, midwives (bidan) or nurses.

⁵⁵ Health insurance is discussed in Chapter 6



Plate 6: Registration locket and dispenser at an assistant puskesmas in West Java

At 8:00 am the registration lockets open and the patients line up to collect a ticket. A young woman at one locket registers patients with insurance cards who pay nothing, while the other locket is for those paying out of pocket. There are various types of insurance, the most common being Jamkesmas health insurance for the poor and Askes health insurance for civil servants and their families. For those paying out of pocket, the fee, set by the kabupaten government, is Rp 4,000 (about \$0.40)⁵⁶ for a first visit and Rp 3,000 (about \$0.30) for subsequent visits. This subsidized rate covers a medical

⁵⁶ During fieldwork (July 2012 – Sep 2003) the US dollar value of the Indonesian rupiah ranged from 9,400 – 11,300. For ease of calculation I have used an exchange rate of Rp 10,000 = US\$1. Source: <http://www.xe.com/currencycharts/?from=USD&to=IDR&view=10Y>

consultation and any generic medicines that are proscribed, provided that they are available at the puskesmas.⁵⁷

Having obtained their ticket the patients return to the wooden benches and wait to be called. Koratanah has elected to emphasize “lansia⁵⁸” among its “development” programs, meaning that it pays special attention to the elderly. There is a separate line for the elderly (those over 45) who will see their own medical practitioner. Koratanah puskesmas is unusual in having several doctors. In addition to the head, who is a doctor, there are two resident doctors, and one intern on a six month stint. Today the intern is dealing with the elderly patients while one of the resident doctors sees the others. I join one of the elderly patients, having asked their permission, and sit in on the consultation, which lasts about three minutes. First, she is weighed and her blood pressure is taken. Then she is asked about symptoms and almost immediately a diagnosis is made and a prescription filled out. There is very little explanation given and the patient does not ask any questions. She takes her prescription and returns to the bench. A few minutes later she is called up to a locket where she is given a small plastic bag with several different coloured pills and a small paper indicating the dose she is to take. There are no packages or labels. When I ask her what medicine she has been prescribed she says she doesn’t know the name or what they are for.

⁵⁷ All of the staff at the puskesmas are paid salaries by central or kabupaten government, and so the fee is used to cover an additional service fee to health providers and some of the operational costs of the puskesmas. The fee compares with rates from Rp 25,000 to Rp 40,000 for a consultation with a private primary care provider, excluding the cost of medicines.

⁵⁸ Lansia stands for Usia Lanjut or elderly and refers to the village community health post for those over 45.

Patients continue through the conveyor-belt like system until 11:00 am, by which time numbers have dwindled. I re-enter the consultation rooms and chat with the doctors until they are called to a meeting. The intern comments that the puskesmas often runs out of the generic medicines they are supposed to hold. One of the residential doctors comments that you need to have a strong sense of service to work in the government sector, most trainee doctors now aspire to work full time in the private sector, a path that was not allowed when he first trained. At that time you had to complete at least three years' government service before you could leave the civil service. Now you only have to do the six month internship at a puskesmas and another six months at a government hospital.

I wander back to the where the two bidan on duty have had a busy morning. At 3:00 am a mother arrived, brought by a paraji. The mother gave birth at 5:45 am. Following standard practice, the bidan are attending to the mother for six hours after the birth. When I arrive shortly after 11:00 am several family members are still present, including the mother's older sister, who is holding the newborn in the front room. I enter the back room where the mother is lying on a bed looking tired with a plate of rice, half eaten, by her side. I learn from her that this is her second child. The first, who is ten years old, was born with a paraji at home and the village bidan only arrived after the birth. I ask why she decided to have her second child at the puskesmas. "Harus dari pemerintah" (we have to, from the government) she answers. Will she pay anything? "No, there is no

charge”⁵⁹ At that moment one of the bidan comes in to check whether she has taken her antibiotics and iron tablets. I move out of the room and meet another bidan entering the Poned. She has just returned from her village where she attended a posyandu and now she will take over from one of the bidan on duty.

Leaving the Poned I find Pk Alam at his office where he administers TB medication. Pk Alam has worked at Koratanah puskesmas since 1971, and he remembers me from my previous research in 2000. We chat about the history of the puskesmas. Pk Alam says in the early days there were very few staff, the head of the puskesmas was a nurse, not a doctor, and there was no transportation to the villages. The family planning agents, and later the village bidan would walk from one village to the next. But there was more camaraderie in those days and everyone helped each other out. Nowadays he does not even know all of the staff of the puskesmas.

I manage to catch the registrars as they are packing up and I ask how many visitors we had today. Those paying out of pocket included seventy-six old patients and twenty-two new ones. The registrar for those with insurance was still calculating her totals, but there were fewer than those paying.

It is approaching 2:00 pm and everyone is keen to go home. The head of the puskesmas offers me a lift to the bus station and I accept, glad for the chance to talk to him. He is rarely in his office since he likes to spend time with his staff, and is often called to

⁵⁹ From 2011 Jampersal health insurance for childbirth covers the medical cost of a birth at a puskesmas or hospital.

meetings at the kecamatan government office or at the kabupaten health office. He has only recently taken over from Drg Marta, whom I knew from my previous research.

With its staff of 34 and its busy PONEK Koratanah is rather better resourced and well attended than some of the other puskesmas, particularly those in more remote areas where daily visit rates can be as low as ten or twenty people. But the short consultation times, the limited scope for patients to ask questions and the anonymous coloured generic medications are typical. But puskesmas staff argue that they should not be judged simply by the curative services since they are involved in numerous outreach programs, including the posyandu, school visits, disease surveillance, “bakti sosial”⁶⁰ free health days, health scouts, mobile health clinic and so on. Thus the public health activities, whatever their impact on the health of the population, provide a crucial justification for the continuing role of the government in the health sector in Indonesia. The following chapters explore in greater detail how health staff talk about and carry out this public health work. But before analysing health workers’ efforts to shape behaviour in line with government health policies it is important to understand the health practices and health seeking behaviour of the people they are trying to convince.

3.4 The View from the Community

The goal of this dissertation is to elucidate how much has changed in the way that health governance is carried out in the era of democratic decentralization. While my

⁶⁰ I attended a Bakti Sosial held at a tea plantation for the six villages of that kecamatan. On offer were circumcision family planning and health check-ups and treatment. Eighty boys were circumcised and a total of 387 people served within 3 hours.

focus is on the health officials and volunteers who manage and implement public health programs, in this section I ask whether those targeted by these programs have noticed any difference. I present community views on health services and offer two cases of health seeking to illustrate how ordinary people engage with government and other health services under decentralization.

In order to understand how ordinary people have experienced the decentralization of public health services I conducted three focus group discussions and numerous casual conversations with people in my selected villages and elsewhere on trends in health and health services. Since the terms “desentralisasi” (decentralization) and “otonomi daerah” (regional autonomy) did not always mean very much to those outside of government I asked people whether they had experienced any change in health services since the Suharto era, a memorable date that coincided with the onset of decentralization. My investigations yielded a remarkably consistent picture. Most people agreed that the economy had worsened, but that health and education services had improved. Although people had not detected a change in the types of services on offer at puskesmas they commented that there were now more puskesmas and more personnel, as well as more private sector providers. Furthermore, under the new health insurance programs⁶¹ health services at hospitals, previously unaffordable for many, were now free of charge for the poor, making them more accessible.

To some extent these trends reflect long term processes that are not directly related to decentralization. For example, the expansion of the private sector dates from the 1990s

⁶¹ Health insurance is discussed in Chapter 6

when the government changed its policy of employing all graduating health professionals, thus allowing for the emergence of the purely private practitioner (Heywood and Harahap 2009b). But decentralization has had an impact on the number of puskesmas and on the number of health personnel allocated to them. Under decentralization the authority to decide on kecamatan boundaries, numbers of puskesmas and allocation of health staff was devolved to the kabupaten level. As in other localities, Lahanbesar kabupaten government has used this authority to split up the largest kecamatan into more manageable smaller units. The process of “splitting” at various administrative levels as an effect of decentralization has been documented by Booth (20011). Since each kecamatan is supposed to have its own puskesmas, the increased number of kecamatan has been accompanied by a corresponding increase in the number of puskesmas from 32 in in 2000 to 58 in 2012.

The positive view voiced by my respondents contrasts with the findings of research conducted during the early years of decentralization by Kristiansen and Santoso (2007) and Halabi (2009). They regard the expansion of the private sector as negative based on the assumption that the poor are thereby excluded from access to affordable health services. This may be true for the extreme poor who can only afford the subsidized services offered at the puskesmas, but many people appreciate having the alternative option of private primary care services even though a private consultation typically costs about ten times as much as a visit to the puskesmas, and it may very well be with the same provider operating a private clinic outside of puskesmas hours.

Several reasons were given for choosing a private provider. Perhaps the most important was that the medicines provided at a private practice were believed to be more effective. For this reason people said they chose private practitioners for serious cases, whereas they would only go to the puskesmas for trivial cases. At the puskesmas only generic medicines are available, whereas branded medicines are the norm at private practices. Even though the official line is that there is no difference in efficacy it is widely believed that branded medicines are more powerful. Another advantage of visiting a private practice is the more flexible opening hours. This is especially important for those employed in jobs with fixed working hours that often coincide with the puskesmas opening hours from 8:00 am to 2:00 pm. Private practitioners often open their practices early, around 6:00am. In many cases this is because they also work at a government facility. They then resume their private practice at 4:00 pm, continuing up to 8:00 pm depending on the number of patients. Private practices are often run from the providers own home, so they may be contacted there even outside of their official hours. In some cases a private provider was chosen simply because they happened to be the closest option. Other people chose a particular private doctor because they were known to them personally or had been recommended.

In general, the concept of a good fit, described by the Indonesian term “cocok” is an important guiding principle of health seeking for ordinary people who have no vested interest in one type of provider over another but simply wish to solve their immediate health problems (Ferzacca 1996). Indeed, as the following two case studies show,

people will often use several different types of provider in response to a single illness trajectory until they find a good fit, and they do not see any contradiction in this.

Bu Sumira's ailing son

I met Bu Sumira at a free clinic for the elderly run by the mosque in the residential estate where I stayed. The doctor in attendance was the same doctor who worked at the nearby government assistant puskesmas every Wednesday (the other days there was a nurse or bidan in attendance). The Saturday morning clinic was popular because she administered a stock of branded medicines donated by the mosque rather than the generic ones available in nameless packages at the puskesmas.

Sitting on the bench outside the mosque along with several other patients waiting to see the clinic doctor, I asked Ibu Sumira about her experiences with health services. She explained that several weeks ago her 6 year old child was hot and was vomiting blood. She immediately took the child to Mantri Dadan (the term Mantri often refers to an unlicensed nurse practitioner) at his private practice at 6:00 am. She did not go to the puskesmas because she works as a housemaid (in the same residential housing estate where the clinic was being held) and the puskesmas does not open until 8:00am. Mantri Dadan said the child had 'masuk angin' (literally "the wind has entered", a common explanation for minor illness) and prescribed medicine, charging Rp 25,000 (about \$2.50).

But the child got worse. Bu Sumira thought perhaps the medicine was not 'cocok' (suitable, fitting) with her child. She was worried about the child vomiting blood. She

heard from a neighbour about a good private doctor, Dr. Siswanto, on the Pelabuhan Ratu road. Because she was so concerned about the child she took the long one hour ride to Dr. Siswanto, leaving at 7:00 am and arriving at 8:00 am. Dr. Siswanto said the child had Typhus and gave a prescription for medicine. He charged Rp 25,000 (about \$2.50) for the consultation, the same fee as Mantri Dadan but the medicines were expensive, bought at Kita Pharmacy on in Lahanbesar Town. The total bill, including the consultation and various medicines came to about Rp 200,000 (US\$20). But the medicines were good and the child recovered. She said Dr. Siswanto was a good doctor, adding: "If you go to the government puskesmas it's so, so, the medicines are all the same."

This belief that whatever ailment you had you would be given the same generic medicine at the puskesmas was widespread. It was reinforced by the experience that medicines at the puskesmas were given to the patient in anonymous plastic bags with no label. Typically the only way of distinguishing different medicines was by their color. People then referred to the medicines they had been given at the puskesmas simply as "the white ones" or "the yellow ones" and often did not know what the medicines were.

Bu Sumira's case reveals how complex health seeking trajectories can be, sometimes involving several different types of provider for the same health incident. In the following case a patient starts out with the government health system but then chooses a traditional healer, further reflecting the wide range of options available in the context of medical pluralism in Indonesia (Ferzacca 1996).

Dewi's swollen leg

I heard the story of Dewi's swollen leg while visiting my friend Leni at her traditional bamboo house in Mendekati Kota village. As we sat on bamboo mats on the veranda overlooking their fish pond I asked Leni's father, Heri, along with a couple of visitors what they did when they fell sick. Pk Heri said he went to the village pustu (assistant puskesmas) and if he didn't get better he went to the government hospital or to a private doctor. One of the visitors, Pk Haji added "if I am seriously sick I go straight to a private doctor". The other visitor adds that he goes to Dr. Tia in town because he has found a good fit. "I am a regular there, my father used to go before me. She practices in the afternoons. She charges Rp7,000, (US\$ 0.70) then gives a prescription and you have to go to the pharmacy to get the medicines." They are just turning from this discussion of biomedical providers to the topic of bengkel tulang (bone setters) whom they say are still prevalent in a nearby town, when Leni's sister appears in the doorway. She is immediately introduced as having an interesting health condition. About a month earlier she had been struck by fever and rheumatic pains in her leg. She took leave from her job as an English teacher and visited her local government puskesmas in Bandung, the provincial capital city. They could not give her a clear diagnosis but were afraid it was a blood disorder. They gave her Amoxicillin (antibiotic). She paid Rp 3,000 (about \$0.30) registration fee.

When the condition did not improve she went to a private general doctor. They did not charge anything because they did not give any prescription as they were also unsure of

the diagnosis. They advised her to go to an internal specialist. Before going to the specialist she came home because she needed family help caring for her small child. On arrival, she went straight to the nearest puskesmas, which is a “balai pengobatan” or treatment center that has more facilities than regular puskesmas. “It’s a major puskesmas, once the Minister even came there” she explained. They did a blood scan and found rheumatic fever. She paid Rp 5,000 (about \$0.50) and they gave her a prescription for medicine (Pirofel 0.5%) that she bought at a private pharmacy, paying Rp 21,000 (about \$2.10). Dewi showed me the other medicines she was given including Amoxicillin and Paracetamol (mild pain killer). At this point Dewi’s mother interrupted: “There are medical sicknesses and non-medical sicknesses.” Dewi continued:

I didn’t get better, I’d already been all over the place, so we asked Pk Haji, who is like an Ustad (Islamic religious teacher), he treats “paranormal”. He said I was being bothered by a creature from Satan. He gave water for me to drink and to paste on my leg, he gave the water and he prayed. Immediately I was able to walk again. After visiting the puskesmas I had not felt any change at all. I went to Pk Haji a week after going to the puskesmas, and I continue to take his treatment. Actually I am being treated by two Ustad. Before there was swelling but now it has almost gone.

Dewi showed me the healing water that she kept in a glass soda bottle. She demonstrated how she took a little water and rubbed it on her leg as instructed by the Islamic healer.

Having tried biomedical care at the government puskesmas, and fearing the cost of a private internal specialist, Dewi had ended up going to the Islamic healer. Compared with other respondents Dewi's family is relatively well off and well educated, the father having retired from the army, the three children having all gone to college. It is perhaps surprising that Dewi would choose a non-medical provider, but it was the mother's faith in spiritual healing that had persuaded her to seek out an Ustad. And the experience had been positive. Whereas the puskesmas treatment had not resulted in any change, she experienced immediate relief from the spiritual healer.

Out of 28 people who provided information to me on their health seeking this was the only case I came across where an Islamic healer had been used, although five people mentioned using herbal medicine and two used unlicensed practitioners who may or may not have formal medical training⁶². There may have been more cases of this type that were not reported to me because I asked people to relate recent or memorable experiences and I did not gather comprehensive information on every provider they had ever used. Furthermore seven of the conversations were held at puskesmas or clinics where people may have been less likely to mention non-medical providers.

Nevertheless, judging from the responses, the use of biomedical practitioners, including private providers, appears to be much more common than the use of non-medical providers. 22 people mentioned using a puskesmas and 13 had used a government hospital. 13 had used a private doctor and four a private hospital.

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A different pattern emerges in the case of health seeking for childbirth. I asked 28 mothers about their choice of birth attendant for all children born to them. Many had used both non-medical and medical providers for different children. Out of 28 respondents, 21 had used a non-medical birth attendant, known locally as “paraji”, 19 a government bidan and six a private bidan. Health seeking for childbirth will be revisited in Chapter 7.

Chapter 4: Voices on Decentralization

In the literature, decentralization is sometimes presented as a panacea capable of addressing a wide range of problems with government (Faguet and Ali 2009). The list of potential “good governance” benefits include an increase in local autonomy leading to more local initiative; improved efficiency in the delivery of public services in line with local needs; increased participation of citizens in policy making and in evaluating public services; and strengthened public accountability (Mitchell and Bossert 2010, Cheema and Rondinelli 2009, Manor 1999, Halabi 2009). These benefits are often seen as inter-related and mutually supporting. The implication is that these “goods” of government are not only desirable for the society as a whole, but they can potentially travel together.

Empirical evidence on decentralization is mixed with some studies suggesting improvements in public service delivery and accountability in line with theoretical predictions, while other studies suggest poor accountability, increased corruption and the capture of benefits by local elites. In recent decades decentralization has often been accompanied by market reforms including the promotion financial self-sufficiency at lower levels of government through allowing local governments to raise taxes or generate income through other means; contracting out of government services and privatization. This development has its proponents who see it as offering the potential for improved efficiency in public service delivery (Bossert and Beauvais 2002, Bossert 2014, Lieberman 2000), while others argue that it encourages providers of services to

focus on profits rather than equitable access to quality services, and that it often renders services unaffordable for the poor (Kristiansen and Santoso 2006).

Aside from the different political perspectives of the analysts, one reason it is hard to find agreement across assessments of decentralization is that decentralization is implemented in many different ways in different countries. Even if the analysis is restricted to cases of devolution of authority from central government to lower levels, as occurred in Indonesia⁶³, some of the key variables include how decentralization is financed, whether by block grants from central government or through income generated locally or a balance of the two; the power balance between the center and lower levels of government, in particular, who has authority to make decisions about what; and the accountability mechanisms that are put into place (Bossert and Beauvais 2002, Agrawal and Ribot 1999).

In Indonesia, as described in Chapter 2, decentralization was implemented as part of a package of reforms following the resignation of President Suharto in May 1998.

Decentralization was primarily a response to political demands for greater regional autonomy rather than a strategy for improving public service efficiency (Turner et al. 2003). In a dramatic move away from the highly centralized New Order regime, decentralization laws devolved authority from central government to over 300 kabupaten with average populations of under two million people. The decentralization process was complicated because the initial decentralization laws of 1999 were later

⁶³ This excludes cases where decentralization involves contracting out or privatization of government services which has not occurred on a significant scale in Indonesia.

amended in 2004, altering the rules of the game, and because regulations to support the law have been staggered over many years. Decentralization remains a contested political field and there is an ongoing tension between the center and the kabupaten. At any one time the question of who has authority to do what maybe unclear leaving ample space for confusion or, put more positively, for negotiation. Indeed “nego” seemed to be a key word used by government officials in relation to decentralization.

In the health sector the role of the kabupaten health office in managing budgets and programs has increased but the center continues to design macro-policy and to manage most of the health programs. The center also retains considerable financial control.

Under decentralization the kabupaten health office is funded via the kabupaten government but, as described in Chapter 2, financial discretion at the kabupaten level is limited by the fact that a large proportion of funds are needed to pay staff employed by the central Ministry of Health and to implement nationally mandated programs (Heywood and Harahap 2009a and b). Both of these examples imply that Indonesia is not as decentralized in practice as the legal framework might suggest.

The legal ambiguities together with ongoing political contestation mean that there are multiple interpretations of how decentralization ought to be implemented. The goal of this chapter is to map out some of the interpretations of health decentralization that I encountered at the kabupaten, kecamatan and village level in the kabupaten of Lahanbesar. Departing from an extensive literature that focuses on the outcomes of decentralization, I present decentralization through the eyes of those charged with

implementing it. I analyze the narratives of kabupaten level government officials who describe their first hand experiences of the decentralization process. This approach reflects my conviction that the outcomes of decentralization, or indeed any other policy, depend crucially on the ways in which people engage with these policies, and this in turn depends on their underlying values and priorities (Faguet and Ali 2009).

Many of the positive expectations and some of the negative outcomes found in the literature emerge from in these narratives. One finding of particular interest is that even where positive outcomes were noted they were found to be only partially fulfilled, and in some cases to undermine each other.

Most government officials whom I met saw decentralization as preferable to the previous centralized system because it had given them a greater sense of control over the programs they were implementing. Some worked hard to ensure that the laws and regulations on decentralization were implemented properly. But many were critical of the way in which the decentralization process was rolling out. Their critiques reveal local understandings of how government ought to behave. Several people took the opportunity for critical reflection on the decentralization process to demonstrate their inside knowledge of the system. Their narratives amount to a moral critique of government and of the political status quo. Their concerns reveal underlying failures and contradictions in the decentralization process.

At another level, their discussions amount to “presentations of the self” as a moral person (Goffman 1990[1959]). And patterns emerge that suggest decentralization is

experienced and assessed quite differently depending on a person's position in relation to the government system. These moral critiques of government call to mind Scott's (1976) concept of the moral economy of the peasant. But whereas Scott presents the peasants' moral critique in opposition to the (im)moral stance of government, the moral critiques that I present here reveal multiple moral voices from within government. Thus a "moral landscape" of views on decentralization emerged.

This chapter is organized around four key moral arguments that I encountered in my discussions. Each argument reveals a gap between an underlying expectation of decentralization and what has actually been delivered. The first argument is that the center is half-hearted about decentralization and undermines the autonomy of the kabupaten by interfering in the day to day affairs of the kabupaten. This argument takes kabupaten level autonomy as the defining characteristic of decentralization. The second argument is that decentralization has halted at the kabupaten level, leaving lower levels of government with no greater decision making power than before. From this perspective, the kabupaten is the new center and nothing else has changed. The underlying assumption of this argument is that autonomy under decentralization should penetrate all the way down to the kecamatan and village level⁶⁴. Taking these two arguments together we see that the kabupaten and kecamatan hold competing definitions of "autonomy" under decentralization. The third argument is that program effectiveness is undermined by the increased powers acquired by democratically elected kabupaten heads. Kabupaten heads, rather than central ministries, now have authority

⁶⁴ This interpretation resurfaces in Chapter 5 in relation to the Desa Sehat Program

to allocate budgets and appoint staff in all of the kabupaten government agencies. This has given rise to complaints that the kabupaten parliament fails to prioritize preventive health because it does not generate votes or revenue. Implicit in this argument is the expectation that democratic decentralization would improve health programming, yet in some respects it appears to undermine it. The fourth and final argument is that democratic decentralization has so far failed to bring about improvements in public accountability. This argument rests on the assumption that decentralization, by bringing government closer to the people, offers the potential for increased public participation and accountability. In the Indonesian case, according to some, this opportunity has been lost. The following sections elaborate on these arguments drawing on the narratives of health managers and practitioners located at Lahanbesar kabupaten health office, at puskesmas positioned at the kecamatan level, and in their private practices.

4.1 Decentralization as Kabupaten Autonomy: The Center is Half-hearted about decentralization

“Decentralization is good for bureaucracy.”

(Head of Health Promotion, kabupaten health office).

My first tutor on decentralization was Pk Yudi, head of the health promotion department at the kabupaten health office. With a background in public health and government he became an enthusiastic supporter of my research and was always eager to discuss the topic of health decentralization. I often met Pk Yudi at his office in Lahanbesar town. As a head of department he has a spacious office divided in two, with

the larger front room serving as a reception area and sporting several sofas around a low coffee table, while the smaller back room, dominated by a large desk, was used for more private meetings or attention to other business. Because of his job as well as his ebullient personality, Pk Yudi receives a constant stream of visitors, including other health personnel, officials from other government offices, journalists, NGO representatives and members of the public. Consequently it was difficult to arrange a private meeting or conclude a conversation without interruption. The following is compiled from several encounters with Pk Yudi at his office, as well as from a focus group discussion that I organized for the four heads of departments and the secretary⁶⁵. It was during this focus group discussion that Pk Yudi offered his most comprehensive definition of decentralization:

Decentralization is a result of the laws on regional autonomy. Within law 32, 2004 there are two goals, decentralization and democracy, that is the mandate.

Democracy cannot happen without decentralization. What is decentralization?

Decentralization is devolution of authority. Devolution of authority from the center to the regions. Many authorities have been given to the regions, 121 if I am not mistaken, only 5 have not been given: religion, law, monetary oversight, foreign affairs and security. Everything else has been transferred to the regions, including health. This means that the center has allowed the regions to manage the locality to become an autonomous region. Starting from planning, budgeting until implementation.

⁶⁵ The secretary is second to the office head, at a similar level in the hierarchy to the heads of department.

Pk Yudi lent authority to his definition by referring to the law, specifically Law 32, 2004⁶⁶. Other respondents at the focus group discussion and elsewhere also referred to the law when defining decentralization, leading to rather consistent definitions. Most made reference to a transfer of authority from the center to the kabupaten⁶⁷, while others referred to a transfer of responsibility, management or technical implementation.

Pk Yudi believed decentralization had brought about some very basic changes. “Before the kabupaten was simply an implementer of central policy both from the point of view of budgeting and programming. Now the kabupaten decides on its budgeting needs and programs within the framework of increasing health services to increase health status.” Based on this assessment, Pk Yudi claimed that “decentralization is good for bureaucracy.” This view was widely shared among the thirty or so senior staff of the kabupaten health office and by some health officials at the kecamatan level as well. Many thought that public services had improved with decentralization because planning and management were now more in line with the needs of the local population⁶⁸.

Despite his positive view, Pk Yudi was one of the most vocal critics of the decentralization process. He believed that the implementation of decentralization was incomplete, and that a key reason for this was that the center was “half-hearted” about

⁶⁶ For details of the decentralization laws see Chapter 2

⁶⁷ There are over 300 kabupaten in Indonesia, divided among 34 provinces. The kabupaten where this research took place is exceptionally large with 2.2 million inhabitants, amounting to roughly one percent of the national population of 255 million people.

⁶⁸ The population of Lahanbesar is 2.4 million, making it one of the largest kabupaten in the nation. Health services are managed by about 3,000 government employees including about 300 at the kabupaten health office with most of the remainder working at the 58 kecamatan puskesmas health centers and pustu assistant health centers.

decentralization. According to Pk Yudi the center was stepping beyond its proper role under decentralization. Along with many of his colleagues, Pk Yudi acknowledged that certain health functions were best managed from the center. He said: “There are some health sector concerns that cannot be left to the regions such as health issues that affect other regions, for example infectious disease outbreaks. Those have to be managed from the center.” But apart from these specific functions, Pk Yudi argued that the center should not become directly involved in the day to day implementation of programs: “Now what is the role of the center? Only to coordinate, facilitate, provide technical assistance, right? Then the third thing is to formulate macro-policy, then to provide guidance and supervision, that is the task of the center, not to be an implementer. Implementation should be from the regions.”

Concrete examples of what Pk Yudi was referring to emerged during the focus group discussion held with the four departmental heads and the secretary. The meeting was held in the head’s office, in her absence. As we sat back in upholstered arm chairs and sofas surrounding a low coffee table laden with snacks I asked participants to describe dilemmas they faced in their daily work. Led by Pk Yudi, the conversation quickly turned to the center’s failure to support the spirit if not the letter of decentralization. Pk Yudi argued that the center should and did design guidelines for specific programs, but kabupaten should be left to choose whether and how to use these guidelines and they should be able to adapt them to local conditions. Instead, guidelines were too detailed providing technical specifications that could not always be followed in the regions.

Pk Yudi used the example of “Jampersal,” insurance for childbirth, to illustrate his point. The guidelines specified that a mother must give birth at a health facility, attended by a health professional in order to be eligible for the insurance. But what if a woman lived so far from a health facility that this was impractical or even dangerous? In this case the centrally determined regulation did not match the local reality. In Pk Yudi’s view, under decentralization, kabupaten should be allowed to draw up their own kabupaten regulations to address such discrepancies. Lahanbesar kabupaten could then draw up a local regulation to allow a woman in a remote location to give birth at home, attended by a health professional and still claim the insurance. This was already happening informally through the issuing of a special letter of dispensation in each case. Although they were in the process of solving this particular issue the implication of Pk Yudi’s critique was that the central guidelines should not have been so specific and rigid in the first place.

Pk Yudi summarized his moral argument thus: “this is the principle: services to the community should not be sacrificed because regulations from the center are too technical and limit community access to services. Because in principle we have to provide services that are fast, appropriate, fair and equitable.” The reference to fairness and equity as principles underlying the provision of public health services show that, for Pk Yudi, public service provision is not simply a technical matter of improving efficiency but also a moral issue of achieving social justice⁶⁹. The implication is that such services

⁶⁹ Social justice is one of the five principles upheld by the state philosophy of Pancasila and references to fairness and equity are common in government laws and regulations.

can only be achieved if the center steps back and allows for decentralized programming and regulation. Other departmental heads broadly agreed with Pk Yudi's political assertion that the center was half-hearted about decentralization.

At one level, Pk Yudi's critique of central government is about program effectiveness. If programs are managed too closely by the central government then the kabupaten cannot fulfil its decentralization mandate to plan and manage local affairs. But a further inference that I draw from Pk Yudi's critical stance is that kabupaten officials feel a sense of moral outrage because they have been cheated out of the autonomy that was promised to them under the laws on decentralization. Regional autonomy in Indonesia was motivated by a sense of injustice at the centralization of resources under the previous regime (Achmad and Mansoor 2002). The laws on decentralization served to formalize a sense of entitlement to autonomy that had long been felt by the kabupaten, cities and provinces. Pk Yudi's argument that the central government is interfering too much in the day to day management of health services can be read as a statement that he feels cheated of this entitlement.

By focusing on the center's "interfering" in kabupaten affairs, Pk Yudi emphasizes what he regards as the essence of decentralization, namely kabupaten level autonomy. At the same time, he stakes out a moral position on government that is founded on his oppositional stance towards the center. Such blatant criticism, blaming the center for undermining decentralization and holding the kabupaten back, is unusual. Pk Yudi's criticism of the central Ministry of Health reflects his outspoken character and his desire

to stake out a clear moral and political position. But it also reflects changes in the political climate in Indonesia. Such open criticism of one's superiors would have been most unlikely under the New Order regime of President Suharto. A civil servant who critiqued the system in any way would likely have lost their job (Antlov 1993, 2000).

The critical stance towards central government adopted by Pk Yudi and other kabupaten officials reflects shifts in lines of accountability and communication resulting from the decentralization process. During the New Order all civil servants were accountable to central government. It was the central government that recruited, appointed and fired all civil servants. Similarly, regional offices at provincial and kabupaten level reported to the central government. Under the decentralization laws, staff are promoted, demoted or fired by kabupaten level human resources offices⁷⁰. The kabupaten health office annual accountability report is presented to the kabupaten government, and it is the kabupaten parliament that votes on resource allocations to health and other sectors. These new lines of accountability are reflected in the planning process. The planning process starts at the village level but the most important level in the planning hierarchy is the kabupaten. The province is consulted at the margins, when extra funding is needed, the center rarely if at all⁷¹.

Since the local parliament and kabupaten head are popularly elected, accountability towards kabupaten government implies accountability to the public who vote for these political leaders. Rather than having to account for their behavior to the center,

⁷⁰ Most civil servant salaries continue to be sourced from central budget lines leading some to argue that kabupaten have limited discretion in practice (Heywood and Harahap 2009b)

⁷¹ See Chapter 4 for details of the planning process.

kabupaten health officials now need to legitimize their health promotion, preventive and curative activities to kabupaten parliamentarians and to the general public.

Weak lines of accountability to the center are reflected in a lack of personal social contacts. Respondents from the kabupaten health office were in constant contact with officials at other kabupaten offices, sending text messages, arranging meetings or receiving them as visitors to their offices. But contact with officials in Jakarta was rare. The only visit I witnessed from Ministry of Health officials was from a team monitoring the centrally managed Jampersal health insurance for childbirth program.

My impression from kabupaten health officials is that these new lines of accountability and resultant networks of social relations have shifted the way in which the center is imagined by the kabupaten. Kabupaten health officials regard the center as a source of good health policies, but recognize that the center cannot enforce compliance with suggested guidelines. In practice they did generally follow the guidelines to avoid potential confrontation with the center, but they were aware that they were not legally bound to do so. According to their understanding, the center was not supposed to interfere in health programming. So in terms of the day to day functioning of the office the center has become somewhat irrelevant.

I argue that the center is currently imagined by kabupaten officials as a “floating mass.” Floating mass was the term used by President Suharto’s New Order government to describe the common people, who were assumed to be ignorant and vulnerable to political manipulation. The concept of the floating mass is documented in an MPR

(parliamentary) decision of 1971, and it was used to justify political suppression below the kabupaten level (Antlov 2000, Antlov and Cederroth 1998). The roots of the floating mass idea may be found in pre-colonial and colonial forms of indirect rule. Neither the Javanese aristocracy nor the Dutch administrators had direct relations with ordinary people, relying instead on local leaders. From their perspective the people were a remote, undifferentiated and powerless “floating” mass (Antlov and Cederroth 1998).

I contend that decentralization has led to a reversal. Now it is the center that is remote, vague, disconnected from and ignorant of local affairs and relatively powerless to determine events. The center has become the new “floating mass”. No wonder, then, that kabupaten health officials are frustrated at the center continuing to control “their” health programs. If the center is imagined as a remote floating mass then it should not be interfering in the day to day management of health insurance programs.

By blaming the center Pk Yudi also deflects criticism away from the kabupaten. The implication is that the kabupaten is trying to practice decentralization as it should. Some of his subordinates working at the puskesmas level do not share the view that the kabupaten is doing what it is supposed to do, as will become evident in the following section.

4.2 Health Center Autonomy

“We’ve been released from a cage but we are still tied.”

(Health center head)

People working at the puskesmas level tended to be less enthusiastic about decentralization than those at kabupaten level because it had not led to a hoped-for increase in autonomy for the puskesmas that they managed⁷². The 58 puskesmas positioned under the kabupaten health office remained under the management of the kabupaten, had limited control over budgets and were restricted in their efforts to engage communities in behavior change. These views are shared by Pk Bujang, head of Pariwisata puskesmas, located on the outskirts of Lahanbesar town, Dr. Mulyadi head of Koratanah, the rural case study puskesmas and by Pk Ali, head of a remote puskesmas near the coast⁷³. Their arguments are examined in the following sub-sections.

The frustration felt by puskesmas heads with the decentralization process needs to be understood in the context of staffing hierarchies within the Ministry of Health and social relations between kabupaten and puskesmas staff. Health center heads manage a staff of 25-40 health professionals and administrators. Many have Bachelor or Masters Degrees, often in public health, or they are doctors, dentists, bidan or nurses. As civil servants they are at a similar level within the civil service hierarchy to the 12 section

⁷² For a description of the organizational structure of the Ministry of Health see Chapter 3

⁷³ See Chapter 1 for a description of puskesmas selection for the research

heads at the kabupaten office, but in their encounters with these staff they are treated as inferior. When kabupaten office heads of section visit the puskesmas, staff are on their best behavior, under evaluation. The visitors receive red carpet treatment and may be given gifts of local produce, or served a meal. When puskesmas heads are called to the kabupaten office for meetings once or twice a month they are the recipients of training, information and guidance. Their own presentations from the field are subject to criticism. The barrier between the kabupaten office and the puskesmas is not impermeable, however. Health center heads may be promoted to the kabupaten office at any one of the quarterly staff rotations, and this did indeed happen to several puskesmas heads during my fieldwork, confirming that the qualifications and experience required are similar. Several of the puskesmas heads I encountered felt their qualifications and capacities underutilized. They had hoped that with decentralization they would be given greater leeway to take initiatives. Many of them have been disappointed with their actual experience of decentralization.

Pk Bujang is a dynamic puskesmas head, and his puskesmas won the award for best puskesmas in the kabupaten in 2011. He is rarely in his office, always busy at meetings or mingling with his staff. He was interested in my research and invited me to his monthly staff meetings, two of which I attended. But my attempts to pin him down to a discussion on decentralization fell through several times as he rushed from meeting to meeting. Finally, he found time to talk seated at a large conference table in the upstairs meeting room at the puskesmas, surrounded by photographs, trophies and awards. His

staff wandered in and out of the surrounding offices, and two of them were simultaneously holding another meeting at the same conference table.

Pk Bujang described the relationship between the kabupaten office and the puskesmas thus: “Health centers are technical units, so it is the kabupaten office that has authority to manage its affairs; the puskesmas is only like the extension of the arm of the kabupaten office (perpanjangan tangan). So there isn't much scope for them to decide by themselves.” His term “technical units” refers to the legal status of the puskesmas as an UPTD (Unit Pelaksana Teknis Daerah), literally Technical Implementing Agency of the kabupaten office. Thus, in formal organizational terms the puskesmas is “under” the kabupaten office.

Pk Ali heads a puskesmas in the less developed south of the kabupaten. He has a Masters in government and held strong views on the role of the puskesmas under decentralization. I met him at a busy kabupaten office meeting about the Desa Siaga project (see Chapter 5), held in a large hall outside of Lahanbesar town. As participants from the 58 puskesmas packed up their bags, anxious to embark on their long drives home I asked Pk Ali if he thought decentralization had made a difference at the puskesmas level. He replied:

There has not been a significant impact at the puskesmas level because, firstly, the puskesmas is only a technical implementation unit (of the kabupaten health office). Secondly although services are based on needs, the needs of the particular area, we are shackled (terbelenggu). We are tied by the guidelines

(juknis) that come out of the policies from regional government including from the kabupaten health office. So it's just the same, until now we are not free. We still have to do things exactly as they instruct us from above...We make suggestions based on the desires of the community but there are no programs (to support us).

In the same way as Pk Bujang, Pk Ali begins by referring to the formal organizational relationship between the kabupaten office and the puskesmas, stating that the puskesmas is simply an implementation unit of the kabupaten office. But his statement that "We still have to do things exactly as they instruct us from above..." moves beyond formal regulations to imply that the kabupaten is wielding its own authority in a way that unnecessarily restricts puskesmas autonomy.

Pk Ali believes the puskesmas should focus on preventive health. In his view this requires direct engagement with local communities. He feels the kabupaten health office is failing to support puskesmas endeavors in this area. He elaborates his critique by describing an initiative he has taken to form community groups for preventive health. The groups meet every month and discuss current health issues. If they notice an increase in a particular sickness, say diarrhea, they plan how to address it through clean water and building toilets. Every member contributes the equivalent of Rp 10,000 (about US\$1) per month, usually in kind. Since this is a coastal area, they are fisherman and contribute a proportion of the income from the catch. Pk Ali frequently makes requests to the kabupaten health office to provide financial support for this initiative,

but no funds have been made available. Certain types of groups do receive funding via Desa Siaga (see Chapter 5) but this does not include groups for preventive health.

Pariwisata puskesmas head Pk Bujang also believes that the goal of the puskesmas is to engage and to change the community, and that the kabupaten health office is failing to support puskesmas efforts. In his account he gives greater emphasis to the lack of funding for puskesmas initiatives. Pk Bujang believes the balance of funding between the kabupaten office and the puskesmas should change. Some of the funds allocated to the kabupaten health office should be transferred to the puskesmas level so that the puskesmas can engage the community. Pk Bujang explained it thus: “We have to do a lot of education, not only posyandu (community health post). Sometimes training is given by the kabupaten health office even though puskesmas staff members are capable of educating the public, so hopefully in future these activities could be done at the village funded via the puskesmas. So there shouldn't be too much funding to the kabupaten office, because what needs to change is the community.” In order to overcome the lack of financial support from the kabupaten health office his initiative has been to form a public-private partnership. Pk Bujang described the formation of this partnership thus:

From my personal view.. what one has to change is the community, and I can't do this on my own, it is necessary to empower the public, because if the goal is to change the attitudes and empower the people or benefit from the potential that there is in the community, we need to work in tandem with the public in policy. At Pariwisata puskesmas this has included forming the BPP, Badan Penyantun

Puskesmas (Public Private Organization), the puskesmas support body. This body works with me, because to actualize the vision and mission of Pariwisata puskesmas, whenever there is a problem we have a consultation (musyawarah), we discuss it, I have to involve the public. With this body God willing, the physical structures can be expanded, assistant puskesmas added, thereby adding empowerment activities and efforts towards health can run more smoothly and better. If the community requests expansion of Pariwisata puskesmas, I say 'please, go ahead I will fight for the physical aspects but you the community have to buy land, your own land that is managed by the community.' Following a consultation as previously mentioned, God willing, the community will buy the land themselves, so that I can propose the physical aspects to the kabupaten health office or to local government.

Public-private partnerships, such as the one established by Pk Bujang to help fund his puskesmas, are allowed within Law 32, 2004 on Regional Administration and are encouraged by policy makers at central government, but only a few puskesmas heads appear to be taking this initiative. Pk Bujang's public-private partnership has generated sufficient funding to build a new assistant puskesmas in 2008 and to expand his puskesmas in 2011. Despite his complaints about decentralization not giving puskesmas enough control over funding and programs, his successful expansion of his puskesmas, through an alliance with private sector organizations, indicates what can be achieved at the health center level under the new decentralized framework. Pk Bujang's work was recognized in 2011 when he received the award for the highest achieving puskesmas in

the kabupaten. He was then promoted to the position of head of the Methods and Media section at the kabupaten health office in September 2013.

4.2.1 Health Center Financial autonomy

Most of the funds destined for the puskesmas pass through the kabupaten health office or the kabupaten government treasury before reaching the puskesmas. For example, the funds designated for the operational budget that are generated at the puskesmas from patient visits must first be sent to the kabupaten health office, and then to the kabupaten government treasury, before being returned to the puskesmas several months later. This causes great frustration at the puskesmas level, both due to the delays and due to suspicions or fears that “cuts” may occur along the way.

Pk Bujang, head of Pariwisata puskesmas, believes that, with regional autonomy the kabupaten office could choose to give puskesmas greater control over budgets. Instead, according to Pk Bujang, Lahanbesar kabupaten has developed regulations that actually limit budgetary control at the puskesmas level: “Each kabupaten has their own authority, because with regional autonomy each kabupaten is given the opportunity to develop or to use their right, the individual right of the kabupaten. It would be better (for funds) to go straight to the puskesmas (by-passing the kabupaten), so the puskesmas could have more leeway in using the mentioned funds, but with regional autonomy and the kabupaten regulations like it or not the puskesmas also has to follow the kabupaten regulation (that limits their budgetary control).”

Pk Bujang offers an example: “So the staff of the puskesmas are not given the leeway to manage (budgets) ...They cannot, for example buy equipment above Rp 1 million (US\$100), it has to be the kabupaten health office, so the puskesmas is not given authority for procurement of physical items and equipment. It can enter the budget but the puskesmas is not given authority to buy it themselves, it’s still the kabupaten health office, procurement and any large level of funding.”

Dr. Mulyadi, head of Koratanah puskesmas shares Pk Bujang’s view that the kabupaten government intentionally limits puskesmas budgetary control. Indeed he goes so far as to suggest a return to centralized control of financial flows: “For funding issues I am happier with centralization, it’s not so convoluted (he uses an expression meaning a serpentine coil). With decentralization it (income) has to be returned again (to kabupaten government), from the puskesmas to the kabupaten health office, to the puskesmas, then back again to kabupaten government, going back again. If it is from the center (central government) it’s simpler. But for quality of services decentralization is good, it is better than before.” Dr. Mulyadi’s radical suggestion that financial control should be returned to the center reflects the degree of frustration felt at the puskesmas level over their lack of control over funding.

Recent changes, however, have increased puskesmas financial control, allowing the puskesmas to manage certain funds. These changes have had a positive but limited impact, according to respondents at the puskesmas level. A central fund for preventive activities (BOK, Biaya Operasional Kesehatan or Health Operational Fund) has been

channeled to puskesmas since 2010. In the first year each puskesmas received Rp 65 million (about US\$6,500) representing about 1/6 of total puskesmas income⁷⁴. In subsequent years the fund varied with the population size of the puskesmas.

In its initial year BOK was channeled from the central government directly to the puskesmas. Rumor has it that the kabupaten health office objected to this, and in subsequent years BOK was channeled via the kabupaten health office. Thus, even though BOK is welcomed by the puskesmas as a fund over which they have some control, it also offers an example of how the kabupaten health office tends to claw back control when it can.

A second change is that since 2012, following a Ministry of Finance ruling, the puskesmas is allowed to retain 100% of out of pocket payments, whereas previously 30% of these funds were held by the kabupaten health office. A complementary change, also since 2012, is that the puskesmas has been given authority to manage its own budget for operational expenses, funded from out of pocket payments and most insurance rebates⁷⁵. Since all of the funds for the operational budget are generated at the puskesmas, they know roughly how much the budget will be and can plan accordingly. Pariwisata puskesmas office manager Bu N described the changes as follows: "Before we just made a plan, we didn't know exactly how much the budget was, whether what we suggested here would be realised or not. We just suggested planning

⁷⁴ The exact proportion would depend on the visit rate. A puskesmas with a higher visit rate gains a higher income from out of pocket payments by patients.

⁷⁵ An exception is Jamkesda, kabupaten level insurance, explained in detail in Chapter 6.

based on needs in the field. Now we plan because we already know the budget, because we have already done the DPA (budget plan) at the puskesmas level.”

But these reforms only affect the operating budget of the puskesmas. The much larger budgets for health programs, including the six basic and nine development programs that all puskesmas must implement⁷⁶, is still managed at the kabupaten health office. Funding for these programs is ear-marked so that it cannot be diverted to other uses. Health center heads wishing to fund other activities have limited options available to them.

For example, a dentist who heads a busy puskesmas on the main road to Jakarta described how day to day management of the puskesmas was constrained by this lack control over budget allocations. She was concerned about how to fund voluntary staff, staff for PONED (24 hour obstetric care unit) and cleaning as well as computer maintenance as there is no budget line for any of them. She currently uses payments for medical services to cover these costs, meaning that her staff receive slightly lower compensation for their services that they otherwise would. Her initiative in diverting some of these funds for computer maintenance has earned her a reputation for having one of the few functioning health information systems at the puskesmas level. The very limited discretion that this puskesmas head has over the funding allocated to her puskesmas reflects the slow pace of financial devolution under decentralization in Indonesia (Heywood and Harahap 2009a). Nevertheless it still marks a departure from

⁷⁶ See Chapter 3 for details of these programs.

the system in operation prior to decentralization. At that time puskesmas heads rarely handled money at all since most resources were procured centrally and allocated in kind (Dr. Nia, personal communication).

4.2.2 Kabupaten Autonomy and Puskesmas Autonomy are in Competition.

A key theme running through puskesmas heads' accounts of the decentralization process is the lack of puskesmas autonomy, both in terms of independent control over budgets and in terms of the related issue of being able to take their own initiatives. The question of puskesmas autonomy is a moral as well as a political issue for these government employees trained in public health. This is because they believe that the government has a moral duty to provide quality health services to everyone in the community. Pk Bujang believed these services should be offered free of charge because of the poverty level of the people served. He was concerned that the only way that the puskesmas was allowed to generate income was by charging people who were sick, and that seemed unethical to him, even though the fees were heavily subsidized. In his view, greater financial autonomy would enable puskesmas to meet community needs without charging patients.

Puskesmas heads Pk Bujang, Pk Ali and Dr. Mulyadi attributed the lack of puskesmas autonomy partly to their formal status as UPTD, implementation units, and partly to the intentional policies of the kabupaten in limiting puskesmas autonomy. Just as Pk Yudi at the kabupaten office critiqued the center for undermining kabupaten authority, Pk Bujang and Pk Ali here critique the kabupaten government and kabupaten health office

for failing to use their authority to grant more freedom to the puskesmas. From the point of view of these puskesmas heads, then, autonomy at the kabupaten level appears to have come at the cost of autonomy at the puskesmas level. Decentralization appears to have halted at the kabupaten level.

The vision of greater puskesmas autonomy held by some puskesmas heads overlaps with that expressed in World Bank documents written during the early years of health decentralization in Indonesia (Lieberman, 2000). Decentralization was seen primarily as an opportunity to increase the capacity of puskesmas heads and staff to take their own initiatives. In order to achieve this it was recommended by the World Bank that puskesmas be given the chance to become “swadaya” self-sufficient. According to the swadaya model, puskesmas would be more financially self-sufficient, receiving little or no subsidy from the government. At the same time they would be able to choose the package of services offered, including choosing not to provide curative health services in areas with ample private sector providers.

This model of financial self-sufficiency aligns with neoliberal forms of governance that extend market mechanisms into government bureaucracies (Foucault 2008, Harvey 2007). Within such a government rationality, financial self-sufficiency is presented as desirable since it increases “choice” even though in practice it would mean that puskesmas would no longer receive government subsidies or policy guidance. The rhetoric of financial self-sufficiency thus obscures what is actually a withdrawal of

government from provision of basic services, a trend that has been observed in Europe, the US and elsewhere (Hyatt 1997, Harvey 2007).

My conversations with puskesmas heads in 2000, prior to the implementation of decentralization, revealed apprehension as to whether decentralization would be beneficial or not. Some feared that it would propel puskesmas into a dilemma where they would have to choose between financial survival and provision of services to the poor. At least one puskesmas head I interviewed in 2000 did share some of the World Bank's optimism. She planned to open a (private) pharmacy at the puskesmas in order to generate more revenue. But when I interviewed her in September 2013 she told me the kabupaten health office had not allowed her to do this, even though there was a shortage of medicines in her area. Clearly the World Bank vision that links "autonomy" seamlessly with the introduction of market mechanisms has not been fulfilled in its entirety, although public-private partnerships such as the one initiated by Pk Bujang offer one avenue along these lines. Indeed the term "swadaya" (self-sufficiency) is conspicuous by its absence in the amended decentralization laws of 2004. A watered down version of "swasembada" (self-management) is available within the current legal and regulatory framework. This status, known as "BLUD⁷⁷", is already enjoyed by most kabupaten hospitals. If puskesmas acquired this status they would manage their own finances while continuing to provide the same standard package of services in accordance with national health policies. There are no self-managed puskesmas in Lahanbesar kabupaten yet, but one puskesmas in Lahanbesar city applied for this status

⁷⁷ Badan Layanan Umum Daerah, literally Regional Public Service Body

towards the end of my fieldwork, and contacts in Yogyakarta mentioned there were self-managed puskesmas there. Many in Lahanbesar kabupaten health office thought puskesmas were “not yet ready” for this status. This could be further evidence of the competition for “autonomy” between the kabupaten health office and puskesmas. But some puskesmas heads shared the view that puskesmas were not ready for BLUD status. Perhaps they feared a reduction in subsidies from the kabupaten health office, provincial office and central Ministry on whom they depend for salaries and program funding.

4.3 Vulnerability of Health to Local Politics

A persistent thread in the narratives of government officials was that decentralization allows for planning in line with local needs. This was seen as one of the main benefits of the transfer of authority from the center to the kabupaten. But another theme that emerged was how decentralization rendered health services vulnerable to local political processes. This was because decision making power relating to staffing and budgets was transferred from central government to kabupaten government, with no guarantee that individual kabupaten would prioritize health and health services. Whereas previously the Ministry of health had lobbied for health at within central government, now each kabupaten had assumed this lobbying role. The following sections address the issues of budgets and staffing for health in turn.

4.3.1 Lobbying for Health

One of the most important changes that kabupaten health managers have experienced with decentralization is that they now develop their own budget proposal and plan. But they have no guarantee that their budget will be fully funded because it is the kabupaten government that ultimately decides on budget allocations to health and other sectors. The bulk of kabupaten government funding is in the form of a block grant from central government. It is up to the kabupaten government to decide how to distribute this grant among the various government offices. This places the kabupaten health office in the position of having to lobby for health funding in competition with other departments. Previously this lobbying role would have been performed by the central Ministry of Health in relation to the Ministry of Finance. Devolution of government administration under decentralization has involved a transfer of this lobbying role as well. Instead of receiving resources allocated by the central health ministry, the kabupaten health office now need to convince the local parliament of the importance of health, particularly preventive and promotive health that does not generate revenue or win votes. Under the New Order government local governments had become accustomed to view health services such as hospitals as a source of revenue (Achmad 1999). At that time, pro-poor policies that ensured equal access to basic services were guaranteed by the central government (Halabi 2009). Under decentralization the transfer of a lobbying role from a relatively strong central Ministry to weaker kabupaten health offices coincides with increased pressure on local

governments to become financially self-sufficient in order to realize the promised regional autonomy.

The increased role for lower levels of government and civil society in lobbying for public services under decentralization has been noted in the literature (Cheema et al. 2007).

For the case of Indonesia, Lieberman (2000), Kristiansen and Santoso (2006) and Halabi (2009) all argue that this places public health services at risk of under-investment because local governments will focus on curative services that generate income rather than preventive and promotive health programs including infectious disease control that had previously been guaranteed by central government. Such programs not only fail to generate revenue or win votes, they may even be unpopular with powerful local interest groups. For example, poultry businesses resisted measures to control Avian flu in Indonesia during the outbreak in 2007 (Padmawati and Nichter 2008).

The Indonesian government has attempted to address the danger of under-investment in health through mandating that kabupaten spend at least 10% of their revenue on health. In practice, few kabupaten have achieved this percentage. Lahanbesar kabupaten health office expenditure reached 4.78% of the kabupaten budget in 2010 and 5.45% in 2011⁷⁸, although this is an underestimate of total spending on health since other government offices also have health related spending. Another strategy of central government has been to ear-mark certain funds for health. For example, the Special Health Fund (DAK) is allocated directly from central government to the kabupaten health office for use in purchasing medicines and equipment. But this represented only

⁷⁸ Source: Lahanbesar Kabupaten Health Profile, 2010, 2011

10% of the overall kabupaten health office budget in 2010. Another fund, BOK, mentioned in the previous section, is ear-marked for puskesmas spending on preventive health, but again it comprises a low percentage of the overall budget.

Despite the vulnerability of certain health budgets under current funding arrangements, senior kabupaten health officials in Lahanbesar kabupaten described their new lobbying role in positive terms. “We propose to the kabupaten government and they accommodate our wishes”. By contrast, under the centralized system it had been much harder for the kabupaten to advocate for any “special” proposal, outside of the standard package that includes six basic and nine development programs as described in Chapter 3. One of the key reasons many kabupaten staff support decentralization, despite their misgivings, is that they now feel listened to, they have more of a voice.

At the same time they recognize the dangers of local government failing to prioritize preventive and promotive health. Whereas hospitals and health insurance are regarded as potential vote winners⁷⁹ promotive health activities such as environmental health and infectious disease control were seen as being in danger of neglect. Several health managers both at kabupaten and puskesmas level took pains to emphasize that the main role of the government in the health sector should be health promotion and prevention.

This view was shared by Dr. Deni, who witnessed the transition to decentralization as a civil servant in the health sector. He had worked at the “kanwil” (kantor wilayah or

⁷⁹ At least one local political party offered a health insurance card to voters during the 2012 elections.

regional office) in West Java before decentralization. At this time there had been two health offices at the provincial and kabupaten level, the Kanwil being the regional representative of the central Ministry of Health and the “dinas” being the health office of the provincial or kabupaten government. Deni explained that the role of the kanwil office had been to safeguard preventive and promotive health and to supervise the dinas. The role of the dinas had been to implement the health programs. At decentralization the kanwil was merged into the dinas office. Deni stayed on working in the new dinas office but became disillusioned with the way decentralization was being implemented. He believed the preventive and promotive role of government had been weakened. Previously the central Ministry of Health had exercised this role via the kanwil offices, but with decentralization the center had lost its coordinating role: “The rod from the center to the village has been lost” he claimed.

According to Deni’s account the government had been failing to perform its role adequately since decentralization. Furthermore, in Dr. Deni’s view, the general public was unaware of the importance of preventive health so there was no demand for these activities from the electorate. People regarded the puskesmas primarily as clinics offering curative services. Health center staff also tended to focus on delivering curative services since their revenue was derived from out of pocket payments from patients. In Deni’s opinion it was the responsibility of the kabupaten health office to ensure that puskesmas instead focus on preventive and promotive health.

According to another ex-civil servant, Dr. Heryanto, this failure to prioritize preventive health was reflected in the local parliament. Dr. Heryanto was head of the kabupaten health office from 1997-2004 during the early years of decentralization. He became frustrated with the failure of kabupaten and provincial government to understand and prioritize health promotion, claiming they only thought about hospitals, not preventive health. Eventually he decided to leave his position and move to the provincial capital to take up a lobbying role.

4.3.2 Staff Rotations Undermine Planning

A concern with staffing dominated my discussion about decentralization with the kabupaten head of the pharmacy warehouse who turned out to be another articulate critic of decentralization. I first met Drg. Saipudin, a dentist, at his large, sparsely furnished office located in the almost deserted pharmacy warehouse complex, which is one of four sites of the kabupaten health Office, located about ½ hour by minibus ride from town. He ushered me into a sofa located at one end of the cavernous room and, taking a seat opposite me, almost immediately launched into his critique. He explained that he had been in his current post only seven months, and that his predecessor held the post only one year. Although he begins with his own situation, and indeed he was “rotated” once more during the period of my fieldwork, Drg. Saipudin is addressing what he sees as a fundamental problem with the decentralization process. He understands that under decentralization the bupati (kabupaten head) now has the authority to allocate personnel, a task that was previously done by the central

government. Indeed, he was himself posted by the central Ministry of Health to Aceh province on graduating in dentistry in 1994. He does not question the authority of the Bupati in carrying out staff rotations since this is within the decentralization Law 32, 2004 on Regional Administration. However, he ventures that it “depends how you read the decentralization policy” and proceeds to offer his personal opinion on the negative impact of frequent staff rotations.

That’s one of the problems with decentralization, it keeps changing, how many times they keep switching. There are many changes, it often happens. So ...it's part of the job now, there are organization regulations we have to follow. Now with these changes perhaps we'll be in post for one to three months how can we plan? We have to carry out actions from the beginning....So if for example I do an activity this year then next year I change position, the functions also change.

In Drg. Saipudin’s view there should be continuity in activities from one year to the next but this is not possible if he is moved to a new post with different functions. The implication of Drg Saipudin’s argument is that managers should be able to follow through on their plans and should not be moved around so much. Through his critique of the Bupati’s policy of frequent staff rotations Drg. Saipudin reveals his conception of the proper conduct of government officials. In his view, providing guidance requires an in-depth understanding of the local area before planning and actions can be carried out. In the following quotation he uses the example of the kecamatan head, a position appointed by the kabupaten head:

You know the Camat (kecamatan head)? He guides the kecamatan, he has citizens, and clearly he has to plan before knowing how to guide the citizens. This takes time you can't do it in one week because he has to understand the land, the economy and so on. So he has to carry out planning first before he carries out actions. Once planning has been done he has to organize how to do it, then action. But if, for example, it happens that the Camat changes several times in one year, so he has just started to monitor, to see...if he is changed it means his policy.... sometimes there are differences between one Camat and the next.... they enter into other directions...the changes are too fast.

In this moral account of government Drg. Saipudin emphasizes the responsibility of government to provide guidance to the people. The role of government goes beyond simply implementing programs. Frequent staff rotations undermine the ability to plan and this in turn undermines the responsibility of government to guide the people. In this way one of the key benefits of decentralization, the opportunity for local planning in line with local needs, is confounded.

The lack of continuity in staff appointments is confirmed by discussions with other government officials as well as by my own observations. Typically there would be a batch reallocation of staff four times a year, with two or three such allocations during the 9 month period of my fieldwork. Of the 28 staff interviewed from the kabupaten health office for whom I recorded the date they assumed their current post, only three had been in position more than three years and 11 of them had been moved at least

once since the beginning of 2012, the year my fieldwork commenced. The longest serving manager was the head of finance who had been in post since 2002.

Drg. Saipudin was not ready to speculate on *why* the Bupati should wish to use his authority in allocating staff to implement such rapid staff rotations. The only justification I ever heard for staff rotations was that it enhanced career development. However, the uneven way in which the policy was implemented, with some staff rotated much more frequently than others, suggests that other factors were at stake. Some health officials confided that the Bupati might have political motives. The same decentralization laws that conferred on the Bupati the authority to allocate staff also stipulated that the Bupati be elected by popular vote rather than, as previously, by government appointment. It was argued that his motives in appointing staff were influenced by his desire to maintain his own position as a popularly elected leader. Thus it was an effect of the democratic reforms that accompanied decentralization.

One rumor that circulated was that only those who supported the Bupati and his political party would be promoted. In this way appointments had become part of the Bupati's political patronage system. For example, it was said that the head of the kabupaten health office was a close ally of the Bupati when she was first appointed. But when she was replaced in September 2013 rumor had it that she had failed to offer him sufficient political support. This argument was considered to be less credible for staff positions lower in the hierarchy, however.

In practice, the short term memory at the level of individual positions was to some extent tempered by the longer term institutional memory embodied in the job descriptions for each post. Again these used to be provided by the central Ministry of Health but are now determined by the Bupati's office. Another factor that likely eased the transition from one post to another was the bureaucratic culture of "teamwork", including monthly kabupaten office meetings through which staff learned about the activities of other sections. Nevertheless, the frustrating experience of frequent staff rotations led some respondents to suggest that "the center" should resume control of staff allocations. Drg. Saipudin's suggestion was that there should be a regional administrative body that would manage personnel independently of the Bupati and regional parliament.

4.4 Public Accountability

In the literature on decentralization public accountability is presented both as an expected benefit (Faguet and Ali 2009) and as a condition for its success (Agrawal and Ribot 1999, Mitchell and Bossert 2010). By "bringing government closer to the people", it is argued, decentralization offers the potential to improve efficiency and quality of public services (Manor 1999). But according to Agrawal and Ribot (1999:478) "if powers are decentralized to actors who are not accountable to their constituents, or who are accountable only to themselves or to superior authorities within the structure of the government, then decentralization is not likely to accomplish its stated aims."

In Indonesia strengthening accountability mechanisms has been a corner-stone of donor efforts to support decentralization (Lieberman 2000, Pollard 2007). While working on a World Bank health program to pilot decentralized health services, however, I found people in government struggling to operationalize the term “accountability”. At one level there was a problem of translation. The term most commonly used to translate “accountability” is “bertanggung jawab” which literally means being prepared to answer for one’s actions but in practice the term has come to refer to responsibility for completing a task or carrying out an order. Bennet (2000:7) has suggested the adoption of the term “bertanggung gugat” that suggests being liable for the consequences of one’s actions. But this term is not yet in common usage and in practice the term “akuntabilitas” is generally used in the context of recent efforts to introduce accountability mechanisms such as open access to information, complaint resolution mechanisms and participation of civil society in monitoring government processes. Similarly, transparency is translated as “transparensi,” and the English term is generally used for “good governance.”

The lack of commonly used Indonesian terms for “accountability” reflects the lack of experience of public accountability within the government system. Public accountability was not part of the culture of the bureaucracy under the New Order. The regime functioned according to a vertical system of accountability whereby civil servants were primarily accountable to their superiors. There were virtually no mechanisms for the public to hold officials to account (Antlov 2000). Corruption was allowed to thrive within this system (Znoj 2007) and public pressure to combat the three evils of collusion,

corruption and nepotism was one of the driving forces for political reform. This created an expectation among the general public as well as intentional observers, that the reforms would render government less vulnerable to corruption. But the government has been slow to introduce accountability mechanisms. Chris Bennet (1999:6) described the situation in 2000 as follows: “Accountability, the cornerstone of good governance, the light that can reach into the darkest recesses of a byzantine bureaucracy and its business partners, is unfortunately not amongst the highest priorities of Indonesia’s decentralization policy-makers, decision-makers, analysts and observers. In the new political establishment, not all who have just won the authority they have long struggled for find it easy to welcome the limits that accountability sets on what they can now do, whether in their own interests or in what they perceive to be the best interests of the nation.”

By the time of my fieldwork in 2012 some progress in strengthening public accountability mechanisms had been made. For example, kabupaten officials pointed to increased sharing of information with the public and the implementation of complaint resolutions mechanisms, measures that they thought signalled increased government “transparensi” and “akuntabilitas”. Others, including ex-civil servants, pointed to the continuing prevalence of various forms of corruption in the system, asserting that public accountability was no better than under the New Order, perhaps even worse. These respective positions will be examined in more detail below.

4.4.1 Transparency (transparensi)

The issue of “*transparensi*” was addressed during a focus group discussion with sections heads at the kabupaten health office. With the support of the head of the office, I had invited seven of the twelve section heads⁸⁰, of whom six took time out of their busy schedule to attend. We gathered in the office of the Secretary, in her absence. The narrow room had a red cushioned wooden sofa bench along one side with just enough space for us to cram in a few plastic chairs from the neighboring office to form a circle. As they arrived one by one the latecomers were scolded, jokingly, reflecting the fact that these section heads all knew each other well and engaged with each other in a relaxed and informal manner. I had already interviewed four of the six present and all were aware of my research, so I felt comfortable broaching the subject of public accountability in order to gain their perspective on the issue. The seven participants were unanimous in claiming that decentralization had led to increased government transparency and that the public had been “empowered” to monitor government programs and to complain if there were shortfalls. This was seen as part of the democratic reforms. As Pk Ence, head of personnel put it: “this is a national issue, a democratic nation must have a strong civil society.” Drg. Saipudin, who had previously discussed the issue of staff rotation, explained it thus: “The public ought to know not only about programs but also about the laws...this is one of the changes with decentralization. Now it is more open...there is more transparency of budgets and

⁸⁰ See Figure 2 for an organogram of the kabupaten health office. The four departments of the kabupaten health office each have three sections, so there are twelve section heads, each of whom has a staff of up to 12 people.

programs. The public now participate in monitoring health office activities, so do NGOs as well the media. If there is a problem they can report it to the kabupaten office.”

Focus group participants pointed to Law 14/2008 on public information as a turning point in government transparency. This law specified that all government departments must share information with the public; they must have suggestion/complaint boxes and every department must include a team to follow up on complaints from the public.

One organization that has emerged in response to this new openness is FITRA (Forum Indonesia Transparensi dan Akuntabilitas). Established in 2004 with funding from the Ford Foundation, it has 26 branches, including one in Lahanbesar. Their activities include social audit of health and education services, facilitating meetings between the public and government representatives and producing an annual calendar that includes local government income and expenditure data. Reflecting the improved relationship between I first learned about FITRA through this calendar, which was prominently displayed in the office of the head of the health promotion department. His willingness to advertise FITRA and display his office’s budget information is indicative of improved relations between government and NGOs since decentralization. I attended one of the public meetings organized by FITRA at the “pendopo” office and residential complex of the Bupati (head of kabupaten). The objective was to inform the public of their rights and to elicit comments and questions from them. The meeting was attended by about 50 people and several voiced their discontent with the quality of government services.

I found government information to be readily accessible either from public websites or by asking civil servants for access to their reports⁸¹. According to FITRA the problem is that the public is largely unaware of its rights to access such information. Also, some NGOs are regarded as too critical of government and officials are reluctant to engage with these NGOs. I witnessed an example of this when representatives from a local NGO came and asked for data at the kabupaten health office. The presence of the NGO representative generated some nervousness as he was passed from one officer to another. This suggests that, despite the claimed increase in transparency, mutual suspicion persists between some NGOs and government officials.

With respect to complaint resolution, Pk Ence, head of personnel, explained that prior to this law suggestion boxes and complaint resolution teams existed only on paper. If a government officer failed to respond to a request for information there would have been no consequences, whereas now they would be investigated by the Public Complaints Team (Tim Pengaduan Publik). He added “before it was not uniform. Everyone had suggestion boxes but it was not uniform you could just be closed; now you cannot because there is this law.”

Some health officials embraced this exposure and took steps to encourage public engagement. For example, Pk Yudi, head of Health Promotion, receives several visitors a day bringing complaints or requests for information. He prides himself on his deft

⁸¹ See Chapter 1 for a description of how I obtained the trust of government officials through following bureaucratic process.

handling of journalists, non-profit organizations and members of the public, directing them to other departments or providing them with further information.

One of Pk Yudi's staff, the head of the Materials and Media section of the Health Promotion department initiated a feedback system according to which members of the public could send SMS messages directly to the kabupaten health office. A professional, usually a doctor, would send a response. Each week a selection of the questions and complaints that had been received was published in a widely read local newspaper, along with a reassuring response from the kabupaten health office. In this way complaints were welcomed and encouraged, but at the same time contained and channeled so as to provide positive publicity for the kabupaten health office.

On other occasions attempts were made to contain exposure to the public, suggesting a certain ambivalence among kabupaten health office staff towards the increased government transparency. For example, during a meeting for the Coordination Team for Jamkesmas health insurance for the poor the head of health promotion, who chaired the meeting, urged participating hospitals not to complain to the press about delays in processing their insurance claims, lest the health of the poor become a "komoditi politik" (political commodity). By this he meant that the press would publicize the failure of the government to pay premiums for the health insurance for the poor programs and in this way the issue of the health of the poor would become a political liability for the government, tarnishing its reputation. Therefore, rather than approaching the media or NGOs, hospitals should bring their concerns directly to the kabupaten health office who

would negotiate additional funding from the kabupaten government treasury if necessary.

On another occasion, during morning roll call, the head of the kabupaten health office warned her assembled staff against “blow ups” if the needs of the poor in health were not met through the effective delivery of government health services and if these shortfalls were picked up by the press. This reveals that senior staff were acutely aware of the increased exposure to public opinion that government offices now faced.

Despite the increase in complaints received at the kabupaten health office efforts to develop formal complaint resolution mechanisms do not seem to have penetrated to the village level yet. I never encountered anyone during my village visits who had heard of the kabupaten health office SMS initiative, nor was anyone aware of the discreetly placed “suggestion boxes” that puskesmas were obligated to provide. During a kabupaten health office meeting involving representatives from all of the puskesmas I did a quick survey, asking puskesmas office managers about their suggestion boxes. One office manager reported that their suggestion box was emptied periodically, with its contents discussed at the monthly puskesmas meetings, but the most said that the box had never been opened or had never received any suggestions.

4.4.2 Responsibility (bertanggung jawab)

Some kabupaten health managers spoke of an increased sense of responsibility accompanying their increased authority under decentralization. They now feel more accountable for the outcomes of their actions. This view was expressed by Pk Yanto,

head of Human Resources, one of the four departments at the kabupaten health office.

Pk Yanto has worked at the kabupaten health office in various roles since 1990. He is a soft-spoken, gentle and thoughtful person. Although he rarely spoke out in group settings he was happy to talk with me in his office.

For Pk Yanto decentralization meant that the kabupaten was now the “executive leader” (pimpinan pelaksana). Although kabupaten authority allowed for planning in line with the needs of the kabupaten, he experienced the increased responsibility for everything as a burden (beratnya bertanggung jawab seluruhnya) believing he would be blamed if anything went wrong: “This management is a responsibility. If everything is successful fine, if not there will be a problem when the inspector comes... before the leader was from the center or the province, the person who would be hit if there was a problem was the provincial or central guy, we just received goods.” This view was corroborated by Pk Dedi, head of the Department of Infectious Disease Control, who also said that “now it is the kabupaten that is blamed if there are any problems”. According to Pk Yanto, the problem with this increased level of accountability was that not all staff were competent to fulfill their new tasks: “...the shortfall, as I said earlier, (pause) human resources not being ready, they couldn't take the responsibility, there are many cases of legal problems arising not only in health...” Here Pk Yanto hints at corruption by referring to “legal problems” without actually using the word. He added that the procurement process was a key site for the emergence of “legal problems”. The issue of corruption was not a focus of the research, but it did emerge in a number of

conversations as evidence for weaknesses in the decentralization process. For this reason it will be addressed in some detail in the following section.

4.4.3 Corruption

As described in Chapter 2, corruption under the New Order provided one of the rationales for government reform and decentralization. According to some respondents, there was an expectation among the general public that corruption would decrease with the demise of the New Order. They added that it was difficult to know whether this had in fact occurred because corruption under the New Order was hidden. Exposures of corruption and public complaints about it are now far more common because of the increased freedom of the press and the regulations mandating sharing of information from government offices. Newspapers frequently report on sensational cases, as well as including editorials on the problem of corruption. Thus, corruption has become more difficult to hide, and the topic has now entered everyday talk of those within and outside the government bureaucracy. As one puskesmas head put it corruption used to be “under the table”, a common reference to the hidden character of corruption (Blundo 2007), whereas now it was “over the table” for everyone to see.

Another common narrative of corruption was that while it had not diminished, it had now been decentralized to many “little rajjas” (kings). This made it even harder to track or to control, leading to “chaos” in the system. The imagination of “chaos” draws corruption critiques into broader critiques of decentralization as auguring in an era of “chaos” in contrast to the previous (New) Order.

A third view that emerged was that those accused of corruption no longer showed any shame. One possible reason for this increased blatancy is that the person accused of corruption was often operating on behalf of a political party rather than simply for personal gain. This reveals complex linkages between democratization, the proliferation of political parties and new forms of corruption as well as representations of corruption.

The most vocal critic of corruption in the system was an ex-civil servant now working in the private sector. Ex-civil servants make excellent key informants on corruption because they have inside knowledge of the government system yet they are no longer under pressure to toe the policy line and are therefore free to adopt more critical positions. Dr. Sandi was ready to expose the corruption he encountered in vivid detail, both to me as a visiting anthropologist and in the media. Corruption was the reason he cited for his resignation from government service. He now works privately as a neurosurgeon. In the following account he builds his own moral identity and his moral critique of government around his crusade against government corruption.

When I met Dr. Sandi at his stylish town house our conversation about decentralization was dominated by his talk of corruption. As we sat on a comfortable sofa overlooking his verdant garden he described his 15 year long career in the civil service as a continuous battle against various forms of corruption. From his first position in a remote village puskesmas to his final post in an urban hospital he had been faced with the same dilemma: should he go along with the corruption in order to sustain some level of health services, or should he reject corruption thereby cutting off services to the public. He

offered the example of puskesmas income from patients in order to illustrate his point. Each patient paid Rp 500 for a visit and the money was sent to the kabupaten treasury. Later Rp 125 from each payment was returned to the puskesmas to cover operational expenses. Dr. Sandi was required to sign for this Rp 125, but in fact he only received Rp 100. The remaining Rp 25 per fee had been skimmed off elsewhere in the system.

Unable to tolerate this pervasive corruption, Dr. Sandi started to make his own receipts for the actual amount of money he received. "We had to sign for Rp 125. In those days it was like that. Because I found this very hard in the end I asked for proof of the cuts, so I made a receipt for Rp 100 when I received Rp 100. Because if it wasn't clear like that I didn't want to take it. But if I didn't take it the puskesmas wouldn't be able to function. ...So my books were transparent."

When the financial auditors came from Jakarta he showed them his books, and the skimming was detected. Dr. Sandi was called to the kabupaten health office the following week: "As it turned out, one week later I was called by the head of the kabupaten health office and he was angry with me 'why did the inspectors have to know that there were cuts?' I said 'my books are transparent! What I receive matches what I used.' Well, the inspectors went to the kabupaten health office, not to correct things but to ask 'hey, let's calculate this.' They wanted to join in."

According to Dr. Sandi's description corruption permeated the entire system from the puskesmas level all the way up to the auditors in Jakarta. The regularity with which cuts were made suggests a set of norms and rules according to which a parallel financial

system functioned. Clearly corruption was not a case of a few “bad apples” but rather a social practice within the culture of the bureaucracy that drew all civil servants into its sphere whether willingly or not. According to Dr. Sandi, this systemic corruption undermined public accountability in the system and resulted in lower spending on public health than budgets and accounting systems reveal. But these hidden expenditures did not undermine the functioning of the bureaucracy. Dr. Sandi’s moral account reveals how programs continued to be implemented within a corrupt system. Indeed tackling corruption directly by refusing to participate in it would have undermined service provision.

Based on a detailed case study of corruption in Indonesia Znoj (2007: 53) concludes from similar cases that “systemic corruption is a disciplining and rewarding practice that confirms the bureaucratic hierarchies”. According to Blundo (2007), within such systems new entrants are obliged to “play the game” or risk being ostracized. Once they have been won over they are unlikely to expose the system since the costs of failing to comply with illicit practices are generally much higher than for transgressions of the official system.

Dr. Sandi had hoped that the political reforms of 1999, including democratic elections and decentralization of government services, would lead to a reduction in corruption. But he encountered it again while working as a neurosurgeon at the kabupaten hospital from 1999-2003, this time in the form of embezzlement of procurement funds. This suggests that the culture of corruption has survived the restructuring of government.

Indeed, democratic decentralization appears to have offered new opportunities for corruption, as suggested in the introduction to this section.

Dr. Sandi found he could not see eye to eye with the director of the hospital because of the continuing corruption. "I was always having to dodge... so that I didn't collide...they talked in idealist terms... but when I tried to follow the ideals I was yelled at." So rather than "collide" with his director he resigned to work in the private sector.

But Dr. Sandi's anti-corruption stance did not end there. Some years later he was invited to a meeting at the Bupati's office because he was head of the kabupaten doctors association. Since he had already left the civil service he invited colleagues working at puskesmas and hospitals to join the meeting. The issue of cuts emerged, and, as it happened, one of his friends from a puskesmas brought her husband along, and he was a journalist from Gatra. Following the meeting Dr. Sandi contributed to an article revealing corruption at puskesmas and hospitals that was published in Gatra.

Dr. Sandi abhorred the corruption he encountered yet he worked as a civil servant periodically signing false papers for 15 years. He was not alone. He named several other specialists who had resigned on account of the corruption from the same kabupaten hospital where he had worked. These resignations did not appear to have any impact the system. Indeed the director of the hospital then went on to become the head of the kabupaten health office. When corruption is part of the system civil servants are faced with the kind of dilemmas Dr. Sandi found himself in, where they choose to corroborate corruption simply in order to provide services to the public. The involuntary nature of

corruption is under-reported in the anthropological literature on corruption (Gupta 2012, Shore and Haller 2005, Roitman 2005, Nuijten and Anders 2007).

4.5 Conclusions

Much of the literature on decentralization focuses on the rationale for decentralization or reviews the outcomes (Manor 1999, Cheema and Rondinelli, 2007). Remarkably little attention has been given to the protagonists at lower levels of government who actually implement decentralization policies, even though their attitudes and performance will affect how policies are implemented and their outcomes (Faguet and Ali 2009). In this Chapter I have demonstrated that paying attention to the views of health managers at the kabupaten level helps reveal underlying failures and contradictions in the decentralization process.

A second finding that emerges from the analysis in this chapter is that people positioned at different levels in the system experience decentralization differently, hence their critiques of the decentralization process focus on different issues. Several different voices on decentralization emerge, all of them from within government. This multivocality of government challenges the impression given by some state theorists of a unitary government morality pitted against the morality of citizens, as depicted in Scott (1985), Ferguson (2006) and Roitman (2004). Rather, what emerges is a complex moral landscape within government.

For example, kabupaten and puskesmas managers presented divergent views on how the decentralization process should occur. According to kabupaten officials the essence

of decentralization is kabupaten autonomy. In their view the main problem with decentralization is that it fails to deliver this because the center interferes in the everyday work of program implementation. This suggests an ongoing tension between kabupaten autonomy and central autonomy. But if we add in the perspective of the puskesmas a further tension emerges. According to puskesmas heads decentralization should extend greater authority to puskesmas. Kabupaten officials claim this will undermine their ability to plan for the kabupaten. Thus autonomy at the kabupaten level is in competition with autonomy at the puskesmas level.⁸²

A second contradiction identified in the decentralization process is that between the improved planning expected from “bringing government closer to the people” and the disruption to planning resulting from politically motivated staff rotations undertaken by democratically elected leaders. Democracy and decentralization are presented in the literature as being mutually supportive. For example, in a study of decentralization in Indonesia Alicia et al. (2007), claim that decentralization should be promoted because it strengthens democratic institutions.

In Indonesia the same legislation that introduced direct elections for the kabupaten head also gave them authority to approve civil service staff allocations, a function previously done by central government. Some respondents alleged that this newly acquired authority was being used in a way that undermined staff motivation and capacity to plan. If this is so, then one of the consequences of democracy – the

⁸² This issue of competing autonomies is developed further in Chapter 5.

increased powers of elected kabupaten heads – appears to be undermining one of the “goods” expected from decentralization, namely improved planning. This contradiction far from being an anomaly is actually a built in tendency since democracy generates political motives in the behavior of popularly elected leaders. If these leaders are then given authority to govern professional cadres of staff then the ethnographic evidence presented here suggests that staff motivation may be put at risk.

Public accountability is another “good” that is supposed to accompany decentralization, but views on this issue varied. Although many agreed that transparency had increased both due to increased press freedom and government sharing of information, this increased transparency had not led to an expected reduction in corruption within government. Rather, as corruption has become more visible people appear to be making less effort to hide it. At the same time corruption is taking on new forms related to party politics under democratic decentralization.

Not everyone shared these criticisms and even those who did believed decentralization was better than the previous centralized system. Nevertheless, these critiques do suggest that the “goods of government” that democratic decentralization are supposed to deliver do not necessarily occur, and if they do they may be experienced as undermining one another rather than being complementary. This poses a significant challenge to the current literature on decentralization.

Chapter 5: The Desa Sehat (Healthy Village) Program – taking Autonomy down to the Village

5.1 Introduction

In Chapter 3 government health managers' critiques of the decentralization process were analyzed to reveal certain key principles that kabupaten health managers associate with decentralization. These included autonomy, effectiveness and accountability. In this chapter and the following one I explore how these principles are operationalized in particular health programs. This gives another angle on what decentralization means to those charged with implementing it at the kabupaten level.

The Desa Sehat (Healthy Village) program was presented to me as a model decentralized health program both because it was designed and implemented by the kabupaten health office, reflecting their newly acquired autonomy, and because it was based on the principles of decentralization as understood by the program designers. Program guidelines focused on village autonomy and "bottom-up planning". In effect, Desa Sehat took the decentralization principle of autonomy and extended it to the village level, at which point it translated into community self-sufficiency and community participation.

I analyze the Desa Sehat program using the lens of a cultural theory of the state. I examine how the program was constructed around cultural forms intended to resonate with the target population. I focus not so much on whether the program achieved its

stated public health goals but rather on what the project stood for and how it mobilized support. Thus, following Mosse (2004, 2005), Apthorpe (1997), Wright (2011) and others, I am less interested in the instrumental effects than in how the project was presented to various audiences and the modes of governance that were used in its implementation. I make three key arguments in relation to the rhetoric of the Desa Sehat program. Firstly, the program claimed to be promoting self-sufficiency yet it involved a marked increase in government intervention at the village level. In this respect it resembled many programs undertaken within the global participatory development movement and indeed it shared both the vocabulary of “participation” and the goals of the movement namely “enabling local people and communities to take control over their own development” (Kapoor 2002:101). The Desa Sehat program was not the first attempt to govern through community participation in Indonesia. I describe two other examples of community participation programs dating from the New Order government. This suggests that the rhetoric of community development is compatible with centralized as well as decentralized styles of government.

My second argument is that the global language of participatory development was translated through the Desa Sehat program into local cultural forms. This served to make the program seem familiar to village populations, as it was framed as being simply an extension of what they were doing already. At the same time, it made the program look authentic and credible to national and international audiences. Self-sufficiency was translated as “mandiri” meaning independent, and this term was linked with two indigenous cultural forms, “musyawarah” (deliberative consultation) and “gotong

royong” (mutual assistance). I describe how these local cultural practices were deployed within the program to promote “self-sufficiency”.

Despite evident continuities with previous programs the Desa Sehat did include some novel features, such as a health endowment fund and community health panels. It was regarded by its designers as an innovative decentralized program. By 2005 the Desa Sehat program had gained national recognition and it was scaled up into a national program named the Desa Siaga program. My third argument in this chapter is that this scaling up involved a shift in the mode of governance towards increasing levels of government intervention into daily life. Public health goals previously open to debate within village level fora were transformed into measurable targets at the individual and national level. I argue that a key reason for this shift towards a more centralized, standardized mode of operation was the intense pressure to achieve the Millennium Development Goals (MDGs). In this way the MDGs pose a challenge to decentralized government.

5.2 Description of the Desa Sehat Program

The Desa Sehat program was initiated in 2001, two years after the passage of the original decentralization laws. This was a time of great optimism about what could be achieved within the new government framework of democracy and regional autonomy. At the same time there was a shift in national health policy from curative to preventive health, reflecting similar trends at the global level. Following the call from the World Health Organization (WHO) for “Health for all by 2000”, the Ministry of Health launched

“Healthy Indonesia 2010”. Under this umbrella program Lahanbesar kabupaten launched their own decentralized effort, “Healthy Lahanbesar 2010”, led by the Kabupaten head and involving other government departments, not only health. The Desa Sehat program was part of this broader kabupaten initiative.

According to program guidelines, the goal of Desa Sehat was to improve health through sanitation, healthy behaviours and improved quality of health services. These rather standard public health goals were to be achieved through applying principles of democracy, participation and decentralization “to give an opportunity to the community to decide what they want in line with their desires, knowledge and independent abilities.” (Lahanbesar Kabupaten Health Office 2005).

Groups called Forum Silaturahmi⁸³ were to be established in every village with membership drawn from local leaders “who have the potential to mobilize the community” (Lahanbesar kabupaten health office 2005). “Leaders” could include those already involved in government programs such as kader and members of the village development committee as well as religious leaders with no government affiliation. The Forum Silaturahmi, together with the wider community, was to “identify and analyse health problems, find alternative ways of tackling them, bring together those who want to be involved and have potential to help, decide on activities, and evaluate the activities” (Lahanbesar Kabupaten Health Office 2005). Steps that the Forum were expected to undertake in this process included carrying out a survey; holding

⁸³ The term Silaturahmi means friendship with the connotation of an instigated, cooperative form of comradeship.

“musyawarah” (consultative meetings) to draw up an annual plan; carrying out interventions and then evaluating them using “gotong royong” (mutual assistance) in order to mobilize community support. In this way the traditional concepts of “musyawarah” and “gotong royong” were deployed to provide a model for how villagers were to cooperate in bringing about health development in their communities. Fora were also established at kecamatan and kabupaten level, where local NGOs were represented. Their role was to motivate, facilitate and evaluate the village level fora.

Pk Yudi, whom we met in Chapter 4, was involved in the design of the Desa Sehat program. He regarded it as a flagship decentralization program that aimed to develop appropriate local solutions to local health problems. In describing the program he emphasized its gradual phasing over several years and how this departed from the “top down” approach experienced under the New Order regime, where identical programs were implemented simultaneously throughout the archipelago. The Desa Sehat program started with only 29 villages in 2001. Thirty-one were added in 2002, 45 in 2003 and so on up to 2006 when 128 villages were added giving a total of 348⁸⁴. Each village passed through a three year cycle. During the first year they were to focus on sanitation receiving a grant from the kabupaten government budget of Rp 8 million (US\$800⁸⁵); during the second year maternal health was added along with an additional grant of Rp 4 million (US\$400); while in the third year infectious disease control was added, along

⁸⁴ At the start of the program in 2001 there were 339 villages in the kabupaten, but by the time of fieldwork in 2012 the number had increased to 357. Decentralization conferred upon kabupaten the authority to agree new kecamatan and village boundaries. This resulted in a process of “splitting” as larger villages and kecamatan elected to divide, a process analyzed by Booth (2008).

⁸⁵ In 2005 one US dollar was worth about 10,000 Indonesian rupiah.

Source: <http://www.xe.com/currencycharts/?from=USD&to=IDR&view=10Y>

with a final grant of Rp 4 million (US\$400). The emphasis on sanitation, maternal health and infectious disease control reflected contemporary global understandings of the determinants of public health as reflected in World Health Organization recommendations. In this way the Desa Sehat program was positioned as a progressive program that tapped into global health knowledge networks (Natividad et al. 2012).

Dr. Heryanto was head of the kabupaten health office at the time, and was also very involved in designing the Desa Sehat program. He regarded it as an attempt to implement community health in line with the principles of decentralization. Aligning the program with his interpretation of decentralization he said: “with decentralization...planning was bottom-up, beginning with the community...at village and kecamatan level”. According to Dr. Heryanto’s interpretation, autonomy under decentralization should extend not only to the kabupaten but right down to the village. And just as kabupaten autonomy required devolution of funding and budgets to the kabupaten level in order for it to be meaningful, so, Dr. Heryanto believed, genuine village level autonomy required that village communities have control over their own funding. In order to operationalize his moral conviction concerning how decentralization ought to be implemented, Dr. Heryanto, along with his colleagues, developed a village level health endowment fund termed “dana abadi”. Each village participating in the Desa Sehat program received Rp 25 million (US\$2,500) as a capital fund that was placed in a local bank account. The Forum Silaturahmi managed the fund and was allowed to use the interest (but not the capital) to invest in the health projects that they agreed to implement or in developing community health insurance schemes. Disbursement of the

fund was phased along with other aspects of the program. The first tranche of Rp 8 million (US\$800) was received in the second year, and the second tranche of Rp 17 million (US\$1,700) received in the third year.

In addition to the endowment fund a plethora of village level saving schemes were encouraged under the Desa Sehat program. Whereas the endowment fund gave control over a budget the saving schemes offered a mechanism for communities to achieve another form of financial self-sufficiency through generating their own funds. The community saving schemes included “beras seliter” or one liter of rice, according to which each participant in the scheme donated a liter of rice each month⁸⁶ into a central fund that was then used in the case of health emergencies, such as transporting a member to hospital. Various similar in-kind saving schemes were initiated, with members contributing one kilogram of fish per month, one kilogram of palm sugar, or other produce depending on local livelihoods. These savings groups were sustained through the Forum Silaturahmi. There were also schemes specifically for reproductive health called “tabulin”⁸⁷ that were managed by the kader and supported by the village bidan. Pregnant women would contribute a small amount of cash each time they attended the monthly community health post for a check-up. Midwife Erna explained how tubulin worked to achieve “self-sufficiency”:

So for tubulin every pregnant woman was informed about it. For childbirth save Rp350,000 (about US\$35), you should save from the beginning, from the first

⁸⁶ In one such group the 380 members donated a spoonful each morning and another each afternoon. This amounted to one liter over a month.

⁸⁷ Tabulin stands for Tabungan Ibu Bersalin or Savings for Maternity

check-up. She gave birth from these savings. If the tubulin was not enough she was helped anyway, then the rest was made up afterwards. It wasn't the bidan who kept the money but a team in the village, it could be the kader, or another person in the village. Later the bidan asked for the money, but it wasn't held by the bidan. That was self-sufficiency ("mandiri itu").

Although such schemes existed in Lahanbesar and elsewhere in Indonesia long before Desa Sehat, the program generated a new impetus and many village level health personnel worked hard to encourage villagers to build up such schemes. The Desa Sehat program was an attempt to show what could be achieved under decentralized government. Previously it would not have been feasible for a kabupaten to develop its own program (Achmad 1998). Even under decentralization, such programs were additional to the compulsory programs⁸⁸, and had to comply with national health policies. No specific resources were available for the kabupaten to develop their own schemes.

5.3 Community Self-sufficiency in Indonesia

As previously mentioned the Desa Sehat program took the concept of autonomy down to the village level. Once autonomy reaches the village level it translates into community self-sufficiency. The term "self-sufficiency" has come to be associated with neoliberal modes of governance (Rose 1999). Within a neoliberal rationality the term

⁸⁸ These included six basic programs: mother and child health, nutrition, infectious disease control, environmental health, health promotion and clinical services and nine "development" programs including mental health, elderly health and school health among others. Desa Sehat was implemented under health promotion.

implies that the individual, and by extension the community, should aspire to be independent of government and should therefore be responsible for their own wellbeing. Critics of neoliberalism argue that governments use the rhetoric of “self-sufficiency” to justify limiting government support or reducing welfare assistance (Hyatt 1997). Reflecting the influence of neoliberal discourses, in Indonesia self-sufficiency, translated as “mandiri” is increasingly used as an indicator of performance in government programs, including the Desa Sehat program that is the focus of this chapter. Such “mandiri” programs do not, however, involve a withdrawal of government support. On the contrary, as I hope to demonstrate, they often involve increased levels of government intervention into everyday life, through mechanisms designed to generate self-sufficient health citizens.

“Self-sufficiency” in these programs reflects the articulation of neoliberal forms of governance promoted by international agencies such as the World Bank (see for example, Lieberman 2000), with an enduring logic of “state led development” (Rudnyckyj 2010) established during the New Order government. According to the state led development logic the government is regarded as the key player in national development. Despite neoliberal restructuring of the economy in line with IMF loan conditionalities (Rudnyckyj 2010), I argue that “state led development” persists in the post-Suharto era. Indeed, as Aspinall (2014) points out for Indonesia and as Sharma (2008) argues for India, democracy reinforces the need for governments to legitimize their rule through programs of welfare assistance to the poor. In Indonesia this is

reflected in the expansion of health insurance schemes in the decentralization era, an issue that will be discussed in Chapter 6.

Through the articulation of neoliberalism with the Indonesian welfare state, “self-sufficiency” operates as a node connecting new forms of governance that deploy self-sufficiency as an output indicator with older forms. Community “self-sufficiency” has been integral to projects of state led national development since independence. These earlier forms have been influenced by colonial policies (Li 2007) and by international development policy, including the community development movement of the 1950s and the participatory development movement that emerged in the 1980s (Chambers 1983, 1984). Contemporary “self-sufficiency” programs in Indonesia thus involve a complex articulation of recent neoliberal influences with these earlier national and international forms⁸⁹.

For example, even though the Desa Sehat program could be read as a neoliberal attempt by a decentralized government to transfer responsibility for health onto the community, the language of the project documents is more evocative of the participatory development movement that came to dominate global development policy in the 1980s and 1990s (Chambers 1983, 1994, Mosse 2005). Robert Chambers pioneered an approach to participatory development and a range of techniques aimed at “enabling local people and communities to take control over their own development”

⁸⁹ My analysis of self-sufficiency draws on Sharma’s (2008) analysis of the closely related concept of empowerment. Sharma analyzes “empowerment” as an assemblage of goals, strategies and institutions through which neoliberal forms of governance articulate with older incarnations of empowerment embedded in Feminist, Ghandian and Freirean political philosophies.

(Kapoor 2002:101). Participatory approaches were designed to draw on local expertise and build on what people were already doing. The movement became popular with non-government organizations but quickly spread to government agencies and international aid organizations.

Participatory development has spawned a great deal of debate and a correspondingly large literature focused on its meanings, how it has been deployed and its effects. As a result it is now widely acknowledged that the term “participation” is open to different interpretations, ranging from attendance at a meeting or compliance with government dictates at one extreme to playing a role in decision making or independently directing a process at the other extreme. Various schemes have been devised based on different categories or levels of participation (Francis 2001). While some of the literature promotes participatory development as a valuable strategy for governments and aid agencies, either as an end in itself or as a means to more effective program implementation (Chambers 1983, Magrath et al. 1997), a more critical literature has also emerged (Kapoor 2002, Green 2000). Several anthropologists examine the use of “participation” as a “buzz word” to enroll support for particular projects and policies (Mosse 2004, 2005, Cornwall and Brock 2005, Cornwall 2007, Leal 2007). At the extreme it has been suggested that participation is the New Tyranny (Cooke and Kothari 2001) used as a cover for manipulative strategies of social control.

In 2001 when the Desa Sehat program was conceived participatory development had gained ascendancy in international development discourse. The influence of the

movement is reflected in program guidelines that describe the government as facilitator of a process whereby villagers would take control of their own health development (Lahanbesar Kabupaten Health office 2005). But even though Desa Sehat was regarded by its proponents as pioneering a new approach, the rhetoric of “community participation” in Indonesia predates the international participatory development movement and has been a persistent thread in the rhetoric and practices of government since independence (Kenny et al. 2012, Quarles van Ufford 1987). Community participation was central both to Sukarno’s vision for the development of an Indonesian nation and to Suharto’s program of national economic development⁹⁰. In this section I examine two longstanding programs with the stated aims of achieving community participation in development: the “musrenbang” or consultative meetings for development planning and the “posyandu” or community integrated health post. An examination of how “community participation” is deployed in these programs helps elucidate whether Desa Sehat involved a different interpretation of “participation” in line with local understandings of village autonomy under democratic decentralization.

5.3.1 Musrenbang

“Musrenbang” is short for musyawarah rencana pembangunan, or consultations for development planning. The term “musyawarah” entered government political discourse in the 1950s and 1960s in relation to President Sukarno’s political philosophy of Guided Democracy. According to this philosophy community participation in the political process was to be achieved through “musyawarah” or deliberative consultation with the

⁹⁰ See Chapter 2 for details of these visions for the development of the Indonesian state

aim of achieving a consensus. Musyawarah was supposed to be a traditional practice within Indonesian communities. Sukarno developed it as a basis for the political process of “consensus politics” that was central to Guided Democracy.

During the New Order government of President Suharto (1966-1998) “musyawarah” consultation was formalised into “musrenbang”. Musrenbang were to be held annually in the form of open public meetings where development options were discussed at every level starting from the sub-village (“dusun”), to the village, kecamatan, kabupaten, province and eventually the center. The musrenbang appears to be a form of “bottom-up planning” that does not fit easily with the impression of a top-down structure of decision-making under the New Order government, as described by Antlov (1998), Quarles van Ufford (1987), Magrath (2010) and others. Musrenbang were likely performed as rituals of democracy in the way described by Pemberton (1994) for general elections. This suspicion was confirmed by several of my informants.

The goal of the musrenbang for bottom-up planning seems more compatible with democratic decentralization than with centralization. Curious to see whether the institution now allowed more active participation from village communities, I tried to follow the musrenbang process from the village up to the kabupaten. I found it difficult to find out when my local village meeting would be held, and I missed it. At the village office I was informed that it had already taken place, but I could see a list of the attendants. Scanning the list of 31 attendants I noticed that most of them had an official or semi-official status. About half were neighbourhood heads and others included the

village secretary⁹¹, village development officers and kader. I was further informed that the attendants had all received written invitations to the meeting. But, I was reassured; the sub-village meetings really were open to the public. Since these meetings had already occurred I was unable to confirm this.

The long list of invited office holders reflects the proliferation of semi-official positions at the village level that was initiated during the Suharto era as a strategy to monopolize political power while providing a mechanism for the delivery of government policies and programs (see Chapter 2). Antlov (2003, 1995) recorded 178 official positions occupied by 95 persons in a single village in West Java in 1998. He argues that in the more democratic post-Suharto era power is less concentrated, so that fewer people hold multiple positions. But based on my observations there appears to have been little or no reduction in the number of positions available. They continue to offer a convenient mode for extending government to the general population and every new government or donor project either uses the existing cadre of volunteers or creates additional ones⁹². Inviting only office holders to the village level musrenbang means that “participation” for other residents does not even meet the restricted meaning of “attendance”. Rather, the majority of citizens are represented by their neighborhood head.

⁹¹ The village secretary is the only salaried civil servant working in the village office. Others, including the village head, receive a small stipend from government to cover travel and other expenses.

⁹² This mode of extending the reach of government differs from that described by Gupta (2012) for India where government officials are forced to adopt various forms of rationing since each official has to deal with hundreds of individual citizens. In Indonesia by contrast individuals are reached via their neighborhood head or volunteer rather than dealing directly with government officials.

Undaunted by my experience at the village office, I attended two musrenbang at the kecamatan level. In both cases the kecamatan head together with a panel of government officials from the kabupaten planning department faced an audience of about 50 people, again all of them office holders, including staff from kecamatan government offices, the head of the puskesmas, village heads, kader, members of village development committees and so on. In the first kecamatan meeting that I attended the musrenbang went smoothly as the planners presented an edited selection of the village plans that would be conveyed to the kabupaten musrenbang. But at the second meeting I witnessed something of a rebellion. One village head stood up and suggested that the meeting was simply a performance, since everything had already been decided. Why didn't they talk about all of the suggestions from the villages, and then evaluate last years' activities? Staff from the planning division of local government responded by saying they were trying to improve the system. They suggested that villagers not wait for government funding, but rather seek other sources of funding from non-government organizations or from the private sector in order to implement their plans.

In his brief outburst the village head claims to be representing the people in his village vis a vis "the government" and its planning process. He is building a moral identity around his ability to pursue the interests of his constituents. This approach has become more common as a political strategy in the decentralization era. Under the previous New Order regime of President Suharto village heads were often regarded as government agents accountable to their superiors and concerned with implementing government policy rather than responding to popular demand (Antlov 2003). Although

the actual picture may have been more complex, with some village heads more responsive to their electorate than others (Quarles van Ufford 1987), the alignment of this village head with “village” interests likely reflects shifts in the political climate that accompanied the reforms of the post-Suharto era (Antlov 2003).

On the other hand, the response from the planning department reflects a government that is more open to criticism. Whereas under the authoritarian New Order regime confrontation with one’s superiors could have disastrous consequences such as losing one’s job or losing access to government resources (Magrath 2010, Quarles van Ufford 1987) in this case the planning department staff were put on the defensive.

As the previously mentioned speaker suggested, the musrenbang remains simply a ceremonial performance with little chance of village plans actually receiving support. This impression was reinforced by the experience of my local village. According to village office staff, not one of their proposals put forward in 2012 were funded. The reasons for this became apparent when I attended the kabupaten level musrenbang. Under decentralization the kabupaten is the most decisive level in the musrenbang system because it is at the kabupaten level that final decisions are made about which plans will be funded. Kabupaten staff may attend a provincial level musrenbang if they need to request additional funding, but they do not attend a musrenbang at central government level.

The kabupaten musrenbang that I attended was a high profile affair held in a resort hotel accompanied by a great deal of ceremony. The Kabupaten head was present along

with many other notables, as well as representatives from all the government departments including health. Sub-kabupaten officials and village heads also attended. The presentations were slick, with elaborate Power Points brimming with statistics illustrating ambitious five year development plans. Village proposals stood little chance of gaining much attention here. One reason for this is that budgets are already stretched to the limit in covering the kabupaten plans. But perhaps there is another issue at stake.

With decentralization the kabupaten has won a degree of autonomy from the center. The kabupaten government now draws up its own plans. Despite the language of “bottom up planning” it may be that village level plans that demonstrate a degree of village autonomy are seen as a threat to kabupaten autonomy since they undermine the kabupaten’s capacity to stick to its plans. In Chapter 4 it was suggested that kabupaten autonomy competes with puskesmas autonomy. The village musrenbang may be a victim of the same logic. The idea of “bottom up planning” gives the musrenbang process a legitimacy that is especially necessary in the era of democratic decentralization and regional autonomy. But when the village plan encounters the kabupaten plan the kabupaten plan tends to dominate.

Pk Budi, the head of Desalindah village confirmed the impression that decentralization has not yet extended autonomy down to the village level. He complained that “the budget is decided by the kabupaten government. Only if there is income generated locally by the village can it be decided by the village. Authority (at the village level) is the

same as before...it's still the kabupaten government that decides." The complaint of this village head echoes that of puskesmas heads quoted in Chapter 4 who argued that decentralization has halted at the kabupaten level and has not given lower levels of government greater voice. Apparently, the only way that the village (or indeed the puskesmas) can experience autonomy is by first achieving a degree of financial self-sufficiency through generating their own income. Although this is suggestive of a neoliberal mode of government according to which villages are forced to become self-sufficient there is a subtle difference. There is no evidence of a withdrawal of government support to the village. Pk Budi is not arguing that government budgets have been reduced. Rather, he is arguing that the expectation that decentralization will encourage greater initiative at lower levels of government has not been fulfilled. Since this initiative cannot be taken within the government system, the only way to achieve it is through financial self-sufficiency from government.

Judging by the advice given to village heads at the kecamatan musrenbang this is an approach that is encouraged by the kabupaten government. Representatives from the kabupaten planning department urged village heads to get funding from outside of government to support their plans that were not taken up through the official musrenbang process. Potential sources are limited but include local and international non-government organizations, international funding agencies, and the private sector⁹³. Such "public-private partnerships" are also encouraged within national government

⁹³ Villages in some regions are able to generate income from local natural resources such as forest products but this option is not available to villages in West Java.

policy. The general lesson appears to be that although the government continues to pay lip service to the idea of village autonomy under decentralization it is not prepared to provide the resources necessary for villages to achieve this through the musrenbang process⁹⁴. Against this background it seems highly significant that the Desa Sehat program, as a flagship decentralization project, did attempt to provide some financial support for village self-sufficiency through the health endowment fund. But before we return to the Desa Sehat program I address another government led community development program, the “posyandu” or integrated community health post.

5.3.2 Posyandu

As described in Chapter 3, the posyandu, a health event held once a month in each neighborhood, was established in 1982 under the New Order government with the public health objectives of improving child survival and maternal health (Kollmann and van Veggel 1996). But although its origins lie with government it is described as being “a community health effort that is managed and implemented from, by, for and with the community” (Ministry of Health 2011a:3). Despite this rhetoric of community management, the kader who run the posyandu are expected to follow detailed government guidelines⁹⁵. For example, each posyandu must have five volunteers including a head, secretary and treasurer. Volunteers must hold a posyandu⁹⁶ once a month in a location provided by the community (usually either in the house of one of

⁹⁴ It is possible that musrenbang operate differently in different kabupaten and provinces. Regional variation in all government programs increased with decentralization.

⁹⁵ The official booklet for volunteers on how to run a posyandu runs to 86 pages, including numerous pictures and charts (Ministry of Health 2011a).

⁹⁶ The term posyandu refers both to the monthly event and to the place where it is held.

the volunteers or in a separate building). Early in the morning, before the posyandu begins, volunteers must prepare five tables allocated to the different activities of registration, weighing, recording, health counseling and family planning. At least one staff from the local puskesmas and family planning office are supposed to attend, both to provide medical services to attendants and to train and supervise the volunteers.



Plate 7: Posyandu showing kader at tables registering and recording data. The posyandu has become an important village institution. During the early years a village might have a single posyandu, but the numbers have gradually expanded so that

Newberry (2006:16) mentions one in every RW⁹⁷ neighborhood, while I encountered some RW with more than one posyandu. For example, in Mendekati Kota village, with a population to 12,686, there are twelve RW and fifteen posyandu. This means that a posyandu will be held somewhere in the village every couple of days. Based on my conversations with mothers at these events, the posyandu was often their first point of contact with the village bidan who is the key representative of government health services at the village level⁹⁸. While the kader chart the growth of under-fives, the bidan or nurse in attendance provides immunization, pre-natal check-ups, family planning and basic clinical services. According to Newberry (2006:16) “This kind of direct access to health care is one of the great successes of Indonesia’s public health system, and it is directly related to the decrease in infant mortality in Indonesia⁹⁹.” Aside from its effectiveness as a mechanism for delivering public health services, the posyandu has become integrated into the everyday life of the village. As a feature of village life that is now taken for granted, it has become part of the local culture. The posyandu thus provides an example of the two way process of everyday state formation. The posyandu

⁹⁷ RW stands for rukun warga or harmonious citizens and denotes a neighborhood of 1-300 households that comprises the second lowest rung in the government administration. Each RW covers about six RT (rukun tetangga) harmonious neighbors. See Figure 1 for a diagram of the government administration hierarchy.

⁹⁸ Some villages have an assistant puskesmas attended by a doctor once or twice a week.

⁹⁹ Achmad (1999) is less enthusiastic arguing that attendance is low and that the posyandu is ineffective in addressing child malnutrition due to the lack of follow-up once cases have been detected. Posyandu performance may have improved since Ahmad made his observations. Performance is also likely to vary with the location. Both Newberry and I observed posyandu on the island of Java. In other locations with fewer resources posyandu may be less active.

draws on culture by claiming posyandu as “community owned” but it also contributes to the culture as posyandu itself becomes a local cultural form¹⁰⁰.

Posyandu declined during the economic crisis in the late 1990s but were “revitalized” in 2007 with funding from UNICEF. In the era of decentralization one might expect an increased emphasis on village autonomy or local initiative under the revitalized posyandu, but the kader I spoke to described instead a trend of increasing duties, regulations and recording requirements¹⁰¹. This trend reflects contemporary demands of funding organizations for increased accountability and evidence of outcomes (Storeng and Behague 2014). But the renewed interest from international organizations and the consequent increased volunteer duties was also spurred by the linking of posyandu to the Millennium Development Goals (MDGs) Goal 4 is to reduce child mortality and goal 5 to improve maternal health, both directly related to the goals of the posyandu. Additionally, under the revitalization program, posyandu was linked with a new government program for pre-school education termed PAUD (Pendidikan Anak Usia Dini)¹⁰² aimed at preparing children for primary school with a view to achieving MDG 2 on universal primary education. This new program was run by a selection of senior volunteers, often in the same location as the posyandu. But whereas the posayndu was held monthly, volunteers were expected to hold PAUD at least four mornings a week for

¹⁰⁰ I am indebted to Jan Newberry for this insight.

¹⁰¹ At one posyandu I recorded fourteen different records that had to be filled out at or immediately after the posyandu. These included eight separate books comprising the SIP (Sistem Informasi Posyandu or posyandu information system), one form on nutrition that went to the puskesmas, and four forms for family planning that went to the kabupaten family planning office. Finally there was a visitors' book.

¹⁰² Prior to the national PAUD program pre-schools were offered only in the private sector

all children from age three to five years old. This greatly increased the workload of those volunteers who elected to join PAUD.



Plate 8: Toddler being weighed by a kader at a Posyandu in West Java

I attended twelve posyandu in seven different villages¹⁰³. The events were relaxed although they could be very busy. Usually there were one or two senior volunteers and two or three who had joined in the past five years. Since volunteers work in their own neighborhoods they know everyone who attends and they interact with them informally. If a volunteer has a child or grandchild under five they bring them along for weighing and health checks. At the same time there is a clear hierarchy, with attendants deferring to volunteers, and volunteers showing considerable respect for the village *bidan* and other attendant health staff.



Plate 9: Village *bidan* checks up on an infant during a posyandu

¹⁰³ All were in villages served by the two case study puskesmas, Pariwisata and.

Each posyandu that I attended felt different, reflecting the personality and style of the volunteers who ran them. Despite the many regulations they used their discretion in deciding where to hold the posyandu, how to integrate it with the PAUD pre-school, how formal it should be, how much consultation would occur and so on. For example, Kader Evi's posyandu, in a remote part of her village, had a relaxed feel to it as mothers gathered and lingered enjoying the social interaction. Kader Rohila's was lively as she organized the children to sing, march and clap while waiting to be weighed. By contrast, Kader Saria's posyandu was efficient but less social, as mothers passed by the five tables, all correctly laid out, but then left as soon as they had fulfilled the requirements.

Some of the senior volunteers had been working with posyandu since the inception of the program in 1982. They remained committed to the public health goals of the posyandu and saw themselves as playing a central role in their communities that often went beyond their posyandu duties. Indeed several had constructed their volunteer role into a life-long career, having decided not to seek other employment, and in one case not to marry. Others hoped to use it as a bridge to other employment¹⁰⁴ or encouraged their children to pursue formal careers¹⁰⁵ in related fields.

For example, Kader Fitriana saw herself as a role model in the community. She was the first mother in her neighborhood to use a medically trained bidan for the birth of her children rather than a local birth attendant. As she explained: "I was already aware of

¹⁰⁴ Although I was told this rarely happened, on my return visit to the field in late 2013 I found that one of the volunteers I worked with had moved on to paid government employment.

¹⁰⁵ One volunteer who won many awards encouraged her three daughters to train as teachers. The daughter of another exemplary volunteer recently qualified as a bidan and worked at the local puskesmas.

the importance of immunization, of giving birth with a bidan. I have to be a role model for other people. I feel bad if people get sick or if they don't go to the bidan. Previously there was no immunization." Now that these services are available through the posyandu, Kader Fitriana feels moved to encourage others to use them. Kader Evi is also committed to helping others and often accompanied her neighbors when they needed to go to hospital. In much the same way as Newberry (2006) described for PKK volunteers¹⁰⁶, these volunteers are using their role in the posyandu to build their moral identities as people committed to their communities. Putting one's community before oneself is highly valued within local Sundanese and Indonesian culture, and one's reputation depends crucially on being seen to be involved in community organizations and activities (Berman 1998, Newberry 2006). The Islamic faith also encourages an orientation towards serving the community and some volunteers make explicit reference to this as a source of motivation.¹⁰⁷ As described in Chapter 2, successive governments have built on this "community first" morality in their economic development programs. When I asked why they chose to become volunteers, several women responded by saying they wanted to "develop their communities" as well as themselves. The regular trainings, often held outside the village at the puskesmas or kabupaten capital, provide rare opportunities for women to broaden their horizons as well as enhance their social status. The behavior of these exceptionally active volunteers is recognized as desirable by the government. Volunteer Eti showed me the many

¹⁰⁶ Newberry (2006) is referring to volunteers under the PKK Women's Empowerment program. Many but not all health volunteers are also PKK volunteers.

¹⁰⁷ See Chapter 7 for an example of this

certificates she had received from trainings she had attended over the years and Kader Saria believed she had won the award for “best volunteer” at the kecamatan level in 2007 because of work in the community.



Plate 10: Kader hands a toddler a bag of homemade bean porridge.

But when I asked a group of volunteers why another volunteer seemed to get more awards and win more of the competitions for “best volunteer” or “best posayndu” I was told unequivocally that it was because she followed the regulations to the letter. The required five volunteers always showed up, the required five tables allocated to the different activities were always set up and labeled correctly, she always offered supplementary foods in the form of a bean porridge she had cooked early that morning, and most importantly, all of the activities were reported correctly with reports submitted on time. It appears that even in the era of decentralization with its related valuation of autonomy, compliance with regulations is valued over local initiative. This is despite the fact that in evaluations of the posyandu the highest attainable category is “mandiri” or self-sufficient.

I discovered what a “mandiri” posyandu looked like when I attended an evaluation of the posyandu carried out by a team from the provincial government. This was a high profile event hosted by the wife of the Kabupaten head, who is a strong supporter of the posyandu. The guests were received at the kabupaten office before visiting the winner of the kabupaten level “best posyandu” competition. I followed the entourage to the selected village and enjoyed the procession of singing school children that led us to the posyandu. It was immediately evident that this posyandu was far better resourced than any of those I had previously attended, and this reflected the higher socio-economic status of the local villagers. There was an impressive array of posters, bookcases filled with books, and even a computer and printer available. The posyandu I had attended elsewhere were held in cramped rooms or outside, and there were rarely

any bookcases or books in evidence, let alone computers. After showing due appreciation for the visible evidence of a superior posyandu, the evaluator interrogated the brightly uniformed volunteers, testing their knowledge of the 10 “clean and health behaviors” they were supposed to monitor among the village population. One volunteer was asked to demonstrate the correct manner of washing hands. The evaluator then offered advice about how the volunteers could improve their performance. Following this somewhat intimidating process, she then demanded that they share any concerns they had, and any innovations they had made. The only innovation that the kader could come up with concerned how they paid transport money to get to the posyandu, drawing on the dana abadi (village health endowment fund). In this context “innovation” seemed to refer only to attempts to overcome problems faced in implementing the regulations. Despite the rhetoric of innovation and initiative borrowed from contemporary neoliberal discourses of development¹⁰⁸, the way this evaluation was conducted suggests that compliance with regulations is actually valued more highly within this program than innovation.

As a mechanism for extending government to the village level and enrolling people into public health programs the posyandu is rather successful. For the posyandu I witnessed, attendance approached two thirds of the targeted population of under-fives and pregnant women¹⁰⁹. On the other hand, as an opportunity for community participation, the posyandu appears somewhat limited. Although some volunteers use the program to

¹⁰⁸ See, for example, Lieberman 2000

¹⁰⁹ Diligent volunteers are supposed to visit those who fail to attend in their homes, and some volunteers I spoke to claimed to do this, carrying the heavy weighing scales to outlying locations. Reasons given for non-attendance included employment and residing far from the posyandu location.

further their own agendas and build social status in their communities, for the majority of residents participation amounts to attendance at the posyandu and following the instructions of the volunteers, who are themselves following the regulations emanating from the Ministry of Health. This does not seem to match the description of the program as “from, by, for and with” the community.

Of course the use of the rhetoric of “community self-sufficiency” may achieve other goals. I witnessed requests for funding the building of a posyandu location that were rejected by the puskesmas and via the musrenbang process on the grounds that communities were supposed to provide the building themselves. Representing the posyandu as “owned by the community” thus lowers the cost of this public health program to the government. Labeling it as a part of the community might also be seen as a way of encouraging participation by people in “their” posyandu.

5.4 The Paradox of Government led Community Self-sufficiency

The musrenbang village plan and the posyandu community health post appear to encounter the twin tendencies of the state towards top-down planning and over-regulation. These tendencies have been noted in the literature. Scott (1998) focuses on the tendency of the state towards central planning and the inherent dangers therein; Weber (1999, 2013) regarded regulation as a defining characteristic of the bureaucracy while recognizing the tendency for excessive regulation to undermine individual autonomy and initiative. Those who designed the Desa Sehat program believed that it could achieve a more genuine form of community participation due to its unique design

as well as the more favourable context of decentralized government. The features believed to encourage village autonomy and community participation included the endowment fund that gave villagers some financial autonomy; the many saving schemes that generated independent funding for village groups; and the Forum Silaturahmi that were run by local leaders who were supposed to generate their own ideas and health development projects.

But despite its improved prospects, Desa Sehat was subject to a fundamental paradox that applies to all three of the programs, namely that the initiative for community self-sufficiency comes from government, not from the community. Typically, in government led community development programs in Indonesia, achieving the status of “mandiri” or self-sufficiency requires that a village must comply with program regulations and perform autonomy according to government criteria. This implies that in order to be capable of managing their own affairs they must first be educated by government in how to do this. The tendency is for participants to become increasingly enrolled in the program and consequently dependent on government. This is even the case when engagement with the government program is supposed to be temporary.

In the case of the Desa Sehat program the institution of the endowment fund did give villagers some degree of financial autonomy, lending credibility to the stated goal of self-sufficiency. Nevertheless, the government provided the capital fund and determined its level as well as making suggestions about appropriate use of the money. It was the government, not the villagers, who decided that Fora Silaturahmi would be

established and who determined the activities that the Fora would undertake.

Kabupaten health officials decided which villages would participate, what public health activities would be undertaken in each year, and the level of support from government.

The program could only happen with a massive increase in government intervention in the village yet the goal was for villages to become self-sufficient in health.

Perhaps this paradox applies to all government initiated community development programs. But in the Indonesian context there is often a further paradox. Government community development programs often claim to be building on an existing capacity for self-help and collective action within the community. Reference is made to indigenous cultural practices that will form the basis for the government program. For the *musrenbang* it is the traditional “*musyawarah*” process of reaching consensus through deliberation. The *Desa Sehat* program integrates the idea of the “*musyawarah*” into the *Forum Silaturahmi* and adds “*gotong royong*” mutual support, seen as providing a foundation for achieving “*mandiri*” self-sufficiency. Ethnographic studies reveal many examples of collective action in Indonesian villages that are based on practices such as *musyawarah* and *gotong royong* (Newberry 2006, Dasgupta and Beard 2007). This begs the question as to why government intervention is needed if these traditions are alive and well, at least in some communities. Tania Murray Li (2007) has pointed out a similarly flawed logic in development programs in Indonesia dating back to Dutch colonial times. She notes that during the “ethical policy” from 1910-30 colonial government development programs claimed to be re-activating a latent potential for community solidarity and mutual self-help. Similarly, the contemporary World Bank

program she analysed, the Kecamatan Development Program, also claimed to be building on an inherent capacity for community collective action, in order to promote self-government at the kecamatan level. Li refers to this as a contradiction in community development programs since they seek to inculcate values allegedly already present within the community. Furthermore, the level of intervention is intense, and communities are required to comply with a plethora of rules and regulations.¹¹⁰

Li (2007) questions the credibility of claims that government intervention can strengthen local institutions. But perhaps the use of these local cultural terms achieves other effects. Seen through the lens of a cultural theory of state, they serve the twin goals of making these programs familiar to targeted populations and legitimizing them to policy makers and donors. For many residents of Indonesian villages terms such as decentralization and participation are recent, as indicated by the use of the modified English terms “desentralisasi” and “partisipasi”. In order to render them familiar and desirable they need to be translated into terms that resonate with meaning and significance in the local context. Gotong royong is a powerful cultural trope that evokes a harmonious community where people help each other. As noted in Chapter 2, even though it has frequently been co-opted by government (Bowen 1986) it is still practiced and valued in Indonesian neighborhoods (Newberry 2006, Dasgupta and Beard 2007).

¹¹⁰ This sentiment was echoed by a villager I encountered who complained that the World Bank PNPM program operating in their village required such strict compliance with regulations that there was no room for local initiative. PNPM is a national program building on the experience of the Kecamatan Development Project studied by Tania Li (2007).

Within government rhetoric such Indonesian traditional values have sometimes been encouraged as a protection against cultural contamination from the West (Lubis 1964). For example, Ferzacca (2002) refers to claims that certain traditional health practices, such as “jamu” herbal tonics and fasting, will protect people from diseases associated with modern Western lifestyles such as obesity and diabetes. But in state development programs such as the Desa Sehat program “tradition” in the form of cultural practices such as gotong royong are presented not as a bulwark against modernity but rather as an avenue for achieving “development” in-line with global models and expectations.

Whereas “tradition” works for local audiences because it renders the program authentic and familiar, for international audiences, “tradition” makes a development project look feasible in the Indonesian context. This balancing act that requires programs to be aligned with the latest global development policy while simultaneously compatible with local cultural forms calls for a hybrid rhetoric combining global buzz words such as “participation” with local cultural tropes and practices. For example, the guidelines for the Desa Sehat program glide seamlessly between the concepts of decentralization, democracy and participation to the concept of gotong royong within the Forum Silaturahmi. In this way the program is presented as simultaneously in line with global norms of “development” and authentic in the Indonesian context.

5.5 The Centralization of the Desa Sehat Program

From 2001 to 2006 the Desa Sehat program operated as a decentralized program independent from the central Ministry of Health. The program was deemed successful

not only in Lahanbesar kabupaten but also at the national level. Pk Yudi, head of health promotion, proudly described how he was invited to the capital to give presentations on the program. Staff at the Ministry of Health in Jakarta were so impressed that they decided to replicate it nationally.

In 2006 the new program, Desa Siaga (Alert Villages¹¹¹), was launched. The Desa Siaga program retained the goal of promoting community self-sufficiency in health development, including sanitation, mother and child health and infectious disease control. The structure of the Forum Silaturahmi was retained but new levels were added at Provincial and central level. Although there were no longer any references to a health endowment fund, nor to community insurance schemes or community saving schemes, villages were expected to find their own funding from the village development fund or external government or non-government sources. Thus, the goal of village financial autonomy was retained.

Despite these similarities, the way in which the program was implemented shifted, and it became more similar to other centralized programs than to the original Desa Sehat program. For example, rather than phasing the activities and villages, Desa Siaga was implemented simultaneously throughout Indonesia. A second shift characteristic of centralized programs was the standardization and regulation of the program. The central Ministry of Health developed guidelines to be implemented in every kabupaten that were updated periodically, becoming increasingly elaborate and complicated. By

¹¹¹ The term “siaga” suggests a readiness for any health event such as a birth or disease outbreak. The idea is that through the program, not only government officials and health staff but everyone in the village should be ready.

2011 the program was renamed Desa Siaga and the guideline was fifty pages long (Ministry of Health, 2011c). It included indicators, measurements and targets had been absent from the original Desa Sehat program.

Under Desa Siaga every village was ranked according to their achievement of eight indicators. These included having an active village Forum Silaturahmi; having active volunteers working on the program; availability of basic health services on a daily basis at a village health post or assistant puskesmas; community organizations capable of disease surveillance and disaster preparedness; having funding available for the program from village development funds, from the community or outside sources; active engagement of the community and community organizations in health activities; having village regulations that provide a foundation for Desa Siaga; and compliance with “clean and healthy behaviors” (PHBS¹¹²). The idea of PHBS as a formula for health promotion predates the Desa Siaga program and it was included in Desa Sehat but under Desa Siaga additional behaviors were added. The list in the Guidelines includes 31 behaviors, including personal hygiene: washing hands with clean water and using a toilet; nutrition: eating fruit and vegetables every day; compliance with maternal health policy: attending the posyandu and using a bidan for childbirth; and infectious disease control: notifying a kader if there is an incident of disease in the household. In effect, all of the objectives of the original program in sanitation, mother and child health and infectious disease control, have been incorporated into a list of indicators of good behaviour on the part of every citizen.

¹¹² PHBS stands for Perilaku Hidup Bersih dan Sehat, or Clean and Healthy Life Behaviors.

Whereas under the Desa Sehat program solutions for public health issues were to be addressed through collective action via the Forum Silaturahmi, under Desa Siaga responsibility appears to have shifted to the individual. The idea that health is a matter for individual responsibility has been associated with neoliberal forms of government (Rose 1998, 1999, Briggs and Hallin 2007). In this context it is argued that government is transferring responsibility for health from the government to the citizen, thereby pushing responsibility for population health down to the local and individual level. In the case of Desa Siaga, rhetorical attempts to shift responsibility for health onto households and individuals are associated with a different form of governance, namely the increased regulation of everyday life and the penetration of a government rationality of surveillance into new aspects of household management. Every individual and household is now assessed by kader for their performance of a short-list of ten of the thirty-one “clean and healthy behaviours” twice a year. The underlying assumption of this form of governance is that people desire self-improvement but require guidance from government on how to achieve it. This departs from neoliberal forms of governance that involve promoting self-governance through reducing levels of government guidance and support (Hyatt 1997).

These attempts at governing citizens’ health behaviour appear to be only partially successful, however. From my observations, awareness of PHBS among the general population is limited. Attendants at one posyandu did not seem familiar with the term “PHBS” although volunteers assured me they were aware of some of the behaviors, such as hand washing with soap. But compliance depends on resources such as clean

water and soap being available and affordable. On the other hand admitting failure to perform such behaviors may involve embarrassment or loss of face. When I asked one kader to describe how she collected the data on PHBS she admitted that it was awkward asking direct questions, so she relies on observation. For example, she explained that if she visited a household and asked someone who was present in the household “do you eat fruit and vegetables every day?” the person would respond “bring me fruit and vegetables and I will eat them!” This comment suggests there may be a substantial gap between government expectations of how citizens ought to behave and what villagers in Lahanbesar kabupaten regard as feasible¹¹³.

In program evaluations for Desa Siaga each village is placed into one of four categories, with the highest attainable level termed “mandiri,” independent or self-sufficient. As noted in the previous section, the paradox is that a village can only achieve “mandiri” independence by complying with all of the government criteria, rules and regulations according to the government’s definition of health development. In this way “mandiri” is transformed from an aspiration that communities are alleged to have, into a target that can be measured by government. It is almost as though the meaning of the term “mandiri” has shifted under the program from its everyday meaning of “independence” to “full compliance”. Indeed there is nothing optional about Desa Siaga. Not only are all residents expected to follow PHBS, the kecamatan puskesmas must achieve 80% “Active” Desa Siaga in order to fulfil the minimum standards of service (“standard

¹¹³ The gap may be even larger in more remote areas of Indonesia. For example, Anna Lowenhaupt Tsing (1993) and Cameron Hay (2001) describe vague notions of government health policies in Sulawesi and Lombok respectively.

pelayanan minimal or SPM) (Ministry of Health 2011c: 14). The only thing left to be decided is *how* to achieve the targets. The intense form of governmentality departs from the vision of the original Desa Sehat program that involved villagers in developing their own responses to preventive health issues.

Despite these evident differences the transition from Desa Sehat to Desa Siaga went smoothly, according to my informants. Indeed some of the health personnel at the kabupaten and puskesmas level explained to me that Desa Siaga was “just the same” as Desa Sehat. The Forum Silaturahmi continued to function as previously and villages were allowed to keep their endowment funds, even though this was not a feature of the national program. Some villages even received additional tranches from the kabupaten government, although the interest they generated declined due to lower national interest rates.¹¹⁴ Health centers and village bidan continued to promote community saving schemes with varied success.

I attended several meetings at the kabupaten office at which members of the Fora Silaturahmi presented the results of their efforts to develop sanitation and other programs in their villages. During these meetings rankings were discussed and laggards challenged to do better. Some of the attendants, such as Ali, whom we met in Chapter 4, did seem to be committed to the ideal of community self-sufficiency. But overall there appeared to have been a dilution of some of the original elements. The

¹¹⁴In 2013, at 2% interest rate the capital fund of Rp 25 million generated Rp 500,000 per year (about US\$50). I was told that funds were often used to buy food supplements distributed at the posyandu, but one health volunteer who was treasurer of her local Forum Silaturahmi said the money was also used to buy materials to repair a collapsed building.

introduction of indicators and targets seemed to have reduced the scope for the Fora Silaturahmi to take their own initiatives and the idea, prominent in the earlier program, that government was merely a facilitator seemed to have been lost (Kabupaten Health Office, Lahanbesar 2005). Participation no longer seemed to be the central guiding principle. It had become dwarfed by another priority, namely the achievement of health targets.

My impression was that the kabupaten level Desa Sehat program had been co-opted by the central government and, as a result, had lost the very features responsible for its earlier success, such as the health endowment fund. But when I presented this interpretation to kabupaten health managers they had a more nuanced interpretation. For example, Dr. Mulyadi, Koratanah puskesmas head, argued that there was still room for local initiative within Desa Siaga, provided that the requirements and targets were met. Others pointed out that since it was a good program they were happy that other kabupaten were now benefitting from it. In the words of Bidan Erna: “one of the activities of the Desa Sehat program was to give birth to the Desa Siaga program. One positive impact of Desa Sehat was that it helped Desa Siaga to go well.”

But I was not alone in noticing a decline in its original focus on village autonomy. Dr. Heryanto who had now left the civil service, and was therefore under less pressure to support current policy, had also noticed a decline in community participation and self-sufficiency as the central government took over the program. In his words “they (central

government) make too many regulations, the community is spoon-fed, they should eat by themselves.”

The centralization of the Desa Sehat program coincided with shifts in the political landscape in Indonesia that involved a degree of re-centralization (Trisnantoro 2009). This is reflected in the 2004 amendments to the original 1999 laws on Regional Administration and Financial Balance (see Chapter 2 and Conclusion for a discussion of the implications of these amendments). Perhaps this explains why Desa Siaga was implemented according to a centralized style of government.

Another factor influencing the centralization and formalization of the program was the increasing pressure to achieve the Millennium Development Goals (MDGs). The MDGs appear as an explicit objective in the Desa Siaga guidelines. This goal was absent from the Desa Sehat program that was linked instead to the kabupaten program, Healthy Lahanbesar 2010. MDG pressure has encouraged a focus on achievement of targets and this seems to have over shadowed the emphasis on community self-sufficiency.

The Desa Sehat program may have been the victim of yet another trend in global development policy. The participatory development movement that dominated development discourses in the 1990s seems to have faded, replaced instead by various types of “pay for performance” models that reward citizens for compliance with indicators and targets (Magrath and Nichter 2012). As David Mosse (2004) points out, in order for a program to be deemed successful it is neither necessary nor sufficient for it to achieve its stated objectives. Rather it must be in line with current policy fashion. The

idea of community participation in development has lost its allure and can no longer command sufficient support from donors. Even though Desa Sehat was hailed as a success both at the kabupaten and national level, it has been superseded by the target driven Desa Siaga.

The same combination of factors that influenced the design of Desa Siaga, including the politics of re-centralization in Indonesia and pressure to achieve the MDGs, have influenced the decentralization process. In the following chapter I explore what a decentralized project looks like in the post-amendment era characterized by the co-existence of centralization and decentralization.

5.6 Conclusion

During the first decade of the 21st century global development policy shifted from “participatory development” to a “pay for performance” approach. Each of these global development discourses has infiltrated Indonesian health policy. The Desa Sehat program aligned with participatory development and its more recent incarnation, Desa Siaga aligns with the demands of the MDGs. My analysis of the two programs illustrates how Indonesian policy makers engage in a balancing act to present public health programs as simultaneously in line with the latest global development policies and authentic in the Indonesian context.

Chapter 6: Health Insurance for the Poor: the Co-Existence of Decentralization and Centralization

6.1 Introduction

Chapter 5 focused on a program characteristic of the early years of decentralization. At this time decentralization was interpreted to mean autonomy at every level right down to the village. In this Chapter I examine Jamkesda¹¹⁵ kabupaten health insurance, a program that reflects a slightly different interpretation of decentralization. Although Jamkesda appears to demonstrate similar principles of decentralization to the Desa Sehat program including “bottom-up planning”, and reliance on local knowledge to develop locally appropriate solutions, the “bottom” in “bottom-up planning” now refers to the kabupaten and there is less emphasis on village autonomy.

A comparison of these two programs suggests that the meaning of decentralization has shifted over time. I argue that the more recent interpretation emphasizing kabupaten autonomy emerged following the amendments to the decentralization laws in 2004. As described in Chapter 2 the amendments gave central government a stronger role in supervising the process of decentralization at the kabupaten level. As a result kabupaten level officials experience decentralization as a tension between kabupaten autonomy and central government control. Decentralization appears to be in constant competition with re-centralizing forces. This tension is reflected in the narratives of health managers analysed in Chapter 4 who argued that the central government interfered too much in

¹¹⁵ Jamkesda stands for Jaminan Kesehatan Daerah or Kabupaten Health Insurance

program implementation. In this chapter I show how the same tension plays out in program implementation.

Taking the example of health insurance for the poor I examine how kabupaten health managers negotiate the co-existence of centralization and decentralization in the post-amendment era. Kabupaten officials developed the kabupaten health insurance program, Jamkesda in order to compensate for perceived failings in the national health insurance program, Jamkesmas. In particular, Jamkesda addressed gaps in targeting in the national program, thereby achieving greater coverage of the poor. By demonstrating a feasible alternative mode of managing health insurance it presented a critique of the central government's style of programming. Although kabupaten officials' analysis of Jamkesmas focuses on program effectiveness there is more at stake here. The central government's continuing control over programming reflects a lack of trust in the competence and commitment of kabupaten level staff. Conversely kabupaten staff feel cheated out of the kabupaten autonomy guaranteed under decentralization. But beneath these political tensions lie different ideas about the proper way to manage health programs.

Kabupaten officials used Jamkesda to demonstrate their vision of decentralized government. In the process they developed an ethic of decentralization. By this I mean that they developed a set of principles and values that they believed should frame government under decentralization. The basic principle was the focus on the local, meaning that local problems should be solved based on local knowledge. The values

that should be applied in this process included flexibility and a willingness to negotiate. In the narratives of my informants this local “bottom up” approach is contrasted with the central government’s “top down” standardized and inflexible approach, illustrated by the central government insurance program, Jamkesmas. I refer to this contrasting approach as a centralization ethic.

The idea of a bureaucratic ethic was put forward by Weber in his analysis of the bureaucracy in the late 19th and early 20th century (1978, 1999). Weber described a bureaucratic ethos that distinguished the moral behaviour of office holders. The bureaucrat had a duty to apply his expertise to the purpose of the office. Although they were to abide by office hierarchy and follow instructions from their superiors, they were expected to develop loyalty to their office, rather than to a particular individual or leader. They were to comply with all rules and regulations with the result that all citizens would be treated equally so that outcomes would be “free of arbitrariness and unpredictability” (Weber 1999:100). During working hours personal considerations, relationships or moral convictions were to be left outside of the office.

In recent decades Weber’s bureaucratic ethos has come under criticism from politicians, social scientists and the general public reflecting shifting expectations of the bureaucracy. Bureaucrats are now expected to be responsive to the needs of individual citizens. While some argue that impersonal treatment is unethical (Lipsky 1980, Hertzfeld 1992), others consider rigid adherence to regulations and “red tapism” as inefficient and inappropriate in a context of rapid change (Du Gay 2000). In an attempt

to render the bureaucracy more responsive, market principles of competition and consumer demand have been introduced, reflected in a new emphasis on budgets, contracts and performance related pay (Rose 1999, Power 1997). In the context of such neoliberal reforms the bureaucrat has been denigrated as outmoded (Du Gay 2000).

In Indonesia, however, the bureaucratic ethos appears to be alive and well. Kabupaten health officials make frequent reference to laws and regulations and use these to construct moral accounts that justify their behaviour (Chapter 4). Democratic decentralization has done nothing to undermine this bureaucratic ethos. On the contrary, adherence to a bureaucratic ethic is needed to demonstrate that the bureaucracy has really reformed and is no longer subject to the patrimonialism of the New Order. New Order rhetoric framed the bureaucracy as an extended family with the boss at each level acting as a father figure and President Suharto as the Father of the Nation (Mulder 1998). Counter to the Weberian bureaucratic ethic, the primary concern of office holders was to develop a personal relationship with their boss and to keep the boss happy. This was far more important for career development than achievement of specific outcomes. This logic is summed up in a term commonly heard during that era “asal Bapak senang” (as long as the boss is happy) (Hull and Hull 1995)¹¹⁶. The patrimonial system became associated with the ills of the New Order, namely corruption, collusion and nepotism. Hence the need, in the post-Suharto era, to demonstrate a move away from patrimonialism and towards a more technocratic

¹¹⁶ I encountered this logic first hand while working for a British Aid project located within BULOG, the Food Logistics Agency from 1989-91

bureaucracy, where bureaucrats focus on getting the job done rather than on keeping the boss happy. This post-reform bureaucracy is closer to the rational bureaucracy described by Weber (1999, 2013).

In this chapter I argue that both the decentralization ethic developed by kabupaten government officials and the centralization ethic that they critique fit within Weber's bureaucratic ethic since both entail following the goals and regulations of office in order to uphold the value that everyone should be treated equally. The bifurcation of the bureaucratic ethic into distinct centralization and decentralization ethics reflects the tendency of decentralization to bring to the fore internal divisions within government.

Following my analysis of the kabupaten perspective on health insurance for the poor, in section 6.6 I turn to the perspective of village health workers. Whereas kabupaten officials saw Jamkesda as good example of how decentralization was being implemented in the kabupaten, village health workers claimed it undermined village self-sufficiency, the goal of the earlier decentralized program described in Chapter 5, the Desa Sehat program. This presents a paradox if one decentralized program, Jamkesda, is undermining another decentralized program, Desa Sehat. Again this suggests that the meaning of decentralization has shifted over time, and that less emphasis is being given to village autonomy in the post-amendment era.

In the final part of the chapter I shift perspective once more to explore the impact of health insurance schemes on the relationship between citizens receiving insurance and the state. Whereas village health workers experience insurance as undermining

community empowerment, I suggest that health insurance may be generating a different form of empowerment, namely a sense of entitlement coupled with an increased confidence in expressing opinions and in dealing with government, either directly or via village level intermediaries. This emerging subjectivity of citizenship is reflected in a change in vocabulary. People no longer refer to themselves as “little people,” suggesting a lack of power, as was common in the past, but rather as “poor people” entitled to a better deal. These shifts in subjectivity reflect broader changes in the political climate following democratic reforms that marked the end of Suharto’s New Order style of government.

6.2 Health Insurance for the Poor in Indonesia

The expansion of government health insurance programs has been a key development in the post-Suharto era in Indonesia (Aspinall 2014). Up until 1998 compulsory health insurance schemes covered only the military and civil servants¹¹⁷, and those employed in the formal sector¹¹⁸. Collectively these schemes covered about 15% of the labour force (Aspinall 2014:4). Although government health services were heavily subsidized, the majority of the population had no health insurance coverage and hospital care was often beyond their financial reach, although private insurance was available for the few who could afford it.

¹¹⁷ The scheme for the military was termed Asabri, that for civil servants Taspen. Both were popularly referred to as Askes after the insurance company running them.

¹¹⁸ Formal sector employees were covered by Jamsostek (Jaminan Sosial Tenaga Kerja or Social Insurance for the Workforce). Jamsostek covered workplace injuries, death benefits and health insurance.

In 1998 the first program delivering health insurance for the poor was launched. The “kartu sehat” (health card for the poor) program was one component within a social safety net program delivered in response to the Asian economic crisis that had precipitated a dramatic increase in poverty. Research studies conducted at the time revealed a doubling in the proportion of the population categorized as poor; a drop in utilization of government health services even amongst the poor; and a lack of imported medicines, following the collapse of the Indonesian rupiah (Suryahadi and Soemarto 2000, World Bank 1999). In response, international donors, including the Asian Development Bank and the World Bank, helped fund the JPS (Jaringan Pengaman Sosial or Social Safety Net). In the health sector funds covered the purchase of medicines and medical equipment; payments to puskesmas and hospitals to cover the cost of health services for holders of the newly issued Kartu Sehat; and supplementary feeding for pregnant mothers and children under three years of age. Given the atmosphere of crisis, rapid implementation was prioritized over rigorous targeting. Health cards were issued by village heads, allegedly, in some cases, to their relatives and friends rather than to the most needy. Kartu Sehat did, however, lead to an increase in utilization of puskesmas and other government health facilities (Soelaksono et al. 1999). At the same time it set a precedent for government health insurance for the poor paving the way for later schemes.

The first of these schemes was established by President Megawati Sukarnoputri in 2003. It was termed JPK Gaskin (Jaringan Pengaman Kesehatan Orang Miskin or Health Safety Net for the Poor) and, in the new spirit of decentralization, it operated at the kabupaten

level “allowing local governments to design programmes that accorded with local needs” (Aspinall, 2015:5). In 2004 Megawati’s successor, President Susilo Bambang Yudhoyono, who was apparently less enthusiastic about decentralization, centralized the program as Askeskin (Asuransi Kesehatan Masyarakat Miskin or Health Insurance for the Poor) which was managed by PT Askes, the same private insurance company that managed health insurance for government employees. After four years Askeskin was replaced by Jamkesmas. The key difference was that management and fund dispersal was transferred from PT Askes, a private insurance company, to the Ministry of Health.¹¹⁹

In addition to the national Jamkesmas program local insurance schemes have flourished in the decentralization era. Democratically elected governments at provincial and kabupaten level have found health insurance schemes to be an effective mechanism for winning votes. At the same time they help build democratic legitimacy by demonstrating that the government is responsive to the needs of the people (Aspinall 2014). For example, Megawati Sukarnoputri, President from 2002-4 and Chair of the populist PDI-P¹²⁰ party, is still remembered in Lahanbesar kabupaten for her promises of “free hospitals”, while Joko Widodo’s¹²¹ popularity as Governor of Jakarta (2012-2014) was founded partly on his widely publicized policy of extending health insurance coverage to all residents. In Lahanbesar kabupaten I witnessed local elections during

¹¹⁹ PT Askes continued to be involved in verification of cardholders. The move was justified in terms of a necessary separation of payer and verifier (Ministry of Health 2008:8).

¹²⁰ PDI-P is the Partai Demokrasi Indonesia – Perjuangan or Indonesian Democratic Party of Struggle

¹²¹ Joko Widodo, popularly known as Jokowi, is also a member of PDI-P. He was elected President of Indonesia in 2014

which political parties competed by offering their own health insurance schemes to voters. The competition to win votes has resulted in a plethora of overlapping schemes being offered at national, provincial, kabupaten and city level, leading some to question whether these schemes are financially sustainable in the long term (Aspinall 2014). In this Chapter I focus on the relationship between the national Jamkesmas program and Lahanbesar kabupaten's Jamkesda health insurance program.

6.3 The Jamkesmas National Health Insurance Program

The goal of Jamkesmas, as stated in the Petunjuk Teknis¹²² (Technical Instructions), is to improve the “quality, equity and access” of health services to the poor (Ministry of Health 2009:3, 2012:1). The program aimed to cover the poorest 40% of the population, those occupying the lowest two quintiles in socio-economic data collected by the National Central Statistics Agency (Badan Pusat Statistic or BPS). According to BPS data from the most recent national survey in 2008, 17.4 million individuals fell into the lowest two quintiles, and were therefore included in the quota to receive health insurance cards under Jamkesmas in 2008. The Ministry of Health issued the cards and distributed them to puskesmas throughout the country, from where they were handed out to the individuals named on the cards. These cards could be used at any government puskesmas or hospital and entitled to user to “free” health services,

¹²² The Petunjuk Teknis or Technical Instructions are the guidelines provided by the central Ministry of Health and distributed to all provincial and kabupaten offices in order to ensure that standard procedures are followed in the implementation of the program. The Instructions detail who is eligible to receive the insurance; what the insurance covers; who is responsible for managing the program; how funds will be disbursed; the reporting requirements and how the program will be evaluated. The Technical Instructions are updated each year. The 2012 version ran to 82 pages. The manager of the insurance program in Lahanbesar kabupaten had a detailed knowledge of the instructions and could refer me to particular pages in response to my queries.

including medical consultations, medicines and transport to another health facility for referrals. The precise details of the program varied overtime as laid out in annual Instructions to government officials and hospital staff responsible for implementing the program (Ministry of Health 2008, 2009, 2010, 2011d, 2012). At any one time, however, the program was standardized with no scope for variation between regions¹²³.

Funding arrangements also evolved over time. Initially a capitation system was adopted according to which puskesmas were provided with funding based on the number of card holders in their administrative area. They received Rp 1,000 per month per cardholder (about US\$0.10) paid into a local post office account directly from the central Ministry of Health. The kabupaten health office was not involved. Health centers could use this money to cover the cost of medical services, medicines, consumables, transport and other operational costs of the puskesmas (Ministry of Health 2009). In 2010 this capitation system changed to a system based on claims submitted by the puskesmas for actual services delivered to cardholders. Operational costs were covered by a new fund, BOK¹²⁴, or from the local government budget (Ministry of Health 2010, 2012). Under the claims systems reimbursements were channelled through the kabupaten health office before reaching the puskesmas. Nevertheless, under both funding systems the Ministry of Health in Jakarta managed the program and controlled the funds.

¹²³ In practice, puskesmas and hospital administrators sometimes adapted the instructions in line with local resource availability leading to unpredictable and variable charges being levied.

¹²⁴ BOK stands for Biaya Operasional Kesehatan or Health Operational Costs. BOK is funded from central government. In 2011 it was paid directly to puskesmas with each puskesmas receiving the same amount. From 2012 BOK funds passed through the kabupaten health office who distributed the funds among the puskesmas according to criteria including puskesmas visit rates.

By the time of fieldwork in 2012, Jamkesmas represented the most comprehensive government health insurance program for the poor. Despite the decentralization laws, Jamkesmas was managed in a highly centralized manner, including data collection by BPS in Jakarta and reimbursement to puskesmas by-passing the kabupaten government. This centralized style prompted criticism from lower levels of government.

6.3.1 The Kabupaten's Critique of Jamkesmas

Kabupaten health officials responsible for implementing Jamkesmas saw it as a good program since it provided health insurance to the poor. But they were critical of the way in which the center retained control of the funding and management of the program. They argued that the budget should be controlled locally, not by Jakarta. In their view the current arrangement undermined the autonomy of the kabupaten. Jamkesmas was not in line with the law on decentralization. According to Pk Yudi, head of Health Promotion, whom we met in Chapters 4 and 5:

One of the budgets that has not been switched with regional autonomy is that for Jamkesmas health insurance. The kabupaten should be given financial control over funds for our (Jamkesmas) insurance. Meanwhile, (the kabupaten) is still dependent on the center. The kabupaten must claim from the center in line with the regulations for Jamkesmas.

Pk Yudi used Jamkesmas as an illustration of his broader argument, outlined in Chapter 4, that the central government was half-hearted about decentralization and was interfering too much in the day to day affairs of the kabupaten.

But kabupaten health officials had a further objection to the Jamkesmas program. The “top down” manner in which targeting was conducted not only flouted kabupaten autonomy it also failed to achieve its stated objective of reaching the poor. Bu Erna, who managed the health insurance program, complained that “the center” had sent enumerators from BPS to households in “their” villages to collect data on who was resident in each household and their economic status. The central level BPS staff¹²⁵ doing the data collection never shared the data with the kabupaten health office, so it was not possible for the kabupaten staff to verify the quality or accuracy of the data. This data was subsequently used to draw up lists of those eligible to receive health insurance. Health insurance cards were then issued, one card for each eligible person. The cards included the name and address of the person who was entitled to use it. Several months after the original data collection these health insurance cards were “dropped” from the central Ministry of Health, and distributed in the villages, yet again by-passing the kabupaten health office. But, according to local health workers, in many cases the people encountered in the villages did not exactly match the names printed on the cards and some of those named did not exist or had moved away. Kabupaten staff explained that this rendered many of the cards useless while leaving numerous poor people without the health insurance they should have been entitled to.

The kabupaten health office carried out a survey in one village to provide evidence for their claim of mis-targeting. I attended a Jamkesmas workshop, attended by representatives from government hospitals, private hospitals and related kabupaten

¹²⁵ The Central Statistics Agency, BPS, is one of the government institutions that was not decentralized.

government offices at which the results of this survey were presented. Using a Power Point presentation, Pk Yudi indicated that out of 1,791 inhabitants who were included in the Jamkesmas quota only 354 (19.7%) had valid cards. In the remaining cases the data on the card was incorrect (date of birth, name, address) rendering the card unusable, and in some cases the person specified on the card had died. The results of this survey were submitted to the central Ministry of Health but no response was forthcoming.

The inflexibility of the center was replicated at the site of the hospital. Hospitals reportedly rejected cards with even the smallest mistake, such as having one incorrect letter in the name. I encountered one such case at a “lansia” (village health post for the elderly) where a woman complained to me that she could not use her Jamkesmas card at the kabupaten hospital because the age on the card was incorrect. Instead of her age, 54, the age on the card was that of her child, who was five years old. The local volunteer had written the correct age over the incorrect one, and the woman was able to receive free health services at the puskesmas. However, when she went to the hospital they rejected the card because of the false age. The woman had to borrow money to pay her hospital fees and couldn't afford the recommended follow-up visit.

In 2012, after Jamkesmas had been running for four years, the Ministry of Health re-issued its insurance cards based on the latest BPS national survey of 2011. The quota was increased from 76.4 million to 86.4 million. The basic design of the program did not change, but the system for distributing the cards was modified to include a role for the kabupaten in monitoring the process. When the original cards were issued in 2007 they

were sent to puskesmas from where they were distributed to the named individuals on the cards. At that time, there was no systematic verification of how many cards were received or distributed. For the new cards a rigorous method of verification was put in place.

First the cards were sent to the kabupaten health Office. I witnessed the arrival of 47 boxes, one for each kecamatan, each filled with several thousand laminated blue cards. According to the packing list there were 730,366 cards. Each card had the name and address of the recipient.



Plate 11: New Jamkesmas cards arrive in Lahanbesar, December 19, 2012

I helped staff from the health insurance section at the kabupaten health office to count the cards from each village to check that they matched the number on the distribution list. The cards were then sent to each of the villages where kader and neighbourhood heads (RT)¹²⁶ distributed them to those named on the cards and recorded errors. These errors were then submitted to the Family Planning Office (BKKBD)¹²⁷ and entered into an excel table with columns for the number of cards with the “wrong name,” “wrong address,” “wrong birth date,” “wrong socio-economic category,” “died,” “moved,” “not known” “torn or broken” and “other”. Based on this verification process the new cards appeared to be more accurate than the previous ones. At the time of fieldwork the analysis was incomplete but according to my local kecamatan office 92% of cards for this one kecamatan were correct and only 8% incorrect. Nevertheless, there were still many people who were not included in the quota, and for the 8% with invalid cards, no prospect of new cards being issued or incorrect cards being replaced.

When I asked a staff member from the Ministry of Health in Jakarta about the targeting process she explained that, as a poverty reduction program, Jamkesmas was regulated by a separate government body, the Tim Nasional Percepatan Penanggulangan Kemiskinan or TNP2K (National Team for Acceleration of Poverty Reduction). This team was located within the Vice-Presidential Secretariat and operated only at the central government level. All poverty reduction programs under its purview were obliged to use

¹²⁶ RT stands for Rukun Tetangga meaning harmonious neighborhood. The RT also refers to the elected head of the RT neighborhood, an official but unsalaried position occupying the lowest level in the government administrative hierarchy.

¹²⁷ BKKBD stands for Badan Koordinasi Keluarga Berencana Daerah or kabupaten office of the Family Planning Coordinating Agency.

the same data set from the Central Statistical Agency, BPS. Therefore the staff at the Ministry of Health had no choice in the matter. Re-issuing cards that were printed incorrectly was also beyond their control because the information concerning errors would be sent to TNP2K, not to the Ministry of Health.

When I enquired further why a local data base could not be used she hinted that there was a concern about fraud because: “perhaps they will just issue the cards to their relatives.” This suggests that the centralized style in which Jamkesmas is managed reflects a lack of trust of the central government in the regional governments. This interpretation was shared by Pk Yudi, Bu Erna and others at the kabupaten level. As a result central government officials appeared to trust the BPS data, collected by centrally controlled staff with no vested interest in the locality, more than they trusted the reports from the field. BPS data collection procedures are designed for national scale monitoring and not for targeting of poverty programs. Nevertheless, these data became more real to the central government officials than the people they were supposed to refer to, who, in reality, had different names, addresses or ages than those recorded in the database. Scott (1998) draws attention to this tendency for centralized planning processes to lose touch with reality, and argues that such blindness ultimately leads to the failure of large scale centrally planned programs. The statistics, maps and other tools of planning take on their own reality, oversimplifying the real world and failing to take account of contingencies including the unpredictable behavior of citizens enrolled in these programs. Similarly, the Jamkesmas program with its fixed statistical data set failed to account for the geographical and economic mobility of the target population.

Verdery (1996) takes the argument further noting that, in the case of Romania under the Soviet Union, files seemed to become more real than the people they were supposed to represent, regardless of whether the data contained in the files was true or false. Scott and Verdery's analyses suggest that the reliance on data rather than field reports in the Jamkesmas program is not an isolated anomaly but rather a common tendency of (over)centralized state planning.

The Ministry of Health did acknowledge that the quota covered by Jamkesmas did not cover all of the poor, and their solution was that local governments should fill the gap with locally funded supplementary programs. According to the Instructions for 2009:

In carrying out the Jamkesmas program the Central Government, through APBN¹²⁸ supports the payment of operational costs for a targeted population of 76.4 million individuals although in the field one still meets many members of the community who have not yet obtained this opportunity so it is hoped that regional governments will make up the funding shortfall... (Ministry of Health 2009:3¹²⁹).

Elsewhere this is stated more strongly as the responsibility of the kabupaten government. For example, in the Instructions for 2010 and again in 2012: "If there are still poor people outside of the data from TNP2K then their health insurance becomes

¹²⁸ Anggaran Pendapatan Belanja Negara or State Income-Expenditure Budget

¹²⁹ "Dalam pelaksanaan program Jamkesmas ini Pemerintah Pusat melalui APBN mendukung pembiayaan khususnya untuk operasional pelayanan dengan sasaran sebanyak 76.4 juta jiwa namun dilapangan masih banyak ditemukan masyarakat belum mendapat kesempatan maka diharapkan pemerintah daerah dapat menyediakan anggaran kekurangannya" (Ministry of Health 2009:3)

the responsibility of the regional government in that area.” (Ministry of Health 2012: 7¹³⁰).

“Responsibility” here refers to financial responsibility. Kabupaten were expected to fund supplementary insurance programs from their own budgets. Thus, the failure of the centralized program translated into a financial burden for the kabupaten governments. Despite the implicit acknowledgement of failure in the capacity of Jamkesmas to reach all of the poor, the central Ministry of Health emphasized that kabupaten programs must be in line with Jamkesmas regulations. As long as these regulations were followed, kabupaten were free to take their own initiative in designing and implementing regional health insurance programs. Many, but not all, kabupaten did indeed develop programs according to various different models. A survey undertaken by SMERU¹³¹ in 2012 and quoted in Aspinall (2014:6) “found that 245 of 262 kabupaten that provided information had some sort of local health financing scheme.”

6.4 The Kabupaten’s Response: Jamkesda Kabupaten Health Insurance

Lahanbesar kabupaten health office seized this new opportunity and developed a program they called Jamkesda, with the “da” referring to daerah or region¹³². The distinctive features of Lahanbesar’s Jamkesda were that it was funded by local government, it relied on local data and it did not use a fixed quota for targeting.

¹³⁰ “Apabila masih terdapat masyarakat miskin dan tidak mampu diluar data yang bersumber dari TNP2K maka jaminan keshatannya menjadi tanggung jawab Pemerintah Daerah (Pemda) setempat.”

¹³¹ SMERU stands for Social Monitoring and Early Response Unit, an independent research organization based in Jakarta, Indonesia.

¹³² Many but not all kabupaten programs were called Jamkesda

The assessment of eligibility for Jamkesda was based on data collected by the Family Planning Department. This data is collected by kader who live in the neighbourhoods where they collect the data, and they update it each month. Detailed information on socio-economic status is recorded and citizens are stratified into five wealth categories. Although collected for monitoring the uptake of family planning methods this data is used by other departments and programs. At the kabupaten level it was widely considered to be more accurate than data from BPS. For the Jamkesda program it was decided that those falling into the lowest two categories of poverty would be eligible for kabupaten health insurance coverage under Jamkesda.

A person wishing to make an insurance claim under Jamkesda needed to obtain several letters including seven signatures that validated their poverty level and medical needs. These letters were obtained from the village bidan, village head, puskesmas, family planning office and other local government offices. For services at hospitals outside the kabupaten a further verification process was required including a letter from the kabupaten health office. The letters were then presented to the hospital administration when the person needed medical care. Because the kabupaten government had limited funds compared with the central Ministry of Health, Jamkesda was more restricted both in terms of health facilities and financial coverage. Whereas a Jamkesmas health card could be used at a government puskesmas as well as a hospital and there was no financial limit, under Jamkesda puskesmas visits were not covered and an individual could claim a maximum of Rp 2 million (about US\$200) three times a year for hospital care only. This limit was not always enforced, however. Bu Erna, head of the Insurance

Section of the kabupaten health office, explained in a meeting on health insurance that in practice it was difficult to refuse a patient seeking assistance beyond this financial limit. This suggests that the guidelines for Jamkesda were open to negotiation.

For people using the insurance Jamkesda was regarded as less attractive than having a Jamkesmas card because of the cumbersome process of obtaining all of the letters and the more limited financial coverage. But for kabupaten health officials Jamkesda offered a superior means of targeting the poor and a fairer way of running the program. For them, Jamkesda exemplified a decentralized approach while simultaneously showing up the shortcomings in the centralized approach. When describing Jamkesda to me they emphasized how they drew on “local knowledge” to develop a program that is oriented towards overcoming problems as they arise. In this sense it was “bottom up planning.” It was also flexible in its definition of poverty recognizing that individuals could move in or out of poverty over time. Thus “the poor” were not a fixed entity as implied by the central quotas. As Bu Erna explained:

Within these categories (the lowest two socio-economic categories from the Family Planning data) there are those who have Jamkesmas cards and those who don't. For those who don't if they are sick and they need a referral to hospital, they can get funding from Jamkesda. They don't use a card. The poor cannot be fixed (“dikunci”). People can become poor because of health costs. The family planning office, village bidan and village officials survey in the field if they are really poor, then they make a recommendation to family planning.

Although she makes no direct reference to “the center” her description of the kabupaten program contains an implicit critique of the center’s Jamkesmas insurance program. The kabupaten voice emerges through a series of implied binary oppositions. In a properly targeted program all of the poor would be covered, but we find that “there are those who have Jamkesmas cards and those who don’t”. Whereas the central program, Jamkesmas, misses people, Jamkesda includes all of the poor: “for those who don’t (have a card) if they are sick and they need a referral to hospital, they can get funding from Jamkesda”. The second key point is that “they don’t use a card.” And this is because “the poor cannot be fixed”. This is an implicit criticism of the centre’s use of fixed quotas that cannot accommodate people who become poor. She then demonstrates the kabupaten’s more sophisticated understanding of poverty: “people can become poor because of health costs”. Again this is a critique of the center’s use of fixed quotas. Finally, she illustrates how the kabupaten exercises discretion on a case by case basis “The family planning office, village bidan, and village officials survey in the field if they are really poor, then they make a recommendation to family planning.” The overall impression is of a flexible approach oriented towards solving problems as they arise, that contrasts with the rigid, blind approach of the center.

6.5 A Decentralization Ethic

I contend that through Jamkesda, kabupaten health officials are performing their own distinct style of decentralized government, constructed in opposition to their perception of the center’s outdated centralized style of government. Although both insurance

programs have the same objectives, to provide insurance coverage for the poor, and they are being implemented under the same national policy, kabupaten officials are using their local version to demonstrate what they regard as a superior approach to health governance under decentralization. This approach is articulated through a kabupaten decentralization ethic, in opposition to their perception of an inferior centralization ethic. The basic principle of the decentralization ethic is that government policies and regulations should be adapted to local needs and situations. This involves the application of local knowledge, flexibility and a willingness to negotiate. The centralization ethic, with its emphasis on standardization to achieve equity, is critiqued by kabupaten officials because it cannot meet local needs due to its inflexibility.

But although the decentralization process has not undermined the bureaucratic ethic it has revealed internal divisions in how it is interpreted. As the above analysis of Jamkesmas and Jamkesda reveals, there are now two distinct bureaucratic ethics in operation, a centralized and a decentralized one. At first sight the centralized ethic, founded on standardization to ensure equity in provision of government services, appears closer to the Weberian bureaucratic ethos than does the decentralization ethic with its emphasis on flexibility in adapting to local realities. Nevertheless I would argue that both of these bureaucratic ethics retain the fundamental principles of compliance with rules and equal treatment. The decentralization ethic then re-interprets equal

treatment to require adaptation to local circumstances in cases where standardized solutions do not match local realities¹³³.

The co-existence of two distinct bureaucratic ethics within the same government challenges the idea of the unity of the state that is implied in some state theories. For example, Marx argued that the state operates in the interests of the owners of capital, implying a unity of interest and intent within the state apparatus (1978 [1848]). More recently, anthropologists Scott (1998, 2009), Ferguson (1999, 2006) and Roitman (2004) continue to convey the impression that the state is a monolithic entity. Their studies of relations between citizens and the state rarely probe inside government offices to explore internal differences. Contesting this unitary view of the state, Painter (2006) argues that the state has many voices, and that this is inevitable given the complexity of government administration. According to Painter inconsistency is an integral feature of the state. But he also argues that public officials spend a great deal of time and energy trying to make the government look consistent. By contrast kabupaten officials in Indonesia use their interpretation of decentralization to reveal internal differences and to show up the central government as ineffective. During official meetings on health insurance as well as in private conversations kabupaten and kecamatan officials repeatedly criticized “the center” in a manner that would have been unheard of under the New Order. In Chapter 4 I argued that the critical stance adopted by kabupaten

¹³³ In this sense government decentralization poses an ideological alternative to the New Managerialism as a mechanism for allowing responsiveness to local demands without the introduction of market mechanisms. On the other hand the New Managerialism introduces its own brand of decentralization through the contracting out of government services to (local) private companies (Rose 1999, Manor 1999).

officials towards central government reflects new lines of accountability under the decentralized government structure. Kabupaten officials are no longer accountable to central government to the same extent as previously. But their criticism of the center also reflects the political tensions that emerged following the amendments to the decentralization laws in 2004. By strengthening the role of the central government the amendments placed pressure on kabupaten governments to maintain the kabupaten level autonomy that they felt entitled to under decentralization. Kabupaten officials' performance of a decentralization ethic operates not only as a critique of the centralization ethic as seen in Bu Erna's description of Jamkesda. It also operates as an implicit critique of the central government's tendency to encroach on kabupaten autonomy by extending the centralization ethic into domains that should rightfully be governed according to the decentralization ethic. This is reflected in Pk Yudi's argument that "the kabupaten should be given financial control over funds for our (Jamkesmas) insurance." Their performance of the decentralization ethic under Jamkesda demonstrates that they would be quite capable of managing the Jamkesmas budget as well.

In this chapter I have used the Jamkesmas and Jamkesda health insurance programs to illustrate the contrasting ethics of centralization and decentralization and the way in which these ethics reflect underlying tensions between central government and kabupaten government under decentralization. At the same time the two programs also demonstrate how centralization and decentralization co-exist in practice. Even though Jamkesmas and Jamkesda compete with one another at the ideological level they

complement one another at the point of implementation. Jamkesmas provides a sustainable source of funding for health insurance while Jamkesda supplements Jamkesmas by covering people left out of the centrally funded program. In this way, the two insurance programs provide an example of the co-existence of decentralization and centralization within the same health insurance policy.

6.6 The Village Health Worker Perspective: Health Insurance Undermines Community Self-sufficiency

Kabupaten health managers critique the way in which Jamkesmas is implemented but they are not opposed to the idea of government health insurance, seeing it as necessary to help the poor. Several village bidan and kader presented a different critique. They argued that government health insurance programs undermined local saving schemes that promoted community self-sufficiency. Within the Desa Sehat program, and later the Desa Siaga program, they had worked hard to develop community saving schemes such as “tabulin” (saving for childbirth) and “beras seliter” (one liter of rice saving scheme)¹³⁴ only to find that these schemes collapsed as soon as the national insurance schemes were launched. It seemed that once people knew that the government would pay they lost the motivation to save for themselves.

¹³⁴ See Chapter 5 for details of these schemes.

Bu Erna¹³⁵ developed tabulin while she was a village bidan. She was then promoted to the kabupaten health office where she became head of the health insurance section.

She explained:

After there was Jamkesmas and Jamkesda it (tabulin) stopped. So many mothers, when they came to give birth they didn't have the money ready. Then there was Jampersal¹³⁶Now the public has Jamkesmas, Jamkesda, Jampersal. Before there used to be families that sold things (to pay for childbirth) I also offered (to help out). Now they run to Jamkesda so there is no "mandiri" self-sufficiency any more.

Similarly, Bidan Ratna who ran a successful tabulin in another village, complained: "It was running well before Jampersal. It started in 2004 under the Desa Sehat program. Now it's already stopped because of Jampersal. It's better and more self-sufficient if there is no assistance (lebih baik, mandiri, kalau tidak ada bantuan)." Bidan Fatimah from Desalindah village added: "Before there was Jampersal the community was more self-sufficient with tabulin. They don't want to save anymore, they just want to convert their ID cards into money.¹³⁷" Bu Erna thought there was still a need for local saving schemes because government insurance did not cover all of the costs:

Actually the self-sufficiency of the community should not be lost but maybe there should be a shift in its function. They should continue tabulin because it's not only to cover the cost of childbirth. It's for transportation, or if, for example, the

¹³⁵ Bu Erna described tabulin in Chapter 5.

¹³⁶ Jampersal is short for Jaminan Bersalinan, a central government insurance program that covered childbirth costs for all mothers, regardless of socio-economic status. The program was started in 2011 and will be discussed in Chapter 7.

¹³⁷ Pregnant mothers must present their ID card to be registered for Jampersal

hospital is not ready with the blood (for blood transfusion) there is money from this saving. But they have the opinion ‘oh, now there is Jampersal, that’s enough already.’” Bidan Dwi, who works in a village located far from a hospital, elaborated on the same point: “We had community saving under the Desa Sehat and Healthy Alert program to pay for the cost of referrals (to hospital). Now, even with Jampersal, savings are still needed to cover transport costs for referrals. If you live in Kotapasar¹³⁸, fine, you pay Rp 10,000 (US\$1.00) to get to hospital, for those living far away the cost is much higher.

This interpretation of events was reiterated by other community bidan and by kader. These village level health workers experience insurance programs initiated by central government (Jamkesmas, Jampersal) as undermining the positive values encouraged under the Desa Sehat program initiated by Lahanbesar kabupaten government. This suggests that tensions between centralization and decentralization are experienced not only by kabupaten health managers asserting kabupaten autonomy but also by village level health workers promoting autonomy at the community level.

I presented the bidan’ argument that health insurance undermined village saving schemes at a focus group discussion involving six section heads¹³⁹ at the kabupaten health office. Since all of those present were already aware of my research, I launched straight into the specific topic of the reports from bidan that government health insurance was leading to the collapse of community saving schemes. Did this mean that

¹³⁸ Kotapasar is located on the main road a short distance from the main kabupaten hospital.

¹³⁹ The setting of this focus group discussion for section heads is described in Chapter 4.

government insurance was in contradiction with the government objective of promoting community self-sufficiency? I sensed immediate discomfort at my use of the term contradiction (“bertentangan”). Anthropologists have drawn attention to an Indonesian/Javanese avoidance of verbal utterances that appear conflictual or suggest contradiction (Berman 1998). This was likely reinforced by a felt need to defend government policy to an outsider as a matter of bureaucratic practice. But it was reluctantly admitted that government insurance, while not contradicting other programs, could constrain efforts to promote self-sufficiency. According to their interpretation, this simply meant that government health personnel needed to strive harder and take further initiatives to encourage saving schemes and other community empowerment efforts. Pk Dodi took the lead, explaining: “They don’t contradict each other, no. But the insurance programs do hamper the process of empowering the community and building self-sufficiency a little bit. Yes, not a contradiction but rather how can we as health personnel develop a strategy to unearth the potential of the community in health?”

Bu Tuti continued: “insurance does not kill off empowerment but we, those of us at the bottom, our health worker friends in the field, they have to be innovative. Perhaps, now that we have these national programs, we have to work towards synergy between tabulin and the national program. Empowerment of the community is part of the vision and mission of Lahanbesar kabupaten. We have a section for that under Health Promotion.”

Reiterating the argument of the community bidan, Pk Dodi proposed: "The saving schemes were established to pay for treatment. Now that is free of charge it can be redirected to pay for transportation and other needs. How can the mother prepare for the birth, for receiving a new member of the family? The new baby will need clothes, food, nappies, a place to sleep. Even though the cost of the birth is already paid by the government, tabulin should keep going and be redirected to these needs. For example, if the mother has saved Rp 400,000 (US\$ 40) by the time of the birth, is that enough to buy nappies, clothes, a place to sleep?"

Meanwhile, Drg Saipudin emphasized the importance of the government health insurance programs: "why do we have Jamkesmas and Jampersal from the center? Because we see that maternal and infant mortality are still very high, right? So we need to accelerate reduction in maternal and infant mortality through health insurance."

Pk Dodi added: "the national insurance programs are extremely beneficial to the people, without them deaths would increase." Whereas health insurance was a priority at the national level, community self-sufficiency was seen as a local priority, something that Lahanbesar kabupaten government was promoting. According to Pk Dodi: "We are promoting self-sufficiency in health services. Perhaps self-sufficiency can emerge on Java but off-Java they haven't got self-sufficiency yet, so the policy of the government is for the whole nation, it has an impact everywhere. Those who are already self-sufficient become less self-sufficient but the center is thinking globally for the whole nation. Perhaps in Lahanbesar kabupaten there are already some villages that are self-

sufficient, in this case we have to persist.” Bu Tuti added: “Empowering the community is a specific goal of Lahanbesar kabupaten”

Pk Dodi and his colleagues seemed to regard “self-sufficiency” as related to the objectives of this kabupaten government under decentralization, whereas government health insurance was a policy from the national government. Both programs were considered necessary and good and it was their job as government health program managers to ensure that both goals were achieved.

In the narratives of the bidan and the discussion of the kabupaten health managers arguments for “self-sufficiency” operate at several levels. Both the bidan and the kabupaten officials present “self-sufficiency” as something that citizens ought to be striving for, as a moral good. In Li’s (2009:4) words the bidan who implement local saving schemes are “educating desires” for self-sufficiency as part of their “will to improve” the community. In these moral accounts self-sufficiency is an end in itself, a goal that aligns with the global participatory development movement aimed at empowering people to develop themselves. At another level, as described in Chapter 5, “self-sufficiency” operates as a mode of governance involving intensive interventions that belie the stated aim of eventual withdrawal of government, once citizens have acquired the necessary skills to manage their own health development. For the bidan there is a third layer of interpretation. Tabulin saving schemes for childbirth helped them to build up a clientele and expand their private bidan practices in the village. Government health insurance schemes undermine these efforts both because insurance

premiums are lower than private practice charges and because mothers receiving Jampersal health insurance for childbirth tend to go to the puskesmas where they are seen by whichever bidan is on duty, not necessarily the village bidan. Perhaps it is not surprising, then, that bidan have been especially critical of the Jampersal insurance program for childbirth.

Although some of the bidan singled out Jampersal, others believed that all of the insurance programs contributed to the dissolution of the saving schemes and therefore of “self-sufficiency.” In their critiques, it was not only the central insurance programs that were under attack but also the kabupaten program, Jamkesda. This adds a further nuance to the argument. It is not just that the centralized insurance policy undermines the decentralized “self-sufficiency” policy; it is also that one decentralized program, Jamkesda, is undermining another decentralized program, the Desa Sehat program under which saving schemes were promoted.

Since Desa Sehat dates from the early years of decentralization while Jamkesda emerged later, this suggests that different interpretations of what a decentralized program should look like pertained at each time period. Desa Sehat epitomized the years prior to the 2004 amendments to the decentralization laws. At this time village autonomy was a top priority. Jamkesda reflects the post-2004 setting, when the focus shifted to kabupaten autonomy. By giving the center a stronger role in supervising kabupaten the 2004 amendments altered people’s understanding of what decentralization was all about. When describing decentralization to me, my informants

at the kabupaten health office tended to refer to the 2004 laws rather than the 1999 laws. Their experience of decentralization was of a tension between the center and the kabupaten reinforced by an ongoing perceived threat of further re-centralization. This may have led the kabupaten health office to focus on its relationship with the center and on the promotion of kabupaten autonomy in an attempt to stave off the clawing back of authority by the center. The issue of village autonomy assumed a lower priority and was left to the puskesmas and village levels. This is reflected in the focus group discussion when Bu Tuti stressed that it was up to the field staff to redouble their efforts to promote self-sufficiency and sustain community saving schemes.

6.7 Health Insurance and Citizen-State Relations

Whereas health providers lament the decline of community saving schemes, I never heard such regret from the general population. On the contrary, rather than feeling that they should be doing more to help themselves, ordinary people seem to be becoming more vocal in their demands for government health services. Government health insurance programs have given people a stronger sense of entitlement leading people to be more critical and liable to complain. In this way health insurance is contributing to a transformation in the relationship between citizens and the state, a point also made by Aspinall (2014:2).

The national Jamkesmas health insurance for the poor has been well advertised on television and in printed media. In Lahanbesar kabupaten health personnel including village bidan and kader have been very active in disseminating information about

Jamkesmas and about their own kabupaten program, Jamkesda. I found that people who had not heard of other government health programs knew quite a lot about the health insurance programs. This included mothers attending the posyandu, street sellers in the kabupaten capital and a family I met on the train to Jakarta. Knowing that the program offers coverage for the poor, people feel more confident about using health services and demanding what has been promised. During interviews and focus group discussions kabupaten health program managers reported that the health insurance schemes had resulted in a marked increase in the utilization of public and private health facilities, especially hospitals, as well as an increase in the number of complaints they received from the public.

Hoping to get a sense of how health insurance was viewed in my neighbourhood, I accompanied Kader (Volunteer) Rohila as she distributed the new Jamkesmas health insurance cards in January 2013. I had first met Kader Rohila at a village meeting for PKK volunteers, at which she had played a leading role. Ebullient and warm-hearted, Kader Rohila filled her days with volunteer work, running a PAUD pre-school in the morning and teaching at an informal madrasah¹⁴⁰ housed in the village office complex in the afternoon. With the arrival of the new insurance cards Kader Rohila found it hard to find a time when she would be free to distribute them in her neighbourhood. After several cancellations, I met Kader Rohila at the local photocopy booth where she was copying the forms that residents would need to sign to prove they had received the cards. As we made our way back to her neighbourhood she confided that she was a little

¹⁴⁰ A madrasah is a religious school for Islamic teaching.

apprehensive about the distribution. While she hoped that coverage would be better than for the old Jamkesmas cards she knew that not all of the poor people in her area would get cards. She anticipated that some people might be angry if they heard others had received cards and they hadn't. She would need to explain to them that that these decisions were made in Jakarta, she was simply the one distributing the cards. Luckily, she could then record their names for the kabupaten Jamkesda scheme. I asked whether other volunteers had had problems. "Not yet, but people may be talking behind their backs" she replied.

Kader Rohila carried a letter from the village head authorizing her to distribute the cards and our first task was to hand this letter over to the neighborhood head (RT). He was out but his wife wanted to know who was going to receive cards. Perhaps she also anticipated trouble from those who didn't receive one. At the first house all six family members received a card, but Rohila cautioned the mother against telling others who may not have received their cards yet. The mother was happy to receive the cards since several family members had not previously been covered. As she laboriously filled in the form indicating the six card numbers and names, signing her name against each one, she explained how she had used her old card frequently as she had dengue fever, typhus and high blood pressure. She even gave birth at the hospital in 2005 using her Jamkesmas card to pay for the service.

We passed a solid looking house, newly painted, where Rohila's younger brother lived. She explained that he is not eligible, but when we entered the dark interior of the

neighbors' house Kader Rohila handed over seven cards to a delighted elderly woman who said they had never received cards before. "Alhamdulillah!" (God Bless) she exclaimed. She asked for details about where she can use the card and was told she must go to the kabupaten hospital, not the city one, and she must take a referral letter from the puskesmas. At the third house we met a mother of seven. Her oldest was 19 years old and worked at a local factory, so she was not eligible to receive a Jamkesmas card. She should be covered under Jamsostek, insurance for employees in the formal sector¹⁴¹. All of the other household members are covered. Kader Rohila repeated her caution about not telling the neighbors and explained the decision is not hers to make. At the next house the woman recognized me from the local puskesmas. Although all her children got cards the name on one card was spelt incorrectly. Komarasari has been spelt Komalsari. Kader Rohila explained they can get a "letter of explanation." Three siblings lived in the next house with their spouses and children, totalling twelve people. None have ever had cards before, but they all received them this time. A mother related how her fourth child contracted typhus while in primary school. She had taken her to the local puskesmas where she was recommended to take the child to the hospital. Since they had no insurance card at that time, they feared the cost and kept the child at home. She had missed three months' of school and one of the teachers was very distressed and came to visit her at home to find out why.

¹⁴¹ According to the mother, her daughter feared using Jamsostek since it did not cover the cost of medications.

These vignettes suggest that Jamkesmas insurance cards are highly valued, and at least some recipients use them frequently. Rohila's apprehension that people who did not receive cards might become jealous suggests she thought most people in her neighbourhood would expect to get insurance cards, especially if they heard that their neighbour had one. This in turn suggests that people are beginning to feel a sense of entitlement to "free" health services.

While Kader Rohila feared jealousy and anger from neighbors disappointed by not receiving a card, what I encountered more often was confusion and frustration. People simply did not understand why some people received the cards while others did not, particularly where this occurred within the same family. Confusion was exacerbated by apparent shifts in policy over time. Under the earlier Askeskin program cards had been issued for families rather than individuals. With Jamkesmas there were many cases where only one family member had a card. For example, one mother explained how her second child who was rarely ill, had a Jamkesmas card, while her first child who was frequently sick, did not. In this way people seemed to experience the distribution of Jamkesmas cards as a lottery.

When I talked to people about their experiences using their cards I received mixed responses. Many were satisfied and grateful for the financial assistance that allowed them to use a hospital without fearing the cost. Others related tales of inferior service compared with those who paid out of pocket, including lengthy delays, neglect of patients, or having to pay for services, equipment or supplies such as blood for blood

transfusions. Whereas the Guidelines for Jamkesmas and Jamkesda promised improvements in quality, in practice chronically under-resourced kabupaten hospitals were overwhelmed with the increase in demand for their services precipitated by the insurance schemes. This resulted in poor quality services and frequent referrals to other facilities, including private hospitals, due to lack of medical personnel, equipment or beds.

Bu Hikmarini gave me a detailed description of her various encounters with the kabupaten hospital when I visited her at her recently built but tiny house in Desalindah village. Bu Hikmarini struggled to raise her six children due to uncertain income and frequent bouts of illness. She was behind on payments for her second daughter's high school¹⁴², while her oldest, who worked at a chain store in a neighboring village, had been unable to take up a scholarship to college that she had been offered. Both daughters helped Bu Hikmarini by accompanying her to the local puskesmas when necessary or by looking after the lively three year old twins, her youngest two children. Even the two middle school children needed to help out at times. But Bu Hikmarini did have some advantages. Her sister was a kader and her aunt was relatively well off, owning the only grocery store in the village¹⁴³. It was her aunt who insisted that she go to the kabupaten hospital when complications arose at the birth of her son in 2000, and who paid the Rp350,000 (US\$350) bill. Bu Hikmarini confided she would never borrow

¹⁴² At the time of the research, the central government covered the cost of tuition at primary (age 6-12) and junior high (age 12-15) school but not at senior high school (16-18).

¹⁴³ She also had a guest room where I stayed on several occasions

off anyone else because only her aunt understood her circumstances. It had taken her a whole month to pay her aunt back.

Luckily, by 2009, when she was due to give birth to the twins, Bu Hikmarini had Jamkesmas health insurance. The village bidan, Bidan Fatimah, urged her to go to the hospital without waiting for contractions. Bidan Fatimah obtained the referral letter and Bu Hikmarini's husband collected it from the bidan's house. A mini-bus was hired and Bu Hikmarini was accompanied to the hospital by her sister (the kader), her mother, her aunt and the village head, Pk Budi and his wife¹⁴⁴.

Bu Hikmarini was satisfied with the assistance she received while giving birth, although she had concerns about the subsequent care of her infant twins in the intensive care unit. As she explained:

I was immediately handled by a nurse. I was treated at the emergency room first, my blood pressure went up to 160. I was treated for one night in the emergency room. Then I was moved to the birthing room in the morning where my contractions were induced via an injection. I was induced at 8:00 am and at 9:30 am the twins were born. The first baby came twenty minutes before the second one. Five bidan helped with the second birth, the breach one.

Both babies then went into the intensive care unit for three days. She stayed at the hospital throughout. She described how babies had to share incubators and equipment:

¹⁴⁴ This was not unusual. Typically women going to hospital to give birth are accompanied by an entourage of family, neighbors and friends.

“There were insufficient facilities. When they wanted to give oxygen they would look for an available tube...if there wasn't one free they didn't use the oxygen.”

Her other concern with the intensive care unit was that some of the staff were impolite and angry. Her cousin, describing her experience in the same intensive care unit, said that she overheard the nurses talking about the babies whose parents were receiving the service “free”, meaning that they had government insurance. She overheard the nurses saying “the government hasn't paid us the money”. She inferred from this that the nurses were angry with the government and passed this anger on to the patients.

Like her relative, Bu Hikmarini also noticed discrimination in the treatment of those who used government insurance compared with those who paid out of pocket. Referring to a later occasion when she used Jamkesda kabupaten health insurance to cover the cost of care for one of the twins who was sick¹⁴⁵:

I, as someone in need, according to me it doesn't matter, the important thing is that my child gets better, but I do feel that they don't pay as good attention to those who use (insurance) letters from the village compared with those who don't use letters, really the service is different, they don't pay such good attention. So it's a bit, how shall I put it? Those who pay and those who don't pay, it's different.for those who don't pay if you haven't got your letters yet you are just left, so you can wait a long time...(Once you have your insurance letters) the service is good only there are those who like to get angry perhaps, I don't know, they're

¹⁴⁵ Although Bu Hikmarini had a Jamkesmas card her twin children did not, so she had to obtain Jamkesda health insurance for the twin when he fell sick.

annoyed or something, that often happens, most of them get into arguments with the patients.

Implicit in these accounts is the expectation that those using Jamkesmas and Jamkesda government insurance ought to be treated the same as those who pay out of pocket. When nurses treat “free” patients differently from those who pay, patients feel moral outrage, a sense that they have been wronged and humiliated. This moral conviction that all patients should receive the same treatment parallels findings from my previous research on health services undertaken in the same kabupaten in 2000. At that time I arranged focus group discussions in which villagers were encouraged to talk about their experiences with the government health services. Initially they were hesitant perhaps fearing negative consequences. My colleague, a well-known doctor, was able to put them at their ease by assuring them we were not connected with the government. Eventually, many narrated negative experiences including long waits at emergency, botched family planning and misdiagnosis. These narratives revealed their sense of what a “proper” health service would look like. In their moral critiques they emphasized equity and fairness in the delivery of government health services, regardless of poverty or education level of the patient. They felt they were getting a poorer service than others because of their poverty. At that time it was possible to apply to the village head for a “kartu sehat” (health card) for the poor. But even those who did not attempt to use such a card felt that they experienced discrimination simply on account of their poverty.

Despite their many grievances, however, no-one had voiced their complaints to anyone in an official capacity, not even the kader. They feared that any hint of a complaint would damage their relationship with health staff jeopardizing future visits to the puskesmas. One participant described her concerns:

I haven't told anyone at the puskesmas about my suggestions I wouldn't know who to go to. I wouldn't dare to make a complaint. I'd be afraid if I make a complaint and ask for improvement I will be disliked and then it will affect my treatment. I can't talk freely to the kader and I do not know any village representatives. (Magrath, 2010:7).

The health ethic expressed in this and other moral accounts from villagers I encountered in 2000 has endured. I found the same emphasis on equal treatment for all, regardless of socio-economic status or method of payment, when I returned to Lahanbesar in 2012. But whereas in 2000 people were afraid of voicing their opinions and there were no mechanisms for channelling complaints to government, by 2012 things had changed. Mechanisms for processing queries and complaints were being established, and people were less fearful of the consequences of expressing their views. Not only did people narrate their stories to me, they also communicated more freely with kader and other village leaders, including the village head in some cases. As members of the community with a semi-official status, these people were able to mediate between patients and the hospital administration. In this way the "citizen-state continuum" that pertains in Indonesia, with its proliferation of semi-official positions at the local level, operates not

only as a mechanism for facilitating the penetration of the state into daily life, but also, in the new democratic era, as a means for citizens to engage with the state in the pursuit of their own interests.

Pk Budi, enjoying his second term as popularly elected head of Desalindah village, was well known and respected for the help he provided to villagers who needed assistance with their health insurance. According to Bu Hikmarini:

From the beginning if there was someone who was sick, or someone died, he would assist straight away. He doesn't look to see if they are a poor person. Unlike those who came before him. I didn't know his predecessor personally but he would only assist if it were a relative of his, other people were treated indifferently. If there was assistance from any source he would call his relatives, those close to him, he wouldn't consider those in need, his relatives came first. ...The current head is unusual ("luar biasa").....He helps those who are well off, those who are not well off. And whenever he goes to help, his wife joins him.

One kader suggested that villagers were becoming too dependent on the village head. I visited Pk Budi at his home to find out more. By village standards his house was unexceptional apart from the larger than average vegetable garden that he enjoyed tending. I was ushered into a reception room barely large enough to contain two cushioned benches on either side of a low coffee table. Perched on the wooden cabinet that housed some matching crockery I noticed a small poster for the P3¹⁴⁶ political party

¹⁴⁶ Partai Persatuan Pembangunan or United Development Party

that Pk Budi had long supported. He described how, during the Suharto era, he had been ostracised (“dikucilkan”), but now anyone could belong to any political party. Turning to the subject of health insurance, Pk Budi justified his prominent role by explaining how difficult it was for ordinary villagers to deal directly with the hospital administration. As he put it: “I’m worried about administrative miscommunications, I am afraid that emotion will emerge, war of words, a lot of talking. The public are not yet aware of the latest regulations. Quarrels have occurred, there was a case where (insurance) was rejected even though the letters were already arranged, it’s more or less like that. “

Pk Budi is a frequent visitor at puskesmas Koratanah where he obtains referrals on behalf of patients, sorts out letters for Jamkesda kabupaten health insurance or catches up on the news with the head or other staff. Where issues cannot be resolved at the puskesmas or the hospital Pk Budi takes them to the kabupaten health office. He is not alone, and staff of the kabupaten health insurance office reported that they receive many complaints each day from individuals or from people representing them, including local non-government organizations and the media. Dealing with such complaints, by telephone or in person, takes up a considerable amount of staff time. On one of my visits to her office, Bu Erna explained a complicated case that she was currently dealing with. Her desk was covered with documents attesting to the veracity of the patient’s claim to health insurance, yet it had been denied by an out of kabupaten hospital. In the end, she telephoned the hospital and demanded that the administrator read the Instructions for Jamkesmas health insurance, itemizing the exact page and paragraph

that referred to the case. These kabupaten office staff, like Pk Budi the village head, regard themselves as defending patients in relation to the hospitals.

The increased sense of entitlement engendered by government health insurance schemes, and the related increase in the incidence of complaints about health services, suggest that a transformation is taking place in the relationship between citizens and the state. Citizens are gaining greater confidence in dealing with the government, either directly or through local mediators. This transformation is reflected in a shift in the way villagers refer to themselves and the way they are referred to by others, including officials. Whereas the term “little people” used to be common in everyday talk and government rhetoric it has now largely been replaced by the term “poor people”.

During my research in 2000 I often heard people refer to themselves as “little people” (“orang kecil”). As recently as 2002 then President Megawati Sukarnoputri claimed to be representing the “little people” just as her father, President Sukarno, Indonesia’s first president, had done before her (Aspinall 2014, Siegel 1998). By the time I returned to Indonesia in 2012 I no longer heard the term. Rather, ordinary people referred to themselves as “orang miskin” (poor people). I believe this shift in vocabulary is significant. The term “little person” implies a position at the bottom of a social hierarchy. Within Javanese/Indonesian thought, one is supposed to accept one’s position and defer to one’s superiors, reflecting understandings of hierarchy, harmony and respect (Berman 1998, Pemberton 1994). According to Mulder (1998) “little people”

were believed to be inherently different from their superiors and incapable ever of becoming a leader themselves.

By contrast the term “poor person” implies someone who is unfortunate, but through a change of circumstances, could become better off. Furthermore, according to Islamic teaching poor people deserve the assistance of others. Similarly, in government rhetoric, it is the responsibility of government to assist the poor. This implies that the poor have entitlements. Indeed, the shift in vocabulary is related to government use of the term “poor person” in the targeting of its development programs. As indicated previously, in the insurance schemes for the poor “poor people” are precisely defined in terms of income levels defined by the Bureau of Statistics, and they are entitled to specific benefits.

This shift in government discourse has effected a shift in subjectivity among Indonesian citizens from a sense of political powerlessness to one of economic disadvantage. Health insurance has not been the only factor that has given people a greater sense of entitlement and consequent confidence to voice their views. The government reforms implemented from 2001, including democratic decentralization and the freeing up of political parties and the media, have generated a political climate where people are less afraid to voice political views or to complain about government. And their voice now counts in general and local elections. The role of health insurance in this broader process has been to delineate specific population groups entitled to particular packages

of health benefits. This enables people to identify where experience falls short of what has been promised and articulate their grievances by whatever means is available.

6.8 Addendum

In 2014 a new comprehensive insurance program was launched, the SJSN¹⁴⁷. SJSN is intended to replace all previous government insurance programs and aims at universal coverage by 2019. First proposed by President Habibie in 1999, the idea was taken up by Megawati Sukarnoputri who formed a Working Committee in 2001 and passed Law 40 in 2004 outlining principles for a universal social security system. Momentum was stalled when President Susilo Bambang Yudoyono assumed power later the same year and it was not until 2011 that a follow-up Law 24 was passed that determined the management of the scheme. SJSN was finally launched on January 1 2014. P T Askes, the same insurance company who had managed health insurance for government employees, and had been involved in health insurance for the poor since 2004, was now charged with transforming itself into a non-profit organization that would manage SJSN. The new management body was termed BPJS¹⁴⁸.

Under BPJS all previous schemes, including Askes, Jamsostek and Jamkesmas, were merged, although payment of premiums remained similar. Those employed by government and in the formal sector continued to pay a share of their premiums through deductions from their salaries while premiums for the poor were still covered

¹⁴⁷ SJSN stands for Sistem Jaminan Sosial Nasional or National Social Security System

¹⁴⁸ BPJS stands for Badan Penyelenggara Jaminan Sosial or Management Organization for Universal Social Insurance

by the government. The real change came for those not previously covered by any of the insurance programs, many of whom worked in the informal sector. They were encouraged to pay Rp 25,000 (about \$2.50) a month to join the scheme. Insurance provided access to public health facilities as well as to private facilities that opted to join the scheme¹⁴⁹. Although the target was universal coverage, kabupaten were left to decide whether or not to continue with their own programs. As of 2014, Lahanbesar opted to continue with Jamkesda. This suggests that the dance between the kabupaten and the center may yet continue.

6.9 Conclusions

In this chapter I have drawn on Indonesia's experience with government health insurance to elaborate a number of arguments. The first argument is that the 2004 amendments to the 1999 decentralization laws exacerbated on-going political tension between centralization and decentralization. In order to illustrate the contrasting styles of government characteristic of centralization and decentralization I compared Jamkesmas central government insurance with Jamkesda kabupaten health insurance. Whereas Jamkesmas uses a fixed quota, allocating cards to citizens identified as eligible, Jamkesda has a more flexible system designed to catch those who are missed by the quota system, based on letters that a person must obtain at the time when they need health care.

¹⁴⁹ This was not necessarily an attractive option for private providers since insurance reimbursements were often substantially lower than the rates normally charged at private facilities. On the other hand, not joining the scheme would risk losing patients to those facilities that did join.

Building on this analysis, my second argument is that kabupaten health officials have developed a distinct decentralization ethos, characterized by flexibility and a problem solving orientation, drawing on local knowledge to provide services appropriate to local circumstances. In the narratives of my informants this “bottom up” approach is contrasted with the central government’s “top down,” standardized and inflexible approach, illustrated by the Jamkesmas program. Both ethics of government fit within Weber’s (1999) bureaucratic ethos, with its emphasis on following regulations and displaying loyalty to the goals of office. What is revealed by this analysis is that decentralization allows for the emergence of internal differences within the bureaucratic ethos, reflecting different understandings of the proper way to do government. In this way it encourages a form of internal competition to occur between “the center” and “the kabupaten.”

My third argument is that although Jamkesmas and Jamkesda compete with one another at the ideological level they complement one another at the point of implementation. In this way, the two insurance programs provide an example of the co-existence of decentralization and centralization within the national health insurance policy.

My fourth argument is that the meaning of decentralization has shifted over time. This is reflected in the way that the government health insurance scheme, Jamkesda, which is held up as an example of decentralization by kabupaten health officials, is experienced by village health workers as undermining village self-sufficiency, the goal of

an earlier decentralized program, the Desa Sehat program, analysed in Chapter 5. Village bidan complained that as soon as people receive assistance from government they stop saving for themselves. If one decentralized program – Jamkesda – is undermining another decentralized program – the Desa Sehat program – this suggests that there are different interpretations of decentralization that manifest within different public health programs. Thus there appears to have been an evolution of the meaning of decentralization over time. The Desa Sehat program is emblematic of the early years of decentralization when there was a stronger emphasis on village autonomy and community self-sufficiency. Jamkesda reflects a re-interpretation of decentralization following the 2004 amendments to the decentralization laws. Kabupaten officials became more concerned to articulate kabupaten autonomy in the face of central government's tendency towards re-centralization. The issue of village autonomy was left for village health workers to grapple with in the context of new challenges posed by central government insurance.

My fifth and final argument relates to the impact of health insurance on citizen-state relations. I suggest that health insurance may be generating new forms of empowerment, namely a sense of entitlement coupled with an increased confidence in expressing opinions and in dealing with government, either directly or via village level intermediaries. This shift reflects broader changes in the political climate following democratic reforms that marked the end of Suharto's New Order style of government. Health insurance has played a role by informing citizens that they have specific entitlements to health care. This has enabled them to measure their experience against

expectations and to articulate a hitherto hidden, but strong “health ethic” that demands equal treatment for all regardless of poverty level or method of payment.

My conclusion from this analysis is that health insurance programs offer a productive lens through which governance relations can be tracked over time, including both social relations within the government and relationships between governors and those they seek to govern. As the national health insurance program SJSN unfolds over the coming years it will continue to provide a rich source of material for tracking evolving governance relations as well as the on-going dance between centralization and decentralization.

Chapter 7: Moral Pluralism in the Crafting of Consent

7.1 Introduction

Chapters 4 and 5 looked at the design of public health programs flagged as “decentralized” by the kabupaten health office. In this chapter I move out of the office to explore how the general public are enrolled into public health programmes. As mentioned in Chapter 1, public health can be viewed as one component of a broader state project of progress towards modernity (Ferzacca 2002, Stein 2009). A key challenge faced by health workers is that the achievement of “modernity” through compliance with health policies and programs often involves radical changes in behaviour from local “traditional” health practices. These traditional practices are associated with deeply held values and beliefs, and often bound up with rituals that resonate with meaning (Hildebrand 2012, Stein 2007, Newland 2001, and Hay 2001). In an attempt to shift behaviors, public health messages are framed as “oughts,” that is, things that one ought to do for the benefit of the family, community and nation. In this way public health messages, along with the broader project of modernization, are framed in moral terms.

My analysis of the moral framing of public health messages in Indonesia draws on and extends Corrigan and Sayer’s “cultural theory of state” (1985). They argue that the state, in its moral regulation of both rulers and the ruled, draws on and transforms existing cultural forms, thereby bringing about a “cultural revolution”. In this way culture plays an important part in “everyday state formation,” a term that refers to the everyday

practices of government that serve to reproduce regimes of rule (Corrigan and Sayer 1985, Newbery 2006:17, 146). Similarly, I observed public health workers drawing on cultural forms that already achieve moral regulation at the individual and community levels in their daily work of health governance. Indigenous cultural forms are regularly adapted to the requirements of particular public health programs. We already encountered one example of this in Chapter 5. In that case the cultural forms of “gotong royong” (mutual assistance) and “musyawarah” (consultation) were engaged within the government Desa Sehat program to encourage people to form Forum Silaturahmi (health consultation and development groups). In this chapter I examine practices of moral regulation in relation to maternal health, a moral field where public health messages still encounter considerable resistance. Whereas government policy encourages birth at a biomedical facility many families wish to continue using traditional birth attendants known in West Java as “paraji.” Even though it is possible to use both paraji and medical providers, the implementation of what is referred to as “partnership” involves shifting the behaviour of mothers, kader and paraji towards increased reliance on medically trained midwives termed “bidan”. Health workers need to use their full repertoire of persuasive techniques to achieve adherence with the partnership policy. In their attempts to achieve this cultural transformation in the domain of mothering and childbirth I observed health workers using at least three different moral frameworks including Islam, evidence based public health (EBPH) and the “right to health”. Evidence based public health is not often presented as a moral framework. I regard it as one because it is used to engender a sense of obligation to shift behaviours in order to

improve the statistics. In a context where health statistics now frame the way that health problems are understood and addressed, statistics are increasingly used to compare health status or program outcomes across different locations, leading to global rankings, as in the Millennium Development Goals (MDGs). In this way the use of statistics in evidence based public health does more than provide a particular form of knowledge. Statistics and their ranking provide a moral injunction to act (Storeng and Behague 2014, Erikson 2012.)

The second moral framework, the right to health, became prevalent in government discourse in Indonesia during the era of “reformasi” or political reform following the resignation of President Suharto in May 1998¹⁵⁰. Since 1998 the term has appeared regularly in health laws and regulations and, as I will show in this Chapter, government health workers now use “right to health” in their public health messages. As a result of the close association between “right to health” and government rhetoric the term is sometimes interpreted by members of the public as an obligation to follow government policy (Hildebrand 2013).

Another characteristic of the use of “right to health” in Indonesia is its close alignment with my third moral framework, Islam (Kenny 2012, Gani 2013). As a world view held by over 90% of the population, Islam is used as a filter through which other moral frameworks and professional ethics, such as right to health and EBPH, are interpreted and assessed. This renders these frameworks more familiar. Furthermore, because Islam

¹⁵⁰ See Chapter 2 for details of this political transformation

is trusted and largely uncontested, the linking of public health behaviours with Islam encourages adherence and reduces the possibility of contestation.

In the following sections I foreground my analysis of “moral pluralism” with an ethnographic vignette illustrating the use of my three moral frameworks during a training of kader. I then examine the three moral frameworks one by one to convey a sense of how and why they are used in health promotion work in Indonesia. I provide numerous examples of the deployment of these three frameworks to legitimize health policies, motivate health workers and to encourage public adherence with government public health policies. I argue that these moral frameworks are used creatively both to achieve public health goals and to build the moral identities of those using them. Health workers use these moral frameworks to present themselves as good Muslims and as globally informed public health workers. In my final discussion section I develop the concept of moral pluralism and explore its implications for conceptions of health citizenship in the contemporary political landscape of democratic decentralization in Indonesia.

Before delving into the world of public health promotion, I open this chapter by stepping outside of government policy to investigate the enduring role of “traditional” birth attendants, known in West Java as “paraji”. The various birthing practices of the paraji are regarded as culturally sacrosanct by many Indonesians but also as dangerous by biomedically trained health providers. The policy solution to this conundrum has been the development of a policy of “partnership” between paraji and biomedically

trained government midwives. I describe the enduring role of the paraji in order to reveal what is at stake in a “partnership” that re-formulates and restricts their role.

7.2 Childbirth in Indonesia

For many mothers and their families in Indonesia a “proper” childbirth is one that is attended by appropriate cultural and religious practices that require the expertise of an experienced traditional birth attendant, known in Indonesia as “dukun anak” (Hildebrand 2012, Stein 2007) and in West Java as “paraji” (Newland 2001)¹⁵¹. Until recently medical providers were not usually approached except in cases of emergency. The role of the dukun anak is inherited. Dukun anak learn the skills needed to assist mothers during pregnancy and childbirth through apprenticeship, often to their mother or another close female relative, and a dukun anak usually only practices on their own once the person to whom they have been apprenticed has died. In addition to learning the technical skills of birthing they acquire spiritual healing powers through ascetic practices (Stein 2007). During pregnancy and childbirth they carry out crucial spiritual and cultural practices believed necessary to ensure a safe and proper birth (Hildebrand 2012). With no standardized medical training their practices vary not only from region to region but from one dukun anak to another within the same village.

I became aware of the important cultural, spiritual and social role of the paraji in West Java when I attended a “seven month” ceremony in Desalindah village. According to Sundanese (West Java) tradition, the relationship between an expectant mother and the

¹⁵¹ Each region has their own tern for these birth attendants.

paraji of her choice begins when a mother is seven months pregnant. This is when she will visit a paraji and make arrangements for the “tujuh bulan” seven month ceremony that will establish a social relationship between the paraji and the expectant mother and her natal and affinal families (Newland 2001). I attended the tujuh bulan ceremony held for the second daughter of Bu Ika in Desalindah village. Preparations began early in the morning when relatives of the husband’s family were invited to share a small meal.

About ten men and women arrived and sat on the carpet in the front room of Bu Ika’s house, joining her husband, Pk Ade, the father of the expectant mother. Bu Ika served sweet snacks made from sticky rice and wheat flour. When these guests had left Bu Ika resumed her preparations by cooking large amounts of yellow rice, chicken with coconut, tempe¹⁵² and vegetables. She also prepared a large bowl of water with seven types of flower in them, and a “rujak” spicy fruit salad with seven types of fruit. In the inner bedroom seven new lengths of cloth were laid on the bed.

In the early afternoon the paraji arrived and she and the pregnant mother retreated to the bedroom where I was informed that the paraji performed a ceremony that included rocking the expectant mother back and forth while she lay in the bed with the paraji holding one of the seven cloths that was wrapped around the mother’s abdomen. This is thought to improve the position of the baby. As the paraji emerged from the bedroom guests from Bu Ika’ family had begun to arrive, along with neighbors and notables from the village, including the village head. Women gathered in the front room, sitting in a circle on the carpet, while men were ushered into a side room. The women were

¹⁵² Tempe is fermented soy bean paste commonly consumed in Indonesia.

clothed as they would be for a visit to the mosque, in head scarves, long sleeves and long dresses, according to the Muslim dress code that only hands and face should be visible. Many had copies of the Koran with them. A silence descended on the group as one of the visitors read verses from the Koran. After the prayer, the food was distributed first to the women, and then, in smaller take-home packages, to the men in the side room.

Following the seven month ceremony, a relationship is established with the paraji that will continue until well after the child is born. The paraji makes several visits before the birth to check on the health of mother and baby and to perform massage to improve the birthing position. When the birth is imminent the paraji will stay with the mother for the duration of the birth, assisting through massage, recitation of Islamic prayer and incantations to coax the baby out (Stein 2007). The outcome of the birth is considered to be in the hands of God, with the paraji simply facilitating the process. Following the birth the paraji massages the baby to stimulate circulation and then she massages the abdomen of the mother to encourage the after-birth of the placenta, which is considered to be the spiritual sibling of the baby (Hildebrand 2012). Following the birth the paraji will typically visit on the third, seventh, fifteenth, twenty-fifth and fortieth days, each time offering massage, bathing the baby and often helping the mother with household tasks such as laundry. Mothers pay the paraji each time they visit. Charges vary but paraji receive about Rp50,000 (about US\$5) for attending a birth and about Rp10,000 – 20,000 (US\$1-2) per pre-natal or post-natal visit. The total package amounts to Rp150-300,000 and, contrary to Stein (2007:59) is not necessarily cheaper than the

services of a village bidan, even if they see the bidan privately, out of government working hours. Birth at a government puskesmas or with a village bidan during government working hours used to cost Rp 150,000, but since 2011 this cost has been covered by the government under the Jampersal insurance program. The going rate for village midwives out of hours during their private practice is around Rp 250,000 – 300,000. Some bidan said they lowered the price for poorer patients.

Biomedically trained health providers, including doctors, obstetric gynecologists and trained midwives (bidan) regard some of the practices of paraji to be dangerous. For example, they argue that massaging the mother's abdomen immediately after the birth can exacerbate heavy bleeding, one of the most common causes of maternal mortality. Several senior bidan recounted tragic stories in which they were called too late to save a mother or a baby. Bidan Ratna told me one such story as we shared lunch at the kabupaten health office one day. She related how, while she was working as a village bidan in Koratanah kecamatan¹⁵³ a stranger came to her house in the middle of the night. It was an ojek (motor-bike taxi) driver whom she had never met. Should she believe his story that a mother had given birth and needed help? Unsure as to whether to trust him, she called a neighbour to accompany her and they both rode on the motor-bike along the mud road to Desalindah village. When they arrived she found a paraji present, the baby had been born, but the umbilical cord had not been cut, and the baby was dead. Bu Ratna explained that this paraji believed she should wait until the placenta was born before cutting the umbilical cord, and the placenta still wasn't born.

¹⁵³ She worked as a village bidan from 1998-2004

Consequently the paraji had neglected to care for the baby. Even though the baby weighed 3 kg and appeared to be healthy it had died from exposure to cold. Bu Ratna explained to me that if there is a fatality, paraji do not blame themselves, but rather see it as the will of God, so there was no point in her scolding the paraji. Instead she noticed that the mother was bleeding heavily. Since this birth, typically for a home birth, had taken place on a dirt floor it was not possible to estimate how much blood had already been lost. Bu Ratna had only brought two blood transfusions. The mother was breathing heavily, short of oxygen, but Ratna had not brought oxygen. Desperately she gave the mother the blood she had, but the mother was still heaving, unable to breathe. It was too far for Bidan Ratna to go back to her house. She asked the family members to get blood from any available source. Eventually they came back with blood and she gave it to the woman. Bu Ratna did a manual removal of the placenta and somehow the mother survived.

The five paraji I visited had collectively attended hundreds of births but could not recall any incidents where they attended a birth that resulted in a maternal or infant death¹⁵⁴. But medical providers and health policy makers, influenced by the extreme cases that they witness or hear about, have worked for decades to restrict the practices of the paraji. Stein (2007) argues that this trend began during Dutch colonial rule when initial attempts were made to provide maternity services, albeit on a limited scale. After independence reproductive health became a concern as Indonesia lagged behind her

¹⁵⁴ It is possible that they chose not to reveal negative experiences to me even though I visited them with no health workers present.

neighbors on maternal health outcomes, and this tarnished Indonesia's reputation as a "developing" and modernizing nation. The non-standard, non-medical practices of dukun anak were considered to be risky by health professionals, and to be contributing to the high rates of infant and maternal mortality.

In an attempt to address this issue a village bidan training program was initiated in the late 1980s (Heywood and Choi 2010). The aim was that every village would have a medically trained bidan termed "bidan". The newly trained bidan, most of whom were young and not from the village where they were posted, were faced with the challenge of persuading mothers to use their services rather than relying on the tried and trusted services of local dukun anak. Thus, bidan were placed in a situation of potential conflict with the popular dukun anak. In order to address this, a policy of "partnership" was developed. Recognizing that there were initially insufficient midwives to cover the population, midwives were encouraged to work together with the dukun anak. A training program for dukun anak was developed by the Ministry of Health and midwives were expected to provide this training to the dukun anak in their village. As an incentive to attend, the puskesmas provided birthing kits to dukun anak, including obstetric scissors for cutting the umbilical cord (Hildebrand 2012), aluminum pans and baby weighing scales.

Bu Aisah, an experienced bidan who now works as head of health services at the kabupaten health office, described how in 1991 she was posted to a puskesmas covering 14 villages, and she was the first bidan to work there. She covered a population of over

100,000 people. She used to hold trainings for paraji (dukun anak) at her home every Saturday morning. About half of the paraji in her area attended, as it was not obligatory. By 2000 there were midwives in many villages and the government policy shifted. It now became mandatory for every birth to be attended by a medically trained personnel, assumed to be the village bidan in most cases. This altered the nature of the partnership. Rather than being able to offer training programs and related equipment to dukun anak, thereby supporting their independent businesses¹⁵⁵, midwives now had to persuade dukun anak to give up their independence and call a bidan anytime a mother in their care was ready to give birth¹⁵⁶.

Despite initial resistance from some paraji and mothers, these policies have met with considerable success in Lahanbesar kabupaten where, I was told, birth with a bidan rose from 47% of births in 2000 to 83% by 2012. In line with the policy idea of “partnership” the vast majority of these births also involve a paraji, reflecting the reluctance of mothers and their communities to give up the important role that paraji play in caring for the practical and spiritual needs of the mother as well as the baby during the perinatal period.

The combined use of paraji and bidan is feasible because the paraji offers a package that does not need to interfere with the package offered by the bidan. The mother’s relationship with a village bidan often starts with a visit to the posyandu (monthly

¹⁵⁵ One paraji had a sign outside her house documenting that she was working under the supervision of the Kabupaten Health Office.

¹⁵⁶ The policy of “partnership” is discussed in greater detail in Chapter 7

community health post) or to a puskesmas during her pregnancy. At her first visit the mother receives a pink booklet that contains information about pregnancy, childbirth and care of newborns and also contains tables for recording the mother's health statistics. She is encouraged to have at least three ante-natal check-ups with a bidan. During these check-ups she receives iron and folic acid tablets. She is also encouraged to make an arrangement with a medically trained bidan (bidan) for the birth.

At the time of the birth the bidan is usually called to the mother's house either by the paraji or by a neighbor or kader. In the past this would have involved visiting the bidan in person, but many kader now have cell phones. Paraji are encouraged by the village bidan to call them, and this message is reinforced by regular trainings at the puskesmas, and most recently through a regulation that will be discussed later in this chapter. The bidan typically responds to the call by visiting the mother at her house and advising her as to whether she should wait, if the birth is not imminent, or accompany the bidan to her village practice or to the puskesmas, or, in the case of complications, to the hospital. Following a birth the bidan will encourage the mother to bring the baby to the posyandu or the puskesmas every month for check-ups and to receive vaccinations and vitamin A at the scheduled times.

The bidan does not offer the comprehensive care package for the mother that the paraji offers. For example, mothers related cases where the bidan was called but was busy or did not stay for the duration of the birth. This is one of the reasons why, after more than a decade of the government policy of "partnership" about 20% of mothers continue to

rely on the paraji without contacting a bidan. Another key reason is fear of the bidan's practices. I became aware of this when I attended a posyandu in a location where many mothers continued to use the popular local paraji and avoided the village bidan. I was accompanied by Bidan Ratna, who had agreed to accompany me to this "problem" posyandu. Based on previous experience Bidan Ratna already suspected why the mothers continued using the paraji. She asked if they were afraid of the bidan. One mother acknowledged that she was afraid of "cutting" (episiotomy). The bidan explained that this only occurred in exceptional cases. Were they afraid of the cost? She proceeded to explain the government health insurance program, Jampersal that would cover the medical cost of childbirth. Finally, through gentle probing she elucidated that the current village bidan was not popular.

On another occasion I spoke to three mothers with children under five at a home in Mendekati Kota village about their decisions over who attended childbirth. The house I entered was in poor condition signaling that these were poor families. I was warmly welcomed and the two mothers who resided in the house, Bu Una and Bu Onang, seemed relaxed. Bu Una had four children, her youngest daughter clinging, shyly to her dress, Bu Onang had three, including an infant whom she was cradling in her arms. The neighbor, Bu Pipin, hearing that there was a visitor came and joined us. She had four children, the youngest of whom was five years old. As we sat informally on the floor in the cluttered front room, and in the absence of any health provider or government official, I asked the mothers who they preferred to attend the births of their children. By contrast with the government policy that all births be attended by a bidan, these

mothers differentiated cases according to the individual experiences of the mothers. Bu Pipin explained that she never had any trouble giving birth, so there was no need to call the bidan. It was much more convenient to use the paraji because you only had to call one person and you didn't need to go anywhere. Bu Una said she preferred "medis" (medical) birth because she usually had difficult births. She always called the local paraji and the bidan. Both lived nearby and they came together ("bareng"). Although she had two of the births at home attended jointly by bidan and paraji, in the case of her second child the waters broke early and she had been advised to go to the hospital as it was dangerous if the baby is not born within six hours of the waters breaking. When her fourth child was born she experienced swelling and was again referred to hospital. The third mother, Bu Onang, presented a mixed picture. Her first two children were born at home with a paraji. Then she moved to Mendekati Kota after marrying Bu Una's brother. The birth of her third child, only one month prior to our discussion, was attended by the same paraji and bidan pair who attended Bu Una's births. She also experienced swelling and was rushed off to the city hospital where she stayed for two days, with the cost covered by the Jampersal government insurance program.

Despite decades of government policy to use the bidan for every birth, Bu Pipin did not think this was necessary in her case. According to her reasoning a bidan is only needed if there are complications or where there is a history of complications. The other two mothers appear to have internalized the government policy of partnership, aided by the good relationship that the local bidan has established with the paraji, as suggested by the term "bareng" coming together. Even for Bu Pipin the impression is that the

threshold for calling the bidan is lower now than in past when it was only in cases of emergency that the bidan was called.

In this section I have presented the perspective of government health providers and mothers in relation to the practices of the paraji. In section 7.4.3.1 I offer the perspective of the paraji in relation to a new regulation on “partnership” between paraji, midwives and kader. Recognizing that the transition from paraji to bidan is a work in progress, in the following section I return to the issue of how government officials carry out the health promotion work that is involved in bringing about this significant shift in birthing behaviors.

7.3 Moral Pluralism in Action

I became aware of the application of these three moral frameworks in health governance work during a training of kader that I attended at Koratanah puskesmas. About 30 kader from the six villages covered by the puskesmas attended the two day training. I joined the volunteers, sitting in rows on hard plastic chairs facing the trainers from the kabupaten office, who sat, smartly dressed, behind plastic tables. Most volunteers wore the batik uniform of their posyandu (monthly community health post), the bright reds, blues and browns contrasting with the Spartan grey furniture. Several had brought toddlers or infants with them, some of whom played and ran about during the training.

The training was based on a book, distributed to attendants, which aimed to boost volunteers’ capacity to support child health, including early detection of specific

diseases and malnutrition, and referral of such cases to the local puskesmas. The book was published by the Ministry of Health (2011b) together with Global Alliance for Vaccination and Immunization (GAVI), who were funding the training. Each trainer covered one of the topics in the booklet. What intrigued me was not so much the content of the booklet as the moral messages that accompanied its delivery. Bu Aisah, the kabupaten head of health services who opened the training framed it in terms of children's right to health, even though there is no reference to the word "right" (hak) or "right to health" (hak kesehatan) in the instructional booklet. She asked the volunteers "we have many health problems in the village, why are we focusing on children?" Because, she said, answering her own question: "according to the Constitution of 1945 paragraph 28 states (she quotes directly from the law) 'every child has the right to survival, growth and development and the right to be protected from violence and discrimination'. So", she continued, "children have rights... You are helping the government to fulfill the rights of the children..., helping them to obtain health services."

Bu Aisah then referred to the government insurance programs Jamkesmas, health insurance for the poor, and Jampersal, health insurance for childbirth. She explained: "So the protection of children by the government starts when the child is still in the womb." She added that the government planned to extend health insurance to the entire population from 2014¹⁵⁷. She added, "this is because to be healthy is the right of the child. The health of the child is an investment that will lead to increased production

¹⁵⁷ See Chapter 5 for a brief description of the National Social Insurance Program, SJSN program.

in future. So we are working towards a ‘smart and healthy generation’ (Generasi Cerdas dan Sehat¹⁵⁸). The right of the child must be disseminated by us volunteers to motivate families so that we can really be sure to follow the regulations ...this is the role of the volunteer, to mobilize the community, disseminate information, monitor, visit people in their homes.”

During her speech Bu Aisah referred to a PowerPoint presentation that included diagrams and statistics, including an age pyramid for Indonesia and a diagram of the Millennium Development Goals. Referring to the PowerPoint she explained the concept of life expectancy and how an infant death would bring it down.

In her eloquent speech Bu Aisah enrolled the moral framework of the right to health to lend authority to her appeal for the kader to work harder to achieve child survival. She linked the child’s right to health with the government insurance programs that ensured access to health services that would fulfill this right. She then connected the fulfillment of the child’s right to health with national goals to increase production and achieve the MDGs. As she tacked back and forth between the rights of the child and references to the statistical terms of evidence based medicine she clearly regarded what I identify as two distinct frameworks as complementary and mutually reinforcing in her efforts to convince the audience of the importance of their work.

Immediately following this rousing speech came the head of immunization. She used the complementary tack of framing the work of the volunteers as fulfilling their Islamic

¹⁵⁸ Generasi Cerdas dan Sehat is a reference to a World Bank funded program of the same name.

spiritual duty to protect the vulnerable, especially children. Rather than regarding their work as a burden they should see it as bringing spiritual benefit. She continued by reassuring her audience that the vaccines were all “halal” (pure, acceptable for consumption by Muslims). They should not listen to rumours that they contained pig fat since the vaccines used in this kabupaten were all produced at “our very own factory” in Bandung.

These two trainers had drawn on different moral frameworks to motivate the kader. Yet the three frameworks of Islam, right to health and evidence based public health were inter-linked in the framing of messages about child survival. I refer to this use of multiple moral frameworks as “moral pluralism”.

Within moral philosophy the term “moral pluralism” refers to the plurality of values that may form the foundation for morality (Mason 2015, Honderich 2005) Anthropologist Cheryl Mattingly (2014) on the other hand, uses the term to refer to different moral spaces such as home, church or school. She argues that individuals need to negotiate these different moral worlds in their everyday interactions as they construct a “good life” for themselves and their families. My use of the term departs from both of these uses. The health workers that I encountered use a plurality of moral frameworks not only to orient their own moral lives but also as a technique of governance used to encourage others to align their behavior with government health policies that reflect the government’s understanding of a “good life” for its citizens.

The particular ways in which these three moral frameworks are being deployed in the art of persuasion within public health programs is the subject of the following three sections. I examine how these moral frameworks are being interpreted and explore reasons for their perceived effectiveness at galvanizing adherence with government health policies.

7.4 Three Moral Frameworks used in Health Governance in West Java

7.4.1 Islam

At the village level in Indonesia Islam is pervasive, accessible and informal. Every neighbourhood has its own mosque that is used for regular meetings and functions of various types. There may be Islamic teachings for the general public (women and men sit in separate parts of the mosque). In addition there may be women's meetings, meetings for teenagers, for parents, for the elderly. My local village of 12,686 residents had 16 Mesjid Jami, main mosques where Friday prayers are held, 34 groups using these mosques for various functions, numerous smaller neighbourhood mosques, eight madrasah (Islamic schools) and two pesantren (Islamic boarding schools).

Kader use the local mosque to deliver their public health messages and advertise their services. The mosque provides a convenient mode for reaching the public because there is always a nearby mosque available and they are already a part of everyday life. At the same time the religious setting lends authority to the public health messages delivered. When I attended a posyandu (monthly community health post) held at Kader Saria's

house compound, I was surprised when she entered the tiny mosque and used the loud speaker system to inform her neighbours that the posyandu was about to begin.

Health workers from the local puskesmas also used the mosques. I regularly attended a health clinic for the elderly held every Saturday morning at my local mosque. The medicines were funded through donations from members of the mosque. Although the clinic was not sponsored by the government, the doctor and bidan who attended the mosque clinic were from the local puskesmas. They offered their services on a voluntary basis during their free time. Another example of the use of Islam is that health workers draw on passages in the Koran to reinforce their messages. For example, I was told that there are verses in the Koran that relate to breastfeeding.

As a world view held by over 90% of the population, Islam is also used as a filter through which other moral frameworks and professional ethics are interpreted and assessed. The alignment of Islam with a bureaucratic work ethic was described in Chapter 1. The head of the kabupaten health office made frequent references to Islam during the morning roll call, and urged the Islamic teacher who gave a talk every Friday morning, to encourage workers to translate the discipline of Islam into the workplace. A similar message was delivered to kader during the training that I witnessed when it was explained to the volunteers that their work was simply an expression of their Islamic duty to help the vulnerable, including children. Other moral frameworks, including the right to health and evidence based public health, used to motivate workers and justify policy in the health sector are also filtered through Islam.

For example, the kabupaten health office framed health insurance as poor people's "right to health." In an attempt to reduce the possibility of people claiming this insurance who were not poor enough to be eligible, they had issued a poster that declared:

REMEMBER!

Kabupaten government health insurance is only for the poor.

DO NOT TAKE AWAY THE RIGHTS OF THE POOR

The poster used "right to health" as a moral framework, to discourage people from manoeuvring to obtain the requisite letters and signatures by pretending to be poorer than they were, perhaps by using their social networks to influence the process. Stories circulated about people wearing gold rings and riding expensive motorbikes turning up to the hospital claiming Jamkesda insurance, although it was not clear from the stories how they obtained the insurance coverage.

But Kader Rohila, whom I accompanied when she distributed health insurance cards in her neighbourhood (see Chapter 5), filtered this "right to health" message through an Islamic lens, regarding it as her Islamic duty not to take health insurance. She explained to me that she was herself eligible for this health insurance, based on her income level, but she recognized that other people needed it more than she did and so she was not intending to claim it for herself. Her understanding of a good Muslim was someone who helped the poor. She elaborated this understanding, saying that she believed God would

not be pleased if rich people used the insurance that was intended for the poor. Kader Rohila did not regard herself as rich. She was referring to other people, more wealthy than herself, who might claim the insurance, in order to emphasize her point about a Muslim's duty to help the poor. As we visited the households she had a similar message for the wealthier relatives of those who received the cards, explaining that they were not eligible because they were not poor. But those whom she knew to be poor who had not received cards were recorded for possible coverage by the complementary kabupaten health insurance, Jamkesda.

Whereas supervisors use Islam to discipline workers, in this case Kader Rohila is using government health policy to present her own moral identity as a "good Muslim". This suggests that the same mechanisms that are used to build consent through integrating government policies within everyday moral practices can also be used by those targeted to build moral identities within their communities. This is the process documented by Newberry (2006) in relation to the PKK volunteers in her neighbourhood in Yogyakarta. This reciprocal aspect of the crafting of consent is often missed in analyses of governance by the state.

The way in which Kader Rohila interprets "right to health" through Islam suggests that Islam can act as a conceptual bridge linking familiar concepts, such as "helping the poor" with new ideas, in this case the right to health. This is similar to the case described by Rudnykyj (2010), cited in the Introduction, where Islam was used to link Islamic ideas of fasting and asceticism with new management approaches.

In the health governance work that I observed Islam provides not only a conceptual but also a social bridge between health workers and those they serve. Islam is shared along the citizen-state continuum to a greater extent than any of the other frameworks.

Committed Muslims are as likely to be found in a government office as in a rural household. This commonality can help bridge the social distance between health professionals and their patients.

Health center staff are distinguished from their patients by higher levels of education, by their professional uniforms and by their social mannerisms. This can be observed at any posyandu or health clinic engagement. For example, when I attended a posyandu on the outskirts of my local village I noticed how the mothers and toddlers gathered in one part of the room, leaving a large space for the bidan to sit, her bag of equipment separating her conceptually as well as physically from the mothers and children waiting to be seen by her. Interactions were characterized by deference on the part of the patient and a studied patience sometimes bordering on condescension by the bidan. Despite all of their social differences, bidan and mother share their Islamic faith, and this can be used to facilitate communication. For example, as one senior bidan explained to me, when promoting the WHO recommended six months' exclusive breastfeeding, midwives and kader can refer to the Koran where breastfeeding for a period of two years is recommended.

These examples illustrate how the use of Islam in everyday health governance work can encourage adherence to public health messages through linking unfamiliar ideas and practices with the known world of Islam.

7.4.2 Evidence based public health (EBPH)

Evidence based medicine (EBM) emerged in the mid-1980s with the goal of developing standardized treatment protocols for clinical medicine based on “systematically reviewed and critically appraised evidence of effectiveness” (Lambert 2006). In order to generate the evidence base, statistical methods developed for population health were honed to clinical medicine, giving rise to a new field termed clinical epidemiology. EBM has caught on and has spread to the domains of public health (Rychetnik et al. 2004), and health policy and advocacy (Storeng and Behague 2014), leading some observers to note that presenting a statistically valid evidence base has now become a prerequisite for receiving funding in the health sector (Erikson 2012).

Indonesians have embraced evidence based public health and this enthusiasm is reflected in a long standing relationship with the International Network for Clinical Epidemiology (INCLIN) dating back to the 1980s (Mark Nichter personal communication, October 13, 2015.) Not only do health statistics offer a powerful tool for managing and monitoring population health, they also signal familiarity with contemporary global discourses and forms of expertise. EBPH thus offers a mechanism for demonstrating progress towards a global modernity. In addition to its practical use and its symbolic value, I argue that EBPH operates as a moral framework used in health

promotion work to encourage behavior changes that will improve the statistics. The power of EBPH as a moral framework derives from certain features of statistics and the ways in which they are used. Statistical knowledge differs from knowledge based on case studies, personal experience or hearsay. In each of these cases many variables come together to produce a particular outcome that cannot necessarily be generalized to other cases. But in using a statistical approach unique features and relationships are lost in the process of aggregation and averaging out. Under the influence of evidence based public health, health statistics now frame the way that many health problems are understood and addressed. Generalized statistical results tend to generate standardized solutions. Another feature of a statistical approach is that it allows for comparison between cases. When applied to health policy and practice, comparisons turn into rankings. This is reflected in the Millennium Development Goals that use health (and other) statistics to define and measure progress towards “development.” In this way EBPH and the use of statistics more generally does more than provide a particular form of knowledge. It also acts as a moral framework because statistics and their ranking provide a moral injunction to act. They reveal deficiency and motivate action to improve the situation (Erikson 2012.)

Although I witnessed statistics being used for different purposes in Lahanbesar kabupaten, in this section I emphasize the use of EBPH as a moral framework, often entwined with other moral frameworks including Islam and the right to health. My emphasis reflects my interest in understanding how staff motivation is maintained and how compliance with public health messages is crafted. I am not suggesting that this is a

mis-use of EBPH; I am simply elucidating how one aspect of everyday state formation is achieved in contemporary Indonesia through the use of evidence based public health. In this section I describe and analyze the use of evidence based public health in health governance work in kabupaten Lahanbesar.

7.4.2.1 Statistics at work

The importance of statistics in the framing of health problems in Lahanbesar was brought home to me during an informal conversation at the kabupaten health office when I asked a group of staff what “development” meant to them. Perhaps under the influence of the MDGs, they immediately referred to the lower maternal mortality rate (MMR) and infant mortality rate (IMR) in the US and other “developed” nations, and their higher life expectancy. It is as though these health statistics have revealed to them that their nation is deficient. The MMR shows that West Java is behind other regions in Indonesia and that Indonesia is behind other nations. Indonesia is not alone in using MMR as a measure of national performance. According to a Belgian epidemiologist quoted in Storeng and Behague (2014:267): “Maternal mortality has become sufficiently part of the collective conscience, so much so that it has become one of the Millennium [Development] Goals. It is now understood by policy-makers to be an important indicator of the health system, which, in turn, indicates the social performance of a country.”

Maternal mortality has been an issue in West Java, and in Indonesia more generally, for decades, but the rise of EBPH and its application in the MDGs has created additional

pressure to improve this statistic. MMR has acquired great symbolic power that orients the kabupaten health offices and permeates health programming at every level. As one staff explained to me, every health program must take reducing MMR as one of its objectives.

Bidan Aisah, head of the Basic Health Services at the kabupaten health office, is passionate about the issue of maternal mortality, and committed to using statistics to address the issue and to get her message across. I had first met Bidan Aisah in 2000, while doing research at Koratanah puskesmas where she was Bidan Coordinator. When I met her again in 2012, at an office luncheon to mark the beginning of the fasting month, she was eager to update me on what had happened since we had last met. She immediately referred to the disappointing statistics on maternal mortality. Despite efforts on many fronts to reduce maternal mortality, the recorded number of maternal deaths in the kabupaten had actually risen from 40 in 2000 to 70 in 2011. Bidan Aisah's concern for the issue of maternal mortality arose from personal experience. She had started her career in the early 1990s as the first village bidan at Koratanah puskesmas, covering 14 villages. She related: "every 2-3 days there was news that a mother had died. We reported all these cases but it was impossible to estimate the number of cases, many cases went unreported. A baby would come to the posyandu without its mother, the nurse would be told, only then did they know that the mother had died."

In 2003 Bidan Aisah was promoted to head of a new puskesmas. I asked her what changes she had put in place at the puskesmas. Her responses related to the use of

statistics. She explained how she encouraged her staff to analyse the data they collected rather than simply sending it on to the kabupaten health office. She wanted them to estimate rates of sickness, maternal, under-fives and infant deaths that occurred in the area. Under her management all the village midwives and nurses had their own output targets, to look for the sick, observe their environment and encourage immunization. She pushed them to look for cases and the causes of cases. As she explained: "I am passionate about data, I really enjoy it" ("Asyik dengan data itu, enjoy").

In 2007 Bidan Aisah was promoted to the kabupaten health office. I asked her how this had come about. She explained: "it was the Bupati (head of the Kabupaten) himself who recommended me. I was head of the midwives association (Ikatan Bidan Indonesia) from 2000 to 2010, for 10 years. I was often called and asked my opinion. In 2006 the Bupati called me and asked how maternal mortality could be reduced. I answered there are 3 factors: there must be enough midwives. At that time only 50% of villages had a village bidan; funding for mother and child health must increase; human resources should be distributed evenly at all health facilities." In line with national policy she recommended that midwives should be recruited so that there was one bidan per 6,000 population. This meant that villages with populations larger than 6,000 should have two midwives.

On her promotion to the kabupaten health office, where she now manages the Health Services section that collects and disseminates statistics on maternal and infant deaths, Bidan Aisah presented her proposals regarding human resources at every opportunity.

She proudly related how they were all were realised by 2008. In particular, the number of midwives had increased from 170 for 347 villages in 2006 to 595 midwives for 364 villages by 2008.

Bidan Aisah has used statistics to promote the issue of maternal and infant mortality at every level from the village through the kecamatan puskesmas to the kabupaten health office and kabupaten government. She has also undertaken surveys on other issues, such as doctor-patient interactions and other aspects of health care quality, and she encouraged the City Health Office to implement a joint study. She is skilled at combining the use of statistics to inform with their use to motivate staff at the puskesmas and to advocate for health policy at the kabupaten government level. In this way she uses statistics simultaneously as a form of knowledge and as a moral framework, often linked in her health governance work with the right to health.

Recognizing the power of health statistics as a motivational tool, some health managers appear to give rather less emphasis to the informational aspect, as the following example illustrates. Once a year the kabupaten health office invites representatives from each of the 58 puskesmas to come to Lahanbesar for “Des” (desk), referring to an exercise at which kabupaten officials sit at one side of a desk and puskesmas staff at the other side, each presenting their version of the year’s statistics. The statistics relate to the 15 health programs that each puskesmas is obliged to implement. Even though the statistics that the kabupaten holds originated from the puskesmas there are nearly always discrepancies between the two data sets. In the process of aligning the two sets

of statistics I noticed two things. Firstly, the kabupaten statistics always appeared to override the puskesmas statistics. Even though the puskesmas is the location where the data is collected, the kabupaten trusted their own version more than they trusted the puskesmas version. No doubt many puskesmas staff trusted their own data, but because the kabupaten staff had greater authority, it was the kabupaten health office version that tended to win. A second tendency was that where there was doubt as to which of two figures were the more accurate, the figure that revealed lower performance by health workers in achieving their targets was preferred. Dr. Eni Kartika (who had used Islamic references in training of kader) explained to me that using the figure that indicated worse performance would be more effective in motivating staff. She seemed less interested in discovering which figure was more accurate. In this case statistics are being used by health managers to supervise and control health workers at lower levels in the system (Nichter 1986). The use of data collection as a means of social control pre-dates EBPH in Indonesia, and can be observed at every level down to the kader. The rise of EBPH has led to an apparently insatiable demand for more data, collected more frequently, while those collecting the data rarely play any part in its analysis or use.

Whereas the examples described thus far relate to the increased use of local statistics, I also encountered the use of global statistics put to work in health governance. For example, Pk Yudi, head of Health Promotion, made reference to global statistics while addressing village midwives who had gathered at a large hall in the kabupaten capital for training on Jampersal insurance for childbirth. Pk Yudi urged the midwives to work harder to enroll people into the insurance program. One of the conditions for

enrollment is that the mother receiving “free” medical childbirth services must give birth at a health facility¹⁵⁹. Pk Yudi argued that in other countries maternal mortality fell when the incidence of facility based births increased, why was this not happening in Lahanbesar kabupaten? Even though births at facilities had increased, the incidence of maternal deaths also appeared to be increasing! Rather than pointing to characteristics of the Indonesian situation, Pk Yudi chose to use a deductive logic based on correlations emerging from other nations. The implication of his speech was not only that the global correlation should apply in Indonesia, but also that the midwives were to blame for Lahanbesar’s failure to conform to the global norm. In this way the global statistic became dissociated from the context in which the original data were collected and was put to work to chastise the midwives and urge them to perform better.

Curiously, several individuals chose to use a statistical approach even when their audience had low levels of formal education and presumably little familiarity with statistics and probabilistic thinking. For example, Pk Bujang, head of Pariwisata puskesmas, used statistics when addressing a group of mothers and paraji (traditional birth attendants) from a remote part of Mendekati Kota village. He had called the meeting because he was especially concerned about a recent infant death in this section of Mendekati Kota village. The death had occurred while the birth was being attended by a paraji, with no medically trained personnel present. The incident had been discussed at the previous Health Center monthly meeting and it had been agreed that

¹⁵⁹ It is common for Bidan to attend births at the mother’s home.

more guidance was needed to encourage paraji to partner with midwives and to urge mothers to seek out the assistance of a bidan.

I attended the meeting intended to provide this guidance, arriving just as the two local midwives were noisily re-arranging the tables. They lined two grey plastic tables up along the front of the room, providing an authoritative barrier behind which the speakers could sit. The remaining tables and chairs were arranged in rows facing the speakers, for the attending mothers and paraji. I recognized one of the kader who were among the attendants and went to sit with her, but was immediately invited by Pk Bujang to sit at the high table with the speakers, which I did.



Plate12: Puskesmas head and bidan educate mothers about maternal mortality

Pk Bujang, who chaired the meeting, made a great deal of effort to build rapport with his audience. He began by inviting the two attending paraji to lead a song that they had been taught about partnership. “Paraji come out and call the bidan” they sang. But in his wide-ranging discussion of the problem of infant death he started with a statistical analysis. He urged mothers to use a bidan in order to help improve the infant mortality rate. He went on to explain the concept of life expectancy, providing numbers to show that the death of an infant in childbirth would have a bigger negative impact on life expectancy than the death of an elderly person. In another section of his speech Pk Bujang said that they were lagging behind on partnership. Even though their village lay at the city limits they were referred to as “village people” because they were ignorant. Please, he begged them, mothers of kampong Mendekati Kota Lebak, join the partnership.

Given that Pk Bujang had called the village hall meeting in response to an infant death, he could also have taken the route of dissecting the particular case so that his audience could draw lessons from it. This would have been more in line with the way his audience usually came to learn about such deaths in their community, through personal experiences, and stories circulating in their social environment. Why would he choose a statistical approach?

Whether or not the audience grasped the mathematical implications, the use of statistics conveyed several messages to the audience. Firstly, they enhanced Pk Bujang’s credibility as an educated person with superior knowledge about the topic at hand. The

use of evidence based public health helped highlight the importance of the issue that had brought such a distinguished person to a gathering of mothers and paraji.



Plate 13: Mothers and paraji attending a meeting on childbirth policy.

At the same time mothers and paraji were encouraged to aspire to a new way of thinking about the problem of infant death and its solution in the form of “partnership.” symbolic association of statistics on infant death with “progress” rendered compliance with the policy on partnership as a way of becoming modern and not being “left behind”. But in addition to playing to individual aspirations, statistics also helped “educate desires” (Li 2007) in another dimension. By presenting infant death in terms of aggregate statistics such as life expectancy rather than as a personal tragedy, Pk Bujang

was encouraging mothers and paraji to “partner” as a matter of civic duty, for the benefit of the community and nation. In this way statistics were used to convey a modern vision of good health citizenship. Mothers are encouraged to give birth at a clinic with a medically trained bidan not only for their own health and that of their infants but also in order to improve statistics for the community as a whole. In this way health statistics are being used to frame the community’s position on the path towards development. It is the responsibility of all citizens to play their part in advancing the statistics and in so doing, to advance the development of the community. Evidence based public health is being used in this example not only as a moral framework but also as a form of governance giving rise to a particular form of health citizenship.

Several months after the meeting I asked the midwives whether they thought it had had an impact. They thought it had. They knew at least one mother who had subsequently decided to use a bidan. But despite the apparent power of statistics as a motivational tool, not everyone involved in health promotion uses statistics in the “art of persuasion”. Case studies and personal consultation are also used extensively by midwives and others to persuade people to change their health behaviors.

In the following example Pk Budi, the head of Desalindah village who is widely known for his health promotion work, uses a more personal approach to convey his message. Clearly a strong supporter of “modern” biomedicine, he has assisted countless villagers in accessing hospital care and health insurance. But occasionally he encountered reluctance on the part of villagers to agree to hospital referral. For example, he related

how one father had refused to allow his daughter to be taken to hospital during childbirth. The bidan had recommended a hospital birth due to a complication. Despite the support of other family members and neighbors the father remained adamant that his daughter would not go to hospital, perhaps because he feared the cost of a hospital birth. In desperation Pk Budi turned to him and said “you have killed one daughter, do you want to kill another?” Apparently, the sister of the expectant mother had already died in childbirth under similar circumstances. Suddenly shamed by this outburst the father agreed to his daughter being taken to hospital, where she and her infant survived the birth. Rather than “blinding with science” in this case Pk Budi chooses to reach across the communication gap by referencing the moral identity of the father as responsible for the health of his daughters, thereby contextualizing the issue in terms that the father could relate to.

Village midwives and other health workers are steeped in local knowledge and personal experience that informs them that not all cases are the same. Furthermore they recognize the wide variation in the competence and experience of paraji and bidan as well as the inadequacies in the health facilities that are currently available to the public. In private conversations some do acknowledge that there may be cases where a mother lives so far from the nearest bidan, puskesmas or hospital that using the neighboring paraji could actually be less risky than transporting the mother to the nearest, possibly under-resourced facility. Yet in their health promotion work with the general public they tend to present the standard government policy that encourages every mother in every situation to use a medically trained bidan or other health personnel for childbirth.

7.4.2.2 Conclusion

Although the use of statistics and targeting is not new in Indonesia¹⁶⁰ with the rise of EBPH statistics have acquired a new presence and they are being used in different ways (Erikson 2012, Storeng and Behague 2014). Statistics continue to be collected “from the bottom up,” that is, from the posyandu and puskesmas. These statistics are used both as a source of health information and as a mechanism through which supervisors manage health workers at lower levels in the system. But with the advent of EBPH global statistics have come to play an important role not only in framing health policies but also in encouraging public compliance through everyday practices of health promotion. It is interesting to note that the “top down” application of global statistics to local settings is occurring at the same time as the decentralization of government is rendering decision making more “bottom up”. Perhaps this is because under decentralization, kabupaten health managers need to lobby for health in competition with other sectors, and in this context the use of health statistics lends them credibility. Even though the global statistics must originally have been generated from specific localities they acquire greater symbolic power the more global they appear to be. Indeed, as suggested by their use in Jampersal training, global statistical correlations are sometimes used as if they represent universal laws of health governance. This renders them, and by implication the speaker, incontestable. No wonder then that EBPH operates in the art of persuasion all along the state-citizen continuum.

¹⁶⁰ For example, statistics and targets were extensively and effectively in the family planning program under the New Order government.

But although the use of statistics in health promotion is common it is not universal. Even where it is used, it is often combined with other approaches, such as the use of case studies, and with other moral frameworks including Islam and the right to health. As the above examples show, choosing EBPH signals a particular type of moral account in which a health manager or worker is presenting themselves as simultaneously modern and beyond contestation.

7.4.3 Right to Health

The third moral framework regularly deployed in health governance work in Indonesia is the right to health (Hildebrand 2013). The language of the Right to health is evident in various laws and regulations and is used verbally in relation to specific government policies and programs. It appears to be entirely a language of government. I never heard the term used by ordinary people in conversation, and when I asked about it it was immediately associated with government programs. Examples of its use in official documents include the decentralization Law 32, 2004, the amendment to Law 22 1999 on Regional Administration, where it is stated that under Regional Autonomy kabupaten and urban governments must provide health services in line with the “right to health” (Government of Indonesia (GOI) 2004). Similarly, Law 36, 2009 on Health opens with the statement that “health is a basic human right....that needs to be formed in line with the future goals of the nation of Indonesia as intended in the Pancasila (state philosophy) and the Basic Law of 1945.” (GOI 2009) These extracts reveal a close alignment of “right

to health” with government policy in the decentralization era and with the government philosophy of Pancasila.

Prior to decentralization, however, the language of “rights” rarely appeared in government discourse. Even though the “right to health” is mentioned in the Constitution that was drawn up in 1945 at Indonesia’s independence (GOI 1999 [1945]), little attention was paid to the concept by the first two governments of Indonesia under Presidents Sukarno (1947-1965) and Suharto (1965-1998). Under these governments the whole society was imagined as being united by a common interest – the development of the nation. Since individual interests were perfectly aligned with this common interest there was no need for guarantees of individual human rights (Antlov 2000, Mulder 1998).

It was only after the resignation of President Suharto in 1998 amidst calls for “reformasi” (political reform) that the language of “rights” entered government discourse. Political reforms in the post-Suharto era were driven by demands for a pluralistic democracy and a more just distribution of resources. The regions demanded a fairer share of resources and individuals demanded opportunities to express their political views. In order to maintain credibility within this changing political landscape the rhetoric of the government needed to change. It was at this point that the government started to use the language of human rights and the right to health. The Constitution was amended and references to human rights were elaborated in more

detail. Perhaps even more significant, a Human Rights Commission was established in 1999 to investigate abuses of human rights both during and since the Suharto regime.

The “right to health” now appears regularly in laws, regulations and health program guidelines. Health officials in Lahانبesar kabupaten regarded the “right to health” as the justification for the government’s still dominant role in the health sector. This helps explain why they frequently used the term “right to health” in their health promotion work both to motivate staff and to encourage public compliance with government health policies.

The deployment of “right to health” by government in Indonesia contrasts with other contexts where “right to health” discourse is used by citizens to put pressure on government to provide health services. For example, in Brazil citizens use the language of “right to health” to pressure the government into financing treatment for HIV and other health conditions (Biehl and Petryna 2011, Jerome 2014). By contrast, in Indonesia “right to health” is exclusively a government discourse that provides government health officials with a rationale for enrolling citizens into public health programs.

A second distinguishing feature of the interpretation and use of the right to health in Indonesia is its close alignment with Islam. Human rights are seen as having their roots in religion rather than in the UN Charter for Human Rights of 1948. For example, Law 39 1999 on Basic Human Rights (GOI, 1999c) describes human rights as a gift from God, stating that it is the duty of the nation, government and every person to respect and protect the dignity of all humans. The relationship between human rights and religion is

elaborated in a recent paper on human rights written for the training of government civil servants (Gani 2012). Gani traces the links between the concept of rights and the world religions recognized in Pancasila, namely Islam, Catholicism, Protestantism, Judaism, Hinduism and Buddhism, quoting from the respective religious texts. Kenny et al. (2012:290) also note that Indonesians interpret the right to health as consistent with Islamic beliefs.

Several of my respondents articulated a strong link between Islam and the right to health. Curious to learn more about the connection, I inquired about human rights from an Islamic teacher following his teaching at the kabupaten health office. He said that the term “hak” (right) was indeed in the Koran. The poor were described as having the right to compassion and material support from the rich. Viewing the right to health through an Islamic lens may encourage certain interpretations over others. In particular it may lead to an emphasis on protection and on the rights of the poor.

I discovered how my key informants from the kabupaten health office interpreted the “right to health” when I presented them with a scenario that had been related to me by a kader. The volunteer had told me the story during a focus group discussion with seven kader on dilemmas they faced in carrying out their work.

Kader play an important role in promoting government policies on childbirth because they interact with both mothers and paraji on a daily basis, whereas the bidan only appears at the monthly posyandu. But volunteers can find themselves caught between their roles as members of their community and as semi-official agents of the

government. In this particular case the kader needed to balance the wishes of the mother with her responsibility to implement the current policy on “partnership” between midwives and paraji (traditional birth attendants).

The kader described how she was at the home of a mother who was about to give birth with the assistance of a paraji, who was already present. When the paraji suggested calling the bidan, the mother refused saying she just wanted to give birth at home with the paraji, and she was “malu” (embarrassed) to call the bidan. The kader was faced with a dilemma because she was aware of the current government policy, dating from 2000, that paraji are no longer allowed to attend a birth without a medically trained person, such as a bidan or doctor, also being present. The paraji was clearly willing to “partner” with the village bidan because she had offered to telephone her. It was the mother who refused to go along with the policy. The kader, who had herself received some training on how to detect signs of a complicated birth, judged that the birth was not risky. She decided not to telephone the bidan. She respected the wishes of the mother and the baby was born at home with the paraji without any problems. In the ensuing discussion with several other kader it was concluded that the volunteer in the story had made a reasonable decision. Only in the case of an emergency should a mother be forced to use a bidan or other medically trained personnel, against her will.

I presented the scenario of the mother choosing the paraji at a focus group discussion with departmental heads at the kabupaten health office¹⁶¹. I asked whether the government policy of using the bidan didn't undermine a mother's right to choose the

¹⁶¹ This focus group discussion is referred to in Chapter 4.

paraji if she so wished. The ensuing discussion revealed how these health managers understood the “right to health”.

Pk Dedi, a nurse by training explained: “so it is our task that every citizen of the Republic of Indonesia has the right to access health services that are good, so when the community is helped by midwives as health workers we have already fulfilled this right. On the other hand every member of the community has the right to choose to whom they will go for health services. But if they go to the paraji this is not a service from a health worker.” Bu Nunung, a bidan, agreed: “really (the paraji) is not a health worker. Pk Dedi continued: “so from the point of view of their rights, they do not obtain the right to access health services that are as good as possible.” Bu Nunung continued: “it does not contravene her rights”.. (if she has to use the bidan rather than paraji), Pk Dedi interrupted “it does not contravene them, it fulfils them.”

This ex-change between Pk Dedi and Bu Nunung suggests that the “right to health” is interpreted as the “right to good health services”. They see it as the responsibility of government to fulfil this right. Since the paraji is not, in their view, providing a health service, using the paraji cannot fulfil the “right to health”.

Drawing on my own cultural background that places a high value on “choice”, I persisted with my query about the “right to choose,” asking: “so the community has the right to choose health services?” Pk Dedi corrects me by interjecting: “to obtain health services.” I add “and to choose...” but I am interrupted again by Pk Dedi and Bu Nunung who say, together, “in line with competency.” I venture: “so in this context a paraji is

not a health service?" "No!" Pk Dedi responded scornfully, "not a health worker." But, I add "apart from the paraji there are other spiritual healers." To this Pk Dedi responds: "yes, really in essence people have a right to choose, you cannot force them, but our role as government is to manoeuvre towards the correct way, that when the time comes to assist with a birth it should be by a health worker who is competent." Bu Nunung adds "to give information, for example, we can say to people: 'actually that is not a health worker in line with competency', in the case of a spiritual healer (laughs) but if they really want..." Pk Dedi adds: "it is the beliefs of the community." Bu Nunung continues: "seeing this belief, go ahead, but it is our duty to provide information... that they have a right to have their health problems handled, for example, basic health services at the puskesmas, at the puskesmas there are health workers who can really provide health services, whether nurse, bidan or doctor, according to their authority. So we, as health officers have a duty to provide information to the communities, but the choice falls on the community themselves."

I infer from this conversation that the "right to choose" is subsumed beneath a more important right, the "right to good health services". To ensure that this right is fulfilled government health workers have a responsibility to inform people that using a medical practitioner is the correct path. If, despite this education, they choose a spiritual healer then they cannot be forced, but the health worker should do their utmost to orient the choices of the community towards proper health services, such as those available at the puskesmas.

The kader who had told the story of the mother choosing the paraji had concluded that since it was a “normal” birth it was acceptable to allow the mother to give birth without medical assistance. But they had all agreed that in the case of an emergency the mother must be forced. Bearing this in mind, I asked the kabupaten health office departmental heads “but in the case of a woman who is bleeding severely you have to force her?”

Pk Dedi responded “you have to” and Bu Nunung added “if it is already an emergency we have to force.. the family.... without asking permission.” Pk Dedi elaborated his reasoning thus: “because the health worker is responsible. Even if (the mother) chooses a paraji for the birth, if severe bleeding occurs we are responsible, the health worker.”

Pk Dedi is referring to a policy known as “wilayah kerja” or working area policy that holds that midwives should know about all births in their area. Even if a woman never uses the government service, their reproductive health is still the responsibility of the bidan who covers that area (Magrath 2010).

Seeking further clarification I asked “but if there is no emergency if for example the birth is safe, do you agree with the kader who said ‘if it is safe just leave it, only in the case of an emergency?’” Pk Dedi and Bu Nunung responded in unison: “we cannot,” and Pk Dedi continued: “agree with the kader, in our case we agree with the regulations, and with the right that the community has to obtain health services.”

This statement confirms the close alignment between the right to health and government policy and regulations in Indonesia. For Pk Dedi upholding the right to health is synonymous with following government regulations. This understanding of

right to health was shared by other government officials. Indeed, when I discussed the same scenario of the mother choosing the paraji with other kabupaten health officials the responses were remarkably similar. Nearly everyone disagreed with the judgment of the kader and regarded the right to health to mean using the medically trained bidan in line with government policy.

For example, Bidan Aisah, head of Health Services and a bidan by training, argued that every birth was inherently risky, and that a medically trained person such as a bidan or doctor should always be present. She added that when a woman opted to use a paraji and not a bidan she was not exercising her right to health but rather following a tradition. Since she lacked health education concerning the relative risks of paraji compared with medically supervised birth she was not making an informed choice.

From my conversations with Bidan Aisah it became clear that her perspective arises from her lived experience of tragic cases where paraji attended births had gone disastrously wrong. Although she acknowledged that the vast majority of births attended by a paraji and no bidan result in no harm, and that individual paraji vary widely in terms of their skills, experience and judgment, it is on the basis of these extreme experiences that she regards a birth by a paraji to be “risky” compared with a birth attended by a medical personnel.

But for Bidan Aisah the paraji is not only dangerous but also “traditional.” This suggests that she finds “tradition” to be incompatible with “right to health.” Rather, “right to health” signifies a move away from “tradition” and towards “modernity,” an attitude

also found by Hildebrand (unpublished) among government midwives in West Nusa Tenggara (NTT). The *bidan* in NTT had a similar interpretation of right to health to that of *Bidan Aisah* and the other *kabupaten* health officials I spoke with. They regarded right to health as meaning the right to access the best biomedical care. This interpretation of the right to health was deemed correct because it was seen to be in line with global health discourses as reflected in the recommendations they received from the World Health Organization. For these midwives, as for *Bidan Aisah*, right to health is a global language of progress towards development and modernity.

My initial interpretation from this discussion was that there was an implicit hierarchy of rights within the “right to health”. For Indonesian government health workers the ultimate right is the right of the public to be protected from harmful practices. This is reflected in the constitution that states that the primary responsibility of government is to protect the people, and in the health laws that render the *bidan* responsible for all pregnant women in her working area. The right to access both medical services and information about them is also prioritized, and this is seen as a key duty of the government in the health sector. The right of a citizen to choose a particular provider comes rather low in the hierarchy, and it is the duty of government health workers to orient this choice towards medically trained personnel.

These three elements of the right to health: protection, access and choice are reflected in global right to health policies (Wolff 2012). But different nations have given greater emphasis to one or other of these rights to health in government rhetoric. On a recent

visit to the UK I was struck by the emphasis given to “choice” when I visited my mother’s local surgery (government health clinic) and found posters advertising patients’ right to choose their own provider displayed prominently both outside and inside the clinic. This appeared to contrast with the perspective of my respondents at the kabupaten health office in Indonesia who emphasized protection from harm and appeared to be restricting choice. On further reflection I realized that such a comparison was misleading. In the UK the rhetoric of choice is believed to resonate with citizens’ preferences, so government policy tends to be framed in terms of citizens “choices”. In the UK childbirth “choices” are intensively regulated in order to minimize harm, just as they are in Indonesia. Although there is no equivalent of a traditional birth attendant and most citizens have long internalized the need for a medically trained attendant, the choice of a home birth with a trained bidan remains contested. In practice, just as in the Indonesia case, citizens “choices” occur within the framework of regulated options.

On the other hand, in Indonesia the contrasting rhetoric of “protection” and guidance evident in my respondents’ discussion mirrors the rhetoric of the government as reflected in the constitution and key policy documents. The governments’ claim to be protecting and guiding the people plays a key role in the legitimation of the Indonesian state. In the UK this might be interpreted as having connotations of the “nanny state” derided by Margaret Thatcher as accompanying the citizen from cradle to grave and stifling individual initiative (Rose 1999:139). But in Indonesia the goal of protection does not appear to be contested. The whole idea of government providing guidance is more culturally acceptable, perhaps because the idea of people needing guidance of any kind

is quite prevalent, whether that guidance is from Islamic teachers, government, parents or other sources.

These different interpretations of the “right to health” operating in different nation states offer an example of government alignment of official policy with cultural forms that resonate locally, just as Corrigan and Sayer (1985) observed. In a sense the UK government has co-opted the cultural value of “choice” just as the Indonesian government has co-opted the cultural values of “guidance” and “protection”.

7.4.3.1 Putting the “right to health” to work: Kabupaten Regulation on Partnership between Midwives, Paraji and Kader

During my fieldwork I witnessed the translation of government “right to health” discourse into a kabupaten regulation on partnership between midwives, paraji and kader, passed by Lahanbesar kabupaten local parliament in April 2013. As described earlier in this chapter, partnership was a national policy intended to reinforce a regulation dating from 2000 that every birth must be attended by a medically trained person. Despite a massive program of training and deployment of village midwives from the early 1990s, in some regions they remained vastly outnumbered by traditional birth attendants known as dukun anak, or, in West Java, as paraji. The national policy of “partnership” was intended to ensure safe delivery through the presence of a medically trained bidan at every birth while diffusing potential competition between bidan and traditional birth attendants. According to “partnership” midwives were to play a medical

role while dukun anak played a complementary cultural role and supported the bidan by, for example, informing her when a birth was imminent.

The decision by the kabupaten health office to push for a kabupaten regulation provides an example of how Lahanbesar kabupaten is using the authority granted to it under decentralization. According to the decentralization laws, kabupaten can pass their own regulations provided that they are in line with national policy. Many kabupaten have not yet adopted regulations concerning partnership between bidan, dukun anak and kader. Hildebrand (2012) researched village bidan and dukun anak in West Nusa Tenggara (NTT). She found that bidan do not talk of partnership with dukun anak, but rather seem to be in open competition with them. In other areas of Indonesia, particularly urban areas, dukun anak no longer operate, and bidan attended births are already the norm, so there is no perceived need for “partnership”. Against this background of wide variation between provinces and between rural and urban areas, Lahanbesar’s regulation represents an attempt to render national policy “appropriate” to the local setting.

According to government health workers the local regulation was necessary in their kabupaten because the Sundanese cultural practice of using the paraji was still very strong in Lahanbesar. Current efforts by village bidan to promote partnership were thought to be having some effect. These efforts included counseling mothers, reaching out to paraji, and promoting the government health insurance for childbirth, Jampersal, which is conditional on birth taking place at a health facility. But some paraji continued

to practice alone, and an estimated 20% of mothers in the kabupaten still preferred to use the paraji, even when the services of the bidan were offered free of charge under Jampersal. The regulation would provide a legal basis to strengthen efforts to draw these recalcitrant citizens into the partnership policy.

Pk Yudi, head of Health Promotion at the kabupaten health office, campaigned hard for this regulation. He allocated some of his staff to research the attitudes of paraji, arranged meetings with the legal department of the local government to help edit draft versions of the regulation, and argued the case for the regulation at a parliamentary meeting.

I was invited to the parliamentary meeting which took place at the main meeting room at the “pendopo,” the office and residential complex of the Bupati (kabupaten head). It was a sparsely furnished room with a stage at one end and doors opening onto a courtyard along one side. A very large rectangular table was arranged with chairs around it. Four senior members of the Parliamentary Health Commission occupied the top end of the table. Along one side, facing the courtyard, were staff from the kabupaten health office, the head positioned close to the top end, followed by heads of departments and sections, then junior staff. At the lower end of the table, opposite the Commissioners, two village bidan sat with two paraji whom they had invited from their villages. Thus, the seating arrangement mirrored the social hierarchy of the local government and health office. I joined some of the parliamentary staff seated along the second long side.

In her opening speech Dr. Nia, the head of the kabupaten health office framed the regulation on partnership as a means of addressing the problem of maternal and infant mortality, a strategy that was echoed by her colleagues, including Pk Yudi, who spoke after her. Dr. Nia skillfully focused on local statistics to make her point. She stated that West Java had the highest number of maternal deaths in the country¹⁶². Out of 77 maternal deaths in Lahanbesar kabupaten in 2012, 25 of them had occurred at births attended by paraji with no bidan or other medically trained personnel present. This amounted to 32% of maternal deaths. Leaving aside the fact that the majority of maternal deaths – 68% - could not be attributed to paraji, and offering no data on the more relevant statistic of the percent of paraji attended births that ended badly compared with the percent of those not attended by paraji, she moved swiftly on to her next point. She recounted how a pilot in regulating partnership conducted in 23 villages in 2007-8 resulted in 95% of births being attended by medical bidan, and the incidence of maternal deaths fell.

Shortly after Dr. Nia, the head of the bidan association spoke, noting that even though there were currently 628 bidan in Lahanbesar kabupaten the ratio of bidan to paraji was 1:5. Pk Yudi commented that in this context competition with the paraji would never work, the bidan would always lose. Therefore partnership was the only solution to addressing the problem of paraji working alone. Paraji Ma Jaja added that partnership

¹⁶² She added that the number of maternal deaths was not estimated in relation to the number of births. She implied that this was unfair since West Java also has the highest population in the nation. Once adjusted for the number of births, the maternal mortality rate for West Java is not the highest.

had been working well in her area since 2007, and that the main concern of paraji who do not partner is that they would lose work (“paraji takut hilang pekerjaan”).

Several of the health commissioners then pointed out that paraji were part of the Sundanese culture, that they were respected in the community and that played an important spiritual role. Furthermore, paraji had rights that needed to be protected. As one member of the commission put it: “We don’t want to eliminate paraji as they have done in some areas. We need to protect the rights of the paraji as well as the bidan.”

The response from the kabupaten health office was that they were not aiming to eliminate existing paraji but, as the head of the bidan association put it, “we have to clarify the limits of their work.” She added, rather revealingly, “we hope that there will not be additional paraji.” Dr. Nia then referred to another government scheme aimed at addressing the problem of paraji, a scholarship program offering the children of paraji training in midwifery to become village bidan. She added that 50 children of paraji, rather than inheriting their mother’s practice in the usual manner, had been trained in midwifery and had become government contract bidan with monthly salaries between Rp 650,000 and Rp 3 million (US\$ 65-300).

The tone of the parliamentary debate reveals how the kabupaten Health office has to tread carefully in the domain of Sundanese culture, especially as it overlaps with the spiritual, including the Islamic culture shared by all of those present. The key moral framework used to persuade the commissioners was evidence based public health, the local statistics on maternal deaths and on the behavior of paraji. In response the

commissioners used the moral framework of “rights” of the paraji. In the end the statistics won out, when Pk Yudi stated that “there were seven deaths in one month” and one of his staff added “and four deaths last month”. To this the head of the health commission responded, laughing, “if there were seven deaths in one month, why have we not done this earlier?” He promised to push the legislation through as quickly as possible.

My visits with paraji left me with the impression that there was more at stake for them than the fear of losing work, although this was an issue in some cases. In Desalindah village Kader Mestina took me to visit her aunt, Ma Halimah, who is a paraji. Several mothers I had met in the village and at Kader Mestina’s posyandu had mentioned they used Ma Halimah, either on her own, or, more recently, together with a bidan. Ma Halimah, who is 80 years old, told me about how she used to go for training at the puskesmas as long ago as the 1980s, and that she has worked with five different village bidan over the years. One of them gave her money when she helped at a birth, but the current one does not, even though she attended a meeting at which the Camat (head of the kecamatan) promised that paraji would receive Rp 50,000 (US\$ 50) and kader Rp 25,000 (US\$ 25) for each birth where they helped a bidan. She has not received any remuneration from bidan since this meeting, although she does receive compensation from the mothers, usually Rp 50,000 (US\$ 5) for a birth and Rp 20,000 (US\$ 2) for the five subsequent home visits she makes. Although Ma Halimah does cooperate with bidan in line with the “partnership” policy, when I asked her which was better, before or after “partnership” she said: “before was better because I could assist at a birth on my

own. Now I have to report (to the bidan). If I don't let the bidan know about a birth I am given a warning ("tegaran"). If a birth happens too quickly and I don't report until afterwards, I am scolded." According to Ma Halimah the main difference between bidan practices and her own is that the bidan has medicines and injections while she uses massage. But she and the kader sometimes go the bidan after a birth to get medicines.

When I mentioned to Pk Yudi that I had encountered paraji who preferred not to partner, he argued that the regulation would benefit paraji because they would no longer be responsible for poor birth outcomes. The bidan would be responsible and the paraji would be protected by the law provided that they partnered with a bidan. He claimed that the regulation would ensure that paraji suffer no financial loss since it included a local government budget to pay them a fee each time they partnered with a bidan. Previously bidan had been encouraged to pay the paraji a proportion of their fee, but not all of them had done this.¹⁶³

Pk Yudi's claim that all parties would benefit from the regulation is reflected in the way that the regulation is framed. The text of the regulation repeatedly uses the language of rights to convey the message that the regulation will benefit each party. It states that a mother has the right to obtain adequate assistance during pregnancy and at childbirth from medically trained personnel; she has the right to obtain contraceptives; her baby has the right to colostrum and to six months exclusive breastfeeding, in line with the latest recommendation from the World Health Organization. The bidan has the right to

¹⁶³ In Desalindah village the bidan claimed to pay the paraji, while the paraji denied receiving any payment from the bidan.

protection from the law, to carrying out her duties in line with her authority and standards of practice, and to receive financial compensation for her services. The paraji and volunteers have protection from the law in carrying out partnership, and the right to financial compensation for partnering with the bidan.

This document reflects the hierarchy of rights discussed earlier, according to which protection from harmful practices takes precedent over patient or provider choice. Indeed none of the protagonists mentioned have any options from which to choose. If this regulation is read in conjunction with pre-existing laws and regulations, then each “right” in fact represents an obligation. The statement that a mother has the right to obtain adequate assistance during pregnancy and at childbirth from medically trained personnel implies an obligation on her part to use the services. If she fails to use medical services for childbirth she not only violates the partnership that is the subject of this regulation, she is also going against the related regulation that a bidan must always be present at a birth. Similarly, the baby’s right to colostrum and six months’ breastfeeding are framed as the baby’s right to health, and this amounts to an obligation on the part of the mother to provide the baby with these “rights”.

The link between the bidan’s rights and obligations is even more direct. Indeed it is included in the regulation. The bidan’s right to carry out her duties in line with her authority and standards of practice is also included under another section of the regulation as her obligation. Furthermore, it is stated that the kabupaten government has the authority and the duty to supervise bidan to ensure that they are in fact

following standards of practice. So if she were to choose not to enjoy this “right” to carry out her duties, she would be liable to be disciplined. She might even lose her job.

The paraji and volunteers have protection from the law in carrying out partnership. This implies that they lose such protection if they do not carry out partnership, again leaving them no choice in the matter. I am not implying that any of the parties to this regulation should be allowed more choice. Rather I am drawing attention to the way in which the term “right” is used in the document to convey a situation of very limited choice, a situation where “rights” in fact often amount to obligations. Similarly, Hildebrand (unpublished) found that bidan and mothers in NTT interpreted a mother’s right to health as an obligation for her to use a bidan for childbirth in line with government policy.

This use of the language of rights by government contrasts with its use elsewhere. As mentioned above, citizens in Brazil have used the language of the “right to health” to press claims on government to finance their medical care (Biehl and Petryna 2011, Jerome 2014). In this case the citizen can choose whether or not to exercise their rights, and they are not under pressure from government to do so. But once they do choose to exercise their rights this immediately implies an obligation on the part of government to fulfill these rights, rather than an obligation on the part of the citizen to comply with government policy.

The case of the regulation on partnership also reveals *how* the language of rights is deployed in the formulation of a regulation. Rights in this document are not universal

invariable entitlements shared by all people as envisaged by the UN in the Declaration on Human Rights (1948). Rather, each category of person has their own specific set of rights that take on meaning only in relation to their relationship to particular policies. For example, the policy, dating from 2000 that women should give birth assisted by a trained bidan or doctor is here framed as the mother's right. The policy, formalized in the regulation that a paraji should partner with a bidan is framed as the paraji's right. Rights are not simply referred to in the regulation, they are actually defined by it. Furthermore, since policies may evolve over time, the implication is that rights may also evolve.

I regard the practice of constructing rights in relation to policy is an example of "everyday state formation". This term has been used to refer to the everyday practices of government that serve to reproduce regimes of rule (Corrigan and Sayer 1985, Newberry 2006). According to this view, the repeated application of the rules and regulations of government amount to a moral regulation of citizens. But in tracing the development of a new regulation I witnessed something more than the reproduction of government. This was a creative act on the part of key actors within the kabupaten health office to generate government through the construction of a new regulation. They chose to use the right to health as a component of this creative process. I contend that the right to health was deployed as a "mobilizing metaphor" (Mosse 2004, Shore and Wright 1997). Mosse argues that "mobilizing metaphors" that are open to a wide range of interpretations are necessary for a policy to be successful, since they ensure buy in from as many stakeholders as possible. In this particular case the "right to health"

operates as an effective mobilizing metaphor for two key reasons. Firstly, it gives the regulation moral force since to oppose the regulation amounts to being against people's rights. Secondly, using the language of rights helps to frame the regulation as being in the best interests of each party to the partnership. It could thus be read as an attempt to address potential opposition from paraji and pregnant mothers who are targeted by the regulation. Rather than acknowledging the opposition directly the regulation transforms it into its opposite – mutual benefit.

7.5 Discussion: Moral Pluralism in health governance

In this chapter I have traced how three inter-related moral frameworks are deployed in everyday health governance in Lahanbesar kabupaten, West Java. I refer to the way in which health workers draw on these various moral frameworks in their health governance work as “moral pluralism”. I observed Islam, evidence based public health and right to health being combined in various ways that allowed speakers to tailor their health promotion speeches to the audience and the material at hand. At the same time, they helped forge the moral identities of the speaker as a good Muslim or a globally informed health worker. But the three moral frameworks are not merely alternative tools in the art of persuasion. They are also inter-related in a number of ways.

For my respondents Islam appeared to be foundational to all other moral frameworks because it amounts to a world view that orients all thought and action. We have already seen that human rights, and by extension the right to health, are seen as originating in Islam. Evidence based public health, as a scientific practice associated with modernity,

can also be aligned with Islam according to the widespread view in Indonesia of Islam as a modernizing force and as the foundation for science and development. I heard this view expressed in an Islamic teaching session that I attended at the kabupaten health office. The preacher insisted that if Indonesia gave up Islam they would never progress. This alignment of Islam with modernity helps explain the widespread use of Islam in the contemporary workplace in Indonesia (Stein 2007, Rudnyckyj 2010).

Evidence based public health is foundational in a different sense. Contemporary health policies are generally founded on a statistical evidence base, whether generated locally or originating elsewhere. Many health policies in Indonesia are based on recommendations from the World Health Organization. These recommendations are evidence based, derived from extensive global health research. An example would be the policy that mothers should breastfeed their infant exclusively for the first six months of their life. Other policies, such as the policy on partnership between bidan and paraji, are based on evidence generated locally on infant and maternal deaths and their causes.

In their analysis of evolving approaches to advocacy for Safe Motherhood, Storeng and Behague (2014) find that the more recent evidence based approach to advocacy on safe motherhood undermined the earlier rights based approach. Whereas the rights based approach used in the 1980s argued for safe motherhood as an end in itself EBPH frames it (also) as an efficient investment in human capital. In this case right to health and EBPH are regarded as alternative justifications for investment in safe motherhood. By contrast, I found health workers in West Java regarded the two frameworks as

complementary and indeed used health statistics to provide a basis for defining right to health. As we have seen, the right to health is interpreted as protection from harmful practices and it is statistics that informs which practices are harmful and how a safer birth can be achieved. Because the statistics indicate that a biomedically supervised birth is safer this becomes the right to health for mothers.

The term “moral pluralism” is intended to capture not only the use of multiple frameworks but also their entwinement with each other. Based on my observations, I argue that these moral frameworks, in combination, help define a new form of health citizenship. Health citizenship has always involved an obligation to conduct oneself in ways that reduce public health risks at the community and national level, through for example, vaccinating ones children or using latrines. Citizens and health workers are now being encouraged to understand health citizenship in new ways through the lens of health statistics and the language of right to health. They are urged to regard infant and maternal deaths not only as personal tragedies but also in terms of their negative impact on statistics for infant deaths, maternal deaths and life expectancy. Their obligation as good citizens is reframed as an injunction to help improve the statistics through changing their behaviors in line with government policy that is itself derived from statistical understandings of the problem. Improving the statistics is framed as a moral duty and a component of health citizenship because it will benefit the community and ultimately the nation. At the national level improved statistics are perceived to translate into “development” and a global health citizenship from which all Indonesians will benefit.

In order to reinforce this message of mutual benefit, adherence with government policy is framed as a right to health. As we have seen, Right to health in this context means “right to health services that are good” since this will protect citizens from potentially harmful practices. According to this perspective, traditional health practices not only put the wellbeing of the individual at risk they also threaten to worsen health statistics thus causing the community to lag behind. This is why compliance with government policies to use medically trained personnel, framed as a right to health, is actually a requirement of good health citizenship and consequently, a “must” (Hildebrand 2013). Fulfillment of the right to health through compliance with evidence based government policy is an obligation both for health workers and for the good citizen. In this way moral pluralism amounts to a form of governance that helps generate new forms of citizenship.

I do not think that moral pluralism as a technique of health governance is new in Indonesia. I do contend, however, that the particular configuration of moral frameworks that I encountered has emerged only recently, in the era of decentralization. The emergent use of Islam, right to health and evidence based public health is related to shifts in the political climate that have determined what is now acceptable and possible in terms of government rhetoric and techniques.

During the New Order government of President Suharto health programs were implemented in a top down, military style, indeed program managers were often military or ex-military officers. A prime example of this is the family planning program that placed intense pressure on health officials and volunteers to achieve numerical

targets. Several health workers I spoke to remembered visits from the kabupaten manager of this program. Woe betide anyone who had not reached their targets! In the post-Suharto era this heavy handed style of government is incompatible with the new political rhetoric of regional autonomy and democratic decentralization. This shift is reflected in a new language of “rights,” and in the health sector of the “right to health”, an idea that had little traction during the New Order government.

Political reform coincided with economic reforms in response to the Asian economic crisis. As a result, the goals of the national project of “development” changed. Under the New Order government development meant building the nation state¹⁶⁴, and developing an Indonesian identity. This required that every citizen sacrifice their individual religious and ethnic identities and their personal desires for the good of the nation state. In the wake of the Asian economic crisis of the late 1990s, this “state led development” project (Rudnyckyj 2010) has been modified. “Development” is now oriented towards achieving and maintaining global competitiveness. In an attempt to meet new goals, existing moral frameworks are being deployed in new ways. As an example, Rudnyckyj (2010) describes how a particular brand of evangelical Islam was used to motivate workers in the Krakatau Steel Factory as they faced the new challenge of privatization, following economic reforms in line with IMF loan conditionalities. Workers were enrolled in trainings combining American business management and life coaching frameworks filtered through an Islamic lens. Muslim virtues were aligned with

¹⁶⁴ The Indonesian term generally translated as development is pembangunan which literally means building. Tsing (1993) notes that the people she lived with in Kalimantan, regarded government development projects as nothing more or less than construction projects.

corporate values in a bid to increase productivity and competitiveness, and eliminate corruption. Giving alms was likened to 'strategic collaboration', a win-win approach (Rudnyckyj, 2010, p.8). Corruption was to be tackled through ascetic practices of self-control, such as fasting. Workers were to feel accountable to God in the workplace. Globalization was not to be viewed as a result of government policy, but rather as an indication that God was raising the workers to a new level, following the economic crisis which had reflected a moral crisis. In this way a (neo)capitalist work ethic is re-framed as a spiritual duty.

I would argue that there is a parallel shift in the health sector, where Islam is being deployed in new ways to meet the latest challenges in public health governance. Although not facing privatization, the health sector is being subjected to a parallel form of global competitiveness, namely the competitive ranking based on statistics such as the Millennium Development Goals (MDGs). Meeting the targets of the MDGs has become a paramount goal requiring new techniques in health governance. It is in this context that moral pluralism has emerged as an important component in contemporary forms of health governance in Indonesia.

Chapter 8: Conclusions: Moral Pluralism in the age of

Decentralization

8.1 Introduction

The goal of this dissertation has been to improve understanding of contemporary health governance in Indonesia. The Indonesian government underwent a dramatic restructuring in 1999, following the resignation of President Suharto in 1998. During the 32 years of Suharto's New Order government resources and administrative control were increasingly centralized and a monopoly of political power was legitimized in the name of national economic development. The government reforms that were implemented in 1999 were framed around a different moral foundation, that of democratic decentralization. Having witnessed the political turmoil surrounding this transition I returned to Indonesia twelve years later, hoping to discover what had changed and what had endured in the culture of the bureaucracy and the ways in which power was exercised. Building on my previous research, I chose health as a lens through which to trace shifts in forms of governance and related ideas about health citizenship.

In my analysis of health governance in the decentralization era I have drawn on Weber's (1999) analysis of the bureaucracy as an administrative apparatus that is both rational and moral, involving rational techniques of government implemented by a workforce expected to conduct itself according to a bureaucratic ethic. The bureaucratic ethic demands that the workers dedicate themselves to the goals of the office and follow the rules and regulations associated with their position. Building on Weber (1999) I suggest

that democratic decentralization in Indonesia has given rise to a decentralization ethic based on the principles of “bottom up planning”, flexibility and negotiation oriented towards solving local problems. This decentralization ethic, developed by kabupaten level officials seeking to assert their new autonomy under decentralization laws, is contrasted with a centralization ethic of inflexible standardization manifested by central government. I suggest that both of these ethics operate within a Weberian bureaucratic ethic, adherence to which is necessary in order to demonstrate that the government has really reformed from the “collusion, corruption and nepotism” associated with the Suharto era. The emergence of these competing ethics offers one example of how decentralization brings to the fore the existence of multiple voices within government, an empirical reality that is obscured in some theories of the state. For example, Marxist theories assume a unity of interest within the state, since the state is seen as promoting the interests of the ruling class. My work agrees with Painter’s (2006) observation that the state tends to be multi-vocal because of its administrative complexity. But whereas he finds government officials striving to present a unified front I found kabupaten government officials emphasizing difference in order to build their own moral and political identities.

Moving out of the office, in Chapters 5, 6 and 7 I examined how these kabupaten officials convey public health messages to the public. Drawing on Corrigan and Sayer (1985) I regard public health promotion as a form of moral regulation. Corrigan and Sayer (1985) argue that the state engages cultural forms to achieve the moral regulation of both rulers and ruled. In their analysis moral regulation through culture serves to

legitimize the state and to orient subjectivities in line with the ideology of those in power. As Ruonavaara (1997) points out, a shift in subjectivity means that the person so regulated wishes to behave in the designated manner. Unlike other forms of social control that only involve behavioural change, moral regulation therefore involves a conscious shift in the management of the self. Following this definition, I argue that the health promotion work that I observed in West Java is just such a form of moral regulation. Through their health promotion work, health workers seek to create good health citizens, people who voluntarily agree to adopt “clean and healthy” behaviours, as the slogan for one public health endeavour phrases it.

The construction of good health citizens is part of a broader state project of progress towards modernity. Thus, the healthy citizen is one who behaves in line with global standards for correct health behaviours that include moving away from “traditional” medicine and towards increased use of biomedicine. For example, armed with global statistical evidence on “safe motherhood” (Storeng and Behague 2014) mothers are urged to give birth at a medical facility, while those who continue to use the familiar local birth attendant, or “dukun anak” are told they are “holding back the nation” (Hildebrand 2012, unpublished).

8.2 Two Balancing Acts

My conclusion from this analysis is that health governance work at the kabupaten level under decentralization involves two key balancing acts. The first balancing act is that between decentralization and centralization that I refer to as a co-existence. This

balancing act involves the negotiation of competing autonomies between the centre, the kabupaten and the kecamatan puskesmas (Chapter 4). The kabupaten asserts kabupaten autonomy against what they see as the encroachment of central government in the day to day management of programs. At the same time the puskesmas demands greater autonomy from the kabupaten. At one level competing autonomies involve a political tension as officials at each level seek to maximize their autonomy. But at a deeper level narratives about competing autonomies are moral accounts that reveal different ideas about how government ought to be conducted. Kabupaten officials believe kabupaten autonomy will allow the kabupaten to plan in line with local needs; puskesmas officials believe puskesmas autonomy facilitates community engagement.

Trisnantoro (2009) describes the political tension between centralization and decentralization using the image of the pendulum. This would suggest that at any one time it is possible to indicate where Indonesia lies on the pendulum. I prefer the more fluid idea of an on-going balancing act in which officials at each level are constantly negotiating their position. This is because my analysis of the implementation of decentralized programs in Chapters 5 and 6 shows that the tension between centralization and decentralization plays out at the level of individual programs. Furthermore, government officials at the kabupaten level can influence the process. For example, kabupaten officials designed and implemented the decentralized Desa Sehat program analysed in Chapter 5 on their own initiative.

Global policy worlds also influence the balancing act between decentralization and (re)centralization. In particular, pressure to achieve the Millennium Development Goals has encouraged re-centralization of some programs as central government seeks greater control over the process of achieving these global targets. This can be seen in the evolution of the Desa Sehat program into the more centralized, indicator driven Desa Siaga program (Chapter 5), and in the centrally managed government insurance programs Jamkesmas and Jampersal (Chapter 6).

This leads me to my second balancing act, that between global health governance worlds and local cultural and moral worlds. In this case there is no overt competition but rather a problem of alignment. Indonesia is incorporated into global knowledge networks (Natividad et al. 2012, Storeng and Behague 2014) that provide not only information but also a vision of modernity framed in terms of improved health. As Indonesia seeks to strengthen its role in global affairs it needs to demonstrate good health citizenship (Fidler 2004, 2008). Global health policies promoted by the World Health Organization and more recently by the Millennium Development Goals provide guidelines as to how this can be achieved and play a dominant role in shaping Indonesian health policy.

I argue that health officials seeking to bridge the divide between the present and an imagined future that is more closely aligned with global models of health development, engage in a form of moral regulation that I term “moral pluralism”. By this I mean that they draw on several different moral frameworks in their efforts to motivate junior staff

and volunteers and to persuade people to shift the way they manage their health in line with government health policies. I focus on three moral frameworks, namely evidence based public health, the right to health and Islam. I regard evidence based public health as a moral framework because of the way in which population health statistics reveal deficiency and urge improvement. Following Nichter (2013), Storeng and Behague (2014), Erikson (2012) and others, this analysis focuses on the performative and rhetorical role of health statistics rather than their informative role. The second moral framework, “right to health” operates as a mobilizing metaphor (Shore and Wright 1997, Mosse 2004) that presents health policies as being in everyone’s best interests and therefore beyond contestation. Finally, Islam offers an ideological and social bridge that helps government officials communicate these global health messages to ordinary villagers.

In a similar analysis Rudnyckyj (2010) describes how managers at a parastatal organize trainings for workers that combine two moral frameworks: American management techniques and evangelical Islam. The aim is to transform trainees into workers who can compete in global markets as they face privatization. I extend Rudnyckyj’s analysis in two ways. Firstly, whereas his analysis examines the deployment of Islam as a mode of moral regulation in a productive workplace I examine is application in the sphere of reproduction. Secondly, whereas Rudnyckyj’s analysis spans managers and workers, mine captures multiple positions along what I refer to as a state-citizen continuum.

The state-citizen continuum arises in Indonesia because of the proliferation of semi-official positions established under the New Order government of President Suharto with the aim of extending government to the household level and shoring up a political monopoly. Examples include the PKK volunteers studied by Newberry (2006) that often overlap with the kader studied here; “hansip” volunteer security guards; and elected neighbourhood leaders who collect census data on the population. In the post-Suharto era, despite the emergence of political pluralism, these positions have been maintained and even expanded to facilitate the expansion of welfare programs including public health. Another example of this is the revitalization of the posyandu (community health post) and its extension to include not only child survival, maternal health and family planning but also pre-school education and the development of “small and healthy families” under various new programs. The citizen-state continuum that pertains in Indonesia contrasts with state theories that present a clear dichotomy between the state on the one hand, and citizens who are acted upon by the state on the other. For example, Scott (1976, 1985, 2009) explores strategies adopted by citizens in order to resist or escape the state, implying that people are either of the state or outside of it. By contrast, in Indonesia many people are partially incorporated into state mechanisms. A prime example of this is the kader who mediates between government health workers, particularly the village bidan or bidan, and the general public.

The idea of a state-citizen continuum provides a background to understanding how “moral pluralism” works. As described in Chapter 7, moral pluralism involves extending various moral frameworks across the state-citizen continuum. In contrast to Scott’s

(1976) representation of a moral economy of the peasant that is in opposition to the (im)moral stance taken by the state, in my analysis of moral pluralism there is an overlap between the moral frameworks held by state representatives and those of kader and communities. In particular, moral pluralism is effective because Islam is a moral framework that is shared along the state-citizen continuum and can therefore be used as a filter for other moral frameworks such as right to health and evidence based public health.

Moral regulation through moral pluralism is not new in Indonesia but I argue that it has taken on a different form in the decentralization era. Since independence successive governments have promoted a syncretic state ideology of Pancasila. Each of the five principles of belief in one God, social justice, humanitarianism, government by consensus and national unity could be regarded as a distinct moral framework. The term “Pancasila democracy”, first coined by President Sukarno but also deployed by subsequent Presidents, can be regarded as a form of moral regulation through moral pluralism. But in the wake of government reforms following President Suharto’s resignation new forms of legitimacy have become necessary to demonstrate that democratic decentralization is in line with contemporary conceptualizations of good governance. In the health sector the moral frameworks of evidence based public health, right to health and Islam are not only engaged to regulate citizens, they also provide a new moral foundation to legitimize decentralized health government.

8.3 Multiple Forms of Health Citizenship

As suggested in the previous section, kabupaten government officials in West Java, Indonesia are engaged in a form of moral regulation that involves transforming the way that people conduct themselves in the field of health. This transformation is intended to benefit not only the individual but also the community and the nation as it develops in line with global standards of modernity. Health promotion thus involves promoting new forms of health citizenship. But just as decentralization reveals multiple voices within government (Chapter 4), so the various public health programs implemented in the decentralization era promote different visions of exactly what the good health citizens should look like.

In Chapter 5 we encountered the idea of the “self-sufficient” citizen in the Desa Sehat program. The self-sufficient citizen is closely associated with the program’s designers’ vision of how decentralized health services ought to operate. Following the principles of “bottom up planning,” self-sufficient citizens participate in meetings to discuss health issues and in group savings schemes to deal with emergencies and fund local health initiatives. They are supposed to achieve community autonomy through building their capacity to find local solutions to local problems.

Chapter 6 focused on government health insurance programs for the poor that seem to promote rather a different kind of health citizen. In this case the citizen is encouraged to be proactive by seeking biomedical care when they are sick. Health insurance enables them to do this by rendering hospital care affordable thereby removing one of the

major obstacles to seeking this type of health care. But this form of governance appears to be having some unintended consequences on practices of health citizenship. The bidan who complain that citizens no longer save are implying that the government insured citizen is incompatible with the self-sufficient citizen envisioned under the decentralized Desa Sehat program. Whether or not this is so, people insured under the government programs are asserting their citizenship in new ways. They are voicing their demands and complaining about poor quality services. In this way they are following a model of democratic citizenship in which people demand services from the leaders they helped to elect. Although this model of citizenship is not explicit in the program guidelines for health insurance, government officials recognize it as a consequence of “good governance” and are adapting to this development through various complaint resolution mechanisms.

In Chapter 7 we encounter new strategies for forming good health citizens. The regulation on partnership between bidan, traditional birth attendants and kader presents childbirth in the clinic as the citizens’ right, and therefore something that citizens should aspire to. Citizens interpret this “right” as an obligation to comply with government policy to give birth at a health facility. In this way, the right to health becomes a duty of citizenship (Hildebrand 2013).

In the same chapter we find evidence based public health used to envision yet another form of health citizenship. In this case the good health citizen is supposed to strive to improve the health statistics that reveal deficient behaviours among the local

population. Following government policy to give birth at the clinic will help improve these statistics thereby benefiting the community and nation. The implication is that the personal tragedy of losing an infant or a mother is not sufficient to stimulate the ideal behaviors of the good citizen. Additional motivation is required, namely a sense of the moral obligation to engage in the collective effort to build a modern Indonesia that can claim its rightful position in the global statistical rankings.

One explanation for the different visions of citizenship embodied in different programs is that there have been shifts in modes of health governance over time as Indonesian policy makers have responded to changes in global health discourses and policies, always seeking to maintain the precarious balancing act between global and local that was described in the previous section. The participatory development movement that promoted “self-sufficiency” has been superseded by a new emphasis on evidence based public health and the indicators and targets associated with it (Storeng and Behague 2014, Lambert 2006, Nichter 2013). This trend is reflected in the Millennium Development Goals (MDGs).

Despite the efforts of government health workers to regulate citizens in line with these various visions of health citizenship, people do not always respond as anticipated. Just as government officials do not simply implement policies but rather interpret them and shape them in line with their moral and social identities, so citizens do not merely adhere with government policies. They use their own judgement in deciding how to engage with particular policies in line with their own interests and identity projects

(Newberry 2006). Evidence for this emerges from stories of collapsed saving schemes, the increase in the incidence of complaints about health services and the continued practices of home births with traditional birth attendants. In this way people are choosing between the different visions of citizenship offered by the different public health programs.

8.4 Directions for Future Research

Democratic decentralization has been implemented in various forms in many countries (Manor 1999), including four other nations in South-East Asia, namely Philippines, Thailand, Vietnam and Cambodia (Denden et al. 2007, Lieberman et al. 2005). In Europe a trend towards re-centralization has been noted (Saltman 2008). Despite the prevalence of these experiments there are remarkably few studies of how decentralization is interpreted and implemented at a local level (Faguet and Ali 2009) and even fewer studies of how decentralization intersects with global health governance. This dissertation offers a model for studying how government officials at the kabupaten level negotiate the local politics of health decentralization while striving to achieve global health citizenship.

Focusing on the kabupaten makes sense in the Indonesian case where government administration was devolved to the kabupaten level. At the same time the increased autonomy at the kabupaten level has allowed for greater variation between kabupaten as well as the adoption of a more parochial outlook as kabupaten have pursued their own agendas. This makes generalizing from a single kabupaten even more problematic

and raises the question as to how typical “my” kabupaten is. The scant literature on health decentralization in Indonesia suggests that West Java may be performing better than other regions. For example, Heywood and Heywood (2009b) find West Java had more complete data bases on health personnel than Central or East Java suggesting that staff may be more competent or more committed than elsewhere. Several of my respondents at the kabupaten health office thought that the provincial Governor and the Bupati (head of kabupaten) had an usually good understanding of health issues and that they prioritized health, particularly maternal health. This may be one reason why my findings diverge from those of Kristiansen and Santoso (2006) and Halabi (2009) who identified negative impacts of decentralization on health services in other provinces. Researching an earlier period in the decentralization process, Kristiansen and Santoso (2006) studied kabupaten in Yogyakarta, Central Java; Lombok, Nusa Tenggara Barat (NTB); and Kalimantan Timur. They found a decline in pro-poor health policies and a neglect of preventive health as puskesmas focused on increasing their profits from curative services. Halabi (2009) found health services to be less accessible to the poor under decentralization, a finding not matched by my observations in Lahanbesar Kabupaten (see Chapter 3).

Despite regional variation in performance, the two balancing acts that I have identified, between centralization and decentralization and between global and local policy worlds, are likely to apply throughout Indonesia and elsewhere. I argue that the first balancing act generates a creative tension reflected in the development of a distinct decentralization ethic through which kabupaten officials assert their political and moral

identities. The second balancing act generates a mode of moral regulation I have termed moral pluralism. Moral pluralism offers a means through which global health policies can be articulated along a state-citizen continuum maintaining moral traction by articulating with local moral frameworks.

These concepts need to be examined in other settings to explore whether they are uniquely Indonesian with its supposed cultural tendency towards syncretism (Geertz 1960, Newland 2001, Chao 2013), or whether they are features of contemporary health governance more broadly. Hildebrand's (2012) work on reproductive health policies in East Nusa Tenggara province suggests that even within Indonesia there is variation in how moral pluralism is enacted within particular health policies. Whereas I found the "right to health" legitimized through its purported association with Islam (Chapter 7), she found village *bidan* giving credibility to "right to health" through its association with global development. Right to health was presented as being what other nations were already doing, indicating that it was obviously correct. In both cases "right to health" is deployed as a moral framework that articulates with local understandings of "modernity".

In Chapter 7 I described how evidence based public health is also deployed as a moral framework to inspire action to address health problems. In the literature statistics are often depicted as a technology of government within a top-down audit culture related to neoliberal forms of governance (Strathern 2000, Power 1997). But I found health statistics used in diverse ways to solve local problems within a decentralized governance

framework. For example, Bidan Aisah used local statistics to improve staff performance at the puskesmas, as well as to get political support for increasing the deployment of village bidan at the kabupaten level. Bidan Aisah was not simply following orders from Jakarta. Her uses of statistics were part of her personal campaign to reduce maternal mortality in the kabupaten. In a creative deployment of global forms to achieve local ends Bidan Aisah associates evidence based public health with the right to health in her health promotion work. This is noteworthy because evidence based public health, or “playing the numbers game” has been seen as undermining rights based arguments in the context of reproductive health (Storeng and Behague 2014). These examples illustrate how, in Indonesia, the global ideological frameworks of evidence based public health and “right to health” articulate with local moral frameworks including Islam in an additive process that renders each framework more persuasive by its simultaneous association with an authentic local and a modern global imaginary.

The Desa Siaga program described in Chapter 5 offers another example of the creative application of global “master narratives” (Nichter 2008) to meet local objectives. The introduction of national indicators and targets within this hitherto “bottom up” program appear to offer an example of the extension of an “audit culture” often associated with neoliberal forms of governance (Shore and Wright 2015, Power 1997). Yet within the Desa Siaga program these apparently neoliberal forms are deployed to further a welfare state rationality of government. The penetration of government surveillance into the village under the Desa Siaga program and the revitalized posyandu are signs that the Indonesian government is not about to withdraw from the health sector. The expansion

of welfare programs including health insurance offer a further indication of this (Aspinall 2014). Since January 2014 Indonesia has begun the roll-out of a national universal insurance program SJSN.¹⁶⁵ The welfare landscape is evolving rapidly, transforming the relationship between citizens and their government, a process that merits close attention from anthropologists and other disciplines.

A key message of this dissertation is that anthropology can yield valuable insights in relation to decentralization, health systems and global health governance, topics often left to other disciplines such as political science and health economics. Further anthropological studies should reveal whether the Indonesian syncretic approach to absorbing and refashioning contemporary discourses and moral frameworks of “good governance” is actually more widespread.

¹⁶⁵ See Chapter 6 for a description of this program

Figure 1: Hierarchy of Government Administration

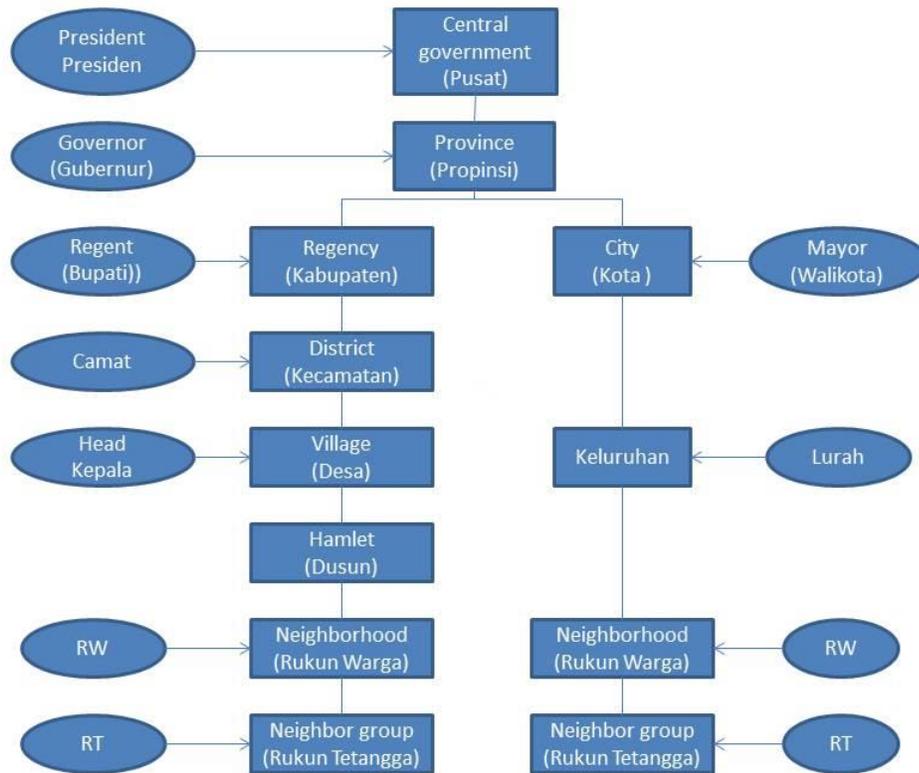
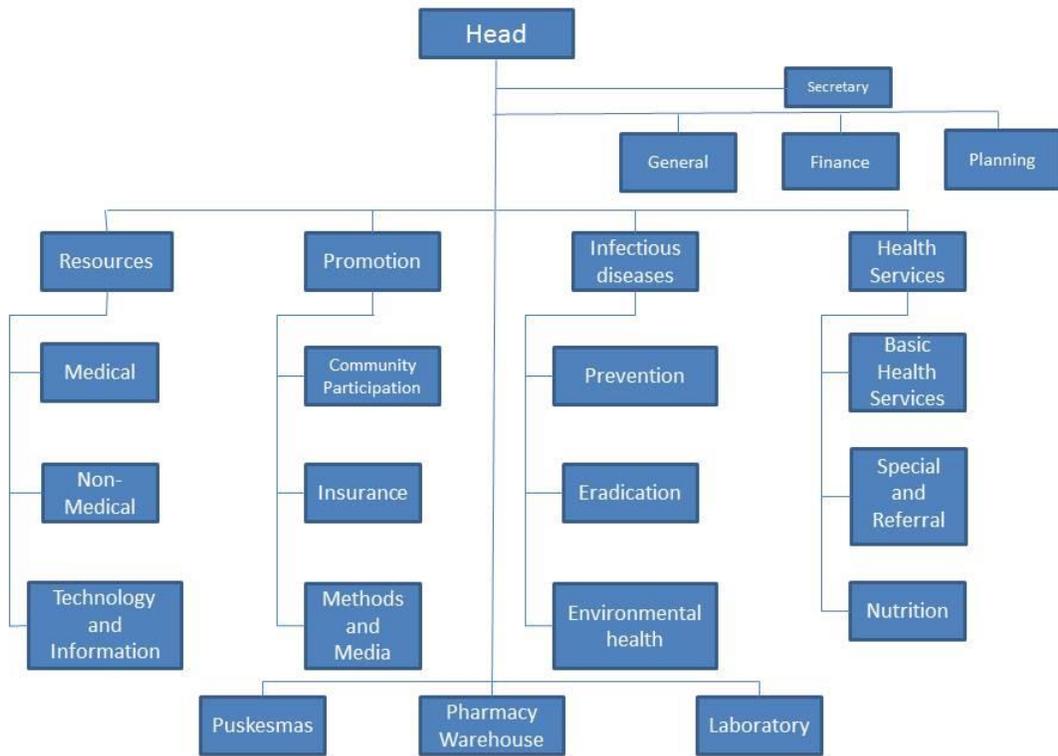


Figure 2: Organogram of Kabupaten Health Office



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