WOMEN'S WAYS OF KNOWING ABOUT CHILDBIRTH IN EAST JAVA, INDONESIA: A CASE STUDY

SITI MAZDAFIAH

NOTE TO USERS

WOMEN'S WAYS OF KNOWING ABOUT CHILDBIRTH IN EAST JAVA, INDONESIA: A CASE STUDY

By Siti Mazdafiah

A thesis submitted to the

School of Graduate Studies

In partial fulfilment of the

Requirements for the Degree of

Masters of Women's Studies

Women's Studies Programme
Memorial University of Newfoundland

April 2004

St. John's Newfoundland

Your file Votre référence
ISBN: 0-494-02356-2
Our file Notre référence
ISBN: 0-494-02356-2

Table Of Contents

Abstract

Not many women realise that what they learn from the practical day-to-day knowledge of childbirth also contains their society's ideology and beliefs, which later have a wider impact on them in giving meaning to their experience of childbirth, and the way they see themselves as women. In a traditional society such as Indonesia, women have both traditional and modern knowledge. Both categories of knowledge can give women choices about how they want to shape their childbirth experience.

In this thesis, we will learn about six Indonesian women's experiences of first childbirth that are widely influenced by their socio-cultural circumstances as well as by their religion, Islam. The experiences of these women include their desire to have children, their feelings throughout the pregnancy, their plans for the birth and their choice of professionals who are going to help them throughout the pregnancy. Throughout pregnancy, these women were also acutely aware of the traditional beliefs and customs about pregnancy, as well as their own feelings and experience about labour. Through a case study method, this study also covers the influence of other people (husband, family and friends) in pregnancy and traces the nature of the knowledge that they transfer to these women. Within the competing sources of knowledge that is given to them, these women learn and build up their understanding about their pregnancy as well as how they see themselves in their new positions as mothers. In this study, we will be able to learn that the meaning of pregnancy varies among women. It can be oppressive, challenging, and liberating or even a combination of these. I provide my account of their experiences

based on feminist theory that agrees that it is not women's biological capacity as reproducers that makes childbirth oppressive to women but the socio-cultural situation that has conditioned them to oppression.

By acknowledging what these women have learned and that impact of that knowledge on them, society will be able to create a better situation for women that will enable them to learn about childbirth in ways that will help them to make informed choices and to mature as a result of the experience.

Acknowledgments

Unlimited thanks to Allah and Muhammad (pbuh), for everything happens in my life.

Special thank to Ibu Marilyn; for trusting me with a very precious opportunity of continuing my study; for giving me a tremendous support along the process of learning to become a feminist and a woman; for her time, energy and patience in guiding me towards the fieldwork and the writing of this thesis; and for her kindness to my family and me.

A lot of thanks to Joan Butler who has done a great job dealing with the administration matters and has been very kind helping me with the copier machines; to all my professors at Memorial University: especially Phyliss Artiss for her special attention in class, Maureen Laryea for becoming a very supportive supervisor and giving me a tremendous help in methodology during the writing of the proposal, Rosonna Tite who reminded me (before I left Canada) about my obligation to finish the program, Karen Weber, Kay Mathews, Shirley Solberg, Elizabeth Yeoman, Laurel Doucette and Christa Bedouin; to all my sisters in class especially Brenda Grzetic and Laura Fitzpatrick; to my Indonesian sisters while in Canada: mbak Nani and mbak Wiwin for their valuable information about Indonesian healthcare and friendships.

I would also like to thank to all the participants in this study; to my mother, brothers and sisters who love me in their unique ways; to my mother-, sisters- and brothers-in-laws who had been taking care of Arra during my stay in Canada; to my husband who has been less supportive in doing housework and childrearing but very

helpful with financial support and computer matters; to my beloved children Arra and Marvel from whom I receive most strength to complete the program. The great part of the process of writing this thesis is that it is also my personal learning to myself as a woman.

Chapter 1

Introduction

It was 9.30 in the morning in the *Puskesmas*[1] lobby. I had been waiting for 30 minutes for a meeting with the *Puskesmas bidan.*[2] About ten people were standing in front of the ticket window where the patients must register before they are called to go inside the examination room. There was no line up; those who were standing closest to the registration officer will be served first. I was sitting on a bench; a latin soap opera was playing on TV. A woman aged about 50 asked me what kind of illness had brought me there. I said that I had an appointment with the *Puskesmas* midwife. Hearing this, she seemed to lose interest in building a conversation with me. Four women with their babies took their places close by and began to chat. One woman asked her friend with the smallest baby who had helped her to deliver her baby. Her friend mentioned the name of a midwife. The woman commented that that midwife was very skilful, kind and friendly.

---

[1] *Puskesmas (Pusat Kesehatan Masyrakat)* is a community health centre. Theoretically, a *puskesmas* is a state run functional organization to provide holistic, integrated, and evenly distributed health services that are easily reached and afforded by the local population (Ministry of Health official website, 2001). The work area for a *puskesmas* is one subdistrict. Puskesmas delivers services: 1) health promotion; 2) environmental health; 3) maternal and child health and family planning; 4) nutrition; 5) communicable disease control; and, 6) basic medical treatment (Wiarsih, 2000).

[2] *Bidan* is a biomedical version of a midwife. A *bidan* has completed 3 years education in nursing (equal to senior high school level) and 1 years education in midwifery. After completing the education, a bidan will be officially placed in a hospital to help an obstetrician's task or in a *puskesmas as a bidan desa* (village midwife). A *puskesmas* has a *bidan desa* who will stand by in the *puskesmas* and some other *bidan desa* who live close by to the community and run their private clinics. Once a month they have a gathering in *puskesmas* to share their experience and receive some instruction on the newest government programs on maternal health.

Another woman did not agree with her and said that it was *cocok-cocokan* [did not apply to every woman]. She said that she came to the same midwife for her second labour, but the midwife sent her to the hospital because she said that she needed a caesarean section. At the hospital, she was told that she did not need the section and she delivered her baby *normally*.[3] She suspected that there was a *kerjasama* [conspiracy] between the midwife and the hospital, whereby the midwife received some *tips* (monetary) from the hospital for sending her patients there. Noticing my presence, a woman who said that she had known me before (unfortunately, I forgot where we had met) asked me how many children I had now. Asking how many children that we have is a common question among Indonesians; it is used in a conversation with a newly met people or between persons who know each other but have been separated for years. Indonesian people believe that having children is something that all people will experience. These women continued their conversation about childbirth experiences and babies, so lively and enthusiastically.

This illustration is important to begin this study. In almost every gathering, when a little baby is present among women, women will talk about childbirth. This is more than just everyday chatting among women. From conversations like the one above I learn about subjectivity and about difference. It struck me first that *ordinary* women were also talking about *conspiracy* between the professionals (a midwife and the hospital). They have their own account of their experience that might be different from those who helped

---

[3] People usually use the word 'normal' to refer a natural labour.

them in labour and from other women's experience. But, as the subject of their own experience, their opinion is almost unheard in public, and such conversations as above only exist among women: hidden from the society and academic studies. The women's conversation in the *Puskesmas* lobby that morning was a very meaningful event to start this study and it made me feel confident that this study is not less meaningful than any medical account of the process of parturition.

The Significance of the Study

I became more interested in the topic of my thesis when I attended the prenatal class at St. John's Grace General Hospital in 1997. I was 7 months pregnant with my first baby at that time and had spent the first 6 months of my pregnancy in Indonesia. Knowing that I had just arrived and still did not have many friends in the city, and was not yet experienced in taking care of a small baby, my Canadian doctor asked me if I was interested in attending the program. I was very enthusiastic because when my husband asked me to join him and deliver my first baby in Canada, I was worried that I would not be able to take care of my baby by myself, even though my mother and my sisters always told me that I would be perfectly competent because to be a mother is a woman's destiny. Further, they said that my experience of helping and watching my sisters in taking care of their babies was enough to handle any problems that might occur with my own baby.

The material that had been taught in the prenatal classes had, more or less, satisfied my inquiries about the process of human conception, anatomical changes in a woman's body, nutritional intakes and prescribed behavior during pregnancy, as well as

pain management during the labour. This new information superceded the traditional knowledge that I previously received from my mother and female relatives. As a young woman, university educated, who believes in rational thinking, the knowledge that I received in the classes sounded reasonable enough in my ears as the teacher explained it scientifically. I remembered again how my scary feeling of labour had disappeared when the teacher took us around the hospital and informed us what we should do when the time to deliver the baby was due: to go to the front office with our records, the nurse will take us to the very (at least in the eyes of woman who comes from a small town in developing country) sophisticated, clean, labour room, the hi-tech medical instruments would monitor our condition, and if the problem persisted we would be rushed to the emergency room where the medical staff would be available 24-hours to help us. I still remember that we heard the bell ring and some people with green uniforms were running out from the door close by. "They are going to the emergency room," said the teacher. I was so amazed; I was sure that I was going to be safe there. There was no need to worry at all about the labour. My anxiety about not being safe in labour was understandable. Indonesia has the highest maternal mortality rate in South-East Asia, with 343 deaths per 100,000 live births (NOVA, 2002).

I left my ante-natal class with the aspiration that someday I myself would carry out this kind of class to build pregnant women's confidence to go through their labour and adjust to their new role as a mother. I believed that to deliver a baby in a hospital with the help of at least an obstetrician is the way of managing childbirth that an expectant mother deserves to get.

It was not until I enrolled in the Women's Studies Programme at Memorial University of Newfoundland (MUN) in 1999 that I was introduced to a feminist analysis of reproduction, that I was able to see childbirth more holistically and had a broader perspective on it. This meant that I no longer over-valued medical obstetrics over other considerations. The combination of my own experience of giving birth and my new knowledge gave me insight into the meaning of the process of childbirth. It was not just that I developed my understanding of my new status as a mother, but also my way of thinking about my own culture and other people's cultures, about tradition and modernity, as well as my understanding of myself as a woman with a new confidence. I never previously imagined this kind of profound changing in my thinking, from my previous acceptance of childbirth as simply a phase of a human life cycle that a woman should go through.

Davis-Floyd in McCurdy (1994) also defines childbirth as a transitional event in a woman's life. As in any other transitional events, the most important feature of a transitional event is whether the participant going through the transition is considered to have knowledge of the impending steps in the transition process and the new status (Turner in Davis-Floyd, 1994b; Belenky, Clinchy, Goldberger and Tarule, 1986: 36). We can see this feature clearly in women who are pregnant for the first time. While women have a *mandate* to conceive, they do not automatically have the skill of taking care of their body and the baby. They need to turn to other people to gain the knowledge about childbirth in order to make the necessary adjustment to their new status and role. Feminist Ann Oakley (as cited in Tong, 1998) states that mothers are not born; they are

made. Her statement is supported by the findings of her study on 150 first-time mothers, which shows that only a few of them knew how to mother their new babies. It is clear that the knowledge to perform the role of motherhood is not a natural endowment. In other words, women need to learn how to be a mother. Some women may need to attend a prenatal classes to prepare themselves to be mothers, some others may hear stories of other women's experience, some others may learn it by playing with their dolls in their childhood, while others, especially women from more traditional societies, have to learn it long before they marry by helping their relatives to take care of their infants (Kitzinger, 1976), just as I did with my female siblings in the past. The ways women learn about childbirth are varied and depend on their social and cultural background, as well as the nature of knowledge that they receive. The myth that every woman was born to be a mother is just that - a myth, and in this thesis I explore some of the consequences of how and what women learn about childbirth.

Further, Kitzinger (1978) and MacCormack (1982) believe that knowledge about childbirth has never been a natural instinct for women; it has always been socially constructed and culturally shaped. This knowledge has not only informed society's wisdom but also the everyday understanding of women themselves. In the case of the expectant mother, the knowledge that she learns from 'maternal authority' (Belenky et al., 1986:62) provides her with the confidence that she, too, can think and know and be a woman, therefore maintaining the pattern that it is only women who have the ability to mother. Within this knowledge transferring process, the society is always trying to maintain the split between private and public by retaining the public sphere as male and

keeping woman in the private sphere. Thus society transfers the ideology of motherhood to women, which keeps women at home occupied with their management of childbirth and in the everyday practices of motherhood.

Davis-Floyd (1994b) explains that women as reproductive agents have a responsibility to ensure the immortality of society's ideology and beliefs. The meaning of childbirth is not only the reproduction of the baby, but also the reproduction of persisting ideology and beliefs. Therefore, giving knowledge to expectant mothers is more than imparting practical knowledge about how to bathe a baby or how to feed the baby with proper nutrition for its development. It has a far wider social and cultural responsibility.

I had never noticed before I came to feminism that the Javanese birth ritual and ceremonies are the perpetuation of Javanese beliefs and ideology about what a woman should be (see further about the rituals in chapter 4). To place women at home and to convince them that they are the ones who are most responsible for taking care of the children and maintaining the house is the ideology that is transferred by Javanese society to Javanese women from generation to generation. I had also taken for granted that it was the women who are blessed with the ability to mother and to practice motherhood. I, like many Indonesian women, believed that women are given the responsibility to mother by God. They are granted the capacity of motherliness, including such characteristics as nurturance, gentleness, patience, etc. In almost every *pengajian*[4] (Qur'an reading

---

[4] Baried (1988) writes that this gathering is a forum to improve women's mental qualities. It is intended to inform women that a woman's most important duty is to her

gathering) for women, the *ustadz/ah* (the leader of *pengajian*) always emphasizes the importance of being obedient to the husband, and serving the family needs, because Allah will reward women with heaven at the end.

Afterwards, I became less interested in building a prenatal class in Indonesia, because I began to see that the biggest problem lies in the everyday practices of motherhood and the ideology that surrounded them. I realize that it needs a radical act to challenge the existing norms and values, and I also began to realize that traditional ways of managing childbirth are not always wrong; many of them are good and medically proven.

Different women may have different ways of applying their technique and belief about motherhood. They have their own ways to comfort themselves during the pregnancy. Some women may believe more in modern obstetrics to save their lives, while some others may believe in the power of the supernatural. There is no need to change every traditional way of managing childbirth into modern obstetrics, as well as there is no need to avoid medication when we really need it. For example, the idea of writing a verse of the Qur'an on a woman's hand to reduce the pain in labour may, for some women, be unreasonable, but as shown by one of the women in the study, it really worked for her. When I heard of such practices from my mother during my first

---

home, where she is responsible for solving any problems that arise. If she succeeds in managing her home, she also has a responsibility to her community and society at large. All that she does to upgrade her capabilities outside the house should be intended to support her first duty to her family.

pregnancy, I believed that it was a kind of *syirik*[5] that is strongly prohibited in Islam. But I came to realize that believing in another divine force besides God, for some women, has caused them to be more careful in taking care of their baby. The problem is no longer whether the traditional way is bad and the modern way is good but how women can have control over their own body so that they will be able to choose from what is considered good and bad for her own good.

Having a holistic knowledge of the childbirth provides the best basis for women to make informed choices. Sciortino (1999:87) underlines the importance of having bio-medical knowledge to deconstruct the existing practices of management of health, including women's health, for the community to have control over their own health. Her study on patient-health professional interactions in Indonesia shows that the knowledge that people rely on today is the knowledge of professional authority. This is not free from particular interests of others that she called "secret construction." In this construction, the professionals know best about what happens to a patient's body and they keep the patients in ignorance about what happens to their own bodies, which works to the advantage of the authority or professionals. In another relevant study, Nicholson (1993) explains that certain kinds of claims to knowledge are given priority over others, and it is those that serve the needs of the socially powerful that pass into popular discourse and come to represent our everyday understanding of what we all take for granted as 'truth' or 'fact.' Women need to know that the truth about childbirth is not one, but many, and

---

[5] Worshipping and to be afraid of any other divine forces besides Allah.

one should not ignore one particular truth to privilege another. I know I was wrong to believe that modern obstetrics is the only way to safeguard women in childbirth not only because it is very costly, but also some studies show that it also precludes women's control over themselves and the process of childbirth (Davis-Floyd, 1998). From the women in the study, I learned that to put women in the hospital, surrounded by hi-tech instruments is not the only way to make them comfortable during the labour; for some of them, it is even frightening. Thus, the problem is how the knowledge that is available for women is to be fairly distributed. The knowledge about childbirth should be presented holistically to women. Knowledge must reach women at all levels and contain not only the advantages of certain kinds of actions, but also the possible negative side effects for women.

Jordan (1997) notes that the legitimation of one kind of knowledge as authoritative knowledge is the devaluation, often the dismissal, of other kinds of knowing. She alerts us to the fact that this phenomenon happens across cultures. Jordan (1983) states that the export of modern technology in obstetric fields to developing countries is having extremely detrimental effects on their indigenous systems. It has not only changed traditional women's perception of the experience of childbirth but also precludes the possibility that their indigenous system can, at least in some respects, be better and safer than modern obstetrics. Rienks and Iskandar (1979) identify that the implication of public health care (Puskesmas and its various extension health services) as a primary health care or the lowest level of public health care has indicated that there is no other health system available under and beyond the service provided by the

government system. This is the negation or ignorance of the existence of an indigenous system that is used by an estimated 76 per cent of the population. In the case of maternal health, the tendency to use modern technology in a normal pregnancy benefits capitalists, who increase their profits, but whether they are essential to safeguard women's lives in labour is not yet proved (Jordan in Davis-Floyd, 1994, Sargent, 1997).

I believe that the Indonesian way of managing childbirth is in transition, from the traditional way to modern obstetrics. There is some evidence to demonstrate this. **First**, the number of women who deliver their baby with the help of medical/health professionals is increasing from 59.06 in 1997 to 62.29 and 66.73 in 1998 and 1999 (The Indonesian Ministry of Health, 2000). **Second**, Sciortino's (1995) study on health centre nurses in rural Java shows that the rural women will not come to the *Posyandu*[6] (Integrated Community Health Service), unless a health care professional, (i.e. doctor, nurse, or midwife) is there. This suggests that rural women, who are usually lower class women, value formal medical knowledge that is possessed by health professionals (Michaelson, 1988) more than the knowledge possessed by the cadres[7] who do not have formal medical education. One of my respondents expressed proudly that she preferred

---

[6]*Posyandu* assists puskesmas to do their tasks especially to monitor mother and child health programs such as; nutritions, diarrhoeal control, immunization, maternal health program. It is run by community volunteers who are women called *kader* (cadres).

[7]Cadres are community health volunteers who help to run the *posyandu.* The cadre is recruited by local authorities with qualifications, such as being an active member of community, having higher status and education than the other members of community, and usually female. The cadre receives a short training about nutritious food, hygiene and sanitation.

the services of a *bidan* if she had a problem with caring for her newborn rather than to *Posyandu* and learning from her fellow mothers with the same problem and experience in the neighbourhood. **Third**, the fact that *Ikatan Bidan Indonesia/IBI* [Indonesian Midwives Association] *allows* village midwives to suture episiotomies at home and to use artificial hormones to induce labour indicates that these practices are considered normal procedures in helping a birth. These practices are not questioned by the community in spite of known harmful effects because they are performed by "professionals." The lack of questioning can be interpreted as a way of assimilating another culture's way of managing childbirth (in this case the western culture). In other words, women open a way to another cultures' beliefs and they move away from their indigenous ways. A study conducted by MacCormack (1982) in Jamaica indicates that a traditional culture has a tendency to welcome modern technology and to value highly the formal knowledge of education in childbirth management. The overuse of technology in a healthy pregnancy and normal childbirth, and accepting it as a normal procedure may, to some extent, put women in jeopardy because it may endanger the women and the babies (Steward and Steward, 1976; Cassidy-Brinn, Hornstein and Downer, 1984).

Finally, I cannot escape from the discussion of how the economic situation has always contributed to the oppression of women. After the economic crisis in Indonesia in 1997, 24.2 per cent of the population or 49.5 million people (Departemen Kesehatan dan Kesejahteraan Sosial Republik Indonesia, 2000) were living under the poverty line because the cost of basic goods increased dramatically, while thousands of people lost their jobs. Many women not only cannot afford a better quality of medication but any

basic medication at all. Many women who did not have enough money to go to the *bidan* had to use the TBA to deliver their babies regardless of their pregnancy condition. The women in the study admitted that they went to an obstetrician for the first check but could not afford to continue to receive regular antenatal care with him. This poses the question of what happens to underprivileged women with high-risk pregnancies. Wiarsih (2002) shows that besides cultural taboos and gender discrimination, poverty has caused women not to receive the nutritious intake that they need during their pregnancy.

A study carried out by Emily Martin (1987) shows that women's responses to the medicalization of their body functions varies according to race and social class. Michaelson's (1988) study found that the pregnancy experiences of poor women are qualitatively different from those of middle-class women. While a middle class woman may select the kind of care she wants to have, the poor must accept the care available in a public clinic. Lazarus' (1988) research shows that poverty, unemployment, lack of support, poor education, lack of continuity of care in public clinics, with long waiting times and resultant stress, are significant factors in reproductive problems. Her next study in 1997 shows that middle class women have the opportunity to choose the physician who will guide them in pregnancy and technomedical control, while this choice is limited for underprivileged women.

Besides limiting women in their access to required care and help, poverty will also limit women's choices of desired maternal services. A study on caesarean sections in the United States by Jordan (1997) shows that women who escape caesarean sections had powerful social networks within which their version of reality was upheld and supported.

Many who got sections lacked a support system. They are often under-privileged women and illiterate. In a related example, a lot of underprivileged women in Indonesia who have to deliver their babies in hospital have to receive care from public hospital with a poorer quality of service than that available in private hospitals.

Perhaps, it is important to underline the major issues that became the focus in this study. In a transitional culture, like Indonesia, traditional beliefs and ideology, and the misinterpretation of many religious teachings, in this case Islam, of what a woman should be has a great influence in creating oppressive conditions for expectant mothers. At the same time, not only has the traditional way of managing childbirth, but also the use of modern obstetrics endangered the health and lives of expectant mothers, especially because of its unknown or undiscovered negative impacts, or the inadequacy of the training or resources available. The routine use of medical actions by professionals in the normal pregnancy and delivery (such as caesarean sections) has prevented the use of possibly better indigenous childbirth practices. And, what women can learn from those everyday practices of managing childbirth in this transitional culture will affect their understanding of themselves as women that will be passed on to future generations.

The Objectives of the Study

The study is based on an understanding that the knowledge women receive during pregnancy and childbirth is the perpetuation of society's ideology and beliefs, and these are oppressive to women and tend to deprive them of control over their reproductive powers. This understanding informs the examination of the importation of medical

technology, which not only imports capitalist practices, but also, in some cases, may even threaten the lives of Indonesian women. These two threads aroused my interest to find out the nature of the knowledge that women learn and rely on during pregnancy and childbirth that is imparted by their society and culture, and how this knowledge develops their perception about their experience of childbirth and about their position in society. I agree with Davis-Floyd (1997) that women's' choices and the treatment they receive from others will influence their own lives and those of their families for better or worse. If women are taught anti-women concepts during pregnancy, they will reproduce that misogyny by teaching it to their children and continue women's oppression in their society. If women are taught that technology is superior in the process of parturition then they will perceive that their roles are inferior, and they will reproduce the same values through their children. If women are taught to have confidence by providing them with knowledge of childbirth, they will be able to have control over themselves, and will have appreciation of their own bodies as women and thus gain a better position in their society.

The Setting

Indonesia is the world's largest archipelago, consisting of about 17,000 islands with total land area, 1.9 square kilometres (United Nations, 1998). It is placed, in the southeast of Asia and to the north of Australia. The total population is 203,456,000 (Statistic Indonesia, 2001). Sixty-two per cent of the population is concentrated in Java Island, which is also the centre of political activities and business. Indonesia consists of hundreds of different ethnicities and traditional languages, as well as various cultural and

religious diversities. The Javanese ethnic group is probably the most influential group in Indonesian history and politics. Its ideology and norms have been adapted into national ideology, especially in President Suharto's era. Another important influencing factor in Indonesian politics and society is religion. Indonesia has the world's largest Muslim population, with 87 per cent of the population practicing Islam. The position of women in Java is influenced by local socio-cultural beliefs. In the area covered in this thesis this is a mixture of Javanese ideology and Islamic values. For some people, it is still difficult to differentiate which one is an Islamic value and which one is Javanese, since the mixture of these two beliefs has happened since the thirteenth century when Islam first came to Java.

Women still occupy a subordinate position in Indonesian society. The educational attainment for women is still lower than men's. For females aged 10 years and over, 46.6 per cent of women do not attend school or never complete primary education (UN, 1998). Even though females outnumbered males in lower level education, the number decreased in the higher levels of education (Saparinah Sadli, Wibowo, Hidayat, Augustine, Sukarlan, Rostiawati, 2001; Data Monografi Kecamatan Suka, 2000; Badan Pusat Statistik, 2000). In some ways, and officially, women are integrated into national development programs. The mobilization of women can be seen in the community participation of health development. They show their active role in the success of the family planning program as acceptors, *posyandu* activists also became the government's political tool to campaign in 'elections' in Suharto's era. According to Nori Andriyani (1999), the Indonesian government's official stated intention to include women in

development is merely cosmetic to gain the favour of the funder/donor countries. Women's participation in elite politics is low. Even though women outnumbered men, about 51 per cent of the population, their representation in parliament and government is still far from the expected. Only 9 percent of DPR members (45 of 500) and only 7 of 360 of regional leaders in a district and province are women (Budi Shanty, 2001). Even though, currently, Indonesia has a female president, her commitment to the advancement of women is disappointing. In one TV show (Jaya Suprana Show in Televisi Pendidikan Indonesia/TPI), the President said that she was still wondering why there are women who still ask for more opportunities when they had them already. In other words, it is women's fault that they are unable to take the opportunities that are available for them.

Women still occupy the domestic realms and continue to do unpaid domestic work, even though their participation in paid work has increased. Marriage is a must among women; it is a part of the Javanese normal life circle: to be born, to marry, to beget children and to die. Socio-cultural norms and values have traditionally favoured universal and early marriage; 70 per cent of Indonesian women are married in their teens or early 20s (UN, 1998). Since their childhood women are prepared to do domestic tasks and taught to be obedient to their parents and their husbands.

Java contains 7 of the total 33 provinces of Indonesia. East Java is the largest province with several small islands including Madura. (Its total area is 46,428.57 square kilometres. It consists of 29 *kabupaten* (districts) and 8 cities. The total population is 34,000,671(Badan Pusat Statisk Propinsi Jawa Timur, 2000), of which 17,323,731 are women. The population density is 732 per square km. The *kecamatan* (sub district) of

Suka, where I carried out my fieldwork, is located in the district of Mede. The district of Mede consists of 15-*kecamatan,* with a total population of 639,825 (Badan Pusat Statistik, 2001). Suka is the place where I spent most of my childhood. It consists of 14 villages. The majority of its inhabitants are Moslem - only 136 are Catholics, 430 are Christians (Protestants) and 4 people are Hindu adherents. Only 34 people are recorded as being of Chinese descent.

The majority of people work in the agrarian sector to produce rice. From the Monographic Illustrations of the Subdistrict of Suka (2000), I received data that about 3000 people work in this sector, but only 5 percent own the land they work. The second most common occupation in this area is civil employee, about 2,109 persons. Another 759 people work as construction workers, while the rest of the population work in several home industries, which produce *tempe* (fermented cassava), bricks, etc, with a small number working in other occupations such as transportation, military, etc. About seven per cent of the inhabitants are officially unemployed (Badan Pusat Statistic, 2000). Women are involved actively in home-industries, especially the *tempe* industry that usually is run by women.

As in many other villages in Indonesia, many young people in the district of Suka leave their village of origin and go to bigger cities to achieve better living. It is part of the impact of the New Order government, which put its development priority on the industrial sector. Along with the development of industries in the Indonesian cities, as part of worldwide globalization, more and more of the village young generations leave their hometown to work in the industries and only a few of them remain in their

hometown. The number of rice fields has decreased significantly. Most of them have become built up areas. No wonder that Indonesia, which had received an award for self-sufficiency in rice in 1980s, has become a rice importer in the late 1990s. Many blue-collar workers, like the husband of one of the participants in this study, go as foreign workers to Malaysia, Saudi Arabia, Singapore, and Philippine etc. And this trend is intensified during economic and political crises. However it is not a cheap solution because a foreign worker needs to have about 11millions rupiahs to pay the agent who will send her/him to the desired country. Even though there is no guarantee that they are going to gain success in the new place, it is still better than staying in Indonesia without a job.

The educational level of the inhabitants in the sub-district of SUKA is low. Few people have finished their college/university education, although the majority of people (about 31,000 persons) finished their basic education (Elementary and Junior High schools level). About 0.8 percent is illiterate. The health condition of the sub district of Suka is hard to assess from the official statistics. There is one *puskesmas* assisted by 4 *puskesmas pembantu* (assisting puskesmas) with 2 physicians, 1 dentist, 22 nurses and 9 midwives. The *posyandu* activities are unrecorded, but the *puskesmas* midwife explains that they are routinely carried out once a month in every *dusun* (sub village).

From the centre of the sub district, it is about 10 minutes to the capital of Mede. A huge group of people on their bicycles travel to the capital of Mede every morning. Senior high students have to go to the capital of Mede because the school is not available in Suka. This condition is not much different from my childhood, even though the

number of people who own motorcycles and cars has increased. My neighbourhood, located in the main street of the sub district, seems to have adopted urban culture in which not everyone knows each other. Some Chinese producers from Surabaya have built their companies' storage/depot with their huge fences, and these have increased almost every year. The owner has never shown up. The situation is different in the inland villages, where people know each other in their neighbourhood and retain the old connections.

There are very active religious groups. There are some *pengajian* among women, with the classical themes (emphasizing the importance of becoming an obedient woman), carried out once a week. I do not see this kind of activity among men except a neighbourhood gathering that is carried out once a month. I do not think this is because their religiosity is better than those of women. One big mosque for Moslems has been renovated in the past 4 years. There are several others inside the villages that are smaller. The Qur'an Reading Groups for children are held every afternoon. One newly renovated Christian church is located in the main street. The Catholics have to go to the capital of Mede, where a beautiful Dutch church is located, while the Hindu adherents have to go to another district.

Thus the sub district of Suka illustrates both traditional and modern living, in a plural and complex society. I see the sub district of Suka as a good place to see the transformation from traditional to modern living for Indonesian women and believed that I would find a wealth of information from the expectant women about their experiences of pregnancy and childbirth in a transitional childbirth culture.

At this point I would like to introduce the reader to the participants as individual women. I do this so that you can have a picture of these women in your mind while you are reading my theory and literature review sections.

The Cases

All the women in the study were living in the same sub district when the interviews were carried out. Henny lives just one kilometre away from my place. Rully and Harni are neighbours, as well as Nurhayati and Sri. Rully and Harni live two kilometres away from my place while Nurhayati and Sri live four kilometres away in different villages. Rukhayah lives about three kilometres away. All of them do their activities at home everyday, at least during their pregnancies. Below is my description of each case based on my impressions and evidence during the interviews with them.

Henny

Henny, 22, has the highest educational level of the women I studied. She enrolled as a university student in Malang, a city about 200 kilometres away from Suka, doing psychology. She decided to go back home and tell her parents after she found out that she was pregnant by her boy friend. Of course it was a big problem for her because being pregnant outside marriage is still considered shameful in Indonesian society. Her parents were very angry with her when they knew about the pregnancy. Therefore, she went back to Malang to her boyfriend, but few days later, her mother called that it would be better for her to come home. Her mother said that all her faults were forgiven. Henny is the

youngest of two children. She has an elder brother, who is still single. Her family just moved from Kalimantan, another island of Indonesia, to join her father's extended family after her father retired as civil servant. They built a house near her grandma's, with a large cement tank in their yard to dry the rice during harvest time.

The family decided to carry out a wedding ceremony for her when she was 7-months pregnant, even though it is not common to do this, but in recent years it has become more common in this situation of an unmarried mother. People usually wait until the baby is delivered. Henny said that she did not receive any *punishment* from her family and neighbours because of what she had done. She said that she has normal social relationships with her neighbours and friends. She tried to hide her feelings at first during the interviews and to act as if everything was fine with her, but soon after we were got to know each other better, she admitted that she was ashamed to be financially dependent on her parents and felt guilty before God. She was worried about the punishment that she would receive from Him because she had even taken some traditional remedies to abort the pregnancy.

Henny decided to leave her education, while her husband continues his programme. During the interview, Henny looked to be very careful about what she said, especially on the topic of her husband's participation. She said that her husband is a very religious man even though, in fact, they both consented to premarital sex and even though that is considered one of the biggest sins in Islam. She said that her husband is a very responsible man, even though he never gives her money to live. Henny is a portrait of the majority of a young Indonesian middle class woman. She is well educated while

still holding the traditional beliefs of what a woman should be. She is very obedient to her parents and her husband. Her decision to leave her education after she has a baby shows that education for a woman is still considered secondary for Indonesian women. Henny was an interesting respondent to interview. I felt that I would be able to come closer to her true feelings about her experience if I had more time to spend with her, because she is very guarded in a new encounter. I had the impression that she felt that she would be analysed and cannot wait to know what I will write about her experience. I understand that, because as a student of psychology, she admitted that she has done research with human subjects before. For me, she placed herself more as an object of analysis than as a companion to share her story. She said that she would join in this study because she knows from her experience as student in psychology that it is difficult to find a respondent who would participate in a research involving humans. No wonder then, that she sees the study merely for academic purpose. But after all, I feel that she is a fascinating woman to talk with.

Rully

Rully is 23 and had spent two trimesters of her pregnancy in Jakarta, the capital of Indonesia. She has a one-year diploma in computerized business and had been working in a factory in an administrative staff position. She speaks fluently, clearly and straightforwardly. I see her as a clever and independent woman. She married a

Batak[8] man who asked to marry her just a day after their first meeting. Hence, they married a day after in a *Kantor Urusan Agama* (The Office of Religious Affairs) without the presence of the parents and relatives of both parties. This is not common in Indonesian culture, which sees marriage as a sacred and communal event that always involves family and relatives.

Rully did not tell in detail how her parents reacted to her decision to get married in Jakarta without telling them beforehand. But she admitted that when she told her parents that she was pregnant, her parents insisted that she came home immediately. Even though she was afraid that the neighbourhood would think that she was pregnant outside marriage, she decided to follow her parents will, with her husband's agreement. Her parents were also little disappointed because she was pregnant before they carried out a wedding party for her, and they were worried about what people would think about their daughter's condition, but they felt relieved to find that their daughter has been married legally according to Islamic and national laws. To break the tradition seems to matter less today, as long as they follow the religious teachings.

Her parents sell Soto (Indonesian yellow soup) in a *gerobak dorong* (a movable kiosk). They live in a very good house compared to their neighbours. Rully's parents always thought that education is important for their children to build a better future for

---

[8]Batak community is extremely patriarchal and patrilineal in culture. It is only boys in the family who will inherit the family possessions while girls must go to their husbands' family after they marry, away from their family of origin. Men are responsible for the continuation of the clan of their father while women are only responsible for the continuation of the clan of their husbands (Sulistyowati, 2003).

themselves. Rully said that her life is really an easy one. She received her diploma, had a job that she wanted, married a man that she had never imagined before and had a son of her own, the things that she hardly believed would come to her as easily as they did. Above all, Rully is a woman who sees her pregnancy experience as a challenge that has changed her so much.

Harni

After graduating from senior high school, Harni, 24, worked in a shoe factory in Surabaya. She had worked for 2 years until one day her parents asked her home. Her parents said that there was a man who wanted to know her better and to look at the possibility of taking her as his wife. Two months later, she married this man. Her husband, 31, works as a civil servant in the Regency office in Mede. He is the only son of his parents with two sisters.

When I came to recruit her, she was teaching the Qur'an to small children in a small *surau*[9] in front of her house with her husband. The house where she, her husband and her parents-in-laws live is very neat and clean. It is surrounded by the relatives' houses. In front of her house, just next to the *surau*, lives her sister-in-law who sells everyday items. Harni is very dependent on her husband. When I asked if she would be willing to join this study, she turned her face to her husband to ask for his consent. Her husband nodded his head and asked me if I needed any formal document of her such as

---

[9]A small mosque. A big family/an extended family living in the same area usually has one.

surat nikah (marriage certificate) or *Kartu Tanda Penduduk /KTP* (ID card issued by local government) that is usually needed by ordinary people to have any business with government.

It was difficult to build a relaxed conversation with her. First, it is because she is very quiet and shy. She answered my questions with 'yes' or 'no' answers. If I asked her 'why,' she would say 'I don't know' or 'they (people) told me like that.' If I asked her opinion about something, she said that she just believed and followed what people said, especially her husband. Second, it might be because of her mother-in-law's presence during the interviews, so that she felt reluctant to express any opinion that related to her husband's family. Her relationship with her mother-in-law seemed not to be a really good one. I noticed that she never turned her face to her mother-in-law when she answered my questions about the discrepancy of some information that she received regarding her pregnancy. For example, I asked her about whose information she relied on most during the pregnancy, she answered with *'I just follow what my husband said about that'* Her mother-in-law responded with *'that is what our ancestors said, if you believe you do that and do not if you do not. I never prohibit her to eat anything that she wants.'*

Surprisingly, in the second interview, Harni told me much more about her experience. She had more confidence to oppose her mother-in-law's opinion such as when the baby should have his solid food, or whether it is good or not for the baby to have his formula besides the breast milk. Our relationship improved and she told about her conditions more openly in the second interview. However, it was difficult to talk to her alone without the presence of her mother-in-law. Her mother-in-law was always

present even in our informal conversation besides the formal interviews, and it is considered very impolite to ask her to leave us alone.

Sri

Sri, 19, had just graduated from senior-high school when she married her husband. Her husband works as a construction worker in Malaysia and has a residence permit as he has worked there for a long time. Usually, he goes to Malaysia for two years and then goes back to Indonesia to see his family. When I met Sri, her husband had left her two months previously to work in Malaysia. Sri lives with her parents, her male siblings and a nephew. It is not clear what her parents do for living. Her house is made of wood with a wide cement terrace in the front of the house. At first, I thought it was a place to dry the rice during harvest time like the people in the village usually have. But, then I realized, it was the front part of a traditional Javanese house. A Javanese traditional house is made of wood and usually consists of two major parts, a front part is usually used to carry out a feast, or to meet guests and a back part that is usually used for the family. The kitchen is the same size as both parts and located in a separate section in the back of the house. If the family needs money, they would sell the front part of the house separated from the land. I think this is what happened to Sri's family. They must have been through a difficult time so that they needed to sell their front house. The inside decoration of the house shows that they were a rich family in the past. Sri has never been involved in paid employment. She stays at home all day to help her mother do the chores for the whole family.

Sri is a typical village woman, quiet, silent and shy. When she decided to participate in this study, she looked as if she still had some big questions about what my intentions were for interviewing her, but she was afraid to ask any more questions even though I told her she could ask me anything that she did not understand about the study as well as about me. She told me that she had a relative who was pregnant and asked me if I was interested to recruit her as well. I agreed with her and said that I would go to her house afterward, but she said that it would be better if she called her relative to come, so she went to the house close by and came back with **Nurhayati**. At my second visit, Sri asked me to have the interview together with Nurhayati. At first, I was afraid that it would contaminate the data of both, but surprisingly the process made them both more independent and they gave me information that is very different from each other.

It was very difficult to get close with Sri. She speaks in high level Javanese language, which is used to people in superior positions. I asked her to speak *ngoko* Javanese, which is used by friends or persons in the same level, but she kept to her way.[10] However, to know her better, I learned from her conversation with Nurhayati during the interview. Especially where the respondent is very shy and quiet, the presence of a close relative, having an equal position and similar condition, is an advantage to breaking down the shyness. The situation would be different if the person who is present in the interview is in unequal position, such as in the case of Henny. The presence of her

---

[10]Javanese language has hierarchical structure. *Ngoko* Javanese is used for people in the same level of social structure or in the conversation with people in the lower level. *Madya* Javanese is used in the conversation with people in the higher level and *Krama Hinggil* Javanese in the conversation with parents, old people or people in authority.

mother-in-law prevented her from telling me her real feelings.

Sri rarely had activities outside her house besides going to school. She admitted that when her husband was away for work even visits to her parents-in-laws were rare. No wonder, when I was trying to find her place, none of her neighbours, who were having a community gathering just about 200 metres away from her house at that time, knew either her or her husband. It is the *PLKB (Penyuluh Lapangan Keluarga Berencana/*Field Staff on Birth Control) who knew her by name from the list of expectant women in her area. This is not usual in an Indonesian village, where the people usually know each other well.

But I appreciated her contribution in this study, her willingness to join the research, as well as her confidence to stand on her own feet while sharing her experience.

Nurhayati

Nurhayati is Sri's cousin, and she lives next door to Sri's house. She was small with a typical Indonesian village women's face, dark brown face and dark eyes. Nurhayati, 24, graduated from a private senior-high school in the district of Mede and has participated in paid employment as a storekeeper in one of the three supermarkets in the capital of Mede. She married a man who has a job in an electronic shop in front of the place where she worked. After she found out that she was pregnant, Nurhayati quit her job following the advice of her parents, her parents in law and her husband.

As a woman who is usually active in organizations and has many activities outside the house, Nurhayati feels unhappy about her condition. Above all, she was not

ready for her pregnancy because, according to her, she feels that she was recently married, with a good job and she was not yet ready for her baby. Nurhayati had been living with her parents-in-law, but after she quit her job she decided to move into her own parents' house because she felt uncomfortable that she could not do anything at home. After she moved in, she helped her grandmother to make *tempe* in her parents' house. Her grandmother sells it to the traditional market that is 2 kilometres away from their house.

In contrast to Sri's family who were always chatting in front of her house whenever I came, Nurhayati's family were always busy doing something, such as making *tempe*, feeding their cows, cleaning up the yard or the tools that they just used in the rice field. Nurhayati is the eldest in her family with a sister and a brother. Her brother was delivered by a caesarean section, which was, according to her, a frightening experience for the whole family especially for her mother.

Her history of pregnancy was a confusing experience because the medical test showed that she was not pregnant at first. She was really afraid of having a handicapped or abnormal baby because she had taken some hormonal pills in her early pregnancy. Moreover, her belief in supernatural power had made her suspect that her baby might belong to another woman who did not want it and hated her for some reason that she did not know.

Nurhayati's house was made of bamboo walls with a ground floor. The rooms do not have their doorframes. A piece of cloth covers every door through which we can see part of the rooms when the wind blows them up. Her life seemed very ordinary but full of

living spirit. During my visits, there was always some of the *tempe* spread on the ground that were ready to sell to the market in the next morning. Nurhayati's family were very friendly, they always served me some tea or cakes during my visits and the family members always gave a smile whenever they had to cross the room where we were doing the interviews.

During the first interview, Nurhayati always sighed and told her story with no enthusiastic feeling, as if she was really bothered about her condition of being pregnant because, according to her, she still wanted to work outside the home and do many more things with her life, which she could not do while pregnant. However, she tried to accept her condition and enjoy her life, as she told me in the second interview. Nurhayati and Sri did not seem to understand what I am going to do with their story or may be they did not even care. I am glad that they both looked as if they enjoyed sharing their experience with me and sometimes, they gave me explanations about health care that I really did not understand, such as about birth control methods and some mystical beliefs and Javanese birth traditions.

Rukhayah

Rukhayah is the most cheerful among all the participants. She is 24 years old with three siblings: 2 brothers and 1 elder sister. After she graduated from senior-high school, she worked in Jakarta, the capital city of Indonesia, as a shopkeeper in a drugstore. Realizing that she was wasting her time waiting for the customers to come to the store, she moved and worked with a dressmaker while taking a dressmaking course. She

married a man who lived close by her parents' house and opened a small dressmaking kiosk in the front part of her parents-in-law's house. She works together with her husband who is also a dressmaker. From the materials that were on the table, I know that they have a lot of customers. Rukhayah's husband comes from a devout Moslem family. They have their own small *surau* where her husband works as an Islamic teacher.

As she can earn money for her family, Rukhayah has an equal relationship with her husband than many wives in her community. She also has a good relationship with her parents-in-law and sister-in-law who live with them in the same house. All the family seems to have a respectful feeling for her, as shown when her mother-in-law wanted her to go to the midwife as soon as she felt the contractions. She refused to do it so that her mother-in-law told Rukhayah's mother to tell her the same thing and it worked. Indonesian women usually feel more reluctant not to obey their parents-in-law with whom they live, than their own mother.

Religious values have important roles in her husband's and her own family as well as Javanese values. They try to combine both values in their lives and do some selection or *Islamicize* the Javanese values. They believe that there is nothing wrong with Javanese values as long as they are framed in Islamic ways (see chapter 5).

Rukhayah is very friendly and soon we were able to be close to each other. She asked me a lot of questions about my pregnancy experience, my studies, my family as well as my experience of having a baby in Canada. We talked about a lot of actual issues as well as religious topics. Her husband was always in another part of their large living room doing his work of making the dress and sometimes he joined us to have a

conversation and to share his opinion about the topics. Both her husband and Rukhayah are very critical about many things that happened in their society. They are able to learn from other people's experience and take advantage from whatever they have learned. Rukhayah is very glad to know me and felt that my presence was one of the good things that was brought by her baby.

Her husband's family is highly regarded in their neighbourhood. It is easy to find their place because almost everybody knows about them. Rukhayah said that there were always some people who came to look at her condition whether it was her friend or her neighbour and to give something to her baby such as some milk, oranges, cakes, etc. It shows that they are really loved by a lot of people and I am sure that is because they are very kind people. Rukhayah asked me in what way her shared experience would benefit other women. So, I told her that her story and opinion would make other women look at themselves and their surroundings more carefully, as she did, so that they would know that they deserve better circumstances for themselves. She looked very glad with that and hoped that it would be really true.

Finally, I must say that I found all the women I talked to very interesting and their situations unique. Before I began my fieldwork I never imagined the richness of the data that ordinary women would share with me. They have both enriched my academic study and my own experience as a mother and student. I really appreciate their voluntary participation in the study and their concerns about other women.

Chapter 2

Theoretical Framework and Literary Review

I always have trouble with theory. It tends to be written in difficult language so that it is hard to understand, especially if it is written in English, which is not my mother tongue. Therefore, I need to translate it into my own language, *Bahasa Indonesia*, and then change it into much easier sentences and expression to understand it better. Then I have to discuss it in a language that I am not really good at, English. So the language barrier makes me write in a way that I find too simple to call theory. This has a wider impact on my personal confidence, that I will not be able to express myself exactly. Then, in order for theory to be relevant the abstract concepts need to be grounded in real life - and that makes the process of learning theory more difficult, especially when there is a discrepancy between the real conditions that we face and the situation the theory comes from, because of cultural differences. Therefore, I have to choose a theory that fits my identified problems, but I have not found any theory that fits them exactly, so I must use a combination of theories in my study.

When I began serious study of feminist theories, I found both their truth and their inappropriateness to my condition in several different theories. As a new feminist, I think it was normal that I wanted to know to what kind of feminist thinking I could identify with but I could not figure out whether I was a liberal or radical, Marxist or postmodernist, psychoanalyst or existentialist as I agreed with some parts of all the ideas but not with other parts. It was confusing especially because I was also filtering my thoughts through Islam. There was a doubt deep inside my heart that I was learning

something that was not religiously correct. I remember asking my Islamic teacher in the St. John's mosque on Torbay road, whether she knew about Nawal el Saadawi, a famous feminist figure from Egypt, which was also her country of origin. I really wanted to know her opinion about feminist ideas as a person who knows Islamic teaching much better than I do. Her response was short, but really shocked me: "She is not a Moslem; she is a feminist." Is it impossible to become a feminist and Moslem at the same time? I came home (to Indonesia) with a belief that both Feminism and Islam are right and hoped that I would find the connection soon.

Before I enrolled in women's studies, I thought a feminist was a career for unmarried women. Of course, for me that meant that a feminist was anti-man and anti-family. Or, if she married, she would be anti-child. I found out later in class that feminism was also associated with lesbianism. During my Women's Studies courses I discovered that the stereotypes of feminists and feminism were not true: that many women who identified themselves as feminists are also married women and have their own families. Tong (1998) defines Feminist strands into (essentially) liberal, Marxist, radical, psychoanalytic, socialist, existentialist and postmodernist. I will not discuss all the varieties of feminism here but only those relevant to reproduction and motherhood, which are appropriate to my study. In this section, I will also include a discussion of Moslem feminism because I cannot let myself live with such a big question about my feminism. I think it is important to let you know where I stand or to know my perspective because the way I am thinking about the problem definitely plays an important role in how I see the issues.

Feminist Theories about Childbirth

Feminist theories about women's reproduction and motherhood are rooted in very different perspectives from the standard male approaches. Early feminist theories portray childbirth as a defect for women and a source of women's oppression. Betty Freidan argued that women's tasks inside the house, including motherhood, caused a "malaise" among women (Pierson, 1998; Tong 1998). Other feminists even viewed childbirth as theoretically uninteresting. Simone de Beauvoir sees childbirth as 'a useless or even troublesome accident', and Hannah Arendt, following Marx's theory on power, describes childbirth as 'animal' (O'Brien, 1989). It was Adrienne Rich (1976) who first explained that even though in some cases motherhood is oppressive to a woman, it also embodies the potential relationship of any woman to her power of reproduction and to children. Regardless of their differences, most feminists now agree that the aim of feminism is not to free women from motherhood but from the conditions in which they find motherhood oppressive (Richardson, 1992).

Liberal feminism alerted us that women's place should not be restricted to the house. Women need to have an equal chance at every opportunity in the public sphere. In her book The Feminine Mystique, Freidan provided a model of an ideal woman; a super woman, a woman who has succeeded in combining her tasks at home and in her public life (Tong, 1998). Her model is not just difficult to follow, because it makes women to be double- or even triple-burdened, but it has also meant that women who cannot participate in the public world tend to feel less valued by society. It also legitimises the myth that the public sphere is better than the private sphere. One Indonesian friend told me that I would

dislike a woman who just stays at home doing 'nothing' after I enrolled in women's studies. Another friend said that I would not agree with Islamic values anymore because to be a mother is a high status for a woman according to Islam. I must say that to be a feminist is challenging, especially if the society only knows and believes the early (stereotyped) ideas of feminism but does not follow its later developments. I think Freidan's idea constituted an important mistake in creating a false feminist stereotype. But Freidan realized later that she was wrong and called for men's participation in her book The Second Stage (Tong, 1998; Pierson, 1998), so that women can actualise themselves both in the public and private spheres.

Feminists continue to bring private issues into the public arena. They try to say that what women are doing at home is as important as what men are doing outside the house. Marxist Feminists argued that what women do inside the house should be recognised as valuable just as much as paid employment. Some went further and said that women should be paid for doing their tasks inside the house including mothering their own children (Tong, 1998). According to Barbara Bergmann in Tong (1998), there are three disadvantages that resulted from this line of thinking. First, wages for housework will keep women at home and less interested in working outside the house. It is a backward step from the liberal feminist efforts to achieve equal opportunities in the public sphere for women or the traditional Marxist feminist goal to integrate women in social reproduction. Second, it will contribute to capitalist tendency to commodify everything. Third, it will weaken women's interest to do public work and men's interest to do domestic work and will strengthen the split between private and public as between

women's work and men's work.

It is interesting that radical feminists also use Marx's theory to explain the politics of reproduction. Radical feminist studies criticize Marx, arguing that by focussing on class, he failed to recognize the difference between men and women: that men's experience is different from women's experience. Marx's definitions of reproduction as the production of human needs on a daily basis failed to let him recognise the process of biological reproduction as a significant event in human life (O'Brien, 1989; Kahn, 1995; Harris and Young, 1981). However, by grounding his philosophical thought onto material existence Marx provided an important foundation for feminism, especially because discrimination against women is based on material difference (O'Brien, 1989).

According to Marx, our understanding of the world is concrete (grounded in the material realm) and historical (O'Brien, 1981). The act of human reproduction is not historical (significant to human history) because it is a natural process. O'Brien's theory treats human reproduction as an analogy for Marx's materialism to show that the process of reproduction is also concrete and historical because it is grounded in the physical characteristics of a woman which are themselves concrete. Because reproduction is socially constructed, it changes continuously along with the changing of the society (historical and dialectical) (Ritzer, 1996), as well as being elaborated and modified over time through the women's oral tradition and childbirth rituals (Manderson, 1998).

The basis of Marx's thinking lies in his idea about human potential (Ritzer, 1996). However, this potential has been oppressed and will be oppressed in all stages up to communism, because before the final stage humans do not achieve their highest potential.

O'Brien draws an analogy from Marx's thinking arguing that women have the potential of reproductive power, but the patriarchy (man) has taken their potential from them. Marx defines power as the faculties, abilities, and capacities of people. Applied to woman's reproductive power, the power of reproduction is the ability and capacity to bear a child, which only women can perform. According to Marx, there are two kinds of power: natural and species. Natural power is the power that we share with other species, while species power is the power that is expressed in a specific and distinctive way. Reproductive power is a power common to all species, but the way we carry out the process of reproduction and its management is distinctively our way, different from those of any other species. Thus, we can say that human reproductive power is species power or in other words, human reproduction is never natural but cultural (O'Brien, 1989; O'Brien, 1981). It is always affected by people's beliefs, expectations and customs (Margareth Mead in Oakley, 1979).

According to Marx, humans need to be conscious in order to acknowledge their potential and they express their potential in labour to meet their human needs. The characteristics of human consciousness, according to Marx are:

1. While animals just "do," people can set themselves off mentally from whatever they are doing.
2. Since they have a distinctive form of consciousness, human actors are able to choose to act or not to act. Furthermore, they are capable of choosing what kind of action to undertake
3. The minds of human beings enable them to plan beforehand what their action is going to be.
4. Human beings possess both physical and mental flexibility.
5. Human beings are capable of giving close attention to what they are doing over a long period of time
6. The nature of the human mind leads people to be highly social. (Ritzer,

1996:p.159)

From those characteristics we learn that, to have a power to control over themselves and achieve their equal position in the process of reproduction, women need to be conscious about the process and in order to have a full consciousness, women need to have circumstances in which they can set themselves off mentally from the process of reproduction, have freedom to choose and to plan regarding their reproductive function, and have a right to determine the shaping their own childbirth experience.

If the process of reproduction is as worthy as the process of production, why is it so oppressive to women? Some feminists believe that it is because the consciousness of men's understanding of labour is different from that of woman (Kahn, 1995). O'Brien explains that the way men and women understand the process of reproduction is differently grounded in their differences of material consciousness. A woman is conscious that she has the potential of giving birth and the expression (medium) of her potential is labour, which will meet her needs and those of her baby. For women, giving birth is a unity of **knowing** and **doing** (my own emphasis), of consciousness and creative activity, of temporality and continuity (O'Brien, 1989:p.14). Men's consciousness of the process of reproduction works in a mode of alienation (O'Brien, 1989). Because man feels the separation (alienation) from the process of production, the capitalist producer needs to be secure that the result of the process is his and expresses his frustration by controlling the process of reproduction. Oakley defines this process as a mode of separation and incorporation (Oakley, 1980). By the mode of separation, man tries to avoid the responsibility of childrearing, but at the same time he structures the

incorporation of the childbirth process, and makes the process of reproduction dependent on technology (or under technological surveillance). Thus man has taken away woman's reproductive power by teaching woman that the success of the reproductive process depends on him.

In the case of production, Marx believes that the realm of freedom can be achieved only when humans are free from the sphere of necessity and necessary labour (Maria Mies in Kahn, 1995). If we apply this to the process of reproduction, women will achieve their freedom in this process only if can they be free from man's control over reproduction and regain control over their own reproduction: when, where and in what ways they will shape their own childbirth experience. A radical feminist, Shulamith Firestone tried to address this problem in the early 70s and produced a solution that was controversial even at the time. She suggested that women give up their biological reproduction and change it into technological reproduction (Tong, 1998). She argued that with modern technology, women do not need to bear their children; they can use In Vitro Fertilization (IVF) or Surrogate Motherhood if they want. Sawicky (1980) responds negatively to this idea. Giving up our biological reproduction to technology is the same as giving up our reproductive power to man, because man is the inventor/operator of technology. Further, Sawicky criticizes the IVF method as a money consuming and stressful process for the woman who wants it, while surrogate motherhood is no more than the commodification of a woman's body. It can possibly create five parents for the baby, namely the surrogate mother who bears and delivers, the mother and father who rear, the mother who donates the egg, and the father who donates the sperm. It is not just

confusing but also religiously incorrect (especially according to Islam). Some feminists believe that keeping away from men enables them to have their freedom. Rich (1976) explains that she has a realm of freedom with her children when the father of the children is away and then she can rear the children in a woman's way. In a culture where the society sees man and woman as complimentary (such as the Indonesian), this idea is unacceptable.

Much of this thinking puts the blame for the alienation of women from their own reproductive power on men, yet to blame man as the source of woman's oppression has inflicted a cost on the feminist movement especially in countries like Indonesia. Feminism appears to be anti-man and anti-family for its criticism of heterosexuality and the nuclear family. For many non-western women, including those with an Islamic background, find these aspects of feminism difficult. As an example, it is difficult for me to understand that for all oppression that women experience, it is men who are to blame, because my father and my brothers are men and they are good. Meanwhile, many times we found that it is a woman who causes the problem. My mother taught a higher standard to become a good woman to her daughters than my father did. When I was a child, my father always told me that I have to study very well, so that I can be whatever I want. He explained that a woman is as good as a man; he said that I could even be a soldier or a pilot. Meanwhile, my mother always reminded me that as a girl, I should be able to cook, to clean up, and many other tasks that I hate to do.

At the same time, Non-Westerners, such as Indonesians find that feminist ideas about gender equality are useful and they have helped diminish gender discrimination in

Indonesia. Let us consider the issue of *Undang Undang* (the legislation) No 1/1974 (about the regulation of polygamous marriage) in Marriage Law, which defines that basically, according to the state, a marriage is monogamous, but polygamous marriage is accepted under circumstances that are desired by both parties: for example, when the wife cannot fulfil her tasks as a wife and reproducer, or got a severe illness. Even though, for some feminists, the legislation is far from ideal it has given advantage for a lot of women. The Indonesian women's movement also succeeded in pressuring the parliament to issue Legislation No 12/2003. This bill insists on a women quota of 30 percent in Parliament, which opens more opportunities for women to be involved actively in politics.

Many non-western women activists do not want to call themselves feminists because of the negative connotations of the name (Ratna Megawangi, 1997). It is difficult for non-western women to understand that the word 'man' as it is used by feminist theorists is not a concrete man but, as O'Brien called it, an abstract man. It is not a man like our father, our brother, but man as patriarchal culture, destructive technology, capitalism, oppressing religion etc. But my view is that feminists were right to criticize male theory as abstract. So I do not agree that feminists should use the same level of abstraction. Non-Western women may find that technology is something that they need to save their lives, or religion is something that gives them comfort and a peaceful feeling in their lives. When natural childbirth activists refused the use of technology and medication in low-risk labour, it may become a big question for Non-Western women who are threatened with unsafe traditional ways of labour management and unavailability

of adequate technology and medication for high-risk pregnancies. Or, when Rich (1976) gives a solution that raising the children away from man is a way to free women from the oppression of motherhood, Indonesian women may find it difficult because they see the role of men as equally important in a family. I think that western feminism is difficult to ground in non-Western women's real life. It remains an abstract concept for women in the non-Western world. If feminists blame previous theory as an abstract concept[1] why should they abstract their own?

Deconstructionist, Robby Kahn (1995) provides a clear criticism of Marx and O'Brien in theorizing the process of reproduction. She defines 'human' as having three natures: biological, social and spiritual. Derived from her own experience of labour, she feels that the experience of pregnancy and labour is the unity of those three natures. It is not only a biological and social process but also a spiritual process. The process of childbirth allows women to transcend their bodily experience and provides the strongest connection to the cycle of birth, death and regeneration (Kahn, 1995). Supporting Kahn's arguments, Jacqueline Priya (1992), who conducted studies about childbirth using a cultural framework across Asia, America and Africa, concludes that, for more traditional societies, childbirth appears to be an event within which the natural, social, cultural and spiritual aspects play a part. I consider spirituality is also an important aspect in Indonesian childbirth. Kahn says that earlier feminist analysis of women's reproduction simply echoed male-stream theorizing by neglecting the other aspects of the process of

---

[1]According to O'Brien, Marx has abstracted women's work and struggle from history.

reproduction. Further it implies that white Western feminists theorists have been neglecting the experience of women from different cultures. She maintains that a purely secular analysis of reproduction does not encompass the condition of women in different cultures. Additionally, by limiting their discussion to the binaries of natural and cultural, individual and social, early feminist analysis of reproduction appeared to non-western women as denying their real situation. As a consequence, feminist theory of reproduction has remained an abstract concept to women from non-western cultures.

Another important theory of motherhood comes from Psychoanalytical Feminism. Nancy Chodorow looks at the way the ideology of motherhood passes from one generation to the next. In her book The Reproduction of Mothering, she denies that women are destined to be mothers by nature and believes that women are conditioned to be mothers by society (Tong, 1998; Chodorow, 1992). Women learn to become mothers from childhood. Parents become role models for their children. The mother-daughter relationship teaches a girl motherhood tasks since she identifies with her mother. By playing with dolls and cooking toys, a girl learns to become a nurturing mother. A boy follows the role model of the father to become a man, who is alienated from domestic work. According to Chodorow, a boy also has the inner capacity to 'mother' but this capacity is suppressed during his childhood and becomes undeveloped. The solution for this problem is to create dual parenting where children can learn from parents who share both domestic and public activities.

Other feminists, especially radical feminists, have criticised Chodorow. By focusing on the development of the child's psyche and family construction, Chodorow

did not take adequate account of the role society has in the construction of gender-differentiated roles. Men stay away from domestic work not because they cannot do the work but because they do not want to (Nicholson, 1993). Dual parenting as a model would also discriminate against homosexual parents and single parents. It also difficult to apply in a situation where the definition of a family does not only consist of the nuclear mother-father-children family, but also the extended family who live together in the house like most of the families in Indonesia.

Postmodernist feminists also try to analyse the way in which ideology about women's reproductive facilities is socially transmitted. These writers criticize the defect of 'modern' thinking, arguing that the knowledge that is transferred to women is expressed as 'discourse.' The word *discourse* means more than the verbal expression in speaking and writing (Kahn, 1995). Language is the filter through which experiences are interpreted and social life is constructed (Davis-Floyd, 1997). The knowledge about childbirth that women have to learn is integrated into everyday practices of managing childbirth that feminists call the language of birth (Kahn, 1995; Rabuzzi, 1992), and because it is repetitive, patterned, and symbolic, it becomes a ritual (Davis-Floyd, 1994c). Further, Davis-Floyd (1994c) explains that as a symbolic ritual, the language of childbirth needs to be interpreted to recognise its meaning. The language of childbirth that carries society's cultural values will be analysed intellectually, as well as being felt through the body and the emotions because women learn the knowledge by 'doing' it.

There are many discourses of childbirth in the world and each has to be interpreted within its social and cultural context (Mohanty, 1991). In pre-industrial

societies, the language of childbirth appears in childbirth ceremonies, taboos and prescribed behaviour, as well as the traditional everyday practices of childbirth. In industrial societies, the language of childbirth follows the techno medical model and becomes an enhancement of capitalist practices. The hegemony of the Western way of life means that the Western ways of managing childbirth is likely to be adopted all over the world. This process of taking over from the indigenous ways of managing childbirth in developing societies receives its legitimation from the dominant global forces (Jordan, 1997; Fox, 1994; Shilling, 1993). Thus the scientific knowledge about childbirth is legitimised by the authorities in most countries and has been practiced as a way to discipline women (Foucault in Shilling, 1993; Fox, 1994). It has become a taken-for-granted to women that the Western way of managing childbirth is better and safer than any other way. Thus, the knowledge of childbirth is hierarchically distributed not only in the labour room (by denying the knowledge of women) but also at the global level (by denying the traditional ways of managing childbirth).

I need to stress that postmodern critics do not want to say that all of modernity is bad, leading them to idealize the indigenous way of managing childbirth, but as Jordan (1997) points out, the knowledge of childbirth should be horizontally distributed. This means that the knowledge of childbirth is a shared knowledge. In the labour room, it is the knowledge of the woman who is experiencing childbirth, the knowledge of the attending professionals and the knowledge of women's significant others that are present in labour. So that the decision that is taken regarding women's experience is – or should be - a shared one between the woman and her labour attendants (Jordan, 1997). And, at

global level it is, or should be, the shared knowledge between the traditional knowledge of childbirth and modern obstetrics, so that we find the best way that is both medically excellent and appropriate to women's cultural background and health condition. In a study conducted by Betty-Anne Davis (1997) she argues persuasively that when the personal, the spiritual and the cultural are given attention, less overall harms will occur to mothers and babies.

In other words, postmodern feminists encourage women to be aware of the negative effects of the authoritative (techno-medical) knowledge. By providing such a critique of the process of parturition and learning to mother, and by drawing attention to alternative views, postmodern feminists provide an alternative for women to look at the practices selectively and decide themselves what is the best for them. Supporting some previous feminist theories on motherhood, many postmodern feminist critics agree that women deserve to have control over their own bodies. Without saying that it is male power or the power of patriarchy that controls women's reproductive experience, their critical theory of hierarchical knowledge is more appropriate to apply in a study on women whose experiences are significantly different from those of white, Western, and middle class women.

It is important to know the perspective of Moslem feminists regarding the issues of reproduction and mothering. I have mentioned before that religious values play an important role in informing Moslem women's perspective on feminism.[2] Moslem

---

[2]There are exceptions: Catholics feminists and Jewish feminists in Western countries tend to struggle harder to integrate their religious values with their feminist

feminists tend to look for their interpretation of the relationship between feminism and Islamic values in their religious texts. They try to reanalyse or reinterpret the religious texts with a gender perspective and make a distinction between the ones that are religious and those that are rooted in a cultural specificity. Rahman (1999) explains that usually Moslem feminists use what Ricouer called interpretation *as an exercise of suspicion.* They look for an explanation of why there are gender inequalities in Islamic texts and why some of the texts seem sexist and misogynist, and do not reflect the universal truth. According to Moslem feminists, the interpretation of the religious texts has been socially and culturally constructed and has been based on the prevailing assumptions of the era (Rahman, 1999). Many believe that religious texts are flexible through time and space, and that religion has never been wrong, but it is the society that creates the sexist interpretations of religious texts in order to give men or political groups special privileges.[3] Moslem feminists try to find other religious texts and interpretations that, possibly, are less well known, and publicise them in order to counter the persisting sexist texts. Rahman explains that Moslem feminists have deconstructed the traditional texts and reconstructed them in new interpretations that are not gender biased.

As part of the postmodernism era, Moslem feminists' movements focussing on women's reproductive rights discuss the philosophical concepts of reproduction, as well as the day

---

ideas, over, for example, abortion.

[3]As an example, Laila Ahmed (2000) explains that the sexist interpretation of holy texts in Kalifah Ali era in the Middle East made by some religious experts under his governance to discredit Aishah (one of Mohammad's widow), who lead a group of people against his government policy.

to day or actual practices of reproduction and motherhood as they have resulted from the existing cultural construction of the issues. Islam sees motherhood positively. Muhammad shows his honor to mothers by saying, "heaven lies under a mother's feet." Another holy story is recited by Bukhari and Moslem.[4]

> One day in the time of Mohammed, a man came to him and asked, "Who deserve my appreciation most?"
> The prophet said. "Your mother." Then the man responded, "Who is else?"
> "Your mother," again, said The Prophet.
> "Then, who is else?" the Man asked.
> "Your mother."
> "Then who is else?" Again, the man asked.
> "Your father."

These two holy texts are used by patriarchy negatively to remind women of their highest position as a mother and nothing else. Many women who devote their lives to motherhood believe that they will be granted a reward from God at last even though motherhood is oppressing them. A lot of women who have to work outside the house are very regretful and blame themselves if their family goes wrong, and many of them have quit their jobs, feeling that it is a part of their responsibility as a mother to fix the situation. Moslem feminists try to change this fatalistic belief and consider it important to have an alternative interpretation of many holy texts regarding women's lives, including their reproductive function (Maria Ulfah Anshor, 2004). Some other feminists try to provide the religious texts that have been hidden from view because of male interests, they try to socialize women to understand that they have control over their own

---

[4]Two of many persons who have done a lot of recitations of many things that happened during the life of Mohammed.

reproductive powers and deserve a special privilege for that. For example, according to Islam, women are free not to do some religious tasks such as, 5-times-prayer and fasting[5] during their menstrual periods. This implies that they also deserve to have special privileges in performing their everyday activities, for example they need a few days off work when they are menstruating to prevent possible harmful effects to their reproductive function.[6] Moslem feminists also remind society that having children is not the main aim of a marriage, which is to love and to know each other (man and woman)[7] and to prevent (man and woman) from doing sin.[8] They challenge the beliefs that view children as wealth,[9] which also means the more children the better, by showing that The Prophet Mohammed had only one daughter who gave him two grandsons, who died in a battle. Mohammed's example also destroys the belief that having a son is better than having a daughter as Mohammed very much loved his daughter. Moslem feminists have also discussed the responsibility for childrearing. While most feminists see the responsibility

---

[5]In the case of fasting in Ramadhan month, they can do it in another month as a replacement.

[6]It is stated in Indonesia labour regulations that women workers are entitled to two days off during their menstrual period, and this is recognised by Indonesian companies.

[7]O Mankind! Lo! We have created you male and female, and have made you nations and tribes that ye may know one another. Lo! The nobles of you is the sight of Allah is the best in conduct. Lo! Allah is Knower, Aware. QS AL-Hujurat [49]:13.

[8]The Hadits of HR bukhari and Ibnu Mas'ud.

[9]Lo! We have given thee Abundance; so preay unto they Lord, and sacrifice. Lo! It is thy insulter (and not thou) Who is without posterity.(QS. Al-Kautsar [108].

for childrearing as a shared responsibility between man and woman, Moslem feminists, more progressively, see childrearing as more of a male responsibility. They argue that the woman has done her responsibility by bearing the child, so that after the birth, a man should do many tasks, even if he needs to hire another woman to breastfeed the child (Mas'udi, 2000). Islam views pregnancy and childbirth as something that is a hard work and an uncomfortable state for women (because women are weaker by the process of childbirth)[10] so that it is needed to give women their rights for what they have done.[11] Even though women are supposed to breastfeed their children up to two years, if women cannot fulfil this task, they will not be considered as sinning.[12]

Undoubtedly, the Moslem feminist perspective on reproduction and motherhood works within the framework of heterosexuality and the institution of marriage. It is also conditioned by the culture in Indonesia where it is generally believed that sex can only be

---

[10]But if they strive with thee to make thee ascribe unto Me as partner that of which thou hast no knowledge, then obey them not. Consort with them in the world kindly, and follow the path of him who repenteth unto Me. Then unto Me will be your return, and I shall tell you what ye used to do. (QS. Luqman [31]:14).

[11]Divorce must be pronounced twice and then (a woman) must be retained in honour or released in kindness. And it is not lawful for you that ye take from women aught of that which ye have given them; except in the case when both fear that they may not be able to keep within the limit (imposed by Allah). And. If ye fear that they may not be able to keep the limit of Allah, in that case it is no sin for either of them if the woman ransom herself. These are the limits (imposed by) Allah. Transgress them not. For whose transgresseth Allah limits: such are wrongdoers QS. (Al-Baqarah [2]:228).

[12]Such of you as thy and leave behind them wives, they (the wives) shall wait, keeping themselves apart, for months and ten days. And when they reach the term (prescribed for them) then there is no sin for you in ought that they may do with themselves in decense. Allah is Informed of what you do. (QS. Al-Baqarah [2]:233).

done within a marriage and that homosexuality is religiously incorrect. Dede Oetomo (see Fantasizing the Feminine in Indonesia, 1998) criticizes Indonesian feminists for their neglect of homosexual rights, especially lesbian and transgendered people who identified themselves as women. I, myself, had been feeling uncomfortable in class anytime we talked about lesbianism. My feeling about this issue is still somewhat ambivalent. On the one hand, I see homosexual practices as religiously wrong while on the other hand, I appreciate their rights as individuals. I have not yet found the right formula for this issue in my thinking and I think it is related to my difficulties in building my perspective on lesbianism. Most religious Indonesian feminists might experience this confusing feeling. No wonder Indonesian feminists do less about this issue.

Finally, I should say that even though Moslem feminists have been criticized for their failure to struggle for homosexuals, they have acted bravely and achieved some significant reforms to improve women's everyday life, especially in the areas of reproductive and domestic issues in Indonesia. Some Moslem feminists have done this by going to the *pesantren* and challenging the traditional interpretations of Islamic texts. An Indonesian Non-Government Organization that has been successfully in this activity is *Perhimpunan Pengembangan Pesantren dan Masyarakat/P3M* (*Pesantren*[13] *and Community Development Organization).* This organization has successfully socialized the newly interpreted religious texts in some *pesantren* as the base for the *reproduction* of traditional texts. The collaboration of both Western feminist thought (as the origin of

---

[13]*Pesantren* is an Islamic school where the students come to learn Qur'an intensively.

women's movement) and local belief and culture is important to consider in initiating the source of women's oppression in non-Western countries, so that we can find the solution of the problem and plan a strong strategy to improve women's condition.

Some Related Studies on Indonesian Women's Reproductive Issues

Studies have been done in Indonesia about particular aspects of women's reproduction, but they rarely take account of women's opinions and perceptions about their experience. Women's opinions are not included in the evaluation of social and economic development. In my search for some references on socio-cultural approaches to childbirth, I found it difficult to find any socio-cultural Indonesian studies on childbirth from the point of view of women while I was in Canada. But, it was worse when I went back to Indonesia. There are a lot of books and articles related to the topic of childbirth, but almost all of them are from the point of view of the medical disciplines. What few studies exist on Indonesian socio-cultural childbirth are also from the experts' point of view. Women are still speechless, or perhaps they speak, but are still unheard, denigrated by the society that now perceives childbirth as part of professional authority and expertise.

A few studies I did find useful. One important anthropological study about Indonesian culture in general, which includes childbirth traditions, is Hildred Geertz's (1983) *Keluarga Jawa* (Javanese Family); although this is now somewhat out of date. Another study is a case study conducted by Marbangun Hardjowirogo's (1980) *Adat Istiadat Jawa: Sedari Seseorang Masih dalam Kandungan hingga Sesudah Ia Tiada Lagi*

(Javanese Culture: From Birth to Death). Yet, neither of these studies sees the cultural traditions of childbirth from a gender perspective. Some literature focuses on women's reproductive rights, but they still do not satisfy my desire to know more about childbirth from women's point of view, because the scope they cover is too general. However, all the literature I read was valuable because it developed my perspective about the experience of childbirth, either to make comparisons or to enrich my knowledge about women's issues.

A case study on the productive and reproductive behaviour of women workers in home industries in Yogyakarta, Indonesia (Hardyastuti and Watie, 1994) shows that poor women usually combine their productive and reproductive tasks by choosing to participate in a home industry. This not only ensures that they have lower wages but also that they are doubly burdened with their housework (including child rearing). Those findings are supported by a study carried out by Ediastuty and Fathurrochman on Fertilitas dan Wanita Pedesaan [Fertility and Rural Women]. The study finds that higher fertility will limit women's participation outside the house. It concludes that there is a need for more home industries for women to participate in the family economy. The conclusions of these studies are not only contradictory, but both also reinforce the existing sexual division of labour that leaves women solely responsible for housework and childrearing. A research on the similar topic, Wanita, Kerajinan Bambu, dan Masyarakat: Study Kasus di Jawa Timur (Women, Bamboo Craft, and Society: A Case Study in East Java) by Pinky Saptandary, provides a more radical solution, arguing that

there is an urgent need for socialized (feminist) values that housework and childrearing are not solely women's responsibility.

There is very little literature that specifically focuses discussion on Indonesian women's experience of childbirth from the standpoint of women. Some studies have examined the way in which the reproductive rights of Indonesian women that have been violated by the state and society. Adrina, Poerwandari, Triwijati and Sabaroedin's book , Hak-Hak Reproduksi Perempuan yang Terpasung (Repressed Women's reproductive rights) (1998), is perhaps the most complete book that I found. In their study they uncovered other facts of women's reproductive health conditions in Indonesia beyond what we can find in government reports. This study found that women are disadvantaged by society. Their social entitlement is neglected because they are taught to sacrifice their own needs to those of others.

Another study on family planning and consumer rights carried out by Dadang Juliantoro (2000) found that the Indonesian family planning program has violated women's rights in three ways. First, to reach their target in reducing population growth, the government used a coercive approach in mobilizing women to participate. Second, privileging one kind of contraceptive method over another has limited women's rights to choose. Third, lack of information to women caused them unnecessary suffering from, for example, the negative side effects of the contraceptive use. This study is an affirmation for the earlier study conducted by Masri Singarimbun (1994). Both of them explain that contraceptive technology as a part of modernity has caused women to lose control over their own bodies and to endanger themselves because of inadequate

knowledge about the effects of those technologies. This study also shows how women's reproductive power becomes bureaucratised/politicised. The same process happens in childbirth. Women give up their process of reproduction to medical professionals. In many cases, women do not know why an obstetrician and a midwife takes a particular action such as stitching, suturing, rupturing the membrane, etc., during the labour.

The impact of modernization on Indonesian women's condition is studied by Ken Surratiyah and Sunarru Hariadi (1990) in Wanita Kerja dan Rumah Tangga [Working Women and Family Life]. They show how the use of technology in the agrarian sector has affected workingwomen's attitudes. Women have longer hours to work in the agrarian sector and less time to do their housework. Their husbands and children have to take their places at home. While this might seem like breaking down the stereotyped division of labour, the women feel that they are entangled in their work commitments outside the home and so have less freedom to allocate and manage their time to work either outside or inside the home. It strengthens the assumption that modernity has made humans dependent on technology.

The current knowledge about childbirth that is publicly disseminated is usually male biased. Let us take, for example, an article in the Indonesian monthly magazine Intisari January 2002 edition written by Beatricia Iswari under the title *Melahirkan tidak sesakit dulu lagi (Giving Birth is not so Painful as It was).* She discussed the advantages of epidural anaesthesia to reduce or even to kill the labour pain but gave her account quite uncritically. On page 162 she writes, "The only factors that make this procedure ineffective (epidural injections), are patient's refusal, blood coagulating difficulties, local

infection at the injection site, unstable blood circulation and general infection."[My own translation] The use of the word 'only' in that sentence shows that women's opinion or agreement is something that she feels she can ignore. What she is really saying is that with the use of this procedure the expectant mother does not need to be afraid of labour pain and we do not need to hear an expectant mother screaming in the labour room.

The disadvantages of this procedure is written in a paragraph consisting of two sentences, "On the other hand, uncontrolled epidural anaesthesia will weaken the pulse (bradycardia) as the result of hypotension of the expectant mother. The fetus will lack oxygen supply which if left uncorrected will cause brain damage." [My own translation] All my respondents said that the labour pain does not make them afraid at all. What they are afraid of in labour is that if the process is not going well they have to have a caesarean section in a hospital. In contrast, the labour pain gave them the sense of being fully or really mothers. I do not think they would take the risk of brain damage as an exchange for their sensation.

Modernization has been experienced not only by women going through the process parturition, but also as an *imperative* for Traditional Birth Attendants to provide a safer birth process for women. Anke Niehof (1992) explains that the medical training for TBAs as mediators between modern obstetrics and indigenous ways is not compatible unless the TBA is given the opportunity to redefine her role in such a way that she does not lose credibility with her own people. The TBA should not be forced to adopt modern ways of managing childbirth because she can lose her traditional legitimacy and thus the confidence of her clients.

A study of the modern health service (primary health care) socialization program in Indonesia, using cadres as mediators to build a bridge between villagers and governmental health care, has been carried out by Rienks and Iskandar (1979). This study shows that the villagers are reluctant to accept the program because there are discrepancies between indigenous health care (which views the illness as biological, cultural and spiritual) and governmental health care (which views the illness as merely biomedical), as well as the philosophy of the cadre program (to enhance government health care program) and the reality of the cadre program (to enhance governmental politics and bureaucracy).

Rosalia Sciortino's studies on the Indonesian health care system are holistically presented and use a gender perspective. In one of her books, The Care-Takers of Cure: An Anthropological Study of Health Centre Nurses in Central Java, (1995) she described the actual day-to-day practices of health centre nurses. According to her, their ideal functions as professionals collapse as they are confronted with local, national and international conditions. She found that the tasks of Indonesian nurses are more curing than caring. Ironically, this situation is maintained by the doctors, who should do the curing tasks, in order to safeguard their own interests. They see the national government as wanting to take their advantages away from them in order to implement their health care programs. In turn, the government forces certain policies because the donor countries insist on certain policies as a pre-condition for funding. All this disregards the needs of the local community. Her work also found the services provided by the community health centre and the professionals' private practices to be of poor quality.

She argues that this is because the health care system has adopted the capitalist principle of maximising profit. Sciortino also discussed how women's reproductive health has been violated by the government through family planning programmes. Her further studies are focused on women's reproductive rights in family and society (Sciortino, 1999) and she calls for more gender-based research on women's health.

I was inspired by the work of Sciortino and I want to contribute this study to the enrichment of gender-based research and literature on Indonesian women, even though it is difficult for me to have access to government policy and literature. I hope my children will read my writing and build just perspectives on this issue (that is just to women in their era) for their own good and that of all women.

Chapter 3

Methodology

Feminist methodology is the practice of feminist theory (Berninghausen and Kerstan, 1992). I developed my methodology with the feminist principle that *the personal is political*, and based this study on women's opinions about their experience of pregnancy and labour in order to identify the influence of society in constructing women's understandings about themselves. By starting with women's experience I tried to bring the domestic world into public awareness. Theoretically, I believe that the childbirth process tells us more than about the creation of a new member in society. It has a wider impact on the life of humankind socially, economically, culturally, and spiritually. It is an important event not just for women but also for the society at large (Oakley, 1979). My emphasis on understanding individuals becomes the first target of this research because we hardly ever hear Indonesian women speak for themselves. And, the most appropriate method to understand women as individuals, who are usually less exposed in research, is through a case study method.

Case Study Method

Case study method is a method that uses a single case or very small sample. One of the characteristics of a case study is that it tries to reach the marginalized groups and those whose situations have not been well documented in the past as well as those who are generally powerless (Reinharz, 1992). In patriarchal society, women are powerless, the split between private and public putting women aside and marginalizing them. In the

area of women's reproduction, the development of technology has also contributed to the takeover of women in childbirth. If we browse the literature on childbirth, we will find thousands of books, articles, and journals which are from a medical point of view, but only a few of them are from the point of view of women. The voice of women is unheard and women's experiences are hidden because they are not considered important. Through the case study method we will be able to probe other aspects of childbirth from women as the main actors of the process, not in difficult medical terms but in women's language that is ordinary, but no less meaningful.

In this study, I chose six women as the cases. They share their story of pregnancy with their commonality as well as their uniqueness as individuals. Robert Stake (1995) defines a case study as the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances. Here, the circumstances of the case are important because no individual can stand by her/himself. That is why, to create a more complete picture of women's experience of childbirth, the interviews with the professionals, the women's husbands, and one woman's mother are included as well as the accounts of the persisting culture in which they live. It will help the reader to fully understand the life of the women in general and their experience of childbirth in particular. An example of a study on Indonesian women using case studies is Stories of Women's Lives, Family Economic Resistance: A Study on Low and Middle Income Women *[Kisah kehidupan Wanita Untuk Mempertahankan Kelestarian Ekonomi Rumah Tangga]* (Ihromi, Suryochondro, and Soeyatni; 1991). This study probes women's economic activities that they carry out in order to achieve the family's financial

sufficiency. It uncovers women's double and triple roles in society and how they deal with the problems. Another example of studies using the case study method is Javanese Lives: Women and Men in Modern Indonesian Society (William and Siverson, 1991), which covers the complexity of life among Javanese people in different social levels and occupations in Java that enables people from different cultures to have a more vivid picture of Javanese people.

Stake (1995) categorizes case study into three groups: intrinsic, instrumental, and collective case studies (for further discussion see Stake, 1995). This study is a collective case study. A collective case study is a study of several case studies in order to understand a particular issue. I try to understand that women's perspective of childbirth is shaped by the knowledge that they learn from society during pregnancy and childbirth. The experiences of childbirth among women differ one from another, especially, among those from different social and cultural backgrounds. I need to underline that the real business of a case study is particularization, not generalization (Stake, 1995; Hamel Dufour and Fortin; 1993). It is a picture of six particular Indonesian women with particular backgrounds.

The Participants

The women who became participants were expectant women in their first pregnancy. I consider the knowledge of this group of women about pregnancy is minimal, or at least, less than those of women who have already had a baby. Thus, I would be able to document their understanding of childbirth from knowing little to

knowing something. I chose 6 women as participants to provide the case study data for the study. Prior to the first interview, I recruited 10 women. Two women withdrew from the study because their husbands did not want them to participate. One husband thought that I would take the midwife's role to examine his wife's pregnancy and help to deliver their baby. I met the couple and explained that my job was not to do that, but they still refused to participate. The husband said that it was up to his wife while the woman said that her husband did not want her to participate. Another husband said that he did not want his wife as an experiment and left me alone in her living room, even though I had been trying to explain the study carefully and told them that there was minimal risk in participating in the study. I explained that it was me who wanted to learn something from his wife but it did not make any difference. Those husbands were peddle cab drivers, one woman was illiterate and the other was an elementary school graduate. I was really disappointed about these refusals because I wanted as much heterogeneity of participants as possible. I have since realised that there are still many Indonesian women who are so controlled by others that they do not have the freedom to decide. And there are men who have so much control over their wives that even the words 'up to you' means that they do not like it, so the wife will not do it. It also suggests that underprivileged women who have less education may suffer most.

One woman showed her resistance by avoiding me whenever I came for the interview even though we had set the appointments. She was not feeling well at my first visit, and told me that she was very busy at my second coming. So, I decided to drop her from the study since I felt it would slow the progress of the study. Nevertheless, I was

wondering whether I had done something wrong before. One woman moved to her own mother's house, which was too difficult to reach by public transport. My own pregnant condition also influenced my decision not to include her in the study. I did not look for more respondents because the result of the interviews with those six women was sufficient to provide the required data for the study. They had shown the very complex conditions of the respondents. Furthermore, six women is quite a large number for a case study. In a case study, intensity is the priority over the quantity of the respondents.

The fact that there were some women who refused to participate makes me realize that I still need to learn more about methodology, especially about the characteristics, either cultural or psychological, of Indonesian women. I think it would have been better if I known the women a little longer prior to the study, especially to do in-depth interviews with Indonesian women instead of just recruiting them and then setting a schedule for the interviews. It is necessary that we create closeness and build a relaxed atmosphere during the interviews. That is why after the first interview, I did some visits to the women and sometimes bought them some snacks to create closeness between us. And it worked very well, I could see a change of attitude in the second interviews; they were very open and relaxed. Indonesian women cannot trust a new person easily especially when women are used to government surveys, which sometimes bring difficulties to their personal lives. For example, to reach the national target, surveys on the family planning programme pressured women in the category of 'fertile couple' to use contraception, which they can see as a violation of their own bodies.

Other participants who took part in the study were two midwives. One was the midwife in the *puskesmas* that had official responsibility to cover the health of expectant mothers in her area, and the other was a midwife who was taking care of these participants. Interviews with them gave me a picture of the quality of care that is provided to the expectant women. A mother and a mother-in-law joined in the study coincidentally as they accompanied their daughters during the interviews. A husband was interviewed after his wife and sometimes gave his comments on the questions that I addressed to his wife. It was a really valuable contribution to find out men's participation in women's experience of childbirth.

For the expectant mothers, the ages ranged from 19 to 24. Four of them had completed senior high school. One woman received her diploma in computerized business and one woman was a university student. The midwives who took part in the study were both civil servants. One works at a Public Hospital in *Kabupaten* (district) who also opens a private practice at her home. She was the midwife to whom most expectant mothers in the area went to have the examinations and deliver their babies. The other is an official midwife in charge at the *puskesmas*. She also had a private practice at home in a different district. The man who participated in this study is a 31- years-old, Islamic senior high graduate and works at home as a tailor. All the expectant mothers are Moslems and, coincidentally, visiting the same midwife for examinations.

The Recruitment of the Participants

While in Canada, I had planned that I would go to the *puskesmas* to find women

with the required criteria, because 56% of expectant mothers in Indonesia have their pregnancy checked in the *puskesmas* (DepKes RI, 1996). However, I did not find any of them there. The *puskesmas* midwife gave me a list of midwives who worked in her area, but she said that only a few women came to the *puskesmas* for pregnancy checkups because they prefer to go to a midwife's private practice. It was one of the discrepancies that I faced between what I read in the texts and the actual Indonesian practice. The expectant mothers were recruited in different ways. Two women were recruited after I received their name and address from the midwife who was taking care of them. Because the address was not complete, it sometimes made it difficult to find the woman's house. It was worse when the women lived with the parents-in-law, who knew them as *"Ibu A* (Mrs. A [her husband's name])." It is very common in Indonesia that married women lose their name and change it into their husbands' name; which is worse than Western women who lose only their family name. To anticipate the same thing happening, I decided to do snowball/chain sampling (Poerwandari, 1998). I asked the first expectant mother about the possibility of finding another expectant mother pregnant for the first time in her neighbourhood. Two women were recruited in this way. Two other women were recruited with the help of *bakul jamu* (traditional remedy seller). I asked her about the possibility of having customers that fitted with the criteria of the respondents because traditional remedies were what most women took during pregnancy. All the respondents were recruited at their homes.

I found the fact that I do not have any relationship with government agencies or authorities and that I am just a student of a university (one that the women did not know

where it is), made the process of recruitment more difficult. It seemed that I did not have any power. Most women usually asked if the study had to do with the government's program or whether I was a university student who was doing *Kuliah Kerja Nyata (KKN)*[1] (Students working in Rural Area). I could notice the change in their facial expression when they knew that I was a "single fighter." I think it was because they felt so free that they could refuse to participate. I tried to ask some women about the reasons but they did not tell me. I hope it was not because they felt this study was not important to the national development. Of course, it disadvantaged my study, but I was really glad to know that the women who did participate in this study did so willingly and did not feel that they had been intimidated to participate.

The Interviews

The interviews were carried out twice, before and after the labour. The duration of the interviews was 1-1.5 hours. One woman wanted to do the interview together with another participant who was a relative and living close to her home. Two women were interviewed in the presence of their mothers, and one woman was interviewed in the presence of her husband. The presence of other people in the interview gave courage to the participants to share their stories, but on the other hand, one mother gave too many comments that were not related to the topic. The same problem was experienced by

---

[1]*KKN* is a course through which university students practice their knowledge in a rural community. It is a credit or non-credit course depending on the university's policy. Their programs in community evelopment are usually the result of coordination between the university and local authorities.

Adrina et.al. (1998) who found the presence of other people in an interview with respondent was both an advantage and a disadvantage to the research. The first interview was held when the women were less than 6-months pregnant. The reason I did not do it immediately after they found out that they were pregnant was that I wanted to give the women some time to analyze their experience and deal with the physical changes in their bodies. The topics that I addressed with them in the first interview were:

- Their physical, emotional conditions at that time
- They way they found out about the pregnancy
- Their feelings about being pregnant
- Their dietary food and prescribed behaviour
- The information that they received prior to and after they found out that they were pregnant
- Their attitude towards the information and advice that they received regarding their pregnancy. Their *Tingkeban* (seventh-months-ceremony) for those who carried it out
- Their plan for labour
- Their readiness to welcome the baby

The second interviews were carried out four weeks after the babies were born. At this time the new mothers were already taking care of their babies by themselves but were still able to remember the details of their labour experiences. The topics that were addressed in the second interview were:

- Their physical and emotional conditions at that time.
- Their experience of their labour
- The rituals that were carried out following the birth of a baby
- Their adjustment to their new role as mothers
- Their significant others' roles in their experience of pregnancy and labour
- Their concluding thoughts on their experience.

All the interviews were open-ended in-depth interviews and guided conversations. I let them talk about anything that they wanted to talk about, even though it was

apparently off the topic, as long as it was regarding their pregnancy experience. I found it was an effective way to carry out a an in-depth interview with rural women because I can catch a lot of valuable data from their story. During the interviews, all women treated me with hospitality. They served me a glass of tea or even cakes. One woman even served me a lunch. All the families seemed very friendly and welcomed my presence. The parents of the women usually met me for a while and then left me alone with the women, except for the two women I mentioned above. The parents usually asked about my origin or whether I knew someone that they knew around my neighbourhood. The parents of one respondent told me that they knew my father. It was an advantage that I lived not so far away from them. At least they would feel that I was not a complete stranger.

The interviews with the professionals were carried out after all the interviews with expectant mothers were accomplished. I did this because it allowed me to 'mediate' the women's questions to the midwife. Often women feel too shy or ignorant to ask questions to the midwife directly. The interview with the midwife who was taking care of the expectant mothers took place at the midwife's home, while the interview with the *puskesmas* midwife was carried out at the *puskesmas*. Both interviews with professionals were done by my research assistant.[2] I had tried to meet both midwives but I failed. I suspected that they were avoiding me, and to make the time more effective, I decided to recruit an assistant. She was a university student who did management economics. She

---

[2]It was because I had to go back to Surabaya to attend my in- laws' wedding as well as renewing my research approval, and decided to stay there for at least one month, because it was too difficult for me to travel back and forth between Surabaya-Mede with a 3-year old daughter and two months baby boy so frequently.

reported that it was also difficult for her to meet the midwife who was taking care of the women. She had to come four times before she was able to meet her. The midwife refused to participate at first, but after my assistant told her that we would keep her identity secret and her husband persuaded her, she agreed to participate. It also helped that, coincidentally, my assistant was also her niece.

The questions that were addressed to both professionals were the questions from the expectant mothers regarding dietary food and behaviour, the facilities and services that they provide to the expectant mothers, their normal procedures in taking care of the expectant mother as well as their opinion about their patients' attitude regarding their willingness to learn about the pregnancy. Especially for the *puskesmas* midwife I added the question about the organizational structures regarding *posyandu* and health services and their official roles as a government agent in implementing health policies.

The interview with a woman's husband was carried out after his wife's interview. I asked his comments on some issues such as his sex-preference for the baby and his role in pregnancy and labour. The husband was sitting in another part of living room doing his work and sometimes giving some comments on everything that I asked to his wife during my interview with the woman.

All the interviews were carried out in *Bahasa Indonesia*, except for an expectant mother and a mother-in-law who spoke in high-level Javanese to me. All the interviews are taped except the interviews with professionals who asked my research assistant not to tape their answers and to disguise their identities.

The Data Analysis

The analysis of qualitative data, especially case study material, is a complex matter. I am the only one who listened to the tapes. All the data gathered were transcribed and each respondent has his/her own file. The data of the expectant mothers were put in one directory and coded based on the common themes such as the beginning of pregnancy which were then ordered into smaller themes such as how they found out about the pregnancy, what are the women's feelings about the pregnancy at the beginning of the process, who become their consultants of their new condition, etc. I maintained the themes as chronologically as possible to maintain the flow of the experience (as the readers are able to see in chapter V) and I was as careful as possible to stick to the major theme of the way the society positions women (as readers are able to see in chapter VI). The uniqueness of their experience was given more attention to show the complexity of the cases. The data from the professionals had their own files and were put in a different directory as well as the data from the husband. Together with the field notes, the data were organized systematically. Some data might need to be interpreted. During the process of analysis, I sent drafts to my supervisor in Canada, as well as meeting her at the field site. I did this to ensure that my interpretation was as consistent as possible. I did not want to give a loose interpretation of the data. I sent her a copy of the transcribed interviews to check the accuracy of the analysis. We found that, sometimes, we disagreed in some interpretations due to our different socio-cultural as well as religious background. Stake (1995) explains that, in a qualitative research, analysis is a matter of giving meaning to first impressions as well as to final compilations. We do not recognise

the meaning immediately after we read them because the data do not speak for themselves (Poerwandari, 1998).

The meaning is not discovered, but is constructed (Stake, 1995). The role of the researcher in a contemporary case study is as an interpreter who constructs a new meaning. In patriarchy, the meaning of childbirth is usually constructed in the context of a male biased knowledge, which makes it difficult for a woman to recognise her experience. In this study, for example, several women saw that being pregnant was an uncomfortable state, even though they were glad that they were pregnant because it proved the normality of their womanliness. It is the role of the researcher to find out *why*, because it is clear from their own statements that they are ambivalent about their experience of pregnancy.

I found that the materials I gathered produced interesting and important insights. I tried to see all the women's opinions about their social condition as related to their experience of childbirth in the context of the overarching idea that *women learn something from their experience* The analysis was the most difficult part of the research process because I did not put the questions of the interviews in a fixed order, which means that I had first to group the data by theme. Also, I was concerned that I did not lose any valuable data in the process of analysis.

Trustworthiness

This study is qualitative and subjective in nature. The subjectivity of the expectant mothers in giving the meaning of their experience and my subjectivity in

interpreting of the data will influence the meaning. My analysis of the data perhaps would be different from analyses of other readers, who come to it with a different perspective. My own experience as a mother and my feminist perspective as well as the fact that I am a Moslem and Indonesian will contribute a great deal in constructing the meaning. However, the validity of the meaning derived from the cases is more difficult to establish (Sarantacos, 1993) and is maintained through a process of multiple checking and rechecking of the raw materials as well as discussing the early findings with my supervisor in Canada. And, that was exactly what I did in the process of analysis. At the end of the study, I went back to the women to tell them about my analysis of their experiences. Their reactions varied from surprised looks to a lack of interest. I felt a bit sorry that I had received so many things from them, but gave so little in return.

Ethical Considerations

This research was carried out with the approval of Memorial University's Research Ethics committee (ICEHR). There is no Indonesian Social Research Ethics Committee in Indonesia. The board that is in charge of granting approval for social research was *Kantor Sosial dan Politik* (The Social and Political Office) that is usually led by a middle rank officer from *Angkatan Bersenjata Republik Indonesia (ABRI)* (The Indonesian Armed Forces) or *Kepolisian Republik Indonesia (POLRI)* (The Indonesian Police Department) In the post-Soeharto era, this office was criticised for being a government agent set up to control civil political activities. Under Gus Dur, this office changed their name into a friendlier name: *Badan Kesatuan Bangsa* (National Integrity

Board) with the same tasks. There are three approvals that I had to hold before starting this research: the approval issued by the Provincial Social and Political Office, the approval issued by the Social and Political Office in the district of Mede and the approval from the local subdistrict office. I had to give one copy of the approval to local Police Department and I have an obligation to declare my research findings and give them one copy of my thesis after the study is accomplished.

The process of getting the approvals was a really difficult one. The absence of the director of *Badan Kesatuan Bangsa* during working hours is common problem, but it did not always mean that I had to wait for a long time because they already had blank forms with the signature of the directors on each form. The fact that I chose the sub-district of Suka as a site of fieldwork brought its own difficulties. First, I needed to go back and forth to Surabaya because as a university student from a foreign university, I had to have an approval at the provincial level and the approval was only valid for six months so that I needed to go to Surabaya more than once.

The process of getting this approval took two months. The major difference of approval function between the approval that was issued by Memorial University and Indonesian *Badan Kesatuan Bangsa* is that the Memorial approval is intended to protect the right of the respondents from any kind of violations during the research and possibly after the research. The Indonesian approval is to ensure that the research would not endanger the stability of the state or the area, and hence the authority. A staff person from the local *Dinas Kesehatan* was very worried that I would write about the failure of his department to implement the government programme and asked me to change the site.

This kind of fear might also explain the reluctance of the midwives to participate in the study.

I always tried to carry out this research as ethically as possible. I made sure that the respondents understood that they would not receive any direct advantages from the study and that their participation was voluntary and that they could withdraw at any time. All the participants signed their informed consent forms prior to the interviews. The expectant mothers did not mind if I used their identities in the findings, while the both midwives wanted me to disguise their identity. The husband did not want to sign the informed consent because he and his wife are one, or as he expressed it in Indonesian as 'we are the same'.

In this chapter I have discussed various aspects of my methodology, from the recruitment of the cases to the analysis of the data. In my next chapter, I turn to the core of my thesis, in a discussion of the socio-cultural context of childbirth.

Chapter 4

Indonesian Cultural Childbirth

In this chapter, I will describe the Indonesian, or more specifically, Javanese cultural view of childbirth. This is important because it is the cultural context in which my participants tried to understand their experience. I will try to argue that we cannot understand all women's experience of childbirth solely from the perspective of medical knowledge. Maternal health problems, for example, are related to and influenced by local culture and beliefs. To be more specific, they have strong rela
tionship with the way the society positions women. One example is the high rate of pregnancy anemia in Indonesia. This condition is correlated with the food consumption pattern in Indonesian families, which dictates that the woman is the last consumer after the man and the children. Because they eat the last, they eat the least and this leads to health problems such as pregnancy anemia. Another example is the case of the high levels of maternal mortality in Indonesia. The chief causes of maternal mortality are haemorrhage, eclampsia and infection. Important related factors are the three delays, namely the delay in the decision to seek care, the delay in arrival at a care facility, and the delay in receiving adequate care upon arrival at the facility (Cholil et al., 1998). The first delay is related to the lack of knowledge that women and their families have about the pregnancy, which makes them unable to recognize danger signs, women's position in the society which prevents women from making decisions for themselves, low economic status, and traditional belief systems. The second delay is related to the distance most women live from the primary health care facilities and poor transportation facilities. The

third delay is related to the lack of emergency care facilities and to the lower dedication and qualifications of the professionals (Cholil et al., 1998). As the state develops, maternal health becomes a part of government responsibility as the health provider both by issuing policies and by action programmes. Therefore, all the factors affecting maternal health cannot be separated from social and political issues. A holistic approach to maternal health will enable us to come to the best understanding of the problem as well as understanding Indonesian childbirth.

In this chapter, I will discuss the way Javanese society manages childbirth. I also want to discuss how this cultural tradition makes its adjustment with Islamic values - from the coming of Islam to Indonesia up to the recent resurgence of purer Islamic teachings, as well as its collaboration with modern health care that is provided by the Indonesian government. Women's reproductive issues, perhaps, is the best example that the personal is political. For the purposes of this thesis I define culture as the pattern of ideas and practices that bind people together and entwine all aspects of their lives, including, maybe especially, their reproductive lives.

Javanese Culture and Childbirth

Niels Mulder (1994) explains that to marry and to become parents, in Javanese culture, is a fact of nature and an obligation to the order of life. Those who do not follow this order are considered deviant.[1] Because Javanese society sees having children as a

---

[1]Unmarried women are considered to belong to this group.

natural phenomenon, the presence of a child is a must in a marriage. But this does not mean that women as reproductive agents will automatically have special privileges and positions in the family. The responsibility for having children in a family is more of a burden for women than for men. They are haunted by fears about whether they will be able to produce a child for the family if the signs of pregnancy are not present in few months after the marriage. Those who cannot get pregnant may have to accept the unfairness of being divorced or of having to live in a polygamous marriage (Geertz, 1983). Only a few couples choose to adopt a child, and if they do, it is usually from a close relative. On the other hand, those women who do have children do not automatically have special privileges. Many women say that they receive special attention from their husband and family, even though they know such attentions are for the baby. But, they also receive various diets and prescribed behaviours which, in many cases, make them uncomfortable in their condition. In the following section, I describe the traditional Javanese pattern of treating pregnant women and childbirth. Some of these traditions persist today, some persist in a modified form and some have been abandoned, as I describe below. But it is important for my argument to understand the Javanese traditions because these still form people's ideas about women and childbirth.

Diets and prescribed behaviours affect both the mothers and fathers to be. Some diets may be very useful for the women and the baby, while others may not have any impact on them, but some others have been proved to have negative effects on women's bodies. Some women do not mind putting themselves on the diet and do the prescribed behaviours even though they do not know what they are all about, while, indeed, some

others are able to take some advantage from them. Those diets and prescribed behaviours carry strong cultural beliefs that the divine forces play an important part in the reproduction of human beings. It is believed that women should obey the diets and prescribed behaviours to avoid the baby being born like a monster, to prevent miscarriage and to protect the baby from the bad forces that would take the baby somehow (Geertz, 1983). Some of the diets have a mystical foundation. In her pregnancy, a woman should say *amit-amit jabang bayi, muga-muga ora nurun sak keturunanku* (may God not bless me with that kind of baby) anytime she sees a handicapped person or an animal that she has never seen before. Javanese people believe that the baby can *tertular* (be affected) by bad things that happen outside the womb. The father to be is not allowed to kill animals and he has to say the same words if he sees a strange animal or a handicapped person. I will discuss these diets and prescribed behaviours further in chapter 5.

No matter what happens to women, children are eagerly anticipated. The future of the parents is one of the reasons for having children. Most Javanese parents would say that the presence of a child is important to secure their lives in the future, economically (to support them financially) and socially (to accompany and take care of them when they are old). It is understandable because Indonesia has no pension plan for the majority of its citizens except for those who work for the government. This ideology may be reflected in a Javanese proverb *banyak anak banyak rejeki* (the more children we have, the luckier we are). From her observation of a Javanese community, Hildred Geertz (1983) found that, in Javanese society, children are responsible to support and to take care of their parents when they are old. Children usually have an obligation to give their parents back what the

parents have done for them. It is very rare to see Indonesian parents live alone in their old age; they usually live with one of their children. Thus, a child is not only an expectation, but also a need. Even though, during their childhood and the time where they are not yet independent, parents must spend money to support their children most parents see the expense as an investment for their old age. Young married couples who are not financially independent usually live with their parents. Or, if they have to work in different places, they will put their children in their parents' house and bring them together after they settle in the new place. Most parents do not mind this pattern as long as they are still able to help, because if their children gain their success in living they will soon take on their responsibility to support their parents in their old age and their younger siblings until the siblings are able to support themselves. In my mother's family, for example, my eldest brother took the responsibility to support his four younger siblings' education after my father died in 1982. This meant that he automatically became the decision maker in the family.

Because children are so important to the family, some feasts and ceremonies will be set soon after people are sure about the pregnancy. Thomas Bratawidjaya (2000) explains that in Javanese society, the ceremonies to celebrate the coming of a baby started when the woman is entering two-months-gestation, followed ceremonies at four-months-gestation, seven-months-gestation and nine-months-gestation. These ceremonies are usually followed with a small feast that is intended to expect a blessing from God for the health of the baby. In Javanese, we call it as *selamatan,* which is to achieve the state of *selamat* (meaning the wellness physically, psychologically and spiritually). The major

ceremony that many people still carry out today to celebrate the pregnancy is the *tingkeban* ceremony. It is carried out when the pregnancy is at seven-months-gestation. The number seven is sacred in pregnancy because it is the time when the pregnancy is considered to have less possibility of miscarriage and the baby is ready to be born (Priya, 1992); it is also true medically except that the chances of its survival are slender. The reason I want to discuss the ceremony in more detail in this chapter is because this ceremony contains various messages about gender, as it is understood in Javanese society. As in Western society there is a slight preference in Javanese society to have a boy. This is rationalized because a male would be able to work outside the house, have a better career, and earn more money than a girl would, so that he can support his parents to raise their siblings. Most Javanese prefer to have a boy as their first child so that he will be able to take care and protect the younger siblings, even though, in fact, most girls start their participation in caring for their siblings much younger than boys do. Javanese girls do domestic work and childrearing while Javanese boys are still playing in the playgrounds.

This seven-months-ceremony also shows that childbirth in Indonesia involves men and the whole family, as well as showing the relationship of the process with the divine forces. The preparation of the ceremony should be done by the future father. He is the one who is looking for a couple of *cengkir gading* (young yellow coconut fruit), *kembang setaman* (certain kinds of flowers that are usually used for traditional ceremonies), egg, new dresses for his pregnant woman and other items. The women in the family prepare certain meals that have a distinctive meaning in Javanese lives. The

ceremony starts with bathing the mother-to-be, first by her husband and then by the two sets of parents. The seven close female relatives then bathe the mother-to-be. The husband will choose one of two yellow coconuts on pictures have been drawn of *Dewa Kamajaya* and *Dewi Kamaratih* (two good looking Gods in Hindu legend). The expectant father does not see the pictures on the coconut. If coincidentally he chooses Dewa Kamajaya, people believe that he will have a baby boy. Otherwise, he will have a baby girl. The coconut and the egg are passed down along the expectant mother's .[2] The egg should be broken as it touches the ground as a symbol of an easy labour. The coconut will be slashed into two. If it breaks into equal parts the baby will be a boy, if not, the baby will be a girl. People still believe in the myth that a man is wiser than a woman and more able to act fairly, as his brain is dominant. On the other hand, people believe that, for a woman, emotion is dominant, and that prevents her acting rationally or fairly. The expectant woman dresses up and changes her dress seven times while asking the people who come to the party whether she looks good in her dress. The people will say that she does not until the expectant woman puts on her last dress. If she really looks good in her dress, people believe that she is bearing a baby girl, because a girl should be beautiful and really good at dressing up. If she looks bad in her dress the baby will be a boy, because a boy does not need to dress up. The foods are ready, and people start to eat. If the foods are too salty, or too hot, or may be not so tasty the baby will be a boy, because a boy does not need to cook in his life. Otherwise, the baby would be a girl, because a

---

[2]A long piece of material with the sides are sewn together, so that makes it a circle. It is usually used by men to pray and as a casual costume at home.

girl should be able to cook. Meanwhile, the expectant mother and her husband are selling *rujak* (a kind of food made of fruit and brown sugar). As well as the food, the taste of the *rujak* also indicates the sex of the baby. The *money*[3] that they receive from the people symbolizes the wealth that the baby will get in her/his life. Some gender stereotypes that women learn from the ceremonies are: that women have to be beautiful, be able to cook, emotional, and are not clear thinkers, and men are.

The expectant mother is now ready for labour. Some women believe that they are not allowed to buy anything for their future babies unless their pregnancies have already passed 7-months gestation. Women usually do not prepare special things for labour because labour is considered natural. I remember my Mom gave me a piece of *jarik*[4] when I was about to go to Canada to deliver my baby there. She said that I had to use it during the labour and to carry my baby when s/he had been born. Many women may prepare themselves with special diets from the beginning of their pregnancy, some foods and behaviors during the pregnancy are believed to be able to ease labour (see further in chapter 5). Psychologically, women do not prepare themselves for labour. Because they see labour as natural, they believe that God will manage everything; Javanese women

---

[3] It is not real money; it is made of pieces of terracotta, which is passed along by the people who come to the party before they enter the house.

[4] A long material that usually used by women in their traditional suit. Women also use it to carry the baby and in all occasions, such as labour. Some people believe that the *jarik* used in labour has a mystical power to heal if the baby is sick by using it as a blanket. That is why some people keep it with them in all their lives.

usually face their labour with great submission. Traditionally, a *dukun bayi* [5]will help the expectant mother in labour, accompanied by the expectant mother's husband who will support her back during the labour. She is also accompanied by her close relatives, usually her own mother. The grandfathers and grandmothers are expected to be present because if there is difficulty in labour, their forgiveness will be needed for the labouring woman. Women who have difficulties in labour have to apologize to God, their husbands and parents. Some people believe that difficulties in labour are caused partly by women's mistakes to those people or their sin to God in the past. Obviously, it shows the hierarchical order in Javanese society that women come after God, the men and the parents. It also implies that labour pain or difficulties in labour is a punishment from God that makes it more frightening for women.

The husband also has important roles after the labour. It is his responsibility to take care of the placenta. Some people believe that he also has the responsibility to clean up the blood in the woman's *jarik* that is used in labour. The placenta has special treatment. People believe that it is a friend, blessed by God, to accompany the baby along her/his life. After it is cleaned up from the blood, it is wrapped in a white calico and pinned with gold and silver needles by those who can afford them. Afterwards, the placenta is put in a bowl made of terracotta and buried outside the house. Some people believe that the place where the placenta is buried will influence the condition of the baby. They will keep it as far away as possible from the well, or the baby would catch

---

[5]Javanese Traditional Birth Attendant.

cold easily; they prefer to put it in front of the house so that s/he would have a good spirit in life rather than to put it in the backyard. Some people put it down a river, so that the baby would not mind going far away from home to pursue her/his aspirations in the future. The placenta will be covered and given a light to protect it from rain and animals. Some people also believe that it will protect the baby from evil spirit.

The new mother soon goes to her postpartum treatment. Traditionally, the *dukun bayi* will help her to massage and to put certain kind of remedies on the woman's belly to make it as elastic as before and to be back into its original shape. She also takes care of the newborn baby, bathing the baby until the cord falls off. The cord of the baby is believed to have healing power. If the baby gets a severe illness, it is put in water and the water is given to the baby to drink. The *dukun bayi* keeps coming to the new mother's house up to 35 days after the delivery. The mother will have a lot of assistants to take care of her baby, because she is not allowed to move a lot. It is not good for the vaginal lacerations. She has to put herself in a tight *jarik* and to sleep half-upright with her legs straight. It is believed that these treatments will prevent the *darah putih,*[6] *which* goes up to the chest and prevents varicose veins. The woman also has to wash her hair at every bathing to make her face look fresh and her eyes bright. Also, she has to take *jamu-jamuan*[7]and follow diets, such as, not taking foods that are too hot or too cold, because they would cause the mouth of the baby to be burned. There are many other diets and

---

[6] Literally it means white blood, but in this context, it means excessive leucorrhoea.

[7] Traditional remedies.

prescribed behaviours that women should do following the birth of the baby (see further in chapter 5). Meanwhile, the presence of the baby will be celebrated several times until s/he is two years old. The husband will be proud that they can have a baby, the family will be happy about the presence of their new member, while the woman will feel that one of her life`s missions is accomplished and is ready to start her new responsibilities and tasks to rear a child.

The Influence of Islam

Treichler (2000) explains that because cultural reproduction depends upon human reproduction, questions of childbearing are invariably significant in the life of a culture, and significant changes in childbearing patterns often signal a broad cultural change. Some of the Javanese childbirth traditions cannot be found today. Some cultural and mystical beliefs of traditional childbirth have been abandoned in the present childbirth ceremonies because they are now regarded as ineffective, too expensive and complex (Hardjowirogo, 1980). Another reason for their abandonment is, perhaps, because they do not fit the religious teaching that the people believe, in this case Islam. When Islam first came it tended to tolerate the Javanese mystical beliefs, but in its later development, it has been trying to pursue its purer values.

According to Ricklefs (1990), the Javanese adopted the new religion, Islam, in the fourteenth century without much fuss. They had been able to adopt Hinduism and Buddhism without a sense of conflict long before. One of the reasons that makes it easy for the Javanese to accept Islam is because this religion also believes in a mystical

dimension (Ricklefs, 1990; Woodward, 1989). However, their mystical dimensions stand on two different frameworks. Islam stands on two main confessions: that there is one God, Allah, and Muhammad is His messenger, while the Javanese belief is a mixture between Hindu teachings and animism/dynamism (which believes in the existence of other spirits and that everything in this world has its own spirit and power). Both Javanese and Islam beliefs experienced acculturation which eventually engendered Syncretic Islam (Geertz, 1960)

This acculturation happened in two ways (Sofwan, 2002). First, the Islamization of many Javanese traditions, for example, some childbirth traditions. People no longer carry out so many traditional Javanese ceremonies and feasts. The *tingkeban* that people carry out today is very different from its original form. A lot of people change the ceremony into a Koran reading along with the *selamatan*. They invite the neighbours or orphans or a group of young people that usually get together in the mosque, to read the Koran asking Allah for the baby's and the mother's wellness. Most of the people who come are males but other people are more traditional, still carrying out the rituals such as the bathing, the dressing up, the *rujak* selling etc, beside the Koran reading, and start every ritual with the word *Bismillahirrohmanirrohim* (in the name of Allah, the compassionate, the merciful) which indicates that the ceremonies are held in Islamic frameworks. Islam also implies that people should omit rituals that are considered *sirik* and anything that is unnecessary to do. For example, ritual bathing is something that nowadays people think does not have any meaning. They say that flowers are not able to clean up the human body, even if the fragrance stays longer, even though the earlier

Islam in Indonesia tended to tolerate this ritual. Another ritual is slashing the coconut. The *Cengkir gading* is now difficult to find and there is almost no one who is be able to carve the character of *Dewa Kamajaya* and *Dewi Kamaratih*. So, people tend to leave it or to change the ritual into simpler activities. This is because *Dewa Kamajaya* and *Dewi Kamaratih* are not Islamic figures, they do not mean anything for Javanese people who are more Islamicised today. They prefer to replace them with the figures of *Nabi Yusuf* (English: Yosef) and *Maryam* (Virgin Mary). Their *surah*[8] are recited in the seven-months ceremony and it is believed the readings will cause the baby to inherit their good looks. The more modern Moslems refuse the logic, because it is impossible for the baby to inherit anybody else's face but their parents'. They believe that the reading of the *surah* is intended to ask for the baby's fidelity as shown by *Nabi Yusuf* and *Maryam.* But, of course, omitting the original ritual also means omitting the symbol of persisting gender stereotypes inherent in the original rituals.

The second way is the opposite - Javanization of some Islamic values. We can see this when Islamic values appear in the Javanese rituals with Javanese names but having Islamic values in its spirit. For example, in the seven-months ceremony, the host usually serves them meals and some of the meals are brought home by the people who join the reading, which is called *berkat* (English means gift or blessing). Some of them will include the *rujak* in the *berkat* to announce to the people at their house that it is the *selamatan* for the baby and the new mother, with a hope that they will also pray for their

---

[8] Part of the Quran. Yusuf and Maryam ave their own stories in it.

wellness. This *selamatan* is in accord with an Islamic value called *shodaqoh* (to share some of your happiness with the poor, and sharing food is part of it).

The close relationship between Javanese culture and Islam has made it difficult to differentiate which one is Javanese and which one is Islam, if we do not look at it carefully and learn about both more seriously. Along with the coming of modernization in which people think more rationally, Moslems try to actualise their understanding of Islamic teachings, and the ways they do this reflects their basic orientation. Borrowing the Western definitions of fundamentalist and modernist, Rahmat (1998) defines Moslems understanding of their religious teaching as follows:

- The modernists see Allah immanently, All Good and All Loving, so that they view the religious spirit as the most important. The fundamentalists view the legal aspect as the most important because they see Allah transcendently, so nothing compares to Him.

- The modernists believe that Islam did not come to a society that was a cultural vacuum, so it is always influenced by the local cultures. These modernists are more tolerant of diversity. The fundamentalists want to practice Islamic teachings that are free from culture, because they believe that Islamic teachings that were practiced by Mohammed the Messenger are universal.

- Because they believe that Islamic teachings are universal, the fundamentalists try to create an Islamic society that is like the original Mohammed society in this modern age. Modernists are more inclined to welcome cultural influences, which tend to lead to an Islam that is syncretic with the local cultural traditions.

- The modernists are able to accept any kind of governmental systems as long as it fits in with Islamic principles. They tend to be nationalists. On the other hand, the fundamentalists want to establish an Islamic country that is as close as possible to all the characteristics of Mohammed Islamic nation in the past, as they believe it to have been.

- Because they believe in diversity, the modernists do not see the necessity of creating a worldwide Islamic government, for which the fundamentalists are struggling.

In practice, Indonesian Moslems are much more complex than the simple categories of Modernists and Fundamentalists would imply. Some modernists will also try to purify their Islamic values from the influence of local culture and to practice their religion more purely. The core of this purification movement is to purify Islamic teachings, the doctrines and norms, to be more logical and rational (Saleh, 2001). Logical and rational are perhaps the most appropriate terms to express modern characteristics. Thus, purification does not belong only to the fundamentalists. Both fundamentalists and modernists feel that purification is needed in the modern era, within which there is so much competition between cultures. Gunawan Mohammad (2002) explained that this purification is needed to show Moslems their identity among the overwhelming influences of foreign culture. On the other hand, the fundamentalists also accept some parts of foreign cultures such as the invention of technology, including modern obstetrical medicine. A major difference between these different versions of purification of religion is that the modernists' purification is an active process of selection. While dropping current cultural values that are considered inappropriate with Islamic values, they try to reformulate new interpretations of religious texts. They also try to find the interpretations that have been hidden from public knowledge and reformulate them to fit with present circumstances. The fundamentalists do not reinterpret the religious texts, but insist that the old interpretations fit all times and all places. My position is that people's understanding of Islam is not something that is static but is a dynamic process. It changes as the cultures around it changes, and that happens in Indonesia and around the world.

As the result of this cultural transformation, a lot of Indonesian Moslems have abandoned Javanese mystical beliefs. These are the people who no longer carry out any *selamatan* or reading of the Quran for special purposes such as the seven-months ceremony. Also they no longer believe in the diets and prescribed behaviours that are considered *syirik.* Instead, they rely on modern obstetrical management that is more logical and rational, and supported by science. They try to actualize Islamic teachings to fit with modern living. At the same time, Javanese Moslems who are afraid to leave their traditional values try to rationalize some beliefs to fit better with both Islamic teachings and modernity. For them, it is tolerable to carry out *selamatan* and any other ceremonies as long as it is within the Islamic frameworks. They view the ceremonies as traditions, which do not have any significant meaning for their life. For example, the bathing ritual used to be a significant purification rite before carrying out traditional ceremonies, but now it means no more than cleaning up our bodies. Basically, no matter what Moslems believe about Islam, they tend to welcome modern inventions such as modern obstetrics, partly because its scientific back up breaks down the mystical beliefs about pregnancy and childbirth, that is concomitant with the religious mission to get rid of any *syirik* practices. In short, the wave of modernity such as the coming of modern obstetrics contributes to the changing of Javanese rites and traditions as well as to their understanding about their religion. In the following section I discuss how the introduction of modern medical obstetrics has changed the experience of Indonesian women in pregnancy and childbirth.

The Medical Takeover of Maternity Care

Pregnancy and childbirth is the focus of attention of modern obstetrical management. It is no longer treated as a natural phenomenon, but as an event requiring medical intervention. This approach was first seen in Indonesia during the Dutch colonial period when the *School voor Inlandsche Voedrowen* (School for Indigenous Midwives) was established in 1852. It was intended that midwives trained in this school would replace the TBAs, whose practices were blamed as the main factor that endangered the lives of mothers. In this period, in Indonesia as elsewhere, virtually all births took place at home. This attitude is the one still prevailing today. However, the number of trained medical personnel is inadequate to serve the expectant mothers' needs, especially women who live in remote areas and the underprivileged women. Therefore, to bring the services closer to women, in 1952, the government established *Balai Kesehatan Ibu dan Anak* (Centers for Mother and Child Health) to provide assistance to pregnant women, babies and infants through health education, vaccination and simple curative practices in every subdistrict (Cholil et. Al.,1998). The BKIA merged its activities with those of the *Puskesmas* as part of the primary health care system in 1965.

However, the role of the TBA could not be replaced by the professionals so easily, because they tended to USE different frameworks. A midwife, at least in Indonesia, works on a medical basis, dealing only with the physical dimension of the patients, while the TBA deals not only with the physical dimension but also the psychological and, sometimes, the religious dimensions of their patients. Trained midwives, at least in Indonesia tend to have a more medical orientation and to put more

emphasis on the physical care of their patients. TBAs, on the other hand, still see their role more holistically, having equal regard for the physical, psychological and spiritual dimensions. Partly because of this, even today, many women trust the TBA more than the trained midwife. Realizing that it was almost impossible to replace the role of TBA, in 1970 the Indonesian government began to provide medical training for the TBAs and equipped them with obstetric kits. This strategy was intended to ensure that the TBAs would work to medical standards but the result has not been satisfactory. Many of TBAs who had (supposedly) been trained just displayed their kit in their practice premises and were not clear about how to identify or respond to an emergency situation (Cholil et.al., 1998).

The next strategy was to try to build a partnership between midwives and TBAs, so that the TBA practice could be supervised by professionals. But midwives have too many activities in their offices and too many patients to deal with in their private practices so that they are not able to or do not want to be present at the deliveries that are helped by a TBA. There are even midwives who think that this strategy is useless because the TBAs would not accept their advice. So the government called for community participation. In 1979, the system of *posyandu* was established. This was a package of community-based and community-organized programs of mother-and-child care targeting five priorities: nutrition, diarrhea control, family planning, vaccination and maternal and child health (Cholil et. al., 1998). Theoretically, this program was to be *'dari rakyat untuk rakyat'* (from the community to the community), which means that the community would take the initiative to establish better health conditions for themselves

with health professionals supervising. Some women from the community are expected to become activists who run the program voluntarily, and they are called cadres. They are trained by the health professionals from the local *puskesmas* to educate other women in their communities. In practice, the initiative always follows a top-down mechanism, which means that the activities that are carried out in *posyandu* are a package provided by the local *puskesmas,* which in turn is derived from the upper structure of the national health delivery system, and even with some input from international organizations. Therefore, for all its good intentions, the *posyandu* program does not fit with the needs of the local community. For example, there are cases where the *posyandu* activists put their emphasis on the importance of consuming healthy food with sufficient vitamins and mineral - to people who are so poor that they do not know whether they will have any food to eat for the day. The schedule of *posyandu* is usually carried out in the morning and this is also the reason why women do not come. Women are usually busy with their household chores in the morning. Many of them take part in economic activities, going to paid jobs or helping the men working in the field until mid morning as well as being busy preparing the meals for the day, or going to the traditional market to sell or to buy their daily needs – which they can only do in the morning as the market will be finished before noon. However, morning is the best time for the *puskesmas* staff(s) to carry out their supervision of *posyandu* activities, and this is why they are held then. Another reason that hinders women coming to the *posyandu* is that they cannot trust the cadre's knowledge about health, because the cadres do not have any formal education in the matter. This situation is worsened because in a *posyandu* where the *puskesmas* officers are present,

the cadres act as *pembantu* (assistant) for them. This decreases expectant mothers' appreciation of the cadres' role in the *posyandu* and thus affect their compliance and interest in the activities. The officers will take responsibility for every activity in *posyandu*, even though it means some of the work does not get done because they have hundreds of *posyandu* to cover in their area (Sciortino, 1999:131). If no nurses from the *puskesmas* come to the *posyandu*, the *posyandu* activities are not carried out – as happens in my own neighbourhood. Some women do not know about the *posyandu* acivities in their neighbourhood because they do not live permanently in their current residence. Many women who live in the bigger cities will come home to their parents to deliver their babies and will then return to the city. They do not feel they belong in their parents' community, even though they gave birth there, because it is not their home and they do not want to become involved in local community activities. Other women do not have access to information about *posyandu* activities because they never have the opportunity to get together with the neighbours, for example, because their husbands do not want them to. And, none of the *posyandu* activists (cadres) visits them to let them know. The reasons for the cadres' unwillingness to do home visits are varied. One reason is that they do not have sufficient commitment to their responsibilities and tasks as *posyandu* cadres. It is difficult to find committed cadres because women are usually busy with domestic work and are already too overloaded to do any more activities. Many women, who are also wage earners for the family, think that it is not important to be active as *posyandu* cadres because they are not paid, and they need money for their family. Thus, women who are active in *posyandu* are usually also the wives of local government officers and

staff, because they are less occupied with domestic responsibilities, and also because as the wives of government employees they have to be active in *Dharma Wanita.*[9] So, the *posyandu* that was expected to be a means for women to be active in community development, becomes yet more work for women to do and as a burden for those who cannot avoid such responsibilities. Women's participation in *posyandu* is never voluntary but almost obligatory or even a measurement of community compliance (Sciortino, 1999). The commitment of the cadres, of course, will influence the quality of *posyandu* services.

Even though many women complain about the attitude of the cadres and the *puskesmas* officers, many women do come to the *posyandu*, and are able to take some advantages of the program. Being together with their fellow mothers enables them to share their experiences and discuss how to solve their own problems. However, with the present difficult economic conditions that affect the majority of Indonesian people, it is difficult to expect *posyandu* to run regularly once a month and to maximize its function for expectant mothers and children under five years old. Many *posyandu* find it difficult to fund their activities. Some people have tried to encourage the more wealthy families to participate in preparing healthy food for children of the poor. But, in a poor community, it is impossible to give other people's children healthy food while your own children are also going short of good food. Lately, *posyandu* has tended to put more of its emphasis

---

[9]Dharma Wanita is an organization of the wives of civil servants. The quality of women's participation in this organization has an impact on their husbands' careers, and is virtually required.

on children rather than mothers. The program for expectant mothers is usually carried out only if the *puskesmas* officers can come to the *posyandu.*

In 1988, the Safe Motherhood Initiative was announced. It called for a 50 percent reduction of Mothers' Mortality Rate (MMR) from 450 per 100,000 live births by the end of *REPELITA* (*Rencana Pembangunan Lima Tahun*/Five-Years Development Plan) VI. To support this initiative the National Family Planning Coordinating Board (BKKBN), in 1991 promoted *Kampanye Ibu Sehat Sejahtera* (Healthy and Prosperous Mother Campaign) which was upgraded to be *Gerakan Ibu Sehat Sejahtera* (Healthy and Prosperous Mother Movement) and more recently has been redefined as *Gerakan Keluarga Sehat Sejahtera* (Family Health and Welfare Movement) (Cholil et. al., 1998: p.34). The activities of these variously named initiatives have included efforts to improve households' socio-economic status (through supporting/developing home industries, such as tempe industries, cakes industries, etc), the mobilization of community participation in promoting nutrition (through healthy food education in *Program Kesejahteraan Keluarga (PKK)*[10] gathering or *posyandu*), antenatal care, and tetanus toxoid imunization for pregnant women as well as the provision of appropriate delivery care by trained village midwives.

It was not only in the *posyandu* that the emphasis has shifted to children's health in its later implementation and development. The change of *Gerakan Ibu Sehat Sejahtera* into *Gerakan Keluarga Sehat Sejahtera* also moves the highlight from women to the

---

[10] Family Welfare Programme.

family. Partly as a result of all this, there has been no significant progress in reducing MMR even though the Infant Mortality Rate (IMR), post-natal mortality, child mortality, and under-five mortality declined at fast rates (1979-1994) (Cholil et.al.,1998:26).

The target of reducing MMR to 225 per 100,000 live births by 1998, seemed impossible to reach. The government then realized that to improve women's health, women's rights and gender inequalities that disadvantage women have to be addressed. In 1996, recognizing the importance of the empowerment of women in accelerating women's reproductive health to reduce MMR, the Indonesian government launched *Gerakan Sayang Ibu* (Mother Friendly Movement). *Gerakan Sayang Ibu* (abbreviated as GSI) works on five basic principles:

- Cross-sectoral and multi-disciplinary approach;
- Integrative and synergic intervention;
- Male participation and responsibility;
- Continous monitoring system;
- Effective coordination by local and and regional government. (Cholil et.al., 1998;p.38).

The GSI program is the first maternal health program that is run using the multi-dimensional approach. In the program planning at national level, in order to view maternal health more holistically, it not only involves people from the medical disciplines but also from sociology, religion, statistics, education, etc. It is also the program that recognizes and accommodates the uniqueness of the socio-cultural conditions of the local community in its implementation. The local government monitors the implementation of the program and ensures that all supplies, facilities, equipment and financial resources are sufficient to safeguard women. To provide better services for

women, the local government carries out in-service training for village midwives to improve their skill. The same training is given to the physicians who head the *puskesmas*. Training about basic emergency obstetric care is also held for medical and nursing personnel in emergency units. In addition, the availability of emergency obstetric instruments and blood supplies has also become the concern.

The GSI is also the first maternal health program that focuses on women which calls for more male participation and more appreciation of women's reproductive rights. Together with Non Governmental Organizations that focus their activities on women's health, the department of health provides education for expectant mothers and their husbands especially about the dangerous symptoms that can arise in pregnancy. They also acknowledge women's rights to have or not to have children, to use or not to use birth control, to choose the birth control methods and contraception, as well as their right to receive good services from professionals. The collaboration between the program organizers and local religious leaders enables it to change the fatalistic belief that maternal mortality is predestined. Instead they are promoting the view that people are be able to make changes by acknowledging the danger signs of high risk pregnancy. Through some discussions in the *Qur'an* reading session in *pesantren,* they (the GSI activists, including P3M activists that I have mentioned in chapter 2) also provide religious texts either from the *Qur'an* or *Hadits*[11] to back up their new interpretation of gender relations related to the issues of women's reproductive rights, such as promoting

---

[11]Mohammed's words.

men's responsibility for the wellness of the expectant mother and her child during the antepartum, labour and the postpartum periods, as well as sharing the responsibility of childrearing. The local community is encouraged to participate to safeguard women's lives by sharing responsibility to provide transportation to the nearest hospital for expectant mothers who are in an at-risk condition. The most interesting idea of this programme is that all the community is also responsible for the financial support of the expectant mother with high-risk pregnancy. The *PKK (Program Kesejahteraan Keluarga)* activists collect some money from the members of *dasa wisma.*[12] Other resources are small industries in the neighbourhood, civil servants via direct cuts of their salary or donations, and BAZIS (*Badan amal zakat infaq and shodaqoh)*[13]/Moslems collections). The local government financially supports the program from their annual budget, which then allocates enough to provide free hospital admission, blood supplies, or even hospital charges for poor expectant mothers who are able to show a letter from her local government proving her inability to pay. Newly wed couples are also encouraged to have a bank account when they have their first child, even though this is unrealistic for very poor couples.

When I first looked at the GSI program I felt that it might face similar barriers to those that hamper the *posyandu* program: the difficulties of finding people who can, and

---

[12]The smallest group in the community, which consists of ten households.

[13] It is an organization within a mosque management that deals with donation of the believers. This organization distributed the donations to the poor, the maintenance of the mosque as well as the religious events.

will, offer their time for volunteer work, especially in communities where poverty is already stretching people to the limit. Maybe using the *PKK* cadres to collect the data on pregnant women in her area and to do the follow-ups such as giving the expectant mother vitamin and iron pills as well as weighing the infants and collecting money from the neighbourhood would overload the *PKK* cadres with yet another unpaid job besides their responsibility as mothers and wives. This might create less committed personnel and have an impact on the quality of the work they do for to women. Collecting money from the community to support women with high-risk pregnancy would be a burden to some people, especially those who live in poverty and those who cannot see the actual benefit of this program in their neighbourhood. The community has been asked too often in the past for donations and they have not known where the money goes. The letter that shows a person's inability to pay hospital charges has been misused by local government officials to get free hospital services for their relatives, while poor families usually feel reluctant to seek it because they are afraid of getting caught up in bureaucratic wrangles. The hospital often wants to make sure that people are going to be able to pay the charge before a patient receives care by asking the people who come with the patient if they are going to be responsible for the financial cost. No wonder so many people who have accidents, in the street and elsewhere, are unable to get immediate help. What happened to my sister-in-law illustrates the deficiencies of the system. She was 7-months pregnant and died in a fatal motorcycle accident in April 2002. Her husband called his friend to come and he brought sufficient money to pay for the medicine that his wife needed. He could just pay the medicine for his wife's immediate help and did not have any money

left, while he himself was still in a state of shock because of the accident. What would have happened if he had also received such serious injuries that he lost consciousness, so that he cannot pay the medicine for his wife or himself? I do not understand why money is that important in cases of an emergency situation in a hospital. And it happens many times that people who bring that kind of letter do not receive good attention, services and care from hospital staff. Moreover, putting more responsibility for health program onto the community is the easiest way to blame the community if the program does not succeed.

However, in its first evaluation in eight pilot districts of the GSI, this program has claimed to show a significant progress of reducing the MMR from 390 to 325 on average. If it is true, hopefully, it will bring the same progress if the program is being implemented seriously in the whole country. I carried out these case studies when the GSI programme had been implemented for five years. This study is not intended to evaluate the programme, but we are able to see some evidence from my data, whether this programme has brought changes for better qualities of maternal services or changed the way the society view women's reproductive function. Women seem not very enthusiastic with the program implemented since there have been so many programs with so many names, which do not bring any significant improvement in the benefit of women.

In the next two chapters we will see how women are juggling between tradition and modern care of pregnancy and how they actualise themselves from what they have

learned from their pregnancy and labour experiences in the cultural transformation from traditional society to modern society.

Chapter 5

Learning the Practical is

Learning about the Ideological

Most women do not know that their experience of pregnancy and childbirth has a greater meaning than something that they have to do and go through as women. I knew since I was a girl, that someday after I got married, I would soon have my own children and raise them, just the way my mother and my elder sisters did with their children. I had not ever thought that the experience of being pregnant and delivering a baby would be very special and interesting because almost every woman experiences it. I heard women talking about their experiences of having a baby with great enthusiasm, but I could not understand it well before I experienced it for myself.

The experience of pregnancy and childbirth is unique to every woman, and to each pregnancy. I can feel how special my relationship with my children is, as special as my experience of bearing them. I still remember that I almost never ate, except for some fruits everyday, when I was pregnant with Arra, my first child, but when I was pregnant with my second child, Marvel, I ate almost every kind of food on the table. Both my pregnancies were unplanned. When I found out that I was pregnant with Arra, I was very happy even though I had not expected to have a child at that time. The happy feeling soon changed into a doubtful feeling that I would be able to raise my child well. So I cried, because I did not know much about child management; and I felt unprepared for living with a child, technically, financially, and psychologically. When I found out that I was pregnant with Marvel, I also cried. Again, I felt unprepared. I was just back from

Canada to do my fieldwork in Indonesia and just reunited with Arra after a seven-month separation. I was really enjoying our beautiful closeness, but suddenly I had to share it with another child. My husband and I discussed the possibility of terminating the pregnancy. Even though he let me decide everything, I did not find that helpful. I, myself, did not know exactly what it was that I wanted. I called my closest elder sister at midnight, talking and crying about my pregnancy. My sister responded with short question "Who is it?" I mentioned my name, I thought that she really forgot my voice. She said calmly, "No. I cannot believe it's you." Therefore, I went on with my pregnancy and swept away the thought of having an abortion. Even though I had decided to be pro-choice, I was still afraid that I would really do something wrong. I am afraid of God. My sisters offered to take care of my second child if I was not ready for it after the baby was born. But when I saw how gentle and cute my baby was when he was just born, I decided to take care of him by myself - a decision that I had to pay for with the extra time and energy I needed to complete my master's program.

Now that Arra is almost 7, and Marvel is 3 years I still cannot believe they had ever grown inside my body. We shared the same food to eat, the same water to drink, and the same air to breathe. Their every move inside my belly I can feel still. And it has created amazing relationships between me and my children, something that my husband will not be able to have as a man. It is something that makes me special as a woman. I agree that childbirth is a very special moment to women. It is very meaningful and gives us so many things to learn. Both my children bring joy and challenges in my life. I also see it as a journey to understand myself as a woman in the world that I now see with the

perspective of feminism - newly learned and brought home from a different culture. For me, it is another masters course; a masters course to become a mother and a woman.

The experience of pregnancy and childbirth is unforgettable in women's lives. They will be able to share details of their story of pregnancy/ies and labour/s still with special feeling years after the experience. The following discussion will show the stories of my participants' experiences of pregnancy and childbirth as they shared them with me. They will remember these stories all their lives.

The Desire to Have Children

I never asked for a child from God, but He gave me two. Most women do not know for sure whether they really want to get pregnant and to have a child. Harni responded to my question about whether she has a particular reason of getting pregnant as follows:

I have married, that is why I am pregnant. (Hr/SOT)

In a society where sexual relationships are only acceptable inside the marriage, the above answer is the most logical. If we look at her answer more carefully, it also implies that she sees pregnancy as merely a natural phenomenon that follows the marriage. There is no way to organize a plan to get pregnant or to avoid it. That's because it is seen as natural, all authority belong to God; a human being, especially a woman cannot do anything about that because she is not the actor but a medium.

Not every woman takes this view that there is nothing that humans can do about pregnancy. There are women who view pregnancy as more than a natural phenomenon

and think that they can do something about it. They want to control their sexual relationships as well as their choices to have or not to have children. They consider that having children is not only a natural happening but also a cultural one that is influenced by the individual and society.

The degree of desire to have children is closely related to the meaning of a child for women themselves. If they view a child as the most important thing in life, their desire to have children is stronger than that of the others. Rukayah, for an example, views a child as an aspiration in a marriage and feels she has to take extra care of her health because having a baby is a priority in her life.

> ... I know I have to work very hard every day and it will have an impact on my health condition. I am afraid that I can have more money, but it would not be good for my health (so that I cannot have a child)... for me, a child is more important, it is an aspiration. Work is only a device/vehicle (to live). (Rk/I/4)

And, people who see a child as the most important thing in life will make extra effort to have it and will worry if the signs of pregnancy do not appear soon after the marriage. Rukayah even had that kind of feeling before she married.

> ... Two years before I met him (again) ... I was worried whether I would marry him or not. So I worked very hard to forget that matter. But, when I was just about to marry, I was worried whether I had worked too hard. I was afraid that it would have an impact (on my ability to have a child). Therefore, to make sure, I went to a doctor (to have a fertility test). The result said I am fertile. (Rk/I/2)

To have a fertility test, like Rukhayah did, is a very extraordinary action for an unmarried Indonesian woman. Usually, they would be too shy to see a professional and to have their reproductive organs examined for that kind of purpose, but Rukhayah had a very

important reason why she decided to have the tests. Rukayah said that the reason for this test was that besides her own worries that she would not be able to have children, she realized that her husband's elder sister had not had a child after several years of marriage.

> I was just afraid that because I worked too hard, I would not be able to have a child. Coincidently, my husband's sister has not had a child yet after many years of marriage. I was afraid that someday I would also find that I could not have a child. (The people would say) both the sister and her brother do not have a child...
> **Are you trying to say that if someday you do not have a child it is not your fault?**
> Exactly. (Rk/I/16)

For Rukayah, the fertility test is also a back up, a protection for her from something that may happen to her if she and her husband do not have a child in the future, because there are still cases where the absence of a child becomes the reason for a man to divorce his woman. If she is, medically proven, fertile, people will not blame her for the absence of a child in their marriage. The fertility test is a way to counter the kind of punishment that society might otherwise hand out to a woman who cannot bear a child.

The desire for a child is stronger when women have been waiting quite long for the child's presence in a marriage. Sri is an example. She has not had a child after a year of marriage.

> .... I have already had a lot of nieces and nephews, but why I do not have a child yet. I am the youngest of the family and the only one who has not had a child yet.... (S/I/2-g)

In a culture where the society views the presence of a child as something that is normal, or even inevitable, in a marriage and the absence of a child is otherwise, a woman will feel worried to be different from the others because she has not had a child.

The desire to have children is also stronger when women feel they or their husband will be too old for their first child if they do not conceive soon.

> … (I planned to have children soon)… He (my husband) is already 31 and I am 24. Medically, it is not good if we are too old (for the first child)… (Rk/I/2-f)

> ... I plan to wait for a year or two after I married before having a child, but he (my husband) is already 32. He seems to really want a child. (Rl/I/3)

Sri is only 19, but she was afraid that she would to be too old for her first baby if she does not have one soon. She said that her husband's family is always asking her whether she was already pregnant whenever she went to visit them. Indeed, in many cases, the desire to have children comes not only from the woman herself but also from their own families and families-in-law..

> …. Especially, from my husband's family, (they) really want me to have a child, soon. (If not, they said) I will be too old for that. (S/I/2-g)

Henny, who became pregnant outside marriage, said that she wanted to have a baby but the fact that she is not married yet and the fact that she has not finished her studies had weakened her desire. Her mother's desire to have a grandchild has been a great support for her to continue the pregnancy.

> …My mom wants the baby. She is able to accept me just the way I am because she wants to have a grandchild soon. (Hn/I/2)

For some women, the desire to have a child weakens for various reasons. There are women who want a child, but feel that they just do not want to have it so soon after the marriage. Rully was married in Jakarta, and none of her neighbours in her hometown knew she had married, so she was afraid that people would think that she was pregnant

outside marriage. Premarital sex is forbidden according to her religion and culture.

> ... I am glad (about having a child), but I am sad at the same time. I just recently got to know my husband, I do not know his character well, what about my family, ...it is just too soon...I do not know ... we still do not have the opportunity to carry out the wedding ceremony. You know for Javanese people (it is important)...I am afraid that people will think that I am pregnant outside the marriage (Rl/I/3)

Nurhayati had a different reason why she did not want to have a child soon.

> I feel that I am still too young to have a baby. I still want to work, to prepare everything if someday I have a baby of my own... (N/I/1-b)
>
> .... I am not ready to have children, we are just married, and how can I be pregnant that soon. I do not want it. I still want to live with my husband alone. (N/I/3)

The other case, Henny, had a more complex problem because she is pregnant outside the marriage.

> I like children. But, I just do not want to have a child right now. First, it is because I do not finish my studies yet. Second, we are not economically independent. Indeed, he (my husband) is working.... He is working while going to university. It is not enough for living. (Hn/I/1)

Even though Rully, Nurhayati and Henny did not want to be pregnant at first, they did not do anything to avoid the pregnancy. None of these women were using birth control, except Henny who was practicing abstinence using the calendar method. However she admitted that, sometimes, she and her boy friend just lose their control. Meanwhile, birth control is not usually used by newly married couples in Indonesia. Women believe that it would affect their ability to have a child later. Some women in the study wanted to postpone the time to have children, but none of them entertained the idea of not having children at all.

In short, society's belief that having children is the next inevitable step after a marriage that women must go through in order to have a 'normal' life cycle has a great influence on women's desire to have children. The desire to have children never comes solely from the women themselves, it always involves other people's desires and external factors, such as religions and what constitutes 'normal' in the society. It is the society that defines not having a child in a marriage or having a child outside the marriage as deviant. It is also the society that defines the normal age for a woman to have a child. Women internalise their society's norms and expectations about marriage and having children; thus, women feel unfulfilled if they fail to conceive.

The Beginning

Even though women know that, biologically, they have the capacity as reproducers, they are not sure about their condition when they are pregnant for the first time. Further, women become dependent on the professionals and technological inventions.

The cessation of her periods is the common sign of pregnancy that women acknowledge.

> I learn from other peoples' experiences, that if we miss our regular period we are pregnant. I also learned it from school in Biology class. So, I think when I missed my periods for two weeks, so I think I might be pregnant.... (Rk/I/1)

Meanwhile, women with irregular periods do not have this early signal of their pregnancy.

> I doubted that I was pregnant at first. Because...I had irregular periods... Sometimes, [it also happens] when I am too stressed with a lot of assignments, or too tired, or doing the exam. So, when I missed my period, I did not think that I was pregnant... But, when I also missed my period in the third month, I bought...do you know the name? [A self-pregnancy test]. (Hn/I/5)

Some women also are aware of other signs of pregnancy.

> I missed 2 periods. (I know the other signs of pregnancy) I got stomachache, vomiting, and lost my appetite. It means that I am pregnant. (S/I/1)

Sometimes, it is another person who is suspicious that the woman is pregnant. The women themselves are often inexperienced and lack knowledge about the preliminary signs of a pregnancy.

> At that time, I did not know...nobody told me (the signs of pregnancy) before... It was not until my sister-in-law told my husband: "Rom [the name of her husband], your wife seems to be getting pregnant..." My husband said *'I don't know.'* I did not know either. It was our first time.
> **When you missed your period, didn't you think that you were pregnant?**
> No. I have irregular periods. So, if I missed it once, it is something that is usual....
> **How did your in-law recognise your pregnancy?**
> She said that my breasts and my buttocks are larger than usual. (Rl/I/1-2)

The next step taken by women after they suspect their pregnancy is going to the professionals to make sure about their condition. None of the women in the study trust completely their own diagnosis of pregnancy even though they used self-administered pregnancy tests.

> I did the test myself. I bought a pregnancy test. I still could not believe it (that I am pregnant). So, I went to the *puskesmas* and did another test. The result is positive... (Rl/I/2)

Puskesmas is one of the health care facilities that is designed to provide cheap services

close to the women's homes. It should be the first place for women to seek care. Some women may take advantage of its maternal services, but, Rukayah, who wanted to have the pregnancy test, found it different.

> I went to the *puskesmas*, but they cannot do it, so I went to MEDIKA [a name of labouratory] and did the urine test.
> **Did you see the *puskesmas* midwife?**
> I did. (She said) that she can do the regular examination, but cannot do the pregnancy test.
> **Why?**
> They do not have the instrument. (Rk/I/1-b)

It is a bit weird that a midwife cannot detect the pregnancy without a urine test. She is trained to detect the pregnancy without any instruments because they are also prepared to work in remote areas where there is no access to urine testing. A *puskesmas* also has a medical doctor who is general practitioner, who heads the *puskesmas*. A medical student should also be able to detect a pregnancy. In Rukhayah's case, perhaps, she came too early for a manual test (two weeks after her regular periods schedule), but it is better to acknowledge the real reason why they need the instrument for the test than to send them to another place that is more expensive for women. Jordan (1987) explains that currently, technologies are privileged by birth participants (in this case the professionals and the expectant mothers) to give information about childbirth. In this case, the pregnancy test instrument is the most reliable information to acknowledge the pregnancy.

The limited expertise of the *puskesmas* to deliver services that women need is, perhaps, a factor for women to go to other places to get the services. An obstetrician's private practice is one of them. Some obstetricians still use internal examinations to detect the pregnancy.

> After I missed my period twice, I went to a doctor (an obstetrician). He did an internal examination, and said that I was pregnant. (H/I/1)

Sometimes, the case is very complicated. Nurhayati had been suspicious that she was pregnant, but neither the midwife nor the obstetrician nor the pregnancy test instrument could prove it until the pregnancy was 4-months-gestation.

> I had fever and had to stay for 3 days in hospital, but they (the doctor and hospital staff) did not say that I was pregnant. I feel there was something wrong, because I missed my periods twice. I was afraid. Therefore, I went to a specialist. [After he did the test] he said, "Nothing's the matter. You are just too tired. *Insya Allah*,[1] you will get your period again next month." I got my period the next month, but I was still afraid, because I had missed my period twice before. The month after that, I missed my period again. But, the obstetrician said, "Perhaps, it is just late." So, I went to Emergency Unit in the local public hospital. They said, "Nothing's the matter." Until the end of the month, I still did not get my period. I was still afraid, so I went back to the specialist, and took another test. The obstetrician said that I was [4-months] pregnant. (N/1/1-a)

A woman's feeling that there is something unusual happening to their body, which alerts them to the possibility of pregnancy, is sometimes, a more accurate sign than any pregnancy test. Nurhayati's case above is an example. An obstetrician I asked about this problem said that it was true that sometimes a pregnancy is difficult to detect even by a urine test.

Sometimes, the professional that we go to does not communicate well with clients. It often happens in Indonesia that we visit a doctor and the doctor does not tell us what is actually happening to our bodies. We tell the doctor about the symptoms, and the doctor will examine us and give us the prescription without informing us about the nature

---

[1]If God be pleased.

of the condition. This situation was also experienced by Sri when she visited a professional, in this case a midwife, to check her pregnancy. Sri told the professional about her condition but did not mention that she might be pregnant. Often the professional does not tell the women she is pregnant, but just gives her the official card[2] that records the medical details of that all pregnant women receive. When she receives this card, the woman knows she is pregnant.

> After I missed my period twice, I went to a doctor. The doctor said that I had to wait until my belly is bigger to have a pregnancy test.... I visited the doctor[3] three times, once a month.
> **[Even though the doctor gave her injection and pills, he never told her that she was pregnant].** I was sure that I was pregnant after I visited the midwife and she gave me a medical card. (S/I/1-2)

The card for Sri means more than a card to record her condition. It is also an announcement of her new identity as an expectant mother.

Not every woman is glad to find out that she is pregnant. For Henny, who is pregnant outside the marriage, the pregnancy presented her with a very difficult situation.

> When I knew that I was pregnant, I was afraid to talk to (my parents), because they were ill at that time. One day, when my father was still sick, my Mom asked me about my condition that was (according to her) different. Therefore, I told my Mom that I was pregnant. She was shocked. (Hn/II/13)
>
> **Had you ever thought to cancel your pregnancy?**

---

[2]In an obstetrician's private practice, a maternal patient that should do regular visits is usually given a card that shows that she was a long-term patient and should do the visit more than once. A woman who does not receive the card may perceive that she does not need to go back for another visit.

[3]I suspected that he is a nurse who practices curing tasks, considering the remote place that is almost impossible for a doctor to locate her/his private practice.

> I had. I took some traditional remedies, but it just did not work. Therefore, I took it for granted. It is a blessing from God. More than that, it is the risk [consequence] that I have to receive for the mistake that I did. (Hn/II/14)

For most Indonesian women who have premarital sex, terminating the pregnancy (having an abortion) is rarely a solution because not only is it illegal, but it is also a sin according to all religions[4] in Indonesia. Even though it is religiously forbidden, some women find it is an unavoidable solution to cope with society's sanction. If the pregnancy happens, they prefer to marry their boyfriends before the baby is delivered. But, if this option is impossible for some reason, for example because of the boyfriends' or the parents' refusal, they usually take some traditional remedies to terminate the pregnancy, even though its effectiveness is not yet proven. Some of them take the risk of having an abortion with the help of a TBA or a doctor's illegal practices.

The moment when women decide to tell about their pregnancy to other people is also the moment when women open themselves to other people's intervention, which in some ways will take away their own control over their bodies. The more people are involved in her pregnancy, the more freedom she will lose. Women start to become dependent on other people who are considered expert in the experience of pregnancy.

---

[4]Abortion is sometimes allowed in special circumstances, for example, if the pregnancy endangers the mother. Abortion for rape victims and women with other unplanned pregnancies (both married and unmarried women) is still a contested issue.

Traditional Birth Attendant (TBA), Midwife or Doctor?

When I was pregnant with my first child, I underestimated the skill of the TBA and midwife to take care of a pregnancy. I never thought of going to the TBA and midwife to do the regular check-ups. The government campaign about the danger of TBA practices seemed to work well in my head. As a university graduate, I believed that science and technology could safeguard women's lives best. Therefore, I went to an obstetrician. When I moved to Canada, I visited a General Practitioner (GP); even though it is not usual in Indonesia for a GP to treat maternity patients. At the time I was unaware of the role of midwives in Canada in childbirth. Indeed the situation is still unclear in Newfoundland. When I was pregnant with my second child, I had returned to Indonesia and had already read a lot of materials on natural and technological childbirth, as well as a bit of postmodernism theory. I was still afraid to go to a TBA and, finally, chose a midwife after being disappointed with a female obstetrician's service. What happened was that she charged me for both the prescription and the supplement that I should buy in her own pharmacy, which is located on the other side of her waiting room. On my last visit, I tried to discuss about the delivery process, such as where I would have the baby. If it is going to be in a hospital, I would like to know which hospital that I should go to and who would be allowed to attend in labour, etc. I was disappointed that she would not allow anybody else, except my husband, to be present during my labour.

> "Who is going to attend in labour, doctor?"
> "Me, two nurses and your husband" the doctor said
> "If I want somebody else to attend, will it be fine?"
> "Somebody else, who?"
> "My niece, she is going to record the process, because my other nieces

> also want to know about the labour."
> "Well. I don't think she can. I allow the husband to come because I need him to support the woman's back. It's already 5 people in the labour room, and it will be too crowded. If your nieces want to know about labour, they just need to study in the faculty of medicine." (The conversation with my obstetrician in February 2001)

That it will be too crowded is understandable. But, I was very disappointed with her last statement and just realized how arrogant she was as a doctor. She acted as if the knowledge of labour belonged only to a doctor. She underestimated women as reproducers, as the ones who do the labour. She also thought that women do not need to have knowledge about labour. What she did not recognise is that knowing about the labour process is very important for women to face or not to face the process. It is a part of women knowing themselves, and what they want in life. And even though my nieces are very curious about pregnancy and labour, they do not want to be doctors. They fully understand that, as women, they are going to experience the process and cannot contain their curiosity about it.

All the women in the study also know the importance of visiting a professional during the pregnancy. Most of the women chose the midwife to help them. Rukhayah, Harni and Nurhayati told me the reasons why they decided to use a midwife's services.

> First, because the midwife lives close to my place, therefore, I do not need to travel so far. Second, because the midwife is experienced. If I go to a doctor, you know [pause]. For a visit we have to pay about 25,000 rupiah. How many times, then, do I need to visit a doctor (during the pregnancy) and how much money do I need for those visits, therefore, I have to think more economically [pause] I know there is an economic gap [pause] I know I am in the lower level [pause] So, I do what fits my economic level (condition). So I do not choose a doctor, I choose a midwife. (Rk/I/6)

> It (going to a doctor) is very costly. The doctor said that it is fine if we want to visit a midwife. (Hr/I/3)
>
> I do not have the card yet (in the doctor practice). The doctor is far from here. There are many maternity patients who visit Bu X (the midwife) and she lives close by. (N/I/5)

Besides his/her expertise, a midwife is preferred to a doctor, because her services are relatively cheaper than those of an obstetrician. Poorer women cannot afford an obstetrician's services. In an obstetrician's private practice, women have to pay 25,000 to 30,000 rupiahs (equal to CAD$5 to $6), for a visit, excluding the price of some supplements that the obstetrician prescribes to the patients, which are usually very expensive. Harni said that she had to pay about 150,000 rupiahs (equal to CAD$30) for the vitamins that her doctor prescribed for her. Meanwhile, going to the midwife women just need to pay 6,000 rupiahs (equal to CAD$1.5) including the supplement that the midwife gives to their patients. The distance also becomes a consideration for women not to go to a doctor. Doctors usually live in a city or on the main provincial roads. Sciortino (1995) has documented the reasons for this tendency. The patients who can afford doctor's services are those from the middle and upper social classes, who usually live in the city. Thus, doctors prefer to live closer to people who can afford their services, and by living on the main roads, they want to limit the transportation problem for their rich patients, who have cars. Another reason is that by living in the city, they are closer to the senior doctors, who may give them recommendations for their career development and their continuing education.

The plan for the delivery also becomes a reason to use a midwife's services. Some midwives offer the transportation to the women's home after the delivery and provide a birth certificate from the local government for all the babies who are born in their private practices. Women are able to take advantage of these services, especially women who come from interior villages with transportation difficulties, such as unavailability of vehicles and bad road conditions. Village women also feel that getting the birth certificate from the midwife is very helpful and easier, because getting it from the local government will be a fussy business. Nurhayati found another advantage if she delivers her baby with Bu.X

> It only needs one day for all the (delivery) process. We can be home on the same day. And, the baby will receive her/his birth certificate. If we deliver the baby with the help of a doctor in hospital, we have to get it ourselves.... I want to deliver my baby with Bu X, if she cannot take care of me because an unexpected situation happens, she will take me to the local hospital immediately. She will go with me there. She has a recommendation letter. So, I will receive immediate help. It will be different if we come by ourselves, the hospital staff will ask us to wait or to do something else. (N/I/7)

As the hospital's employee, Bu X will automatically have easier access to the local hospital because she works there. Knowing some hospital staff will also influence the quality of care and services for her patients.

Women cited the attitude of a midwife and the experiences of other people who have delivered their babies with the midwife's help as reasons why they chose to use her services.

> ... But, for me, the attitude of the midwife is the most important thing (to consider). Even though it is cheaper, if she is not nice to her patient, no (I will not use her). (Hn/I/8)

None of the women in the study chose a TBA's services for regular check-ups and delivery; they had acknowledged the danger and felt afraid to do. But, Nurhayati said that, indeed, there are some women in her neighbourhood who come to a TBA to deliver their babies because they do not have enough money to go to a midwife. Sri said that, actually, she wanted to go to a TBA to deliver her baby.

> I actually wanted to deliver my baby with a TBA's help, because I wanted to deliver a baby at home.[5] But, the TBA said that. "It is your first time; do not deliver your baby with the help of a TBA. Go to Bu X, to prepare for the unexpected". She was angry with me and asked me to go to Bu. X. While, I think I will be more satisfied if I deliver my baby at home. I think it would not be too painful [pause]. But, probably [doubt], there would be nothing different either if we deliver the baby at home or at the midwife's house. But if we deliver the baby at the midwife's house, usually we get incision and stitches, something that we would not get it at home. (S/II/6)

Sri is correct in saying that if a woman delivers a baby at the midwife's private practice, she usually will get an incision and stitches, but, in fact, there are midwives who will not do that. My midwife, for example, said that she never does the incision, but would do the stitches if tearing happens.

Reluctance to deliver their babies in a hospital is, perhaps, is the most common reason for women not to use an obstetrician's service. Even though women can use a midwife's help in a hospital delivery, if women have their pregnancy care with an obstetrician, they will automatically have the delivery in a hospital. Sri told her impression of hospital care as follows.

---

[5]An experienced and well-known midwife usually does not do home delivery because she usually has more than one patient to help at almost the same time. Usually a TBA will help delivery at women's home.

> ....If we deliver our baby at the hospital, the staff usually does not care about us. If we are still in early labour, they do not take care of us. Only if we are 7 cm dilated already, for example, (they will do something). My cousin delivered her baby at the hospital. She had registered in the morning and they told her to walk outside the [labour] room. It seemed they did not care about her. If she had not felt that the baby would come out immediately, they did not let her to go inside the labour room. If we deliver our baby at Bu. X's [the midwife's] place, she lets us go home if she thinks that the birth is not for a while. If we deliver our baby at the hospital, it is not convenient to wait for a long time and to come outside their office hours. We also have to stay with non-maternity patients with their various illnesses. (S/I/5)

Even though, currently, almost all hospitals have separate maternity wards, people still think that delivering a baby in a hospital is not a good idea. Rukhayah's husband had his own impressions of delivering the baby in a hospital, and said,

> She wants me to be present in labour. I pray for her, so that she would not need to deliver the baby in hospital, because if she delivers the baby in hospital, they will not let the husband be present. My sister's friend could not be with his wife inside the labour room during the delivery. He heard his wife was crying and moaning so that he himself was crying, "How could everything be like this?" He climbed the wall and peeped. I do not want to experience that. I want to be with her [my wife] in labour, so that I can recite my baby an Adzan soon after s/he is delivered. I also do not want to end up like my neighbour whose wife had a caesarean section. He was going home to take some clothes for his wife while his wife was in the ICU. He got back and got the news that his child has died. He did not have opportunity to recite the *adzan*.[6] All that he knew was taking his child's dead body home. If we deliver the baby in a midwife's place, the husband can go inside. I think women are more comfortable if there is somebody with them through the labour process.. (Rk-I/I/22)

> If we deliver the baby in a hospital, the nurse will be so rude. It is usual if a woman is screaming during the labour, but the nurse will then yell at the woman. They have so many patients, the nurse usually said, "How could

---

[6]Praying call. A father has to recite *Adzan* in the right ear of the baby soon after the delivery to introduce the baby with her/his God. Hopefully, the first sound that the baby heard after being born is the voice of God.

> you scream like that, think of other patients, they might get headache because of that." Then the woman will cry. Then the husband who is waiting outside the labour room will feel very sorry to hear that. It is better if he cannot hear or see anything (than to hear that kind of thing).(Rk-I/I/22a)

I asked Rukhayah and her husband that if delivering a baby in a hospital was free for every woman, would they go to a hospital to deliver their baby?

> People are reluctant to deliver their babies in a hospital because they give bad service. Therefore even if the hospital does not charge anything from the patients they will not go there to deliver their baby because the hospital still delivers poor quality services. (Rk-I/I/22b)

> If delivering a baby is free, perhaps the services will be worse. If the patients are rich, it is better to pay [and get better services]. (Rk-I/I/22c)

The women in the study believe that going to a hospital for delivery is not a good choice. The quality of care that the hospital offers to their patients is disappointing. For some women with high-risk pregnancy, a hospital delivery is inevitable and unavoidable.

If women prefer to go to a midwife's private practice for visits and delivery, what is the role of *puskesmas* in maternal health? The local *puskesmas* midwife, who was interviewed by my assistant, said that the *puskesmas* offers maternity services for women as follows:

- To carry out routine examinations for expectant mothers
- To carry out home visits
- To give immunization for expectant mothers
- To give expectant mothers Iron pills
- To give expectant mothers some vitamins.

These programs are carried out routinely every Tuesday and Thursday in the *puskesmas*. Home visits are carried out by village midwives who are responsible for expectant mothers in their areas. The *puskesmas* midwife admitted that it is very difficult to carry out home visits due to the limited personnel. But, Rukhayah said that the village midwife came to her house once, examined her pregnancy and offered her services in her private practice, which is only about a hundred metres away from Rukhayah's place. The midwife also took her data. It is part of the responsibilities of village midwives to collect data of expectant mothers in their area for mid year reports to the Ministry of Health. The *puskesmas* offers the cheapest maternity visits (only 1,500rupiahs or CAD$0.6 approximately). They also have some instruments to support the services they provide, such as fundascopes, scales and blood pressure measurements.

Though the *puskesmas* has qualified personnel (at least 1 physician, 1 dentist, a couple of nurses and 1 midwife, who heads several village midwives) and adequate instruments for normal pregnancy and delivery, as well as immediate access to local hospital for emergency situation, the *puskesmas* is not so attractive to women. Adrina et al (2000) found that there are some reasons why expectant mothers are reluctant to come to *puskesmas* for regular visits. First, the *puskesmas* is located too far from the women's homes and public transportation is not available to take them there. Second, women find that the *puskesmas* staff's attitude is sometimes degrading to them. Third, the *puskesmas* service hours are limited to a short period in the morning that is also women's busy time working on their chores at home. The women in the study said that because the *puskesmas* only opens in the morning, their husband would not be able to accompany

them since their husbands are also still busy with their work. The government, which has committed to encouraging men to take more responsibility for women's reproductive health is failing by not providing *puskesmas* opening hours at a time when men can attend with their wives. Some *puskesmas* do not offer pregnancy tests and delivery services, which is another reason why expectant mothers do not want to go to a *puskesmas*. Rukhayah said that it is better to go to a midwife for regular visits and delivery rather than to go to the *puskesmas*, even though it is relatively more expensive, because she does not then need to find another place to deliver her baby.

> The *puskesmas* does not offer delivery services. I was just thinking more practically. If we do the pregnancy care in the *puskesmas*, the *puskesmas* knows about my condition, but then I should find a midwife to deliver my baby [because the *puskesmas* does not offer the service]. If something happens to me, the midwife will not know anything unless I do the [regular] visits at her private practice. Once we go to a midwife, it is better to stick to her. Moreover, the midwife lives close to my place. I am more comfortable to do the check ups at her place. Women who come to the *puskesmas* will also go to the *puskesmas* midwife's private practice [later]. Perhaps it is because doing the check ups at the midwife's private practice gives women more freedom. We do not have to spend so much time to wait for our turn. If we go to the *puskesmas* during the day, it is disturbing our working schedules. If we are in third trimester we will need our husband to take us to the *puskesmas*, and they cannot do it because they have to work. Therefore, it is better to do it in the evening. And, it is the midwife's private practice that is open in the evening. (Rk/I/9)

I was able to see women's unwillingness to check their pregnancy in the *puskesmas* when I came to the *puskesmas* to look for some expectant mothers to take part in my study. The *puskesmas* midwife did not have maternity patients in her list. She admitted that expectant mothers preferred to go to midwives' private practices, even though this statement negated what she had said earlier in her formal interview, when she

had asserted that a lot of women are able to make use of the *puskesmas* maternity services.

Posyandu was also designed to provide maternity services. All the women in the study said that they did not use the *posyandu* programme in their neighbourhood during their pregnancy. Henny, Rully and Harni were not sure that there was a *posyandu* activity in their neighbourhood. Rukhayah said that there was a *posyandu* in her neighbourhood, but it did not give maternity services. Her *posyandu* only carried out some activities for children under five-years-old even though she knew that some posyandu in other districts do provide programmes for pregnant women.

> I did not go to the *posyandu.* The reason is because the *posyandu* only carries out programmes for children under-five-years- old. I had gone to a *posyandu* in Magetan [a different district], they had programmes for expectant mothers.... The expectant mothers were able to have a Tetanus Toxoid (TT) injection. The announcement said that 'Under-five-years-old children and expectant mothers are welcome'. Here, it is not familiar. We do not see expectant mothers going to *posyandu.* (Rk/I/8-9)

No matter where women go for pregnancy examinations, they know the importance of sticking to the same professional to have sustainable care from early pregnancy up to delivery.

> I never visit (a different midwife). People say that if we do the visit to more than one midwife, the midwife (who helps us in delivery) will not know our condition from zero. Once we choose a midwife, there we will deliver the baby. (Rk/I/18)

Women believe that if they have regular visits and delivery with the same midwife, it will influence the quality of care that they receive during the labour.

> If I come to her (the midwife's) place from early pregnancy, I will receive better care than if I come later. (S/I/4)

But no matter which professional takes care of the women in their pregnancy, it is not only professionals who will give them help and advice. They rely on many different sources, which sometimes give them completely different advice. In the next section I will discuss some of this different advice that the women receive and have to balance.

Food Diets and Prescribed Behaviours

Traveling across the world, Leveber (1998) found that in some countries, food to be eaten by expectant mothers is divided into 'hot' and 'cold'. The hot food is prohibited during pregnancy, whereas cold food is regarded as suitable for expectant mothers (Laderman, 1983). In Indonesia, it is like this – 'hot' food is food that is hazardous for pregnancy and 'cold' food is safe to consume. I summarize the list of hot and cold foods from the information I received from the women in the study as follows,

Foods that should be avoided

Foods	Defects
Too much sugar and carbohydrate	To cause the baby in the womb to move too strongly so that it may hurt the mother
Salted fish	To cause the breast milk to have a fishy smell
Chicken	To cause the vaginal wound to recover more slowly
Sugar plant, Ice and cold water	To cause the baby to be born too big
Hot rice, Sour soup,	To cause the baby's skin to be wrinkled
Durian, fermented cassava or any kind of rice	To cause miscarriage
Cucumber	To cause leucorrhoea

Pineapple	To cause itchy and skin rash as well as miscarriage
Young bamboo plant	To cause the baby is having a very big head and too small legs
Zalacca	To cause constipation
Water melon	To cause severe bleeding
Jack fruit	To cause heartburn

Some people believe that the physical appearance of some foods will affect the physical appearance of the baby. For example, if the pregnant women eat crab, the baby will have more than five fingers, or if the pregnant women eats a twin banana it will cause Siamese twins. Sour soup, pineapple, and young bamboo plants, among other foods, are supposed to affect whether the baby or the labour process. Red food is believed to cause bleeding. Fish and chicken are prohibited by the same logic that the smell would be passed to the baby. Meanwhile, durian, fermented cassava or any kind of rice, and jackfruit, are gassy, and can warm the belly, so they are considered hot foods. Some people get heartburn after eating them. Zallacca has sticky taste, so that people believe that they will cause constipation. Some women do challenge these beliefs. For example Sri said about the belief that ice and cold water cause the baby to be too big 'It is not the temperature that cause the baby too big but the sugar which is put in it'. Ice in Javanese refers to cold juice or syrup with some ice cubes in it that is usually very sweet. Beliefs about the causes of large babies are frightening for women because the baby will be difficult to deliver.

> The elderly said that we cannot eat sugar plant, but my mom did it [and she got caesarean section for her last child]. People said that it is better to take coconut oil, not sugar plant. My parents also tell me not to drink ice [cold water] so I drink warm tea, warm coffee, warm water and so on, therefore, the baby will be born small. It is fine to bear a small baby, because we can make the baby big outside [after the baby is delivered]. (N/I/18)

Of course, many of the beliefs do have some foundation in fact, for example, sugar plant, too much sugar and carbohydrate are possible causes of diabetes. However, we should not be worried about the baby moving strongly because it is a sign of the baby's healthy condition. There is some evidence that some hot foods are hazardous during pregnancy. I also learnt from a medical friend that there is some scientific evidence that pineapple will cause miscarriage. However, a midwife that I asked about the same issue said that she had never heard about it and I could not find any literature explaining that which foods might be hazardous in pregnancy. But, from a book about healthy eating in pregnancy, I know that jackfruit is rich in vitamin A. My own puzzlement about these issues demonstrates how difficult it is for young expectant mothers to know what is right.

Foods are good to consume

Foods	Usage
Coconut water Turmeric and tamarind remedy	To cause the baby to be clean from grease
Apple, orange, papaya	To help the digestive process

It is certainly recognised medically that all kinds of fruit are good for digestion process, but I could find no reasonable explanation of the advantages of taking coconut water to clean up the baby from grease. In any case, 'grease' (medically, it is called

Vernix Caseosa) on a newborn baby is not a sign of ill health even though the Javanese believe that it is not good for a baby. Turmeric and tamarind, according an article in one Indonesian magazine, *Intisari*, will help to clean up the ovaries after delivery.

Besides food and diet, the Javanese also define the appropriate behaviour that women should or should not do during pregnancy.

Prohibited Behaviour

Activities	Consequences
Eating near the stove	[Untold]
To scratch the skin during pregnancy	To leave marks on her skin
To kill animals	To avoid miscarriage or the unexpected events during the birth.
To hurt somebody's feeling, to call other people names, and to say something bad about other people.	To avoid the same things happening to the baby because they might be contagious.
To massage woman's back	To hurt the baby's face
To pluck the feathers of chickens	To cause baldness of the baby

There is no explanation as to why plucking the feather of a chicken would cause the baldness of the baby, or why this should matter. Even though there is still no medical/or scientific explanation of why massaging the woman's back would hurt the baby's face, Rukhayah has her own logic,

> Besides massage, to do *kerokan*[7] is also prohibited. Our back is the place for the face of the baby... (Rk/I/10)

---

[7]To rub the back with hard object (usually a coin) so there will be red mark on the women's back. This method is believed can give comfort to the person who gets it.

To scratch the skin during the pregnancy may, indeed, leave some marks on a woman's body. Women should prevent with rubbing some lotion on the skin during the pregnancy. Nurhayati also told me,

> People say that we cannot stretch our body after waking up from sleep so that the skin will not get stretched, and do not rub if it is itchy because the mark will not disappear. (N/I/24)

Meanwhile, to hurt somebody's feelings, to call other people names and to say something bad about other people, of course, should not be done during pregnancy or at any other time. This is an example of the double standards that expectant mothers should obey: expectant mothers must be better people and to be more careful during the pregnancy, otherwise they will have a bad baby.

> ...That because now I am pregnant, I have to be more careful and not to be so careless. Having massage is also being advised. I was informed about the diets and prescribed behaviour during the pregnancy. People say that we cannot say something bad about other people; for example, if we say in our heart such things as, "that person is ugly" we should say "naudzubillahimindzalik." It means that we ask for God's protection from that kind of thing, because we are afraid that the baby is going to be like that. What the mother thinks will be passed on to the baby. (Rk/I/4)

During the pregnancy, husbands have to obey the traditionally prescribed behaviour as well as his wife.

> My husband cannot kill animals and he should not say something bad of another person. He cannot be careless as well. (S/I/5

> My husband is not allowed to kill animals while I am pregnant.(Hn/I/4)

Nurhayati said that her husband does not need to obey the diet and prescribed behaviour like she does, but -

> My husband does not need to obey the diets and prescribed behaviour, but he has to be obedient to me and has to be more careful. (N/I/6)

Husbands also have responsibilities while expecting the baby. Like his wife, he is not allowed to say something bad about other people He has to keep silent and hope that the bad thing would not be passed on to his future baby if he sees something weird. A friend of mine has a deformed thumb, which has two tops. She told me that when her mother was pregnant with her, her father, who is a doctor, was visited by a patient with the same deformed thumb. Being curious, her father asked the patient what happened to the patient's finger. The patient said that his thumb was a special gift from God. When her mother delivered her, she had the same thumb as that of the patient who came to her father's private practice.

Food diets and prescribed behaviour that women must conform to during pregnancy and childbirth come not only from the professionals but also from the women's family. Obstetricians usually do not suggest either any particular foods to avoid or healthy food to consume. This is partly because they have so many patients to take care of, so that they only have little time to explain about such things. To fulfil women's nutritional needs, obstetricians usually prescribe artificial multivitamins rather than educating women about healthy eating. Those artificial vitamins have become a new diet for expectant mothers in this modern age. Obstetricians also do not recommend any kind of behaviour to avoid or to do. One advice that I received from both obstetricians that I visited in my early pregnancies was that my belly should not be massaged. Sri also had the same advice.

> The doctor examined my belly and said that I cannot have my belly massaged by the *dukun*.[8] (S/I/2)

Meanwhile, midwives still believe that some foods are hazardous and they will ask their patients to obey. But they also give the expectant mothers supplements.

> I was forbidden to eat many kinds of foods by my parents, but the midwife said that it is fine to eat anything but durian [because it is hot]. So, I can eat pineapple [pause] as long as I am fine with that... (Rl/I/5-a)

Sciortino (1995) explained that nurses (in this case, I also include midwives) are trapped between two kinds of methods; traditional and modern. In a situation where the health care has more than one healing system - modern and traditional, each of which have their own different views of an illness, the health care providers will experience a conflict about which system to rely on. On the one hand, they will rely on medical knowledge and, on the other hand, they will also rely on traditional knowledge.

TBAs tend to rely more on taboos and prescribed behaviours than the midwives do. They still believe in the mystical connection of some foods and prescribed behaviour to the condition of the mother and the future baby, even though the connection is unexplainable in rational terms. So they continue to tell their patients that certain foods might cause miscarriage or the baby might be born like a monster. Family and friends' advice usually derives from their own and other people experiences as well as what their earlier generations told them. If a conflict between different kinds of advice occurs, women have some ways to juggle in this situation; some try to negotiate the difference.

---

[8] *Dukun* is traditional healer including a TBA who is called *Dukun Bayi* (*bayi* means baby).

The degree of conformity to the diets and the prescribed behaviours among women in my study varied. Women everywhere demonstrate a wide range of choice in their degree of compliance (Davis-Floyd and Georges, 1996b). Some women believe that it is true that some foods have mystical power to cause the baby to be born like a monster. Therefore, they obey the diet and prescribed behaviour. Sri told me about her experience as follows.

> [I am] not allowed to eat the foods [that are] served in *selamatan* [feast]. I had tried [to eat] once and disobeyed the taboo, and it is true. I felt very weak, all over my body, dizzy and the pain is like...I don't know [how to tell], like *sawanen.*[9] And, my belly was so uncomfortable. (S/I/3)

Some women found that their dietary restrictions were supported by a professional's explanation. Rukhayah is one of them.

> I went to the market and saw some jackfruit. I really wanted to take some. 'It must be delicious' I think. [pause]. But, then I threw up. So I stopped eating it. When I went to Bu X, she told me that jackfruit is among the foods that are not recommended. 'No wonder I threw up the last time I ate it' I told the midwife. The midwife said that it was better that I was throwing it up rather than I got diarrhea, because it was going to be more painful inside... (Rk/I/4-5)

Some women decided to do the diet and prescribed behaviours because they assumed that the people who give them the prescriptions for the vitamins are more experienced. Henny is one of them.

> I am not saying that what other people say is correct, but I am thinking that they are more experienced, they have had the children, and they are our seniors. So, it would be better to say 'yes..yes..yes' even though sometimes I find it very funny. (Hn/I/3-a)

---

[9]A state of physical illness caused by unexplainable reason.

Henny also said that she decided to follow the instructions in order to make other people happy.

> Even though, sometimes, their advice is irrational, but I decided to obey. [I want] to make them relax [happy], especially my grandmother, though sometimes I feel it is very funny [pause] irrational. (Hn/I/3-b)

> I am not the only woman who refused to obey superstitious taboos during my pregnancy and had tensions with my mother because of my refusal. Rully said that she experienced the same thing.

> I was prohibited from eating so many things, but I just do not care about that. My Mom is often angry with me, but I keep drinking cold water because it is proved that I do not gain so much weight so far. (Rl/I/5-b)

Sometimes, even though there is no medical/scientific explanation for the diet and prescribed behaviour, some women decided to obey the diet because they are afraid that some of the threatened consequences might be true. Belenky et al. (1986) explain that such women see blind obedience to authorities as being of the utmost importance for keeping out of trouble and ensuring their own survival. For women in this stage trying to know "why" is not thought to be either possible or important. My midwife friend who has some knowledge of nutritious intake admitted that she followed the food taboos for the same reason [anxiety], (or as defined by Hardjowirogo (1980) as x-factor). Even though I claimed I was a modern woman and refused to follow my mother's advice because I viewed her injunctions as unscientific, I myself did something that was illogical. Just a few days before I went to Canada to join my husband, I called a TBA to do the massage, because I presumed that the trip would be very long and tiresome. Knowing that I was going to do a long trip, the TBA advised me to put a long string with some kinds of spice plants around my belly to avoid the unexpected. I followed the

advice even though I knew that it was very funny to believe that a string can save my life, but in fact, I did it, simply because I was afraid that the unexpected might really happen. Being scared that the bad things are really going to happen is also a reason for Harni to obey the diets and prescribed behaviour.

> Yes, I do the diets and prescribed behaviour. I am afraid that the bad things are really going to happen to my baby. I will feel sorry for that. (Hr/I/4)

If women cannot find either a scientific explanation or a religious teaching to support the injunctions, then they tend to rationalize the food taboos and prescribed behaviour any way they can so as to minimize their anxiety. For example, Rukhayah said that she is not allowed by her mother-in-law to take her baby out during Maghrib prayer [immediately after the sunset] because the evil spirit will take the baby from her. She does not want to be labelled as believing in superstition or to blame her mother-in-law as irrational, so she rationalizes it as good advice because the baby is too small to go out because s/he will be more vulnerable to an illness than an adult is.

Some Western Feminists have used taboos and prescribed behaviour as evidence for pre-industrial society's beliefs that there is correlation/symbiotic relationship between the expectant mother and the foetus (Jordan, 1983; Priya, 1992; Davis Floyd, 1996b). I feel that the superstitious taboo and prescribed behaviour are also something that make us – people from pre-industrial society—look very stupid in Westerners' eyes. I do not want to overvalue scientific explanation in this case, but I am just trying to say that not all scientific explanations are bad, just as not all technological inventions are harmful and unnecessary in the birthing process. For an expectant woman who has eaten crab, for

example, she will be very afraid that her baby is going to be an abnormal baby. The scientific explanation is needed to tell her that the belief is not true and that crab is a good source of nutrition. Such scientific advice will mean that a woman will not be irrationally afraid and will be able to enjoy her pregnancy, because to live with the food taboos is often very uncomfortable for a woman. Besides being oppressive, for women who live in poverty, traditional food taboos can also preclude the mother from eating nutritionally beneficial food. A recent study on pregnancy anaemia, carried out by Wiarsih (2000) explains that bad eating habits is one factor that contributes to anaemia among expectant mothers in West Java. The traditional beliefs about foods taboos contribute to these unhealthy habits. Food diets and prescribed behaviour patterns in pregnancy are a social phenomenon. Pregnancy cannot be separated from what the society thinks about what is good and bad for women in their first journey to motherhood.

Sex-Preference and the Tradition of the Seven-month Ceremony

At the beginning of the pregnancy most women are confused about their new condition and are busy looking for people to provide them with information, professionals or people around them. In the second trimester, women are getting used to their condition and are beginning to enjoy it more. When the baby starts moving inside their belly women come to accept the presence of the baby and begin to realize that the new member of the family is about to come. The women in the study expressed their feelings at this stage as follows,

> I am more ready than before [in the beginning of the pregnancy]. Then I was not ready because I did not know. Now, I have experienced myself, therefore I am more ready. (N/I/8)

> I am so glad with the baby is moving. The baby is getting bigger and I just need to wait for the delivery. (S/I/3)

> ... From the beginning of this pregnancy, when the baby had not moved, and then moved gently and now the move is getting stronger, I feel that it is a very good. I really enjoy it.... (Rl/I/9)

At this point, people start to predict the sex of the baby. Although it is less important today, most Javanese still want their first child to be a boy.

> My husband said that it does not matter if the baby will be a boy or a girl, but I want to have a boy. He said, "You are not the one who creates it."... (Rl/I/10)

> I want a boy. My mom and my husband do, too. I asked him, "Why do you want a boy?" He said, "I do not know." Perhaps he thinks that if he is going somewhere, there will be somebody taking care of the family. Someone who is responsible. If it is going to be a girl, it will be difficult. (Hn/I/10)

> I want a boy [pause] I wish. **[Why?]** Because a boy does not need to marry immediately, it is different from a girl. Therefore, he can stay longer to help his parents. (Hr/I/8)

Women still believe in gender myths about men and women. They believe that a man is responsible and a woman is the responsibility. Thus having a boy is better than having a girl. Harni's mother-in-law commented that if she had had a boy before their four daughters, she would not have needed to deliver so many children. A boy will carry the responsibility for the family when he grows up. Thus, a family without a boy is not perfect yet. Henny even said:

> According to the people here, to be able to deliver a baby boy is to become a real woman. (Hn/II/12)

Rully, whose husband is a Batak (a particularly patriarchal ethnic group), said that the presence of a boy is significant to the continuation of their familial name, and that having a boy will give her special status.

> Why do I want [to have a boy]? Well [pause] for me, I am not really demanding that the baby has to be a boy or a girl; perhaps it is my husband's family who is emphasizing [the importance of having a boy]. For Batak people, a wife will receive a special status in the family if her first child is a boy. So, that is why I really really want it. If we do not have a boy, the family is not perfect yet. If the first child is a girl, the next child has to be a boy. (Rl/I/11)

She went on to say that her desire to have a baby boy is strengthened because only a few of her husband's siblings have sons.

> My husband said that it does not matter whether it is going to be a boy or girl. But, a boy will carry the family's name. He was the one who married last. He has few nephews from his siblings. Therefore he really hopes that the baby will be a boy. (Rl/I/11)

Even though most people still believe that a boy will help the family by taking some responsibility when he has grown up and become "human"[10], Rukhayah's husband and Rukhayah have realized that a boy is not always be able to carry responsibility for the family.

> My neighbour's first son is a boy and now has become a teacher, but he forgets his family. The daughter is now the one who support the family financially.... (Rk-I/I/21)

> It does not matter if the baby will be a girl. I am going to educate her well. It is my intention to have a child [no matter it is a boy or a girl]. Having a boy as first child will have no meaning if the child is not potential [qualified]. (Rk-I/I/21)

---

[10] 'Human' in this context has broader meaning. According to Javanese ideology, a 'human' is wealthy, well educated, and honoured person.

That is why he and Rukhayah do not have sex preference for their first child.

> I just want my baby will be delivered safely, physically and psychologically. People often ask me if I want a boy or a girl, but I said that there is nothing different whether it is going to be a boy or a girl. The most important thing is that the baby will be a good person, and obedient to his/her parents. I will take care of the baby well no matter it is a boy or a girl. (Rk/I/20)

Meanwhile, Sri also does not care if the baby will be a boy or a girl. This may be because she had been waiting for a year to have a baby; therefore the sex of the baby is not that important. Nur is different. Even though she wants a boy, her husband and his family want a girl.

> Actually, I really want a boy as my first child, but my husband's family wants a girl, so I want to make them happy, because they do not have any daughters. My family do not emphasize that it should be a boy or a girl. But, for me, if my first child is a boy, he will be able to protect his younger siblings, especially if his younger sibling is a girl. (S-N/SOT)

> According to my husband's family, a girl is cuter than a boy. We can put a ribbon in her hair and beautiful dresses. My mother-in-law always loves to see a baby girl, anytime she sees a baby girl; she says "How beautiful." A boy does not have beautiful dresses; it is boring. (N/I/10)

Some people believe that the sex of the baby can be predicted before s/he is delivered from the physical appearance of the mother as well as her attitude during the pregnancy.

> It is not only my husband but also some other people who have said that my baby is going to be a boy. I asked 'how can it be?' One woman, who had delivered more than three babies, said that she could see it from the place of the baby in the womb and the shape of the belly. If the belly is sharp round, it will be a boy.... (Rl/I/10)

> ...."It is a boy, isn't it? I told you. I knew it from how you behave [during the pregnancy]," said my husband **[How did you behave?]** I got angry easily, stubborn and arguing. Besides, I was controlling and did not want

> to listen. So, my husband said, "Your baby must be a boy."(Rl/II/6)

> People thought that my baby would be a boy and Sri's baby is going to be a girl, because people looked at the changes of our faces [during pregnancy]. Sri looked more beautiful, and clean, while I was gloomy and was getting sick easily. (S-N/SOT)

> My neighbours said that my baby was going to be a girl. They said that I was beautiful when I put on the make up. (Hn/I/10-11)

Some women also believe that the position of the baby in the woman's belly indicates its sex even though there are no medical grounds for this idea.

> .... The TBA told me that I have to pay extra attention to the right side of my belly, even though I need my right leg to sew. Therefore I am not working for a while. The TBA said that if I feel the kick in the right side, it is a boy. If I feel it in the left side it is a girl. (RK/II/10)

Rukhayah and her husband had a unique experience regarding the sex of a baby. Even though they did not care about the sex of the baby, Rukhayah's husband predicted that they were going to have a boy after receiving some visions.

> I do not care whether it is a boy or a girl, but I received some visions that, *Insya Allah*, my baby would be a boy. I had met, in my dreams, three times, a man who gave me a boy's name. He taught me something; therefore I asked his name every time we met. And he said a name. I was wondering if my baby is going to be a boy. (Rk-I/I/20)

> .... One day, I went to the mosque. The *Imam* [a leader in a prayer] had a good voice and he read the *Surah* beautifully. I was so impressed, so I asked what his name was. Coincidentally he had the same name as that of my dreams. (Rk-I/I/20-21)

Preference for male children gives a message to women that they are inferior to men – and this, in turn affects their own preferences for boys over girls.

People also predicted the sex of the baby in the seven-month-ceremony. Every rite in the ceremony has a particular meaning that tells if the baby is going to be a boy or

a girl (see chapter IV for the detail of the ceremony). Rully, Rukhayah and Henny did not carry out the ceremony because they did not see the importance of it. However, Rukhayah and Henny did carry out *Reading Qur'an Group* in a *selamatan*. Rully, who had been living in Jakarta for several years and who had a non-Javanese (Batak) husband saw no importance in carrying out either the seven months ceremony or *selamatan*. Rukhyah told about her seven-month *selamatan*:

> We held a reading Qur'an, *Surah Yasin*[11], and I was bathed with water full of flowers.
> **[What did the bathing mean?]**
> I did not know the meaning of that, but a glass of the water was prayed over by the *ulama*[12] and I have to drink it. That was for the wellness of the baby.
> **[Did you believe in that?]**
> Well [pause] I half-believe in it. That is ritual, so there are people who believe and there are people who do not.
> **[Did the *surah* that was read have a particular meaning?]**
> Yes, they did. We read *Surah Yusuf* and *Surah Maryam*. We shared them among the people who come to the *selamatan* to save the time, because the *surah* is quite long.
> ***(Rukhayah called her husband to join our conversation. She said that her husband knew better about the matter)*** **[here is my conversation with her husband].**
> Well [pause] we are trying to make the baby to become a good person, so we read her/him *Surah Lukman, Surah Maryam, Surah Yusuf* and *Surah Al-Baqarah*. The more people do the prayer, the more opportunities that God will give us what we ask. The *Surah Yusuf* and *Maryam* are to ask for the baby's faithfulness, the *Surah Al-Baqarah* is to ask for the baby's blessing while *Surah Luqman* is to ask for the baby's education. We want to educate our children in the way *Lukman* did. Javanese people believe that if they read *Surah* Yusuf and *Surah Maryam*, the baby will be good looking.

---

[11] A *surah* of the Qur'an that is usually read in a *selamatan* with any purpose to ask for safety.

[12] Religious leader

> **[I heard about that. Do you think it is true?]**
> If the parents are not good looking, how can it be? [laugh] The truth is both *surah* is asking for the baby's faithfulness. We do not know for sure how *Yusuf* and *Maryam* looked. (Rk/II/19)

From Rukhayah's seven-month ceremony, we can know the mixture of Javanese tradition and Islamic teaching. *Selamatan* is derived from Hindu culture that was later adopted as Javanese. The use of flowers is the characteristic of this culture. We can see Hindu culture in Bali, where there is a Hindu majority. They use flowers in all their prayers and ceremonies. However, we should notice that the rites that people usually use to predict the sex of the baby have been abolished from the ceremony, because Islam views boys and girls are equally important[13].

Henny carried out a feast and reading Qur'an for her neighbourhood, but she did not understand what the *surah* was that the people read on that occasion. She is sure that Surah *Yasin* is one of them. Nurhayati also carried out a *selamatan,* and she used a *dukun manten*[14] to head the ceremony. She said that she and her husband were bathed and put on some make-up. She wore a *sarong* and her mother put a piece of wood into the sarong and let it fall down. Somebody was ready with a long scarf to get it. If the wood fell down on to the scarf, the baby would be a boy, if did not, the baby would be a girl. Nurhayati said that the wood was falling down to the ground and it meant that the baby would be a girl. Her husband kicked a small coconut, but the meaning of doing so was

---

[13] Islam had successfully changed the Arabian beliefs in having a baby girl was a bad luck for a family so that a lot of baby girl were murdered after they were born.

[14] Spiritual healer for wedding ceremony.

not clear to them. Nurhayati and her husband dressed and changed their traditional suits several times during the ceremony. Nurhayati said that both she and her husband looked good in their suits, which means that the baby would be a girl. They entered the main house and sold the *rujak* afterwards. She and her husband seized the money. Even though she got more money than her husband did, they had to say that they had the same amount. The *selamatan* was carried out after all the rites had done. A *tumpeng*[15] was served. It had seven tops; the numbers symbolized the seven months of pregnancy. Nurhayati's way of celebrating the seven-months-pregnancy is an example of the adoption of palace tradition by the lower community. The tradition has been experiencing this kind of acculturation in various ways. The lower class people have changed some parts of the rites to be much simpler and more affordable. The egg in the original version, for example, was replaced by a small piece of wood. While an egg symbolizes the foetus that is also a woman's fertilized egg, a small piece of wood does not seem to have any significant meaning. But a piece of wood is more efficient, because an egg is more expensive and it is better to cook it than to break it. The way they treated the coconut is also different from the way most people do in the seven-months-ceremony. Usually, people use two coconuts instead of one in the ceremony. The coconuts are decorated with the pictures of *Dewa Kamajaya* and *Dewi Kamaratih*. In Nurhayati's ceremony it was much simpler, using one coconut with no picture on it. It is not needed to slash as well. In the seven-month-ceremony, the

---

[15] *Tumpeng* is a traditional meal in Javanese celebration. It is rice that shaped as a mount that symbolizes the journey of life, from the bottom to the top, closer to the place of GOD, way up there.

parents to be usually do not need to seize the money of selling *rujak.* The *dukun manten*, perhaps was confused with a ritual in a wedding ceremony when the bride and the groom have to seize a roasted chicken that is served for them. In a wedding ceremony, the rite has a symbolized meaning that both the groom and the bride have responsibility to make their ways in life. They can have a competition in creating a better life for both.

Harni also had a different way to celebrate the seven-months-ceremony. After she was bathed, a small coconut was put inside her sarong and it fell down to the ground. The coconut was slashed in two. Afterwards, she dressed up, and had to run around the house. Neither she nor her mother-in-law knew what these rituals meant. She sold the *rujak* afterward. She did not know why the *rujak* did not taste good, but people believed that it meant that the baby is going to be a boy.

The different ways of celebrating the seven-months-ceremony, as well as not celebrating the event, shows the cultural transformation-taking place in Indonesia. Most women in the study do not understand why they need to do the rites. Harni's mother-in law responded to my question saying,

> (We are) carry out the seven-month-ceremony just to follow the tradition. Actually, if we decided not to do it, it is fine too. I have a neighbour who did not carry out the seven-month ceremony for her baby. The baby is just fine. Harni's mother even did not know anything about the ceremony. (H/I/SOT)

If the rites do not have any meaning but simply follow what people did in the past it is bound to be irrational. No wonder that there are many people who no longer feel they need to do it, especially among younger people, who are more modern, and/or less religious as well as those who practice purer religious values. Surely these traditions will

gradually disappear from the Indonesian society. Nowadays Indonesian people tend to focus on more practical matters, such as preparing items that are necessary to welcome the baby.

Labour

When I was pregnant with Arra, I asked my mother about the labour process. My Mom said that I did not need to worry about that because the baby will find her/his way out and the professionals as well as the technology will save me if it was going wrong. So, I was waiting for Arra to deliver herself and did not do anything. Arra was delivered after 13 hours of severe pain, 24hours of dilatation process, a nubaine injection, an incision and five stitches. I went home after 3 days in hospital. Marvel's labour was easier. Perhaps, that is because he was the second child. But I also already knew that a labour is a collaboration of effort of both the baby and the mother. I felt that I was able to lead him out and to work with him together through the process. Marvel was born after only 6 hours of dilatation process and 3 hours of severe pain with a confident feeling that I could control the pain. I had no incision, and only two stitches to repair the stitches from Arra's labour, which tore. I went home 4 hours later and did not bother to wait for the discharge documents.

Apart from the cultural traditions to mark the seven-month-gestation, women also start to prepare themselves for the most unforgettable individual experience, namely labour. Most women in the study were aware that the seven-month gestation is important to their pregnancy because some babies are ready to be born alive at this stage. Nurhayati

had an opinion about seven-months-gestation,

> ...People said that if we deliver our baby at 8-month-gestation the baby would be younger than if we deliver the baby at 7-month-gestation. So, it is better if we deliver the baby at 7-month-gestation [than to deliver her/him at 8-month-gestation]... (N/II/2)

Her statement is a simpler version of the medical explanation that in the uterus, the baby is moving up and down in the lower and upper parts of women's belly. At the 7-month-gestation, the baby usually places her/himself in the lower part of the belly and will go up at the 8-month-gestation. S/he will go down again at 9-month-gestation, as s/he is mature enough and ready to deliver.

Close to the labour time, women are usually getting bored with the pregnancy and are longing to return to their lives as they were before they were pregnant. Pregnancy is perceived to be something that limits their activities after women have been through the joyful, sad and confusing feeling at the beginning of pregnancy and the phase of acceptance and adjustment afterwards.

> Sometimes, [pause] to be honest, I get bored with the pregnancy. I feel it is very long to wait; there is one more month to go. I cannot wait to be called *'ibu'* (English: mother)... (Rl/I/9-a)

> I feel that now I cannot work as much as before. I want to work and work and work [pause], but I hurt my spine. So, I stopped and had some rest. While, I believed that if I got pregnant I would be able to work as usual. But, it is just impossible now. I used to finish one cloth in a day, but now, sometimes I cannot finish even a half. (Rk/I/14)

> Sometimes, I get bored. Every time I see people bike, I think of the time when I can be on my bike again. (Rk/I/15)

At this stage, women are beginning to think more about the labour. Easy (fast and painless) labour becomes a sign of success for every woman in labour. Taking a spoonful

of coconut oil everyday is believed to cause the baby to slip out easily and to smooth the process of delivery.

> Starting at 7-month pregnancy, people said that we have to take some coconut oil. They said that it would make the delivery easier, because it will cause the track to be more slippery. Starting at 9-month we have to take it three times a day. (N/I/4)

The truth of this idea is questionable. However, coconut oil is used by some TBAs for delivery but they put it in the surface of the vagina instead of taking it orally, to ease the process of labour. Some women are advised to walk during the pregnancy. Walking is proved to be able to strengthen the muscles that are used in labour; professionals also medically advise it.

Labour pain is frightening for women, but most women think positively about it. The pain is something that women should endure in labour.

> I know that it is going to hurt, but it is fine... We cannot predict when the baby will be born. If the time comes, s/he will deliver her/himself... (S/I/4)

> .... I cannot imagine how painful the labour pain is. Anytime I oppose my parents, they always reminded me about the pain. "Wait till you feel the labour pain." I had often heard that since I was a girl and I heard it more often recently. (Rl/I/8)

> I do not know how to say, yes I am afraid of the pain, but it is challenging. I want to feel the pain so that I can understand why my parents reminded me about that all the time. My friend said that it was like going to die. I want to know how it is to be about to die [pause]. (Rl/I/8)

The pain will even give a woman a feeling of being a mother.

> I want to deliver my baby in my own way. I really want to know how it is to deliver a baby naturally that other people said will be painful to death. It will not scare me, but I really want to know how it feels to deliver a baby normally. I do not want to have caesarean section; I want to do it in a

> natural way. The pain will make me feel how it is to be a mother. (Rl/I/12)
>
> It is better if we can feel the pain. Therefore, we are able to feel how it is to have our own child.... (S/I/4)

Most women believe that trusting their God for everything that happens in delivery process is the most important factor throughout the process. Pain is not something that they should be afraid of because they believe that God will help and that it is natural.

Prescribed Behaviours to Cope with Pain

Prescribe Behaviours	Purpose
To write and say Quranic verses To rub the woman's belly To stay on hands and knees with the head lower than the back	To decrease the pain during the labour

There are some traditional advice for women to cope with pain. Writing and saying Quranic verses seem to decrease the labour pain for some women, probably in the same way that yoga meditation helps. Women concentrate on something else, their God, instead of the labour pain during the delivery. For women who believe in the power of prayer, they believe that God is helping. Rully and Rukhayah described their experiences as follows,

> My Mom asked me to pray. My husband had told before he left the last time that if I feel the pain, he asked me to read *Surah Al-Fathihah*[16] three times while rubbing my ears at the same times. I do not know if it was right, but I felt my pain was gone. (Rl/II/4)
>
> My husband had been told by my uncle that if I cannot bear the pain anymore, I should write the word '*bismillah*(in the name of Allah)' in Arabic on my both hands, so that I would have a new spirit to struggle. And, it was true... (Rk/II/4)

---

[16] A name of a *surah* (a part in the Qur'an) in the Qur'an.

> To stay on a hands and knees with the head position lower than the back is also believed to decrease the labour pain. My midwife also suggested that it would help to position the baby in her/his right place. I had felt the pain in the lower part of my belly that hurt me while sitting and sleeping. My midwife said that the baby should go up and asked me to stay in the position for about 30 minutes. After 15 minutes, I could feel my baby was changing his position and the pain was gone.

Women are more afraid if the labour is not going well and they cannot deliver the baby naturally and have to go into a hospital.

> We pray so that we will not have an abnormal baby. I pray for that everyday. I wish I would deliver a healthy baby. I am afraid that I will not be able to deliver the baby normally. (Rk/I/16)

> No, I am not afraid of labour pain. I am more afraid of medical instruments [pause]. I had gone to hospital too often before... (Hn/I/11)

But, no woman in the study was as afraid as Nurhayati. She expressed her feelings about labour as follows,

> I am not afraid of labour [pain]. I am afraid more of having an abnormal baby. You know [pause] I did not know that I was pregnant until it was 4-month-gestation. It was strange. I did not know it at one or two-month –gestation like the other women did. How could it (the baby) just be here so suddenly? I am afraid that it is not really a baby. The elderly said that there are some cases that people who do not want their pregnancy give their pregnancy to another woman [using supernatural power]. I am wondering if it is really my own baby. If it is, it is fine. If it is not, I am afraid. I wish that it is not going to be a handicapped baby [that I bear]. [Even though I am not ready for a baby] if it is really my own baby, I am going to take care of the baby well. Some women, perhaps, would have an abortion [with a doctor's help] or go to a *dukun* to massage the belly [having an abortion] or even ask the *dukun* to put their baby in another woman's body. If my pregnancy is one of those practices, I am afraid. It happens a lot, you know. My friend who was pregnant 8-months-old had lost their baby. It was just gone and she hasn't had any child now. [Nur believes that there was a woman who hated her friend who stole the baby with supernatural powers]. She wants to have a child, but she just cannot. My neighbour had been pregnant 5-month-gestation, but it was also just gone. Because there have been many examples, therefore I have a

> suspicion that, perhaps, there is a woman who does not like me and gives me this baby. I am scared [crying]. (N/I/14)

Some women may experience losing their pregnancies and miscarrying. It also happens when they have a false pregnancy. Apparently the false pregnancy has the same symptoms as the normal pregnancy but the urine test result is negative and hCG (human Chorionic Gonadotropin) concentration is high. The case is called blighted ovum and is caused by psychological factors. Another case is called prolivirasi vili, which is caused by protein deficiency. Another possibility is that it is caused by the development of a benign tumour in the ovary.

Some women believe that difficulties in labour and having an abnormal baby are caused by women's behaviour in the past. For a woman who is pregnant before she married, like Henny, having an abnormal baby is seen as the consequence of her sin.

> I am afraid of having an abnormal baby. You know, because this baby is the result of doing premarital sex. That is why, when the baby was just delivered, I asked the obstetrician about my baby's condition, whether the baby is healthy. (Hn/II/13)

Rukhayah asked me whether there is a relationship between the case of placenta previa and women's behaviour in the past.

> According to you, is there any connection between some conditions [difficulties in labour] with, for example, the mother's sin in the past?
> **I do not know for sure, God is unpredictable. It might be. Do you believe that?**
> I half believe it, because I have a friend with placenta previa. She was pregnant outside marriage, therefore she was asked to apologize to her mother and everyone who attended the labour. (Rk/I/17)

Rukhyah believes that another way to avoid difficulties in labour is that women should

keep all the promises that she made to God before they are in labour.

> I had a friend who had promised God that she would finish reading all the 30 *juz*[17] of the Qur'an before she delivered the baby. When the time came, she had not finished the last two *juz* of the Qur'an. The contractions came and went and then stopped. She remembered that she had not finished the last two *juz*. The family invited some people to read all the *juz* of the Qur'an. Suddenly, she could feel the contractions again. That is why, before we go into labour we have to fulfill all of our promises to God, as well as to our future baby. If not, we will receive the punishment. I used to be angry if my husband was still working while I was about to sleep. I would not go to sleep if he did not want to. Now the baby does the same. If his father works until late midnight, the baby also does not want to sleep. (Rk/III/11-12)

Rukhayah is probably right, but what she does not know is that women may experience contractions that are hours or days or even weeks apart (Eisenberg, Murkoff, Hathway, 1995). Anyway, a lot of good women who are considered kind, generous and devoted to God and their husbands and parents also have difficulties in labour.

Even though before the actual labour women feel that the labour pain is not a big concern, most women said that the labour pain that they felt was more painful than they expected.

> The pain was more painful than I imagined. It was like menstrual pain but much more excessive and continually. I wanted to concentrate on the pain and tried to enjoy it, but it was too painful to enjoy, so I screamed and tried to forget the pain. If I did not scream, I could not breathe. I was stressed if I did not scream. But, I did not scream too loud. It was embarrassing. Besides that, I would not be able to enjoy the pain. (Rk/II/4)

During their struggle to deliver their baby, women felt various feelings. Facing death is one of them. Rukhayah told her feeling as follows,

---

[17] Part of the Quran

> I felt that I have to struggle… but then I felt very tired. I told my husband, "Please promise me not to give my child to other people if I cannot come through this all… My husband answered, "What are you talking about?" people always talk like that (that being in labour is in between life and death). Perhaps, it was because I was very frustrated with the progress. I could not take it any longer. (Rk/II/4-5)

> I wanted to go home. **[Why?]** It was very inconvenient to be seen and taken care of by other people (in that condition). (Hr/II/9)

> My Mom could not bear to see me suffer with the pain, moreover, she saw me panicking during the process. I held her hand during the labour and did not let her go even for a minute, we prayed together. I could see that she was crying. After the baby was born, my Mom hugged me tight. *Alhamdulillah*, the baby is girl, healthy, safely… I was afraid that it was going to be a handicapped baby. I remembered the obstetrician said that I might not be pregnant, at first. It was just too tired. I was afraid that my baby was going to be a handicapped baby. I always pray for that. Before the delivery, I had been worried if the baby was going to be a boy [her husband and his family want a girl]. Even before I did the push I was thinking about that; how if the baby is a boy, how if the baby is handicapped… I was thinking of various feelings. (N/II/6)

During the labour, even when the pain is reaching the peak, women cannot put away their fears about what other people would say about them.

After a long struggle with pain and fear, women's feelings are varied. After I delivered Arra in the Grace Hospital in St.John's Canada, I felt so much relief that the pain was gone. I was also a bit disappointed because Arra is a girl. That the first night I felt very tired because I had to carry my baby almost all night long. My husband and I could not allow our baby to go in the babies' room with other babies without special caring from the nurse, because we felt that she was very special to us. After I delivered Marvel, I felt happier because I knew that I do not need to have another child if I do not want to because Marvel is a boy. The sex of the baby really does mean something for

women even after a long labour.

> I was so glad, moreover when the midwife said that it was a boy. The baby was crying so loud... (Rl/II/5)

Some women do not feel an excitement after the delivery.

> I did not have any feeling. There is nothing special. Well... yes I am happy, but only a little. I am happy because I have had a child right now...(S/II/4)

> I could not feel anything. I had been very tired; when the head of the baby came out I already could not feel anything. When the midwife said, "It's boy." I remember my husband's prediction that it is going to be a boy. *Alhamdulillah*[18] my husband is right. (Rk/II/5)

> When the baby was just delivered, the helper said, "It's a girl." My Mom said in my ear that the baby is not handicapped. My husband was glad because the baby is a girl, because his mother wants a girl. I am also glad even though my wish of having a baby boy is not fulfilled, but I am glad because I can bring happiness for my husband's family. But I am not so excited about delivering a baby, because I actually do not want a child yet. (N/II/7)

Because society treats labour merely as a natural process, none of the women feel they have played an important role. When the difficulties happen during labour, it is a time for God to play His role. None of the women suspected that the feelings of worry or fear that they or their birth attendants had might cause difficulties during the delivery. After the labour, as a consequence of this view, women feel that one of their responsibilities as a woman--to bear a child--has been accomplished. Women's happiness lies in their success of fulfilling other people's expectations, and not on what they did, by their own effort, in labour.

---

[18] Thanks be to God

Afterwards

Labour is not the end of the process of having a child. Women still need to obey traditional injunctions for the health of the baby and themselves. Besides the religious imperative not to have sex during *masa nifas,*[19] women have to be aware of socially/culturally diets and prescribed behaviour.

Postnatal Diets and Prescribed Behaviours

Diets and Prescribed Behaviours	Purposes
Hot food and drink	Cause the breast milk to be too warm for the baby so that baby's tongue could be burned and the baby's skin becomes wrinkled
To tie woman's toes together To wind women from their belly down to her legs	To hasten vaginal wound healing process
To sleep with nearly vertical spine	To avoid "*darah putih* (white blood)", which goes up goes up to the chest
To keep the legs in a straight position while sleeping	To avoid varicose vein
Not to take a nap	To cause *sawanen*
Not to nurse in lying position	The breast would block the baby's nose and the baby cannot breathe. To cause *sawanen*
To put on herbal remedies on woman's belly and wind the belly with *setagen*	To cause the belly to be as elastic as before and be back to its original shape
To consume various traditional remedies	To produce more breast milk To clean up the ovaries after delivery

Both professional opinion and folklore agree that to breast-feed lying down would be dangerous for a baby. There is seen to be a risk that the breast might block the baby's nose and cause breathing problems. The advantages of sleeping with nearly vertical spine

[19]A period of bleeding following the birth of a baby.

and straight legs as well as tying both toes together are not medically proved. Dr Boyke Dian Nugraha on *Berita Siang* Metro TV (28 October, 2003) explains that to wind a woman's belly during the postpartum period has proved to be able to strengthen the belly muscles. Meanwhile, to sit with back support while nursing, indeed, gives some women more comfort. Rully admitted that she suffered from the prescription given by her mother after she delivered her baby. She does not know if it is true that sleeping with a nearly vertical spine and keeping her legs straight while sleeping could prevent the '*darah putih*' and varicose vein on her legs, but she decided to follow the advice.

> [My mother asked me] not to sleep lying on my back. I had to sleep with almost vertical spine. I felt my bottom was warm and my back was very painful. Moreover, [my mother] tied both my toes. It was really hurt. I wanted to free the knot but my mother said, "No You can't do that," It really hurt... (Rl/II/9)

She had to do it for 40 days and put herself in the *setagen* [long material that is twisted around her belly] for up to 9 months after delivery. All the women in the study say that they have to put themselves in the *setagen* for different periods of time. Some women say they have it for up to 40 days and some others for up to 7 months

Women in the postpartum period also have to take some traditional remedies. Some are homemade and are sold from house to house in the neighbourhood by a *'bakul jamu'* and some other are industrially made and sold in stores.

> I take *"Jamu Komplit Bersalin"* [remedies for women in postpartum]. It is available in several different kinds. The first step is to clean up the ovaries, the second step is to strengthen and cool the belly and the next step is to purify the breast milk. (Rk/II/9)

> I am taking some remedies called "*anggur beranak*" [literally means delivering wine]. I can take anything else as long as it's healthy. And, I

> have to sleep with nearly vertical spine and straight legs for almost a month. (N/II/8)

Some remedies are good for women especially those are not taken orally. For those taken orally, women need to be aware of their impact on the newborn.

> My husband bought me a traditional remedy for the bleeding and *sawan*. But the baby had diarrhoea because of that. Therefore, I went to Bu. X. "Do not take any traditional remedy. It is not good for the baby." Finally, I changed the remedy. (Hn/II/4)

The postpartum period is usually under the care of the TBA, who takes care of the mother and the baby. Some TBAs, who no longer help in deliveries, still help to take care of the newborn and the postpartum treatment for the new mother instead. Henny's TBA who helped her to ensure the time of delivery is an example. She has given up her profession as birth attendant and does the traditional caring for the mother and the newborn baby instead.

> *(Henny called a TBA to ensure that what she was feeling was the first signs of labour)*
> She (the TBA) did not want to help me to deliver my baby. She had training (for TBA). She is only able to acknowledge the signs of labour, and do the massage for the newly mother and newborn baby. (Hn/II/2-a)

The role of a TBA during the postpartum treatment helps women. They are able to take some rest after an exhausting labour. Most women believe that to be too active during the post-partum period will slow the healing process. Some women start to take care of their newborn baby after the umbilical cord drops off, some other women after 35 days, and some others start earlier or later depend on the situation, for example, their speedy recovery or the absence of female siblings in the family.

A Learning Time for Women

Pregnancy and delivery are perceived as a learning time for a woman. It is the time for a woman to learn to become a mother for her child. Some women have been learning to mother since their childhood. They have had some experience of mothering their own siblings or relatives.

> Even though I am the youngest in the family, I never felt that I was treated special. I used to take care of my younger cousins. I have some here… (Hn/I/2)

However, it does not guarantee that they are capable and confident to mother their own children.

> I do not know how, even though I used to take care of my little brother in the past, but to take care of my own child, to be honest I still do not know what to do. (N/I/3)

Besides learning from their own experience, women are learning from other women's experience to mother since they were girls. Nurhayati said that her friend's experience of not having a child has encouraged her to accept her pregnancy.

> I used to refuse my pregnancy, but now I realize [that it was wrong]. I have a friend who does not have a child; she does not have a good relationship with her husband, or with her parents-in-laws. Therefore I think that it probably right that a child can be something that brings a family together. S/he will be able to bring reconciliation between [a woman] and her husband, her parents-in-laws and her parents, too. I hope this child is also a blessing from the Almighty. (N/II/9)

Other people's experience sometimes provides guidance for women.

> There was an accident around here, that a woman got her belly massaged by a *dukun*. The woman complained about the pain that she felt in the lower part of her belly. She was seven months pregnant. A few days later [after she had been massaged], she delivered a dead baby …. My neighbour wanted to deliver her baby in a hospital, but when the time

> came, she could not find any transportation to go there so that the baby was delivered on the way to the hospital. I am afraid [that I will experience the same things], that is why I chose to visit the nearest midwife. (Rk/I/18)

> I went to *posyandu*. There is a village midwife there, bu Z. I learn from mothers who are coming, who are experienced, about the care of my child, eating patterns, etc. [pause]. (S/II/5)

Some women may learn to mother from books. Henny said that she did even though she read the used (old) ones.

> I read some books about pregnancy. All my family loves reading; therefore we have a lot of books here. Even though they are used ones, they are still useful. (Hn/I/8)

Rukhayah said that she is learning anytime and anywhere she has opportunities to do so.

> I do not have any experience of taking care of a baby, but, sometimes I accompanied my sister to go to a midwife or a doctor, therefore I know how it is being pregnant. Besides that, I read all that is written in the midwife's private practice. For example, it is written in the midwife's private practice, 'Breast milk is better than formula.' I did not have formula when I was child, my teacher said that if we had formula, we would behave like a cow; disobedient and not smart [pause] There is a study that the babies who are given formula are getting sick easier than those who are given breast milk. But, the quality of the breast milk depends on what the mother is taking. I knew that since I was in junior high. I remember the knowledge about practical things much easier than if I learn, for example, history. That is difficult. I hardly do that. (RK/I/11-12)

Since the beginning of the pregnancy up to delivery and even the period after that, every woman agrees that having children for the first time is a time to learn to mother. When women learn the practical things about mothering, they are also learning the ideological parts of mothering. The way women mother their children should be a continuation of what society believes is a good way to mother a child. The complex

structure of the society has provided women with a lot of choices and information even though, many times, the decision to choose and to rely on the information just does not belong to her.

In this chapter I have discussed the participants' experience of childbirth since the beginning of pregnancy up to post-natal period, from which we can see that within the day-to-day practice of childbirth there is an ideological transferring process along with the process of transferring practical knowledge about motherhood. We have seen that sometimes the practical needs of the woman and her baby are supported by tradition and by the ideological or cultural frameworks (such as the honor and support provided by the father-to-be); in other cases (such as the gender lessons of the 7 months ceremony or some of the food taboos) the traditions actively disadvantage women and contradict the lessons of modern obstetrics. On the other hand, we can also see women being influenced by the ideology implicit in modern obstetrics (such as the refusal to acknowledge women's knowledge about their own bodies). Another thing that women realize is that pregnancy and delivery is not only the time for a woman to learn to mother her child, but also the time to learn how to become a woman. It is a time to acknowledge and to position herself as a woman in her complex society. The next chapter will discuss the position of women as society positions them.

Chapter 6

Women Delivering:

Lessons Learnt from Women's Experience of Pregnancy and Delivery

Pregnancy and delivery is a time for women to learn how to be a woman in their society and to learn how that position is seen by other members of society. Even in a society where to have a child is considered necessary, the position of women does not automatically improve when they become pregnant and bear children. There is a belief that women with children are luckier than those who are not, but in real life this is not always the case. From the very beginning of pregnancy up to the postpartum period women are the objects of control, and only few of them become subjects who have the freedom to control themselves in matters regarding their pregnancy and delivery. To know the position of women in a society, it is important to understand how the society itself has positioned them. The following discussion is about participants' interactions with others during the pregnancy and after delivery from which we can better understand the position of women in Indonesia.

Women, the Professionals and Authority

Interaction between women and professionals in Indonesia is marked by a lack of communication between them (Sciortino, 1999). Professionals usually underestimate women's ability to absorb knowledge about their health; therefore it is not necessary to tell them about their condition or to listen to them. In the case of pregnancy, most

professionals do not give sufficient information to their patients. None of the women in the study felt that they had received the necessary information from the professionals. When the professionals prescribed medication or supplements, for example, they provided only minimal information about them, which did not include information about the name of the medicine or the supplement. Many times I myself bought the medicines that a doctor prescribed me in a drug store and the staff there would provide the medicine with the name of the medicine (or its trade mark) already covered with a label with the drug store's name as well as my name and the dosage on it. Information about possible harmful side effects and the contents of the drug is written on a piece of paper inside the box - but that has already been removed by the time the patient gets the medicine. Thus the pharmacist and the doctor seem to collude to avoid the patients using the medicines without a prior consultation with them. And this keeps women in ignorance about their treatment. By hiding the name of the medicines they prescribe, the professionals are compelling patients to come to them, when often the right drugs are non-prescription and easily available without a doctor's prescription. In fact, this device doesn't work, because the patients can easily get a copy of the prescription from the drug store and can then buy the medicines whenever they want. Some patients only need to bring a sample of the medicine to the drug store, to get the same medicine even though officially they need a doctor's prescription for that.

In any case, because the women receive minimal information about the medicine most women in the study are only able to describe the physical appearance of the

medicines and what they have been told the medicines are for. They do not know the proper name, the chemical composition or the possible side effects.

> The medicines are big white, red and pink. (S/I/1)
>
> She gave me vitamins and some pills to strengthen the womb. The colours are white, yellow and red. (Hr/I/3)
>
> I received one kind of pill. That was for the stitches. (Hr/II/3)
>
> Yes (the doctor informed me) that this is for the headache, this is for the stomach-ache. If the pain is gone I should stop taking the medicines. (Hn/I/5)
>
> The obstetrician gave me pills. The colours are white, red and pink. The white one is for the headache, the red one is for blood supplement and the pink one is for the vomiting. (N/I/5)
>
> I worked in a drugstore before, so that I know that the red one is blood supplement, the yellow one is vitamin C, and the white one is calcium... (Rk/I/6-7)

Such little information about the medicines is dangerous if improper dosages are hazardous, and the women – in ignorance – do not follow the suggested dosages.

> Sometimes I did not take the medicines regularly. I received ten pills for a month. I did not take the pills everyday, sometimes once in two days, or one in three days. The pills are big. I hate that. (Rk/I/10)

Usually, women do not see health professionals during their pregnancy unless they experience physical discomfort. Actually, the women would like to consult their professionals more, but the professionals only seem to be interested in physical symptoms.

> After he (the doctor) gave me injection, the condition was not getting better, but I did not visit the doctor again. Only if cannot I bear the pain I will visit the doctor. If I only have headache or nausea, I could take that. (S/I/1)

It is the patients who communicate the symptoms that they experience (to the professionals); the doctor provides very little explanation about the illness/the condition of the patients and often fails to follow up the information from the patient.

> She asked me why I was complaining about my condition. But, I did not complain about my health, therefore I did not tell her anything. Only if did I get headache, I asked about that to Bu X (Hr/I/4)

The professionals rarely take the initiative to give information to the patients. The information is one way from the patients to the professionals (Sciortino, 1999). Thus, the professionals react to a problem and the women do not have the knowledge to prevent the problem happening.

Some professionals think that it is no use to inform the patients about their treatments, taking the view that Indonesian people are not ready for information related to medicine and medical procedures. People who are not trained in medicine often have trouble understanding, but they are not too stupid to understand an explanation in simple language with easier terms. In fact, patients are eager to know what is happening to their bodies.

> Anytime I went to a doctor, I regretted that I did not ask what was happening to my body while I had to pay a lot of money for that visit. If somebody asked me what kind of illness that I had after I was home from a doctor's visit, I said I did not know, because the most important thing was that I already received the medicines. (Rk/I/10)

> The doctor is not the only one who knows about birth. We know and need to know about that, too. The doctor is just helping; s/he does not do anything [s/he is not the main actor]. We are the ones who experience that; therefore we need to know. (Rk/I/19)

There are other factors that may discourage women from making inquiries of the

professionals during the examination. Nurhayati said that the number of patients that were waiting outside the examination room in the professional's private practice affected whether she asked more questions.

> If there are only a few people waiting outside during the examination, I have more opportunities to ask the obstetrician whether my condition is normal.... The doctor said that it is normal. I also have an opportunity to ask about my pregnancy. (N/I/5)

> I did not have opportunity to ask about birth control methods more detail. There were so many people were waiting outside the examination room. (N/I/6)

Some women use their knowledge about the professionals' private practice situation to improve their situation for consultation.

> I come every Tuesday or Friday once a month. There were only few patients on those days. (Rk/I/7)

The number of patients also influenced of the quality of a midwife's services during the labour time.

> I was the only maternal patient at that time. The midwife was very friendly; she was accompanying me since the beginning of the process of labour. She gave me advice about what I should 'do' and 'don't.' What is the best for my baby, etc. (Rl/II/5)

Sciortino (1999) explains that most professionals tend to deliver their services to as many as patients as possible and to spend as little of their time with each patient as possible in order to reach the number of patients that has been targeted by the government. For instance, a midwife has to examine 1,000 pregnant women to get two credits point (PPNI in Sciortino, 1995). Giving the patients more time to build a conversation would encourage women to talk about their condition and enable them to learn about their

health. The health education would help both the patients and the professionals. Patients' knowledge about their health would encourage them to take better care of themselves. Further, Sciortino (1999) explains that patients with health knowledge will be able to give the professionals more accurate descriptions about their health condition. It will also influence the degree of compliance of the patients towards the professionals' advice if they have complete understanding about the advice and the reason for giving them a particular medicine. According to Sciortino, incomplete information is the source of patient's dissatisfaction with the professionals' services and it encourages them to do 'doctor shopping' (going to another professional for better services). However under the present system, most health professionals tend to work in a hurry so that they only spend a few minutes with their patients.

Another factor that would encourage women to make inquiries about their condition is the professionals' attitude during the interaction. Women will seek another source of information if the professional is silent and apparently uninterested in talking to them.

> The midwife is so silent. If I do not ask about something, she will not talk. She said that my baby is going to be small. I read a book about pregnancy and I found that if the mother is small, therefore the baby will be small. (Rk/I17b)

Rully who experienced half of her pregnancy in Jakarta said that there are differences between the midwives' services in Jakarta and in the district of Mede. One of them is that, in Jakarta, she had more opportunities to ask about her pregnancy.

> The procedures (of examination) are not so much different. Our blood pressure and weight gain are measured. The difference is that the midwife in Jakarta asked me so many things. I told her about the problems and the midwife explained the solutions. The midwife here is so silent. If we do not ask, she will not say anything. Therefore, we have to be active. In Jakarta, it was the midwife who took the initiative to build a conversation. It was more comfortable. (Rl/I/7)

Rully had the opportunity to experience different treatment by different midwives, so she can make comparisons and decide which one is best for her. Besides increasing women's knowledge of their health, understanding the choices they have of health services is another source of knowledge for women (Sciortino, 1999). On the other hand, if patients are kept ignorant it will create difficulties for both the patients and the professionals. Nurhayati's condition is an example. When Nurhayati suspected that she was pregnant, she went to an obstetrician to check her pregnancy, but the obstetrician did not think that she was pregnant, and informed her that there was nothing the matter with her health. She took some pills for her periods. Because she felt uncomfortable, she made another visit to ensure that she was fine, but this time the obstetrician said that she was four-months pregnant. The obstetrician blamed her for not visiting him earlier, even though she had.

> ...The obstetrician said,"It is already four-month gestation. How could you come so late?" I was cross with him. I reminded him that he said on my visit a month before that I was just too tired, but then he said it is already four-months. I was so shocked. He said, "You have to be careful of taking medicines. What had you been taking?" I said that I took some hormonal pills. The obstetrician said that I should stop taking them.(N/I/1)

The obstetrician did not tell Nurhayati all the possibilities why she missed her periods. Because she did not think she has pregnant she was less careful with her health, so his misinformation could possibly harm the foetus. Most professionals tend to trivialize and

generalize patients' concerns. Many of them are even careless about keeping records of their patients as happened to Nurhayati.

The lack of information about professionals' procedures gives women negative feelings about themselves and bad impressions about what the professional is doing to her.

> I could feel the hand of the midwife going inside the vagina, I thought I was having stitches, but my husband said no I was not. But, I felt hurt and my husband said, "Off course it hurt. It was her hand that went inside your vagina." (Rk/II/6)

> I noticed the doctor had changed the instruments three times. How could this happen to me [pause]. They play with my body [I am like a toy]. (Hn/II/5)

The lack of knowledge about what women should do in labour causes trouble for women: the professional becomes impatient with them.

> ... The midwife was giving up, because she asked me not to push, but I did not obey. She said that I would not have enough energy through the process if I pushed too often, but I did not mean to push. It just happened, I could not control the push. It came from inside. The midwife said,"Don't push! Don't push!"
> "I do not know how to do it, Mam. I cannot control it."
> The midwife was getting angry because I was moaning, "It was labour, you know. It is always painful,"
> I was sick of her words.... The midwife came to assist. She told me to push, but everything that I did was wrong according to her. "Don't do it in your chest! Do it inside your belly!" I just did not have any idea. "I did my best, Mam," I keep trying.
> "No! Not like that. That's wrong! That's wrong!" (Hn/II/3-4-5)

Another example of the difficulties caused by patients' ignorance about their health is illustrated by Rukhayah's story. While Rukhayah was in labour there was another woman, who rang the bell too often so that the midwife got mad at her. The labouring woman thought that the baby was about to deliver, but the midwife said that they still had

to wait for a couple hours for that, therefore she was angry with the woman and blamed the woman for calling her too often. However, it is not only the professionals who assume that it is the patient's fault that s/he does not know. Even women themselves feel that it is their fault if they do not know. Rukhayah gave her opinion about the incident as follows

> I think Bu X's services are good. But, some women said that she is rude and fussy. Bu X is able to predict when the baby will be born from the dilatation progress. She was educated for that and already knew the theory. Therefore, if she thinks it is not the time for the baby to deliver, she will not take any action but will ask the women to walk, but because the patient is afraid she often rings the bell. It is attached to the wall, but we cannot ring the bell too often, once is enough. If we bring our parents, they usually have had experience of that and understand if we are asked to walk, but if they have not had any experience of that we will ring the bell too often, and the midwife will be very angry with that... "I told you to wait. It is not the time, yet" (Rk/II/11)

The women in the study, who had incision and stitches, said they were not informed by the midwife and the doctor who helped them in labour why it was necessary to have them. None of the women were complaining about the procedures because the procedures did not hurt; they almost could not feel them when the professional were carrying out the procedures.

> **When the midwife is doing the incision, did she ask your permission?**
> No
> **Did you ask for that because you did not want the baby to deliver at the Maghrib prayer?**
> No, I did not...
> **Were you afraid when the midwife was doing it?**
> No. She did not tell me. I just feel 'srit' (no bother). (S/II/3)

> Did the midwife ask for your permission when she gave you the incision?
> No, she did not.
> **Did she inform you the reason?**
> No she did not. She just asked me to hold on. (Hr/II/3)

Henny felt hurt when she got incision and stitches, but she can accept them because she knows that it was an emergency situation and she understands that the doctor will do the best for her. Informing her about what the doctor was doing would perhaps be scary for her.

> **So, you had the incision?**
> Yes, I did it. I felt 'krezz.' It hurt.
> **Did the doctor inform you about everything that he did?**
> No, he did not. I realized that it was an emergency situation.... Indeed he asked my permission when he was about to give me needles. "I'll give you needles, first."
> **Do you know what were they?**
> I do not know. What were they?
> **I do not know either.**
> Was it for the contraction?
> **Probably.**
> Uh, needle. My husband said, "It's okay."
> Then I was asked to lie on my side. I had two injections. He (the doctor) did not tell me when he was about to change the instrument or when he was about to give me an incision, perhaps he knew that if he did inform me about that, I would blackout... (Hn/II/7)

Because women feel they cannot ask for information or if they do ask they do not receive satisfactory answer, they feel they have to take the doctor's skill on trust. They have to believe that the doctor will not do anything to harm them.

> No, [I never told about what I am worried about during the pregnancy to the midwife]. If there is something wrong happening, like the baby is in the breech position, [I am sure] she will tell me about that. (Rk/I/17)

> I can accept if the doctor did not ask for my permission for every action that he took. I realize that he was in hurry.... I tried to think positive. (Hn/II/7)

Sciortino (1999) explains that the cultural norms prevent women from complaining or expressing their doubts to people with higher social status, in this case, the health care

providers. Patients' acceptance of the current pattern of women-professionals relationship has meant that the pattern continues.

The professionals also benefit from women accepting the current pattern of their relationship with professionals. The lack of communication between the professionals and their patients is perpetuated by the professionals to cover their ignorance of the problem (the patients' real condition), and to build an intellectual gap between them so that they will be able to legitimate their power and control over their patients (Fox, Parsons, Van de Geest and Vrijhof, Waitzkin and Stoekle in Sciortino, 1999).

Apart from having less knowledge and education than their professionals, women are sometimes victims of capitalist practices. Women know that if they use the doctor's services and deliver the baby in a hospital, they will have to spend so much money. They also recognise that they will have to pay for artificial vitamins. Harni said that she had to pay about 150,000 rupiahs (equal to CAD$30) for the vitamins that were prescribed by the obstetrician. A doctor will receive 30 per cent of the price of the medicines and supplements that s/he prescribes to her/his patients. But the pressure to prescribe expensive vitamins sometimes comes from the women themselves.

> I was afraid that I had been given medicine that is dangerous for my baby by the physician that I visited before, therefore I asked Dr. Z to give me some good vitamins. The doctor mentioned some brand names of vitamins, and he said that a lot of other good vitamins were sold freely in drugstores. (Hn/I/11)

It is not just the doctors who maximize their profit in managing women's pregnancy and delivery, but also the midwives, as illustrated by the following conversation

between one of my respondents and her midwife.

> [The expectant mother came to visit a midwife for her first check after she found out that she was pregnant]
> "Where did you check your pregnancy?" [The midwife asked]
> "In the lab Medika" [the woman answered]
> "You can do it here, too"
> "I asked my sister, she said you could not"
> "How much did you pay to the lab for the check?"
> "Ten thousands"
> "It is just seven thousands here"
> "Well… it's cheaper, but I did that already" (Rk/I/7)

The conversation shows that the midwife has already had a technological instrument to detect the early pregnancy and uses it to commodify her services to compete with her fellow health professionals. Women become an object of capitalist practices for health care professionals to maximize their profit. Some midwives offer birth certificate services for the babies that are delivered in their private practices. Rukhayah gives her opinion of getting birth certificate using a midwife's service as follows,

> If we are getting birth certificate with the help of a midwife, it is going to be costly (about 20,000rupiahs). If we do it by ourselves it is not going to be that expensive. It is about 15,000rupiahs. Actually, it is easy to get it…. (Rk/II/8)

Some midwives also provide napkins, panties, cotton, nappies and some other needs for the mother and the newborn and include the cost within their bill. The cost that women have to pay for a midwife's delivery in my district is between 150,000 rupiahs and 200,000 rupiahs. I was lucky because I have a midwife who never mentions how much money I should pay her for her services. Some women who had delivered their babies with her help said that they paid her anything from 30,000 rupiahs to 200,000 rupiahs. She also carries

out a home visit for her patients a week after delivery to check whether the mother and the baby are doing fine, whether the vaginal wound is healed and whether there is something wrong with the women's belly. She also sends her assistant to take care of the baby's cord until the cord is healed. I thought that those were part of a midwife's responsibility to the patient, so I asked my respondents whether they receive the same treatment from their midwife and doctor. None of the women received the same treatments; although most of them were satisfied with the treatment they did receive.

> There is a midwife who carried out those services around here, but we have to pay more. If we deliver our baby with the help of a village midwife, they will have enough time to carry out all those services because her patients are not so many as [a well-known midwife's]. If we expect bu X to carry those services, I bet she will not have enough time. She only has two assistants. She even cannot help all the women who come to deliver their babies in her place by herself. (Rk/II/9)

None of the woman came to the midwife/doctor who helped them in labour after delivery, for the postpartum treatment: not even Sri, who had a problem with her vaginal wound.

> My wound still hurt three months after that (delivery) especially in the back part of the vagina. The stitches are the worst. Perhaps, it is because they go straight backward. I had put some oil and cotton on it, but it did not work.
> **Didn't you receive any information about the healing process, for example, when the approximate time for a wound to be fully recovered?**
> No, I did not.
> **Did you worry about your condition?**
> I did, but I preferred to keep it for myself. (S/II/7)

Sri's condition can be dangerous if it becomes infected. Some women are very shy talking about their problems, especially regarding their reproductive organs.

Besides becoming an object for health care professionals, women also become an object of capitalist practices for the government in its capacity as health care providers. The Tetanus Toxoid (TT) Injection programme for women is one example. Having TT injection is compulsory for all expectant mothers and all women who get married in order to reduce tetanus infections among newborn babies. One of the requirements to have a marriage registered in the *Kantor Urusan Agama (KUA)*[1] is that women have to show a letter that states she has had a TT injection from the local *puskesmas* or a health professional. The cost for an injection varied depending on the region where the women are taking the injection. In my district, for example, I had to pay 21,000 rupiahs, while my sisters-in-law in different region only paid 500 rupiahs. According to one physician, there should be no charge for the injection, but the local governments have been given authority to charge their community in order to improve their local incomes. Rukhayah shared her experience of this policy as follows,

> I had TT injections twice before [I married]. I had them in the village meeting hall. I did not need to pay for those [injections]. When I prepared the administrative requirements for my wedding, I knew that I had to have the letter [that showed I had had those TT injections] first. Therefore I went to the local *puskesmas* for the letter; they asked me if I had had the TT injection. I said that I had it twice. [They said,] "Well, now you just need to pay for those injections.'
> "What? Now I need to pay for them?" I said surprised. But, finally I paid them 11,000 rupiahs. It means I had to pay 5,500 rupiahs each injection. (Rk/I/8)

It is no secret that anytime there is a mass immunization or birth control program, there

---

[1]The local Religious Affairs Office.

are always abusive practices in its implementation. There is no careful taking of data by responsible staff. The staffs are under pressure to reach their targets and seem only to care about that. They do not care about giving women, as the main participants of the program, clear information. They certainly have no motive to provide health education for women. Rukhayah questioned her TT injection as follows,

> I had TT injections in the village meeting hall. Is it true that the injection can cause infertility? How can immunization cause infertility? [I asked my friend about that, and she said,] "I do not know. People said like that." Well, I did it already. I was afraid of the effect with the fact that I still had my periods after I married. Was the immunization really having that effect? Nothing I can do but pray. Every time I got my period, (I said to myself) perhaps, God thought the time had not come. (Rk/I/10)

The materials I have cited here suggest that the professionals and authorities tend to objectify women and take advantage of them in every sphere of childbirth. The professionals have created circumstances where women learn not to be confident or to count on their ability to take care of themselves and to be able to cope with every problem that arises during their pregnancy and labour. Women become dependent on the professionals and their authority for their safety to bear and to deliver their baby. At the same time women become a market for both the professionals and the authorities. This also implies that childbirth is not only a natural phenomenon, but also a medical and economic one (Treichler, 2000).

Women, the Husbands, Friends and Families

Women's families and friends play important roles during the pregnancy and after

delivery. From the beginning of the pregnancy, women turn to those people for advice about their new condition.

> If I felt something new about my pregnancy, I told my mother, my mother-in-law, my relatives... (Hr/I/5)

> I received a lot of advice from my mother, my friends, therefore I am more ready. They said that the presence of a child in a family will bring joy, if the child is not present, the family will be lonely. (N/II/2)

> My friends often gave me advice such as taking care of my condition. Anything that we got in the class they reminded me about... (Hn/I/11)

The role of women's family and friends can be very supportive to women. The presence of their husband, close friends or families in labour, for example, proved to be very supportive to the women.

> Even though the midwife cannot be with me all the time during the labour, I was not afraid, because I had somebody else with me in labour. (S/II/2)

The most important person involved in pregnancy and delivery is the woman's husband. Some women see their husbands as someone who is more religious, and therefore see their husbands as a spiritual advisor.

> My husband has better knowledge about religious matters than I do. He supports me spiritually and gives me inputs on that matter. He knows better about that. (Hn/I/9)

Most women in the study said that their husbands are the first people that they inform about their pregnancy. The husband is also the person who is expected to accompany them for the regular visits and to be present in labour. For Rukhayah, a husband is a partner to learn about pregnancy and delivery.

> I always talk about everything that I heard (about pregnancy and delivery) with my husband; we discuss and analyze it together. We both learn together...(Rk/II/11)

Besides discussing pregnancy and delivery with his wife, Rukhayah's husband also learnt about pregnancy from a book.

> I learn from a book, what do I have to prepare beforehand, so that there will not be anything left to do in labour.(Rk-I/I/21)

Some women feel that their husbands are more worried about the pregnancy than they are.

> My husband always reminds me to visit the midwife. He seemed more worried about my condition than I did.... I think he has been preparing himself like I am doing now. (N/I/6)

> My husband was the one who worried most. He asked me to go to the midwife so many times, but I said that the time had not come yet. Be calm...(Rk/II/2)

Some husbands experience *'couvades'* like Rukhayah's husband.. Couvade (English: to hatch) is a term that refers to both pre- and postnatal behaviour that experientially links the father to the pregnancy (Davis-Floyd, 1996). The husband may show symptoms, like morning sickness, weight gain, and when his wife goes to labour he may complain of abdominal pain.

> ... Sometimes, both of us (my husband and I) cannot work, if I feel the pain, my husband can feel it, too. Therefore, both of us cannot work.... I am the one who is pregnant, but he is the one who gets the morning sickness...(Rk/I/15)

> My husband was called to come (because I was about to deliver the baby). He said that he had had a feeling about that as well. (Hn/II/2)

> My husband was feeling pain in his hip and dizziness, while I almost could not feel anything, either in my hip or my shoulders. Well...if any, it is a mild one. (S-N/II/4)

The husband's participation reaches a climax immediately after delivery. According to Javanese culture, a husband has responsibility to take care of his wife before she can do it herself. He has to take care of the vaginal wound and to bathe his wife as well to wash all dirty nappy and clothes.

> My husband washes the nappies and our clothes after the *Subuh* [morning] prayer. Then he cleans up himself and goes to work, everyday up to now. He is worried that I will not be able to do it while taking care of the baby. (Hn/II/10)

> My husband washed the dress and the *jarik* that I used in labour. He was sick to smell the blood. Actually, the midwife offered him that service, but my husband wanted to do it by himself... (Rk/II/7)

> Before I was discharged from the hospital, my husband was taught by the nurse how to clean up the wound. (Hn/II/9)

> My husband also helps me to put some remedies on my belly and he is the one who helps me to put on my *setagen*. (Hn/II/10)

> I am not allowed to do anything but to sit. My husband does all the cleaning up. I f I want to clean up my vagina, my mother in-law gives me *daun sirih*[2] water. (Rk/II/10)

A husband also has the responsibility to take care of the placenta. Some Javanese people believe that the placenta also has a relationship with the baby. The placenta is the baby's *baturan* [friend]. The treatment of the placenta will affect the wellness of the baby. My elder sister buried the placenta of her daughter next to the well. Some people believe that her daughter catches the cold easily because my sister's husband put the placenta in a cold place. Most women in the study believe that the best place for the placenta is in front of

---

[2]Kind of plant that has been proved as an antiseptic.

the house, so that the baby will become a leader someday because a leader always stands in front of her/his followers. The placenta is buried following certain rituals that a father described as follows,

> ...The placenta was washed up and put in a bowl made of terracotta. We put some flowers on it and then wrapped it with a white calico. We buried it. Then we cited *sholawat* [appraisal for the Prophet], *Syahadat* [Islamic confession], and *Al-Fatihah* [the first Surah in the Qur'an]. Then we called the baby's name and said "be quiet, baby, please don't cry easily, don't be fussy, don't be indifferent, don't say bad things, don't challenge your parents, your teachers or your relatives. Then we say, yes...yes...yes"(Rk-I/II/13)

From the placenta ritual we can see that the father wants to combine indigenous rituals with Islamic teaching. The use of flowers is part of Javanese indigenous culture. The Qur'an citations is a way to make the ceremony more Islamic. During the night, people put some lights at the place where the placenta was buried in order to keep the evil spirits away, which is now rationalized as being to keep animals away that might dig it out and eat it up.

Not every husband is supportive of his wife during the pregnancy. Harni told me in tears that she actually wanted to deliver her baby at her own mother's home, but her husband did not agree with that.

> I want to deliver my baby at my mother's house, but my husband does not allow me to do that because it will make difficulties for him because he has to go here and there (between his mother's house and my mother's house). (Hr/I/9)

Her husband's reason is supported by her mother-in-law.

> It is no different whether Harni delivers her baby here or there (in her own mother's place). I feel sorry for her husband because he has to go here and

> there. If my son lives with his parent-in-law, therefore, there will not have anybody take care of me because my husband is old. It will be very difficult for me if my son is leaving. (Hr/I/9)

Harni's mother-in-law lives with three of her daughters and their families next door. Therefore, there should be no reason not to do, as Harni wanted.

Some husbands feel that having children will restrict their wives to their homes. Women can become the captive of their children, but only a few women realize that.

> ...My husband said that he is more comfortable leaving me at home (after having a child) because I have already had a friend (my child), therefore I will not go anywhere. My husband said that if I go for walk, automatically, I will take my son with me, hence I will not look at other men. (S/II/4)

> ... My husband wants a wife who will stay at home to educate his children. He does not want a workingwoman as his wife. If he marries a workingwoman, the children will be disobedient and will not receive a good education. I do not mind to stay at home after I have a child. I love to do that. I do not want to work outside the house. I never go outside alone after I married, not even to go to a grocery. My husband does not allow me to do that. He is afraid that I will hear something bad from the neighbourhood. I follow what he said. If he said I cannot do it, I will not do it.... **[Do you want to go outside and get involved with your neighbourhood?]** Yes, I do. But I want to receive a reward from God for being obedient to my husband. Besides that, I have responsibility to carry his and his family's good name.... (Hr/II/11)

> My husband allows me to go back to work with one condition that my child should be breastfed in his first two years. If not, he will not give his approval. It is fine for me to stay at home for two years. Afterwards, I can work (outside the house) again as long as I do not forget my obligation as a mother. (Rl/II/14)

Sometimes husbands use their religious knowledge to legitimise their control over their wives and take to advantage of them by stressing on women's main task as a child educator and carer. Such men define child caring and education as women's natural role

following their biological destiny as child bearers.

A women's mother usually helps her to take care of her newborn baby right after the delivery. Even though it is unusual, a new grandfather also sometimes takes part in taking care of the newborn baby during the postpartum period. Henny said that her father played an important role in teaching her how to mother.

> I began to try to take care of my baby after my mother was sick. My father helped me to do that. Suprisingly, my father was more expert than me. He had experience because he had to take care of his two younger siblings when he was child. (Hn/II/12)

Women need the involvement of other people whose opinion they respect during the pregnancy and childbirth. Some of these people go too far and their involvement becomes a form of control, by insisting that the women do everything (prescribed behaviours and diets) that they are expected to do. They also try to control women's feelings during the pregnancy. Under their influence, pregnancy and delivery can be presented as a good state for women rather than something that brings ambivalent feelings. Women's families do not expect women to show their negative feelings about pregnancy and delivery.

> If I tell you that I am getting bored with the pregnancy you will think that I do not accept this pregnancy. (Rk/I/16)

> I used to complain because my body was not beautiful anymore. I used to be unconfident to put on the clothes. But my husband said that I had to enjoy the physical and psychological changes during the pregnancy. Later, I was able to do it. Let's say that to be pregnant is to have a special responsibility. We can do everything what we want to do, as long it does not endanger the baby. Even though people said that labour is going to be painful, I would say 'No, I am going to enjoy the pain.' Therefore, I had the confidence to face the labour because my husband already said that. The same things happened after delivery. Even though it is not comfortable to walk around and to sleep in a particular position, in which I cannot move

> freely except lying on my side, my mother said "You can bear the nine-months, how couldn't you bear the forty-days?" Finally, after forty-days I can feel free and relieved... I am so happy. (Rl/II/12)

It is Harni who expressed her negative feelings of the experience most clearly.

> Being pregnant is difficult... I feel overloaded and cannot move freely. Delivery is painful. I do not want to have another child. *Kapok* (a feeling of giving up). (Hn/II/7)

Women's interactions with their relatives confirm the social dimension of pregnancy. Thus pregnancy has natural (religious), medical, economical, and social aspects. There are so many other dimensions of pregnancy along with the development of human beings. The various dimensions of the experience of pregnancy and delivery have created various meanings of the experiences for each woman.

Creating the Meaning

The women in the study gave their meaning of pregnancy and delivery as follows. First, pregnancy and delivery are perceived as a transition to a new state as a parent within which women should learn to fulfil their new responsibilities (Oakley, 1980).

> It is like going to school again. We are looking for an experience for the future, how to do for the next child. (S/II/9)

> If we want to have a child we have to go through it all (we have to take all the consequences of having that wish). I want to raise my child in my own way. It is by trial and error. [Even though it is uncomfortable and painful, all the consequences of] pregnancy and childbirth have to be gone through. It is an effort, not a barrier or something that is [pause]. It is something that we have to go through if we want to make our wish come true. I hope this child will be able to learn from that. (Rk/II/14)

> My husband and I realized that having children means a new responsibility as parents and the family. (N/II/11)

> I see that, currently, a lot of children are not good to their parents. I can see it when I accompanied my wife in labour; I went out with tears, hot and cold, "Oh, God... How children could not be good to their parents. I saw my wife was struggling. We both felt the pain and did not sleep all night long." (Rk-I/II/15-b)

Second, pregnancy also means giving up a job or rearranging women's activities outside the house to be synchronized with the tasks of motherhood.

> My feeling is, I am still not ready for a baby. How could I have a baby while I cannot do this or that? I had a plan that after I got married I would have a chance to go back to work. My boss said like that, too. I feel much occupied after having a child. I have not had good feelings about having a child [pause] but, I still love my child. I just do not want a child for a while.
> **Do you want to say that you do not like the workload and the consequences after having a child?**
> Yes, you are right. I am very busy right now. I am no longer active in the organization.[3] I am very tired. I always feel I am being interrupted. Having a child means we cannot go anywhere. If my husband has to go outside for a business, I have to stay [because of this child]. I used to go with him in the past. (N/II/11)

> I had a wish that someday if I am pregnant I want to keep my job (as a dressmaker), because it is my soul. I want to keep myself active... I might be pregnant but I do not want my routine to be broken by the condition (that I am pregnant). But, it is just impossible. (Rk/I/15)

> I have been thinking how to coordinate my task as a mother and my job outside the house. I will be back to Jakarta with my child. Who is going to take care of my child when I am working outside the house? I can have a baby sitter to do it, but I cannot wholly trust other people to take care of my baby. I have not asked my husband the solution. Perhaps, it will be better if I quit from the job; it is up to him (my husband). No matter how busy we are, it is better if we take care of our child ourselves. (Rl/II/10)

---

[3]Nurhayati is involved in a local youth organization under one of the Indonesian parties.

If women have to choose between their paid jobs and mothering their child, they usually choose the second option, because society believes that to mother is a woman's primary task.

Oakley (1980) explains that pregnancy and delivery tend to confirm women's femininity. For Rully, pregnancy and delivery had so much influence that they changed her personality as a woman.

> I used not to listen to what people said and to be tomboy in the past, now, after I have a husband and a child I learn to behave like a woman. I try to be more feminine. My husband always reminds me that it is not good for a woman to behave like a man. I have to realize my nature as a woman...I never talk too loud again because it is embarrassing for a woman with a child. My husband said that my motherly attitudes have been developed. I hope all my bad attitudes and behaviours will be gone. I try not to get angry easily everyday, I try to keep smiling even though my baby does not want to stop crying. He really is able to bring happiness for life, moreover my wish has been answered; I wanted a boy, God gives me a boy. (Rl/II/13)

Third, the religious dimension of pregnancy and delivery has moved women as well as their husbands to be closer to God. The fatalist perception of God as superior, in some ways has decreased women's appreciation of their active participation in pregnancy and delivery. They do not have an appreciation of themselves.

> I am not proud of myself because I can have a child. It is an arrogant feeling. A child for me is more as an *'amanah* [mandate], ' Thank God... who has given us a child. So, we have to strive how to keep this responsibility. I am not even proud that I can give my husband happiness. Because, happiness does not come from people who are giving, it lies in the people who are feeling. If we are able to thank God for everything that we have had, we are happy. (Rk/II/15-a)

People must strive to create a better condition for her/himself; God is the one who defines the result. God does not forbid anybody to appreciate her/himself, because it is a way for someone to have appreciation of others.

All these things make pregnancy and delivery a time for both the man and woman to contemplate their past and future lives. Henny realizes that she was wrong to have sex before she married and feels guilty that she had disappointed her God. She feels that all the bad feelings and bad things that happen to her were caused by her fault. She does not want the same things to happen to her child (Hn/II/SoT).

Rukhayah felt that her son is a part of God's heavenly magic.

> I can feel that my son is special. He brings magic from heaven. When I was pregnant, I never bought any fruit because there was always somebody who brought them to me. I wanted some milk; a friend of mine came with some fresh milk from her own cow. When he was delivered a lot of people came, including those who hated me. Since his life in the womb, he has brought goodness with him. (Rk/II/16)

In conclusion, the interaction between women and their close relatives and the proffessionals during pregnancy and childbirth shows the society's expectation of what a woman should be. Childbirth is not only to deliver a child but also to deliver a woman: a woman who will become the object of control. As an object of control, women have to be silent and obedient. No matter what kind of controls women have during the pregnancy and childbirth they should be silent and obedient to the control. As an object, they are not encouraged to participate actively in their own pregnancy and labour. Most professionals, as well as their close relatives see that the women do not know anything about their new status as mothers to be and, later, as new mother. Therefore they think that women should

be dependent on others. Making women so dependent on others has decreased their role in pregnancy. Therefore the meaning of childbirth is more socially created than individually created.

Chapter 7

The Conclusion

I will open this concluding chapter by briefly summarising the arguments I have made in this thesis. In the beginning of the thesis I discussed about the change in my way of thinking about what women actually need regarding their maternal health during pregnancy and childbirth. I changed my perception from taking for granted that modern obstetric safeguard women's lives and that we should get rid the traditional beliefs and management of childbirth, into an awareness of the value of both approaches. In more traditional societies a cultural shifting happens in every sphere of human lives including its management of childbirth. In Indonesia it is clear that there is an evolution from traditional ways into modern obstetric management. Women as the subject of human reproduction are trapped between these two competing ways. The ignorance of women as the main actors in the process of reproduction and the ignorance of their spirituality and the culture that they live in have disadvantaged women and even endangered their lives. It is necessary to see women's reproductive function, in this case childbirth, in more holistic ways instead of taking as a merely natural or medical phenomenon. In this thesis, I am interested to find out the nature of the knowledge that women learn and rely on during pregnancy and childbirth that is imparted by their society and culture, and how this knowledge develops their perception about their experience of childbirth and about their position in society. Within this context I have argued that the knowledge that they receive during pregnancy and childbirth carries the society's ideology about women. The ideology about women that women learn will then influence their understanding of the

meaning of childbirth and their position in society.

This study is based on a feminist theoretical background. Feminists view women's reproductive function as both liberating and oppressing to women. Feminists agree that it is not women's biological destiny that is oppressive to women but the socio-cultural situation that gives men more privileges and causes childbirth to become oppressive to women. There are many feminist theories about reproduction but I have only considered those that fit with the actual women's live. Non-Western feminists found that Western Feminist theories are difficult to ground in their real lives due to the differences in their socio-cultural background. Through a process of selection, Non-Western Feminists will be able to formulate new theory(ies) that are appropriate to their real condition. The local ideology and beliefs (including religion) are important to consider when we are constructing a theory that is acceptable and applicable to the lived lives of Indonesian women.

This intersection of Western feminist theories, Indonesian culture (in this case Javanese) and Islam became my point of view to work on this study. Working with feminist theories in a world where feminist ideology is still contentious is not easy. While carrying out my fieldwork I never called my study a feminist study even though I use feminist theories as a framework for my thinking and seeing the problem, and work within a feminist methodological framework. Several participants asked me what I am going to do with the data after I collected it. I feel that I was not completely honest as a researcher by not telling the participants that I am going to work in a feminist framework. I explained to them that I would accommodate their opinions and give them my personal

account in a woman's way with the language that is easy for women to understand. I hope that other women will be able to learn from their experience and accounts if I never mention about feminism or call myself a feminist. Partly, I did that to avoid my participants' resistance to feminism, which has a negative connotation to them. For me, it is an opportunity to fix the stereotype with a gentle approach to women by not labeling myself and the study as feminist. Another reason is to avoid trouble with the difficult terms. Some women may not understand the word feminist and what feminism is all about. I do not want to load them with something that might be confusing. What is in the name, anyway?

In my methodology chapter (Chapter III) I discuss how patriarchal culture has used men's language of childbirth by expressing it in difficult medical terms and this has disadvantaged and confused women in some ways. It has also distanced them from their experience of childbirth. It needs an alternative study in understanding women's experience, based on the fact that women have been marginalized and ignored in most academic studies. A comprehensive understanding of women's experience from the voice of women is needed because women will speak differently in their own language. A case study on women will be able to probe women's lives, and this is especially necessary for women who live in the non-Western world. Understanding women as individuals will enable us to know women better because each woman will be free to give their own opinion about her own experience. I found a case study with in depth interviews were the best way to carry out a study with Indonesian women, especially because they tend to be shy and silent.

As a novice researcher, I found a lot of difficulties in practice, for example, how to get closer with women during the interview so that they will trust me to listen to everything that they are feeling about the problem and how to get a conducive conversation which will encourage them to tell me their true feelings. I found my first interviews with women were very formal and I could feel the gap between us, a researcher and her participants, which I did not expect. To break the gap down I made some visits outside the interviews and I brought my daughter Arra with me. As long as I feel the gap is gone and we get closer each other I set the second interview. To get closer with the participants is needed in the study of Indonesian women. It might also be helpful if I did it before the recruitment of the participants.

In Chapter IV I focus on understanding women's socio-cultural background. I consider this is important to the success of the study. The Indonesian culture, which is the background of these participants, is a complex mixture of the Javanese culture and spirituality about childbirth, the Islamic beliefs and the modern obstetrics. This cultural and ideological mix became a primary focus for me as I dug deeper into my study. The fact that Indonesian childbirth is changing from the traditional way of managing childbirth to modern obstetric management shows that women's understanding about the process is also changing. A careful insight and comprehensive knowledge of the women's situation is needed in order to suggest different approaches to the problems and to create better alternatives for women.

In this concluding section, I want to return to a key theme of this thesis – how and what women learn when they become mothers- which also became the main focus for my

discussion in chapter 5 and 6. Women learn about pregnancy and childbirth from their close relatives and from professionals. The relatives that women turn to are not always women but also men. Women learn to mother from other women, - it could be their mother, their relatives, their neighbours or friends. They might see other women's experience of being pregnant and taking care of their children while some of them might have already experienced mothering their own siblings or niece/nephews since their childhood, although to mother one's own child is always more challenging.

Women also learn to mother from men. While some men experience taking care of their siblings during their childhood, it is not this practical information that is important but rather it is from men that women learn most about their new identity as 'mothers'. Husbands are the first people that women think they need to inform regarding their pregnancy. The limited knowledge that husbands have about the experience has limited their role as advisors. Meanwhile, the grandmothers move in to take their place. Some husbands still show their support by accompanying their wife to visit professionals. Women share their experience of pregnancy with many people: husbands, relatives, neighbours, friends and professionals, from all of whom they receive a lot of information.

From their relatives, both men and women, expectant mothers learn about the social and cultural dimensions of pregnancy and delivery. From the professionals, women learn about the biomedical dimension of pregnancy and delivery. Biomedical is seen as identical with modernity, technological invention, and capitalism. When women learn about the biomedical dimensions of pregnancy from the professionals, they are learning about their bodies and how it can be controlled with technological inventions. At

this point, women are learning about an economic dimension of pregnancy and delivery, as well as technological mastery.

The nature of knowledge that women learn from others can be divided in two categories: practical and ideological. When women learn how to take care of their pregnancy, such as how to prevent miscarriage, how to produce a 'perfect' baby, how to cope with labour pain and difficulties, as well as how to keep themselves healthy and beautiful after delivery, they learn the practical things about their experience. When women learn why women should keep their pregnancy, what characteristics belong to a 'perfect' baby, what is considered a successful labour and why women have to keep beautiful and healthy after delivery, women learn the ideological parts of motherhood. The practical and the ideological aspects of motherhood cannot be separated one from the other because the practical is the reflection of society's ideology in daily practices of the life of society. Thus, women learn while doing it.

When women desire to have a child, their desires are much influenced by the social, cultural and religious beliefs that they rely on. When the society views a child as a must in a marriage, women learn that first, they have to have a child someday; and second, they must get a child within a marriage. If they cannot fulfil both, they will receive social sanctions. If they can, they have to be thankful for that because they are considered as fulfilling the expectations of their role as women.. Women cannot refuse to have children, nor even to postpone the time because their society believes that having a child will give them and their families many advantages. Therefore, women view the presence of a child as necessary. It means that if they have a child one of their needs is

fulfilled. That is why women learn to view pregnancy and childbirth as a good state for them rather than an experience that is ambivalent in meaning. The fact that pregnancy is also biological experience, as well as a religious requirement, has caused women to fail to recognise their own ambivalent feelings.

Entering the state of pregnancy, women also enter their new status as a mother. Soon after they tell other people about their new condition, women must open up their private experience of pregnancy to become a social experience. Women will then receive a lot of advice about pregnancy and their preparation as a new mother. The information varies according to where it comes from. Women have a right to decide which information they want to rely on, even though at times they seem to lose this right. There are many reasons for this. When they deal with the elderly, for example, women will give up their rights because of the seniority that the elderly have in Javanese culture. The elderly in Javanese culture have great authority and respect. When they provide advice (even if that advice is sometimes wrong) women defer to their authority over their own 'rights' to decide about their lives.

Since their childhood, women learn that they are inferior to men. Many women do not feel confident to take any decisions regarding their lives, including their pregnancies. On the other hand men feel that they are superior, and thus are overconfident when they take control over women. It is the husband or male relatives who have the decision-making authority over decisions regarding her pregnancy, and, more generally, over decisions regarding any of her reproductive functions. Women also defer to people with higher formal education. There is an intellectual gap between the professionals and the

women that makes it difficult for most women to have good interaction with them. The attitude of the professionals has prevented a knowledge transfer between them and this keeps women in a state of ignorance, which makes them vulnerable to several abuses, such as becoming the object of unnecessary, and possibly dangerous, medical procedures.

During their pregnancy and delivery, women also learn about their cultural traditions. The traditional ceremonies around childbirth are full of symbols that contain meanings and are dedicated to the wellness of the baby and the mother to be, but they also carry many loaded ideological messages about the role of women. Even though neither the women nor their families really believe in the correlation between the rites and the wellness of the baby and the mother to be, they still carry out a version of the rites. From this tradition, women learn that there is a "Superior Being" above them as humans. The childbirth rites are changing to reflect the changing of culture and society. When the society is more religious, childbirth ceremonies are adapted to women's religiosity. When the society is more modern, modern obstetrics procedures become the new rites for expectant mothers. The use of modern pregnancy tests, going to the professionals for pregnancy examination and labour, taking artificial vitamins and supplements are parts of the modern childbirth rites. Women do not question the capitalist practices behind the modern childbirth rites that benefited the professionals because the professionals act as if they are the unquestionable authorities, in the same way that the traditional ceremonies were not questioned. At a time when society and culture are changing rapidly, women learn to deal with all the changes. The fact that the information appears in various guises might create tensions for women, or, as I would

suggest, it might enable the women to have more choice in the management of their pregnancies.

During the period of their pregnancy and delivery women also learn about their feminine capacities. Being pregnant has confirmed their difference from men. It confirms their womanliness. Women might be tomboys before they are pregnant, but soon after they realize they are pregnant condition, their feelings about being *women* is gets stronger. They learn about being a woman from the society and society also convinces them that they can, and have to learn to become a woman.

This study finds that the lack of knowledge about pregnancy and childbirth is an *invitation* for other people to invade the woman's body. It is crucial to provide complete information about pregnancy and childbirth to women so as to create a supportive environment for women and provide them with real opportunities to make meaningful choices. Living in a period of cultural upheaval provides the women with different kinds of information (traditional and modern pregnancy management). A fair explanation of both methods is needed for women to be able to make the right choices for themselves in full consciousness. The professionals and the government as health care providers, as well as the woman's family are expected to share their knowledge with women and support them. The professionals should be active in giving information to women and should be more appreciative of women as having authority over their own bodies. In giving biomedical information to women or taking a procedure, the professionals should accommodate women's individual backgrounds and not hide any information from women, especially about procedures that might be hazardous to the women or their

babies. The professionals should improve their services by changing their attitude to be friendlier to women so that women will not have a traumatic experience when they visit the professionals, but instead will be able to trust them with her health. As health care providers, the professionals and the government should have humanity as their priority rather than economic benefit. Meanwhile, women's relatives also have to be open to other kinds of knowledge besides the knowledge that they already posses. Together with the pregnant women they should learn and update their knowledge of childbirth. When the women are sufficiently knowledgeable, they should be able to make good decisions about their experience of childbirth because it is the women who experience the changes and know about what is going on in their own bodies.

I do not see the need to set up another program for maternal health. I would rather expect that we could improve the posyandu to be as effective as possible. They could become a place for women to receive their knowledge by using *posyandu* as a women's support group, like the breastfeeding support group in St John's Canada. In this group women do not need to bother with the official thing but to share their experience in pregnancy and taking care of their babies. Women can learn together the knowledge that they need from the books provided or from the nurse or health-trained volunteer in charge to supervise the mothers and to act as the women's sister or friend.

This study is very limited, and a more extensive study might discover other aspects of what women learn from childbirth. My range of participants was limited (in economic status and educational background) as well as in numbers. I believe that women are complex beings and childbirth is such a broad topic that it cannot be squeezed

into just one study of childbirth. Indonesia is a complex society with hundreds of distinct ethnic groups, so I cannot say that my study covers all Indonesian women. To have a complete understanding of Indonesian women, we need to carry out studies of other women from different ethnic backgrounds. This study is also limited to a discussion of married and heterosexual women even though the topic of childbirth is also important for all women. The account of childless women should also be included to give a complete picture of women's experience. However, I also believe that even with its limitations, this study is able to contribute in acknowledging women's problems regarding their experience of childbirth, and to suggest what is still needed to explore to create a better supportive environment to women.

We still need further studies of traditional and modern childbirth management as well as the way that cultural notions of childbirth are changing, the tensions between traditional views and modernity, the attitudes of professionals to their patients, the quality of services delivered by health care providers, as well as the sharing authority and power during pregnancy and childbirth.

Throughout this thesis I have tried to integrate my own experience of childbirth and motherhood with both the theoretical literature and with what I learned from my participants. In pointing the way forward to further work, I want to situate it in my some of my own experiences of trying to combine motherhood and research.

The most difficult part in carrying out this study was how to integrate my personal life with academic requirements. I found that trying to combine my roles as a mother and a student was difficult, if not impossible. I tried to adjust my academic

schedule to coincide with my personal life. But my second pregnancy was not planned. While that had its good side, it did slow down the research. I was also bothered with financial difficulties and the fact that my husband and I do not have our own house. I had to live separated from him, which meant there was nobody who was able to fix my old computer when there were problems and nobody was there to share childrearing. It happened too many times that I was too tired to study at night after a long day with children and did not have enough money to employ a maid. My husband was home only during the weekends, and that was the only time I could go to meet my participants, because there was somebody who was taking care of my children while I was away. But, many times he was too tired to do that after working for 9AM to 9PM for 5 days and travelling 170 kilometres by bus to come home. During this time I lived with my mother in Mede, but she is too old to take care of the children. I also did the chores, which were very exhausting. My live was so messy.

The fact that we do not have a house in Surabaya meant that I had to travel back and forth to Surabaya for renewing my government approval or for family business, and it caused difficulties in doing the interviews with the midwives.

This is one example of how the problems of childcare make the difficulties of fieldwork worse. It took a long time to see the *puskesmas* midwife because as a government officer she had a lot of public tasks to do (remember that fulfilling the task is very important for them to get points for their professional careers). In my first visit to the *puskesmas* to interview the *puskesmas* midwife, I could not meet her because she did the training for village midwives in the area for a week. The next week, she was off

because her son was sent to the hospital because of an accident. I did not think it was a wise idea to interview her at that time. The interview with another midwife ends up with the same kind of problem. I had to come to her house that is also her private practice three times, but I had never met her. Once I came on Saturday evening,[1] and she said that Saturday is not a good day. She did not look pleased with my coming at that time. So, we set an appointment for Monday evening. I came on Monday evening but she was not at home. The girl who met me said that she was away for couple days, so I came a week after but still could not see her. I knew she was avoiding me, but I really wanted to make her understand about the study clearer. So, that was why I kept trying before I gave up and decided to take a research assistant.

After almost two years my husband's salary increased and we were able to move to Surabaya, the city where he works. His friend lent his house for us to live in while he was doing his master's degree in Japan. We could employ a maid to help me with the domestic work. But it seemed that I was not so lucky because I later found that that maid was stealing money and using my phone without telling me first. The next maid was lazy and not very kind and patient to my children, so I decided not to use her. The last maid was very good one. I felt that I could trust her with the work and the children, but one day she went home and her parents did not allow her to go back to work. Most of my thesis was done while they were working with me. So, it is unfair not to thank them for

---

[1]In Mede, Saturday is also a working day for government offices, but usually a day off for professionals' private practices. I chose Saturday evening with the expectation that she did not have patients to take care of so that she would not be too tired to do the interview.

replacing me in doing domestic work.

Another annoying factor was the fact that I had a bad connection to the Internet while living in the Mede. The Internet staff who dealt with this problem said that I needed to buy their modem. I did not think that was the right solution because I never had any problem with the same modem if I used it in Bangkalan, my mother-in-law's house. It seems that capitalism has been everywhere. I expected that I would be able to search a lot of papers and journals related to the topic of childbirth from the Internet since it had been difficult for me to have access to up-to-date literature. I had to travel about 200 kilometres away to find a good library of the closest state university and that was difficult and tiresome to do it with two small children and, of course, very costly.

Now that my children are bigger, I can manage my life better. I can trust Arra to take care of and play with her little brother, Marvel. I used to be angry at her every time if I was very tired with the workload, or I failed to reach the target to have at least a paragraph a day of my thesis, or to find out that my husband was got sick during the weekends (the best time to work on my thesis), or to find that if he was already recovered, it was my children's turn to get sick. I am often watching her during her sleep or giving her a lot of kisses to make up for the anger that I had addressed during the day with tears. I apologize to my supervisor and my co supervisor that I have been working very slowly with this thesis. I have learnt so much from my experience that, in the mean time, women can be both a good mother and a good student at the same time. I can learn many things from what happened during the past two years. My daughter has taught me to reconsider, to put the choices in a hierarchy of priorities that puts my children first.

May she forgive me and I hope that we both are able to learn from our experience as women. May the women of the future generations learn that motherhood needs good planning with a lot of consideration about marriage and childbirth if they are to make genuine choices to fulfil themselves and not simply fulfil society's expectations of them.

References

Adrina, et al. (!998). Hak-hak Reproduksi Perempuan yang Terpasung. Jakarta. Pustaka Sinar Harapan.

Andriyani, N. (1999). *Taking Development in Our Hands: a Reflection on Indonesian Women's Experience.* In Porter, M. et al. (1999). Feminists doing Development: a Practical Critique. London. Zed Books.

Anshor, M. (2004). *Perlu Fikih Alternatif: Untuk penguatan Hak Kesehatan Reproduksi.* In KOMPAS. Senin, 2 Februari 2004. p.28.

Aprianti, Y. (2002). *Berkunjung ke Desa Siaga: Setiap Warga Siap Antar Ibu Hamil.* NOVA. 739/XV/28 April 2002. p.6.

Aripurnami, S. (1999). Hak Reproduktif antara Kontrol dan Perlawanan. Jakarta. Kalyanamitra.

Barr, J. et al. (1998). Women, Science, and Knowledge. Bloomington. Indiana University Press.

Bratawidjaya, T. (2000). Upacara Tradisional Masyarakat Jawa. Jakarta. Pustaka Sinar Harapan.).

Bulbeck, C. (1998). Re-Orienting Western Feminism: Women's Diversity in a Post-Colonial World. New York. Cambridge University Press.

Burgess, R. (1984). In the Field: An Introduction to Field Research. Boston. George Ellen and WINN.

Canadian Research Institute for the Advancement of Women (1996). Feminist Research Ethics: A Process. Ottawa. CRIAW/ICREF.

Chodorrow, N. (1978). The Reproduction of Mothering: Psychoanalysis and the Sociology of Gender. Berkeley. University of California Press.

Cholil, A. et al. (eds). (1998). The Life Safer: The mothe Friendly Movement in Indonesia. Jakarta. The State Ministry for the Role of Women Republic of Indonesia and the Ford Foundation.

Davis-Floyd, R. (1992). Birth as an American Rite of Passage. Berkeley. University of California Press.

Davis-Floyd, R. (1994a). *Culture and Birth: The Technocratic Imperative*. International Journal of Childbirth education, (1994) 9(2), p. 6-7.

Davis-Floyd, R. (1994b). *The Technocraic Body: American Childbirth as Cultural Expression*. Social Science and Medicine, (1994). 38(8), p. 1125-1140.

Davis-Floyd, R. (1994c). *The rituals of American Hospital Birth.* In McCurdy, D. (ed). (1994). Conformity and Conflict: Readings in Cultural Anthroppology. New York. Harper Collins.

Davis-Floyd, R. (1996a). *Dictionary Entry on Childbirth.* In Barfield, ed. (1996). Blackwell Dictionary of Anthropology. Oxford. Blackwell Publisher.

Davis-Floyd, R. et al. (1996b). *Entry on Pregnancy.* In Encyclopaedia of Cultural Anthropology. New Heaven CT. Human Relation Area Files.

Davis-Floyd, R. et al. (1997) Childbirth and Authoritative Knowledge: Cross-Cultural Perspective. Berkeley. University of California Press.

Davis-Floyd, R. (1998). *From Technobirth to Cyborg Babies*. In Davis-Floyd et al. Cyborg Babies: From Techno-sex to Techno-Tots. (1998). New York. Routledge. P. 255-284.

Departemen Kesehatan dan Kesejahteraan Sosial Republik Indonesia. (2000). Profil Kesehatan Indonesia 2000. Jakarta. Pusat Data dan Informasi Kesehatan.

Ediastuti, E. et al. (1995). Fertilitas dan Aktivitas Wanita Pedesaan. Yogyakarta. Pusat Penelitian Kependudukan Universitas Gadjah Mada.

Fauzi, A. et al,. (eds). (2001). Jender dan Kesehatan: Kumpulan Artikel. Jakarta. Pusat Komunikasi Kesehatan Bersperspektif Jender and Ford Foundation.

Foucault, M. (1980). Power/Knowledge: Selected Interviews and Other Writings 1972-1977. New York. Pantheon Books.

Fox, N. (1994). Postmodernism, Sociology and Health. Toronto. University of Toronto Press.

Gunawan. (2001). *Pelayanan Kesehatn Reprouksi: Tradisional vs Modern.* In Sketsa Kesehatn Reproduksi Perempuan Desa. Malang. Yayasan pengembangan Pedesaan and Ford Foundation.

Hamel, J. et al. (1993). Case Study Method. London. Sage Publication.

Hardjowirogo, M. (1980). Adat istiadat Jawa: Sedari Seseorang Masih Dalam Kandungan Hingga Sesudah Tiada Lagi. Bandung. Patma.

Harris, O. et al. (1981). *Engendered Structures: Some Problems in the Analysis of Reproduction.* In Joel Kahn and Joseph Liobera (Eds.), The Anthropology of Pre-Capitalist Society. London. MacMillan Press.

Hardyastuti S. et al. (1994). Produksi dan Reproduksi: Study Kasus Pekerja Wanita pada Industri Rumah Tangga Pangan di Daerah Istimewa Yogyakarta. Yogyakarta. Pusat Penelitian Kependudukan Universitas Gadjah Mada.

Heckman, S. (1990). Gender and Knowledge: Elements of Postmodern Feminism. Oxford. Polity Press.

Ihromi, T.O. (1990). Para Ibu yang Berperan Tunggal dan Berperan Ganda: Laporan Penelitian/Kelompok Studi Wanita FISIP UI. Jakarta. Lembaga Penerbit Fakultas Ekonomi Universitas Indonesia.

Iswari, B. (2002). Melahirkan tidak Sesakit dulu lagi. INTISARI. Januari 2002. p.158-164.

Cukup Tinggi, Angka Kematian Ibu Melahirkan: Masih Banyak yang Percaya Dukun. JAWA POS. Rabu, 15 Mei 2002.

Jordan, B. (1983). Birth in Four cultures. Montreal. Eden Press.

Jordan, B. (1987). *The Hut and the Hospital: Information, Power and Symbolism in the Artifacts of Birth.* In BIRTH 14:1 March 1987. p.36-40.

Jordan, B. (1997). *Authoritative Knowledge and Its Construction.* In Davis-Floyd, R. et al. (1997) Childbirth and Authoritative Knowledge: Cross-Cultural Perspective. Berkeley. University of California Press.

Kahn, R. (1995). Bearing Meaning: The Language of Birth. Urbana. University of Illinois Press.

Kitzinger, S. (1978). Women as Mothers. Glasgow. Fontana Books.

Kitzinger, S. (1979). Birth at Home. Oxford. Oxford University press.

Menyatukan Ilmu Sosial dan Medis demi Kesehatan. KOMPAS. Minggu, 27 Oktober 2002.p.22.

Laderman, C. (1983). Wives and Midwives: Childbirth and Nutrition in Rural Malaysia. Berkeley. University of California Press.

Lazarus, E. (1997). *What do Women Want?: Issues of choice, Control, and Class in American Pregnancy and Childbirth.* In Davis-Floyd, R. et al. (1997) Childbirth and Authoritative Knowledge: Cross-Cultural Perspective. Berkeley. University of California Press.

Lazarus, E. (1988). *Poor Women, Poor Outcomes: Social Class and Reproductive Health.* In Michaelson, K. (1988). Childbirth in america: Anthropological Perspective. Massachusetts. Bergin and Garvey Publisher Inc.

Lefeber, Y. (1998). Indigenous Customs in Childbirth and Child-Care. Assen. Van Gorcum.

MacCormack, C. (Ed.) (1982). Ethnography of Fertility and Birth. New York. Academic Press.

Manderson, L. (1998) *Shaping Reproduction: Maternity in Early Twentieth-Century Malaya.* In Ram, K. et al. (Eds.) (1998). Maternities and Modernities: Colonial and Postcolonial Experiences in Asia and the Pacific. Cambridge. Cambridge University Press.

Martin, E. (1987). The Woman in the Body: A Cultural Analysis of Reproduction. Boston. Beacon Press.

Mas'udi, M. (2000). Islam dan Hak-Hak Reproduksi Perempuan: Dialog Fiqih Pemberdayaan. Bandung. Mizan.

McCurdy, D. (Ed) (1994). Conformity and Conflict: Readings in Cultural Anthropology. New York. HarperCollins.

Megawangi, R. (1997) *Feminisme: Menindas Peran Ibu Rumah Tangga.* In Anshori, D. et al. (Ed) (1997) Membincangkan Feminisme: Refleksi Muslimah atas Peran Sosial Wanita. Bandung. Pustaka Hidayah.

Merriam, B. (1988) Case Study Research in Education: A Qualitative Approach. San Fransisco. Jossey-Bass Publisher.

Michaelson, K. (1988). Childbirth in america: Anthropological Perspective. Massachusetts. Bergin and Garvey Publisher Inc.

Mohamad, G. (2002). Eksotopi: Tentang Kekuasaan Tubuh dan Identitas. Jakarta. Graffiti Press.

Mohamad, K. (1998). Kontradiksi dalam Kesehatan Reproduksi. Jakarta. Pustaka Sinar Harapan, PT Citra Putra Bangsa and Ford Foundation.

Mohanty, C. (1991). *Under Western Eyes: Feminist Scholarship and Colonial Discourse.* In Mohanty, C. et al. eds. (1991) Third World Women and the Politics of Feminism. Indiana University Press.

Mulder, N. (1994). Individual and Society in Jawa: A Cultural Analysis. Yogyakarta. Gadjah Mada University Press.

Nicholson, P. (1993) Motherhood and Women's Lives. In Richardson, D. et al. (Ed.) Introducing Women's Studies. Hampshire. The MacMillan Press Ltd.

Niehof, A. (1992). *Mediating Roles of the Traditional Birth Attendant in Indonesia.* In Bammelen, S. et al. (eds). (1992). Women and Mediation in Indonesia. Leiden. KITLU Press.

Oakley, A. (1980). Women Confined: Towards a Sociology of Childbirth. Oxford. Martin Robertson & Co. Ltd.

Oakley, A. (1979) From Here to Maternity: Becoming a Mother. Middlesex. Penguin Books.

O'Brien, M. (1981). The Politics of Reproduction. Boston. Routledge.

O'Brien, M. (1989). Reproducing the World: Essay in Feminist Theory. San Fransisco. Westview Press.

Pierson, R. (Ed) (1993). Canadian Women's Issues. Toronto. J. Lorimer.

Pigg, S. (1997). *Authority in Translation: Finding, Knowing, Naming and Training "Traditional Birth Attendant" in Nepal.* In Davis-Floyd, R. et al. (1997). Childbirth and Authoritative Knowledge: Cross-Cultural Perspective. Berkeley. University of California Press.

Priya, J. (1992). Birth Tradition & Modern Pregnancy Care. Rockport. Element Books Ltd.

Poerwandari, K. (1998). Pendekatan Kualitatif dalam Penelitian Psikologi. Jakarta. Lembaga Pengembangan Sarana Pengukuran dan Pendidikan Psikologi (LPSP3) Fakultas Psikologi Universitas Indonesia.

Rabuzzi, K. (1994). Mother with Child: Transformation through Childbirth. Blomington. Indiana University Press.

Rachman, B. (1999). *Kesetaraan Jender dalam Islam: Persoalan ketegangan Hermeneutis.* In Sarapung, E. et al,. (1999) Agama dan Kesehatan reproduksi. Jakarta. Pustaka Sinar Harapan.

Ram, K. et al. (Eds.) (1998). Maternities and Modernities: Colonial and Postcolonial Experiences in Asia and the Pacific. Cambridge. Cambridge University Press.

Reinharz, S. (1992). Feminist Methods in Social Research. Oxford. Oxford University Press.

Ricklefs, M. (1990). *Islamization in Java.* In Ibrahim, A. et al. (eds). (1990). Readings on Islam in Southeast Asia. Singapore. Institute of Southeast Asian Studies.

Rich, A. (1976). Of Woman Born: Motherhood as Experience and Institution. New York. W.W. Norton Company.

Richardson, D. (1992). Women, Motherhood and Childrearing. London. Macmillan.

Rienks, A. et al. (1979). Pengamatan Anthropologis tentang Pembentukan dan Pelaksanaan Program Kader. Yogyakarta. Rural and Regional Studies Centre Gadjah Mada University.

Ritzer, G. (1996). Classical Sociological Theory. New York.The McGraw-Hill Company.

Ruzek, S. (1978). The Women's Health Movements: Feminist Alternative to Medical Control. New York. Praeger.

Sadli, S. et al,. (2001). Wanita di Indonesia: Ikhtisar Nasional. Proyek Kemitraan Masyarakat-Universitas dalam Study Wanita.

Saleh, F. (2001). Modern Trends in Islamic Theological Discourse in Twentieth Century Indonesia. Leiden. Brill.

Sargent, C. (1989). Maternity, Medicine, and Power: Reproductive Decision in Urban Benin. Berkeley. University of California Press.

Sawicky, J. (1991). Disciplining Foucault: Feminism Power and the Body. New York. Routledge.

Sciortino, R. (1995). Care-Takers of Cure: An Anthropological Study of Health Centre Nurses in Rural Central Java. Yogyakarta. Gajah Mada University Press.

Shanti, B. (2001). *Kuota Perempuan Parlemen: Jalan menuju Kesetaraan Politik.* In Jurnal Perempuan No.19. p.19-37. Jakarta. Yayasan Jurnal Perempuan.

Shilling, C. (1993). The Body and Social Theory. London. Sage Publication.

Singarimbun, M. (1994). Keluarga Berencana di Sriharjo. Yogyakarta. Pusat Penelitian Kependudukan Universitas Gadjah Mada.

Soedarsono, R.M. et al (1986) Nilai Anak dan Wanita dalam Masyarakat Jawa. Yogyakarta. Departemen pendidikan dan Kebudayaan Direktorat Jenderal Kebudayaan Proyek Penelitian dan Pengkajian Kebudayaan Nusantara, Bagian Jawa.

Sofwan, R. (2002). *Interelasi Nilai Jawa dan Islam dalam Aspek Kepercayaan dan Ritual.* In Amin, D. (Ed). (2002). Islam dan Kebudayaan Jawa. Yogyakarta. Gama Media.

Steward, D. et al. (Ed.) (1978) Safe Alternatives in Childbirth. Chapel Hill. Napsac Inc.

Stake, R. (1995). The Art of Case Study Research. London. Sage Publication.

Suratiyah, K. et al. (1990). Wanita Kerja dan Rumah Tangga: Pengaruh Pembangunan Pertanian terhadap Peranan Wanita Pedesaan di Daerah Istimewa Yogyakarta. Yogyakarta. Pusat Penelitian Kependudukan Universitas Gajah Mada.

Sukri, S. et al. (2001). Perempuan dan Seksualitas dalam Tradisi Jawa. Yogyakarta. Gama Media.

Sulistyowati. (2003). Perempuan di antara Berbagai Pilihan Hukum: Study mengenai Strategi Perempuan Batak Toba untuk Mendapatkan Akses kepada Harta Waris melalui Proses Penyelesaian sengketa. Jakarta. Yayasan Obor Indonesia.

Sumartana, TH. (2002). *Pergulatan Wacana Theologi Islam Abad 20.* In KOMPAS. 19 Oktober 2002.p.33.

Tan, M. (1997). *Kontekstualisasi Progresif: Pemahaman Determinan Non-Medis, Sosial-Budaya dan perilaku dari "Safer Motherhood".* In Raharjo, Y. et al,. eds. (1997). Lokakarya Nasional mengenai masalah pengukuran pencapaian Intervensi terfokus terhadap kesejahteraan Ibu dan Tumbuh Kembang Anak dalam Konteks Pembangunan Sumberdaya Manusia Indonesia. Jakarta. Puslitbang Kependudukan dan Ketenagakerjaan, Lembaga Ilmu Pengetahuan Indonesia, UNICEF and Biro Pusat Statistik.

The Boston Women's Health Book Collective. (1998) Our Bodies, Ourselves: For the New Century. New York. Simon & Schuster.

The Indonesian Ministry of Health (1996). Profil Kesehatan Indonesia. Jakarta. Pusat Data dan Informasi Kesehatan.

Treichler, P. (2000). Feminism, Medicine, and the Meaning of Childbirth. [On-line]. Available at: http://www.hsph.harvard.edu/rt21/medicalization/treichler-childbirth.html.

Trevathan, W. (1997). *An evolutionary Perspective on Authoritative Knowledge about Birth.* In Davis-Floyd, R. et al. (1997) Childbirth and Authoritative Knowledge: Cross-Cultural Perspective. Berkeley. University of California Press.

Tan, M. (1997). *Kontekstualisasi Progresif: Pemahaman Determinan Non-Medis, Sosial-Budaya dan Perilaku dari "Safer Motherhood."* In Raharjo, Rusman, and Yogaswara (Eds.), Lokakarya Nasional: Mengenai Masalah Pengukuran, Pencapaian Intervensi Terfokus Terhadap aakesejahteraan Ibu dan Tumbuh Kembang Anak dalam Konteks Pembangunan Sumberdaya Manusia Di Indonesia. Jakarta. Puslitbang kependudukan dan ketenagakerjaan-LIPI.

Tong, R. (1998). Feminist Thought: A More Comprehensive Introduction. Boulder. Westview Press.

United Nations (1998). Women in Indonesia: A Country Profile. New York. United Nations Publication.

Wiarsih, W. (2001). Empowerment as A Way To Improve Nutrition in Pregnancy in Waru Jaya, West Java Indonesia: An Action Research Study. A Master Thesis. St. John's. Memorial University of Newfoundland.

Wisnubroto, P. et al. (1994). Wanita, Kerajinan Bambu, dan Masyarakat: Study Kasus Jawa Timur. Yogyakarta. Pusat Penelitian Kependudukan Universitas Gadjah Mada.

Woodward, M. (1989). Islam in Java: Normative Piety and Mysticism in the Sultanate of Yogyakarta. Tucson. The University of Arizona.