

University of Hull

**Patterns of Breast-feeding Practice in Semarang,
Indonesia
Comparison between Women in
Peri-urban Area and Urban Area**

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by

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ABSTRACT

Like many women in other developing countries, Indonesian women face cultural and gender inequalities; and high rates of maternal mortality and malnutrition are prevalent amongst Indonesian women. UNICEF (2000) showed that an estimated 450 women in Indonesia die every 45 minutes because of complications during delivery, late referral to hospital or maternity services and poor treatment, as a result of poorly trained health staff, including midwives, and a lack of emergency facilities and transport. The economic crisis which hit Indonesia in 1997 has worsened these conditions. A study conducted by Helen Keller International showed that as a result of the crisis both iron deficiency and vitamin A deficiency were increasing amongst women and their children (Helen Keller International, 2000). Indonesia also still has many problems regarding infant malnutrition and infant mortality, although the child survival rate has been improving over the past two decades. UNICEF (2000) reported that 7 per cent of Indonesian children die before their fifth birthday.

According to WHO and UNICEF, breast-feeding is the best way to feed babies. In developing countries, breast-feeding has been the subject of rapidly growing interest, not just because breast milk is sterile and safe and beneficial to the health of children, but can also lower fertility. In Indonesia, an exclusive breast-feeding campaign was introduced more than 20 years ago. Although UNICEF reported that 95 to 97 per cent of Indonesian babies are initially breastfed, the 2004 Indonesian Demographic and Health Survey (IDHS) showed that the rates of bottle-feeding practice have increased sharply.

This thesis documents patterns of breast-feeding practice in Semarang, Indonesia, focusing upon Indonesian women living in peri-urban and urban areas in Semarang and their attitudes towards and practice of breast-feeding, and also examines the various factors which influence breast-feeding, such as health services, socio-economic factors and cultural values from within the community. Lintang village (a pseudonym), which is located 15km from the city centre of Semarang, is a developing industrial zone of Semarang, and is used to represent a peri-urban area. The city of Semarang is used to represent an urban area. The sample group in the peri-urban area included pregnant women, mothers with babies less than 2 years old, a few husbands and a small number of women of reproductive age. For the urban area, the sample group included pregnant women who were undergoing ante-natal care and mothers/breast-feeding women who were attending the mother/children health care centre at Melati Hospital (a pseudonym) in Semarang. A combination of qualitative and quantitative data collection methods were used in this research.

This research found that peri-urban and urban women had different attitudes towards ante and post-natal treatments. The *Puskesmas* or public health centre was where mothers in the peri-urban area went for ante-natal treatment. By contrast, mothers in the urban area with a higher socio-economic status had access to better ante-natal care. For post-natal treatment, women in the peri-urban area still preferred the traditional services of the *dukun bayi* (traditional midwife) for post-natal treatment. There were no *dukun bayis* in the urban area and a higher level of education and income seemed to influence the women in the urban area to turn away from traditional practices; they preferred the services of midwives or obstetricians for post-natal treatment. This research also found that most mothers in both areas stated that breast-feeding was healthy, cheap, practical and natural. However, this research found that there were differences in breast-feeding practices for mothers in both areas, and that most of the working mothers in both areas had experienced difficulties in continuing to breast-feed their babies after their maternity leave was over.

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CHAPTER I INTRODUCTION

Woman is the symbol of life, and the bringer of life, of fertility, prosperity, of well-being. She is not just a wife to a husband. Woman is the centre which circles and from which comes the giving of life, and life itself. This is how you should look upon this old mother of yours, and what should guide you in bringing up your daughters.

(This Earth of Mankind, Pramoedya Ananta Toer, 1990 [1975] cited in Sears, 1996:1)

1.1. Background and Research Questions

Women around the world have always had the multiple roles of caregivers, wives, and mothers, as well as contributing to social and national productivity. Women also have critical reproductive roles, which involve pregnancy, giving birth, and breast-feeding. This thesis focuses upon Indonesian women living in peri-urban and urban areas in Semarang and their attitudes towards and practices of breast-feeding. It examines the various factors which influence breast-feeding, such as health services, socio-economic factors and cultural values from within the community. Lintang village (a pseudonym) represents a peri-urban area. Lintang village is part of Sekar district (a pseudonym), located 15km from the city centre of Semarang, and, at the time of my research, was undergoing development as an industrial zone of Semarang. Semarang city is chosen to represent an urban area.

Women have often been labelled the ‘poorest of the poor’, particularly women in developing countries (Vickers, 1993). Women are often expected to carry the double burden of both reproductive and productive roles. They are both producers and carers, caring for their children, sick people and old people; whilst at the same time carrying out domestic chores, such as preparing food, cleaning, etc. The demands of the formal labour market in a modern urban context have added yet another role to women’s already heavy burden (UNICEF, 2000; Momsen, 2004).

Women's health is an important investment within every society. A woman whose life is healthy and happy can be a better mother and wife. She is more likely to bond well with her newborn if her pregnancy was planned. Unfortunately, as with many women in other developing countries, women in Indonesia face cultural and gender inequalities. High rates of maternal mortality and malnutrition are prevalent amongst Indonesian women. Data from UNICEF (2000:14) estimates that 450 women in Indonesia die in childbirth for every 100,000 births¹. An Indonesian woman dies every 45 minutes because of complications during delivery, late referral to hospital or maternity services and poor treatment, as a result of poorly trained health staff, including midwives, and a lack of emergency facilities and transport. The 1995 Survey of Maternal and Child Health (cited in UNICEF 2000:32) revealed that about 24 per cent of women of reproductive age in Indonesia have chronic energy malnutrition, indicated by an upper arm circumference (UAC) of less than 23.5 cm.

These situations have been getting worse since Indonesia was hit by an economic crisis in 1997. The impacts from the economic crisis have led to a full social crisis with wide-ranging effects on wages, employment, and access to health, nutrition and education services. For Indonesian women, the effects of the crisis have been even more severe. A study carried out by Helen Keller International (HKI) found that a year after the onset of the crisis, the mean Body Mass Index (BMI)² amongst women in rural Central Java had decreased from 21.5 to 21.0 kg/m². Consequently, the prevalence of maternal malnutrition increased from 15 per cent to 17.5 per cent. Helen Kellen

¹ According to the World Health Organization (WHO) maternal mortality ratios remain as the most important indicator of reproductive health. Worldwide, 585,000 women die each year in pregnancy or childbirth. Mortality differentials are found amongst regions; in Eastern and Western Africa, more than 1,000 women die for every 100,000 live births in some countries, while in Europe including UK, maternal deaths ranges from only 0-11 per 100,000 live births (http://www.wpro.who.int/themes_focuses/theme2/focus3/trends/trends1.htm).

² The Body Mass Index (BMI) is calculated as an individual's weight divided by her/his height squared (kg/m²). A subject with a low BMI has a low bodyweight in relation to height, due to temporarily or chronically inadequate food intake. Maternal malnutrition expressed by BMI is a good and early indicator of the population's food insecurity, because, very often, a woman reduces her own food intake before reducing that of her children and/or her husband (Helen Keller International, 1998).

International also found that as a result of the crisis both iron deficiency and vitamin A deficiency were increasing amongst women and their children (Helen Keller International, 2000). Malnutrition amongst women has significant consequences for social and economic development. Malnutrition can reduce work capacity, increase morbidity and mortality, reduce the quality of breast milk and also increase pregnancy complications.

Indonesia, like many other developing countries, still has many problems regarding infant malnutrition and infant mortality, although the child survival rate has been improving over the past two decades. Yet the infant and child mortality rates for Indonesia are still higher than those of its neighbouring countries in South East Asia: 4.6 times higher than Malaysia, 1.3 times higher than the Philippines and 1.8 times higher than Thailand (the Ministry of Health cited in UNICEF, 2000). UNICEF (2000) reported that 7 per cent of Indonesian children die before their fifth birthday. This means that of the approximately 4 million children born in Indonesia each year, 300,000 die before they reach age the age of five. Calculated on a daily basis, 300,000 deaths per year imply that about 800 children die every day and, on average, one Indonesian child dies every two minutes. Moreover, UNICEF reported that every seventh child death occurs during the first year of life. Of these, about one third of infant deaths occur in the first month of life. Although child mortality declined by 25 per cent between 1991 and 1997, and infant mortality declined by 20 per cent, neonatal mortality decreased by only 12 per cent. Clearly, in the perinatal period child survival still needs to be improved.

In developing countries, breast-feeding has been the subject of rapidly growing interest because of its important implications, not only for the improved health of children, but also for lowering fertility. The suckling infant stimulates the flow of hormones within the mother that delays the return of ovulation (Mannan & Islam, 1995). WHO has also asserted that breast-feeding practices in developing countries

could save about 1.5 million infant lives per year (Irawan, 1995; Abada et al, 2001). Decreasing breast-feeding practices in developing countries can have serious consequences for the health of infants, because of the risk of contamination in preparing infant formula with unhygienic drinking water, and the absence of the immunological properties of breast milk (Moffat 2002:166).

In Indonesia, an exclusive breast-feeding campaign was introduced more than 20 years ago. UNICEF (2000) reported that 95 to 97 per cent of babies are initially breastfed, thus total non-breast-feeding is not widespread. Although the percentage of babies that are not breastfed is relatively small (5 per cent), it is still a matter of significant concern particularly because many of these babies are from families with a low socio-economic status for whom lack of breast-feeding greatly increases the risk of malnutrition, morbidity and mortality. Some studies have indicated that the lower rate of breast-feeding is due to psychological, social, and environmental factors (Kusin and Kardjati, 1994; Nordenhall and Ramberg, 1998; Untoro, 2004). An incomplete understanding of the advantages of exclusive breast-feeding, coupled with the massive commercial campaigns to promote infant formula and additional baby foods, are probably largely responsible for the rise of the misconception that breast-feeding is not nutritious for a baby.

This thesis documents patterns of breast-feeding practice in Semarang, Indonesia. I will compare mothers in a peri-urban area with mothers in an urban area, concentrating specifically on examining how breast-feeding practice is based on socio-cultural factors. However, before I start to analyse patterns of breast-feeding practice, I examine the situation and position of Indonesian women in a broader context. Also, I examine the health seeking behaviour of mothers, such as where and how they find the health facilities for ante-natal treatment and for giving birth. Also included is an examination of the various health facilities, the services and treatments which are

available, in particular those which influence breast-feeding practices. Cultural aspects amongst the community, such as religion and ritual, particularly during pregnancy and birth, are also analysed in the thesis, looking at what kind of rituals are practiced by the people in the research site, why and how they hold such ceremonies; and how these beliefs and practices may influence breast-feeding in both areas. As a background to my analyses, I have included an examination of the various social factors in the areas where my respondents lived, such as employment, household management, housing, family, and social attitudes towards children and child rearing.

The second interest of this thesis is bottle-feeding. I will analyse the background to bottle-feeding practices in Indonesia, including how and in what ways the mothers in both areas respond to the commercial campaigns of formula milk producers both from within the health services and in the mass media. An examination of government regulations about infant formula and bottle-feeding is also included in this thesis. I further examine how working mothers cope with breastfeeding their babies after they have returned to work, and whether or not workplaces support mothers who are breastfeeding by providing the relevant facilities. Underlying these various interests is the question of how the differences between the peri-urban and urban areas influence and affect breast-feeding practices.

1.2. Structure of the Thesis

This thesis consists of nine chapters and is divided into three sections. Section I (Chapters I, II and III) draws the conceptual map of this thesis, including theoretical considerations, concepts, assumptions and the methodology used in this thesis. Section II (Chapter IV and V) provides the landscape of Indonesia and Java, with specific reference to Indonesian women in a socio-cultural context; religion and social class amongst Javanese people, as well as how religion and ritual influence birth and

pregnancy. The last section, section III (Chapter VI, VII and VIII) details the findings of this research study. In these chapters, the questions motivating this research are addressed. Moreover, these chapters provide an overview of the peri-urban and urban area in Semarang where my respondents lived, and a description of the factors influencing breast-feeding amongst women in Semarang. This description also includes information on bottle-feeding, the development of the infant formula industry, the costs of infant formula, and which factors determine the consumption of formula milk in Semarang.

More specifically, chapter IV examines the socio-cultural context of Indonesian women. In this chapter the state of women's health, gender relations and the position of women in Indonesia are described, with particular reference to gender relations in Javanese culture and society, and how the government has managed its health policy in Indonesia. I also examine how the economic crisis of 1997 affected Indonesian women, especially with regard to health. Chapter V provides an overview of the central characteristics of Javanese society, customs and religion. This chapter examines the culture, religion and society of the Javanese, and in particular the rites and customs associated with pregnancy and giving birth. In examining the central socio-cultural and religious tenets of this culture, I focus on *slametan* as a rite linked to life cycles, particularly pregnancy and birth, and examine how the Javanese who are living in Semarang practice the *slametan* of *tingkeban* or *mitoni*, which celebrates the 7th month of pregnancy, and *brokohan* and *selapanan*, which celebrate the baby's birth³. I also examine my respondents' perceptions of the concept and meaning of *slametan*.

After the landscapes of Indonesia and Java have been described in Chapters IV and V, I turn to an overview of the peri-urban and urban areas which I chose as the

³ *Tingkeban* or *mitoni* is one type of *slametan* which shows that the cycle of rites begins when the individual is not yet born. *Brokohan* is one type of *slametan* which is celebrated on the day the baby is born to tell relatives and neighbours that the baby and the mother are in a state of well-being. *Selapanan* is held when the baby is 35 days old.

research setting for this thesis. Chapter VI provides information regarding the situations and conditions within my research area, including an overview of the socio-demographic features of Central Java, including Semarang and Lintang. I focus particularly on the women of Lintang, analysing different socio-cultural and economic aspects of their lives. Chapter VII examines breast-feeding practices amongst Indonesian women in Semarang. This chapter presents findings from my field research that focused on mothers who were breast-feeding. I compare the breast-feeding practices amongst mothers who live in the peri-urban and urban areas; and the determinants which influence breast-feeding practices, such as socio-economic background, health services and also cultural aspects. After an analysis of breast-feeding practices in chapter VII, bottle-feeding is discussed in chapter VIII. This chapter examines the background to the bottle-feeding phenomenon in Indonesia, and provides a description of government regulations and bottle-feeding practices amongst women in Semarang. Finally, the conclusions of my thesis are presented in Chapter IX. These conclusions address the political and theoretical implications of breast-feeding practices amongst Indonesian women in Semarang, confronting the basic assumptions underlying health policy, and the influences of socio-cultural factors on breast-feeding practices amongst women in both areas. In the following chapter, I will examine the theoretical framework of this research. I will explore breast-feeding as a feminist issue and also how concepts of gender and development are related to the themes underlying this research.

CHAPTER II

BREAST-FEEDING: GENDER ANALYSIS AND FEMINIST PERSPECTIVES

2.1. Introduction

As mentioned in the previous chapter, this thesis analyses the socio-cultural differences in breast-feeding practices of women in peri-urban and urban areas. An integration of several levels of analysis is used in order to get more a comprehensive understanding and appreciation of the complexity of the issues discussed in this study. This thesis explores where and how women find health facilities for ante-natal treatment and for giving birth; and how ritual and religion influence pregnancy and birth. It also examines women's responses to the commercial campaigns of infant formula companies both from within the health services and in the mass media. A further area of focus is the ways in which working mothers cope with breast-feeding their babies after they have returned to work, and whether or not workplaces support mothers who are breast-feeding by providing relevant facilities.

This chapter outlines the gender and development framework and feminist perspectives which are used to analyse this study. A gender and development framework is useful for guiding an analysis of patterns of breast-feeding in Semarang; particularly with regards the double burden of women's roles and as a way to analyse women as agents of development. I will also explore feminist perspectives which have contributed to critical debates on breast-feeding practice in the context of dominant socio-biological discourses.

2.2. Gender and Development

National development is a process of allocating and utilizing resources for the social and economic benefit of all citizens. However, the development process affects

women and men in different ways. The term 'womanhood' is used to convey the full range of women's multiple roles as women: as productive members of society and in terms of their reproductive roles as wives, mothers, caregivers, and, in many cases, unacknowledged heads of households. The term 'womanhood' also highlights the special needs and risks of women as they carry out their critical reproductive roles, such as pregnancy, giving birth and also breast-feeding. This term distinguishes between productive and reproductive roles, while recognising the complementarity of these roles as women work to optimally achieve their potential both as women and as key agents in national development (UNICEF, 2000:26). Because of the double burden of women's roles, women's health is crucial. A woman can be a better worker, mother and wife if she has a healthy and happy life. One important role of gender and development programmes is to improve women's health, such as through breast-feeding programmes.

From a biological perspective, the difference between men and women is their reproductive systems. These anatomical and hormonal variations are the basis upon which individuals are allocated to a particular sex. Equally important are the socially defined characteristics that different cultures assign to those individuals defined as female and those defined as male, i.e. gender. In reality, however, gender differences are social constructions that can potentially be changed in ways that most biological characteristics cannot (WHO, 1997; 2000). As Momsen has pointed out:

"Gender (the socially acquired notions of masculinity and femininity by which women and men are identified) is a widely used and often misunderstood term. It is sometimes conflated with sex or used to refer only to women. On the other hand, gender identities, because they are socially acquired and based on nurture, vary. Gender relations (the socially constructed form of relations between women and men) have been interrogated in terms of the way development policies change the balance of power between women and men. Gender roles (the household tasks and types of employment socially assigned to women and men) are not fixed and globally consistent and indeed become more flexible with the changes brought about by economic development" (2004:2).

According to Moore (1988) and Papenek (1990), cited in WHO (2000:5), “despite their diversity, all societies are divided along what we can call the ‘fault line of gender’”. This means that women and men are defined as different types of beings, each with their own opportunities, roles and responsibilities. The most obvious illustration of this is the split between the public domain of employment, work and politics, which is seen as ‘naturally’ male, and the private arena of the family and the household, which is seen as ‘naturally’ female. Thus, women in most societies are expected to take the major responsibility for domestic tasks and care of the children, the elderly and the sick. Men, on the other hand, are allocated the primary responsibility for supporting the family (WHO, 2000:5).

These gender divisions shape the lives of both women and men in fundamental ways. As individuals with particular identities and as actors in an infinite variety of social contexts, they are shaped and reshaped by their femaleness or their maleness. In one sense then, both women and men are constrained by their membership of a particular gender group. But these variations represent more than just difference. In most societies they are also used to justify major inequalities, with those in the category of female having less access than those in the category of male to a wide variety of economic and social resources. This inequality is most obvious in the distribution of income and wealth. According to WHO (1997:24), in 1995, the United Nations Development Programme (UNDP) reported that around the world, women now make up about 70 per cent of those who are poor. UNDP has explained that this ‘feminization’ of poverty is found both in rich countries and in poor countries and reflects women’s unequal situation in the labour market, their less favourable treatment in most social security systems and their low status within the household. Many of them have no access to independent income and those who do earn their own wage receive on average around three quarters of the comparable male salary (WHO, 1997).

The development process affects women and men in different ways (Momsen, 2004:1). There is no doubt that development has made a positive impact on women's daily lives. However, little has been done to change women's position in society. Women's economic, social and political status has remained largely unchanged and in some communities has actually deteriorated (United Nation/INSTRAW: 1993; Kabeer: 1994; Young 1993 cited in WHO, 2000). Most dimensions of economic and social life are characterised by a pattern of inequalities between women and men that routinely value what is 'male' over what is 'female'. Unless these divisions are taken seriously, policies designed to improve the situation for women's lot are likely to offer only limited and often short-time solutions. Moreover, to solve these problems, a growing number of development agencies and other organizations are adopting the 'gender and development' or GAD approach as a more appropriate methodology for tackling the massive inequalities that continue to limit the potential of so many women around the world (MacDonald, 1994; Moser, 1993; Canadian Council for International Cooperation, 1991; UNDP, 1995 cited in WHO, 2000).

According to Østergaard "development and health are intrinsically interrelated: without a certain level of economic and social development, we cannot provide the population with basic health care; also, without a basic state of health, the population does not have the physical and mental energy necessary to develop the society" (1992b:110). Patterns of health and illness in women and men show marked differences. Most obviously, women as a group tend to have longer life expectancy than men in the same socio-economic circumstances as themselves. It would appear therefore, that as many societies have undergone economic and industrial development, a variety of social and cultural factors have combined to allow women's inherent biological advantage to emerge. The hazards of infectious diseases and the perils of childbearing have been reduced in industrialised countries while certain risks associated with masculinity have

increased, giving women longer, but not necessarily healthier, lives than men. These processes continue to be evident today but progress towards improved life expectancy for women differs markedly between societies. With regard to life expectancy, compared to other Western countries, for instance, in India and Pakistan, have a much lower life expectancy than in US and Britain (WHO, 1997:46-47). In addition, Østergaard also mentioned that economic, social and cultural conditions, lifestyle and life stress are the major determinants of health (1992b:111).

According to UNICEF, key health issues for women of reproductive age (15 to 49 years old) include considerable problems regarding sexuality and reproduction (UNICEF, 2000:29). Sexuality is not merely about sex, but about the right of women to make choices and decisions related to sexual behaviour and practices, relationships, breast-feeding, contraception and abortion. Reproductive health problems are affected by women's access to the means to protect themselves from unwanted pregnancies and sexually transmitted infections, including HIV. A key factor in the health status of women in this life-cycle group is access to family planning services. It has been estimated that if all women who wanted to control their fertility had access to safe and effective contraception, maternal mortality would drop by as much as 50 per cent as a result of reduced reproductive health risks related to pregnancy, childbirth and unsafe abortion. Child morbidity and mortality would drop significantly as well (UNICEF, 2000:29-30).

Poverty and health are closely related, but economic improvement does not necessarily lead to better public health (Momsen, 2004). In many parts of developing countries, the increased cost of health care occurs under structural adjustment policies; moreover, in those countries there seems to be a widening gap between the income-generating ability of women and that of men. It has frequently been the case that development has not helped to improve the status and health of poor women, but rather

has had negative effects (Østergaard, 1992b:113). According to Momsen (2004:76), the suffering of poor women is especially marked because of their relative low social status, few decision-making rights, their heavy workload, including family health care, and their experience as bearers of children. Momsen also stated that with regard to nutrition status, women's lower status relative to men and their biological role in production often puts them at higher risk than men for many nutritional problems. Many women in developing countries are last to eat in the family and so may have to survive on less food in terms of both quality and quantity (2004:78).

The size and make-up of the household determines to a large degree the burden of work on women. It has been shown that, in nuclear families, the full burden of social reproduction falls on the wife and mother, but in extended and female-headed households there is much more sharing of tasks because the mother has more autonomy (Momsen, 2004:73). The first assumption is that the predominant household structure consists of a nuclear family of husband, wife and two or three children. Linked to the model of the nuclear family as the basic unit of society is the concept of headship. The idea is that a 'head', normally assumed to be a man, represents and manages the household (Moser, 1993:16). Based on this assumption, Roger (1980 cited in Moser, 1993:16) has developed the definition of head of household. According to Roger, the definition of 'head of household' is "the man as the breadwinner who is perceived to be the financial supporter, with all other members defined as 'dependents'". This definition is often applied in both rural and urban contexts, even when the woman is the primary income-earner and it is the man who more accurately should be defined as a dependent (Moser, 1993:16).

Moser has stated that more recently, several non-nuclear family structures have reached the attention of policy makers. The extended family does not necessarily disappear with 'modernization' and 'urbanization', but within the context of

development, the extended family is often ignored and the concept of 'female-headed household' with regard to non-nuclear family structures is not always acknowledged. Amongst the very wide range of households, two main types have been identified. First, *de jure* female-headed households, in which the male partner is permanently absent due to separation or death, and the woman is legally single, divorced, or widowed. Second, *de facto* women-headed households in which the male partner is 'temporarily' absent. In this situation, the woman is not the legal household head. It is estimated that women head one-third of the world's households. Female-headed households also emerge under conditions of war, insecurity and disaster, whether 'man-made' or natural (Moser, 1993:13).

According to Momsen (2004), the term 'reproduction' is a concept which not only refers to biological reproduction but also includes the social reproduction of the family. Biological reproduction encompasses childbearing and the early nurturing of infants, which only women are physiologically capable of performing. Social reproduction refers to the care and maintenance of the household (Momsen, 2004:47). While 'biological reproduction' refers rigidly to the bearing of children, the term 'reproduction of labour' extends further. It includes the care, socialization and maintenance of individuals throughout their lives, to ensure the continuation of society to the next generation (Edholm et al, 1977 cited in Moser, 1993:29). Definitions of 'productive' work, however, are fraught with complexities (Moser, 1993:31). As Moser has pointed out:

"The productive role comprises work done by both women and men for payment in cash or kind. It includes both market production with an exchange value, and subsistence/home production with an actual use-value, but also a potential exchange value. For women in agricultural production this includes work as independent farmers, peasants' wives and wage workers" (1993:31).

Momsen (2004) has stated that feminist theories emphasize the importance of social and cultural factors in restricting women's access to the labour market. These

approaches tend to see the interaction between the reproductive and productive roles of women as a key issue rather than a fixed condition. Female labour participation in urban areas affects household composition; families tend to be smaller, but at the same time, domestic help is becoming scarcer and more expensive as alternative formal sector opportunities become available for women. Consequently, the burden of domestic responsibilities falls ever more heavily on one particular woman in the family (Momsen, 2004:179).

The issues concerning the relationship between productive and reproductive labour and changing household composition and headship all have important implications for Indonesian women in general and for examining breast-feeding practice in particular, as I will demonstrate throughout the rest of the thesis. Just as importantly, the gender and development perspective which underpins the above discussion provides the overall theoretical framework for an examination of the patterns of breast-feeding practice in Indonesia. However, before further outlining the ways in which gender and development provide the conceptual framework for this thesis, I briefly outline and discuss some of the important issues raised and debated by feminists in considerations of breast-feeding.

2.3. Breast-feeding as a Feminist Issue

Humans have two basic modes of responding to change: cultural and biological. Biology and culture are inextricably related, and an alteration in behaviour can have a reciprocal effect on biology. Breast-feeding is the ultimate bio-cultural phenomenon; in humans breast-feeding is not only a biological process but also a culturally determined behaviour. Breast milk and breast-feeding have become intricately linked to physiological processes and health and disease patterns of both mothers and infants (Stuart-Macadam, 1992b:7).

According to Quandt (1992), breast-feeding is better viewed as a behavioural domain rather than as a single feeding behaviour. This domain consists of a number of dimensions that can be isolated and described to characterize the breast-feeding individual woman or the modal patterns of breast-feeding by groups. She mentioned that the most important of these dimensions of breast-feeding include: (1) whether and when breast-feeding is initiated; (2) the frequency, duration, and timing of breast-feeding episodes, and (3) the duration of exclusive breast-feeding. Quandt also stated that breast-feeding is similar to other forms of eating in that the variation in its component behaviours is regulated by the social and cultural milieu in which the participants interact, and as with other types of eating behaviour, variants of breast-feeding behaviour have meanings and values ascribed to them that are consistent with other aspects of the culture of which the mother – infant dyad is a part (Quandt, 1992:128).

Breast-feeding is regarded as good practice today. Women are encouraged to breast-feed and to continue breast-feeding for at least four to six months. The long term beneficial effects of breast-feeding on the health of breast-feeding mothers are beginning to emerge, as epidemiologists uncover the relations between parturition and the risks of reproductive cancer on the one hand, and the possible impact of parturition plus sustained lactation on the other. For babies, there is really no dispute that in an ideal situation what babies ought to have is human milk. Breast-feeding is, in other words, an important aspect of birth. Birth does not end with the delivery of the baby, but rather with the delivery of a healthy young person into the adult world (Oakley, 1993:130).

Maher (1992b:1) has pointed out that in the 1960s and early 1970s; maternity was not a prime feminist issue in the West. During this time, women were more concerned with freeing themselves from childbearing and rearing than with realising the

potential of these roles as a female resource. The 1980s brought a widespread visibility to childbirth in medical and women's circles but breast-feeding did not share the limelight. According to Van Esterik (1989:67), infant feeding and the decisions regarding breast-feeding and bottle-feeding are generally acknowledged to be women's issues. She explained that since infant feeding requires a decision on the part of women, breast-feeding is therefore a feminist issue. She wrote that:

“The breast-bottle controversy is a feminist issue for both theoretical and practical reasons. Theoretically, the controversy helps us think through some difficult dilemmas in feminist thought - some of the most difficult dilemmas in feminist thought and action – the sexual division of labour and the fit between groups with very different agendas and philosophies (1989:68).

Carter (1995) argued that providing a feminist perspective on breast-feeding is not necessarily straightforward. Although breast-feeding is a uniquely female activity, and all literature and practices concerned with infant feeding are by definition about women, it has not tended to be a focus for feminist writing in spite of the fact that, as she pointed out:

“The breast-feeding literature contains often explicit ideas about feminism. Breast-feeding in fact represents one of the central dilemmas of feminism: should women attempt to minimize gender differences as the path to liberation or should they embrace and enhance gender difference through fighting to remove the constraints placed on them by patriarchy and capitalism, thus becoming more ‘truly’ women. One might see bottle feeding as freeing women from the demands and restrictions of lactation or, on the other hand, as imposed on women by the manufacturers of baby milk depriving them of a unique womanly experience, based on centuries of skill and knowledge. Feminism has been attributed with both these points of view in the infant feeding literature” (Carter, 1995:14).

Carter (1995:24) also mentioned that the lack of sustained feminist attention, both with regard to practice and theory, to infant feeding means that it is difficult to describe clear distributions from particular feminist perspectives. As mentioned earlier, Van Esterik argued that breast-feeding and the infant formula controversy are feminist issues. She stated that although there is agreement amongst feminists in identifying certain features of contemporary society as oppressive to women, feminists differ in how to explain and

analyze these features. These values affect not only the explanation of issues, but even the description of 'the facts'. There are a variety of ways to categorize contemporary feminist theory. Jaggar attributes these disagreements to differences in values connected conceptually to differing views of human nature (Jaggar, 1983). The classification developed by Jaggar serves as a useful framework for analysing the deep-seated contradictions in the assumptions and ideological forces women and men bring to the infant feeding and formula controversy. Van Esterik suggests that the most significant positions include the liberal, radical and socialist feminist arguments, which are discussed below (Van Esterik, 1989:91).

Western feminists, be they liberal, radical or socialist feminists, reject the conservative socio-biological arguments that deny the oppression of women and accept the proposition that human nature is determined by innate biological differences between the sexes (Van Esterik, 1989:91).

Raphael (1979) has stated that in much literature (mostly medical, demographic and nutritional) dealing with gestation, birth, and rearing of children, reproduction is treated as subject to 'natural laws' rather than to human choices and cultural pressures. Inch (1987) has pointed out that cultural factors such as the variable configurations of gender relations which determine women's work, kinship roles, or the importance of reproduction as a political strategy are rarely discussed. Based on these views, Inch also stated that breast-feeding is often viewed in a social vacuum, as a 'biologically imperative' function of the 'biological dyad' formed by mother and child' (Inch, 1987). Elements of such socio-biological logic pervade the discourse on breast-feeding and bottle-feeding. According to this logic, women are totally fulfilled only through pregnancy, birth and lactation. Socio-biological messages stem partly from the facts of women's reproductive capacity. Lactation as part of our mammalian heritage is suppressed only with difficulty through medical intervention such as pills or injections

to suppress lactation. Hence, breast-feeding is seen as the natural continuation of pregnancy and birth. Socio-biologists such as Simpson (1980 cited in Van Esterik, 1989:93) and Einstein (1983 cited in Van Esterik, 1989:93) make much of the 'naturalness' of breast-feeding, which increases the confusion for mothers who encounter breast-feeding problems (Van Esterik, 1989:91-93). Simpson (1980 cited in Van Esterik, 1989:93) stated that in some parts of the world, 'natural' breast-feeding involves continuous body contact between mothers and infants, as the infant is seen as still a part of the mother and symbiotically identified with her. Maher explained that the mother frequently appears as the only or main caretaker in the child's infancy. The father is rarely mentioned – men as fathers are not mentioned as caretaker and also are never held responsible for their children's welfare by doctors or nutritionists. Although in many societies many children spend much of their time in the care of women who are not their mothers such as grandmothers, sisters, nannies, or the other relatives (Maher, 1992c:154).

Maher also has pointed out that "when breast-feeding is discussed, it is assumed that women breast-feed 'naturally' but that their various inadequacies or involvement in outside work may lead them to abandon exclusive breast-feeding, or to carry on for a shorter time, thus endangering the child's physical or mental health" (Maher, 1992c:155). According to Laukaran, et al. (1986) in developing countries, a decline in breast-feeding has an affect on increasing the number of institutions surrounding birth rather than to changes in maternal attitudes. In other words, despite a decline in breast-feeding, breast-feeding continues to be perceived as an ideal of good parenting, more than simply as a form of feeding. As Maher stated that:

"Physical contact between a new-born or young baby and its mother, creates relationship between them such that the mother 'cares' for her offspring, a sort of adult imprinting. Breast-feeding is supposed to enhance the effects of skin contact at birth and so favour 'maternal bonding'" (1992c:155)

As mentioned earlier, socio-biological messages stem partly from the facts of women's reproductive capacity (Van Esterik, 1989). Ruth Bleier also stated that "socio-biologists attribute mothers' major responsibility for child care to the greater maternal biological investment in conception, gestation and lactation" (Bleier, 1984: 35). She cited Van den Berghe and Barash who claim: "Amongst most vertebrates, female involvement with offspring is obligatory whereas male involvement is more facultative" (Bleier, 1984:35). Based on these assumptions, Maher pointed out that:

"The idea of 'maternal bonding' is a Western folk notion which sustains other cultural notions such as those of exclusive maternal responsibility for the care of offspring, the biological determination of gender roles and therefore of male political dominance although, and perhaps because, all these notions have come to be challenged" (1992c:156).

Hence, according to Maher, strong maternal bonding is a feature of culture – not nature. It is extremely unlikely that they are formed through skin to skin contact. Rather it is formed as a result of well-known forms of learning, including exposure, imitation and conditioning (Maher, 1992c:156).

The early second-wave feminists who led the liberation movement of the sixties and seventies wanted to see opportunities increased for women in order for them to 'catch up' with men and participate more fully in the mainstream of modern society. For example, the liberal perspective rejects the socio-biological view that persons assume their status in life because of ascribed (biological) characteristics, and attributes the different statuses that people acquire to social learning and the denial of opportunity. Hence, liberal feminists reject the conservative socio-biological belief that women are bound to particular roles and statuses because of their biological capacity to bear children (Anderson, 1993: 291). According to Duley (1986 cited in Van Esterik, 1989:95-96), breast-feeding from a liberal perspective can be viewed as restrictive and unappealing, tying an otherwise emancipated working women to the restrictive roles of wife and mother. Based on this argument, bottle-feeding is the solution to allowing

women to carry out both reproductive and productive roles. This perspective also sees bottle-feeding, nursery facilities, and maternity leave as means that allow women to compete more equitably with men. On the other hand, Campbell (1984) provides a Marxist feminist account of infant feeding, which she distinguishes from the liberal concern about baby milk manufacture. According to Campbell, the liberal perspective accepts the fundamental capitalist socio-economic system and sees the rapid population rise in developing countries as a major threat. She pointed out that “in relation to infant feeding women were persuaded to become consumers of infant formula because ‘the alternative to formula is breast milk, a home-made subsistence product which, like other such goods, is devalued because it does not permit the extraction of a profit’” (Campbell, 1984:559). She also suggests that ‘liberal’ pro breast-feeders believe that the regulation of infant formula companies is necessary to support the long term survival of this system. In this context, breast-feeding is seen as a tool for controlling the fertility of the populations in developing countries. Based on this assumption, she has added that many breast-feeding programmes and, indeed, other aid programmes in developing countries are ultimately contained within an ideology which makes the third world useful for capital (Campbell, 1984).

With regard to breast-feeding programmes in developing countries, Maher has pointed out that the ‘baby-milk’ scandal brought to light that the feeding of infant formula to children in developing countries has resulted in the death of great numbers of babies (Maher, 1992a:3). According to Maher, commercial infant formula can, in some circumstances, be a vehicle for disease and death. Therefore, mothers should be encouraged to breast-feed, particularly those whose ‘ignorance’ has made them an easy prey to the aggressive marketing of infant formula companies (Maher, 1992a:3). Based on this argument, models of ‘successful breast-feeding’ are often sought in developing

countries, particularly in rural areas, which have been compared with the trend of increasing bottle-feeding practice in an urban context.

Radical feminists such as Weichert and Bloom believe that the oppression of women in all societies, including socialist and capitalist, originates in part from their reproductive functions, which force them to become dependent on men. They also believe in the existence of universal patriarchy and use the most powerful rhetoric and ideology to fight it (Van Esterik, 1989, 97). Jagger (1983) has argued that if motherhood is the basis of women's oppression, lactation is also a part of the reproductive system oppressing women. The radical feminist perspective also provides contradictory arguments about motherhood. Such perspectives fight for the right to refuse motherhood while at the same time exploring the potential for lesbian mothers to experience pregnancy and lactation and embracing the concept of motherhood as the inspiration for feminist values and activities, such as mother-goddess rituals.

Socialist feminists consider gender discrimination to be inseparable from class discrimination (Van Esterik, 1989:99). Stamp (1988 cited in Van Esterik, 1989: 99) has stated that socialist feminists combine political economy arguments with gender analysis. According to Stamp, the socialist feminist perspective encourages a broader examination of institutions in class societies that oppress women and a more culturally relativistic examination of the experiences of different groups of women in order to observe the interaction of class and gender relations in specific historical and cultural contexts and how they reinforce each other (Van Esterik, 1989:99). From this perspective, Jagger has pointed out that with regard to the infant feeding controversy; socialist feminists place the conflict squarely in the capitalist expansion of market forces into developing countries rather than in the context of sexual politics or the personal decisions of individual mothers. Jagger (1983) has also argued that, breast-feeding is not part of socialist feminists' view of reproductive freedom. The

transformation of social conditions that socialist feminists envision would generally be beneficial to breast-feeding, although this issue is not defined as a primary concern. The broader perspective of socialist feminism encourages an examination of the ways in which society and its institutions influence physiological processes like menstruation, menopause, childbirth and lactation.

According to Carter, in order to pursue a feminist based analysis of infant feeding, it is useful to examine those areas of reproduction – childbirth, contraception and abortion – which have been more extensively explored (Carter, 1995:17). In traditional communities, pregnancy and birth are seen as normal processes central to a woman's life and identity. A woman will marry, give birth and bring up children, which, like the seasons of the year, is the natural progression of a female life (Fildes, 1986:68). Today, according to Oakley (1993:124), in many places in the world, birth is considered an abnormal event. It is an episode in women's lives and in the lives of families which is not part of everyday life, but an occasion for medical surveillance and treatment. Oakley mentioned that obstetricians and paediatricians are not the only experts on birth who have helped to make it special in this way. Other professional groups have also participated, including childbirth educators, social workers, health visitors, psychiatrists, psychologists, sociologists, anthropologists, epidemiologists, technicians, and other members of the commercial and professional world surrounding birth. While these different professional groups have had different perspectives on birth, they have all, in effect, collaborated in transforming birth into a professional subject (Oakley, 1993:124).

Oakley suggests that "it is crucial to the sociological view of birth that it happens to, and within, a society, as well as to an individual who may, or may not, be the subject of medical control" (1993:127). Thus, the way in which birth is 'managed' has important implications for society as a whole; for its view of reproduction, for the

position of women, for family relationships and for child socialization and the construction of adult personality. A second implication flowing from the cultural status of birth is that, from the point of view of the individual woman, her career as a pregnant and parturient patient is not isolated from her other social roles. Oakley explained that, for example, a women who has just given birth might also be the mother of other children, a wife for her husband, a daughter who has responsibility for her elderly parents, and she is perhaps also responsible for domestic work in her home or may have a career, etc; whilst beyond all these roles, she is also an individual, a woman (Oakley, 1993:128).

Based on the anthropological line of thought, Oakley also considers what kind of transition rite motherhood in modern society really is. According to Oakley, there are at least four key features of the transition of motherhood (Oakley, 1993:128). Firstly, in the developed world, a characteristic of motherhood is the divorce between motherhood as an institution and motherhood as an experience. The 'institution' of motherhood is how society – including medical professionals – defines motherhood. The 'experience' of motherhood is how mothers themselves perceive it. In other words, there is frequently a clash between the way that women are led to think about motherhood and the way it feels to them. Secondly, Oakley argues that, today, becoming a mother is physically safer than it has ever been, but that this gain in physical safety is more than balanced by an increase in psychosocial hazards. The most obvious manifestation of this is post-partum depression. Thirdly, she has stated that the major agents controlling and shaping motherhood today are health professionals, particularly obstetricians. This carries the risk that the needs of mothers as identified by health professionals may not be the needs identified by mothers themselves. Finally, Oakley has stated that motherhood is a life-crisis, a life-event – there are many different terms. The essential message is that, for the individual woman, becoming a mother is an important transition

– it is often accomplished with some difficulty and the need for substantial personal adjustment (Oakley, 1993:128-129).

Oakley has pointed out that there are different social factors associated with breast-feeding, but has also pointed out the need to look more closely at the medical factors involved. Oakley has explained that there is a great deal of evidence showing that successful breast-feeding is jeopardized by the same medical structures that argue for its promotion (Oakley, 1993:132). To explain her argument, she used two national surveys of infant feeding in Britain carried out in 1975 and 1980 to indicate some of the mechanisms responsible. These surveys showed that the likelihood that mothers will stop breast-feeding within two weeks of birth increases with the amount of time elapsing between birth and the first feed; twice as many women stop breast-feeding when the interval to the first feed is twenty-four hours or more, as compared with less than one hour. These surveys also found that the longer stays in hospital were associated with giving up breast-feeding by the time the baby was two weeks old, as was feeding at set times rather than demand feeding (Oakley, 1993:132).

To conclude, many scholars have pointed out that although breast-feeding is a women's activity, relatively few feminists have paid specific attention to it. Sociobiologists view breast-feeding as a 'natural' phenomenon, which increases the conflict for mothers who encounter breast-feeding problems and tensions between the 'natural' capacity and their socio-economic position. Within a third world context, Campbell argues that from a Marxist feminist perspective, that the competition between 'breast-feeding' and 'infant formula' is a direct expression of the capitalist socio-economic system, which attempts to balance out the need for profit with control over expanding populace. The socialist feminist perspective also places the conflict squarely in the capitalist expansion of market forces into developing countries rather than in the context of sexual politics or the personal decisions of individual mothers. In the

following section I outline my own theoretical perspectives and the conceptual framework of this study drawing together both the gender and development analyses discussed in the previous section and on the feminist perspectives of breast-feeding which have been discussed above.

2.4. Conceptual Framework

The overall theoretical framework guiding this research is one of gender and development for example as developed by Østergaard (1992a), Moser (1993) and Momsen (2004). Gender and development provides a framework for the analysis of the integration of patterns of breast-feeding practice in Indonesia. The model is applied to analyse class differentiation, health seeking behaviour, the government's policy about women's health, particularly breast-feeding programmes, and also women's reproductive and productive roles in the urban context in developing countries. The relationships identified by this model are also useful for abstracting to yet another level of analysis – that of inter-sectoral ties. This framework integrates key variables for analyses at the micro level, i.e. class differentiation, household, housing and family, including socio-cultural attitudes towards children, health access and facilities and also health behaviour.

Momsen (2004) has argued that the development process affects women and men in different ways. Although development has made positive impacts on women's daily lives, little, however, has been done to change women's position in the community. Based on this assumption, I argue that, firstly, women, particularly women in developing countries, are labelled the 'poorest of the poor' because they are expected to carry the double burden of both reproductive and productive roles. Unfortunately, with regard to health, Indonesian women still face many problems, and, as with women in other developing countries, still face cultural and gender inequalities. Health problems

include high rates of maternal mortality and obstetric complications; chronic energy malnutrition and anaemia; lack of care during pregnancy and delivery; delayed referral services and emergency obstetric care; poor reproductive health status and access to family planning services; and also an increased risk of sexuality transmitted infections and diseases. Indonesia also has many problems regarding infant malnutrition and infant mortality. The economic crisis which hit Indonesia in 1997 made these situations worse. The crisis has had wide-ranging impacts on wages, employment, and access to health, nutrition and education sectors; and for Indonesian women, the effects of the crisis have been even more severe.

Secondly, it has been assumed that in developing countries breast-feeding has many good impacts, since breast milk is sterile and safe; and breast-feeding not only improves the health of children but also lowers the fertility of mothers. In Indonesia, although an exclusive breast-feeding campaign was introduced more than 20 years ago, the 2004 Indonesian Demographic and Health Survey (IDHS) showed that compared to the 1997 IDHS data, the rate of exclusive breast-feeding for 4 month old babies had increased, but that the increase was not significant. However, the IDHS data also showed that bottle-feeding increased sharply; from 10.8 per cent in 1997 to 32.45 per cent in 2002. Some studies (Kusin & Kardjati (1994), Nordenhall & Ramberg (1998) and Untoro (2004) conducted in Indonesia found that the lower rate of breast-feeding practice, particularly exclusive breast-feeding, is due to psychosocial, social and environmental factors. The massive commercial campaigns to promote infant formula and additional baby foods are, I would argue, also heavily responsible for the declining breast-feeding practice in Indonesia.

Within my study of breast-feeding practices in Semarang, Indonesia, I have taken the stance that women from different demographic, educational and economic backgrounds might have different patterns of breast-feeding practice. With regard to

class differentiation, in this research I used 'area' as a criteria of these differences. 'A peri-urban area' and 'an urban area' were chosen as places which could represent the differences between women. Comparisons between mothers who live in a peri-urban and an urban area are central to my examination of patterns of breast-feeding practice, and in order to make these comparisons I have concentrated specifically on how breast-feeding practice is based on socio-cultural factors. It is assumed that the various social factors in both of the areas in which my respondents lived, such as employment, household management, housing, family, and socio-cultural attitudes towards children, influence breast-feeding practices amongst women in both areas. I have demonstrated that the women who lived in the peri-urban area tended to have a lower socio-economic status than the women who lived in the urban area. The peri-urban area in this research was a village which is located on the outskirts of the city of Semarang. This area is undergoing development as an industrial zone of Semarang. However, although the distance between this village and the city centre of Semarang was only 15km, the general situation of the village could be described as rural, based on such conditions as poor transportation, lack of clean water, and an absence of many facilities, including health services. The urban area used in this research was based within the city of Semarang. I also considered that women in both areas may have different attitudes with regard to health seeking behaviour, including attitudes about ante-natal treatment, choosing a place to give birth and assistance during the birth, and also post-natal treatment. The questions posed in this thesis directly address aspects of the different attitudes and practices of health seeking behaviour amongst women in both areas.

The basic unit of Javanese society is the nuclear family; and Wolf (1992) found that compared with previous research (Geertz, 1961; Jay, 1969, Koentjaraningrat, 1985), nowadays there are even more nuclear Javanese families than in previous studies. Within the Javanese family, children are much desired for both practical and emotional

reasons, and the first pregnancy is very blessed. Couples feel happy about pregnancy, partly out of a sense of duty, and also because pregnancy is always expected of couples after marriage. However, the number of children in the family has ceased to be a symbol of prestige in many parts of society. Based on my assumption above, I have argued that mothers in a peri-urban and mothers in an urban area have different attitudes and practices as a result of the aforementioned social factors. Many of the respondents in the peri-urban area were migrants, who had come to find work in factories, had started families and had settled in the village. I have assumed that socio-economic factors influence child rearing and feeding patterns. I use such points to make comparisons between mothers in both areas.

I would argue, following Newman (1995) the promotion of breast-feeding enlists scientific evidence with regard to the impacts on the health and the psychosocial wellbeing of both mothers and babies; and is supported by considerations of economic prudence and accompanied by an ongoing discourse on 'motherhood', 'nurture', 'naturalness' and 'modernity'. Also, as Fisher (1983) have^s pointed that the choice of whether to breast-feed or not is often viewed as a 'lifestyle' and personal choice issue, although for the mother the choice to breastfeed or not encompasses subtle, but compelling and conflicting demands, reflecting some of the tensions and contradictions women face in contemporary society. As mentioned earlier, women often face conflicting demands, since many women are expected to carry the double burden of both reproductive and productive roles. Social and economic changes present difficulties for women in combining their roles as workers and mothers since the demands of the labour market in a modern setting means they have to leave their children when they are working. This thesis directly addresses how working mothers in both areas cope with breast-feeding their babies after they have returned to work, and

whether or not workplaces support mothers who are breast-feeding by providing the relevant facilities.

According to WHO and UNICEF, breast-feeding is the best way to feed the baby, particularly in developing countries such as Indonesia, because breast milk is sterile and safe (UNICEF, 2000; Moffat, 2002). In order to understand this assumption, this thesis examines breast-feeding practices amongst women in both areas to reveal different patterns of breast-feeding practice, including such aspects as ante-natal institutions, knowledge about, attitudes towards and practice of breast-feeding and post-natal care, and women's reactions to the birth, weaning and introduction of other foods, and also women's public roles. In identifying patterns of breast-feeding practice, I have applied Hull's model of breast-feeding practice. This model is based on the different terms of breast-feeding practice amongst the Javanese. The first term is *meneteki* (suck the nipple) and the second term is *menyusui* (suckle milk) (Hull, 1984). I have adopted this model because this model highlights different levels of knowledge, different attitudes and practices of the mothers in both areas towards breast-feeding practice as alternately a means of providing comfort and care and a source of nutrition.

Unlike feminist perspectives discussed in the previous section, I argue that in order to analyse patterns of breast-feeding practice in Semarang, it is useful to adopt some of the socio-biological perspectives about breast-feeding. This perspective argues that mothers have major responsibility for child care due to the greater maternal biological investment in conception, gestation and lactation (Bleier, 1984:35). This perspective also argues that breast-feeding is supposed to enhance the effects of skin contact at birth and so favours 'maternal bonding'. Based on these arguments this perspective argues that breast-feeding is related to the emotional welfare of the child rather than purely the form of feeding (Maher, 1992c: 155-156). However, whilst I begin with 'socio—biological' frames that breast-feeding is a 'natural'; biological

function of women's reproductive capacity. I would also along with other feminists, critique this position for failing to place this biological capacity in the context of cultural factors. As I demonstrate, the Indonesian women perceive breast-feeding to be a 'natural', part of womanhood and reproduction. This is particularly the case for mothers in the peri-urban area who primarily perceived breast-feeding to be a natural part of parenting. However, as with many women in developing countries, they also face conflicts in their dual roles – as a mother and also working women.

As mentioned earlier, the second interest of this study is bottle-feeding practice. As the 2004 Indonesian Demographic and Health Survey showed, the rate of bottle-feeding practice has increased sharply. This survey indicated that the increasing involvement of women in the public domain has led to an increase in bottle-feeding. To analyse bottle-feeding practice, I adopt Campbell's argument that a Marxist feminist perspective is useful for analysing the massive infant formula campaign in Indonesia. As mentioned earlier, bottle-feeding practice in Indonesia has increased sharply not just as a result of mass media infant formula advertising campaigns but also through the health sector in which health providers such as doctors and midwives are directly and indirectly advocating the use of infant formula. According to Campbell (1984), breast-feeding programmes and other aid programmes in developing countries are useful for capitalist institutions. She sees the attempt to regulate the activities of baby milk manufactures as an accommodation between liberal governments and capitalists which actually results in more stable and better profits for infant formula manufacturers. I also argue that to analyse bottle-feeding in a third world context, Maher's arguments about breast-feeding programmes in developing countries are also useful. As mentioned earlier, Maher stated that the 'baby-milk scandal' brought to light the fact that the feeding of artificial milk to babies in developing countries had resulted in the death of great numbers of babies. As Maher has pointed out, models of 'successful breast-

feeding are often sought in developing countries, particularly in rural areas whose breast-feeding customs are compared favourably with the trend to bottle-feeding in 'transitional' and urban areas (Maher, 1992c:152). Based on Maher's points of view, I have analysed the length of exclusive breast-feeding for babies in developing countries such as Indonesia. I have argued that as a result of the poor health of both mothers and babies in developing countries, exclusive breast-feeding for four to six months is too long. Such health conditions and the lack of knowledge about health, particularly nutrition, means that many people in developing countries are not sufficiently aware of the adequate quantity and quality of breast-milk for infants, nor of the necessary food intake for mothers during the lactation period.

Oakley's analysis of motherhood, the sociological view of birth and the medical factors involved in successful breast-feeding are also useful for analysing patterns of breast-feeding. I argue that for some women, the birth process is a life crisis, as Oakley has stated. From this premise, I propose that medical intervention and also the experience of birth can influence the success of breast-feeding for women in both areas.

I have concluded that on a micro level, from a gender and development framework, the health seeking behaviour of the women, such as where and how they find the health facilities for ante-natal care and also for giving birth, influences the practice of breast-feeding and the health status of both mothers and their children. Various social factors in both areas, such as employment, housing and family, and also socio-cultural factors, such as attitudes towards children, also influence the patterns of breast-feeding. On a macro-level, both through gender analysis and from a feminist perspective I have analysed the bottle-feeding phenomenon; including such aspects as government policy, women's attitudes towards and practice of bottle-feeding and also the advertising campaigns of infant formula manufacturers both in mass media and in maternity services.

2.5. Summary

In this chapter I have examined breast-feeding as a feminist issue and outlined the framework of gender and development which I have adopted as the conceptual basis for this research. As WHO and UNICEF recommended, breast-feeding is the best way to feed the baby since breast milk is safe and sterile particularly for babies in developing countries such as Indonesia. However, although breast-feeding is cheap, sterile and safe, breast-feeding practice also brings conflict, particularly for working mothers, since they carry the double burden, of productive and reproductive roles. Socio-biological perspectives argue that breast-feeding is a 'natural' phenomenon and involves continuous body contact between mothers and infants, as infants are seen as still part of mother and symbiotically identified with her (Simpson, 1980 cited in Van Esterik, 1989:93). However, because women have dual roles, although breast-feeding is natural, cultural factors, such as women's capacity as agents of development and their involvement in formal employment increases conflicts for those who encounter breast-feeding problems and tensions between the natural reproductive capacity and their socio-economic position. The following chapter, chapter III, provides an outline of the research design and methodology of this study.

CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

3.1. Introduction

The following chapter provides an overview of the research design and methodology employed in this study. I discuss the rationale for site selection, the various methods and instruments used in data collection and the process of data analysis. I also discuss some of the major methodological issues that I confronted during fieldwork.

It is important to make clear at the outset that as a Javanese woman carrying out research about Javanese women, I enjoyed various advantages. I had no language difficulties, nor did I have any problems in understanding the culture since I was born and grew up in Yogyakarta, the centre of Javanese culture. However, although I have the shared experience of being a Javanese woman, I do not have any experience of being pregnant, giving birth, or of breast-feeding, so I have no personal knowledge to draw upon regarding the main issues within this research. Nevertheless, during research, I always introduced myself to my respondents as a married mother with two children, because if I introduced myself as a single (and childless) woman I would be faced with many questions and negative perceptions about my single status that would have affected the way in which other, particularly married women, interacted with me. Also, by placing myself in the position of fellow mother, I hoped my respondents would feel more comfortable and willing to share their personal stories and emotions with me. The other reason that I chose to hide my single status was related to personal security; a convenient way of avoiding any social problems during my stay in the research sites.

3.2. Research Design

According to Yin (1984 cited in Wolf, 1986:59), a research design is ‘an action plan for getting from here to there’; a map which enables travel from the initial research questions and hypotheses to answers, analysis and conclusions. He added that the design includes the questions motivating the research, hypotheses, and specifies the unit of analysis. It provides a logical link between the data gathered and the questions asked.

As discussed in the previous chapter, this study is concerned with the differences in breast-feeding practice between women in a peri-urban and an urban area. The aim of the study is to describe how patterns of breast-feeding practice are based on socio-cultural factors. More specifically, this study analyses how mothers from different backgrounds and living in different socio-economic contexts practice breast-feeding and bottle-feeding. With this in mind, a micro study was chosen to discover and suggest relationships which could be further explored in larger and possibly comparative studies.

The respondents for the study were, respectively, pregnant and breast-feeding women living in a village in a peri-urban area, and pregnant and breast-feeding women attending the mother/children health care centre at a hospital in the urban area. The research design of this study was not based on a cohort or longitudinal study but used a cross-sectional design as the data collection and observation were not carried out over a long time period. Thus, this study did not observe and follow breast-feeding practices for individual babies from birth through the whole weaning period, but just focused on mothers’ experiences of breast-feeding at various points in the process during a 10 months period, from October 2001 to July 2002.

3.3. Choosing the Sites

As mentioned earlier, the aim of the study was to analyse the differences in patterns of breast-feeding practice amongst women in a peri-urban and an urban area. For the peri-urban area, I needed to choose a village in which I could conduct individual and household level research. I decided that I would use a village in the suburbs of a city which represented certain socio-economic and cultural characteristics. Since one of the aims of this study was to examine how working mothers cope with breast-feeding after they have returned to work, I needed a village where the female population were largely engaged in paid employment – in this context as factory workers. It was for these reasons that I chose a village in the industrial suburbs close to the city centre of Semarang.

Whilst I was visiting some districts in Semarang to find a village with the right characteristics for my research, I met with a doctor in a public health centre in Semarang municipality to discuss ideas about potential respondents for my study. We discussed numbers of pregnant women, numbers of breastfeeding women, children less than 2 years old, women in the reproductive age group, and the industries in the surrounding areas. Finally, I found Sekar district (a pseudonym), which fulfilled all the demands of my research aims. Sekar district is located 15km from the city centre of Semarang. It forms part of the Semarang municipality, and is undergoing development as an industrial zone of Semarang. Its position is ideal for industry as it lies along the road between Semarang and Jakarta, which passes through some major industrial towns in Central Java. Sekar district is divided into ten villages¹, including Lintang, Raja, Duta, Prima, Sekar, Kencana, Emas, Perak, Artha, and Pamit. I chose Lintang as the village for this study because of the factories located in Lintang. Amongst the population in Lintang are migrants from surrounding areas who came to look for factory work, some

¹ All of the village names are pseudonyms.

of whom chose to settle and start families in Lintang. The other reason that I chose Lintang is that although Lintang village is under the supervision of the Raja public health centre (*Puskesmas Raja*), there is another *Puskesmas* in Lintang, which is the Ratu public health centre (*Puskesmas Ratu*), which has facilities for hospitalization (*puskesmas rawat inap*) and a maternity clinic. Lintang village itself is further divided into 14 RWs (*rukun wilayah* – a neighbourhood, hamlet or sub-village).

To represent an urban area, I chose the city of Semarang as my research site. Melati hospital (a pseudonym), which is located in the city centre of Semarang, was my chosen research site to collect data about urban women. I chose a hospital as a place to collect data from the respondents as opposed to visiting respondents one by one in their homes since I felt I would find a greater variety of respondents from different parts of Semarang rather than a concentration from one or two areas. Moreover, I chose a private hospital rather than a state hospital or state/private maternity clinic service, since I felt that patients who sought medical treatment in this private hospital were more likely to represent a higher socio-economic group than those who attended a state hospital or private/state maternity clinics, since in this study, the women in urban area represent women with a higher socio-economic status.

3.4. Data Collection and Analyses

Table 3-1 below provides an overview and timetable of the major data collection phases of the research both in the peri-urban and urban areas.

Table 3-1
The Timetable of Data Collection

Activities	Area			
	Peri-Urban		Urban	
	Dates	Number of Samples	Dates	Number of Samples
Focus Group Discussion	Oct – Nov 2001	267	Jan – Mar 2002	94
Survey (quantitative data)	Dec 2001	174	Apr – May 2002	117
In-depth interview	Oct 2001 – Jul 2002	194	Jan – Jul 2002	111
Participant Observation	Oct 2001– July 2002		Jan – Jul 2002	

As can be seen from the above table, a combination of qualitative and quantitative data collection methods were used in this research. Maynard (1994a:11-12) has reminded us that feminists have argued that there are aspects to women's lives which cannot be pre-known or pre-defined in quantitative research, particularly in surveys and questionnaires, which have been seen to represent a 'masculinist' form of knowing, where the emphasis is on the detachment of the researcher and the collection and measurement of 'objective' social facts through a value-free form of data collection. To escape such limitations, research about women's lives should maximise the capacity to explore experience rather than impose externally defined structures upon them. To this end, feminists have emphasized the importance of listening to, recording and understanding women's own descriptions and accounts (Maynard, 1994a: 12). However, while qualitative methods provide more in-depth and sensitive data, quantitative methods were also used to collect systematic information about respondents, their socio-economic status, the places chosen to give birth, and baseline data on breast-feeding practices.

The following sections provide the details of data collecting and analysis. First, I discuss the qualitative methods used in both areas. This is followed by an overview of the process of quantitative data collection, including a discussion of the use of secondary quantitative data on breast-feeding practice amongst urban women.

3.4.1. Qualitative data

3.4.1.1. Peri-urban Women

The methods employed for qualitative data collection in the peri-urban area included focus group discussions, informal and in-depth interviews and participant observation. In total there were 267 participants in the focus group discussions in the peri-urban area. Participants in informal and in-depth interviews were comprised of 54 pregnant women; 69 mothers with babies less than 2 years old; 15 husbands, and 23 women of reproductive age. I also interviewed some key informants including 2 medical doctors from both of the health centres (*Puskesmas Ratu* and *Puskesmas Raja*), 4 midwives, 13 health volunteers (*kader kesehatan*), 5 factories' officers, 2 traditional midwives, and 7 childminders.

3.4.1.1.1. Focus Group Discussions

In the early phases of this research, qualitative data were gathered through focus group discussions. Jerome, Kandel and Pelto (1980) have suggested that qualitative methods are important during the early phase of research in collecting data about the general knowledge, perceptions and understandings of respondents and also to determine the contextual situation in the research site. During October – November 2001, focus group discussions were held twice in each sub village, with the number of participants for each discussion between 8-12 respondents. The total number of participants in the focus group discussions carried out in Lintang were 267 respondents, and included pregnant women, mothers with baby less than 2 years, and women of reproductive age. I guided and facilitated the discussions and my research assistants

took notes and recorded the discussions.² I asked general questions about health facilities in Lintang village; health behaviour and maternal health issues, including attitudes to breast-feeding and bottle-feeding practices. Based on the results of focus group discussions, I compiled more specific sets of questions to form the basis of the questionnaire survey, and to guide in-depth interviews.

3.4.1.1.2 In-depth Interviews and Participant Observation

In-depth interviews and participant observation were carried out throughout the period of research in the peri-urban area, though the focus of the interviews evolved in response to data emerging from initial focus group discussions and quantitative data collection through questionnaire survey (see discussion below). Rubin & Rubin (1995:3) have pointed out: “qualitative interviewing is an extremely versatile approach to doing research, with qualitative interviewers we can listen to people as they describe how they understand the worlds in which they live and work”. The aim of these interviews and observations were to seek clarification and gain more detailed understanding of breast-feeding practice and experience, building upon the data collected in the early phases of the research.

In-depth interviews were conducted between October 2001 and July 2002, during which time I interviewed my respondents either in their homes or while they attended their monthly health service (*posyandu*) and health centre (*puskesmas*). I visited my respondents without making any prior appointment, in order to avoid them feeling obliged to make any preparation for my visit, such as preparing food, cleaning up the house, etc. Also, I did not want interruptions from other persons such as husbands, relatives, friends or neighbours which is likely to have been the case were my

² I hired 4 of my undergraduate students from Department of Psychology, Diponegoro University, Semarang, to work alongside me as my research assistants. All of them are Javanese women aged between 21-23 years old.

visits to become an 'event'. I wanted to observe 'the real life' situation of my respondents and in keeping my visits informal, wanted to make the respondents feel more at ease. While in the focus group my research assistants and I took notes during the discussions, during the in-depth interviews I tried to minimize taking notes in front of the respondents, except for the identity of the respondents and some key points. However, in order to avoid missing data, I wrote the field notes of these respondents directly after I returned back to my house in Lintang. Interviews were conducted in both Indonesian and Javanese, depending on the individual and the particular situation. Interviews with working women were usually held in the late afternoon or evening after they had returned home. Interviews with mothers who did not work outside of the home were held either in the morning or afternoon. I repeated interviews with some respondents if they seemed to have further interesting information or perspectives on my research.

The interviews were used to explore in detail women's choices, constraints and attitudes towards breast-feeding, bottle-feeding, and maternal health issues. I asked, for example, why they chose a particular health centre; why they preferred certain health providers, and explored the breast-feeding practices and experiences of individual mothers. However, to make the respondents feel more relaxed I tried to conduct the interviews in an informal conversational way.

As mentioned previously, in-depth interviews were also held with some key informants, including doctors from the two health centres – *Puskesmas* Raja and *Puskesmas* Ratu; midwives, traditional midwives, factories' officers, and childminders. From those respondents, in addition to gaining information about health and breast-feeding practice from their perspectives I also sometimes sought to get clarification on information provided by other respondents. Participant observation also formed of key aspect of this research. In this way, I was able to observe and absorb much greater

contextual detail than could be gained purely from other methods. Since I wanted to be so far as possible a participant in the everyday life of the people in Lintang, I lived in the village over a 10 month period, although during this time I also made frequent trips back and forth to Semarang where I was simultaneously conducting focus group discussions and in-depth interviews with urban women in the hospital there (see below). By living in Lintang, I hoped I would garner information from everyday conversations such as from chatting, rumours, etc. I was also able to be present both for regular events and special occasions in Lintang, such as going to the health centre, attending family gatherings and participating in monthly meetings for health volunteers.

3.4.1.2. Urban-Women

As in the peri-urban village of Lintang, qualitative research in the urban area included both focus group discussions, in-depth interviews and some participant observations. The participants included pregnant women who were undergoing antenatal care and mothers/breast-feeding women who were attending the mother/children health care centre (BKIA – *Balai Kesehatan Ibu dan Anak*) at Melati hospital. The total number of respondents in focus group discussions were 94 women. In-depth interviews were conducted with 42 women in the hospital. An additional 27 mothers who lived in Semarang were selected for interview in their homes using a purposive sampling method. Total respondents for qualitative methods in the urban area were 163 pregnant and breast-feeding women.

Focus group discussions were held every Wednesday over a three month period from January – March 2002. The numbers of participants for each discussion was 6-8 mothers. In-depth interviews with women in the hospital were held every Friday over a six month period from January to July 2002. Wednesdays and Fridays were selected because these were the days in which women attended the mother/children health care

centre (BKIA) in the Melati hospital. The focus group discussions and in-depth interviews were carried out in a private room provided by the hospital. In each case the medium of communication was the Indonesian language. The discussions were guided and facilitated by my self with assistance provided by a female colleague from the Department of Psychology, Diponegoro University, Semarang. For the additional respondents (27 mothers) who lived in Semarang, data was gathered through visits and interviews conducted in the participants' home. As in the peri-urban area, further interviews were carried out with health professionals such as medical doctors including paediatricians (12 respondents), midwives (7 respondents), officers from the Ministry of Health at the district (3 respondents), provincial (6 respondents) and state levels (5 respondents) and some NGO workers (3 respondents), from WHO, UNICEF and YLKI (Indonesian Consumers Foundation).

The focus of the discussions and interviews was upon maternal health issues, health seeking behaviour, particularly in terms of ante and post natal treatment, breast-feeding practice, the use of infant formula, and also forms of social support for maternal health and infant nutrition. Overall, in the qualitative methods, I was able to observe and absorb much greater contextual detail than could be gathered purely from other methods. I could listen to my respondents talk about their life and health, and hear about their experiences of breast-feeding practice and approach to infant nutrition. Moreover, although most of the discussions and interviews were carried out in the hospital, interviews and meetings with women in their homes provided with further ethnographic and contextual detail.

3.4.2. Quantitative Data

3.4.2.1. Peri-urban Women

As outlined above, a questionnaire survey was conducted in the peri-urban area following preliminary analysis of the data collected through focus group discussion. The samples for the survey were drawn from two resources; population data from the head of the neighbourhood or sub-village, and from the *posyandu* (monthly health service), which is carried out in each village every month. Both sources of data were used to avoid missing data in the population study since there were many migrants in this village and some of them were not registered in the village population data. Based on these data, purposive sampling methods were used to select samples of the population. The total respondents for quantitative data in the peri-urban area were 174 women; this sample included women of reproductive age and pregnant women who had no experiences of birth processes. The total sample of respondents who were able to answer specific questions about the birth process and breast-feeding practices was 155 mothers. Hence in the following chapters, particularly chapter VII, the samples will sometimes refer to the total sample size of 174 respondents and sometimes to 155 respondents depending on what the nature of the questions was.

The questionnaire was compiled based on data collected through the focus groups discussions which were held in each sub-village and also on initial observations. In particular, the quantitative data were used to collect basic information about respondents such as socio-economic levels, general health seeking behaviour as well as certain aspects of breast-feeding practice. However, based on the information collected through FGDs and participant observation in the peri-urban area, I excluded some questions such as whether or not they practiced breast-feeding exclusively, since based on the data from FGDs, I had already found that the majority (between 70 – 80 per cent of the 267 participants) of mothers in Lintang routinely introduced additional food when

the babies were less than 4 months old. I therefore did not consider it necessary to include a question about exclusive breast-feeding in the questionnaire. It was also important to keep the questionnaire relatively short and well focused to facilitate both faster data collection and to ensure that respondents did not get bored. The questionnaire survey was administrated by my research assistants who were also asked to observe the housing conditions, make notes on the condition of both mother and baby and also the general attitude and response of the participants while they answered the questions on the survey. Based on these data, a report on each of the respondents was also made.

3.4.2.2. Urban Women

While I designed and oversaw the administration of the questionnaire survey for quantitative data collection in the peri-urban area, the quantitative data for mothers in the urban area is based on secondary data from a research study carried out in the hospitals and maternity clinics in Semarang at approximately the same time as my research between April and September 2002 (Mexitalia & Budhihartani, 2003). Even though this research was carried out separately from my own, the research broadly correlates with my own research project in the design and scope of the questionnaire survey. Moreover, the researchers were colleagues in the Department of Paediatrics, School of Medicine, Diponegoro University & Dr. Karyadi hospital, in Semarang. Both the researchers are paediatricians who have research experience in quantitative methods, and we had previously collaborated on research about children and health. Hence, I felt confident in relying on the data collected by them.

The aim of their research was to investigate the correlation between knowledge and attitudes about breast-feeding and actual practices of breast-feeding, including exclusive breast-feeding. Their research was carried out in 6 maternity services (2 hospitals and 4 maternity clinics) in Semarang. As mentioned earlier, I chose Melati

hospital as the primary site to collect data about urban women, in order to ensure a greater variety of respondents from different parts of Semarang. Similarly, the secondary quantitative provided a greater variety of respondents from women in urban areas since this research was carried out not only in the Melati hospital but also in some maternity clinics in Semarang. The sample group for the secondary study was comprised of women who had given birth in these maternity services and the total number of respondents in this study was 117 mothers.

In summary, although there were some minor differences in the kinds of questions asked, on the whole, the secondary data were similar in scale and scope to the quantitative data I gathered in the peri-urban village of Lintang. Hence, I have incorporated their data into my analyses in this thesis. The similarities and differences in the data collected will be discussed in chapter VII and the Conclusions.

3.4.3. Data Analyses

As indicated above, data analyses formed part of the research process from the outset. In the first stage, for example, focus group discussions in the peri-urban area were analysed and used to inform the construction of the questionnaire survey and in-depth interviews. Data from the focus group discussions were transcribed both from field notes and tapes and were written up in a narrative descriptive form based on topics such as sub-village condition, health facilities available, the distance from the sub-village into health facilities, general health seeking behaviour and more specifically cultural attitudes and customs regarding breast-feeding and bottle-feeding practice. These data were compiled in each sub-village and then the data from those sub-villages were combined for Lintang village; these data were then used to compile questions for the questionnaire and in-depth interviews, and to guide participant observation.

After the survey or quantitative data were collected, my research assistants edited and coded the result of each questionnaire. Data entry was completed by 2 research assistants. I then used SPSS to generate summary statistics that could be used as a basis for providing systematic comparison between peri-urban and urban women, drawing on the statistical analyses provided in the secondary data for urban women. This was particularly useful for providing basic information about socio-economic background and employment status, and for providing a general indication of what women reported about their breastfeeding practice.

Following on from the analysis of the quantitative data, was qualitative data analyses of in-depth interviews and observation for both peri-urban and urban women. First, I wrote a life history for each respondent including a summary of the condition of the mother and the baby including her family, experiences of pregnancy and birth, approaches to child rearing and child care, and general health seeking behaviour. More specifically, I focused on attitudes towards and understandings of maternal health issues and infant nutrition, breast-feeding and bottle-feeding practices, and identified major issues that informed and constrained women's choice of infant feeding. In compiling these reports, I extracted key quotations from interviews that seemed to summarize well individual's perspectives and experiences. The next step was to look across each of these life history reports I had compiled to see if there were general themes and notable points of similarities and differences within and between the individuals in peri-urban and urban areas.

The final stage was combining the quantitative and qualitative data together to see if the findings from each set of data were supported by the other and to build up a general analysis for the thesis. In general terms, what I had observed and had heard from women were generally confirmed through the quantitative data collected. However, because the data provided through the survey was inevitably of a very general

nature, many of the key findings only emerged in the analysis of qualitative data collected through observation and interviews. For example, the majority of women in both areas said they thought breast-feeding was best for both mother and baby. However, what I only came to appreciate through observation and in-depth interviews was that there was a clear distinction between women who understood and practiced breast-feeding primarily as a means of matter of soothing their child, and those who understood breastfeeding as a matter of infant nutrition and feeding. As I discuss further below (see chapter VII) this conforms to the distinction first made by Hull (1984) about the two forms of breast-feeding practice amongst Javanese women, one of which is referred to a *meneteki* (suck the nipple) and the other as *menyusui* (suckle milk).

In sum, data analyses were conducted at different levels across the various phases of the research, beginning with the preliminary data analyses from FGDs in the early phase of research, through to the analysis of quantitative data from the surveys and qualitative data from interviews and observation, and finally ending in the drawing together of both sets of data to produce the final analysis for each chapter of my thesis. Where appropriate and useful I have provided summary statistics from the quantitative data to support and draw out key points of comparison. Where I am relying on data gathered through interview and observation, I have expressed these findings in terms of estimated proportions of women interviewed and observed, rather than give a definite number. However, it is important to remind the reader that the data gathered through in-depth interview and observation is drawn from a very large sample, and while I cannot always be precise about specific numbers, the qualitative data is nonetheless robust as it draws both on what I heard and saw in practice.

3.5. Summary

The aim of this study was to describe and critically explore patterns of breast feeding practice amongst pregnant and breast-feeding women in two different social contexts, namely peri-urban and urban Semarang. However, because the study also seeks to relate patterns of breast feeding practice in these different contexts to women's own experiences and accounts of breastfeeding, a combination of qualitative and quantitative data collection methods were used in this research. In this research, the qualitative methods employed included focus group discussions, in-depth interviews, and participant observation. In the peri-urban area I conducted a questionnaire survey, while in the urban area I relied on secondary data from a similar questionnaire survey that was part of research study carried out in Semarang by colleagues over a similar time period to my own (Mexitalia & Budihartani, 2003). While the majority of the data is derived from pregnant or breastfeeding women, I have also drawn on data collected from men, older non-breastfeeding women as well as various health care professionals in order to provide a broader picture of the situation.

In the peri-urban area, total respondents for qualitative methods were 189 respondents for in-depth interview and 267 participants for FGDs. In survey or quantitative methods the total sample in the peri-urban area was 174 women. In the urban area, the total samples were 117 respondents. For qualitative methods, the participants for FGDs in the urban area were 74 women; and for in-depth interviews 111 respondents. The analysis of the data was an ongoing part of the research process, moving between quantitative and qualitative data and finally brought together to produce the analysis presented in this thesis.

The results of the research and my analysis will be fully discussed in Chapters VII-IX. However, before presenting these data, the following section (Chapters IV - VI) provides further background and contextual information on gender, culture and social

geography. In particular, chapter IV explores gender relations and the position of women in Indonesia, with particular reference to Javanese women, focusing on the present condition of reproductive health amongst Indonesian women, and the impact of the economic crisis on women's health more generally. Chapter V provides an overview of religion, focusing in particular on key aspects of ritual practice surrounding pregnancy and birth. Finally, Chapter VI provides a detailed over-view of the social and economic conditions and issues confronting women in the specific research areas of Lintang and urban Semarang.

CHAPTER IV

INDONESIAN WOMEN IN SOCIO - CULTURAL CONTEXT

4.1. Introduction

The term ‘womanhood’ is used to cover the full range of women’s multiple roles as women, wives, mothers, caregivers, and productive members of society and, in many cases, unacknowledged heads of households. Women have responsibility for a wide range of household-based tasks. Women generally have major responsibilities within the family, involving caring for family members, household management, food preparation, cleaning duties, health care, education and supervision of children. The concept of ‘womanhood’ distinguishes between productive and reproductive roles, while recognising the complementary nature of these roles as women work to achieve their optimum potential both as women and as key agents in national development. At the same time, ‘womanhood’ highlights the special needs and risks of women as they carry out their critical reproductive roles, such as pregnancy, giving birth and breast-feeding (UNICEF, 2000).

Research has shown that, in comparison with women in South and East Asia, women in Southeast Asia, including Indonesia, and in particular Java, are thought to have relatively high status because of their ability to control their own movements outside the village and in the marketplace, to control their earned income, and to own property (Stoler, 1977; Hull, 1982b; Wolf, 1992; Brenner, 1998; Saptari, 2000; Blackburn, 2001). The role of Indonesian women in shaping the very fabric of Indonesian society is integral to the history of the nation of Indonesia itself. The struggle by Kartini, the Javanese woman’s hero, to promote women’s rights to education in the early 1900s and the holding of the first women’s congress – *Kongres Perempuan* in Yogyakarta on 22 December 1928, as well as many other women’s activities in the following decades, have exemplified their contribution to Indonesian

society (Parnohadiningrat, 2002:xxiii). Since Indonesia's independence in 1945, the government of Indonesia has consistently supported the raising of the status of women to achieve greater equality with men. The government has set up several programmes that focus specifically on women and on improving their social welfare and raising incomes.

In this chapter, I will explore the state of women's health, gender relations and the position of women in Indonesia, with particular reference to gender relations in Javanese culture and society. I will examine how the government has managed its health policy in Indonesia. I will also examine how the economic crisis of 1997 affected Indonesian women, especially with regard to health.

4.2. Gender Relations and the Position of Women in Indonesia

As mentioned earlier, it has often been remarked that in Southeast Asia, even from pre-colonial times, women enjoyed a relatively high status compared to their counterparts in South and East Asia (Stoler, 1977; Hull, 1982b; Reid, 1988; Wolf, 1992, 2000; Brenner, 1998; Saptari, 2000, Blackburn, 2001). Indonesia has long been regarded as a nation that accords a relatively high status to its women. For centuries, observers have commented on the prominent role of women in the economy, the equality conferred by the bilateral kinship system found in much of the archipelago, and other indicators of status (Blackburn, 2001:270). Reid argues that the influences of Islam, Christianity, Buddhism, and Confucianism have not undermined their status. Although Islam made women legally and economically dependent on their husbands, and also restricted their rights to initiate divorce, these impacts, according to Reid, were mostly felt by the wealthy urban mercantile elite and not by the ordinary working

population¹ (Reid, 1988). Even the arrival of the Dutch colonial powers did not bring major changes in the gendered representations presented by the state. During the colonial era, the struggle to improve the condition of women focused on the provision of education for women, which was felt to be a prerequisite for national liberation. The other main issues uniting women's activities at the time were their opposition to polygamy, and to restrictions on women's activities in the public domain (Parawansa, 2002:68).

Indonesia has a history of formal women's organizations stretching back to the 1920s when several associations were formed alongside the modern nationalist movement (Sullivan, 2000). The first National Women's Congress, which was held on 22-26 December 1928, was part of the spirit of national integration. The congress attracted the participation of 31 women's organizations from all regions of Indonesia, and passed an important resolution calling for improvements to women's access to education and the provision of better information at the time of marriage on women's divorce rights (Parawansa, 2002:69). During this era, the ideal of the 'good wife and mother' was firmly established in Indonesia; a good woman should be able to manage her family and home well; and the concept of 'woman' was synonymous with 'wife'. Traditionally, women are thought to be less refined, less spiritual, and less potent than men and more spontaneous, more emotional, and thus less deserving of prestige. According to Keeler (1987 cited in Mulder, 1996) male dignity reflects self-restraint and strong inner resources, which is called potency. The male domain is seen to encompass the public domain of politics, power, work, position, prestige and hierarchy; whilst the female domain is centred on the home, the children, education and care (Mulder, 1996:84). Within this context of gender relations, women are supposedly earthier, actively caring for things, earning and handling the family's resources,

¹ Many scholars have inserted a cautionary note to descriptions of women's high status which do not take into account the local context (Saptari, 2000:25; Wolf, 2000).

emotional, and not so restrained in their behaviour, whereas men are expected to be dignified, somewhat removed from daily cares and activities, pursuing, shaping, and expressing the prestige of the family.

In 1945, national interest was overwhelmingly focused on defending Indonesia's newly proclaimed independence, which deflected attention from women's issues. Nevertheless, the National Women's Congress, which represented 31 women's organizations from all regions in Indonesia, continued to develop relationships with women's organizations abroad. In time, the Indonesian government gained international recognition. Women's political organisations were established, and married women's organizations, including those associated with national defence institutions, flourished (Parawansa, 2002:70). The emergence of women's organizations in the early twentieth century paved the way for the articulation of women's own representations, even though these were never far from the prevailing dominant notions. Debates on the marriage law, and on access to employment as well as education, were, however, key issues brought up by these organizations. The national independence movement brought with it the involvement of women in the public sphere through these women's organizations (Saptari, 2000:18). However, during the 1950s and early 1960s, it was difficult for women's organizations to politically organise rural working women. Radical organizations that tried to do so were suppressed, first by the colonial government before World War II, and later by the New Order. Only during a relatively few years of the 20th century, therefore, was it possible to organise working women in rural areas independently. In the urban areas, under the eagle eye of the colonial and New Order regimes, it was also made extremely difficult for women's organizations to reach out to ordinary working women (Blackburn, 2001:273). In Indonesia, women's organizations were dominated by better-educated women living in Java. Organizations tended to be run by and to recruit members most easily from amongst people of greater wealth and

higher education who had the time and skills to gather information, express their views publicly and attend meetings. Consequently, organizations tended to over-represent the interests of such women and subsequently overlooked the needs of poorer women and women living in more remote rural areas (Blackburn, 2001:272-273).

Following the fall of President Sukarno in 1965, Indonesia experienced a period of very high inflation of up to 600 per cent. As a result, women's issues were once again pushed out of the public arena. The focus of Sukarno's successor, President Suharto, was on improving economic conditions. The new government succeeded in its economic stabilisation policies, bringing inflation down to single-digit levels by 1969 and setting the preconditions for continued economic growth. Such success gave the government the power to be the most important agent of development (Parawansa, 2000:70; Blackburn, 2001:273). Under the New Order (led by Suharto from 1966 to 1998), the domestication of women was quite a strong feature within state ideology and programmes. The Suharto regime laid down the basic principles of gender relations as they manipulated family ideology towards one based on the nuclear form, with a clear distinction between the female housewife and mother as the husband's supporter, the children's nurturer and the society's guardian of morals and culture (Saptari, 2000:18). Under the New Order, the state-controlled Family Welfare Programme (*Pembinaan Kesejahteraan Keluarga - PKK*)² was intended to promote 'family welfare' and more

² To organise women better to fulfil their roles as mothers and wives, the government's Family Welfare Programme (PKK) was initiated in 1973, and was presented as the field of interest, influence and activity of the non-political women's movement. Thus, women's participation in national development became law in 1974 (*Undang-undang No 5 Tahun 1974*). This legislation specified the links between the women's movement and the state at all administrative levels, and institutionalised units of the movement in village and urban neighbourhoods as components of the Village Social Institution – *Lembaga Sosial Desa* or LSD. Of course, the relationship between the PKK and the state and the stipulated PKK functions made a nonsense of general claims of the women's movement's non-political status. The movement was undeniably a state creation and an integral part of the Suharto state. This movement imposed the notion that the most basic programmes began in the family. Its proponents asserted that the family was the fundamental social institution in which was formed the crucial roles, attitudes and behaviours on which fruitful development depended. Woman, as the critical central agent of the family, was attributed five major roles: (1) as loyal backstop and supporter of her family; (2) as caretaker of the household; (3) as producer of future generations; (4) as the family's prime socialiser; and (5) as an Indonesian citizen. To help women understand their place based on the five major roles of women outlined above in the new developmental trajectory, the government elaborated a 10-point formula (*10 Program Pokok PKK*)

generally to help implement the government's development plans, especially with regard to family planning (Blackburn, 2001:273). The Family Welfare Programme (PKK), enacted at all bureaucratic levels, operated to install state notions of womanhood and the family. The family planning programme was closely associated with an official representation of the nuclear family as a father, a mother and two children, and this representation was distributed in books, leaflets, brochures, etc. across more than 100,000 villages in all the Indonesian provinces. Educational primary textbooks have shown the clear gendered division of labour between mother and father, with pictures depicting the mother in the house and the father going out to work (Saptari, 2000:18-19).

The government vision was similar to that of the colonial regime: women's issues were predominantly concerned with their position as wives and mothers. Government policies on women did not address their advancement as such but rather tried to improve their status within the family (Parawansa, 2001:71). The way that the New Order era emphasized the dual role of women has been interpreted in different ways by feminist scholars (Saptari, 2000:19). Wolf (1992; 2000) argues that the dual role of Indonesian women can be seen as a means to justify the secondary role women play in the labour market or in production. On the other hand, Sen (1998) tends to view this as the conflictual role that women in reality have with the State, where on the one hand women are seen basically as housewives but their role in paid work cannot be ignored.

specifying the areas in which women could work best to modernize and develop their families, communities and nation. The 10-point formula was as follows: (1) the creation of good relations within and between families; (2) correct childcare; (3) the use of hygienic food preparation techniques and close attention to nutrition; (4) proper clothing functions – physical and moral protection; (5) organising the spatial dimensions of the house; (6) managing family health in all dimensions – physical, mental, spiritual, moral; (7) effective household budgeting; (8) effective basic housekeeping based on cleanliness and order; (9) creating an emotionally and physically secure and tranquil home environment; (10) developing the family attitudes appropriate for national modernisation and planning (<http://www.ciaonet.org/wps/sun01/sun01.pdf>).

As noted earlier, for most of the 20th century, therefore, the kinds of public demands put forward by women's organisations were largely representative of urban, better-educated and wealthier women (Blackburn, 2001:273-274). Reform of the marriage law was a high priority for Indonesian women's organisations for most of the 20th century, until the Marriage Law of 1974 was introduced. Previously, Muslims married according to Islamic law, and family law matters, such as divorce, were determined by religious courts run entirely by men with virtually no supervision by the state. Marriage law was often implemented in ways that discriminated against women and appeared arbitrary and unpredictable (Blackburn, 2001:275). In accordance with the Marriage Law of 1974 (during the New Order era), a regulation was developed requiring government officials to obtain the permission of both their first wife and their work supervisor to take a second wife, or face sanctions at work (Parawansa, 2001:71).

In 1978, in response to the United Nations' declaration of the Decade for Women (1975-85), the government established the Ministry for the Role of Women. Its mission was to increase women's capacity to manage their dual roles (*peran ganda*) in the domestic and public spheres – but without challenging the underlying social structure in which women's primary responsibility was for the domestic sphere. The New Order government's support for women was reflected in its ratification of several international conventions and agreements on women, including the UN Convention on Political Rights of Women (under law No. 68/1968) and the Convention on the Elimination of All Forms of Discrimination against Women – CEDAW. It endorsed the resolutions of the International Conference on Social Development in Copenhagen in 1994, the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995 (Parawansa, 2002:71). Besides CEDAW, the government of Indonesia also implemented the Convention on the Rights of the Child (CRC), both the CRC and CEDAW – the latter which Indonesia

ratified through Law No.4/1984, represent a new 'social contract' for children and women. In ratifying the CRC and CEDAW, Indonesia assumed the obligation to implement the conventions and is required to report periodically to the Child Rights Committee on the progress achieved. In the public sphere, the fulfilment of this vision requires commitment in terms of policy, legislation and funds. In the private sphere, the vision needs to be manifested in better caring practices within families and communities (UNICEF, 2000:3).

Nevertheless, women remained firmly subordinate to men. Even though organising the domestic domain was held to be the task of women, they were not fully empowered to act, even in household decision-making. Men were the beneficiaries of most government development programmes. While in the latter part of the New Order era (1966-1998), women were given access to some of these programmes; the budgets allocated to them were very small compared with the overall budgets for programmes accessed mainly by men. The productive activities of women were regarded as 'side jobs' to supplement the husband's income, and the time spent on non-household activities was secondary to household tasks. In the domain of politics, female representation in the legislature did not reflect women's actual advancement because most women politicians were appointed on the basis of their connections with prominent men (Parawansa, 2002:71-72). Women hold only 7 per cent of executive positions in the civil service; and there are very few high-ranking women in traditionally 'masculine' political domains such as the military. In politics, women's representation stands at about 9.2 per cent in the legislature (DPR) and 9 per cent in the general assembly (MPR) (Parawansa, 2002:73). Based on these numbers, Oey-Gardiner has pointed out that the number of women in the DPR declined during the 1990s, from 60 in the 1992-97 sessions to 56 in the 1997-99 session and only 44 in the parliament

elected in 1999. In the MPR the proportion of female representation has also declined, from 12 per cent in 1997-99 to 9 per cent at present (Oey-Gardiner, 2002:106).

However, development did bring some progress for women. For example, the success of family planning programmes freed women to enter the public domain, such as retail and labour markets, while improvements to transport infrastructure increased their mobility. Government programmes to reduce poverty improved living standards and the maternal mortality ratio dropped from 549 per 100,000 mothers in 1986 to 308 in 1998. Life expectancy for women rose from 63 years in 1990 to 67 years in 1998, compared with an increase from 60 to 63 years for men. Women's participation in education began to catch up with that of men, particularly during the first nine years of schooling, which were made compulsory for both girls and boys. When the first family planning programmes were introduced in the early 1970s, the total fertility rate was 5.61; by 1997 this had fallen to 2.78 children per family. As the average number of children per family fell, women experienced better health and had more time for their own self-advancement and self-actualisation (Parawansa, 2002:70-74).

The democratic values introduced under Suharto's successor, B.J. Habibie, in 1998-1999 were continued by Abdurrahman Wahid in 1999-2001. A democrat, Habibie disseminated the need to empower civil society by letting people manage their own affairs. The transition periods from Suharto to Habibie and to Abdurrahman Wahid gave Indonesians the opportunity to reposition themselves. This has certainly been true of the relationship between women and men. Freedom of speech encouraged people to express their opinions and aspirations, especially in the urban areas. Consequently, the number of non-government organisations (NGOs) representing women's interests and demands has greatly increased. A new approach based on gender equality was introduced in 1999 in the Broad Guidelines on State Policy (GBHN). This stated that 'empowering women is achieved by improving women's role and status in national life through national

policy implemented by institutions that struggle for actualisation of gender equality and justice', and sets the goal to 'improve the quality and the role and self-reliance of women's organisations by maintaining the value of integration and the historical value of women's struggle in continuing to empower women and society' (Parawansa, 2002:72-73).

In 2001, Indonesia appointed its fifth president – a woman. In July 2001, Megawati Sukarnoputri, one of Sukarno's daughters, became Indonesia's first woman president. Megawati's appointment came some 21 months after the 'election' of Abdurrahman Wahid, Indonesia's fourth president. There was little mention in the national media that only two years earlier the political elite of all colours had written her off as a possible president for Indonesia. From the end of 1998, and particularly from the time of the spectacular success of the Indonesian Democratic Party of Struggle (PDI-P) in the 1999 elections through to the installation of Abdurrahman Wahid as president, conservative Islamic and liberal intellectual leaders found dozens of reasons to publicise why Megawati could not and should not become the nation's leader (Sen, 2002:13). At the time of Abdurrahman's election to the presidency in October 1999, Megawati's gender was used as an argument against her assuming the reins of government. Citing Islamic restrictions against a woman leader, powers in the People's Consultative Assembly (MPR) supported Abdurrahman Wahid – who had the advantage of being a man and the leader of Islamic party (Robinson and Bessel, 2002:1; Sen, 2002:13; Oey-Gardiner, 2002:100). Serious problems in the government began shortly after Abdurrahman Wahid's presidency; and various scandals eventually led to his impeachment. The MPR finally removed the president from office, unanimously replacing him with Megawati (Aspinal, 2002:28-30).

In the international media, Megawati has always been compared unfavourably with other female political figures in Asia such as Cory Aquino, Aung San Suu Kyi and

even Benazir Bhutto. She is deemed to share many of their political disadvantages – like Aquino she is described as a ‘mere housewife’, like Suu Kyi her charisma is really only ‘reflected glory from her father’, like Bhutto she is saddled with a ‘husband who is a liability’. Furthermore, her lack of education has been criticised, as she never finished university. Megawati does not have any of the redeeming qualities that make some other women leader favourites with the Western media: she does not speak English fluently and she has not been ‘Westernised’ in her social behaviour by long years of living in England and America (Sen, 2002:16). Megawati, while part of the political elite by birth, shared nothing with the intellectual political actors who had honed their ‘deliberative’ ideals precisely in opposition to her father’s mass mobilisation. In the last years of the Suharto era, as the intellectuals revived their discourse of democracy, she remained an outsider to this group – not just because she was a woman, but because of the kind of woman she was. Megawati Sukarnoputri, much more than her predecessor, is both the symbolic vehicle (as Sukarno’s daughter) and the product (as the winner of the largest number of votes) of mass politics (Sen, 2002:25).

In her cabinet, she has gone some way towards addressing feminist concerns by appointing two women to her cabinet; one holds the usually male post of Minister of Trade and Industry, the other one is the State Minister for Women’s Empowerment. However, it is noticeable that when Megawati does something right, her gender is not mentioned; at such times the media and commentators appear to consider the presidency to be gender-neutral. But when her statements are considered weak or when problems arise, her gender is underscored. For all the euphoria felt by women following Megawati’s rise to the presidency, experience elsewhere suggests that having a woman at the top – especially one not known for being particularly sensitive to gender issues – is no guarantee that women’s issues will become a mainstream concern in public and civic life (Oey-Gardiner, 2002:100-102).

In summary, women in Southeast Asia, as well as Indonesia, and in particular Java, are thought to have held relatively high status with regard to their ability to control their movements outside the village and marketplace, and also their ability to control their own property. In Indonesia, the history of the role of women is integrated with the history of the nation of Indonesia itself. Starting with the Javanese woman's hero 'Kartini', continuing with the holding of the first women's congress in Yogyakarta in 1928, it has progressed to the appointment of Megawati as Indonesia's first woman president. In the next section, I will explore in more detail key aspects of gender relations and the position of women in Java, and how they relate to the subject of my study.

4.3. Javanese Women

As noted earlier, much literature documents the favourable position of Javanese women with regard to high status and their capability to control income, property, etc.³ A number of scholars have remarked on the prominent economic roles of Javanese women and their central position in the household (Geertz, 1961; Jay, 1969; Stoler, 1977; Hull, 1982b; Koentjaraningrat, 1985; Wolf, 1992; Brenner, 1998). These scholars almost always link women's dominance in the household to economic clout, particularly inside the home. Hull (1982b) noted that the status of women in Java appears to be ahead of that in other Asian countries. Wolf (1992), who conducted research in Central Java comparing female autonomy in Java and in Taiwan, confirms Hull's notion. Previously, Geertz (1961) and Koentjaraningrat in the 1970s conducted research about the Javanese family, finding that Javanese women have a relatively high status in the

³ <http://www.unu.edu/unupress/unubooks/u113se/uu13seog.htm>

family and in society⁴. Based on her research in Modjokuto, Geertz (1961) found a certain equality between Javanese husbands and wives. She wrote that:

“..... in general, then, husband and wife together are the nucleus of a living unit which is concerned not simply with the processing and distribution of consumption goods but also with the production of goods and services to secure income for the group; and the potential or actual participation of the wife in all aspects of this economic endeavour gives her a freedom and bargaining strength equal to that of her husband” (1961:45).

With regard to the domestic domain, she pointed out that “the wife makes most of the decisions; she controls all family finances, and although she gives her husband formal deference and consults with him on major matters, it is usually she who is dominant” (Geertz 1961:46). Men frequently defer to other family members, including their wives, which could be taken to indicate significant levels of equality in the household. In formal dealings with the outside world, such as matters concerning state bureaucracy, men are usually considered the heads of their households. However, the fact that most decisions about the daily running of the household are left to the wife, and that she almost always holds the family’s purse strings, leads one to suspect that in many households men may serve more as figureheads than anything else (Brenner, 1998:137).

According to Koentjaraningrat (1985), on the normative or ‘high conceptional level’, the equality of men and women and that of husband and wife are recognized amongst the *Agama Jawi*⁵ as well as amongst the *santri*⁶ Javanese. Moreover, he pointed out that:

⁴ <http://www.ciaonet.org/wps/sun01/sun01.pdf>

⁵ According to Koentjaraningrat (1985), *Agama Jawi* (*kejawen*) is the religion followed by Javanese people. In principle, *Agama Jawi* is similar to Islam, although the Javanese do not follow Islamic principles as correctly as other Muslim people. For more details, see chapter V (Religion, Ritual, and Their Influences on Pregnancy and Birth).

⁶ *Santri* was a social classification based on religious activities. In his book ‘The Religion of Java’ Geertz (1960) classified Javanese people based on religious activities into *abangan* and *santri*. For more details, see chapter V (Religion, Ritual and Their Influences on Pregnancy and Birth)

“The Javanese household, however, is considered to be the woman’s domain. The woman is also the main and direct authority figure over the children and notes the periods during the year when religious ceremonies are to be performed for the benefit of the family. She often also has her own income because she sells food or garden products in the market, or works as an agricultural *buruh tani* (labourer) during certain periods of the agricultural cycles, such as planting, harvesting, and rice thrashing. In public, social, and political affairs, however, the village women do not play an overt leading role, and although female landholders do have the same voting rights as men, they are usually not interested in such matters, and prefer to send their sons to represent them at village meetings” (1985:139).

It should be noted that Koentjaringrat’s analysis refers to the rural areas and the lower class of the urban population (*wong cilik*). Furthermore, for elite women, Hull (1982b) and Koentjaraningrat (1985) proposed that although elite or upper class women (*priyayi*) were more dependent economically on their husbands than others in all classes, the wife also plays a dominant role in household affairs⁷. A husband’s main areas of influence and responsibility were thus identified as non-domestic. The point should be made, however, that in handing over the money to his wife, a husband also handed over responsibility for managing the domestic realm. He delegated power to her but this power was circumscribed by her association with domestic life.

In the marketplace, the relationship of men and women to money often closely parallels the situation in the Javanese home. Based on her research in the Klewer market in Solo, Central Java, Brenner (1998:132-138) found that the majority of the faces that one sees in the *Pasar Klewer*, buyers as well as sellers, are female. The Solonese say that the market is a woman’s world (*ndonyane wong wedok*). Amongst the ethnic Javanese of Solo, there is no question that women control the marketplace, although there are a number of male traders of Chinese and Arab descent. The prevailing stereotype is that while the Solonese woman goes to the marketplace to earn a living, her husband stays at home, amusing himself by whistling to his songbirds. This image

⁷ *Wong cilik* and *priyayi* were social classes within Javanese society. Many Javanese scholars have pointed out that with regard to social class, the Javanese can be divided into *wong cilik* (small people or common people) and *priyayi*. *Wong cilik* refers to the majority of Javanese people; whereas the *priyayi* class includes officials and intellectuals (Koentjaraningrat, 1985; Magnis-Suseno, 1996). For more details, see chapter V (Religion, Ritual and Their Influences on Pregnancy and Birth).

aptly sums up what a number of Javanese scholars have already pointed out. In most families, regardless of social standing or occupation, it is the wife who handles household finances. Javanese women often voice the opinion that men are incompetent in managing money, and many men seem to agree. Husbands are expected to turn over most or all of their income to their wives, who in turn allocate it as they see fit for household expenditures, sometimes giving their husbands only pocket money with which to buy cigarettes or snacks (Brenner, 1998:136).

Stoler, who conducted research on the role of women in rural society in Yogyakarta, found that the status of women in a society is not so much determined by their rights and obligations as defined in the legal system, nor by their participation in social and political affairs, but the extent to which they control the strategic economic resources in the community. According to her, in this respect Javanese women rank high, but she also describes, with well documented statistical data, how women of large landholding households have greater opportunity to control the strategic economic resources in the community than those of landless households (Stoler, 1977). Conversely, based on Stoler's findings, Koentjaraningrat (1985:140) has pointed out that with the recent technological changes occurring in Javanese rice cultivation; the opportunity for women of lower socio-economic status to play a role in the village economy has also diminished⁸.

⁸ According to Momsen (2004) modernization of agriculture has altered the division of labour between the sexes, increasing women's dependent status as well as their workload. Women often lose control over resources such as land and are generally excluded from access to improve agricultural methods (2004:1-2). In Indonesia, the Green Revolution was introduced by the government in the 1970s, with several technologically related changes that particularly affected women's labour and the income of the poorest households. *Ani-ani*, a small razor, was the traditional tool used to cut rice (*padi*) in the rice field. The introduction of the sickle was one example of female economic displacement noted in the literature on women and development (Charlton 1984; H Papanek, 1983 cited in Wolf, 1992:48). The *ani-ani* was replaced by the sickle, which is used by men and is estimated to reduce labour requirements in harvesting by up to 60 per cent (Collier et al. 1973; Hart, 1986 cited in Wolf, 1992:48-19). A similar phenomenon also happened in Malaysia. One study conducted by Cecilia-Ng in West Malaysia found that the introduction of various technological innovations has led to a significant reduction in women's agricultural labour. The machines that have been introduced for planting and harvesting have been appropriated by men. Since the Green Revolution, women have contributed considerably less to total agricultural labour input (Cecilia-Ng, 1991).

A small ritual that is included in many Javanese wedding ceremonies seems to encapsulate the ambivalence with which the gendered division of domestic power is viewed in Java (Brenner, 1998:137). At a certain point in the ceremony, the bride and groom approach each other. When a few paces still remain between them, each one takes up a small packet of betel (*sirih*) and throws it at the other, the idea being that the one whose betel hits the other person first will be the dominant partner in the marriage. It is often said that the bride should make sure that she loses the contest, but apparently the outcome is not always predictable. The dominant gender ideologies of Javanese society dictate that the wife should defer to her husband's greater prestige and authority as the head of the household; thus, the bride is supposed to make sure that the groom wins the betel battle, and she washes his foot 'in a token of loyalty and loving submission'. However, the reality of the situation is that in many Javanese households, women enjoy a *de facto* power which outweighs that of their husbands. Consequently, no one is too surprised if the bride's betel strikes the groom first (Brenner, 1998:137-138).

The aforementioned studies seem to suggest that Javanese women do indeed enjoy a position of some dominance within the domestic domain. The symbolic value of men and women appears to be dramatically differentiated, indicating their supremacy in different realms in life (Mulder, 1996: 84). As Mulder has pointed out, the male domain is the outside world of politics and power, of work, position, prestige and hierarchy; the female centres on the home, the children, education and care. Mulder describes the roles of Javanese women as performing:

“ their 'traditional' roles of housekeeper and mother. By giving birth and nurture, she is the living symbol of self-sacrifice; by being accessible and attentive to her offspring, she extends trust and emotional warmth; as the first teacher, she lays the foundation for the evolution of the child on its way to becoming fully Javanese, fully human. Altogether, this makes her the most important person in early life, creating an emotional bond that is most often not undone by passage of time.

The father, being the elder and the progenitor, is entitled to the highest honour, and is hierarchically far away. In contrast to the approachable and emotional mother, the symbol of warmth and homeliness, who earns her honour because of self-sacrificial care, the father seems to embody prestige per se. In that position, he needs to be dignified, in charge without much to do, somewhat remote from his children, and often from his wife, too. He especially represents life outside the home, the world of work and male affairs, and the family's prestige. Whatever respect children and wife may earn for themselves, their main honour in life lies in their belonging to him" (1996:83-84).

In general, in Java, as in other parts of Indonesia, women do hold relatively high status and positions of some power and authority, particularly in the domestic realm. Javanese women also contribute to the household economy by earning income from paid labour, trading and agricultural activities. Javanese women also have the right to own and control land. Social class amongst Javanese people (*wong cilik* and *priyayi*), however, affects both women's contributions to the household economy and their capability to control income, property, etc. Moreover, women are overall still symbolically subordinate to men, and while they contribute to the household economy through labour outside of the home, they also carry the 'double-burden' of authority over and responsibility for children, household management and family decision making⁹.

The full implications of the above gender system for women in terms of breast-feeding practice will be detailed in subsequent chapters. Here I would simply note that because the care of the household and of children in particular is regarded to be the primary responsibility of women, considerations over infant-feeding are largely left to women to decide upon. If they choose to breastfeed, it is women who shoulder the responsibility for ensuring that others in the household are cared for, fed and clothed. Where resources are limited, and particularly during times of economic crisis (see section 4.5 below), this can often mean that women themselves are not only the last to eat, despite the fact that as working women and breast-feeding mothers their nutritional

⁹ <http://www.unu.edu/unupress/unubooks/u113se/u113se09.htm>

requirements may be greater than the needs of others in the household. The point is that the persistence of women's double-burden not only constrains their ability to successfully breastfeed, but also, as I discuss in the following section, is an important factor in women's health more generally.

4.4. The Present Condition of Indonesian Women's Reproductive Health

Women's health is an important investment in a community's future. A woman who has gone through a healthy, happy, planned pregnancy is more likely to bond well with her newborn. She can be a better parent if she is in good health and leads a happy life. Key health issues for women of reproductive age include problems concerning sexuality and reproduction. Sexuality is not merely about sex, but about the right of women to make choices and decisions related to sexual behaviour and practices, relationships, breast-feeding, contraception and abortion. Reproductive health problems are affected by women's access to the means to protect themselves from unwanted pregnancies and sexually transmitted infections, including HIV. The death of a mother in a family has a profound impact, not only in terms of the loss of one life but also due to the affects on the health and the longevity of her surviving family members (The Population Council, 1998).

According to Dyck et al. (2001), spatial differences in gendered health problems have rarely been considered but are becoming increasingly complex as international flows of population increase. In 2002, according to the World Health Organization (WHO), the three leading health problems, measured in disability adjusted life years, in low-income countries were malnutrition (14.9 per cent), unsafe sex (10.2 per cent) and unsafe water, sanitation and hygiene (5.5 per cent), while in middle-income countries the most common causes of poor health were alcohol (6.2 per cent), high blood pressure (5.0 per cent) and tobacco (4.0 per cent) (Dyer, 2002 cited in Momsen, 2004:76).

Poverty and health are closely related, but economic improvement does not necessarily lead to better public health. Poor women suffer more because of their low status, few decision making rights, their heavy workload, including family health care and their experience as bearers of children (Momsen, 2004).

It is estimated that 450 women in Indonesia die in childbirth for every 100,000 live births (UNICEF, 2000)¹⁰. A woman dies every 45 minutes because of complications during delivery, late referral to hospital services and poor treatment. The causes of these problems are complex but include poorly trained health staff and midwives, late referral, and lack of emergency facilities and transport. Only one in two pregnant women uses a trained midwife for her delivery. This substandard of maternal care at the village level has been aggravated by the economic crisis. Data from the 100 Villages Survey conducted by UNICEF (2000) show that from 1997 to 1998, up to 10 per cent fewer women used a trained midwife during delivery. Women are also working longer hours, which can have an impact on their health. The 100 Villages Survey showed an 11 per cent increase from 1997 to 1998 in the number of women working more than 35 hours a week (UNICEF, 2000:14).

In some cases, pregnant women face the same level of maternal death risk. The literature suggests that about 15 per cent need obstetric care to manage unpredictable complications that are potentially life threatening to mother or infant. Data from the 1995 Household Health Survey (HHS) show that the principal causes of maternal death in Indonesia are haemorrhage (46.7 per cent), eclampsia (14.5 per cent), and infection (8 per cent). These complications occur during or shortly after delivery, when many women are cared for only by untrained traditional midwife (*dukun bayi*) or family members and do not receive the essential obstetric care needed (UNICEF, 2000:36).

¹⁰ This estimation is different from data mentioned on the previous page. In Indonesia there is no available vital statistic data for maternal mortality, and maternal mortality data are based on surveys such as the Indonesia Demographic and Health Survey (IDHS), the National Socio-Economic Survey (SUSENAS), Household Health Survey (HHS), etc.

Data from the Ministry of Health (1999 cited in UNICEF, 2000) show that although a high proportion of pregnant women (87 per cent) were found to have made at least one ante-natal clinic visit in 1997, only 69 per cent had the recommended four check-ups during pregnancy. It has been estimated that increasing the proportion of women who receive four check-ups to 85 per cent would significantly reduce problems such as iodine deficiency, signs of pre-eclampsia, tuberculosis, syphilis and malaria, as well as help to identify abnormal foetal positioning or risk of ante-partum haemorrhage. Some studies found that pregnant women in Indonesia often do not take seriously danger signs during pregnancy, such as swelling, vomiting, seizures, and bleeding (UNICEF, 2000). According to the 1997 Indonesian Demographic and Health Survey (IDHS) data, the total number of births assisted by a traditional midwife (*dukun bayi*) fell from 63.7 per cent in 1991 to 54 per cent in 1997. Yet the high rate of home deliveries – 73 per cent of all deliveries, according to 1995 and 1997 IDHS data – results in inappropriate management of emergency obstetric complications during delivery. The unpreparedness of families, especially husbands and birth attendants, to cope with complications of delivery dramatically increases the risk of maternal death. Late referral to an adequate health facility in the event of complications is associated with the inability of husbands or other family members to act promptly, often because of economic concerns or logistical constraints (UNICEF, 2000:42).

Maternal mortality has always been a serious problem in Indonesia. UNICEF (2000) has pointed out a number of key problems which are common in female adolescents and women in Indonesia. These problems include: (1) a continued high risk of maternal death and obstetric complications; (2) lack of care during pregnancy and delivery; (3) delayed referral services and emergency obstetric care; (4) chronic energy malnutrition and anaemia; (5) poor reproductive health status and access to family planning services; and (6) increased risk of sexually transmitted infections and diseases.

Highly traditional attitudes about the role of women in society that still exist in Indonesia fail to recognise the special responsibilities that women often have in fostering the care and well-being of their families. Although, as described earlier, Javanese women enjoy relatively high status, not all Indonesian women are in the same position, and in many places in Indonesia the paternalistic culture still regards men as the primary decision-makers in the household, exercising authority even over decision making about family planning, pregnancy and delivery services (UNICEF, 2000:46).

Indonesia does not have reliable statistical data to calculate maternal mortality rates (MMR). Data for maternal mortality is usually based on surveys, such as the National Socio-Economic Survey (SUSENAS), the Indonesian Demographic and Health Survey (IDHS), the Household Health Survey (HHS), etc. Indirect estimates of MMR from the 1994 Indonesian Demographic and Health Survey (IDHS), which collected data from responses provided by sisters of women who had died in pregnancy, childbirth or the post-partum period, suggest a rate of 390 per 100,000 live births for the period 1989-1994 and 360 for 1984-1988. The 1995 Household Health Survey (HHS) estimated a national MMR of 373 per 100,000 live births. Prior to the 1997 changes in the Indonesian cabinet, the goal was to reduce the national MMR from 450 (1995) to 225 by 1999. The calculated MMR trend showed a decline from 350 (1994) to 308 in 1996, with indications that the national MMR would fall to 214 per 100,000 live births in 1998. Recent analysis of the 1995 HHS data reveals that MMR estimates differ substantially between provinces in Java and outer Java (UNICEF, 2000:42).

By the close of the *Pelita* (Five Years Development Programme) VI in 1998, it was hoped that the MMR would have decreased from 425 at the end of *Pelita* V to 225. The achievement of this goal is difficult to confirm. However, from a rough estimate using a model of the proportion of maternal deaths amongst females of reproductive age (PMDF), using data from the National Socio-Economic Survey (SUSENAS) of 1995, it

seems that the trend is towards a significant decline in MMR. The estimated MMR of 350 in 1994 had fallen to 327 in 1995 and 308 in 1996. Furthermore, it was projected that in 1997, the MMR would be about 259 and would have fallen to 214 maternal deaths per 100,000 live births by 1998 (Soemantri, 1997:10). However, we must interpret the MMR estimation with care because the accuracy and significance of the figures are influenced by many factors, and the variations by province and district are extremely wide. Deaths of pregnant women or women in childbirth are generally caused by five types of complications that have been acknowledged and understood for a long time: haemorrhage, eclampsia, infection, obstructed labour and unsafe abortion. Intervention to prevent maternal death must therefore be focused on three areas: (1) reduction of high-risk pregnancies; (2) reduction of the risk of obstetric complications; and (3) reduction of the fatality risk if complications of pregnancy or delivery arise (Soemantri et al., 1999).

Women of reproductive age can also be subject to high risks from chronic energy deficiency, and measuring upper arm circumference (UAC) is a way of monitoring this condition. Based on 1995 HHS data, 8.4 per cent of the women surveyed had a body height of less than 145 cm, while nearly a third had a UAC of less than the threshold measure of 23.5 cm. Furthermore, 14.5 per cent of married women in five provinces, including West Java, Central Java, East Nusa Tenggara, Maluku and Irian Jaya, were shown to have chronic under-nutrition, as indicated by an average body mass index (BMI)¹¹ of less than 18.5 kg/m². This BMI measure can reflect maternal

¹¹ According to Helen Keller International (1998) The BMI or Body Mass Index is calculated as an individual's weight divided by her/his height squared (kg/m²). A subject with a low BMI has a low bodyweight in relation to height, due to temporarily or chronically inadequate food intake. Maternal malnutrition expressed by BMI is a good and early indicator of the population's food insecurity, because, very often, a woman reduces her own food intake before reducing that of her children and/or her husband. Moreover, the Helen Keller International also stated that there are many consequences for a woman with a lower BMI, such as: (1) reduced capacity; (2) increased morbidity and mortality; (3) less energy available for other activities, such as housework, care, and leisure activities; (4) greater risk of pregnancy complications; and (5) reduced quality of breast milk. Furthermore, maternal malnutrition, as indicated by a low BMI, will also have indirect repercussions on all sectors of society, including: (a) increased risk of infant mortality due to the increased risk of complications during pregnancy; (b) increased risk of

malnutrition, caused in part by the tendency of poor women in Indonesia to reduce their own food intake rather than reducing that of their children and husbands. Women experiencing chronic energy malnutrition are at high risk of having a baby with a low birth weight; if they bear a female child with a low birth weight, the offspring is likely to grow into an adolescent and then adult with chronic energy malnutrition and anaemia (Hellen Keller International, 1998; UNICEF, 2000).

Thus, maternal morbidity and mortality can be caused by malnutrition or under-nutrition during pregnancy or before pregnancy, for example, chronic malnutrition, anaemia, iodine deficiency and vitamin A deficiency in adolescence. During pregnancy, women need higher quality iron for fetal development. Pregnant women must improve their intake of calories, protein, and calcium and increase their body weight by 11-13 kg by the end of their pregnancy. Based on UNICEF data for 1997, 41 per cent of pregnant women in Indonesia have chronic energy malnutrition, which increases the likelihood of maternal morbidity, especially in the third semester (months 7-9), and increases the risk of having a low birth weight baby. In the post-natal phase, a woman’s condition often quickly worsens and she can easily face health problems. Production of breast milk will be affected, and the mother may be unable to care for the child or herself, and, furthermore, the baby may face severe malnutrition, which will worsen if she/he is not

having a child with intellectual and physical impairment due to decreased maternal capacity and/or disease or infection; (c) decreased level of social reproductive activities, such as household chores, child care, exercise and general socialization; (d) decreased output in the workplace resulting in lost productivity and its negative impact on the economy.

Prevalence of low BMI (<18.5 kg/m2) amongst the adult population and the severity of food insecurity

Prevalence of BMI <18.5 kg/m ²	Severity of food insecurity
3-5 %	Normal, no food insecurity
5-9%	Warning sign, monitoring required
10-19%	Poor situation
20-39%	Serious situation
≥ 40%	Critical situation

(Source: World Heath Organization, Physical Status, the use and interpretation of anthropometry. Report of WHO expert Committee, WHO Geneva, 1995 cited in Helen Keller International, 1998)

provided with the nutrients to promote immunity which are contained in the mother's milk. Adult women's nutritional status is based on their nutritional experience as a child and this in turn influences not only their own adult health but also the health of the children they bear. Most nutrition interventions in developing countries have been designed primarily to reduce malnutrition amongst children. Even programmes that include women tend to focus on pregnant and lactating women. This approach limits the success of interventions since action to improve nutrition related to reproductive outcomes is most effectively implemented before women become pregnant, and should be undertaken before girls reach reproductive age (World Bank, 1999; UNICEF, 2000).

Interventions to improve access to maternal health services in Indonesia started a long time ago in the Dutch colonial era in the 1930s. Health development programmes have been directed towards improving the quality of human resources as well as the quality of human life in the community. A child with a good quality of life will have a mother with a good standard of nutrition and health; if women suffer from poor nutrition and poor health, the future generation of Indonesia will be affected as well (Cholil, 1997).

Indonesia has made impressive gains in community health and nutrition during the past 25 years. Health and family planning programmes have substantially reduced infant mortality from 145 per 1,000 live births in 1967 to 46 per 1,000 live births in 1997. The family planning programme contributed to a dramatic reduction of the fertility rate from 5.7 in the late 1960s to 2.8 in 1997. By 1997, according to the 1997 Indonesia Demographic and Health Survey (IDHS), more than 57 per cent of married women used contraception. However, although almost 90 per cent of women receive some care during pregnancy and childbirth, 73 per cent still give birth at home and only about 40 per cent are attended by a trained healthcare provider (BPS, 1994 cited in UNICEF, 2000; World Bank, 1999).

Indonesia's National Family Planning Programme, established in the early 1970s, reflects a growing political commitment to reduce the burden of disability and death related to pregnancy and childbirth. In June 1988 President Suharto announced the Safe Motherhood Initiative, and in 1991 the Ministry of Health established a national strategy to accelerate the reduction in maternal mortality. In 1994, an Indonesian delegation returned from the International Conference on Population and Development in Cairo and launched a new series of comprehensive initiatives and commitments to improve maternal health. Early government initiatives to reduce maternal mortality included strengthening the partnership between traditional midwife (*dukun bayi*) and trained or village midwives (*bidan desa*) and establishing maternity huts. When neither of these actions achieved the desired results, the government initiated an accelerated midwife's training programme in 1993 to place more than 54,000 trained midwives (*bidan desa*) in almost every village in the country. The training midwives are hired on three-year renewable contracts to work in villages throughout Indonesia. They are often the primary source of basic healthcare and maternal and child healthcare in the village. Although access to maternal care has improved, several challenges to the programme's success remain. First, the quality of training was compromised as a result of the emphasis on quantity and the push to get trained midwives into the villages. Second, there is real concern about the commitment of many of the young trained midwives, who are reluctant to stay in remote areas. Third, there is still uncertainty about the long-term viability of the programme, which depends on the villages to sustain the services of the midwives. Field studies in some provinces, such as East Nusa Tenggara, Maluku, South Kalimantan, Irian Jaya, and West Java have indicated the extent of this problem (Cholil, 1997; World Bank, 1999; UNICEF, 2000).

Overall, as with many other developing countries, Indonesian women face many problems regarding reproductive health. A high rate of maternal mortality and

malnutrition are still serious problems in Indonesia. Complications during delivery, poor treatment, late referral, lack of emergency facilities, including poorly trained health staff and midwives, are the causes of these problems. This situation has been getting worse since Indonesia was hit by the economic crisis in 1997. In the next section, I will examine how the economic crisis has impacted on women's health.

4.5. The Indonesian Economic Crisis and its Impact on Women's Health

After almost three decades of sustained economic growth, Indonesia fell deeply into a major economic and financial crisis, which started in 1997. The present economic crisis has transformed Indonesia from an 'East Asian Miracle' with rapid economic growth and low inflation to a country with negative economic growth. The exact mix of causes that led to Indonesia's present economic crisis has been widely debated, but most analysts cite factors that include overspending for consumption and construction, over expansion, misallocation of financial resources and lack of financial discipline, which led to a loss of confidence in the economy and in the national currency, the *rupiah* (UNICEF, 2000:8; Stalker, 2000). Compared with other Asian countries, Indonesia was the country worst affected. Not only did it suffer the steepest economic decline, it was also the only country where the monetary crisis set off a social and political chain reaction that threatened the dissolution of the state (Stalker, 2000:4). Gross National Product (GNP) in 1998 was estimated to be about 15 per cent below its level in 1997. The *rupiah* came under pressure in the latter part of 1997, falling from around Rp 2,400 per US\$ to about Rp 4,800 by December that year. In January 1998, the *rupiah* collapsed to Rp 15,000 per US\$. For the first three quarters of 1998 the *rupiah* fluctuated wildly, but by the end of the year it had strengthened and stabilized between Rp 6,000 and Rp 7,000 per US\$ (Frankenberg, Thomas, and Beegle, 1999) By March 1998, the Central Bureau of Statistics (BPS) announced an annual inflation rate of 34.2

per cent for the 1997/98 fiscal year. Conditions continued to worsen when inflation reached 47 per cent in April 1998 and 59 per cent in July 1998. Devaluation continued through July 1998. By early 1999, the *rupiah* had stabilized somewhat, at around Rp 8,000 to the US\$. However, fluctuations continue to be common (Gardner and Amaliah, 1999).

The instability within the economy affected both macro- and micro-economic conditions. Economic growth saw a sharp fall from a growth rate of 7.9 per cent in 1996 and 4.6 per cent in 1997 to a decrease of 13.7 per cent in 1997. BAPPENAS (National Development Planning Board) predicted a growth rate of 2 to 4 per cent in the 1999/2000 fiscal year. As a direct result of this decrease in economic activity, unemployment and the number of families living in poverty increased. Based on a survey conducted by the Central Bureau of Statistics (BPS) with the United Nations Development Programme and the United Nations Support Facility for Indonesian Recovery (UNSFIR), 49.5 million people were identified as living in poverty in Indonesia at the end of 1998, or 24.2 per cent of the population were living in poverty in February 1999 (Stalker, 2000; UNICEF, 2000)

As mentioned above, one of the biggest problems emerging from negative economic growth, high inflation and unemployment in both the formal and informal sectors was increased poverty. According to the BPS in 1999, the proportion of people living below the official poverty line increased from 11.3 per cent in 1999 (22.5 million) to 24.2 per cent (49.3 million) in 1998 (UNICEF, 2000). The latest data from BAPPENAS showed that in 2001, the proportion was 18.4 per cent, decreasing to 18.2 per cent in 2002 (38.4 million)¹². According to these data, even though the poverty line decreased slightly in 2002, poverty amongst Indonesians is still high compared with its neighbouring countries. The people worst affected were those in urban areas. This was

¹² Kompas, 31 July, 2003

because the crisis started in the financial system, where the collapse of the currency, rocketing interest rates, and the flight of foreign capital brought much of the formal sector, particularly manufacturing and construction, to a halt. People in the rural areas suffered the knock-on effects, through inflation and a fall in agricultural wages as more people competed for the same jobs. But, in general, rural areas were less directly affected, particularly in the outer islands. The Indonesia Family Life Survey (IFLS) found that between 1997 and 1998 per capita household expenditure fell nationally by 24 per cent, but by 34 per cent in the urban areas. Information regarding expenditure can, however, be misleading since people might be sustaining expenditure by selling assets. This means that the real drop in living standards could actually have been much greater (Stalker, 2000).

However, Stalker (2000) has also pointed out that calculations of poverty rates everywhere are fraught with difficulties. There is general agreement that consumption falls below the national poverty line when it is less than 2,100 calories per day, and it is also realistic to assume that the cost of this will be higher in urban than in rural populations. Yet problems persist when measuring, for example, how much people should have to spend on non-food items, and on how much higher the cost of living is in the urban areas. Moreover, the poverty line is constantly changing. The general consensus now is that the poverty line established by the BPS was too low. The United Nations Support Facility for Indonesian Recovery (UNSFIR) argues that this poverty line underestimated both the cost of living in the rural areas and the proportion of expenditure that poor people typically devoted to non-food items, taking the latter to be around 15 per cent when in reality it is nearer 30 per cent. Using its own assumptions on the rural cost of living and non-food expenditure, the UNSFIR calculated that in 1993, for instance, the poverty line would rise from the BPS figure of Rp 21,000(\$ 9.13) to Rp

28,000 (\$ 12.56)¹³. This is a significant increase, and since a large number of people were living around the BPS poverty line, many more would be defined as poor. Moreover, by late 1999, there seemed to be general agreement that the level of income poverty was between 25 and 30 per cent, which represented a significant increase. Nevertheless even this may underestimate the true impact of the crisis on the very poorest (Stalker, 2000).

The present crisis can affect poverty levels both directly and indirectly. Loss of jobs or a move to low productivity work yielding a lower income can easily push those who were already living close to the poverty line to a level below the line. This was what happened to many people who became unemployed or underemployed in 1998, adding a considerable number to the 22 million who were already below the poverty line. One indirect way in which poverty indices were exacerbated is through a downward pressure on the wages of those workers who were lucky enough to retain their jobs despite the crisis. This might have come through employer resistance to increases in wages or an outright reduction in money wages. The latter possibility cannot be ruled out, especially in the informal sector, which will now have the dubious benefit of a substantially augmented labour supply (Islam, 1998).

Thus, the economic crisis in Indonesia ballooned into a full social crisis with wide ranging effects on wages, employment and access to health, nutrition and education services. The crisis has also led to a rise in the prices of basic commodities, such as rice; as a result, many families have had to sacrifice the quantity and quality of their food intake (Helen Keller International, 1998). The development process affects women and men in different ways. The pressure on gender relations of the changing status of women, and of rapid economic restructuring combined with growing impoverishment at the household level for many is crucial to the success or failure of

¹³ In 1993, the currency rate between the Indonesian *rupiah* and the US dollar was 1 \$ US = Rp 2,300. Presently, the BPS poverty line is defined as Rp 96,956 for people in urban areas, and Rp 72,780 in rural areas, with a currency rate of 1 \$US = Rp 8,540 (Kompas, 31 July, 2003).

development policies (Momsen, 2004:1-3). Women are the 'poorest of the poor'; poor men in the developing world have even poorer wives and children. In societies worldwide, women are both producers and carers; they care for children, for old people, the sick, the handicapped, and others who cannot look after themselves. They prepare food, clean, make or provide clothing and, in many cases, water and fuel. Yet their work is not assigned any monetary value (Vickers, 1993:15).

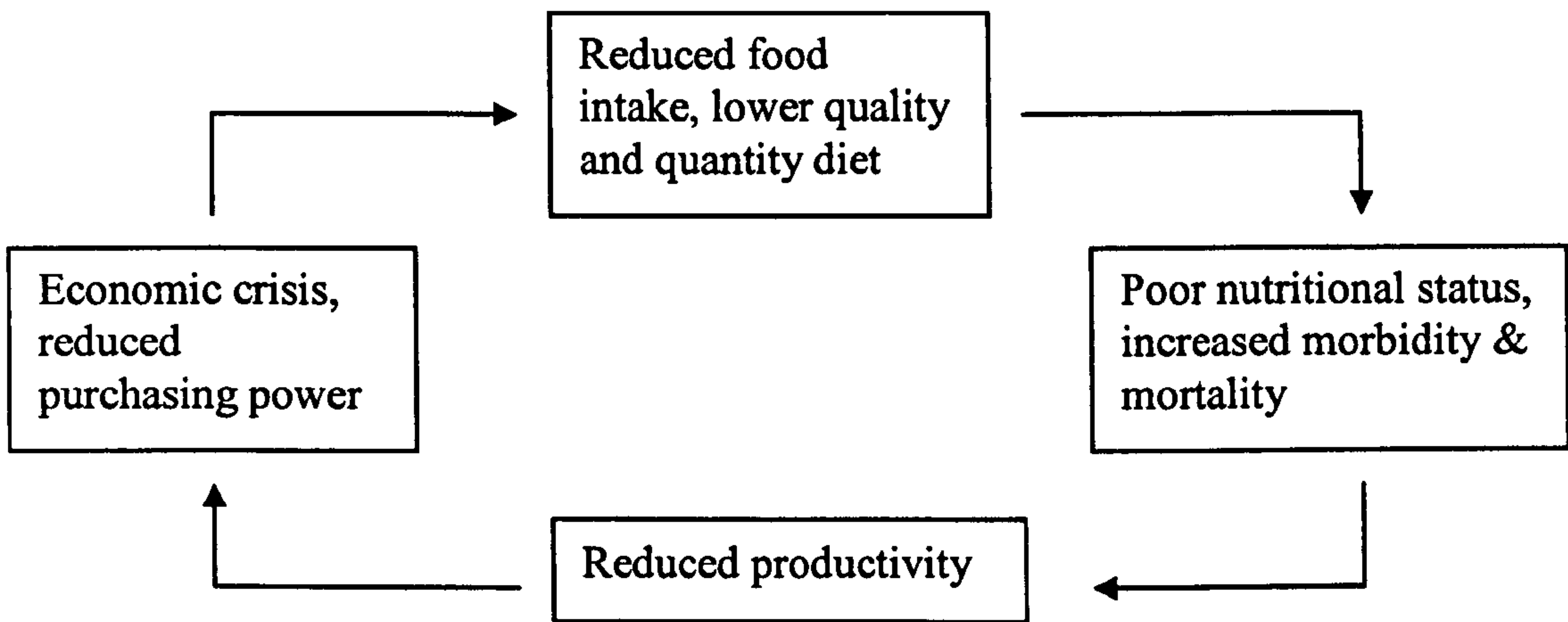
Similarly, in the Indonesian context, while it is true that the economic crisis has undermined progress for the whole population, the effects on women are even more severe. In 1998, 13 per cent of all poor households in Indonesia were female-headed. Of this total, 81 per cent of women were divorced or widowed. Data have shown that about 65 per cent of women who head household's work, while more than 93 per cent of all men who head households work for wages. These data suggest that, in general, households with female heads will be worse off economically, which influences health seeking behaviour (UNICEF, 2000:40). This condition creates a range of effects, beyond poor nutrition and diseases that include dependency, shame, and psychological suffering. For these women and their estimated 2 to 3 million children, the constant daily struggle against poverty constitutes the major threat to their rights for survival, development and protection (UNICEF, 2000:46).

Malnutrition is a complex issue related not just to overall food consumption, but also to many other factors, including the quality of food, health standards, and the levels of education amongst parents (Helen Keller International, 1998; 2000). Helen Keller International (2000) found that the high rates of malnutrition in Indonesia, especially amongst the youngest children, whose food consumption does not necessarily impinge greatly on the family budget, must be due not merely to a lack of food but also to inadequate feeding practices – including the type of complementary food given and the family's levels of hygiene. In addition to the protein-energy malnutrition that hampers

children’s growth, many children and women also suffer from deficiencies in micronutrients, notably vitamin A, iodine, iron and zinc. A shortage of vitamin A, for instance, can lead to blindness and weakened immunity, and a shortage of iron to anaemia and risks to pregnancy. The Helen Keller International survey in 1999 also found that as a result of the crisis both iron deficiency and vitamin A deficiency were increasing amongst young children and their mothers (Stalker, 2000:14, Helen Keller International, 2000).

Maternal malnutrition is part of a vicious cycle which often begins with crisis-induced poverty that in turn translates into low food intake, leading to malnutrition. Malnutrition is perpetuated through decreased work output due to decreased stamina and more frequent, more severe and more protracted illnesses, resulting in lost of productivity in the work place and at home. Lost productivity results at an individual level, in low-to-no chance of improvement of personal socio-economic conditions, and, on a wider social scale, in the perpetuation of the economic crisis. On both levels, it ensures the cycle of poverty, malnutrition, and ‘lost economy’ continues if nothing is done to break it (Helen Keller International, 1998). Figure 1 shows the self-perpetuation of the economic crisis.

Figure 4-1. The Self-perpetuating Cycle of the Economic Crisis



Source: The Helen Keller International (HKI) Indonesia Crisis Bulletin 1(4)
October, 1998

Hence, the 1997 crisis in Indonesia has clearly worsened the problem of malnutrition amongst many women of reproductive age. Data from an analysis of 30,000 households by Helen Keller International (HKI) and Diponegoro University showed that, a year after the onset of the crisis, the mean BMI amongst women in rural Central Java had decreased from 21.5 to 21.0 kg/m². Consequently, the prevalence of maternal malnutrition increased from 15 per cent to 17.5 per cent (Helen Keller International, 2000). In comparison, the 1995 maternal and child health survey indicated that amongst different age groups of women of reproductive age, approximately 62 per cent of chronic energy deficiency cases occur in adolescents aged 15-19 years old and young adult females aged 20-29 (Helen Keller International, 1998;2000; UNICEF, 2000:32).

The Indonesian economic crisis has also had an impact on the use of health services. The majority of the Indonesian population (70 per cent) use health services financed by government subsidies and household out-of-pocket payments, but the economic crisis has increased the number of people who rely on public health facilities for care (UNICEF, 2000:44). The Indonesia Family Life Survey (IFLS), for example, indicated that there was a fall in the use of health services by adults in the same communities between 1997 and 1998 (from 14.4 per cent to 13.3 per cent) (Gardner and Amalia, 1999).

Indonesia has a network of 7,100 health centres (*puskesmas*), to which are linked 23,000 sub-centres, over 4,000 mobile clinics, and 19,000 village maternity rooms (*polindes*). In addition there are 240,000 *posyandu*, the monthly health posts run by health volunteers who promote maternal and child health (UNICEF, 2000; Stalker, 2000). However, although the public network is extensive and well distributed across the country, it is not as effective or as well used by the poor as it should be. One reason for this is charges. In 1998, each visit to a health centre or a sub-centre cost on average

Rp 2,300 (26 cents), this costs approximately the price of a kilo of rice. These charges clearly deter some people. SUSENAS data for 1995 suggest that the richest one-fifth of households were 50 per cent more likely to use public outpatient health facilities than the poorest families, and the imbalance was even greater in the rural areas. However, other people may be deterred by the quality of care on offer. There are similar problems with the *posyandu*: far fewer people use them than might have been expected. In 1997 more than one-third of children under five (*balita*) did not go to the *posyandu*. Compared with other health programmes, the *posyandu* have had much less support, both administrative and financial. Nor have they put down strong community roots. Many studies show that, although these health posts have been expanded to cover every district in Indonesia, they have not been very responsive to community needs and lack a stable base of volunteers (health volunteers – *kader kesehatan*). Moreover, the training of volunteers has generally concentrated on technical rather than social issues (Stalker, 2000:13-15)

Dissatisfaction with public services has been driving more people to seek private care. Consequently, Indonesian people, particularly those with greater financial means, tend to seek private health care rather than use a public health centre, even though the cost is more expensive. Around half of the total national expenditure on health is spent through the private sector. This includes treatment in private hospitals and clinics, often by doctors employed by the public sector who are also allowed to offer private care during normal hours in public facilities. Such treatment is correspondingly more expensive: each consultation with a private nurse costs on average Rp 6,300 (73 cents), and with a private doctor Rp 20,000 (\$2.33). Even before the crisis people had been deserting the public clinics. According to the World Bank, the percentage of users accessing public providers had fallen below 30 per cent by 1995 and by 1998 had

slipped below 20 per cent. Around 28 per cent of people sought modern private care while most of the rest opted for traditional healers or self treatment (Stalker, 2000:15).

Stalker also points out that the unpopularity of public health centres is partly a consequence of underfunding. Underfunding has reduced the standards of equipment and the supplies of drugs (2000:15). Moreover, underfunding has compounded the health-related problems that women in Indonesia face. The Ministry of Health (MoH) implemented a Safe Motherhood programme in 1991 that draws on resources – services, facilities, personnel and drugs – across several MoH divisions. The development budget of the MoH rose by 47 per cent, while the routine budget increased only 5.7 per cent from fiscal year 1994/95 to fiscal year 1998/99. In the 1999 fiscal year, all divisions of the MoH received a budget increase, ranging from 5 per cent to 63 per cent. The Directorate General of Community Health received an increase of 10 per cent, which might have translated into increased funding for Safe Motherhood initiatives. However, the percentage increases were far below the inflation rate triggered by the devaluation of Indonesian currency, which means the MoH budget, including the budget for Safe Motherhood initiatives, has actually declined in real terms (UNICEF, 2000:44).

The economic crisis which hit Indonesia in 1997 has affected all Indonesian people, resulting in negative economic growth, high inflation and unemployment in both the formal and informal sectors, leading to increased poverty. This social crisis impacted on wages, employment, nutrition and access to health services. For women, the affects of the crisis are even more severe. In a country where women already suffer from malnutrition and a high rate of maternal mortality, the crisis has exacerbated such situations.

4.6. Summary

In this chapter, I have explored the situation of Indonesian women in a socio-cultural context as the background of my study. Indonesian women, as with women in other countries in Southeast Asia, are thought to have a relatively high status in gender relations.

The government of Indonesia has consistently supported the raising of women's status to achieve greater equality with men. The government has set up several programmes that focus specifically on women and on improving their social welfare and raising incomes. Developments have brought some progress for Indonesian women; more women have been freed to enter into the public domain, in retail and labour markets, while improvements to transport infrastructure has increased their mobility.

A number of scholars have remarked on the prominent economic roles of Javanese women and their position of control in the household. The Javanese believe that husband and wife should work together as a team. In the domestic domain, female autonomy has been widely recognized. With regard to their strong position in the domestic domain, Javanese women are the main and direct authority figures over children, dominating in the management of the household and family decision-making. However, this 'authority' over the household can be another form of inequality commonly expressed as the 'double-burden' with women shouldering the primary responsibility for and doing the majority of labour within the home, while also engaged in various economic activities outside of the home.

As with many women in other developing countries, Indonesian women also face poverty and health problems, such as malnutrition and a high rate of maternal mortality. UNICEF (2000) reported that in estimation, 450 women in Indonesia die in child birth for every 100,000 live births. The high rate of maternal mortality is usually because of complications during delivery, late referral to hospital services and poor

treatment. The Helen Keller International data (2000) also show that 24 per cent of women of reproductive age in Indonesia have chronic energy malnutrition. Women experiencing this condition are at high risk of having a baby with a low birth weight.

The economic crisis that began in 1997 ballooned into a full social crisis with wide ranging effects on wages, employment and access to health, nutrition and education services. While it is true that the economic crisis has undermined progress for the whole population, the effects on women are even more severe. The 1997 crisis in Indonesia has worsened the problem of malnutrition amongst many women of reproductive age. The Indonesian economic crisis also had an impact on the use of health services. The IFLS (1999) indicated that there has been a fall in the use of health services by adults in the same communities between 1997 and 1998 (from 14.4 per cent to 13.3 per cent).

These situations suggest that the condition of Indonesian women, particularly with regard to reproductive health, still needs improvement, and the wider structural and societal changes in thinking about gender roles and responsibilities are still required. In the following chapter I will examine religion and ritual amongst the Javanese, particularly during pregnancy and birth, since amongst Javanese pregnancy and birth are crucial times within an individual's life cycle.

CHAPTER V

RELIGION, RITUAL AND THEIR INFLUENCES ON PREGNANCY AND BIRTH

5.1. Introduction

The Javanese are the largest of Indonesia's 36 major ethnic groups. The homeland of the Javanese is Java Island, which is the most heavily populated island in Indonesia. Their homelands are in the central and eastern parts of the island. As the centre of colonial activity, by 1930 Java had already experienced a long period of agricultural intensification, construction of irrigation facilities, and development of the infrastructure for colonial economic activities, making it the dominant region in Indonesia (Hugo et al., 1987).

As a part of Southeast Asia, Javanese culture shares several features with neighbouring countries, including the heritage of Hinduism, Buddhism, and Confucianism. Islam was also introduced after the arrival of Muslim merchants from Gujarat India. The culture of Yogyakarta and Surakarta stand out as the court civilisation of the Javanese, and the courts of Yogyakarta and Surakarta gave rise to cultural influences that have spread across the whole country. Within Javanese culture there are two kinds of community groups, the first of which is called '*budaya pesisir*' or '*pesisir culture*' (coastal culture) and includes inhabitants of the north coast. Semarang belongs to this cultural group. The *pesisir* culture extends from Indramayu – Cirebon in the west all the way to Gresik in the east. Puritan Islam dominates the religious and cultural life of the people in *pesisir* communities and a four-century old literary tradition also shows a strong Muslim character (Koentjaraningrat, 1985:21). The second group, '*kejawen*' (homelands), can be found in the royal cities of Surakarta and Yogyakarta and in the interior areas of some parts of central and east Java. In the homelands of Java, it boasts of a four-century old literary history and the sophisticated art of court dances

and music, and is characterized by a highly syncretistic religious life, combining elements of Hinduism, Buddhism, and Islam (Koentjaraningrat, 1985).

This chapter examines the culture, religion and society of the Javanese, and in particular the rites and customs associated with pregnancy and giving birth. However, before focusing on rites linked to such life cycle patterns, I will provide an overview of the central characteristics of Javanese society, customs and religion. Furthermore, I will be focusing on *slametan* as a rite linked to life cycles, particularly pregnancy and birth, and will examine how the Javanese living in Semarang (peri-urban and urban areas) practice the *slametan* of *tingkeban* or *mitoni*, which celebrates the 7th month of pregnancy, and *brokohan* and *selapanan*, which celebrates the baby's birth. I will also examine my respondents' perceptions of the concept and meaning of *slametan*.

5.1. Religion and Social Class amongst Javanese

Many scholars have pointed out that Islam came to Indonesia from India, brought by merchants in the fourteenth century or perhaps even earlier (Geertz, 1960; Koentjaraningrat, 1985, Woodward, 1989). The history of the spread of Islam in Java and the conversion of the Javanese to Islam is still largely open to question, and much data collecting and research remains to be done before the main speculations and hypotheses concerning the process are documented through established facts (Koentjaraningrat, 1985:44-56). However, there is general agreement amongst scholars that Islam came to Java from India to the commercial towns on the east coast of present day Aceh in North Sumatra, and subsequently to Malacca, a newly emerging state on the west coast of the Malay Peninsula.

According to Koentjaraningrat (1985:316-317), in the past, Javanese people followed a form of Islam called *Agama Jawi (kejawen)*. In principle, *Agama Jawi* is similar to Islam. However, as Koentjaraningrat points out, the Javanese do not follow

Islamic principles, or *Rukun Islam*¹, very strictly. For instance, they do not perform the five daily *shalat*, and rarely perform the weekly Friday praying (*shalat Jum'at*). Many Javanese do not undertake the *hajj* or the pilgrimage to Mecca, but they do fast during the month of *Ramadhan*. Javanese Muslims believe in God (*Allah*) and, like Muslims in other areas, they believe that Mohammad is Allah's prophet. They also believe that if they lead a good life, their soul will go to heaven, but a bad life will take them to hell.

Many scholars have found an intense concern with status and hierarchy to be one of the most distinctive features of Javanese language and society (Geertz, 1960; Geertz, 1961; Jay, 1969; Brenner, 1998). Status is determined through a complex but somewhat fluid system of social hierarchy based on rank, class, age and seniority, occupation, education, and other considerations, such as whether one is a villager or an urbanite (Brenner, 1998:58).

With regard to social class, the Javanese distinguish between two broad social classes. The first of these social classes is the *wong cilik* or *tiyang alit* (small people; little people or common people), which includes the mass of agricultural workers, traders, merchants and low-income urban people; whilst the second class is *priyayi*, which includes officials and intellectuals (Magnis-Suseno, 1981; Koentjaraningrat, 1985). However, Koentjaraningrat also pointed out that Javanese society is relatively open and people can be socially mobile. For instance, peasants usually classed as *wong cilik* may move upward and become *priyayi*, by way of education, or by being employed in white-collar government positions (1985:230). In other words, social status may change over the course of an individual's lifetime, as he or she rises or falls in social position through education, marriage, parenthood, acquisition or loss of wealth,

¹ *Rukun Islam* is the five principles within Islamic religion. A good Muslim must follow the principles or cornerstone of Islam, which include a declaration of two chapters of the *syahadat* statement, praying 5 times a day (5 times *sholat*), fasting during the month of *Ramadhan*, sharing one's goods and money with the poor (*zakat*), and going on a pilgrimage (*hajj*) to Mecca.

promotion or demotion, and other achievements or changes in fortune (Brenner, 1998:59).

The highest Javanese social class is *priyayi*. This class is composed of officials and intellectuals (Koentjaraningrat, 1985, Magnis-Suseno, 1996). The most important *priyayi* were engaged in the administrative service. They were the heads of administrative regions, and, as a social category, they were in colonial times called *pangreh praja* (those who administer the state); after the war, the term was changed into a less authoritative-sounding term, *pamong praja* or *pegawai negeri* (those who foster the state) (Koentjaraningrat, 1985:274) . Brenner (1998:59-60) has pointed out that the traditional *priyayi* elite consisted of hereditary nobility as well as others who served either the palaces or, in the colonial period, the Dutch government. In late colonial and postcolonial Java, the term *priyayi* gradually came to include other Javanese who were not necessarily associated with the aristocracy or the government but who were considered to belong to the elite professional, clerical, or managerial class, such as doctors, teachers, and those employed in white-collar positions on private terms. The *priyayi* enjoy high regard, and they might sometimes try to further raise their status by marrying into the aristocracy and emulating the high lifestyle of the royal courts. Furthermore, the *priyayi* are considered the bearers of traditional Javanese urban culture. In *priyayi* circles various forms of Javanese culture are still fostered today, including classical dance, *gamelan* music, shadow plays and batik (Magnis-Suseno, 1996:16).

With regard to religious activities, Geertz (1960) classified Javanese people into *abangan* and *santri*. According to Geertz, the *santri* differ sharply from the *priyayi* and the mass of the *abangan* in that they try to order their lives in accordance with the precepts of Islam. As Geertz (1960:127) stated “*abangans* are fairly indifferent to doctrine but fascinated with ritual detail, while amongst the *santris* the concern with

doctrine almost entirely overshadows the already attenuated ritualistic aspects of Islam". Clearly, the *abangan* people know when they have to hold *slametan* and what kind of food should be prepared for these *slametans*, such as porridge (*bubur*) for birth *slametan* and pancakes (*apem*) for a death. For *santris*, on the contrary, the basic rituals are also important, particularly the prayers. What concern the *santri* is Islamic doctrine, and most especially the moral and social interpretation of it. Another difference between the *abangan* and *santri* concerns social organization. As Geertz points out: "for the *abangan*, the basic social unit is the household – a man (husband), a wife and the children; for the *santri*, the sense of community – of *ummat* – is primary; Islam is seen as a set of concentric social circles, wider and wider communities" (Geertz, 1960: 126-128).

These days, education has emancipated the commoners, and has given rise to a mixed, educated middle class that is giving shape to a new Javanese - Indonesian culture. Consequently, the *abangan* - *putihan* (*santri* and *abangan*) opposition will no longer be the stress line along which conflicts are expected. Moreover, there now appears to be a much stronger identification with Islam and at least a basic knowledge of Islamic doctrine. Hence, Mulder (1996), in his book 'Inside Indonesian Society', argues that in modern Indonesian society, Clifford Geertz's categorization is no longer applicable:

'..... most students of Javanese society are familiar with the dichotomy between faithfully and nominal Muslims (*santri* versus *abangan*). As a formulation claimed to describe social reality, it still guides the thinking of many scholars, as if life in Java were static and not subject to change. Nowadays, there are good reasons to doubt the heuristic value of the *santri-abangan* cleavage. This fission, elaborated in Geertz's *The Religion of Java*, can now be seen to have belonged to a former structure of society that has vanished rapidly over the past twenty years. At present, at least as it appears at the level of the urban educated middle classes, the two mainstreams in Javanese culture seem to be converging. Moreover, and this is often insufficiently appreciated, all Javanese, whatever their degree of Islamicization, share in Javanese culture. That culture is not necessarily religiously expressed, but contains a common

vision of man, society, and the ethical conduct of life” (Mulder, 1996:211).

To summarize so far: many scholars have pointed out that status and hierarchy are two of the most distinctive features of Javanese language and society. However, both the rigid social divisions between *wong cilik* (common people) and *priyayi* and the traditional religious distinctions between *abangan* and *priyayi* are increasingly being challenged and in some cases discarded all together in the context of new class and consumer based categorizations and stronger Islamic identification. Despite these changes, as Mulder suggests, there continue to be some widely recognized practices that are seen to define key elements of Javanese culture. One of the chief amongst these is the *slametan* which I describe in detail below.

5.3. Slametan

Most anthropologists studying Java agree that the *slametan* lies at the heart of Javanese religion (Beatty, 1999:27). Geertz (1960), in his book ‘The Religion of Java’, wrote:

“The *slametan* is the Javanese version of what is perhaps the world’s most common religious ritual, the communal feast, and as almost everywhere, it symbolizes the mystic and social unity of those participating in it. Friends, neighbours, fellow workers, relatives, local spirits, dead ancestors, and near-forgotten gods all get bound, by virtue of their commensality, into a defined social group pledged to mutual support and cooperation” (1960:11).

According to Koentjaraningrat (1985), *slametan* or *wilujengan* is the most important of religious acts and practices amongst Javanese people. Beatty (1999) pointed out that *slametan* is a ceremonial meal consisting of offerings, symbolic foods, a formal speech and a prayer. He added that “the *slametan* is the pattern of cultural compromise: the attitudes and rhetorical styles it exemplifies are, in varying degrees, carried over into the different spheres of religious life; the *slametan* throws light on

aspects of Javanese religion which might otherwise remain obscure and contradictory: the nature of syncretism as a social process, the relation between Islam and local tradition, and, more abstractly, the multivocality of ritual symbols” (1999:26).

In general terms, the purpose of the *slametan* is to create a state of well-being, security, and freedom from hindrances of both a practical and spiritual kind, achieving a state that is called *slamet* (safe). Amongst Javanese people, *slametan* is held in response to almost any occurrence or occasion considered worthy of celebration, such as birth, sorcery, death, house-moving, harvest, name-changing, opening a business, circumcision, illness, etc. The *slametan* ceremony is usually held in the evening in the main room of the house, which is usually the living room. Traditional carpets made from bamboo, called *tikar*, are placed on the floor, and all of the guests sit correctly on the *tikar* (with sitting position on the floor) in the *sila*² position. On the middle of the *tikar*, usually they put *tampah* (large bamboo trays), measuring approximately two and half feet in diameter, on which the food is placed. The food consists of rice cones, which are about fifteen inches high (*nasi tumpeng*), and elaborately decorated side dishes of fried fish, meat, eggs, vegetable salad (*gudangan/urap*), and fresh fruits, creating a variety of colours and shapes. There are one or two kettles containing tea, and the host provides glasses and plates for all the guests attending the *slametan* (Jay, 1969, Koentjaraningrat, 1985)

The *slametan* ceremony is started with a brief address by the host, delivered in Javanese language in the *krama*³ style, which is the highest form of the Javanese language. He expresses his appreciation to all the guests for their attendance, explains the purpose of the gathering, apologizes for all the shortcomings of the arrangements,

² *Sila* is the correct Javanese sitting position on the floor, which consists of folding the legs inward and crossed in front of the body, with the feet hidden under the things.

³ *Krama* is a level of Javanese language which is characterized by an elaborate system of at least nine styles of speech, which incorporate obligatory distinctions according to differences in status, rank, seniority, and degree of regular acquaintance between addresser and addressee. In addition to the nine styles, three of which – familiar (*ngoko*) – semi-formal (*madya*) – and formal (*krama alus*); these levels are the most basic of Javanese language (Koentjaraningrat, 1985:17-18)

the organization of the ceremony, and the inadequate food served, and finally requests a religious official (*modin* or *kaum*) who has been specially invited for the occasion, to lead an Islamic prayer (*ndonga*), which consists of one or two verses (*ayat*) from the Quran. When the *modin* starts his *ndonga* chant, the guests remain in the *sila* sitting position, placing their hands on their knees with the palms turned upward, their heads slightly bowed, and their eyes closed. Occasionally they accentuate the chant of the *modin* by uttering *amin* in chorus. When the *ndonga* is finished, the *modin* is invited by the host to begin the meal, after which the other guests can begin (Koentjaraningrat, 1985). The size, style, and cost of the *slametan* ceremony depend on the importance of the occasion and the material resources of the host. For instance, a *slametan* for a wedding ceremony is much more costly than a *slametan* to mark a death or other occasions. The costs of the *slametan*, which have been described by Geertz (1960), Geertz (1961), Jay (1969) and Koentjaraningrat (1985) vary greatly in Indonesia. In rural areas, when a family holds a *slametan* neighbours and relatives will help with the preparations (*rewang*).

Although many social scientists have indicated that males are the dominant characters in Javanese religious ceremonies, including *slametan*, Stoler has also pointed out that Javanese women do play an important role in these activities, such as deciding on the date of the *slametan*, on whether it is or is not necessary to have a *slametan*, on who is going to prepare the food, and who is to be invited and sent *besekean* food parcels. These activities show that Javanese women do play an important role, albeit behind the scenes (Stoler, 1977). Now we turn to a description of the rites surrounding pregnancy and birth amongst Javanese people.

5.4. Rites around Pregnancy and Birth

As with other cultures across the world, the Javanese use different ceremonies to celebrate many kinds of important events in their life cycles. According to Koentjaraningrat (1985), Van Gennep (1909), in his book 'Rites de Passage', argued that life cycle rites are the oldest forms of religious activity in human culture, and are an indispensable component in most societies, including Javanese. Many *slametan* are held during the life cycle, including *slametan* held for women during their pregnancy and also to celebrate the baby's birth. Some of these ceremonies are outlined below.

5.4.1. *Tingkeban/Mitoni*

Tingkeban or *mitoni* is one type of *slametan* which shows that the cycle of rites begins when the individual is not yet born. In Javanese culture, a baby gains the attention of his/her family whilst still in the womb, and this ritual reflects the ambivalent feelings of the Javanese about birth. In one sense, this ceremony is performed to celebrate and tell others that there is going to be birth. In another sense, this *slametan* reflects the anxiety surrounding the birth. The host usually provides many kinds of food. The food items in the sacred communal meal and also the taboos to be observed by the prospective mother and father suggest symbolic attempts to neutralize the inherent dangers of childbirth, and to protect the prospective mother and child, and also the rest of the family. The ritual meals of the *mitoni/tingkeban* include *tumpeng* (rice built in the shape of a pyramid), *rujak* (fruit salad), *dawet* (a kind of drink made of rice flour and coconut milk), other traditional snacks, and fresh fruits. In addition to celebrating the seventh month of pregnancy, the name, colour and appearance of the foods symbolise a successful delivery that will be quick and smooth. For instance, the name '*jenang procot*' (thick porridge/pudding or sweet cake made of glutinous rice),

can also be interpreted as 'easily born', as the term *procot* actually means 'to slip out'. *Mitoni* or *tingkeban* is usually held on a Friday afternoon or Saturday morning, which in the Javanese calendar is counted as 'setu wage' or 'wage Saturday'⁴, and is chosen because of its similarity with *metu age*, which means 'come out quickly' (Koentjaraningrat, 1985).

During this rite, seven women elders, led by the traditional midwife or *dukun bayi*, bathe the mother. As she is bathed, the pregnant woman follows some ritual acts in order to ensure a safe birth. The traditional midwife puts two coconuts inside a traditional cloth (*jarik*) engraved with *Betara Kamajaya*, a traditional puppet character symbolizing a strong and handsome baby boy, and *Dewi Ratih*, symbolizing a beautiful baby girl. After that the pregnant woman is made up in front of the guests six times with different traditional cloth. Each time she tries the cloth on the guests should say that the cloth is not suitable. Finally, she wears the seventh cloth, '*kain/jarik lurik*' (*lurik* cloth), composed of a '*lasem* weaving cloth' and '*dringin*' (*selendang* – a small cloth wrapped around her chest), and then the guests say that the cloth is suitable and that the mother looks very beautiful wearing it. This last cloth is considered to be very cheap compared with the previous six, meaning that the mother can face the birth simply.

The rite is usually carried out during the first pregnancy. During subsequent pregnancies another rite, called '*madeking*', is carried out. This rite is also to ensure a smooth, safe birth, as it is believed that a woman might also experience difficulty with her second or subsequent births. However, this rite is seldom carried out nowadays. One traditional dish of the *madeking* rite is '*nasi aking*' (rice mixed with dried rice - *intip*). Other food served includes vegetable salad, eggs and bananas. The food is distributed to neighbours, relatives and friends. The food symbolizes a simple life when facing the birth. *Madeking* is more popular in coastal areas, such as Semarang, than in Yogyakarta.

⁴ In the Javanese calendar, any time after 3pm is counted as the day after. If the ceremony is held on a Friday in *jumat pon* (late afternoon, after 3pm) that means that the ceremony has, in effect, fallen on *Wage Saturday* or 'setu wage'.

My respondents in Semarang mentioned that their mothers had held this ceremony, but respondents in Lintang stated that they would rarely hold a *madeking* for a second or third pregnancy.

Koentjaraningrat commented that nowadays amongst the *priyayi*, *mitoni* or *tingkeban* is becoming more and more a secular celebration. Amongst the *priyayi*, this ceremony in anticipation of a child's birth is an especially happy event, not just for the nuclear family but for the extended family; they can enjoy the food and the social aspects of the ceremony, while older women prepare the sacred communal *slametan* meal. He also stated that very elaborate *mitoni* ceremonies, which include many items offerings, such as the five-coloured porridge (*bubur ponco warno*), the five-coloured flowers (*kembang setaman*), chicken (*ingkung ayam*); and a large *slametan* meal to emphasize the religious aspect of the event, still occur amongst *priyayi* families outside the Central Javanese court, particularly in Yogyakarta and Surakarta (1985:235).



Picture 5-1 *Siraman* (bathe) - one activity in *tingkeban* ceremony in Semarang



Picture 5-2 Drinking coconut water after *siraman* in *tingkeban* ceremony



Picture 5-3 Offerings (*sesajen*) for *tingkeban* ceremony

5.4.2. **Brokohan**

On the day a baby is born, a simple ritual called *slametan brokohan* is carried out to tell relatives and neighbours that the baby and the mother are in a state of well-

being. In this *slametan*, some families find a name for the baby on the day the baby is born. Others, however, do not consider this ceremony a name-giving one, but only one to celebrate the birth, as the name is given to their child automatically (that means they gave the baby's name) on the day when the baby was born. Families who take Islamic principles seriously (*santri* families) usually have a name-giving ceremony on the seventh day after birth. They perform a sacrifice ceremony, called *kekahan*, which includes distributing the meat of a sacrificed animal to neighbours and the poor (Koentjaraningrat, 1985:104). Koentjaraningrat also pointed out that the ambiguous attitude towards the name-giving ritual of a newborn child apparently stems from the fact that a child's name is not important. Amongst Javanese, only when a person becomes an adult does his/her name become important, and the ceremony of assuming a new adult name is considered an important social as well as religious event (1985:356).

At the *brokohan* ceremony, the food served includes rice, vegetable salad, eggs and bananas⁵. My informant, an old woman, explains that in contrast to northern coastal areas (Semarang, Cilacap, etc), people in Yogyakarta (southern areas of Java) celebrate *brokohan* by serving other food, such as a piece of coconut, which symbolises the mother's womb; *dawet* (a kind of drink made from sugar, coconut milk and jelly-like pieces of dough), which symbolizes the fetal membrane; duck's eggs, which symbolise the foetus, and palm sugar (*gula jawa*), which symbolises the placenta; and some flowers such as roses, jasmine, and greenish flowers, which symbolise safety.

In Javanese society, when the baby is born the placenta is taken home, washed and buried in front of the door. Different treatment is given to the preservation of a male and female placenta. In the past, when Geertz (1961) carried out her research in Modjokuto, East Java, the *dukun bayi* would take special care of the placenta because of its significance for the Javanese people. The placenta that follows the birth of a boy is

⁵ Amongst the Javanese, every kind of food has a different symbolic meaning. For instance, eggs are a symbol of life. Bananas are always presented in every kind of *slametan* since banana is available in every season.

preserved in an earthenware jar and sometimes thrown into the river or buried in the back yard. The placenta that follows the birth of a girl is always buried at the right side of the house, together with several symbolic objects, such as a piece of paper on which a letter of the Javanese alphabet is written, a needle, or a *canting*⁶ (Geertz, 1961; Koentjaraningrat, 1985:355). This ritual showed the division of labour amongst Javanese people. Paper symbolised a baby boy, which means he will be engaged in the public domain; on the other hand a baby girl was symbolised by a *canting* or needle, which means she will be engaged in the domestic domain, doing sewing or painting batik cloth. Nowadays, since more Javanese women give birth in the hospital, usually the members of the family will take care of the placenta, such as the mother, mother-in-law and husband. They will bury the placenta in the house near the main gate; if the baby is a boy, it is buried on the left side and on the right side if the baby is a girl. Men in Javanese society are considered to be the protectors, while women are thought to be the ones in need of protection. Near the place where the placenta is buried a traditional oil lamp (*senthir*) is placed and lit for 35 days to ensure that the baby will be safe (Geertz, 1961).

5.4.3. *Selapanan*

The *selapanan* rite is held when the baby is 35 days old (*selapanan* means 35), on the baby's *weton*. The word '*weton*' is derived from the Javanese word '*metu*', which means going out, or a combination of certain days. For the Javanese, '*weton*' is very important in deciding important events in people's lives, such as their wedding date, house moving, opening ceremony, and many other events⁷. There is a belief amongst

⁶ A *canting* is an instrument used to draw the patterns of a batik cloth with molten wax.

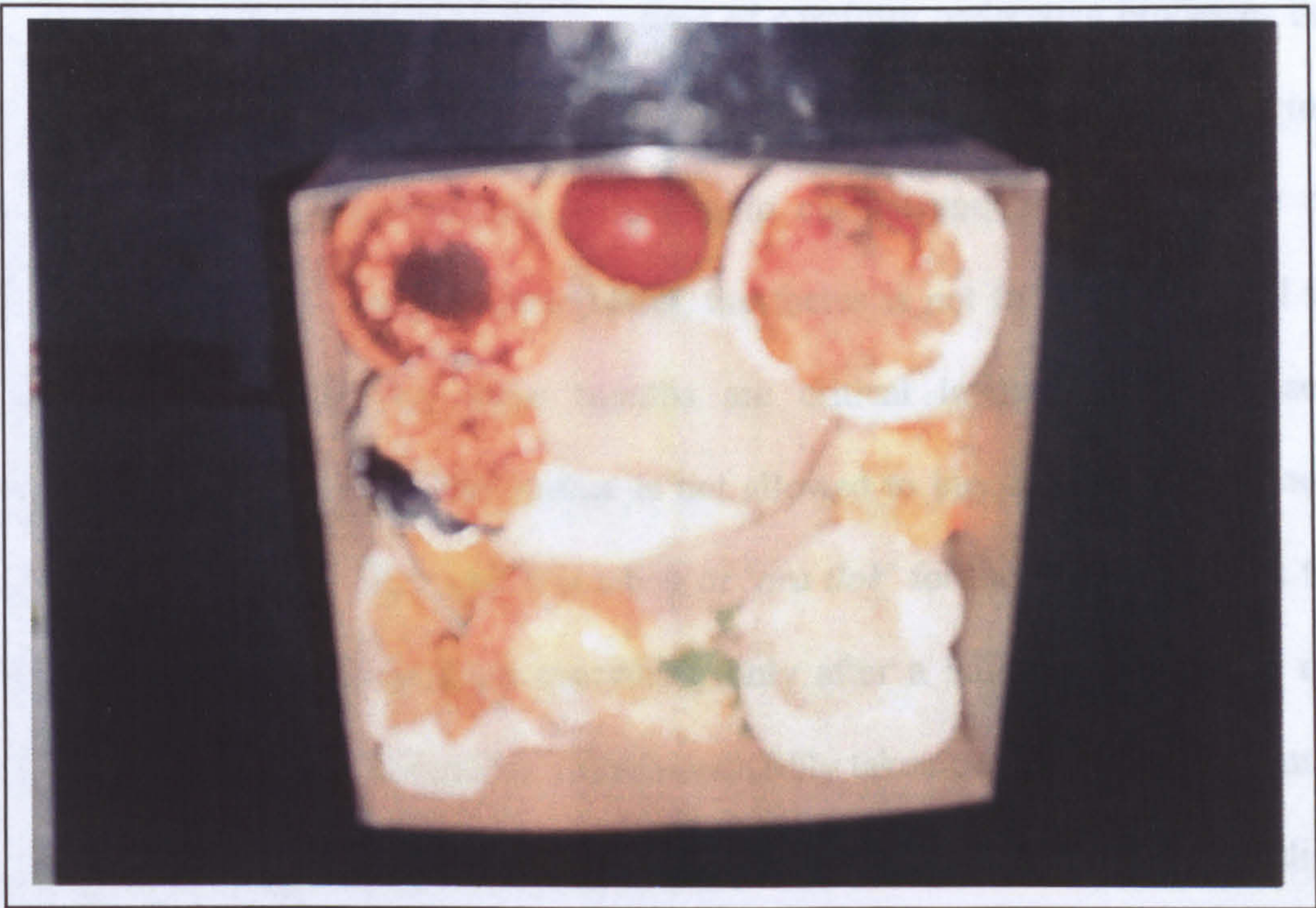
⁷ Based on the Javanese calendar, *weton* is a combination of certain days. *Senin* = Monday; *selasa* = Tuesday; *rebo* = Wednesday; *kemis* = Thursday; *jum'at* = Friday; *setu* = Saturday; and *minggu* = Sunday with the Javanese day, such as *legi*, *pahing*, *kliwon*, *pon* and *wage*, and repeated every 35 days, for instance *Selasa Pahing* occurs every (just available) 35 days on the Roman calendar. According to Geertz (1961), each day in the Javanese calendar has a number (*neptu*):, Sunday = 5, Monday = 4, Tuesday = 3,

the Javanese that members of the same family should not share the same *weton*. This will bring danger, so a special rite is carried out. In this rite, the father puts away the baby who has been born on the same *weton* as another family member after the birth. The baby is put in a certain place and then 'found' by the relatives and given back to the mother (Koentjaraningrat, 1985). For example, my elder sister was born on the same day and *weton* as my mother, on *Selasa Pahing* (Tuesday *Pahing*). To avoid bad luck, she was put away symbolically by my grandmother and then given back to my mother.

During the *selapan* rite, Javanese people serve a special dish consisting of rice and vegetable salad, a five-coloured porridge (*bubur ponco warno*), eggs, bananas, chicken or beef. Unlike the dishes for *brokohan*, which are served on plates, the dishes for *selapanan* are served in boxes, and a piece of paper upon which the baby's name is written is put in each box. This means that the baby will be safe. It also tells the neighbours and relatives what the baby's name is. In the house, the host prepares the five-coloured porridge (*bubur ponco warno*), *jajan pasar* (snack meals) and vegetable salad (*gudangan* or *urap*). When the food boxes are delivered to neighbours, friends and relatives, the porridge, vegetables salad and *jajan pasar* are then given to local children. During the *selapanan* rite, the father cuts the baby's hair. People believe that when the baby is born, his/her hair is from heaven, so that after his/her parent cuts it, the baby will then have worldly hair. In some Muslim societies, birth rites include a *kekahan* ceremony (the slaughtering or sacrifice of certain animals, usually goats). For a baby boy, two goats are slaughtered, while for a baby girl one goat is slaughtered. Nowadays some people hold this ceremony on the seventh day after the birth or on the same date of the *selapanan* rite. The meat is distributed to poor people and some of it will be distributed to neighbours and relatives. The purpose of the slaughter is based on Islamic

Wednesday = 7, Thursday = 8, Friday = 6, Saturday = 9; *Legi* 5, *Paing* 9, *Pon* 7, *Wage* 4, *Kliwon* 8. If we add the number, thus came on *Sabtu-Wage*, which is 9 for Saturday, plus 4 for Wage, giving 13. This number is very useful as a direction for making important decisions, such as wedding date, house moving, etc.

principles, which hold that the sacrifice of certain animals will help people get to heaven on *kiamat* (judgement day).



Picture 5-4 Meals box for *selapanan* ceremony

Table 5-1 shows a summary of Javanese *slametan*, categorised by the name, time and the purpose of each *slametan*.

Table 5-1
Summary of *Slametan* during Pregnancy and Birth

Name	Time	Purpose
<i>Tingkeban/Mitoni</i>	Seventh month of pregnancy	To reflect the ambivalent feelings of the Javanese about birth.
<i>Brokohan</i>	The day when the baby is born	To tell relatives and neighbours that the baby and the mother are in a state of well-being, and to name the babies in some families
<i>Selapanan</i>	35 days after the baby is born	To celebrate the baby's first <i>weton</i> , and to tell relatives, friends and neighbours that the baby is safe and his/her name

5.5. Forbidden Acts, according to Custom and Belief, during Pregnancy, Birth and Breastfeeding

In Javanese society, pregnancy is a time of carefully undergone processes that will ensure the safety of the baby and the mother. There are many forms of behaviour and certain foods that are forbidden according to custom and belief to ensure the mother's safety. According to Javanese belief, the foetus is not fully formed until the seventh month and the first seven months are critical in terms of unforeseen occurrences. During this time, the mother is not allowed to buy any baby equipment, such as baby clothes, baby box, etc. It is taboo or '*ora ilok*' for the mother to break this rule and she is allowed to prepare everything only after a *mitoni* or *tingkeban* rite. During this critical period, the mother must be carefully taken care of, especially during her first pregnancy. She cannot go out in the late afternoon (*maghrib*). People believe that evil spirits are roaming about in the human world during this time and may enter a mother's body, causing the baby to have convulsions (*sawan*), a mysterious kind of disease, or even miscarriage (*keluron*). These spirits can harm the baby, and lead to deformity or miscarriage (Geertz, 1961; Koentjaraningrat, 1985).

Many kinds of food should be avoided during the pregnancy. Food taboos usually start at the first signs of pregnancy, and include avoiding eggs, young chicken, kepel fruit, shrimps, fish with stings, such as *lele* fish (a freshwater fish), and fruits that have seeds lying in horizontal lines, such as *kepel* fruit. Old people often give different explanations for these taboos, but most have symbolic meanings relating to pregnancy and childbirth. The fruit with the horizontally-lined seeds, such as *kepel* fruit, suggest the wrong position of the foetus; and the prohibition to eat such fruits is believed to prevent such a pregnancy (Koentjaraningrat, 1985:353). Another forbidden food is ice, which is believed to make the baby bigger and the birth therefore more difficult. Another is hot or spicy food, especially when the mother is breast-feeding, because the baby gets a shock when drinking the milk. The *kepel* fruit should also be avoided

because the inside of this fruit is shaped upside down, which is believed to influence the position of the foetus in the womb and can result in a breach position (*sungsang*). The *lele* fish (a freshwater fish) should be avoided because this fish lives in holes, and it is believed that if the mother eats it she may find difficulty in delivering the baby. Sugar cane should be avoided because it is believed to disturb the process of the birth in that the baby will become stuck many times during the birth. It is also believed that the mother should wash her hair everyday, so that if she dies during the birth she will die clean, and that she should not sit in front of an open window, otherwise the baby will have a big mouth and like to make a noise.

The expectant father and mother have, in addition to considering these food taboos, to watch out for little things as well. For instance, they must not leave a salt spoon in the salt pot, cover an ant hole, sit on a rice pounder, etc (Koentjaraningrat, 1985:353). The husband has the same responsibilities as the wife in adhering to certain rules in order to prevent difficulties with the birth and to prevent the baby from becoming too large in the womb. During the pregnancy, the husband is not allowed to kill or hurt any animals. If he does the baby will suffer the same wounds that the husband inflicts on the animals. In the event that he is forced to kill an animal, he can avoid any ill effects by yelling '*nyuwun sewu amit-amit jabang bayi*' ('I am really sorry'). This utterance is often expressed in daily conversation amongst the Javanese, even when they are not expecting a baby, in order to avoid disaster. Nowadays, as communities become better educated, some of these precautions are no longer taken by couples who are expecting children. Couples who are still living with their parents tend to adhere to them because they feel awkward about violating them, and will avoid killing animals, even mice or cockroaches. Only small numbers of the respondents interviewed (approximately 20 per cent) still avoided certain foods, such as ice, although they still consumed small amounts of it. The frequency and the history of the

pregnancies influenced their levels of adherence to the rules of avoiding certain foods and different behaviour.

5.6. The Pattern and Meaning of Rites around Pregnancy and Birth

As mentioned earlier, Javanese rituals begin when the individual is not yet born. *Tingkeban* or *mitoni* is very important for Javanese, and reflects their feeling about life. On the one hand, *tingkeban* demonstrates happiness that a family member will give birth but also reflects the anxiety surrounding the expected birth. For the Javanese, pregnancy is a part of the life cycle about which they are *eling* and *prihatin* (perpetually concerned). A pregnant woman has to start to teach her baby when it is still in the womb, and the pregnancy is a time of carefully undergone processes to ensure the safety of the baby and the mother. The concept of *eling* and *prihatin* is part of the Javanese outlook on life, and Javanese parents tend to teach their children a pessimistic view about life, describing life as a series of hardships and misfortunes. They frequently refer to the idea that a human being should *ingkang nrimah*, or ‘accept fate willingly’ in life, and talk often about the burdens of life and how humans must *pasrah lan sumarah*, ‘surrender and accept fate’ (Koentjaraningrat, 1985).

Brokohan and *selapanan* are Javanese *slametan* that are held to share with others the sense of happiness felt about the birth and concern that the mother and child will be safe throughout childbirth. The Javanese value of respecting and maintaining social harmony (*rukun*⁸) reflects a basic principle of normative and moral behaviour for social interaction within both the family and the community. To achieve *rukun*, people should be primarily group members; and their individuality should be expressed through the

⁸ In his book ‘Mysticism and Everyday Life in Contemporary Java: Cultural Persistence and Change’ Mulder describes ‘*rukun*’ as the ‘soothing over of differences, cooperation, mutual acceptance, quietness of heart, and harmonious existence. The whole society should be characterized by the spirit of *rukun*, but whereas its behavioural expression in relation to the supernatural and to superiors is respectful, polite, obedient, and distant, its expression in the community and amongst one’s peers should be ‘*akrab* (intimate) as in a family, cozy, and *kangen* (full of the feeling of belonging)’. (Mulder, 1978:39)

group. All overt expressions of conflict should be avoided. Unlike Western culture, which regards individualism and group belonging as mutually exclusive, most Javanese consider the two as intimately related (Mulder, 1978). Mutual assistance and sharing of burdens (*gotong royong*), within both the family and the community, should reflect the concept of *rukun* (Mulder, 1978; Koentjaraningrat, 1985). This respect, described by Geertz (1960) and Koentjaraningrat (1985), is based on the lineal value orientation in social relationships. Koentjaraningrat (1985) explains that given this linear value orientation, the Javanese respect and trust their seniors and superiors. Older people in the community and village notables are respected. If someone disagrees with these people, it is done by not responding or by agreeing in a particular manner, which actually indicates subtle disagreement. This respect is also reflected in Javanese social behaviour in other contexts, such as the workplace, schools, and political organizations. The strong emphasis on *rukun* (social harmony) has led to a stereotype of the Javanese character as inexpressive, avoiding social and personal conflict. Geertz noted that to the Javanese “..... emotional equilibrium, emotional stasis, is of highest worth, and on the corresponding moral imperative to control one’s impulses, to keep them out of awareness or at least unexpressed, so as not to set up reverberating emotional responses in others” (Geertz, 1960:147).

Whilst carrying out this research, I attended *slametan tingkeban* in Semarang and also *slametan selapanan* (held together with *kekahan*) both in Lintang and Semarang. Based on information from respondents in Lintang, *tingkeban* should be held during the first pregnancy. For women in the peri-urban areas, this rite reflects the tradition of showing respect for one’s parents or parents-in-law. In contrast, for some women in the urban areas *tingkeban* or *mitoni* was more complicated. Some female guests are invited to attend this ceremony, usually relatives, neighbours, and friends. As mentioned above, *tingkeban* is held on Friday in the late afternoon or on Saturday

morning. In the urban areas, this ceremony is led by the *dukun manten/paes* (bridal beautician)⁹, since *dukun bayi* are no longer available in the city. One respondent in Lintang stated that they held the *slametan* because it was a common ceremony within the community and also out of respect for their parents. Even those experiencing some economic hardship will hold a simple *slametan*, in order to feel safe and secure. On the other hand, however, one of the respondents in Semarang stated that she just followed her mother's wishes in this regard.

Nowadays, *tingkeban/mitoni* or *selapanan* differ greatly from the descriptions of Geertz (1960), Geertz (1961), Jay (1969), and Koentjaraningrat (1985). At the village level, some respondents mentioned that they hold *tingkeban* to ensure safety (*slamet*). Usually the ceremony is held in the parent's or parent-in-law's house and some respondents who had migrated from other villages would return to their home villages to hold *tingkeban*. I had no opportunity to attend a *tingkeban* in Lintang during the research process. One respondent stated that they never held a big *tingkeban* ceremony because it was too expensive. Usually some relatives, neighbours and friends will be invited to attend and a *dukun bayi* will be invited to lead the ceremony. They do not prepare *sesajen* (offerings), as this is forbidden by Islam. Food is prepared by some of the women; they cook it together and distribute the food to all of the guests. However, in the urban areas, *tingkeban* is a *slametan* or ceremony which they feel obliged to hold, just like a wedding ceremony. One pregnant woman told me that she did not know about the ceremony, even though she had attended this kind of ceremony before; she just followed her mother's wishes. Guests, including relatives, friends and neighbours, are invited with an invitation letter. All the food, including the major elements of the

⁹ In the past, those holding the profession of *dukun manten/paes* had the responsibility for ensuring a successful wedding ceremony. Both the *dukun manten* and the bride had to fast for forty days before the wedding to ensure the bride would be beautiful and angelic (pretty as an angel). The responsibilities of the *dukun manten* included preparing all the offerings (*sesajen*), as well as making up the bride. Nowadays, however the *dukun manten* acts only as a beautician (her job is less than the job of *dukun manten* in the last decade), making up and dressing the bride. The *sesajen* or wedding ritual is no longer her responsibility, even though she may still practice certain rituals before she starts her job.

ceremony, was ordered from a catering company. Socio-economic factors play a large part in determining how people celebrate this occasion

All of the respondents, both from the peri-urban and the urban areas, stated that they celebrated *brokohan* as an announcement, as a way of telling neighbours and relatives that the baby had been born and both baby and mother were doing well. With regard to Hildred Geertz's description of '*babaran*' (giving birth), many of the rituals or *slametan* have completely changed. Just a few women used a *dukun bayi* to assist with the delivery, as most were assisted by trained staff in maternity clinics or hospitals, which affected the process of washing the baby during the delivery (Geertz, 1961). My respondents who had given birth with a *dukun bayi* mentioned that they did not carry out any rituals after giving birth, but that the *dukun bayi* just helped to clean both the baby and the mother, although the *dukun bayi* took care of the mother until the baby was 35 days old. One respondent in an urban area argued that the decline in birth related rituals is because women no longer lived with their parents, but as nuclear families, which meant that when they give birth their parents, and most importantly their mothers, are not present.

Jay's study (1969) in rural Modjokuto, East Java, found that after the birth of a child a *slametan* is held as soon as food can be prepared, and the family holds an open house (*jagongan bayi* – visiting the baby) for kinsmen and neighbours for five days and five nights. Yet in both Lintang and Semarang *jagongan bayi* has almost ceased to exist. Relatives, neighbours and friends will visit the mother and baby when they are still in the maternity clinic or a few days later when the baby and mother have returned back home. Socio-economic conditions and busy lifestyles are two factors that have led to a decrease in *slametan* during births. One of the respondents in Lintang stated that she had budgeted for prenatal care, the delivery fee and a *slametan*. With regard to the *slametan*, she preferred to hold a *selapanan* rather than a *sepasar* or a *jagongan bayi*,

since the *selapanan* is held as an occasion to celebrate the baby reaching 35 days, and to inform everyone of the baby's name.

In the past, if one family held a *slametan*, such as a *selapanan*, family members would prepare all of the meals in their house, with the help of some of the women living in the neighbourhood (*rewang*). They would cook the meals, which would then be distributed to relatives, friends, and also neighbours. Some families in rural areas still do this in order to preserve good social relations within the neighbourhood. But in urban area, my respondents stated that they preferred to order in a catering company for all of the food. The reason given was that they did not want to bother the other families; they felt that it was less complicated, even though they had to spend much more money. When I was attending a *selapanan* in Semarang, the family held a *selapanan* and a *kekahan* (slaughtering of certain animals, usually goats) at the same time. In the afternoon (after *sholat dhuhur*, around 1pm), they started the *slametan* with a *pengajian* - praying together and reading several chapters (*ayat*) of the Quran. They asked a *modin* to lead the *pengajian*. The aim of the *pengajian* is to give thanks to God that all of the members of the family are safe and well, especially the baby and mother. They pray for the baby's good health and development and that he or she will grow into a child who will always obey his or her parents (*anak yang sholehah – sholehah* child). After the *pengajian* was finished, all of the meals in the boxes, which contained rice, vegetable salad, eggs, beef, bananas, snack meals and a lamb dish (*gulai kambing*), were distributed to neighbours, relatives and friends. In each box was a piece of paper with the baby's name printed upon it.

My respondents both in the peri-urban and the urban area stated that they never prepared *sesajen* (offerings), such as *kembang setaman* (the five-coloured flowers), *dupa* (incense), etc., but they did prepare *bubur ponco warno* (the five-coloured

porridge)¹⁰, *nasi gubahan* (rice with vegetable salad) and *jajan pasar* (snack meals). I asked one of my respondents the meaning of some kinds of food, to which she replied that she herself did not understand it but simply followed what other people did.

As mentioned earlier, many scholars agree that *slametan* is at the centre of Javanese religion. For Geertz (1960), it was how the *slametan* was viewed that defined important differences between *abangan* and *santri*. For the former, *slametan* was the primary component of their religious life. For the latter, while *slametan* was important as a ritual event, primary religious importance was accorded to formal Islamic doctrine and keeping of *Rukun Islam*. However, as I have argued above, Geertz's typology reflects a former Javanese social structure that is no longer relevant. Javanese people, identify themselves as Muslim and they practice, or at least say they practice *Rukun Islam* more seriously than before. Furthermore, I agree with Woodward's concept (1989), which has given the terms of the debate a further twist by claiming that Javanese religion, in both its popular and mystical forms, is basically an adaptation of Sufism and therefore constitutes a local form of Islam. The dichotomy of *kejawen* and *santri* thus refers to a division within Islam.

Accordingly, Woodward (1989:29) argues that: "(i) the *slametan* is the product of the interpretation of Islamic texts and modes of ritual action shared by the larger (non-Javanese) Muslim community; and that (ii) the *slametan*, at least in Central Java, is not especially or even primarily a village ritual but is modelled on the empirical cult of the court of Yogyakarta, which was Sufi in inspiration".

¹⁰ In his book 'The Religion of Java', Geertz (1960) wrote that one offering (*sesajen*) consists of three kinds of rice mush: plain white and red (made so by adding coconut sugar), and a combination of the two: white around the outside and red in the centre of the dish. The white represents the 'water' of the mother, the red the 'water' of the father, and the mixture (called *bubur sengkala* – literally, 'misfortune porridge') is considered especially efficacious for preventing the entrance of harmful spirits of any kind. However, Beatty (1999) wrote that *jenang ponco warno* (the five-coloured porridge) refers to the *dulur papat lima badan*, literally the four siblings, and the five body elements. The four siblings are personal guardian spirits, important in magic and protection from sorcery. Based on my personal experience as a Javanese, I have seen my mother often preparing the five-coloured porridge when she holds any kind of *slametan*, such as to celebrate the anniversary of my father's or grandparents' deaths or during a *selapanan* for my nieces or nephews in my hometown, Yogyakarta. The five-coloured porridge is white, red, a mixture of red and white, white surrounded by red, and red with sliced coconut in the centre. My mother told me that the red porridge symbolises the female, and the white porridge symbolises the male. My mother also prepared rice with vegetable salad and *jajan pasar* (snack meals). Different interpretations have probably arisen as a result of the fact that research has been carried out in different areas or cities.

Based on social changes in the community regarding the concept of religion, in this case Islam, people tend to hold *slametan* as a ritual or in a cultural context. The mothers in both areas stated that they still wanted to hold all the *slametan* since they believed it would bring them safety. As the Javanese believe that pregnancy and giving birth are critical periods in the life cycle, they are *eling* and *prihatin* (perpetually concerned) during these periods, as described earlier.

However, *slametan* around pregnancy and birth are different from *slametan* to celebrate the anniversary of a death or a house moving, etc., and such occasions are unrelated to breastfeeding practice amongst Javanese women. On the other hand, during the time that they breastfeed their babies, Javanese women should be careful about their food intake, because they believe that the food which they eat will be passed to their babies through breast milk. In local communities, there are usually rules or guidance about the kinds and quantities of food which can be eaten by family members, based on status, age, gender, and special conditions. Besides such rules, certain foods are taboo for certain people at different times based on the customs or traditional ways. For pregnant and breastfeeding women foods that are considered taboo usually include eggs, fish, and milk, all of which have a high nutritional value for pregnant and breastfeeding women and their babies. The reasons behind such food taboos are unclear (Margawati, 1996). However, as mentioned earlier, my respondents stated that they no longer adhere to such food taboos during their pregnancy or when they are breastfeeding as they are aware of the high nutritional value of such foods.

5.7. Summary

In this chapter, I have analysed the changing rites surrounding pregnancy and birth. Javanese people hold many ceremonies, or *slametan*. *Slametan*, according to Geertz (1960), is at the centre of Javanese religion. While, social and religious

conditions in Java are different from when Geertz (1960), Geertz (1961) and Jay (1969) carried out his research in Modjokuto in the early 1950's and also when Koentjaraningrat carried out his research in the 1970's in Central Java and in Semarang people still believe in holding *slametan*. Javanese people view pregnancy and birth as critical periods during the Javanese life cycle. Amongst Javanese, many *slametan* are held during the life cycle, including during pregnancy and birth, to reflect their feelings during these cycles. Also, for Javanese people, pregnancy is a time of carefully undergone processes that will ensure the safety of the baby and the mother. To ensure the mother's safety, there are many forms of behaviour and certain foods that are forbidden according to Javanese custom and belief.

This research found that respondents in both areas still hold *slametan tingkeban*, *brokohan* and *selapanan* during these periods. However, many of them hold *slamentan* out of a sense of obligation, since *slametan* is perceived to be a custom or tradition amongst Javanese people. But they have simplified the ceremonies, particularly respondents in the peri-urban area, because of changing socio-economic conditions. On the contrary, people in urban areas hold *slametan* as a ceremony or party, an occasion for displays of wealth and affluence. My respondents stated that they did not quite understand the various meanings within these ceremonies, but just wanted to follow their parents' ways. Respondents in both areas stated that they no longer prepared offerings (*sesajen*), such as *kembang setaman* (five-coloured flowers) or *dupa* (incense), etc., since they no longer believe in the significance of the offerings and because Islam, their main religion, does not permit it. Nevertheless, while they said they carried out *slametan* either out of a sense of obligation to their parents or duty to preserve 'Javanese' culture, the majority in addition also often stated that the aim of holding *slametan* was to create more safety in their lives (*slamet*). Having provided a discussion of some key aspects of culture and religion in Java, particularly as it relates to rituals

surrounding pregnancy and birth, the following chapter, provides a more detailed picture of my research site and respondents. I examine key socio-demographic features of Semarang and Lintang where my respondents lived, and consider issues of employment, housing, household, family and social attitudes towards children and child rearing.

CHAPTER VI THE AREA

6.1. Introduction

Semarang is the capital city of Central Java province. It is bordered to the north by the Java Sea and to the south by Yogyakarta province and the Indonesian ocean. Central Java's topography and geography are varied, and include coastal areas, low land, and high land or mountainous areas. As well as Yogyakarta, Central Java, particularly Surakarta, is the homeland of the Javanese people, and is significant for giving birth to the court civilization of the Javanese. Nowadays, some cities in Central Java, such as Surakarta and Pekalongan, are famous for batik production. Some parts of Central Java, such as Tegal, Rembang and Semarang, which are located in the north, are part of Javanese coastal culture, or *pesisir* culture.

This chapter provides information regarding the situations and conditions within my research area, which is in Semarang, particularly Lintang village (a pseudonym). I will provide an overview of the socio-demographic features of Central Java, including Semarang and Lintang. I will focus particularly on the women of Lintang, analysing different aspects of their lives, including employment, household management, housing, family, the value of children and also child rearing.

6.2. Social and Demographic Features of Central Java and Semarang

Central Java is divided into 29 regencies (*kabupaten*) and 6 municipalities (*kotamadya*) and the capital city of Central Java is Semarang municipality. Semarang is a large urban area with more than one million inhabitants. Compared to other big cities on Java, such as the Indonesian capital of Jakarta, the West Javanese capital of Bandung and the East Javanese capital of Surabaya, Semarang is relatively small with regard to

population, size, and development. Although the Javanese language in the north (Semarang) does not differ sharply from the south (Yogyakarta and Surakarta); people in Surakarta and Yogyakarta tend to use a higher level of Javanese (*krama alus*), whereas people in Semarang tend to use a lower level (*madya* or *ngoko*)¹. With regard to food, northern food tends to be salty, whereas southern food tends to be sweet.

The city of Semarang is comprised of high land, low land, and hilly areas. As such, the city is divided into uptown (*kota atas*) and downtown (*kota bawah*). Downtown or *kota bawah* is also called *kota lama* or old town, since in this area there are many buildings which were built during the time of Dutch colonialism. The city centre of Semarang lies in this part, and within the centre there are offices, the train and bus stations, shopping malls and also residential areas. Candi Baru, one elite residential area which is located in between uptown and downtown, was a Dutch residential area during the era of Dutch colonialism in Semarang. Uptown or *kota atas* has developed into expensive residential areas, such as Bukit Sari, Srandol and Banyumanik; and some universities are also located in this area. Semarang is also famous as a city that is prone to flooding, and in every rainy season many parts of this city are flooded. As in many other cities in Indonesia, the gap between the rich and the poor is very wide. Although some areas of the city have been developed as real estate for rich people, slums have also been expanding since the economic crisis hit Indonesia in 1997. Table 6-1 shows the population indicator in Central Java, based on the 2000 National Socio-Economic Survey (SUSENAS) data.

¹ For more detail about the Javanese language, see more detail in chapter V (Religion, Ritual and Their Influences on Pregnancy and Birth).

Table 6-1
The Population Indicator in Central Java Province

Indicator	1999	2000
Total Population	30,761,221	30,775,846
Male	15,245,718	15,253,438
Female	15,515,503	15,522,408
Sex Ratio (%)	98.26	98.27
Percentage population based on age group		
0 – 14 years	29.46	28.26
15 – 64	64.29	65.58
65 +	6.25	6.16

Source: The 2000 Central Java National Socio-Economic Survey (SUSENAS)

Based on these data, women in 2000 still outnumbered men, with a ratio of 100 women to 98 men. In 2000, the population of Semarang was 1,341,730; composed of 703,523 females and 638,207 males. The average total monthly expenditure of a household in Central Java in 2000 was Rp 109,500 (\$9.8); and food expenditure was 66,100 (\$5.9).

Agriculture still employs the greatest number and proportion of women and men in Java, including Central Java, but the growth of agricultural employment has been minuscule and certainly has not kept up with the population growth. In contrast, in Semarang, community and social services provide the greatest source of employment. Table 6-2 shows the number of people working in different sectors in Semarang and Central Java in 2001.

Table 6-2
Population 10 Years of Age and over who Worked during the Previous
Week by Region and Main Industry in 2001

Sector	Region	
	Semarang (thousand)	Central Java (thousand)
Agriculture, Forestry, Hunting and Fishery	16	6730
Mining & Quarry	5	78
Manufacture	112	2447
Electricity, Gas, and Water	5	14
Construction	35	688
Trade, Restaurant, and Hotel	145	2826
Transportation, Storage and Communication	37	592
Finance, Insurance and Real Estate	11	121
Community, Social service	154	1570

Source: The Central Bureau of Statistics (BPS) Central Java, 2001²

Since the main issue of this thesis is about women's health, it is necessary to explore the health situation in Central Java. As mentioned in the previous chapter, maternal mortality is a problem in Indonesia particularly in rural areas, given the limited number of skilled attendants to assist at births and an adequate referral system. Recent analyses of the 1995 Household Health Survey (HHS) data reveal that the maternal mortality rate estimates differ substantially between provinces in Java and other provinces in Indonesia. Table 6-3 shows the estimated maternal mortality rate and maternal mortality ratios in five provinces.

Table 6-3
Estimation and Ratios of Maternal Mortality Rates in Five Provinces

Province	Maternal Mortality Rate	
	Ratio	Estimated MMR per 100,000 live births
West Java	19.9	686
Central Java	15.6	248
East Nusa Tenggara	25.2	554
Maluku	31	796
Irian Jaya	34.2	1025

Source: Soemantri et al., 1999

² <http://jateng.bps.go.id/b0213.htm>

This table shows that Central Java has the lowest estimated maternal mortality rate, while the rate in West Java is, surprisingly, as high as that of East Nusa Tenggara.

The prevalence of maternal morbidity during pregnancy, giving birth and the post-partum period is about 23 per cent from 1995 Household Health Survey data of 2901 married women with a pregnancy in the last five years. The lowest prevalence was found in Central Java (16 per cent) and the highest in East Nusa Tenggara (40 per cent).

Table 6-4
Prevalence of Maternal Morbidity during Pregnancy, Giving Birth and the Post-Partum Period in Five Provinces, based on 1995 Household Health Survey Data

Prevalence of	West Java (n=847)	Central Java (n=744)	East Nusa Tenggara (n=454)	Maluku (n=564)	Irian (n=292)	Total (n=2901)
Maternal morbidity	17.1	15.9	39.9	27.1	22.6	22.8
Morbidity during pregnancy	6.5	3.4	22.9	13.1	7.5	9.7
Morbidity during giving birth	10.5	12.5	20.5	15.8	16.4	14.2
Morbidity during post-partum	3.5	1.2	8.4	2.1	2.1	3.3

Source: 1995 Household Health Survey cited in UNICEF, 2000:36

Note: Maternal morbidity has different durations for the three time periods: nine months of pregnancy, typically 12-24 hours of giving birth (intra-partum) and six weeks of post-partum.

Unfortunately, since Indonesia does not have vital statistical data to directly calculate maternal mortality rates, there is no specific data for the maternal mortality rate in Semarang.

Based on an analysis of the 2000 SUSENAS data, fevers, headaches, coughs and influenza were the primary complaints suffered by people in Central Java. In 2000, 3.2 million suffered from fevers, 1.6 million from headaches, 4.3 million from coughs, and 4.7 million from influenza. These complaints were also the main complaints suffered by people in 1998. In 2000, the number of the patients suffering from coughs increased from 4.1 million in 1998 to 4.3 million, and the number of patients suffering from influenza increased from 4.3 million in 1998 to 4.7 million. The next most common

complaints were diarrhoea and toothache, even though the numbers of people suffering from these illnesses has decreased. For example the number of patients reported with diarrhoea decreased from 458 thousand in 1998 to 341 thousand in 2000. Other complaints, such as breathing difficulties, increased from 244 thousand to 262 thousand, whilst the number of asthma sufferers decreased from 135 thousand to 126 thousand. 49.18 per cent of illnesses lasted less than 4 days, and 36.29 per cent lasted between 4 and 7 days. In 2000, 61.51 per cent of patients used traditional treatments or bought medicine in drugstores, whereas 38.49 per cent sought the advice of medical professionals. Environmental factors, such as sanitation, water, and housing might influence the rate of some of the above illnesses. In Central Java, the SUSENAS data show that 34.36 per cent of housing has flooring made from packed earth.

6.3. Lintang Village

Kelurahan Lintang or Lintang village (a pseudonym) is a part of Sekar district (a pseudonym) in Semarang and is located about 15km from Semarang city centre. Sekar district is an expansion of Semarang's industrial zone. As part of Sekar district, Lintang is located strategically in a suburb that lies along the road between Semarang and Jakarta, which passes through some industrial towns in Central Java, such as Pekalongan, Tegal, Batang, and Cirebon in West Java. Administratively, Lintang was established through government regulation No. 50. in 1990, and consists of 5 villages comprised of upland, high land or hilly areas. Before this regulation, Lintang was part of Ratu district. Lintang is divided into 14 RW (*rukun wilayah* – neighbourhood or hamlets or sub-villages). Although electricity is available in Lintang some people cannot afford to install it. Water is also a problem in this village, since there is no public source of clean water³. For the sub villages in the hilly areas, these conditions are even

³ It should be noted that in Indonesia, water, electricity, gas, and telephones are provided by the State; there are no private companies offering such services.

worse, as people have difficulties finding clean water for cooking, washing and toilets, and only a small number of people with a better economic status can afford to install artesian wells. Some people turn these conditions to their own advantage by selling water from their artesian wells. However, people in some areas still use water from the small river for cooking, washing, toilet, etc.

As mentioned earlier, Sekar district, including Lintang village, is an expansion of Semarang's industrial zone, and this has attracted people to move to this area to look for jobs, especially in factories. In Lintang village there are many factories so many migrants from surrounding areas have come to find jobs, settle and build families in Lintang. Based on the Lintang Village Data Monograph of 1995, there were 2,244 people of productive age (15-49 years old), which was 45.68 per cent of the total population. 46.56 per cent work as industrial labourers and the rest as civil servants, merchants, farmers, in the armed forces, and in many other jobs.

With regard to public health services, Lintang is under the supervision of the Raja public health centre (*Puskesmas Raja*), which is located in Sekar District. There is another public health centre in Lintang called *Puskesmas Ratu*⁴, with facilities for hospitalization (*puskesmas rawat inap*) and a maternity clinic. The existence of *Puskesmas Ratu* in Lintang means that the people of Lintang prefer to go to *Puskesmas Ratu* rather than *Puskesmas Raja* for medical treatment, and pregnant women attend *Puskesmas Ratu* for pregnancy examinations or ante natal care (ANC). The increasing number of people going to *Puskesmas Ratu* for treatment has meant that fewer cases are recorded at *Puskesmas Raja*. In addition to these two public health centres, there are other health services in this village, including one private doctor, one midwife and three traditional midwives (*dukun bayi*). However, transportation is a problem in the village, as there is no public transport available from the main road of this village, which is the

⁴ *Puskesmas Ratu* or Ratu public health centre is under the supervision of a different district from Sekar. It is under Ratu district; because before Lintang village was expanded to become part of Sekar district, it was part of Ratu district.

road between Semarang and Jakarta, into the sub villages. Village offices, public health centres and the other health services are located on the main road, but given the limited number of health facilities in the sub villages and the poor transportation facilities in many of the housing areas, the people find it difficult to get assistance and attend the health services.



Picture 6-1 One part area in Lintang village; this picture illustrates a local people's house with *srotong* roof and made from plaited bamboo (*gedek*)



Picture 6-2 Washing, bathing, and laundry in Lintang village

6.4. Industrialization in Indonesia, Gender Issues in Industrialization, and Working Women in Lintang

In this section I will examine the situation of working mothers in Lintang who are largely engaged as factory labourers in this area. I will first of all examine industrialization in Indonesia, how the government developed and applied industrialization policies, and will also explore gender issues in industrialization, particularly in the Third World context.

Industrial growth in Indonesia has been described as both ‘substantial’ and ‘patchy’ (Hill, 1988). Industrial policy under Suharto’s New Order was devised by Berkeley-trained economists, who created policies ‘designed to win the sympathy of the Western capitalist powers and Japan’ (Anderson, 1983). They encouraged large-scale industrialization and foreign investment based on the free-market ideology of Western liberal economics and favoured by the International Monetary Fund (IMF), the World Bank, and the Inter-Governmental Group on Indonesia (IGGI) (Robison, 1986). From the late 1960s to the mid-1980s industrial growth was ‘sustained and rapid’, broadly comparable to that of the Asian newly industrialized countries, although substantially smaller. During that period, real industrial output grew by about 10 per cent per annum, and the manufacturing sector quadrupled between 1970 and 1982, ranking tenth amongst less developed countries (Wolf, 1992:36).

During 1967-97, expansion of the labour force and capital stocks explains about 60 per cent of GDP growth, meaning that about 40 per cent was due to more productive use of available labour and capital, since the expansion of industrial output explains a large part of economic growth. Industrial expansion was largely based on the employment of newly imported production technology and the improvement of the education and skill levels of human resources, which also contributed to productivity growth (Van der Eng, 2001:185).

Part of the attraction that Indonesia had and still has for international capital is its large, low-wage labour force. In an effort to attract foreign investors, during the Suharto era or the New Order regime (1966 – 1998), the Indonesian government advertised one of the lowest average wage rates in Asia and proclaimed that workers are controlled by the state, which forbade strikes (Wolf, 1992:40). As Robison points out: “export oriented industrialization requires a higher level of state involvement in disciplining labour than does import substitution industrialization; without question, the Indonesian state has sought to control the labour force, keeping wages and labour unrest down and unions inactive” (Robison, 1986: 71). The New Order regime played an active role in paralysing the unions and suppressing labour unrest. In theory, the Ministry of Manpower monitors factories’ adherence to labour laws, but in practice it ignores most violations. Unions in factories, when they exist at all, are there in name only. Unions are not allowed to educate workers on their rights, and they can intervene only at the workers’ request. Under the leadership of Suharto, the government of Indonesia stated that strikes and lock-outs were strictly forbidden since they were not ‘in harmony’ with the state philosophy of labour relations. According to the Indonesian ideology of *Pancasila* – the five principles of Indonesian Nationhood, strikes were opposed to national development, ‘irreconcilable’ with national goals, and ‘unnecessary’ (Goderbauer, 1987:16).

However, with the 1997 Indonesian economic crisis, the economic situation in Indonesia turned from a ‘miracle’ to one of the worst recessions in the country’s history⁵. One of the biggest problems emerging from the negative economic growth, high inflation and resulting unemployment in both formal and informal sectors, was increased poverty. Estimates of the total number of unemployed and the proportion of the labour force made newly unemployed by the crisis vary, but figures from

⁵ For more details about the Indonesian economic crisis, see chapter IV (Indonesian Women: Socio-Cultural Context).

BAPPENAS (the National Development Planning Board) and the Ministry of Manpower suggest that in 1998 some 10 to 13 million people were unemployed and the impact on women may have been greater. As in many other countries, women in Indonesia are subject to culturally constructed gender limitations in their choice of jobs and even when given the same job opportunities, they usually earn lower salaries than men. Many of the unemployed women had been engaged in the informal sector and in export industries, such as textiles, garments, toys and electronics (UNICEF, 2000:10).

The gendered composition of the labour force and employment in Indonesia are economically important issues. The impacts of the crisis have also meant an increase in the role of women as household providers. Women have always played an important economic role in poor households, and there is evidence that the impact of the crisis on jobs and job security may have even further increased the importance of that role. Between 1980 and 1990, for example, the female labour force participation rate increased by 6 per cent, whilst male employment participation rates increased by just 2.7 per cent over the same period (The Population Council, 1998). Similarly, increasing unemployment during the first year of the crisis was greater for men than for women. This was in spite of the much more rapid growth in female labour force participation, reflecting the shift for women from their more passive, housekeeping roles to a more active participation in the labour market (UNICEF, 2000).

It has been suggested that women's role in production becomes progressively less central and important during capitalist industrialization in developing countries (Momsen, 2004:173). This theory of female marginalization posits that women are pushed out of higher-paid sectors and into lower-paid, low status jobs as industrialization proceeds (Scott, 1986). But, as the statistical and sectoral indicators of industrialization grew in many developing countries, women's share of employment also grew. No longer was it argued that industrialization marginalized women; on the

contrary, the increase of women's share of employment seemed to go hand in hand with the successful industrialization in many Third World economies from 1970 onwards (Pearson, 1992:224-225). Pearson also argued that a major feature of Third World industrialization was the employment opportunities offered to women, though there was much dispute as to why women were the new industrial labour force, and what such employment offered to women in terms of wages, training , promotion, working conditions, etc. (1992:225).

Neo-classical economic theory assumes that in competitive conditions, workers are paid according to their productivity. Based on this approach, male-female differentials in earnings are due to either the lower productivity of women or to market imperfections. Another assumption is that women have lower levels of education, job experience and training than men, since men are allocated more out of household resources for their education than women and, as they grow up, women spend more time on housework and childcare for which training is not seen as necessary (Momsen, 2004:173-176).

In many developing countries, differentiation within the capitalist sector is given less emphasis since women tend to be generally excluded from employment in this sector. The industrialization process in developing countries is capital intensive and is dominated by foreign capital and imported technology. This type of industry, often referred to as the 'modern' or 'formal' sector, has a low level of labour absorption and is biased against the employment of women because of their lack of formal educational qualifications, their supposed lower job commitment and because capital-intensive skills tend to be considered 'male' skills (Momsen, 2004:177). Yet Pearson (1992:225) has argued that the rapid growth of export-oriented industrialization did increase women's share of industrial employment in many Third World countries.

Wolf has pointed out that in Indonesia, in the mid-1980s, three-fourths of manufacturing employment was 'in rural areas', most of it in cottage and small-scale industries and as self-employment or unpaid family work (Wolf, 1992:43). The Industrial Census (1974-75) documented that 80 per cent of the manufacturing work force was located in cottage industries, with the majority in rural areas, and women constituted half the work force. Women tended to be unpaid family workers, while males tended to receive a wage. More than half of these cottage industries engaged in bamboo weaving or coconut sugar production, both of which provide extremely low returns to labour. These returns are often below the agricultural wage, but are steadier. Small-scale household and cottage industries also produce such goods as foodstuffs, for example, tofu, shrimp crackers, and other products such as chicken coops, bricks, roof shingles, furniture, batik, etc. (Wolf, 1992:40-44).

Macro-level statistics demonstrate an increase in non-agricultural employment for the rural population. The Green Revolution and the New Order tipped the balance in favour of the rich and the landed, leaving the poor with little bargaining power. For instance, many investigators documented an increase in *tebasan*, a commercial process of harvesting that replaced village-level patron-client ties (Wolf, 1992:47)⁶. Consequently, poor households had to engage in long hours of labour with low returns in order to survive. Although some poor households have benefited from non-agricultural employment, they have less of a safety net underneath them. According to a World Bank report, socio-economic conditions in rural Java are indeed unequal. World Bank researchers found that rural Java 'has a higher incidence of poverty than Indonesia as a whole; it contains 55 per cent of all households, but 77 per cent of poor households and only 25 per cent of rich households (Wolf, 1992: 49-50). Agrarian class divisions have worsened over the past two decades: most rural households now own a tiny piece

⁶ For more examples of the impact of the introduction of various technological innovations on the reduction in women's agricultural labour, see chapter IV (Indonesian Women: Socio-Cultural Context).

of land. Husken and White found that '73 per cent of rural households had a farm – of more than 0.1 ha, in 1963 and only about 57 per cent in 1983, suggesting a rather dramatic increase in absolute landlessness'. In rural Java, for example, in the late 1980s, a small proportion of households, 10 to 20 per cent, control 70 to 80 per cent of all farmland (Husken and White, 1989). Moreover, White (1989) added that changes in agricultural technology have increased output per hectare, so that the few who own land and have been able to keep it have become wealthier over time.

According to Wolf⁷, research on gender, households, and employment in Java add up to one critical fact: households in Java tend to be units not of production but of consumption. Most rural households still gain some income from agricultural production, but this income is insufficient for minimal reproduction. White (1989) and Manning (1988) have also pointed out that approximately 80 per cent of rural households must seek income from non-agricultural activities in order to survive.

Factories began to locate in Central Java in the early 1970s (Wolf, 1992:111). Based on her research in Semarang, Wolf has pointed out that there were two principal reasons that attracted owners and managers to this area. Firstly, the 'push' factor, which was a result of the State's increased restrictions on industrial development in the urban city of Semarang, and the advice of State officials at the provincial and regency level to investors to consider moving to rural areas. The 'pull' factors which attracted industrialists were the low costs of land, utilities, and labour, as well as the abundance of labour in the area. From the perspective of multinational corporations, costs in Java, particularly labour costs, are much lower than in other nearby Asian countries such as Malaysia, Singapore, Hong Kong, or Thailand (Wolf, 1992:111-113).

⁷ In the late 1990s Diana L Wolf carried out a study about factory daughters in Semarang, Central Java, Indonesia. In her research, she focused on how factory employment affected the availability of labour and capital within the family economy. Since Wolf's study was located in Semarang, the same area as my research site, I refer to Wolf's study as background information concerning conditions in factories for labourers and industrialization in Semarang. The aims of Wolf's study, however, differed from my own. Wolf's study focused on family economy, whereas my research is about women's health, particularly with regard to the breast-feeding practices of working mothers in Lintang.

I have not documented fully all of the factories in my research areas since this was not a key focus of my research beyond the fact that many of my respondents in the peri-urban area did work in factories. As with Nuwun village, where Wolf carried out her research in Semarang, the factories located in Sekar district are a combination of domestically- and multinationally-owned firms, whose output is oriented toward both the global and local markets. Table 6-5 shows the factories in Lintang.

Table 6-5
Factories in Lintang Village

	Factory's name ⁸	Level and Production	Numbers of Employee	Wages	Working Hours	Health Services
1	Bintang	Multinational (Food production)	Male: 30% Female: 70%	Monthly	1. 07.00-15.00 2. 15.00-23.00 3.23.00-07.00	Available
2	Merpati	Multi-national (Production – plastic product)	Male: Female 1 : 2	Daily	07.00-15.00	-
3	Matahari	Multi-national (Production – Food, e.g. chicken product)	Male: 30% Female: 70%	Daily	1. 07.00-15.00 2. 15.00-23.00 3.23.00-07.00	-
4	Kutilang	Multi-national (Production – plastic product)	Male:45 Female:69 Staff:18	Daily	07.00-15.00	-
5	Langit	Local (Production – tofu)	Total:720 Male:288 Female:432	Daily	07.00-15.00	Available

Source: Primary Data 2001-2002

Table 6-5 shows data about those factories in Lintang for which data were available. There were 5 other factories for which data were not available⁹. Based on table 6-4 above, the majority of the labourers in these factories are female; and most female employees are unskilled or semi-skilled labourers. According to Pearson (1992), ‘a feminization of the workforce’ has taken place, which has two distinct aspects. Firstly, female workers are historically less militant and cheaper to employ than the traditional male working class; secondly, all working conditions are being reduced to those previously endured only by female workers, making the preference for women to

⁸ All of the factory's names are pseudonyms.
⁹ My research found that working mothers in Lintang were employed by various factories, such as Bintang, Matahari, Bulan, Garuda, Rajawali, Merpati, Elang, Kutilang, Kenari and Langit.

carry out low-paid 'unskilled' work less imperative (1992:225). Pearson also added that "women are also considered to be 'naturally' more docile and willing to accept tough work discipline, 'naturally' less inclined than men to join trade unions, and to take 'naturally' to tedious, repetitious and monotonous work. In addition to the grounds that women's work was unskilled, low wages were rationalized on the basis that women did not have the primary responsibility of earning a family wage: high levels of productivity could be attained in training or compensation for formal qualifications" (1992:233). During her research, Wolf (1992:116) found that when questioned about the sexual composition of the work force, owners and managers clearly stated that they greatly preferred female workers to males. Females were thought to be easier to control, quicker, and more diligent. Males, by contrast, were described as too aggressive and assertive toward the firm's hierarchy, and were often described as lazy.

My research found that most working mothers in Lintang maintained that they worked for economic reasons. By working they sought to improve the family income, especially in response to the greater daily expense caused by the economic crisis in Indonesia. Another reason cited was that they had been working before they got married, so they felt reluctant to give up their jobs. Some respondents stated that they made an agreement with their husbands that they would keep working even when they had children.

Working mothers usually worked for 8 hours a day in the factories, such as Bintang, Matahari, Bulan and Garuda, on any one of 3 shifts. Workers hired on a daily basis in Rajawali usually worked for 13 hours a day. The consequences of working in a company with 3 different shifts meant that women sometimes had to work in the middle of the night, necessitating overnight child care arrangements. Moreover, they sometimes had to work overtime. Bintang Factory had a policy to prevent pregnant workers from working night shifts and overtime.

In Indonesia, female wages tend to be much lower than male wages, although the government has set a minimum wage. When comparing females and males who were earning the lowest official wages in 1982 (Rp 25,000/month), 52.2 per cent of all Indonesian women were to be found in this category, compared to 14.2 per cent of all men (Grijns, Smyth and van Velzen, 1994:17). Wolf also found that female workers in Central Java earn much less than their counterparts in other Asian countries, which makes Java more attractive to foreign investors. Moreover, she added that male factory workers were paid at least 50 per cent more than female workers were, an amount sufficient for subsistence, according to union calculations. Management used two arguments to justify paying higher wages to males: males did 'heavier' work and thus received a higher wage, and they also needed the money to support their families. On the other hand, the management argued that single working women 'do not need the income to live' because they could turn to their fathers and families, and the low pay for females was justified because it represented surplus income, or 'pocket money' (Wolf 1992:116-119).

There are no data available to compare female wages and male wages in this research. But I found that the average wage for working mothers is around Rp 300,000 (\$26.78) – Rp 400,000 (\$35.71) per month. For those hired on a daily or casual basis the average salary was Rp 8,000 (71 cents) – Rp 15,000 (\$1.34) per day.

In labour legislation, there are a number of clauses intended specifically to provide protection for women workers. The clauses form a part of Law No. 1/1951. Clauses 7 to 9 prohibit the employment of women at night (6pm to 6am) and also their employment in jobs that are dangerous to their health. The four paragraphs of Clause 13 deal with an allowance of two days off per month for menstruation, maternity leave of 1.5 months before and 1.5 months after childbirth, the extension of maternity leave, and the breast-feeding of a baby in the workplace. But as with labour regulations in general,

these conditions tend to exist only on paper. It should also be noted that regulations concerning menstruation and maternity leave apply only to women who are permanent employees; for the majority, who are employed on a daily basis, the word 'leave' has no meaning. Two days off per month for menstruation is rarely given (Utrecht and Sayogya, 1994:60).

This research found that most of the working mothers in Lintang got maternity leave. It was usually taken 1.5 months before and 1.5 months after the birth. Other respondents took it one month before and two months after the birth. However, this policy only applied to permanent employees, and for those mothers who were casual workers, giving birth meant quitting their jobs.

Moreover, every factory has a different policy for working women regarding maternity leave. Some factories, such as Bintang, Kenari, Bulan and Rajawali, give the women leave when they are 7.5 months pregnant, and offer three months leave in total. But if the women take their leave when their pregnancy is over 7.5 months, their leave will be less than three months. This policy is different in PT Merpati and PT Elang, and for civil servants. Working mothers in Bintang, Kenari, Bulan, Garuda and Langit, and civil servants, still get three months salary during their maternity leave, but employees in Rajawali and Elang are unpaid because they are classified as casual workers. Only Bintang factory offsets the expense of the birth, whereas other companies do not offset the expense of the birth process at all, and some companies offer only half of the expense¹⁰. Moreover, no factories give special time for working mothers to breastfeed their babies, and they do not provide nursery facilities or childcare. Such conditions, of course, influence the poor implementation of exclusive breast-feeding as it is impossible for mothers to take their babies to the workplace to be breastfed.

¹⁰ In Indonesia, some factories, particularly multi-national factories, offset the expense of the birth process for female labourers. But this policy usually only applies to permanent staff or permanent labourers.

6.5. Household, Housing and Family

The basic unit of the Javanese family is nuclear (Geertz, 1961; Jay, 1969; Koentjaraningrat, 1985; Wolf, 1992). Compared with previous research (Geertz, 1961; Jay, 1969), Wolf (1992) found that nowadays, there are even more nuclear families in Java than in earlier studies. In the past, once children began to marry and have children, relatives would live as extended families for many years, particularly if they were poor and could not afford to build a separate house. Once children move out, elderly parents often move in, usually to live with a daughter, or may live alone. Ideally, marriage is an occasion for the Javanese to establish a new, nuclear, and autonomous household. Since it is not easy to acquire a new house, young couples usually live in the home of the wife's parents until they become economically and residentially independent (Koentjaraningrat, 1985). When Javanese women marry, they live initially within an extended family context. Post-marital residence is predominantly matrilocal for five to ten years, until the couple can build their own house (Wolf, 1992:55-57). However, according to Koentjaraningrat, there is no fixed rule of residence determining where a newly married couple, constituting a nuclear family, or *batih*, should live. The ideal is to set up an independent neolocal *somah* (household), demonstrated in the Javanese term *emah-emah*, which means 'to wed', or more literally, 'to set up a household' (1985:133). Koentjaraningrat also added that "the Javanese kinship system is flexible and if the groom's parents are better off than the bride's, the couple will choose patrilocal residence" (1985:133). Based on their study in Srihardjo, Yogyakarta, Singarimbun and Manning (1974) found that another option is *ngalor-ngidul* (going north and south), when each spouse stays at home with his or her parents, and the couple occasionally sleep together.

This research found that the majority of respondents both in Lintang and Semarang were part of nuclear families. As mentioned earlier, Lintang attracted a large

number of migrants, amongst them many young people. Some of them had decided to settle, raise families, and become village members. For the respondents in Lintang, migration from other areas, districts or regions to seek work in factories was the main reason why they lived apart from their parents. My respondents, who had been born in Lintang, still lived with their parents. The respondents in Semarang commented that they preferred to stay separately from their parents in their own homes since they wanted to live more independently with their own new families. However, the respondents stated that they still lived with their parents since they did not want to leave their mother or father living alone, or were not yet economically independent enough to build a house and live as a nuclear family. Based on these findings, it would seem that the concept of family amongst the Javanese is already changing. People in Semarang tended to move from their parents' home to establish a nuclear family. However, amongst the people in Lintang, the socio-economic conditions seemed to influence their decision to live separately from their parents, as they had moved from their villages to seek jobs, and ended up establishing their own families in Lintang.

In the past, amongst Javanese families, the size and style of a house was a symbol of prestige and class, and the style was determined by the shape of the roof (Koentjaraningrat, 1985). Since these roofs were a symbol of prestige and class, the materials used for building also showed the prestige and class of the owner. As shown in figure 6-1, ordinary village people would have a house with a *srotong* or a *trojogan* roof, which was usually made from dried coconut leaves. A house with a *limasan* roof would belong to families who considered themselves descendants of the original inhabitants, and who often formed a sort of village nobility; in the past this roof was usually made from tiles. The house of the village head and some of the village officials would usually have a *limasan* roof, or sometimes even a *joglo* roof, which in the past used to be restricted to houses of members of the administrative service in the towns

and cities, or to houses of people of noble origin in the court centre, usually made from tiles. However, the wealth of Javanese people today cannot be judged by the roofs of their houses (Koenjaraningrat, 1985:135-136). Nowadays, most of the roofs both in the villages and the cities are *trojogan* and *srotong*.

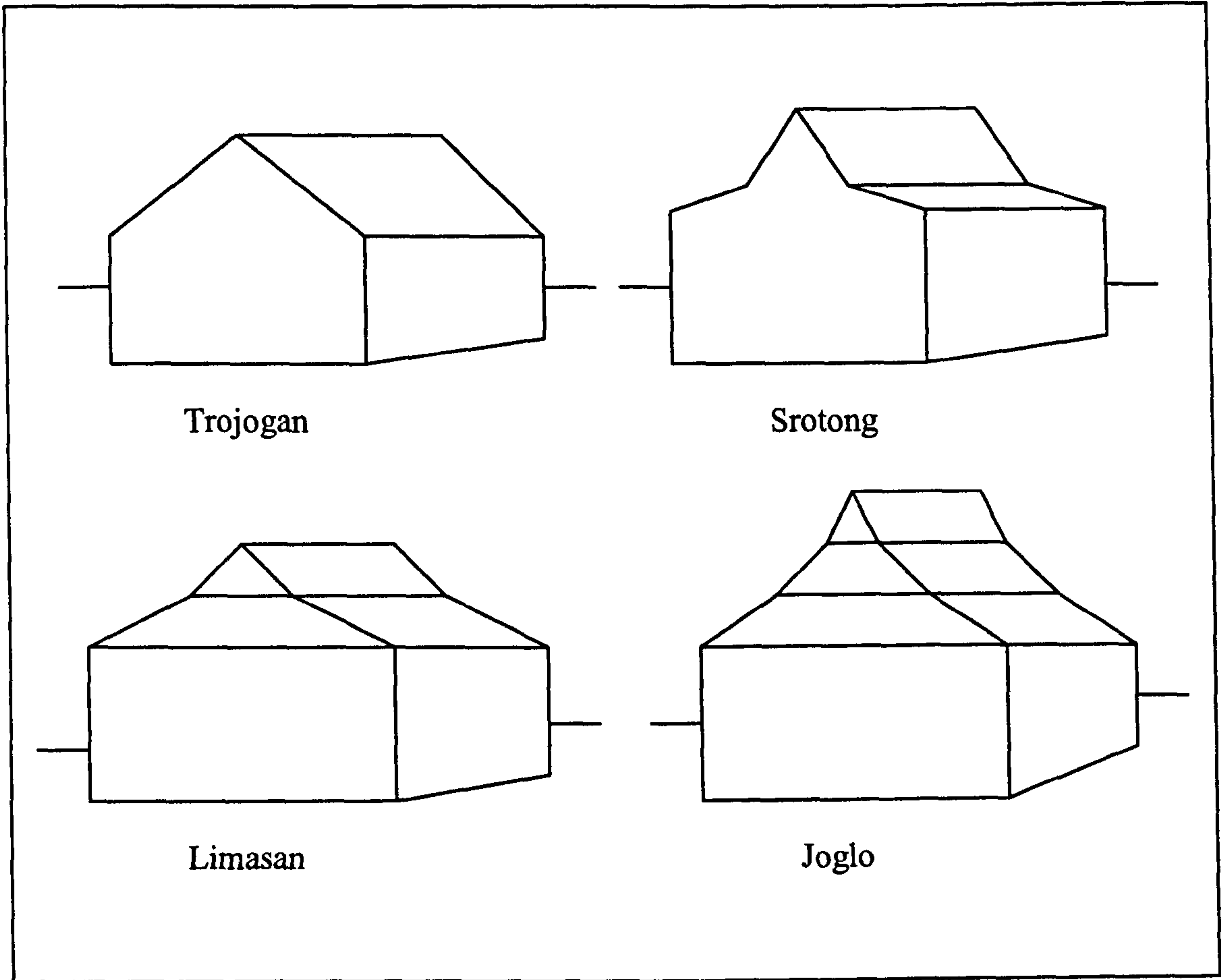


Figure 6-1. Shapes of Roofs of Javanese Houses
(Source: Koentjaraningrat, 1985:136)

Based on his research in Modjokuto, East Java, Jay (1969) has described the typical Javanese village house. Jay pointed out that a village family maintains the best house it can afford. According to Jay, the architecture of most village houses is highly standardized. The basic unit is a rectangular structure, wider across the front than deep, raised a foot or two on earth foundation reverted with brick, and with a peaked roof running the width of the house. The front eave is usually extended to form a shallow porch. A door is set in the middle of the house front and a smaller one on the side or

back serves as an entrance to the kitchen area. Windows are small or are not available (1969:47-48). According to Koentjaraningrat, the walls for the original style of Javanese village house (*griya* or *omah* or house) are made of *gedek* (plaited bamboo), and often do not have any windows. There are sliding bamboo doors at the front and the rear of the house, and easily removable plaited bamboo partitions divide the interior into a number of rooms. The floor is of *jogan* (packed earth), and there is a peaked roof, consisting of several layers of dried coconut leaves (*bleketepeng*). The kitchen often consists only of a hearth, which is situated at the rear of the house, or is a small unit attached directly to the outside wall behind or on one of the sides of the house (1985:134). Koentjaraningrat pointed out those villagers who can afford to buy construction materials like those used in the towns and cities, for example, bricks, wood for the walls, tiles and zinc plates for the roof, wood and glass for doors and windows, concrete or tiles for the floors, are usually relatively wealthy (1985:136).

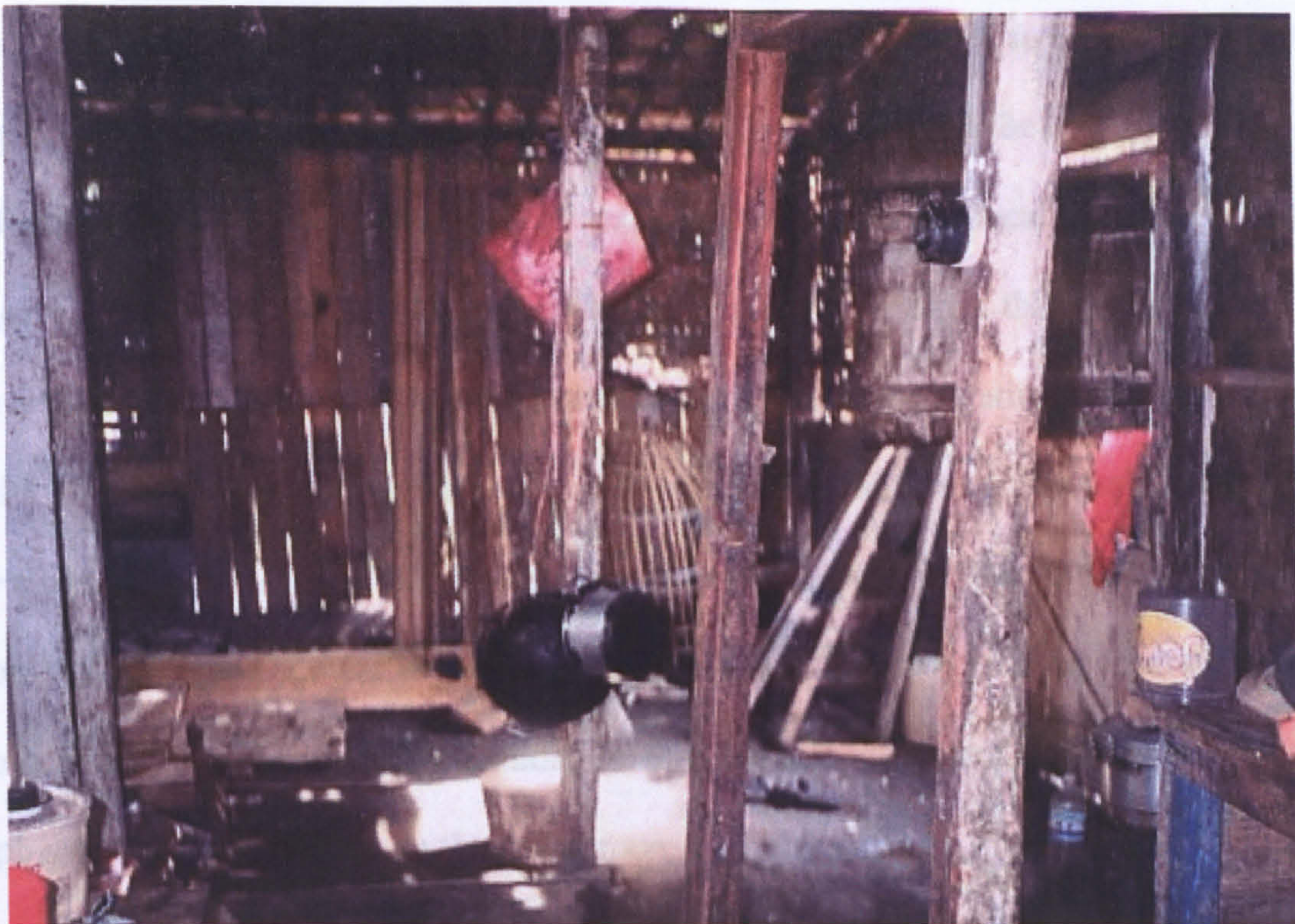
The village of Lintang is one of many developing areas in Semarang. In general, the situation in Lintang is similar with *kampung*¹¹ wards in the urban areas; in that there is less and less land available for agricultural use due to the increased demand for industrial sites. As an expanding area of Semarang, many developers have built housing or real estate for the middle or lower classes, usually consisting of small houses. Since most of the people in Lintang are migrants and work as labourers in factories, there are two types of model housing in this area. Migrants with a better socio-economic status live in the *perumnas*¹² or lower or middle class real estate or else rent a small house.

¹¹ A *Kampung* ward is a residential area for people of a lower socio-economic status in urban areas. In the past, most of the houses were built from plaited bamboo or *gedek*, near open countryside and rice fields.

¹² It should be noted that the government of Indonesia has developed housing programmes for lower class people called *perumnas* – with different types of house based on size and the quality of the materials, such as T-70, T-45, and T-21. Usually *perumnas* are allocated to civil servants and payment is deducted from their salary every month. The increasing of the Indonesian population and decreasing land in the city has increased the demand for housing in suburban areas. However, the economic crisis which hit Indonesia in 1997 affected the price of the *perumnas* as well, and many people complained that they could no longer afford even the cheapest *perumnas*.

However, most factory workers can only afford to rent one room or *kost* even though they are married and have children.

Local people tend to live in their own homes. In general, the housing situation in Lintang village, except the *perumnas*, is much as Jay and Koentjaraningrat described above. The construction materials for permanent houses vary depending on the socio-economic status of the owner. For people with a higher socio-economic status, walls are made from brick; whereas poorer people build the walls of their houses from concrete brick or plaited bamboo (*gedek*), and most of them use packed dirt for the floors. The number of rooms depends on the number of people living in the house. In general, the houses consist of a living room, which is used as the dining room as well, two bedrooms, and a kitchen, usually built outside behind the wall. Permanent doors are usually made for the front of the house or as a main gate, and other rooms usually have no permanent doors. Residential areas in Semarang also vary according to the socio-economic status of the inhabitants. Lower class people usually live in the *kampung* wards, but, nowadays, the houses in the *kampung* are made from brick or wood, and only a few people build their houses from plaited bamboo or *gedek*. People with a higher socio-economic status tend to live in more expensive real estate, in the expanding areas mentioned earlier, such as Bukit Sari, Banyumanik, Spondol, etc



Picture 6-3 A kitchen in Lintang (local people's house)

In such conditions it is difficult to ensure bottles and infant formula are prepared in hygienic conditions and with access to sterilisation and refrigeration.



Picture 6-4 Mother and her children; this picture illustrates some of the relatively impoverished conditions experienced by mother and her children in Lintang

As mentioned above, people who living in *perumnas* tends to be newcomers or migrants, and most of them are young couples. The location of the *perumnas* is in a different area or neighbourhood (RW – *rukun wilayah*) from the local people. The type of *perumnas* in Lintang is T-21, which is the smallest one. Since this type of house is the smallest and cheapest one, the construction materials are relatively cheap, and the walls are made from concrete brick, and the roof from asbestos¹³. The model of these *perumnas* houses is very simple; one house consists of 4 rooms, including a living room, a bedroom, a shower room, and a small kitchen. Since there is no separate dining room, most of the residents put most of their house equipment, such as television, cupboard or other furniture, in the living room.

Usually, residents of the *perumnas* have a ‘good’ position in the factories, such as supervisor or permanent staff. One of my respondents, Ibu Suyatmi¹⁴, stayed with her family in the *perumnas*. Her husband worked in Bintang Factory as a supervisor; and they had met each other in the factory before getting married. After having a child, Ibu Suyatmi decided to give up her job since there was no one to care for her child when she went to work, even though giving up work would put the family in financial difficulties. She told me that before they stayed in that house, they rented one room (*kost*) in another sub village for 4 years. She said that “*she and her husband had been struggling to save money to get the house. After we got married, we rented one room, until we moved here. I could not imagine, actually, finally, that we had our own house, since both of us are from poor families, and we could not expect help from our parents to get land, house, or money. Even though we must keep the household budget very tight, especially after I quit my job, we are very proud and happy to have this house*”. Like most of the houses in the *perumnas*, Ibu Suyatmi’s house consists of one bedroom, one living room, a

¹³ The health hazard from the use of asbestos has been well-documented in the West but has not yet become a public health concern in Indonesia.

¹⁴ A pseudonym (October, 2001)

shower room and a small kitchen. The floor is made from cemented tile and they have linoleum in the living room.

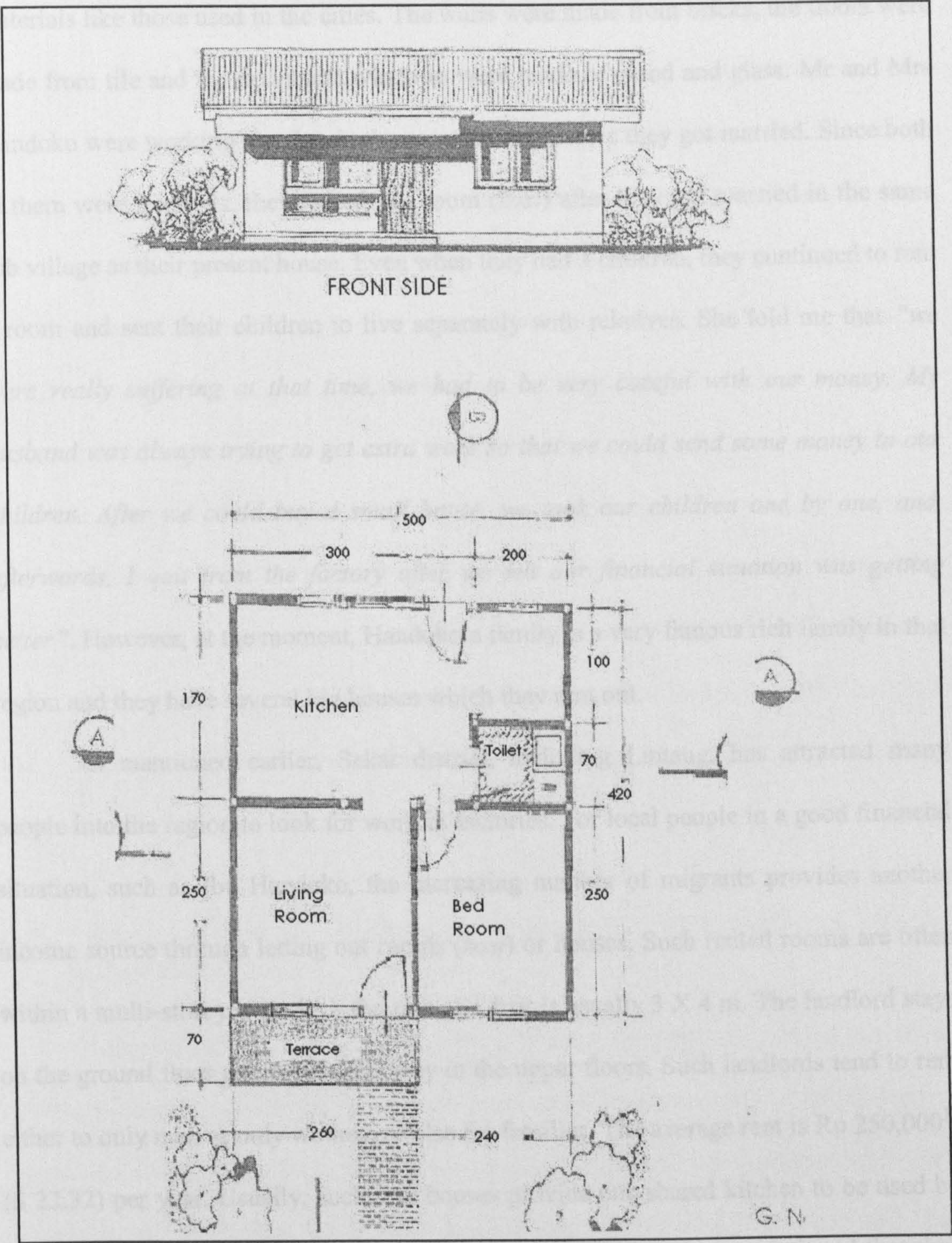


Figure 6-2. The *Perumnas* House

Ibu Handoko¹⁵ had a similar background to Ibu Suyatmi when she started to build her family in Lintang. She lived with her family in a different neighbourhood from Ibu Suyatmi in a *perumnas*. Her house was quite big, and made from good construction materials like those used in the cities. The walls were made from bricks, the floors were made from tile and the doors and windows were made of wood and glass. Mr and Mrs Handoko were working together in the same factory before they got married. Since both of them were migrants, they rented one room (*kost*) after they got married in the same sub village as their present house. Even when they had 3 children, they continued to rent a room and sent their children to live separately with relatives. She told me that “*we were really suffering at that time, we had to be very careful with our money. My husband was always trying to get extra work so that we could send some money to our children. After we could buy a small house, we took our children one by one, and, afterwards, I quit from the factory after we felt our financial situation was getting better*”. However, at the moment, Handoko’s family is a very famous rich family in that region and they have several big houses which they rent out.

As mentioned earlier, Sekar district, including Lintang, has attracted many people into the region to look for work in factories. For local people in a good financial situation, such as Ibu Handoko, the increasing number of migrants provides another income source through letting out rooms (*kost*) or houses. Such rented rooms are often within a multi-storeyed house – the size of a *kost* is usually 3 X 4 m. The landlord stays on the ground floor and the tenants stay in the upper floors. Such landlords tend to rent either to only men or only women, or else for families. The average rent is Rp 250,000¹⁶ (\$ 22.32) per year. Usually, such *kost* houses provide one shared kitchen to be used by all the residents, including the landlord. A few of my respondents mentioned that they

¹⁵ A pseudonym (October, 2001)

¹⁶ IDR = Indonesian *Rupiah* (Rp). When this research was carried out, the exchange rate was \$ US 1 = IDR 11,200 and the average monthly salary for women in Lintang who were working in factories was between Rp 300,000 – Rp 400,000 (\$26.78 - \$35.71).

preferred renting a *kost* to renting a small house because it was cheaper. Ibu Rina¹⁷ who worked in the Bintang factory stated that she and her husband were not permanent staff in the factory, and they did not plan to stay in the village a long time, especially if better work could be found elsewhere, so they were happy just to rent a *kost*. Another respondent, Ibu Tuti¹⁸ stated that if she and her husband rented a small house, it would be difficult to find someone to take care of her daughter. In the *kost*, on the other hand, there were other residents working different shifts who often took care of her daughter. During my fieldwork, I often saw landlords or other tenants take care of other people's children in *kosts*.

In one sub village, a ceramics factory called Garuda factory provides dormitory accommodation (*mess*) for the workers. One section is for single women; one section is for single men; and another section is for workers with families, however, only workers who are supervisors or above can live in the family dormitory. Based on observations made during this research, housing conditions in factory dormitories are much better than in the *perumnas* or in local houses with regard to the condition of the building, water supplies, environment, etc. Those who stay in the dormitory have to pay rent every month, which is deducted from their salaries.

6.6. Socio-cultural Attitudes towards Children amongst Javanese

According to Koentjaraningrat (1985), in Javanese families, children are much desired for both practical and emotional reasons. Children are greatly enjoyed because they give an atmosphere of warmth (*anget*) to the family, and the Javanese believe that if there is warmth in the family there is calm and peace in the heart (*tentrem*). The second reason is the feeling of security, especially as children provide and care for their parents in old age. Parents traditionally leave their houses in their wills to their youngest

¹⁷ A pseudonym (October, 2001)

¹⁸ A pseudonym (October, 2001)

child, especially their youngest daughter, who usually remains in the parent's home even after her marriage, and is later charged with the obligation to care for elderly parents, living with them until the parents die. As Geertz (1961:68) stated: "When you are old, your children will care for you: even if you are rich, the kind of care your children give you cannot be bought". Finally, there is a third, more materialistic or economic reason for Javanese people to have many children, especially within peasant society. At a very early age, children are already actively involved in the household economy. They care for younger siblings, clean the house, and are even sent out for wage labour (Koentjaraningrat, 1985:100).

Koentjaraningrat has also pointed out that the Javanese like to have more children for the status they believe it brings. Having many children is perceived as prestigious; a man can have as many children as he can afford. The number of children a man has also increases his status at work. Javanese in white-collar occupations consider persons with many children higher in status than those with only a few. Also, according to social etiquette, those with more children should be addressed in formal terms, even if their age, education, and experiences are the same as those who address them (1985:100). However, since the introduction of rigorous family planning campaigns, the Javanese attitude towards the ideal number of children has begun to change. Based on research carried out in East Java by Megawangi (1997) almost 90 per cent of couples interviewed in both urban and rural areas stated that they no longer believed that having many children would be lucky. Instead, 55 per cent of the respondents stated that the ideal number of children to have is one or two. Nowadays, although many families still have many children and still love to have them, they cannot be as proud of them as they used to be. The number of children in the family has therefore ceased to be a symbol of prestige in many parts of society.

Nevertheless, children are seen as integral to all heterosexual partnerships, so an infertile Javanese couple will feel very unhappy after the second or third childless year of marriage. As Geertz (1961:72) wrote: "A woman with many children is envied; a barren woman is pitied". A childless couple usually adopts a child, often from relatives either on the husband's or the wife's side. Infertility may become a source of family problems that end in divorce. It used to be customary to blame the wife for being barren (*gabug*) and this was frequently used by the husband as a reason to divorce her. Recently, however, the impact of family planning programmes in Indonesia which have included information on problems of infertility has made Javanese people realize that husbands also can be the cause of a childless marriage (Koentjaraningrat, 1985:101).

I found in my research, the mothers interviewed both in the peri-urban area and the urban area, stated they felt happy being pregnant, partly out of a sense of duty and because pregnancy is expected of couples after marriage. Amongst Javanese people, relatives and neighbours will always ask a newly married couple whether the woman has got pregnant or not a few weeks after their marriage.

First pregnancy will be very blessed by the wider family. By being pregnant a woman will be considered perfect, because she can continue the family line, especially in the first pregnancy. Everyone in the couple's families are seen to be happy about the pregnancy and looking forward to the new family's member. Most couples do appear to really welcome the new member of the family, even though the pregnancy might be unplanned. Even though finances may be tight, couples rarely choose to abort their babies. It should be noted that abortion is illegal in Indonesia. However, as UNICEF has pointed out, lessons from other countries where abortion is illegal, as in Indonesia, indicate that legal prohibitions do not deter women from having abortions. They may attempt it themselves using a variety of means including traditional herbs (*jamu*) or massage or else consult illegal practitioners (*dukun bayi*, midwives, or nurses), or

trained doctors or other medical personnel. UNICEF also reported that abortion is obviously not limited to adolescents and unmarried women. One study conducted by one NGO in Indonesia in the late 1970s indicated that it is also a resource to many married women who are sexually active and do not want more children but have not used regular contraception or have experienced contraception failure (UNICEF, 2000:31).

The mothers felt that pregnancy was something married women should experience, although pregnancy could be a burden if it was not well planned. One mother¹⁹ from Semarang told me that she had not expected to get pregnant even though she had been married for a long time, and she did not want to be bothered by the presence of children in her house. Finally, in her eighth year of marriage, she got pregnant, which interrupted her daily routine. She decided to quit her job as an employee in a private bank in Purworejo, a region in Central Java, and moved to Semarang to live with her parents, leaving her husband on his own. She said that she did not feel happy about the pregnancy until the fourth month. When she could feel the baby moving in her womb then she began to feel excited about her child.

Ibu Sri²⁰, who lives in Lintang, told me that her third pregnancy was unexpected. She already had two children, which she thought was enough for her family. However, she never used any contraception to avoid pregnancy, since she had problems with side effects when she used any methods of contraception. During the early months of her pregnancy, she did not tell her husband anything about it since she planned to have it aborted. She tried aborting her baby with a traditional medicine woman, but failed. Finally, she told her husband that she was pregnant. Her husband got very angry with her when he found out that she had tried to abort it. He said that she should feel ashamed, telling her: *"You will regret what you have done. Don't you feel guilty?"*

¹⁹ Ibu Sinta (February, 2002)

²⁰ A pseudonym

This evidence is in line with the UNICEF data mentioned earlier; since abortion is illegal even for married couple they could not do anything for unwanted pregnancy

One middle class mother from Semarang had a nine year old son and a baby²¹. She said that she did not plan to have any other children because she wanted to continue with her studies, but she had fallen pregnant unexpectedly. At first, she really did not want to spend time taking care of the baby, which would mean that she could no longer continue to study. However, after the baby was born, she felt very happy about having another child.

Geertz (1961) has pointed out that Javanese people value children of both sexes equally. Preferential treatment based on gender has never been noted in Indonesia. However, according to the World Bank analysis of SUSENAS data, the prevalence of malnutrition is 6 per cent higher in boys than girls. This may be explained by the fact that boys have slightly higher nutritional requirements related to their slightly higher average height and weight (UNICEF, 2000:55). My research found that both mothers in peri-urban and urban areas stated that female and male babies are treated equally. They felt that having children is a blessing and a gift from God. With regard to the number of children, as mentioned above, having many children is no longer a symbol of prestige, and most of the mothers in both areas stated that two or three children is an ideal number. They added that having many children is very costly since they need proper food, good health care and a good education.

6.7. Child Rearing

During the first couple of years, until the child is weaned or begins to walk, a Javanese mother is the most important person in the child's life. She is with the baby whenever she can be. If she works outside the home, she leaves the baby with someone

²¹ Ibu Susi (January, 2002)

she trusts, usually her sister or her mother (Geertz, 1961). Javanese babies spend most of their time carried in front of the mother's body in a shawl where they can nurse on demand. It is believed amongst the Javanese that if a Javanese mother carries the baby with a *selendang* (sling with shawl – *digendong*), then the baby is close to the mother's body and her breast, and hears her voice addressing him/her with sweet words in infant language, and singing lullabies until he/she falls asleep in her arms. A small child always looks for his/her mother when he/she is frightened of something, or when he/she has hurt himself. In Javanese language, when an individual gets hurt or feels a sudden pain, he/she shouts '*aduh biyung !*' (Ouch mother!) (Koentjaraningrat, 1985:108-110).

In the past, amongst *priyayi* families, it was customary to have female servants (*mbok mban*), who worked as nanny to the family's small children, usually until the child reaches school age. Javanese servants, including *mbok mban*, usually serve their employers for a lifetime and reside in the house, often becoming very much part of the family. Recently, the old *priyayi* custom of having female servants for small children has re-emerged (Koentjaraningrat, 1985:237-238). The female servant – maid or *pembantu*, nowadays called sister or *mbak*, is employed to clean the house, cook, do the laundry and the gardening. Many rich families are employing nannies who have the exclusive duty of taking care of a baby.

The changes in family structure caused by the shift from extended family to nuclear family have changed baby sitting patterns. Although the mother was at the centre of the early life of a child in the past, a child or baby was often taken care of by other family members who lived with the main family, such as grandmothers, aunts, or others. As mentioned earlier, it was very common for those Indonesian people with the resources to employ one or two servants to do the housework and also a nanny if they had a baby or children. Nowadays, houses tend to be smaller in size, which means that only the members of the main or nuclear family can live in the house.

Most people in Lintang are working, which has resulted in an interesting phenomenon in baby sitting associated with the increasing number of working mothers and the change in family structure from extended family into nuclear family. As mentioned above, the majority of the community are migrants who live in rented houses or in small houses (*perumnas* T-21 type). In these poor housing conditions, it is impossible to accommodate other relatives or servants. There is an increasing number of childminders, most of whom are women around 50 years old or over, who take care of babies in their own houses. Working mothers who have no relatives to take care of their babies during working hours generally entrust their child to them while they are at work, usually from 7am to 7pm. The mothers provide some milk, food, and clothes for their children. Besides taking care of the children, the childminder also feeds the babies and gives milk to the babies, and some of them also take them to the *posyandu* (monthly health service). Some of them care for as many as four children at the same time. One of these childminders stated to me that actually she felt very tired after minding the children, but it filled the gap left by her own children leaving home and prevented her from feeling lonely. These childminders are also driven by economic reasons, as it is one way to earn a living, particularly for elder women. I suggest that taking into account the number of children being taken care of by a childminder it would appear that such childminding is not always of the highest standard for individual children.

During my fieldwork, for example, I talked to one childminder during the *posyandu* programme. She had to go to the *posyandu* to have the baby immunized. The *posyandu* officer was late in arriving and the 4 month old baby cried loudly. The childminder said that she had forgotten to bring a bottle of milk for the baby, but she did not want to go back home to get the bottle since the location of the *posyandu* was quite far from her home. On another occasion, during the *posyandu* programme, another childminder carried the baby while holding an open bottle of milk by the rubber

mouthpiece of the baby's bottle. I felt that such evidences indicate a lower standard of care for some babies than could be expected.



Picture 6-5 Childminders' take the babies to the *Posyandu* programme



Picture 6-6 A working mother looking after her children after returning home from factory

The fee for childminding ranges between Rp 60,000 – Rp 100,000 (\$5.36 - \$8.92) per month. If the average salary of working mothers in Lintang is around Rp 300,000 – Rp 400,000 (\$26.78 - \$35.71) the fee for childminding, according to some mothers in Lintang, is quite expensive, particularly if they entrust more than one child to the childminder. One respondent said that actually she did not have the heart to leave her child with somebody else while she was working, but she had little choice. She said: *“I always try to go back home during my lunch hours, I just want to see how my child is, and during this time I always try to feed him - give him some food or milk”*²². Another mother said: *“I have tried to have a good relationship with the lady who takes care of my child, since I left my child with her during my working hours. I do not want something to happen to my child while I am away. To keep a good relationship, I always give her not just her salary, but also rice, clothes and some cookies”*²³.

However, working mothers interviewed told me that they felt uncomfortable leaving their children with an unqualified childminder. Mothers in a better financial situation stated that they hired servants, even though the fee was more expensive than childminders (the fee for servants in Lintang is around Rp 150,000 (\$13.39) – Rp 200,000 (\$17.96) per month). The mothers with lower economic condition who lived in *kost* accommodation asked other tenants or their landlord to take care of their children. This meant that they would not have to pay out a regular childminding fee, but relied instead on the supportive relationship that existed amongst tenants and landlords.

As Koentjaraningrat has pointed out, Javanese people of a higher socio-economic status, such as *priyayi* in the cities, employ servants or *mbok mban* to take care of their children. This research also found that of the mothers in the urban area employed servants or childminders to take care of their children. According to them, having their children looked after by the servants is a risk that career women have to

²² Ibu Wati (November, 2001)

²³ Ibu Rini (November, 2001)

take. It might be that servants go out often or do not look after the children well. However, respondents who still lived with their parents did not face this problem, since their mother or mother-in-law usually took care of their children while they were at work.

The middle and upper class mothers in the urban area stated that they preferred having more than one servant when they had a child under five years old. However, they commented that they did not fully trust their servants. One mother said²⁴: *"I have employed two servants in my home, and it takes a lot of money from our household budget, but I feel happier leaving my child during my working hours"*²⁵. Mothers mentioned that they looked for servants or childminders who were organised, trained or had experience. One mother said that she trained her servant before her maternity leave was over, and another mother said that she employed her childminder one month before she gave birth. They added that they just wanted to make sure that the servant or the childminder could carry out their job well, take care of the baby carefully and behave well. One of the mothers who lived in an expensive area stated that she always took her baby and her childminder to her parent's house, since she didn't feel comfortable leaving her baby with just her childminder in her home while she was in the office. She said that she felt less worried if her mother could supervise the childminder²⁶.

However, approximately 40 per cent of mothers in the urban area stated that they preferred employing servants to take care of their children. According to them, employing a servant was cheaper because, unlike a childminder who only cared for the baby, servants could do other domestic jobs, such as cleaning, cooking or laundry. Surprisingly, my respondents especially in the urban area, stated that they did not want to bother their relatives, such as mother, mother-in-law, niece, etc., to help them take

²⁴ Ibu Titi (January, 2002)

²⁵ The average fee for servants in Semarang is between Rp 250,000 (\$22.32) – Rp 400,000 (\$35.71); the fee for childminders is Rp 350,000 (\$31.25) – Rp 700,000 (\$62.5).

²⁶ Ibu Santi (February, 2002)

care of their child. They stated that having children and looking after them, or employing others to do so, was their responsibility, and they were happy if their parents visited them and looked after their children for a short while.

The increasing numbers of working mothers feel more and more burdened with domestic chores, including taking care of the children. As Geertz (1961) has pointed out, within a Javanese family, husband and wife work together as a team. However, they complained that their husbands still have the misconception that it is a woman's duty to do the domestic work, whilst husbands are responsible for earning a living and acting as the head of the family. Mothers in Lintang interviewed said that they often got upset and 'nagged' their husbands because their husbands did not help them. In the end they gave up and, instead of getting more upset, thought that they had better do all the domestic work by themselves. Since the mothers in the urban area tended to be in a stronger financial position, domestic work was not a problem. They employed servants to live with them and do all of the domestic chores, thereby lightening their burden of domestic work.

6.8. Summary

In this chapter I have examined the setting of my research area, which is Semarang and Lintang village. Lintang is located in Sekar district, which is a suburb of Semarang and an industrial zone.

This research found that the majority of people in Lintang are working in factories. Most of them are migrants from surrounding areas, some of whom have decided to settle, raise families and become village members. The mothers, both in the peri-urban and urban areas stated that a high value is still attached to having children; and children of both sexes are equally wanted. However, even though being pregnant is considered a blessing for women, the number of children in the family is no longer a

symbol of prestige. One to three children is considered an ideal number of children in a family, and by having fewer children parents hope to give them better lives.

There are several types of housing in Lintang, including permanent houses, *kost*, *perumnas* and dormitories. These types of houses influence childminding patterns in this area. With a poor standard of housing or smaller houses overall, there is no room for relatives or servants. As a result, an interesting phenomenon has arisen in Lintang with regard to childminding. Working mothers employ unqualified childminders to take care of their children during working hours; and some mothers ask other tenants or their landlords to take care of their children. Yet those working mothers in a stronger financial position employ servants and/or childminders, which is in line with the Javanese *priyayi* tradition.

In the following chapter, chapter VII, I provide a comparison between women in Lintang and women in Semarang with regard to breast-feeding practices. I will examine how and where the mothers in both areas find ante-natal care, a place for giving birth, their knowledge of and attitudes towards breast-feeding practice, and also how working mothers cope with breast-feeding their babies after they have returned to work.

CHAPTER VII

BREAST-FEEDING PRACTICES AMONGST INDONESIAN WOMEN IN SEMARANG

7.1. Introduction

According to the World Health Organization (WHO), breast-feeding is considered the best way to feed babies (Hull, Thapa and Pratomo, 1990:625). In Indonesia, a campaign for exclusive breast-feeding was introduced more than 20 years ago. The Ministry of Health (MoH) have set a target that 80 per cent of newborn babies will receive exclusive breast-feeding by 2005. The latest data from the Indonesian Demographic and Health Survey 2002 show that only 55.1 per cent of babies were breastfed exclusively until 4 months old. Previous research has indicated that the lower rate of exclusive breast-feeding was due to psychosocial or behavioural factors affecting the mother and her family, and also environmental factors (Kusin and Kardjati, 1994; Nordenhall and Ramberg, 1998; Untoro, 2004).

This chapter presents findings from my field research that focused on mothers who were breast-feeding. I will examine the differences between women in the peri-urban and urban areas who practice breast-feeding. I will also analyse where the mothers in both areas received ante-natal care, how the mothers chose settings in which to give birth, forms of post-natal care, women's reactions to the birth, knowledge and attitudes about breast-feeding and also how returning to work affected the breast-feeding practices of working mothers.

7.2. Breast-feeding Programmes in Indonesia

As data from the National Socio-Economic Survey (SUSENAS) of 1998 show, the 1997 economic crisis led to a further deterioration of the already poor nutritional status of the majority of Indonesian children. In 1999, more than 23,000 cases of severe

malnutrition were reported to the Directorate of Community Nutrition at the Ministry of Health. Based on the re-analysed SUSENAS 1998 data above, Jahari et al (1998 cited in UNICEF, 2000) found that in 1998, 10.5 per cent of *balita – anak dibawah lima tahun* (children under five years old) were severely underweight, as indicated by a z-score¹ of less than -3 STD of weight-for-age. This implies that 2.3 million of Indonesia 23 million children under five years old are severely malnourished. A meta-analysis of 28 studies from 11 countries estimates that malnutrition contributes directly or indirectly to an estimated 56 per cent of infant and child deaths. Since socio-economic circumstances in many of these countries are similar to those in Indonesia, it is likely that malnutrition is also a significant contributing factor to infant mortality in Indonesia too. If the figures hold true for Indonesia, it can be estimated that approximately 170,000 of the 300,000 infant and child deaths per year are due indirectly to malnutrition (UNICEF, 2000). The latest data from the 2002 Indonesian Demographic and Health Survey show that the infant mortality rate (IMR) is 49 per 1,000 births; and perinatal mortality accounts for 38 per cent of the IMR, mainly due to tetanus, low birth weight (10 per cent) and asphyxia. The mortality rate amongst children under five year olds (*balita*) is 70 per 1000, mainly due to acute respiratory infection (ARI - 35 per cent) and diarrhoea; and one in three children under five years is underweight (Untoro, 2004).

As mentioned earlier, in Indonesia, a campaign for exclusive breast-feeding for 0 - 4 month old babies was introduced more than 20 years ago. Breast-feeding promotion was explicitly mentioned in the country's National Five Year Plan

¹ Z-scores uses a statistical equation to measure how far a subject's weight is from the average (the median) as determined by the NCHS/WHO values of the weight of a child of the same height (in the reference data). This 'distance' is called a Z-score. It is expressed in multiples of standard deviation and is derived as follows:

$$\text{weight-for-height z-score} = \frac{\text{observed weight} - \text{median weight}}{\text{standard deviation}}$$

where both the median weight and the standard deviation (how the different values are distributed about the mean) are taken from the normalised growth curves described in the NCHS/WHO reference values for the given height (<http://tantaprojects.org/downloads/pdfs/dataanalysis/zscores.pdf>).

(REPELITA – 1982-1987). Non-governmental agencies and organizations have also taken increasing interest. A non-governmental agency known as BKPP-ASI (Indonesian Breast-feeding Promotion Foundation) was established as a national coordinating body for the promotion of breast-feeding in Indonesia. International agencies such as UNICEF, the Ford Foundation, the US Agency for International Development (USAID), and the International Nutrition Communication Service have also provided assistance to support projects that promote breast-feeding. Several Indonesian doctors and nurses have been trained in the management of lactation programmes, counselling and monitoring breast-feeding programmes (Hull, Thapa and Wiknjosastro, 1989). Also, Indonesia has a comprehensive national policy and strategy on breast-feeding; last updated in May 1994, advising on such matters as when to introduce complementary food. Based on various WHO and UNICEF documents which were published before May 1994 and a number of national studies undertaken in Indonesia, the existing breast-feeding programme in Indonesia recommends that: (1) babies should be breastfed until 4 months of age; (2) colostrum should be given; (3) breast-feeding should be continued until the age of two years, in addition to supplementary food; (4) the promotion and the use of infant formula should be prohibited at public health service units; (5) rooming-in² should be practised; (6) information about breast milk and breast-feeding should be increased.³

In Indonesia, as in many other countries, women used to breast-feed for two or three months exclusively, but this has become rare and even in younger infants exclusive breast-feeding is becoming less common (Baumslag & Michels, 1995)⁴.

² The rooming-in programme is part of the 'Baby Friendly Hospital' scheme which was launched by WHO & UNICEF in 1991 to help increase the rate of breast-feeding. The aim of the rooming-in programme is to encourage the mother to breastfeed her baby on demand since the baby is put in the same room as the mother after giving birth (Baumslag and Michels, 1995; WHO, 1998)

³ de Haan, personal communication

⁴ It is necessary to define the various patterns of breast-feeding: (1) timing of initiation of breast feeding is based on the duration between delivery and first breast feed, and is usually defined as 'early initiation' when a breast feed takes place within the first half hour or first hour after birth; (2) exclusive breast-feeding means that the baby receives no other food or liquid, including water; and (3) partial breast-

According to UNICEF (2000), in Indonesia, 95 per cent of babies are breastfed initially, thus not breast-feeding at all is rare. Although the percentage of babies who are not breastfed is small (5 per cent), it still accounts for approximately 200,000 infants, which thus remains a matter of great concern. This is of particular concern because many of these babies are born into families with a low socio-economic status for whom the lack of breast-feeding greatly increases the risk of malnutrition, morbidity and mortality. In comparison with many other Asian countries, based on the 1994 Indonesian Demographic and Health Survey, the median duration of exclusive breast-feeding in Indonesia is short at only 1.3 months, shorter than other Asian countries, such as India (4 months) and Bangladesh (6 months) (UNICEF, 2000).

As mentioned above, UNICEF (2000) reported even though 95 per cent of babies are breastfed initially, the data also show that unfortunately only 14 per cent of babies in Indonesia are breastfed within the first 12 hours after birth. This percentage needs to be increased because breast-feeding within approximately 30 minutes after the birth can hasten the expulsion of the placenta, initiate the flow and volume of breast milk production, and allow infants to benefit early from the protective colostrum in breast milk. Unfortunately, the benefits of colostrum are as yet under-appreciated and research show that 10-20 per cent of mothers express and discard their colostrum believing it to be dirty and / or detrimental to the baby (Hull, 1984). 'Pre-lacteal feeding', or the giving of small tastes of food during the first hours and days before breast milk has supposedly begun to flow, is also widely practised and equally detrimental (Ebrahim, 1978; Vincent, 1999). Some studies have suggested that up to 75 per cent of infants are given some form of pre-lacteal feeding and that this practice can result in a long term growth handicap. The 1997 Indonesian multi-site Demographic and Health Survey on complementary feeding found that pre-lacteal feeding was associated with weight for

feeding means a baby receives breast milk but also consumes other liquids or solid foods (Huffman, Zehner & Victora, 2001)

age which was lower by -0.14 z-scores in infants between 6-11 months of age (UNICEF, 2000).

The biggest problem that results from the premature termination of exclusive breast-feeding and the premature introduction of complementary foods or liquid other than breast milk is the infant's increased risk of catching an infection due to the interruption to the natural chain of immunity which only breast milk can impart. The 1997 multi-site complementary feeding study found that exclusive breast-feeding gives children a growth advantage of approximately 0.14 STD in weight for age at 0-5 months. However, the same study found that only 63 per cent of infants are exclusively breastfed in the first month of life; 45 per cent in the second, 30 per cent in the third, 19 per cent in the fourth, 12 per cent in the fifth and only 6 per cent in the six month (Sharma et al., 1999).

Complementary feeding and illnesses affecting the mother or child may also interrupt or lead to a termination of nursing. According to UNICEF (2000), about 11 per cent of Indonesian women have terminated breast-feeding 12 months after the birth. Research indicates that about 75 per cent of infants are given small tastes of food in the first few hours and days after the birth when women feel that their breast milk has not yet begun to flow. One study found that 22 per cent of newborn babies receive infant formula, 1 per cent are fed bananas, and 22 per cent have honey in some form (UNICEF, 2000). Another study, carried out by Hayman, et al. (2000) amongst indigenous urban Australian communities, also found that the early introduction of solid food was common amongst babies, and only 25 per cent of children were introduced to solid food after the age of six months. Of those babies who were aged 0-3 months, 37 per cent were regularly fed solid food.

Table 7-1 shows the comparison between the 1997 and 2002 IDHS data. The 2002 Indonesian Demographic and Health Survey (IDHS) show the situation of breast-

feeding practices in Indonesia. Based on these data, it would appear that only the rate of exclusive breast-feeding for 4 month old babies has increased in comparison to the 1997 IDHS data, although the increase is not significant. Other data, such as the rate of ever breastfed babies and babies who have been exclusively breast-fed until 6 months old have decreased, although not significantly. However, the data show that bottle-feeding has increased sharply; from 10.8 per cent in 1997 to 32.45 percent in 2002.

Table 7-1
Breast-feeding Practices in Indonesia

Resource	EV.BF	IBF WT 1 HR	EBF 4 MO	EBF 6 MO	BTL < 12 MO
IDHS 1997	96.3	8	52	42.4	10.8
IDHS 2002	95.9	3.7	55.1	39.5	32.45

(Untoro, 2004)
 Note:
 IDHS: Indonesian Demographic and Health Survey
 EV.BF: Ever Breastfed
 IBF WT 1 HR: Initiation of Breast-feeding within 1 hour
 EBF: Exclusive Breast-feeding
 BTL: Bottle-feeding

There are many key factors affecting breast-feeding in Indonesia. As mentioned earlier, Kusin & Kardjati (1994), Nordenhall & Ramberg (1998) and Untoro (2004) have indicated that the lower rate of exclusive breast-feeding practice in Indonesia is due to psychosocial, behavioural and environmental factors. These factors are a result of a lack of knowledge about the advantages of exclusive breast-feeding, and the massive commercial campaigns to promote infant formula and baby foods which are thought to be responsible for the emergence of the mistaken belief that exclusive breast-feeding causes infant malnutrition.

Overall, exclusive breast-feeding practice in Indonesia is still low. As mentioned earlier, the lack of knowledge about breast-feeding, especially exclusive breast-feeding, and the massive infant formula and complementary baby food campaigns have been partly responsible for the decreasing trend in exclusive breast-feeding practice. To stop this worrying trend, the Government of Indonesia has developed different programmes

to support breast-feeding. Non-governmental agencies and organizations have also been involved in such programmes. The next section will compare the breast-feeding practices of the mothers in both areas.

7.3. Breast-feeding Practices amongst Women in Semarang

The remainder of this chapter presents some of the major findings of the research which compares breast-feeding practices amongst two groups of women in the urban and peri-urban areas of Semarang. I shall deal with each in turn, looking at key aspects of ante-natal care and pregnancy, choice of birth place, post-natal care, women's attitudes towards and experiences of birth and breast-feeding and issues around returning to work. Before proceeding, however, it is important to have a sense of some of the key social characteristics that distinguish the two groups of women who were participants in this study.

While the majority of women respondents to the questionnaire survey in the peri-urban area were under 30, the majority of women respondents in the urban area were over 30 (see Table 7-2 below).⁵ This age differential confirms observations made during qualitative data collection and reflects the fact that women from lower social and economic backgrounds tend to marry and have children earlier than those from higher social and economic backgrounds.

⁵ As previously discussed in Chapter III, the data I present here draw both on my own survey in the peri-urban area and on the data of Mexitalia & Budihartani, (2003) for women in urban Semarang.

Table 7-2
Age

Women in Peri-urban Area		
Age	Frequency	Percentage
< 30	134	77
≥ 30	40	23
Total	174	100
Women in Urban Area		
Age	Frequency	Percentage
< 30	43	36.8
≥ 30	74	63.2
Total	117	100

These differences in social background are seen in terms of the both educational attainment and household expenditure of the respondents from each area. In terms of socio-economic level (Table 7-3), approximately 75 per cent of the peri-urban women had lower income levels, with an expenditure of less than one million *rupiahs* (US \$89.92 per month), whereas in the urban area, a slight majority (55 per cent) had a family expenditure of more than \$100 per month. Similarly, with regards to education (Table 7-4), respondents in the peri-urban area had a significantly lower educational achievement than their counterparts in the urban area.

Table 7-3
Socio-Economic Level

Women in Peri-urban Area		
SES ⁶	Frequency	Percentage
Low	130	74.7
High	44	25.3
Total	174	100
Women in Urban Area		
SES	Frequency	Percentage
Low	51	43.6
High	65	55.4
Total	117	100

Table 7-4
Education Level

Women in Peri-urban Area		
Education ⁷	Frequency	Percentage
Low	40	23
Medium	122	70
High	12	7
Total	174	100
Women in Urban Area		
Education	Frequency	Percentage
Low	9	8
Medium	80	68
High	28	24
Total	117	100

Finally, there were also differences in the proportion of respondents who were working women (Table 7-5 below). Amongst respondents to the questionnaire survey in the peri-urban area, women were almost evenly split between those who worked outside of the home (47 per cent) and those who did not (53 per cent). Amongst respondents from the urban area, there was a much more pronounced difference between the proportion of

⁶ The level of SES was calculated from family monthly expenditure for consumption and non consumption. Low referred to an expenditure of less than Rp 1,000,000 (\$89.92) and high of more than Rp 1,000,000.

⁷ A low level of education was elementary school (≤ 6 years education); a medium level was junior and senior high school (≤ 12 years education); and a high level was college or university (≥ 12 years education).

women who worked outside the home (68 per cent) and those who did not (32 per cent). It is important to note here, however, that the quantitative data on the number of peri-urban mothers who worked outside of the home does not tally with my own observations and data collected through qualitative research which suggested that there were far more working than non-working mothers in the peri-urban area: roughly 70 per cent of women respondents in FGDs and in-depth interviews were working women. The difference between the data collected may be explained by the fact that, as detailed in Chapter III, the questionnaire survey was administered by students who usually carried out the survey during normal working hours, whereas I held in-depth interviews at times that would best suit working women.

Table 7-5
Status of employment

Women in Peri-urban Area		
Status ⁸	Frequency	Percentage
Working mothers	81	47
Non-working mothers	93	53
Total	174	100
Women in Urban Area		
Status	Frequency	Percentage
Working mothers	79	68
Non-working mothers	38	32
Total	117	100

In sum, women respondents in the questionnaire survey from the peri-urban area tended to be younger, have lower levels of education and lower incomes, than the respondents in the urban area. These differences were born out both in the quantitative and qualitative data. While the results of the questionnaire survey suggested that not as many of the peri-urban women respondents worked outside the home as their urban counterparts, there were roughly the same proportion of women participants in the

⁸ The definition of working in this research was that the subjects (mothers) leave the house to earn incomes, leaving their families and babies for more than 4 hours at a time.

qualitative research in both areas who worked outside of the home. This does not mean to say there were no differences in terms of employment between the two groups. Certainly, there were more constraints on women in the peri-urban area in terms of finding appropriate childcare. Moreover, while work outside of the home for better educated and relatively affluent women was about establishing a career, work outside of the home for the less well off peri-urban women was more a case of economic necessity. There were also important differences in the kinds of employment the women entered with peri-urban women generally working in factories, while the more educated urban women working in a variety of sectors including various professional and civil service occupations. These differences provide an important backdrop and context for understanding some of the points of comparison I discuss below in respect of breastfeeding practice.

7.3.1. Breast-feeding Practices amongst Peri-urban Women

7.3.1.1. Antenatal Institutions and Place of Birth

There are two public health centres in Lintang called *Puskesmas Raja* and *Puskesmas Ratu* (a pseudonym). *Puskesmas Ratu* is a public health centre with facilities for hospitalisation (*puskesmas rawat inap*), which also serves as a maternity clinic. Both centres, however, employ midwives and provide maternity services. There are also other health care facilities in the village, including one private doctor, one midwife⁹ and three traditional midwives (*dukun bayi* – traditional midwife – here after referred to as the *dukun bayi*). Ante-natal care (ANC) is provided by the midwives in the public health centres, and doctors seldom examine the patients in receipt of ANC, which is seen as

⁹ Trained midwives, certified midwives or permanent midwives provide basic emergency obstetric and neonatal care. It should be noted that permanent midwives are different from village midwives (*bidan desa*). Permanent midwives are permanent civil servants (PNS) and trained/village midwives (*bidan desa*) are PTTs (*Pegawai Tetap*) or contract midwives. In this research area, the midwives are permanent midwives, and most of them are senior midwives.

the responsibility of the midwives¹⁰. The respondents in Lintang reported that ante-natal care is provided in several places, all of which are mentioned above. Unfortunately, given these limited facilities and the poor transportation for those who live farther away, many people find it difficult to access the health services.

The qualitative data both from FGDs and in-depth interviews show that the respondents mentioned several factors, including their financial means and the distance from their homes to the health care centres, affected their choices concerning pregnancy examinations. The quantitative data show that 72 mothers chose private midwife clinics for their ANC; 54 mothers chose the public health centre; and 19 mothers went to hospitals (see Table 7-6). The cost of ante-natal care varies according to place. For instance, registration in the public health centre costs Rp 3,000¹¹ (\$ 26 cents); Rp 10,000 (\$ 89 cents) in the private midwife clinics, and ranged from between Rp 30,000 – 60,000 (\$2.67 - \$5.37) for a gynaecologist in a hospital. In the private certified midwife clinics the cost includes vitamins and any medication.

Table 7-6
Places for Ante-natal care in the Peri-urban Area

Places for ANC	Frequency	%
Private Midwife Clinics	72	46
<i>Puskesmas</i> (Public health centre)	54	35
Hospitals	29	19
Total	155 ¹²	100

Source: Primary Data, 2001

¹⁰ To minimize the mother and baby mortality rate in Indonesia, the government has introduced many programmes, such as a safe motherhood programme, which involves the midwives as key players within the programme implementation. One such programme has been sending out trained/village midwives (*bidan desa*) since 1995/1996 to minimize the mortality rate of mothers. It is hoped that these midwives can compete with the traditional birth attendants or traditional midwives (*dukun bayi*) to ensure safer births.

¹¹ IDR = Indonesian *Rupiah* (Rp) or Indonesian currency. When this research was carried out, the exchange rate was \$ US 1 = Rp 11,200 and the average monthly salary for women in Lintang working in factories was between Rp 300,000 – Rp 400,000 (\$26.78 - \$35.71).

¹² The total number of respondents excluded of respondents from women of reproductive age and women who had no experienced of birth process and breast-feeding practice (see more detail in Chapter III - Research Design and Methodology)

While the public health centre was the cheapest option, respondents complained about the poor quality of service provided by the midwives in those centres. One respondent interviewed stated that she had 'moved to a midwife who practiced in a private health centre' because she did not feel satisfied with the service at the public health centre, the officers were 'cruel' and did not give any counselling. Besides the lack of counselling, it was felt that the health officers were reluctant to attend the centres, so the respondents went to other places for check-ups. One respondent felt disappointed because the health officers often went home early. Respondents in a stronger financial position also said they preferred having their pregnancy check-ups at the private maternity clinic where they planned to give birth.

Only 20 per cent of participants in FGDs stated that they received any counselling about breast care for after the birth, such as massaging and cleaning the nipples with baby oil. The rest of the respondents said that their older female relatives usually provided them with such information.

About 65 per cent mothers interviewed said that their husbands rarely took them to the public health centres, midwife private practices or maternity clinics. The main reason was that their houses were relatively close to the health centre or the midwives where the mothers went for check-ups. The second reason was that their husbands were reluctant to take time off work. Most of them were blue-collar workers who were paid daily and would lose wages if they did not go to work. However, other women stated that even though the husbands did not accompany them to the check-ups, they always considered their wives' needs and wishes and were involved in such matters as planning names for the baby. One of the respondents said: *"I understand that my husband seldom accompanies me to the health centre, I know that he is busy with his work, and we need more money for our baby so that's why he is working hard. But even though he is busy*

with his work, he still gives me plenty of attention – he bought some foods for me and when he was off work we went shopping together and bought the baby's equipment’’¹³.

As with their choice of ante-natal care, there were several factors affecting women's choice of birth place, such as the location, the costs, and also the perceived quality of the services provided by nurses, doctors, etc. As shown in table 7-5 below, the most frequently reported place of birth (34 per cent) was private midwife clinics, while the second most frequently reported place of birth was the hospital (23 per cent). The cost for giving birth in a private midwife clinics range between Rp 150,000 – Rp 300,000 (\$ 13.39 - \$ 26.79), while hospital rates range between Rp 2,000,000 - Rp 4,000,000 (\$178.57 - \$357.14), depending on the standard of the room and whether doctors or midwives assist at the birth. While private midwife clinics cost less than hospital, both private clinics and hospitals cost considerably more than giving birth either in the public health centre (*Puskesmas Ratu*) or the village maternity clinics. However, only 16 per cent of respondents said they choose the village maternity clinics, while 9 per cent said they choose the public health centre. The respondents who choose the private midwife clinics and hospitals said they did so because they considered them to be safer and provide better nursing care than other options. Similarly, respondents who choose village maternity clinics over public health centre (*puskesmas*) said they did so because of the poor service provision in the public health centre, though the distance between their homes and the centre and the limited transportation available might also have contributed to their decision to give birth in the village maternity clinics.

¹³ Ibu Siti (October,2001)

Table 7-7
Birth Places Chosen by Women in the Peri-urban Area

Birth places	Frequency	%
Private midwife clinic	52	33.5
Hospital	36	23.2
<i>Polindes</i> (village maternity clinic) ¹⁴	25	16.1
<i>Puskesmas</i> (public health centre) ¹⁵	14	9.0
Home	28	18.0
Total	155	100.0

Source: Primary Data 2001

However, there were also 28 mothers (18 per cent) who gave birth at home. In these cases, women were often assisted by a *dukun bayi* (traditional midwives) as well as a government trained midwife (*bidan desa*). The women interviewed said that they prefer using a *dukun bayi* partly because it is the least expensive form of maternal care, since the *dukun bayi* do not charge a fixed fee. Instead the payment for the *dukun bayi* can be given in instalments or in the form of rice, coconut, or other goods. Another reason for their continuing popularity amongst women is their status; they are elderly women who are considered to have a great deal of experience about the birth process and its related treatments. *Dukun bayi* are common place throughout rural Indonesia, and even though the government already employs trained midwives (*bidan desa*) in the villages, some people still prefer the *dukun bayi* as a birth assistant. To acknowledge this preference, the government developed the concept of '*pendampingan*'¹⁶. This is where a *dukun bayi* delivers the baby but is assisted by a trained midwife (*bidan desa*). The trained midwife supervises the *dukun bayi* to ensure that the delivery is carried out according to medical guidelines and with the proper, sterile tools. In addition, the

¹⁴ *Polindes* is a small maternity clinic, located in the village and run by trained/village midwives (*bidan desa*)

¹⁵ *Puskesmas* or public health centre is located in the district; usually one district in Indonesia has one public health centre, depending on the number of villages in the district. The *puskesmas* is run by a doctor.

¹⁶ The concept of *pendampingan* is based on a partnership ('*pendampingan berbasis kemitraan*'), and was developed in a meeting held between the provincial and district Maternal Child Health – MCH (*KIA – Kesehatan Ibu dan Anak*) held on the 12 – 13 February 2001. The idea of *pendampingan* is that at the time of delivery the *dukun bayi* assists the trained or village midwife, rather than developing any working 'partnership'. The rationale behind *pendampingan* is to prevent complications where risk factors exist and where a *dukun bayi* is not trained to deal with cases of neonatal tetanus.

midwife is on hand if an emergency arises, and can supervise and oversee the *dukun bayi* in the care of the baby for the first post-natal hour.

One respondent¹⁷ said that she asked the *dukun bayi* for help during the birth, even though she always went for ante-natal care in the health centre and had no problems with what was her third pregnancy. However, just before the birth, the *dukun bayi* could not help her as the baby was in a breach position (*sungsang*). The respondent was taken to the Ratu public health centre to get medical assistance, but even there the officers were unable to deliver the baby so she was taken to Mawar hospital¹⁸ in Semarang, where she finally underwent a caesarean section.

In the private midwife clinics, Mawar hospital and public health centres, women are usually nursed for between 2-4 days after the birth. All of the above maternity services officially operate rooming-in programmes. The aim of the rooming-in programme is to encourage the mother to breast-feed her baby on demand since the baby is put in the same room as the mother after giving birth. However, the perception amongst respondents was that they had to take responsibility for the baby due to the lack of nurses. On average up to 60 per cent of mothers interviewed complained that having the baby in the same room prevented them from resting.

Approximately 70 per cent mothers interviewed said that the baby was given to them after they had taken a bath. As shown in table 7-8 below, 47 per cent of respondents in the questionnaire survey said they breastfed their baby within the first three hours, and a total of 70 per cent within the first five hours.

¹⁷ Ibu Ijah (Oktober, 2001)

¹⁸ Mawar is a pseudonym. This hospital is the main hospital in Central Java and located in Semarang.

Table 7-8
Length of Time after the Birth that the Baby is Given Breast milk

Time	Frequency	%
Less than 3 hours	67	43
3 – 5 hours	43	27
> one day	45	29
Total	155	100

Source: Primary Data, 2001

Mothers reported that they practiced breast-feeding the baby for two hours. However, roughly 80 per cent of participants in FGDs also claimed that during the immediate post-natal period, they produced no breast milk, so the baby was fed infant formula or other kind of food such as honey, sugared water, etc., results which were also born out in the quantitative data (see Table 7-9 below). Moreover, in interviews, respondents who gave birth in private maternity clinics said that the baby was also fed infant formula with a bottle. In order to support the breast-feeding programme nurses are supposed to give infant formula with a spoon and not with a bottle, yet they reportedly used bottles because there were so many babies to take care of and bottle feeding was quicker.

Table 7-9
Foods given to the Baby after Birth

Foods	Frequency	%
Sugared water	27	17
Honey	42	27
Young coconut	4	3
Boiled rice water	16	10
Infant formula	66	43
Total	155	100

Source: Primary Data, 2001

Bottle feeding newly born babies with infant formula in the clinic may not only inhibit breastfeeding but also means that the babies were not receiving colostrum from their mothers (Hull 1982a). In fact, the perception and understanding about colostrum varied amongst respondents. Just small numbers of mothers (less than 30 per cent

participants of FGDs) knew that colostrum referred to the first milk to come out from the mother's breast, which is yellow and very good for the baby's immune system. However, other respondents did not know about it, or were unsure about whether they should give it to their babies.

The mothers who gave birth in the home mentioned that either the midwives or *dukun bayi* taught them how to breastfeed the babies. The responsibility of having to take care of the baby seemed to encourage the mothers to breastfeed the baby immediately after birth. However, some of them also stated that they also prepared infant formula for the babies.



Picture 7-1 Rooming-in facilities at *Puskesmas Ratu*

7.3.1.2. Post-natal Care and Women's Reactions to the Birth

The post natal treatment for village women in Lintang usually continues at home. Either the midwives or the *dukun bayi* visit the new mother in her home. The treatment given by the *dukun bayi* lasts for about 35 days after the birth (*selapan*), while

the treatment given by the midwives is until the umbilical cord falls off (*puput puser*). The midwives and the *dukun bayi* usually bath and massage the baby (*didadah*). The purpose of this massage is to stimulate muscle growth and is thought to prevent the baby from being fussy.

Besides treating the baby, the new mother is also treated by the *dukun bayi*. Javanese people believe that the mother is very weak after the birth and needs to be massaged and to drink '*jamu*' (traditional herbs) to recover her strength. The massage is for restoring the womb. The *dukun bayi* also trains the new mother to breast-feed the baby properly, and advises her to eat certain foods to improve her breast milk, such as beans, peanuts, and also one kind of leaf called *daun katu*.

Under the public health service, midwives are supposed to visit the baby and the mother after the birth at home. If the baby is born under average weight (less than 2.5kg) the midwives are responsible for carrying out home visits to monitor the baby's growth. However, it was found that the lack of midwives in the health service meant that home visits were rarely made.

The respondents felt that their husbands played an important role during the pregnancy. The husbands said that they sometimes worried when they saw their wives in pain before the birth. It is thought to be the husband's duty to stay with their wives during the birth. It is hoped that the presence and the support of the husbands can calm the wives and help them to be brave and strong during the birth. In Javanese society, the husband takes the placenta home to be washed and buried in front of the house. Amongst the Muslim population, the husband's other duty is to invite the voice of an '*adzan*' to the baby to introduce to him or her Islamic principles. While the mother is still in the maternity clinic, the ritual ceremony of '*brokohan*' is held at home to announce to the neighbours the family's happiness about the new baby¹⁹.

¹⁹ For more details see chapter V (Religion, Ritual and Their Influences on Pregnancy and Birth)



Picture 7-2 *Puskesmas* Raja: a mother registers to attend mother/children health care centre (BKIA)



Picture 7-3 Breast-feeding practice in Lintang village: while some women said their husbands did not want them to breastfeed in public, many women were comfortable breastfeeding in public.

7.3.1.3. Knowledge about and Attitudes towards Breast-feeding

Based on FGDs and in-depth interviews, I found that mothers in Lintang agreed breast-feeding provides the best nutrition for the babies. Approximately 60 – 70 per cent

of respondents thought that breast-feeding was natural for women, like menstruation, pregnancy and giving birth. About 70 per cent mothers interviewed considered that breast-feeding was a woman's obligation or duty, and in Javanese society, breast-feeding is considered part of parenting. One mother told me: *"As women, we have an obligation or duty to get pregnant and also to breastfeed the baby. I was so happy because just a couple of weeks after I got married, I got pregnant, I felt perfect as a woman, and I thought that I should also try to breastfeed my baby as much as I can"*²⁰.

Women who were pregnant with their first babies always hoped to breast-feed their babies, while those who were pregnant with their second or subsequent babies tended to go by their experiences from the first pregnancy; *"when I breastfed my first baby, I was so depressed at that time, since my baby cried quite often and I did not know what should I do. But now I try being patient, which is easier because I've already got experience in how to take care of a baby"*²¹. Working mothers interviewed stated that they really wanted to breast-feed their babies when they returned from work, but the babies refused their milk. They said that after they go back to work their babies do not want their mother's milk. One mother told me: *"I work 8 hours a day in the factory, and I have to leave my baby in the early morning, and since I have to start work at 7am, I don't have time to breastfeed my baby before I leave. After I return back home, I want to breastfeed my baby, but my baby always refuses my milk"*²². This case demonstrates that if a baby is fed formula milk, he/she will get used to bottle-feeding and may refuse breast milk. Sucking on a bottle teat is quite different from nursing at the breast, and this is one of the reasons why bottle-feeding often leads to the cessation of breast-feeding.

²⁰ Ibu Tari (October, 2001)

²¹ Ibu Nur (October, 2001)

²² Ibu Wahyuni (October, 2001)



Picture 7-4 A breastfeeding mother in Lintang.

One respondent said that she was willing to exclusively breast-feed her baby. However, she noticed that her baby was not as fat as her friend's baby who consumed infant formula. There was a perception amongst the communities that a healthy baby should be a fat baby, and such a perception is influencing breast-feeding practice. In many cases, bottle-fed babies tend to be fatter than breastfed babies. Another respondent commented that she did not like breast-feeding, since the baby was often fussy. The babies tended not to enjoy suckling if the mother's physical and psychological conditions were under par. One woman said that she preferred not to give her new baby breast milk because her baby was fussy and also because if she fed her infant formula she was free to leave the baby with other people to be fed.

After the birth the breasts are often swollen (*mbangkaki*), which can lead to fever. This is a difficult period because the mother is still weak and the baby is not good at suckling. For women having their second or subsequent birth, this period tends to be easier. Not every woman can breast-feed her baby successfully, since sometimes the milk has not been produced and the baby is not used to sucking milk from the mother's nipple. The production of breast milk varies amongst women. In general, the production

of breast milk will get better 2 - 3 days after giving birth. Before that period the respondents said they did not succeed in breast-feeding. Besides the swelling of the breast, the baby is not used to suckling. One respondent mentioned that she often felt pain during this time. She wanted the baby to suck her nipples, but the baby's mouth couldn't suck properly, which made the baby distressed because she was hungry. The respondents said that while their breasts were painful they would give their babies the bottled milk that they got from the maternity clinics. Various traditional remedies are used to improve breast milk. Beans, or peanuts fried without oil (*sangrai*), fried corn, vegetables, and traditional herbs (*jamu*) are considered the best foods for the new mothers. Only two respondents mentioned that they took medicine to stimulate milk production. They knew about these medicines from TV commercials.

The place where the mother delivers the baby influences their motivation to breast-feed. Whilst this research was being carried out, I found that some maternity services in Lintang provided infant formula milk for the babies, perhaps making the mothers less motivated to breast-feed their babies. The fact that some mothers could not produce breast milk or needed to rest were the main reasons why the nurses gave out bottled milk. The doctor in the Ratu health centre and some of the midwives said that they supported the exclusive breast-feeding programme, and always encouraged the mothers to breast-feed their babies. However, the respondents who had given birth in the health centre said that they still received bottled milk to give to their babies even when they were producing breast milk. The availability of one particular brand of infant formula milk in those maternity clinics suggests a relationship between the hospital and the milk company²³.

The majority of mothers interviewed (approximately 60 – 70 per cent) in Lintang really did not know the term of 'exclusive breast-feeding'. Most of them had

²³ For more details see chapter VIII (the Bottle-feeding Phenomenon)

of it for the first time when I mentioned it. However, they eventually understood that it refers to feeding the baby only breast milk until he or she is about 4 - 6 months old. According to the mothers interviewed, breast-feeding is considered a mother's duty or responsibility, regardless of whether the quantity of breast milk is sufficient for the baby or not. Babies tend to be offered to suck the nipple when they are crying. In this way, breast milk is not considered to be the main food for the baby i.e. the primary source of nutrition. Rather, solid food such as bananas and baby porridge come to be seen as a primary source of nutrition, with breast-feeding primarily regarded as a form of comfort. But if the baby keeps on crying the mother will feel very embarrassed about her baby's distress. One respondent told me that she wanted to give her baby only breast milk, but that the baby was often fussy and her neighbours reprimanded her. One neighbour said that it was not good to let the baby cry, and perhaps the baby was hungry and wanted something to eat. Finally, the respondent fed her baby a banana even though the baby was only one month old.

About 60 per cent of mothers interviewed stated that they did not have any problems regarding breast-feeding in public places. Some of them mentioned they did not want to breast-feed the babies in public places because it was impolite. One mother told me that she felt comfortable breast-feeding her baby in public places, but her husband did not like it so she always fed the baby with a bottle if they had to go out.

7.3.1.4. Weaning & the Introduction of Other Foods

As mentioned earlier, the mothers in this area stated that breast-feeding is women's duty or responsibility and also a part of parenting. However, very few women (about 20 – 30 per cent) understood or practiced exclusive breast-feeding, and the majority (70 – 80 per cent) introduced additional foods and/or infant formula soon after birth. Breast-feeding was seen as one method to take care of the babies and keep them

satisfied, but was not regarded as the sole or even primary source of nutrition. Honey, young coconut, soft rice, bananas, and instant baby food/porridge are some of the baby foods introduced to babies under 4 months old. One respondent said although she had intended to feed her baby only breast milk, her baby always cried, so she decided to give her baby some instant baby porridge. Another mother told me that she had difficulty in feeding her baby. She added that she had fed the baby many kinds of food, such as banana, vegetable soup, baby porridge, but the baby only wanted to eat a little of the food. Once during a *posyandu* programme, I saw one mother with a child of 18 months. She told me that she fed her child only breast milk. When I asked her why she did not give the baby other kinds of baby food, she said that the baby did not like it, and she told me: *I thought it's good for my child if I just give him breast milk. Isn't it? "*

The general lack of understanding and knowledge amongst the women about breast-feeding and the introduction of additional foods is not only due to lack of education but is also associated with the poor implementation of the '*posyandu*' programme. *Posyandu* (the Monthly Integrated Health Service Post) is supposed to be composed of 5 activities: weighing, recording, additional food distribution, counselling and immunization. Based on personal observations, the *posyandu* programme seemed to be unsuccessful in the research community. There, the *posyandu* only functions as a place for weighing babies and children under five years old, but doesn't offer any counselling about their growth and nutritional requirements. Additional food to supplement children's nutrition is poorly distributed as well. Some respondents said that they do not like the food prepared by the health volunteers because it has artificial sugar in it that they believe makes their children cough. For these reasons, some respondents never joined the programme to weigh their babies. One respondent said²⁴ that she usually goes to the Mother-Children Health Care Centre (BKIA) in the Mawar hospital

²⁴ Ibu Rudjito (November, 2001)

in Semarang. According to her, the weighing programme in the hospital is different from the *posyandu* one. She said that *“in that hospital, they take my baby’s clothes off, and then they weigh her. I also get a lot of information about my baby’s growth”*. However, although the mother received some vitamins and recipes for nutritious baby food from the hospital, she was not able to prepare the food because she did not have enough money to buy the ingredients. She also reported that *“my baby might not want to eat it. For the family meal I only prepare one kind of food, such as a vegetable dish, for all the members of my family, so there is no special menu for me. My husband and I might add some chilli sauce to make it taste better for us”*.



Picture 7-5 Registration in *Posyandu* programme in Lintang. There are limited resources to run this programme

Picture 7-7 A Midwife gives an immunization injection to the baby



Picture 7-6 Weighing in *posyandu*: there are no accurate scales to measure the baby's weight in this programme.



Picture 7-7 A Midwife gives an immunization injection to the baby



Picture 7-8 Distribution of additional food in *Posyandu*: the food distributed was sponsored by one of the food's factories in this region. It was heavily processed and not healthy food.

7.3.1.5. Work, Public Roles and Breast-feeding

When women work outside the home, as many do in Lintang, they often encounter a number of barriers to breast-feeding. Working women usually work 8 hours a day, making it impossible for them to breastfeed their babies. Offices or companies do not allow their female employees to breastfeed and do not provide childcare centres in the workplace. The distance travelled to work might make it impossible for mothers to go home to breast-feed their babies or for baby sitters to take the babies to the workplace. The qualitative data show that 80 per cent mothers said that they had never used a breast pump, either at work or at home. In any case, workplaces do not provide a special room for mothers to pump their breast milk. Breast milk is thus only produced when the baby is suckling, and if the mother does not feed the baby often or pump her milk, her milk production will decrease.

Unsurprisingly, the main reason women in Lintang go out to work is economic. They work to supplement the family income and help make ends meet, which has become more difficult in Indonesia since the economic crisis in 1997. Women also go out to work because they worked before they got married, and do not want to quit their jobs. About 40 per cent of working mothers interviewed said that they had made an agreement with their husbands to keep working even though they had children. The other respondents from Lintang who did not work stated that their husbands do not allow them to work and want their wives to devote all their time to the family, while others said that they do not work because of poor health.

Working mothers who work for certain companies, such as Bintang, Matahari, Bulan, and Garuda, usually work one of 3 daily shifts²⁵. Workers in Rajawali Factory usually work for 13 hours a day. The night shift is from 11 pm – 7 am, which means women workers must leave their children during the night and may sometimes have to work overtime. PT Bintang operates a policy of not putting pregnant workers on night shift or overtime.

The Indonesian government has set maternity leave at 3 months, for all employees, including civil service employees. All of the respondents said that they got the leave they were entitled to. They usually take 1.5 months before and 1.5 months after the birth. Other respondents took one month before the birth and 2 months after the birth, which gave them more time to take care of their babies. During this maternity leave respondents said that they get paid their monthly salary as usual.

I found that companies such as Bintang, Kenari, Bulan, and Rajawali offer maternity leave when the pregnancy is into 7.5 months, and offer three months leave. It will be withdrawn if the workers do not take it. In other words, if the pregnant worker gives birth in the eighth month of her pregnancy, her maternity leave will be only 1.5

²⁵ For more details, see chapter VI (the Area)

months. This withdrawal system does not apply for civil servants and workers in Merpati and Elang companies.

I found in this research that many companies have different policies to reduce the workload of pregnant workers. They are usually moved to another division or allowed to do their jobs sitting instead of standing. This policy is enforced in Bintang, Kenari, Bulan, Garuda, Langit companies and in government offices, whilst in Rajawali and Elang companies, the management do not reduce the workload of pregnant women. Employees in Bintang, Kenari, Garuda, Langit companies and in government offices still get their monthly salary while they are on maternity leave, but employees in Matahari and Bulan do not. These companies cut their salary because they are paid on a daily basis. Unlike Bintang, which offsets the expense of the birth, some companies do not help with the expense of the birth at all, while others offset half of it.

Companies do not give any special time for the workers to breast-feed the baby, nor do they provide childcare in the workplace. This condition, of course, influences the poor implementation of the exclusive breast-feeding programme, and there were no babies during the research who were taken to the workplace to be breast-fed. When the maternity leave is over (1.5 months after the birth) the baby ends the exclusive breast-feeding programme because he or she is given bottled milk while the mothers are at work.

Overall, the mothers in the peri-urban area lacked real knowledge and understanding about breast-feeding practices. The majority of mothers in Lintang thought that breast-feeding was the nutritious way to feed the baby, and that breast-feeding was natural, like pregnancy and giving birth, or was part of parenting. However, in practice women in peri-urban areas seemed to regard breast-feeding as supplementary comfort food rather than as the primary source of nutrients. Socio-economic factors, such as educational and economic levels, seemed to influence breast-feeding practices.

It was found during the research that the mothers did not know whether they had given colostrum to the babies or not; and most of the mothers felt that they did not really understand what exclusive breast-feeding meant. Approximately 70 - 80 per cent participants of the FGDs stated that they introduced either infant formula or additional food before the baby was 4 months old. Although this was particularly the case amongst working mothers, who often returned to work within 1.5 months after giving birth, it also held true for non-working mothers who introduced additional foods to their babies at a very early age. The next section examines breast-feeding practices amongst women in the urban area.

7.3.2. Breast-feeding Practices amongst Urban Women

7.3.2.1. Antenatal Institutions and Place of Birth

All of the respondents in the urban area said that ante-natal care (ANC) was very important during their pregnancy. ANC was usually carried out in hospitals, at private medical practices and at maternity clinics. About 60 per cent of mothers interviewed said they preferred using a midwife, because it was cheaper than using a doctor. Roughly a third of participants, however, reported that they preferred to go to a gynaecologist, even though it was more expensive. As mentioned in the previous section, the cost of ANC ranges from between Rp 30,000 – Rp 60,000 (\$2.67 - \$5.36). Both from the discussions and interviews, approximately 80 per cent mothers said they never went for ANC alone, but would ask their husbands to accompany them to the hospital or maternity clinic even if their check-up was in the morning.

The mothers who did ANC with doctors said that they felt more secure during the birth since the doctor was aware of their condition during the pregnancy. Furthermore, the mothers also stated during ANC they ask either the midwives or the doctors for counselling for their conditions. Small numbers of respondents (20 per cent)

said that as they had paid already for this treatment, so they wanted to get as much counselling as they could.

Table 7-10 and 7-11 show the places chosen to give birth and the kinds of assistance received during the birth. Table 7-10 shows that the majority (52 per cent) of mothers in the urban area preferred to give birth in private maternity clinics. Thirty one mothers (26 per cent) chose hospital and 21 per cent of the mothers gave birth in the state maternity clinics. Table 7-11 shows that, as with mothers in the peri-urban area, 65 per cent chose midwives to assist in the birth process, while 41 mothers asked gynaecologists to assist it.

Table 7-10
Places of birth

	Frequency	%
Private maternity clinics	61	52
Hospitals	31	26
State maternity clinics	25	21
Total	117	100

Source: Mexitalia & Budihartani, 2003

Table 7-11
Assistance

	Frequency	%
Doctor	41	35
Midwife	76	65
Total	117	100

Source: Mexitalia & Budihartani, 2003

As mentioned earlier, the Government of Indonesia has developed programmes to support breast-feeding practices, particularly exclusive breast-feeding. One of these is the ‘rooming-in’ programme, which means that the baby is put in the same place as the mother in order to train the mother how to breast-feed properly and on demand. However, some private maternity clinics and hospitals, such as Melati hospital, do not adhere to this policy, and the baby is put in a separate room and only put in the mother’s room during certain times. This is to allow the mother time to rest and recover quickly

and to prevent the baby from transmitting any infection that might be brought by the guests who visit the mother. One senior nurse said that she had argued with one paediatrician about infant formula in this hospital; the doctor had insisted that his patient should breast-feed her baby exclusively, whilst the nurse had insisted that the mother needed a rest after giving birth.

As with many women in Lintang, approximately 70 per cent said that they had produced no breast milk just after giving birth, so the baby was fed infant formula which was provided by the clinics during their stay in the maternity clinic or hospital. The availability of infant formula in the maternity services seems to influence the motivation of the mothers to breast-feed the babies. There were many reactions to the extent of the distribution of infant formula in the maternity clinics. In general, the women just accepted the hospital or maternity clinic's policy. One respondent said that she agreed with the policy in Melati hospital to give infant formula to her baby. She argued that she felt weak after the birth, and moreover, her breast milk production was poor, so she preferred giving some infant formula to her baby. However, another respondent who had given birth in an expensive maternity clinic in Semarang said that she was disappointed with the nurse who did not support the practice of breast-feeding. She added that after the baby was born, the nurse asked her what kind of infant formula brand she would give to her baby. Furthermore, the nurse neither helped her to breast-feed her baby, nor trained her how to do it properly and was insistent to the point of rudeness that the woman use infant formula.

7.3.2.2. Post-natal Care and Women's Reactions to the Birth

For the mothers in the urban area, since they gave birth in the hospitals and were assisted by gynaecologists or midwives, they never received treatment from the *dukun bayi* as in the peri-urban area. They continued to have check-ups after the birth with the

midwives or gynaecologist; and they went to a paediatrician to check the baby's health. The majority of the mothers interviewed (70 per cent) added that they did not want anyone to massage their baby whilst he or she was still very small and weak, and they did not want to put their babies at risk. However, some respondents (30 per cent) said that they asked the nurse or midwife to bath the baby until the umbilical cord fell off.

As with the mothers in the peri-urban area, the mothers in the urban area also had difficulties in breast-feeding immediately after birth. The breast milk had not yet been produced, the breasts were swollen and more than half the respondents said that breast-feeding was painful. Approximately 80 per cent of mothers interviewed said that they gave the baby infant formula during this time. Eating more vegetables was mentioned by most of the respondents as a way to solve the problem of low milk supply. Some of them said that their family had brought them fried peanuts in the hospital. One respondent said that she had tried to eat all kinds of nutritious food to increase her breast milk production, even though she had a problem with low body weight throughout her pregnancy. Just small numbers of mothers interviewed (20 per cent) said that they consumed traditional herbs, but most tried other foods as they did not like the smell and the taste of the herbs. One respondent mentioned that she had obtained a prescription from her doctor to increase her breast milk production, but finally she decided to stop taking the medicine, as she realised she had put too much weight on. Women in the urban area with higher socio-economic status than women in the peri-urban area thought more about their body image, especially working women. The mothers interviewed stated that they wanted to continue to breastfeed the baby, stay healthy and maintain their looks.

7.3.2.3. Knowledge about and Attitudes towards Breast-feeding

As was case with mothers in the peri-urban area, mothers in the urban area also agreed that breast milk provides the best nutrition for the baby, since breast milk is healthy, natural, practical and cheap, especially when compared with infant formula. The qualitative data, both from FGDs and in-depth-interviews show that half of my respondents (50 per cent) said breast-feeding is essential for babies, while 20 per cent said that infant formula makes the babies fatter and healthier. Around 20 per cent mothers explained that bonding between them and their babies was an important factor in deciding to breastfeed. One of the respondents said, *"I feel perfect as a woman, I can get pregnant, give birth and breast-feed my baby. I feel happy when I breast-feed my baby, I can touch her, and I feel she understands that I am her mother"*²⁶. In addition, breast-feeding is also considered to be a natural contraceptive.

The qualitative data also show the majority of the mothers (approximately 70 per cent) in this area could explain properly what colostrum was. However, some of them were not sure whether they had given colostrum to their baby or not, but they did want to give colostrum to their baby.

Respondents stated that they breastfed their baby as much as they could, but that it depended on the baby's health and their own breast milk production. One of the mothers said: *"I prefer to breast-feed my baby than give him bottle-feeding, and I am so lucky I can produce enough breast milk. With breast-feeding I do not spend a lot of money for infant formula and also I already quit from my job, so I hope I can breast-feed my baby exclusively"*²⁷. If their breast milk was abundant they tried to give it to their babies for the first 4 months. The mothers interviewed mentioned that they really wanted to breastfeed their babies, but were unable to do so due to the perceived poor

²⁶ Ibu Nuning (February, 2002)

²⁷ Ibu Dina (February, 2002)

production of breast milk, the baby's inability to suck the nipple properly, or because they had to leave their babies to go to work. Both in the discussions and interviews, the working mothers stated that they introduced infant formula before they went back to work. Working mothers mentioned that they did not want any difficulties in feeding the babies after their maternity leave was over.



Picture 7-9 Mothers and fathers who were attending the mother-child health care (BKIA) in Melati hospital, Semarang.

7.3.2.4. Weaning & the Introduction of Other Foods

As with women in Lintang, the place where the mother delivers the baby influences their motivation to breast-feed for women in the urban area. Poor implementation of the 'baby friendly hospital' with 'rooming-in programmes' also have led to an increase in bottle-feeding practice in Semarang. The majority of the respondents (70 - 80 per cent) said that they still wanted to give the baby breast milk without any additional foods until the baby was 4 months old. However, since they had

difficulties with breast milk production, they gave infant formula to the baby. Water and infant formula were the two most common food stuffs given to the baby after the birth.

The fact that mothers in this area said they only gave the baby either breast milk or infant formula without any additional food suggest that they have better knowledge about infant's food. In particular, they understood that breast milk or infant formula should be the primary source of nutrition until the baby is 4 months old. This does not, however, imply that no other foods were introduced before this period. Some of the mothers interviewed (35 per cent) in the urban area stated that they sought advice or suggestions from their paediatrician about giving their baby early or additional food, but they did not accept all of the suggestions. They told me that when the baby was between 2 - 4 months old, he or she was given fruits, such as bananas, tomatoes and oranges, and the rest of the respondents mentioned that they fed their baby instant baby food. However, whereas women in the peri-urban area seemed to regard breast milk as supplementary to other sources of food, women in the urban area regarded breast milk and/or infant formula as the primary source of nutrition with other food regarded as supplementary.

Regarding exclusive breast-feeding, large numbers of the mothers interviewed (80 per cent) understood that exclusive breast-feeding means that the baby receives no other food or liquid, including water, until the baby is 4-6 month old. However, as the data in Table 7-12 below shows, only 32 per cent of women respondents in survey-questionnaire in the urban area said they practiced exclusive breast-feeding.

Table 7-12
Exclusive Breast-feeding Practice amongst Women in the Urban Area

Exclusive Breast-feeding	Frequency	%
Exclusively	38	32
Non exclusively	79	68
Total	117	100

Source: Mexitalia & Budihartani, 2003

There are number of reasons for the low frequency of exclusive breast-feeding, including both the introduction of infant formula in the maternity clinics and hospital after birth and because the length of maternity leave in Indonesia is too short to make exclusive breast-feeding practical for working mothers. Unsurprisingly, I found during qualitative research that non-working mothers stated they tried to breastfeed the baby as much as they could. The quantitative data also showed that non-working mothers tended to practice exclusive breast-feeding longer than working mothers. Table 7-14 below shows that the majority of working mothers (64 out of 79 respondents) did not practice exclusive breast-feeding exclusively, while the majority of non-working mothers (23 mothers out of 38 respondents) said they breastfeed the baby exclusively.

Table 7-13
Correlation between Working/Non-working mothers and Exclusive Breast-feeding

	Breast-feeding Practice		Total
	Exclusively N (%)	Non exclusively N (%)	
Working mothers	15 (13%)	64 (55%)	79
Non-working mothers	23 (19%)	15 (13%)	38
Total	38 (32%)	79 (68%)	117

Source: Mexitalia & Budihartani, 2003

7.3.2.5. Work, Public Roles and Breast-feeding

As mentioned earlier, the majority of working mothers (70 – 80 per cent) said that before the maternity leave was over, they introduced the baby to infant formula. Both from FGDs and interviews I found that working mothers said that they tried to

introduce infant formula during maternity leave to avoid the babies being fussy about infant formula later. Moreover, the mothers interviewed claimed that after the baby had been introduced to additional foods, especially infant formula, the baby always refused breast milk.

There were, however, a minority of working mothers who did try to practice exclusive breast-feeding and their experiences demonstrate just how difficult this can be. One of the respondents said that she asked her boss if she could come to the office a little bit later and go home earlier, so that she could take care of her baby. Another respondent said that she never introduced the baby to infant formula during her maternity leave. Two weeks before her leave was over, she gave some infant formula to her baby, and the baby refused it. Moreover, her work place was far from her house, so she finally decided to rent a room close to her work place. During her lunch break she could go back to her room to breast-feed her baby. They stated that it was hard to leave their babies when they went back to work but that they had to support their families. Those who worked near their home always tried to go home during their lunch break to breast-feed their babies.

The Government of Indonesia has set the maternity leave at 3 months, both for civil service employees and other employees. The different kinds of jobs that women in peri-urban and women in urban areas have, however, meant that in practice maternity leave differed between them. Working mothers in Semarang who worked as civil servants said that their working hours were more flexible and usually their colleagues understood. One of the respondents, who is a lecturer, said that she did not go to the office every day; usually she attended if she had a class or a meeting. On the other hand, one respondent who worked as a banking officer for a private company said that she felt she had to give up breast-feeding her baby after her maternity leave was over. She said that she had to leave the baby early in the morning and came back home late in the

evening. She had tried to give her baby breast milk during the night but the baby always refused it. She said that she had tried to pump her milk and put it in the fridge but eventually her breast milk production had decreased. The working women claimed that because their workplaces did not provide nursery places, it was difficult for them to breastfeed the baby during working hours.

In addition to the difficulties working women faced in combining work with exclusive breastfeeding, approximately 70 per cent mothers in this area said that they did not want to breast-feed in public places. Some of them explained that they would feel embarrassed and others mentioned that it would be impolite and that bottle feeding would be more suitable in public places. Whilst this research was being carried out, I saw some mothers in the Melati hospital feed their babies with bottles because they felt it was impolite and embarrassing to breast-feed the baby in a public place, even in the hospital.

In general, knowledge about breast-feeding was better amongst women in the urban area than amongst women in the peri-urban area. According to the urban women, breast-feeding was good, cheap and practical for the baby. Unlike mothers in the peri-urban area, the majority of the mothers stated that they knew about colostrum and exclusive breast-feeding. The majority of women (80 per cent) wanted to breast-feed their babies as much as they were able, but they also found that their working situations prevented them from doing so. In the following discussion I will analyse the differences in breast-feeding practices amongst mothers in the peri-urban and the urban areas.

7.4. Discussion

With regard to ante-natal care, the mothers in both areas preferred to use the services of midwives. This decision was made for financial reasons or because of the distance between the home and health services, especially for women in the peri-urban

area. The mothers in Lintang chose public health centres (*puskesmas*) for ANC because the cost was cheaper. However, the mothers with more disposable income complained about the poor services in the health centres, and had moved to private clinics. According to them, they seldom received any counselling regarding their pregnancy. On the contrary, since the mothers in the urban area had a higher level of education and better incomes, they found it easier to access good ante-natal care. About 50 - 60 mothers interviewed mentioned that they preferred the services of midwives, whilst others who had a better financial status felt more secure with gynaecologists.

The fact that public health centres are not providing good ante-natal care is very disturbing, since in Indonesia the *puskesmas* (public health centre) is the primary health facility, with lower costs that are affordable for people with lower socio-economic statuses. Actually, public health care services in Indonesia are highly subsidised by the government and funded through taxes, international grants and contributions from the private sector, but, unfortunately, these resources have shrunk as a result of the economic crisis in Indonesia (UNICEF, 2000). Moreover, the economic crisis has undermined progress for the whole population; and its effects on women are even more severe, since women generally figure amongst the poorest of the poor (Vickers, 1993). Furthermore, according to UNICEF (2000:36) and the World Bank (1999: 22-23), all pregnant women face some level of maternal death risk, which means that regular ante-natal care is needed to help detect and manage some pregnancy related complications, such as pre-eclampsia, infection, etc. and to educate women about danger signs, potential complications, and where to seek help. Ante-natal care is also an opportunity to provide preventive care that will benefit the baby as well as the mother, such as counselling on hygiene, breast-feeding, nutrition, family planning, tetanus toxoid immunization, and iron/folate supplementation. According to UNICEF (2000:42), pregnant women in Indonesia often do not take danger signs seriously during

pregnancy, such as swelling, vomiting, seizures and bleeding. Even when they know such symptoms should be checked and treated promptly, many hesitate to seek care. Bleeding or haemorrhage, dizziness and vomiting are the most common symptoms reported to midwives and doctors, according to a study of 300 women who had given birth in the past year in the district of Semarang in 1996 (ibid).

Limited skills, including managerial skills and the low salary of health providers in Indonesia are also contributing to poor services in the health centres. Within the health centre, midwives are supposed to be responsible for maternal and child health (*KIA – kesehatan ibu dan anak*), yet because of understaffing they often have to take on other duties. Moreover, some of them also work in private clinics. If these conditions do not improve in the future the maternal mortality rate in Indonesia will increase.

For mothers in the peri-urban area, there were many factors influencing the choice of birth place, such as location, costs, and the quality of the services provided by nurses, doctors, etc. On the other hand, mothers in the urban area with a higher socio-economic status stated that they preferred giving birth in private maternity clinics and hospitals because such places were more secure and convenient with a higher standard of health services. The quantitative data show that just a small number of mothers (14) in the peri-urban area gave birth in the public health centre (*puskesmas*). The poor services in the *puskesmas* could be forcing the mothers in this area to use other places in which to give birth. 28 mothers in the rural area gave birth at home, assisted by midwives or *dukun bayi*. On the contrary, no mothers in the urban area gave birth at home.

Peri-urban and urban women had different attitudes towards post-natal treatment. As mentioned earlier, there are three *dukun bayi* in Lintang. The presence of these *dukun bayi* meant that post-natal treatment was administered in the traditional way, whereby the *dukun bayi* visits the mother in her home. On the other hand, none of

the urban women mentioned that they had asked a *dukun bayi* to treat them during the post-natal period. Only a few mothers had asked a midwife to bath their baby until the *puput puser* (the umbilical cord falls off). Surprisingly, most of the mothers said that they did not want a midwife or anyone else to massage their babies, unlike the mothers in the peri-urban area. Most of the urban women (60 – 70 per cent) stated that they received post-natal treatment from either a visiting midwife or an obstetrician. There are no *dukun bayis* in the urban areas and the higher levels of education and incomes also seemed to influence the women in the urban area away from more traditional practices.

The data mentioned above suggests that women in the village still preferred the services of the *dukun bayi*, even though they had access to trained midwives. In the late 1950s, Jaspan who conducted research in Sewon, Yogyakarta, found that on the fortieth day after the birth of her child a mother request *dukun bayi* to turn her uterus to one side or to 'raise it' (Jaspan & Hill, 1987:6). In the early 1960s, Geertz (1960) and Geertz (1961) also found during their research in Modjokuto that the *dukun bayi* assisted at births and also treated the mother during the post-natal period, and nowadays the situation in rural Indonesia remains largely unchanged. Recognising the need for improvement, the Government of Indonesia implemented the 'Mother Friendly Movement' in 1996, which focused on initiatives such as community mobilisation (*gotong royong*) to provide transportation for pregnant women in need of referral, and community savings schemes, supported by village heads (*kepala desa*), to finance the cost of more specialised care. At the village level, trained midwives (*bidan desa*) provide basic emergency obstetric and neonatal care. Between 1989/90 and 1997/98, out of 68,724 targeted villages in Indonesia, *bidan desa* were placed in 53,247 or 98 per cent of villages. As mentioned earlier, another programme also developed the concept of 'pendampingan' in Indonesia²⁸. Under this scheme a trained midwife is called to

²⁸ http://www.developmentgateway.com.au/pdf/health/Midwife_birth_attendant.pdf

attend whilst the *dukun bayi* assists at the birth. The role of the trained midwife is to supervise the *dukun bayi*, and to ensure that the proper, sterile tools are used.

This research found that the majority of the mothers in both areas (up to 80 per cent) knew that breast-feeding is healthy, cheap, practical and natural and they also stated that breast milk was the best food for their babies. Approximately 60 – 70 per cent of the mothers in the peri-urban area stated that breast-feeding is natural for woman, like menstruation, pregnancy and giving birth. In addition, they explained that breast-feeding is a woman's obligation or duty, and in Javanese culture, breast-feeding is considered part of parenting. On the other hand, about 20 per cent mothers in the urban area argued that there are differences between breastfed babies and bottle-fed babies, while about 20 per cent mothers interviewed in the urban area thought that bottle-fed babies were fatter and healthier than breastfed babies.

As mentioned above, some mothers (estimated 60 - 70 per cent) stated that breast-feeding is part of parenting, women's duty and responsibilities. Sometimes, particularly in the villages, women will breast-feed their children even though their breast milk production is poor and the child is more than two years old. They will do this if the child is being fussy or is difficult (*rewel*) to breastfeed (*ngempeng*). Based on her research findings in Ngaglik, Sleman, Yogyakarta, Hull (1984:11) indicated that in Javanese culture there are different terms for breast-feeding. The first term is *meneteki* (suck the nipple) and the second term is *menyusui* (suckle milk). Building on Hull's distinctions between different kinds of breast-feeding practice, *meneteki* is seen as part of parenting, and in Javanese society mothers tend to breastfeed on demand. If the baby cries the mother assumes the baby is hungry, sleepy or fussy so she will breastfeed regardless of whether the quantity of the breast milk is sufficient or not. The second term, *menyusui*, is concerned more with the production of breast milk. According to this

term, when the mother breast-feeds her baby, she is giving breast milk to her baby, as opposed to using suckling as a means to calm her baby.

With regard to the two forms of breast-feeding as mentioned above, based both on the observations I made over the course of the research and also on findings from the qualitative data about breast-feeding practice in Lintang, I argue that the mothers in Lintang village practice a *meneteki* (suck the nipple) form of breast-feeding rather than a *menyusui* form. The qualitative data show that the mothers interviewed told me that breast-feeding is a mother's duty or responsibility, regardless of whether the quantity of the breast milk is sufficient for the baby or not. I argue that '*meneteki*' is not the same as systematic breast-feeding, rather it is a form of comforting a 'fussy' baby. In this way, solid food such as baby porridge, soft rice, bananas come to be seen as a primary source of nutritious food, while breast-feeding primarily as a form of comfort.

Also, I found in the qualitative data, both from focus group discussions and in-depth interviews, that the mothers in the peri-urban area lacked knowledge about the nutrients contained in breast milk, the duration and frequency of breastfeeding and the relationship between the production of breast milk and food intake. This lack of knowledge is a result of socio-economic factors, such as poor education and a lack of adequate counselling in that area. Approximately 60 - 70 per cent of the mothers stated that they felt satisfied when they breastfed their babies and assumed that the babies would not be fussy or cry. In the Javanese perception, a baby who cries often is assumed to be hungry and the mother must breastfeed to satisfy her baby. If the baby keeps on crying, he or she is still deemed to be hungry, and the mother will feel very embarrassed if her baby often cries.

On the contrary, urban women, particularly working women, are more aware that their baby may be fussy because he or she is not satisfied with breast milk. Moreover, some of them (estimated 70 per cent) prefer to give their baby infant formula

as soon as possible, even though they still keep giving them breast milk. However, they complained that after the baby was used to bottled milk, he or she preferred the bottle to breast-feeding. I found that the women in the urban area have a greater awareness of breast-feeding, possibly since their level of education is higher than rural women. Some of them said that they got information about breast-feeding from books and magazines and, most importantly, from doctors. Socio-economic factors also influenced their access to information. They had more money and could therefore choose better health services.

The lack of understanding about breast-feeding amongst women in the peri-urban area is also closely related to poor counselling. Based on information from the Ministry of Health (MoH), there is a breast-feeding counselling programme, which is associated with the Nutrition and Children Programme (*Program Gizi & KIA – Kesehatan Ibu dan Anak*). This Nutrition Programme supervises the ‘exclusive breast-feeding’ programme, while a maternal and child health programme (KIA) offers counselling. Unfortunately, there is only a small budget available for this programme. One officer in the MoH said that the limited budget results in an assumption that the breast-feeding programme is not really necessary. The existing fund is used to produce flipcharts or posters to distribute across the districts.

Lactation clinics are available in many hospitals, as well as in maternity clinics. These clinics are used to give training to mothers about how to breastfeed the babies, but, in fact, these facilities are never used. On the other hand, in the public health centres (*puskesmas*), such as Ratu public health centre, which is used for hospitalizations, there is no lactation clinic. Posters describing breast-feeding are attached to the walls of health centres, maternity clinics, and hospital buildings. In fact, these posters look more like wall decorations than important messages. There are some short slots on talk shows on the television or radio about babies and children but the

topic of breast-feeding is rarely mentioned. While this research was being carried out, some private TV channels showed some short spot about the benefits of exclusive breast-feeding. Unfortunately, the show was sponsored by one infant formula brand.

As mentioned earlier the government of Indonesia has in recent years taken steps to promote breast-feeding. Non-governmental agencies and organizations have also taken increasing interest. A non-governmental agency known as BKPP-ASI has been established as a national coordinating body for the promotion of breast-feeding in Indonesia. International agencies, such as UNICEF, the Ford Foundation, USAID, and the International Nutrition Communication Service have also provided assistance to augment the momentum and support the project to promote breast-feeding practice. Unfortunately, the growing interest in the promotion of breast-feeding, which has had a positive impact on health professionals, seems not to have taken hold at the grassroots level. Thus, breast-feeding counselling is rarely carried out at the village level. At the district level (*kecamatan* or *puskesmas* / public health centre), midwives are expected to be in charge of counselling. However, due to understaffing, this counselling is not always delivered.

According to WHO and UNICEF, breast-feeding should be initiated immediately after the birth of the child. The initiation of breast-feeding is based on the duration between delivery and first breastfeed, and is usually defined as 'early initiation' when a breast-feed takes place within the first half hour or first hour after birth (Huffman, Zehner, & Victora, 2001). Based on the focus group discussions and in-depth interviews in the urban area, I found that approximately 70 - 80 per cent of mothers interviewed stated that they started to breastfeed their babies more than 5 hours after the birth and usually after they and the babies had bathed. For the mothers in the peri-urban area, the quantitative data shows that 67 mothers (43 per cent) breastfed their babies for the first time less than 3 hours after the birth, 43 mothers between 3-5 hours

after the birth, and 45 mothers took more than one day to breast-feed their babies. The large number of mothers in the peri-urban area who breastfed their babies less than 3 hours after the birth had given birth at home, in the public health centre and also in private midwife clinics. The poor services at the health centre and the limited number of nurses both in the public health centre and in the private clinics means that the mothers have to take care of their babies, which includes trying to breast-feed the babies as soon as possible. They could initiate breast-feeding earlier than mothers who gave birth in birth places which did not implement the rooming-in policy, such as the maternity clinics in the urban area.

The initiation of breast-feeding in the research area was in line with data from UNICEF. UNICEF (2000) reported that in Indonesia 95 per cent of babies are initially breastfed after birth, although these data also show that only 14 per cent of babies in Indonesia were breastfed within the first 12 hours after birth. It would therefore seem that in Indonesia, including Semarang, breast-feeding initiation is delayed (past 30 minutes), whereas international recommendations suggest that breast-feeding should be initiated immediately after the birth. However, this research found that mothers, particularly in the peri-urban area, initiated breast-feeding earlier than the UNICEF data suggests (within the first 12 hours after birth). 1997 and 2002 IDHS data, however, show that the initiation of breast-feeding within one hour has decreased quite significantly (8 percent in 1997 to 3.7 per cent in 2002).

There were many factors influencing the delayed initiation of breast-feeding in Indonesia. In Indonesia, the health provider (the doctors, the midwives, and even the *dukun bayi*) gives the baby to the mother after both of them have been bathed. Immediately after they give birth, they hold the baby up for the mother to see and tell her the sex of the baby. It is only after both the mother and baby have been washed that

they might ask the mother to try to breast-feed the baby. This procedure can take some time.

The other factor is the rooming-in programme. The rooming-in policy is not implemented in most of the maternity services in Semarang, which delays the initiation of breast-feeding. This means that the timing of breast-feeding initiation does not accord with the ideal expressed by health providers. In Indonesia, including Semarang, some hospitals have been termed 'baby friendly' hospitals²⁹ (*Rumah Sakit Sayang Bayi*), which means they have a policy of putting the baby in the same room as the mother after giving birth and encouraging the mother to breastfeed her baby on demand. However, the paediatricians interviewed claimed that the hospitals do not really apply this policy. There were various reasons offered for this. It was felt that the mothers needed to rest after the birth and the baby should be kept separate to prevent infection from guests in the hospital. On the other hand, the Ratu public health centre and private midwife clinics in Lintang implemented the rooming-in programme. However, whilst this research was carried out, I found they implemented the rooming-in policy because there was a shortage of nurses in this health centre. Up to 60 per cent of the mothers complained about having to take care of their babies, since it prevented them from resting after the birth.

Health providers, such as doctors and midwives who assist at births, all stated that they really support the 'exclusive breast-feeding' programme and always encourage their patients to breastfeed until the baby is 4 months old. Hull, Thapa and Pratomo (1990) have explained that the role of health providers is crucial to the successful initiation and maintenance of breast-feeding in maternity clinics and hospitals. Doctors, midwives and nurses can all provide the necessary motivation, support and information

²⁹ The Baby-Friendly Hospital Initiative (BFHI), launched in 1991, is an effort by UNICEF and the World Health Organization (WHO) to ensure that all hospitals become centres of breast-feeding. A hospital is designated 'baby-friendly' when it has agreed not to accept free or low-cost breast milk substitutes or feeding bottles, and to implement 10 specific steps to support breast-feeding (WHO, 1998).

not only to assist during the early postpartum days, but to establish a firm foundation for continued breast-feeding and the solving of problems which may emerge once the breast-feeding woman has left the hospital to return home. However, many of the babies had been given bottled milk since birth, which suggests that there is a relationship between the midwives and the procedure of giving infant formula³⁰.

Regarding colostrum, my respondents stated that they did not know whether to give it to the babies or not. Even in the peri-urban area, the respondents stated that they delayed giving breast milk in order to avoid giving the baby colostrum. These statements clearly showed that they delayed initiating breast-feeding their new born babies because of the confusion concerning the benefits or otherwise of colostrum.

More specifically, the perceptions about colostrum in both areas varied to a certain degree. The respondents knew (about 30 per cent in the peri-urban area and the majority of mothers in the urban area - 80 per cent) that colostrum referred to the first milk coming out from the mother's breast, which is yellow and very good for the baby's immune system. However, some mothers (70 per cent), particularly in the peri-urban area, did not know about this, so they did not know whether to give it to the babies or not, and a small number of respondents delayed breast-feeding in order to avoid giving the baby colostrum. About 30 per cent mothers claimed that colostrum was bad but did not know why; they said that they avoided feeding colostrum because of advice from relatives or neighbours, but without full knowledge of the underlying reason. Despite some strong statements against colostrum by some mothers, there is no widely held taboo against it, nor are babies invariably denied this important early food. Hull (1984) found in Ngaglik that 60 per cent of all respondents avoided giving the baby colostrum, and most of the traditional midwives in Ngaglik advised against giving the baby colostrum. In another study in 1990, she found that in spite of a relationship between the

³⁰ For more details see chapter VIII (the Bottle-Feeding Phenomenon)

early initiations of breast-feeding and rooming-in programmes in the hospitals, only 48 per cent of the sample group reported giving colostrum and only 26 per cent of women whose babies were kept in the nursery (Hull, Thapa and Pratomo, 1990).

Furthermore, not all of the women could breastfeed successfully after the birth. Their condition was still weak, and their breasts were painful and swollen. As described above, several kinds of food are consumed to improve the production of breast milk. The most common are dark green vegetables such as *katu* leaves, spinach, and also fried peanuts and corn are seen as good in this respect. Some of them consumed traditional herbs, and some stated that they increased their intake of nutritious food.

During the breast-feeding period, mothers are usually advised to avoid certain kinds of food, such as spicy food, which will make the breast milk taste too hot for the babies. There is also a myth in Javanese society that breast-feeding women should not eat chilli because the seeds will come out in the breast milk suckled by the babies and choke them³¹. Mothers are also prohibited from drinking ice since it is held that it will make the baby suffer from influenza. Other foods that are prohibited for breast-feeding women include fish (fresh or salted) and eggs, as these two kinds of food are considered 'stinking' or rancid and not good for the baby. Only small numbers of respondents (estimated 20 per cent) stated that they did not consume such foods, but others disregarded the notion that fish and eggs should be avoided as they knew that both are nutritious.

Mothers in the peri-urban area consumed the same food as other members of the families due to financial constraints. It was not possible for them to consume nutritious food, which could be very expensive. One of the mothers stated that she did not think about the kinds of food she ate but if she had enough money, she would buy fish or eggs. Moreover, she said that she felt quite full after '*sayur lodeh*' - one kind of

³¹ For more details see chapter V (Religion, Ritual, and Their Influences on Pregnancy and Birth)

vegetable dish served with crackers - which was enough for herself and her family. Another mother confessed that she only consumed bland food since she worried that her nipples would itch otherwise. Yet the avoidance of certain foods may also result in poor nutrition for breast-feeding women and may even affect the production of breast milk.

It is very common that the food intake of mothers is less than other household members, because mothers may reduce their own food intake before that of other household members. As a result of the economic crisis, malnutrition amongst women of reproductive age has increased significantly amongst Indonesian women. In a household hit by the economic crisis, purchasing power is reduced and the household will purchase less food. The first consequence of this will be a reduced consumption of relatively luxurious foods, such as animal products and industrially-produced fortified foods, which will increase the prevalence and severity of micronutrient deficiencies. As mentioned in the previous chapter, Helen Keller International (HKI) found that before the start of the crisis, the mean body mass index (BMI)³² amongst women in Central Java was 21.5 kg/m², but a year after the onset of the crisis, that mean BMI had decreased significantly to 21.0 kg/m² (p<0.000) (Helen Keller International, 2000). In addition the quantity of food available will be reduced. For mothers, the most important immediate cause of loss in body weight is reduced food intake. Amongst mothers, as opposed to young children, disease is much less of an immediate cause of loss in bodyweight, because the prevalence of disease is relatively low and generally does not cause a substantial loss of weight. When there is less food available for the household, the mother is likely to first reduce her own food intake before that of her children and her husband. Therefore, she will be the first to lose weight when the household's access to food is reduced; but when the household's access to food increases again due to

³² The Body Mass Index (BMI) is calculated as an individual's weight divided by her/his height squared (kg/m²). A subject with a low BMI has a low bodyweight in relation to height, due to temporarily or chronically inadequate food intake. Maternal malnutrition expressed by BMI is a good and early indicator of the population's food insecurity, because very often, a woman reduces her own food intake before reducing that of her children and/or her husband (Helen Keller International, 1998).

increased purchasing power as a consequence of economic recovery and/or due to crisis relief programmes, her bodyweight will increase again (Helen Keller International, 1998; 2000).

As mentioned earlier, not all of the mothers could breastfeed the baby successfully after the birth. During this time most of the mothers stated they felt weak and that they were not yet producing breast milk. The purpose of the rooming-in policy is to train the mothers to breast-feed the baby on demand. However, during this difficult period the maternity clinics often gave the baby infant formula. To support the breast-feeding programme the nurses are supposed to feed infant formula with a spoon, not with a bottle, in order to train the baby to suck the mother's nipple. However, since the babies were often already full with infant formula from being fed in the baby room, they did not want to suck their mother's nipples, and usually when the nurse put the baby in the mother's room the baby was already asleep.

Honey, sugared water and infant formula are the kinds of food given to babies in the peri-urban area after birth. On the other hand, mothers in the urban area mentioned only water and infant formula as foods given to the babies. In the peri-urban area, soft rice, bananas and instant baby porridge are introduced to babies under 4 months old. Approximately 20 - 30 per cent of the women in the urban area claimed that they sought advice from paediatricians before feeding their babies such food as fruits. Other women said that even though they did not give the baby additional food, they introduced the baby to infant formula when he or she was under 4 - 6 months, citing the need to get their babies used to infant formula before they returned back to work. The other reasons given for the introduction of food and formula milk were that the baby always cried, was hungry and also that family members and neighbours had influenced their decision. Other research (Hull, 1982a; 1984) has pointed to the very early introduction of supplementary foods in the infant diet amongst the Javanese, although this custom is

fairly common worldwide (WHO, 1998). Usually in the first month, but often in the first week, the mothers gave the babies soft food, such as instant porridge or bananas. Mothers interviewed in Lintang argued that early supplementary feeding is very common and ensures the baby will not be fussy. The other reason given was that early feeding ensures that children become accustomed to regular food and develop healthy appetites. In some cases, where the mothers did not really understand why their babies were fussy, they gave milk, particularly breast milk (*ngempeng*). However, in many other cases the mothers, especially in the peri-urban area, preferred to give additional foods, such as soft rice and instant baby porridge.

My respondents stated that breast milk was the best food for their babies, because it was healthy, cheap, convenient and natural. However, just a small number of mother breastfed their babies exclusively. In the early phase of this research, I found in the peri-urban area that approximately 70 - 80 per cent of respondents in the focus group discussions gave their babies additional food when they were aged less than 4 months. Similarly, in the urban area my data shows that only a minority of women (32 per cent) stated that they exclusively breastfed their babies, whilst the majority (68 per cent) did not breastfeed exclusively. Based on these findings, I found that there is strong correlation between the low rate of exclusive breast-feeding and women working outside home in the urban area. Mothers who returned to work after maternity leave were forced to introduce formula and other supplementary food. Non-working mothers, however, could continue to breastfeed the baby on demand and they did not need to introduce either infant formula or supplementary food. In the peri-urban area, however, the majority of both working and non-working women had already introduced additional food to babies less than 4 months old. Nevertheless, even if women in the peri-urban areas did understand and wish to practice exclusive breast-feeding, as with

the women in the urban areas, working conditions would effectively prohibit many from doing so.

The choice of whether to breast-feed or not is often viewed as a 'lifestyle' and personal choice issue, since it is believed there is reasonable, and even excellent substitutes for it (Fisher, 1983). For the mother, however, the choice to breast-feed or not actually involves conflicting demands, reflecting some of the tensions and contradictions women face in contemporary society. On the other hand, the promotion of breast-feeding enlists scientific evidence regarding its superior health and psychosocial benefits, both to babies and mothers, further supported by considerations of economic prudence (Newman, 1995) and accompanied with an ongoing discourse on 'motherhood', 'nurture', 'naturalness' and 'modernity' (Guttman & Zimmerman, 2000:1458). On the other hand, breast-feeding becomes increasingly complex and difficult when women are employed, especially outside the home, since they are expected to do many important jobs at the same time.

Clearly, breast-feeding women who are working must manage complex schedules over extended periods of time and contend with the stresses associated with the job itself and their desire to maintain lactation (Yimyam, Morrow and Srisuphan, 1999). As is evidenced above, when breast-feeding mothers return to work they encounter problems that include fatigue and finding time to express their milk and many feel exasperated by worrying about breast milk supply. Moreover, there are many barriers for working mothers to breast-feed, such as the lack of places to express breast milk in the work place, which exemplifies a host of labour-related constraints on workers in general. These include inflexibility in working hours, limited worker control over work schedules, and fear of job insecurity (Katcher and Lanese, 1985; Barber-Madden et al., 1987). Unsurprisingly, for some working mothers, returning to work after the baby is born is one of the most common reasons for weaning, or for not

initiating breast-feeding at all (Van Esterik and Greiner, 1981; Aurebach, 1984; Morse et al., 1991; Chalmers et al., 1990; Buxton et al., 1991 cited in Guttman & Zimmermen, 2000:1458-1459).

As with many women in other developing countries, women in Indonesia are expected to perform often conflicting productive and reproductive roles, and this conflict has been intensified by rapid development and social change. As Momsen (2004:49) says “development has not always brought greater freedom for women and in many cases they are now expected to carry the double burden of both reproductive and productive roles”. The demands of the formal labour market in a modern urban setting mean that mothers ordinarily leave their children when they are working. These social and economic changes present difficulties for women in combining their roles as workers and mothers (Richter et al., 1992).

My research found that the working mothers in both areas experienced difficulties in breast-feeding their babies after their maternity leave was over. The Government of Indonesia determines maternity leave at three months for workers, including civil service employees. Some of the mothers stated that they took their leave 1.5 months before and 1.5 months after the birth. Other mothers took it one month before and 2 months after the birth so they would have more opportunity to take care of their babies. As mentioned earlier, most of the mothers (60 per cent), particularly in the peri-urban area, stated that the main reason to go back to work was economic, so they returned to work after the birth to supplement the family income. The main problem for breast-feeding mothers in Indonesia is that there are few or even no places where women can express breast milk in the work place. The working day is usually at least 8 hours long, making it impossible for them to breastfeed their babies. This situation is worsened by the fact that the companies or offices do not allow their female employees to breastfeed in the work place and they have no nursery or child care facilities. The

mothers in the peri-urban area, most of whom are working in factories, have more problems than working mothers in the urban area, since most of the factories have 3 shifts that mean sometimes they have to leave their babies in the middle of the night.

There were many reactions in both areas to these problems. About 20 per cent of mothers in the peri-urban area who worked in factories quite close to their homes stated that they went back home during their lunch break in order to breastfeed their babies. Working mothers in the urban area who were working as civil service employees stated that they arranged their schedule to try to breastfeed their baby as much as they could. However, they stated that they gave the baby infant formula after the maternity leave was over, or even before the leave was over, and some of them stated they had already introduced the baby to infant formula at least two weeks before they returned to work. Such conditions clearly have a profound influence on the implementation of exclusive breast-feeding.

7.5. Summary

This chapter provides a description of breast-feeding programmes in Indonesia and the breast-feeding practices of women in Semarang. Breast-feeding has long been recognized as superior to artificial feeding for a variety of reasons. Many scholars have found that breast-feeding brings significant benefits to babies, mothers and, consequently, societies.

In Indonesia, a campaign of exclusive breast-feeding was introduced more than 20 years ago. However, the median rate of exclusive breast-feeding in Indonesia is short at only 1.3 months, and shorter than in other Asian countries. Although the Indonesian Demographic and Health Survey shows that the rate of babies breastfed exclusively until 4 months old has increased (52 per cent in 1997 to 55.1 per cent in 2002), it has not increased significantly. However, the Indonesian Demographic and Health Survey

data show that bottle-feeding has increased sharply; from 10.8 per cent in 1997 to 32.45 per cent in 2002.

This research found that mothers in both areas stated that they preferred to use the services of midwives for ante-natal treatment. However, the respondents in the peri-urban area complained about poor services in the public health service. Location, costs, and also the quality of the services provided were factors influencing the choice of places to give birth for the mothers in the peri-urban area. In contrast, the mothers in the urban area with a higher socio-economic status preferred giving birth in private clinics or hospitals because they felt such places were safer and more comfortable. With regard to post-natal treatment, peri-urban and urban women had different attitudes. Women in the peri-urban area still preferred the services of the *dukun bayi* even though they had access to trained midwives. There are no *dukun bayis* in the urban areas and a higher socio-economic status seemed to influence the women in the urban area away from more traditional practices. Mothers in the urban area stated that they received post-natal treatment from either a visiting midwife or obstetrician.

With regard to the initiation of breast-feeding, for peri-urban women, quantitative data showed that 67 mothers or 43 per cent started to breastfeed their babies less than 3 hours after the birth. The poor services in maternity clinics in the peri-urban area meant that they had to take care their baby and the fact that 28 of these mothers gave birth in the home influenced mothers to breastfeed the baby as soon as possible since they had to take sole responsibility for their babies the babies from the outset. Mothers in the urban area stated that they initiated breast-feeding more than 5 hours after the birth, longer than mothers in the peri-urban area. The poor implementation of the rooming-in policy had influenced the initiation of breast-feeding in the urban area. Although this research found that the initiation of breast-feeding in this area had been delayed by 30 minutes longer than international recommendations, mothers, particularly

in the peri-urban area, initiated breast-feeding earlier than UNICEF found (within the first 12 hours after birth).

The majority of mothers in both areas (up to 80 per cent) stated that breast milk was the best food for their babies, since breast-feeding is healthy, cheap, practical and natural, though knowledge about breast-feeding and in particular perceptions of colostrum in both areas varied widely. Building on Hull's distinctions about forms of breast-feeding practices amongst Javanese women, which include *meneteki* (suck the nipple) and *menyusui* (suckle milk), based on my qualitative research, I argue that mothers in the peri-urban area practice the *meneteki* form rather than the *menyusui* form. Although they breastfeed the babies on demand, the mothers in the peri-urban area seemed lacked knowledge about the nutrients contained in breast milk, the duration and frequency of breastfeeding and the relationship between the production of breast milk and food intake . On the other hand, the mothers in the urban area were more aware that their baby might be fussy because the baby was not satisfied with breast milk. Mothers in this area, particularly working mothers preferred to give their baby infant formula even though they still kept giving them breast milk

Honey, sugared water and infant formula were the kinds of food given to babies in the peri-urban area after birth. On the other hand, mothers in the urban area mentioned only water and infant formula as foods given to the babies. Soft rice, bananas and instant baby porridge were introduced to babies under 4 months old in the peri-urban area. These findings showed that babies in both areas did not breastfeed exclusively, which is not in accordance with international recommendations which advise exclusive breast-feeding, meaning the baby receives no other food or liquid including water until the baby is 4 - 6 months old. The early termination of exclusive breast-feeding appears to be influenced in particular by the short duration of maternity leave and by the fact that work places in Indonesia do not provide nursery facilities for

place are all factors which adversely affect breast-feeding amongst working women and often lead to the introduction of bottle-feeding, which is the subject of the next chapter.

As such, the next chapter focuses on bottle-feeding practices. In particular, I will examine the development and the economic cost of infant formula. I also provide a discussion of Indonesian policy towards infant formula and show how and in what ways the mothers in Semarang respond to the promotion of infant formula both within the health services and in the media.

CHAPTER VIII

THE BOTTLE-FEEDING PHENOMENON

“Breast milk is one of the few foodstuffs which is produced and delivered to the consumer without any pollution, unnecessary packaging or waste. It is the only food which passes on immunization and other health benefits to the consumer and its production also benefits the health of the producer. It is a valuable renewable resource which is usually overlooked” (Andrew Radford, *The Ecological Impact of Bottle Feeding*, 1991 cited in Baumslag and Michels, 1995:140)

8.1. Introduction

It has been shown that although women understand the value of breast milk, many women choose not to breast-feed their babies or may try to combine breast-feeding with bottle-feeding. Women may refrain from breast-feeding for a number of reasons: aggressive formula product marketing; lack of support from family and friends; insufficient knowledge amongst medical professionals about breast-feeding techniques and challenges; practices within maternity hospital; religious beliefs; cultural attitudes; and lack of public acceptance (Weimer, 2001:1¹). Previous studies have identified different reasons for this, such as the fact that many women work outside the home, insufficient breast milk, problems with baby and maternal health, lack of social support, and the availability of artificial milk (Rice and Naksook, 2000:11).

Recent evidence suggests that the duration of breast-feeding is declining in many parts of the developing world (Iskandar, Costello and Nasution, 1992:90). Research shows that the decrease in breast-feeding practices in developing countries stems from a variety of reasons, as mentioned above. One such issue is that of mothers having insufficient milk, or what is sometimes referred to as insufficient syndrome. In some cases, this syndrome prompts mothers to discontinue breast-feeding altogether and

¹ http://www.breastfeedingtaskforla.org/econ_review_bf2002.pdf

to switch to infant formula. The other problem is that some mothers introduce non-breast milk foods and liquids before the baby is 4-6 months old (Moffat, 2002:166-167). According to Winikoff and Laukaran (1988), decreasing breast-feeding practices in developing countries can have severe consequences for the health of babies because of the risk of contamination in preparing infant formula with unhygienic drinking water, and the loss of the immunological properties of breast milk.

Although most Indonesian women initiate breast-feeding, the rate of breast-feeding, particularly exclusive breast-feeding, is decreasing and the consumption of infant formula has increased sharply. This chapter outlines the background to the bottle-feeding phenomenon in Indonesia, and provides a description of government regulations and bottle-feeding practices amongst women in Semarang.

8.2. The Development of Infant Formula

Anthropological literature is full of descriptions of how peasant societies cope with the infant for whom mother's milk is not available because of illness or death. At that time, the commonest way is for such an infant to be fed by a close relative within the extended family system or the clan. Usually it is a woman who is breast-feeding an infant on her own, but there are now several recorded instances of the maternal grandmother putting the baby to the breast and being able to produce milk (Ebrahim, 1978:61). Margaret Mead (cited in Ebrahim, 1978:61) found that in some villages in Java, the baby was breastfed by the deceased woman's sister, even though in several cases these sisters had not born a child before and were virgins. According to Fildes² (1986), four conditions make artificial feeding essential for children at any level of society: (1) lack of breast-feeding; (2) congenital defect or birth injury; (3) prematurity; (4) congenital or acquired infantile syphilis. The use of cow's milk for feeding the older

² For more details see Fildes, Valerie (1986) "Breasts, Bottles and Babies: a history of infant-feeding".

child has been an established practice since ancient times (Ebrahim, 1978:65). Although non-human milk has long been used as a beverage for children, its use for babies is relatively new.

8.2.1. The Commercialization of Infant Milk

As knowledge about the composition of breast milk increased, cow's milk was modified or 'humanized', and treated in a variety of ways to reduce its tough curds and make it more digestible. The method most commonly used was to dilute it with water and add sugar or barley water (Baumslag and Michels, 1995:120).

The problem with the use of fresh cow's milk for infant feeding was its adulteration and an appalling lack of cleanliness during the early days of its use. Moreover, another problem with cow's milk was its indigestibility. Early studies and observations had shown that cow's milk forms larger, tougher curds than human milk. A considerable amount of attention was paid to improving the digestibility of the protein of cow's milk. The easiest approach was to reduce the protein content by diluting it with water, or barley water, and adding sugar. Many paediatricians believed that minute variations in a single food element could make a great deal of difference to the digestibility and food value of the milk, so that milk was prescribed with the precision of a drug. Acidification was another method used to improve the digestibility of milk. Lactic, citric or tartaric acids were used for this purpose. In some cases milk was diluted with acidified whey. Tartared whey, citric acid whey and white wine whey were recommended by Still and quoted by Cautley in his *Diseases of Children* 1910. Cautley also recommended peptonised or pre-digested milk (Ebrahim, 1978:65-66).

The first proprietary formula was developed by a German chemist, Liebig, in 1867. The formula was called the 'perfect food' for babies. It was made from cow's milk, flour, potassium bicarbonate, and malt. Although this product was patented and

commercialized and delivered in liquid form, it did not sell very well. From then on, introducing the public to different milks soon became a major business in some parts of the world. Condensed milk was first developed and patented by Newton in 1835. It was made by boiling milk and then evaporating it to one-fourth of its original volume, with significant amounts of sugar added as a preservative. Borden was one of the main producers of condensed milk. Anglo-Swiss, which later became Nestlé, was also an important supplier of condensed milk. By 1911 around one hundred varieties of machine-skimmed and forty brands of full cream condensed and evaporated milks (evaporated milk was developed in 1885) meant that for the first time in history a baby could be fed cow's milk without the family having access to a cow (Baumslag and Michels, 1995:121).

In Paris, Pierre Budin, a well known obstetrician, launched milk stations, where babies were weighed weekly and their progress charted (Baumslag and Michels, 1995:121). If the babies did not gain weight satisfactorily, bottled, sterilized milk was prescribed. The milk could be obtained from the milk stations or 'Gouttes de Lait' as they were called. These milk stations later evolved into child care clinics (ibid). The main project of the clinics was to encourage the mothers to breastfeed, and, when breast-feeding was not possible, to provide safe and effective substitution. Moreover, special bottled formula and teats were supplied to mothers with infants. Different formulas were prepared and prescribed for three age groups of infants. Mothers were instructed in the proper feeding and care of children. It was said that the milk stations saved the lives of many babies.

In England, these milk stations, which were known as 'child welfare clinics', provided powdered milk marketed under the name of Glaxo, which was imported from New Zealand. This was sold at the child welfare clinics for half the store price. The Truby King Program, which was operating in New Zealand, was also implemented in

England in 1925. Through this programme, nurses were trained to visit mothers with newborns in their homes and talk to them about the child's well-being. If the child was not gaining weight and it was thought that the mother had insufficient milk, milk samples were collected and tested for fat content. It should be noted that Truby King, whose ideas came largely from veterinary science, helped to successfully re-establish breast-feeding (Baumslag & Michels, 1995:121-123)

If infant formula companies in the 1890s worked hard to develop formulations that could be used to save the lives of foundlings and sick babies, by the turn of the century, the goal of the infant formula companies was no longer to produce a product solely for sick babies or for times when the mother's milk was not available; the aim became to make a product that could replace mother's milk. Skilful marketing and promotion efforts, combined with medical complicity, succeeded in giving artificial feeding an aura of medical legitimacy. People believed that these products could be as good as or better than the real thing. By the end of World War II, bottle-feeding had become the standard method of infant feeding in the United States and Europe. Since the developed world was leading the way, the formula industry expanded their markets by trying to make bottle-feeding the norm in the developing world as well (Baumslag and Michels, 1995).

In the early twentieth century, the infant food industry expanded, even though doctors continued to highlight the risks of artificial feeding (Palmer, 1988; Baumslag and Michels, 1995). The situation remains the same today in spite of all the advances made in modern medicine. Bottle-feeding does not merely put the child at risk from a contaminated bottle, but also deprives him/her of the immunological properties in breast milk. Some studies have found that bottle-fed babies are four times more likely to die from a respiratory infection and fourteen times more likely to die from diarrhoea than those exclusively breastfed (UNICEF, 2000; Dorosko and Rollins, 2003; Moffat, 2002).

Such illnesses are more likely to be fatal if the baby is born into a poor family which is badly housed, has little formal education, and who are unable to get medical help quickly³. The fundamental fact is that poverty is a major contributor to suffering and death, which makes breast-feeding such a vital issue, for even the poorest child has a better chance of survival if his/her mother does not fall victim to the political, economic, and cultural forces which deprive her of the ability or desire to feed her own child (Palmer, 1988:180).

Two-thirds of the world's population lives in developing countries. On average, up to 80 per cent or more of the population in a developing country is rural, living in small villages or hamlets, whilst the other 20 per cent lives in larger towns and cities. Between a quarter and a third of the population in a developing country is literate (Ebrahim, 1978). Illiteracy, ignorance, traditional beliefs and customs prevail in all developing societies. Poverty is often prevalent and the resources available to the average family for nutrition, housing and improvement of environment are acutely limited. Environmental sanitation in many areas is virtually non-existent, so that there is high endemicity of water-borne diseases in many rural communities. Unhygienic conditions, poor nutrition, a lack of clean water, inadequate health facilities, lack of knowledge and sometimes traditional attitudes can act together to perpetuate a vicious circle of disease and death, and the feeding and rearing of infants in developing countries should be viewed against this social and environmental background (Ibid).

The impact of inappropriate infant feeding is immeasurably greater in developing countries. A formula fed baby in a developing country experiences higher rates of disease not only because the baby does not receive the protective benefits of breast milk, but also because of exposure to pathogens in contaminated infant formula and bottles (Dorosko and Rollins, 2003:119). Lack of safe water for mixing the formula

³ <http://www.unicef.org/sowc98/under5.htm>

and the contamination of feeding bottles are the main reasons why formula-fed babies die; another is that families in poorer countries often cannot afford adequate supplies of infant formula, so they may dilute it too much. Moreover, compared to babies who are exclusively breastfed, those who are fed formula have 10 times the risk of incurring bacterial infections requiring hospitalization, 4 times of the risk of meningitis and 3 to 4 times the risk of developing middle ear infections and gastroenteritis (Dorosko and Rollins, 2003; Moffat, 2002). The ‘baby milk scandal’⁴ in the 1970s brought to light the fact that artificial feeding for babies in developing countries where mothers had no access to clean water had resulted in the death of great numbers of babies in those countries (Maher, 1992a:3)⁵. To solve the problem, WHO/UNICEF developed ‘the International Code of Marketing Breast-milk Substitutes’ in May 1981⁶. The code is a simple document that recommends that member governments restrict the advertising and sales promotion of breast milk substitutes. Each nation is free to adopt the code within the national and legal frameworks of its own society. It was adopted as a

⁴ The baby milk scandal brought to light the bad impacts of bottle-feeding in developing countries. It started with an interview in 1973 with David Morley and Ralph Hendrikse, two paediatricians who had worked in Africa; then in 1974, the British charity, War on Want, published *The Baby Killer*. Journalist Mike Muller wrote a dramatic account of the tactics used by formula companies to capture the market. In 1975, *Bottle Babies*, a documentary by Peter Krieg, was released. This film was documented in Kenya, with powerful visual images of starving, malnourished, bottle-fed babies. In one scene, a mother was shown scooping water from a filthy pool and mixing it with baby formula. In another scene, a graveyard littered with bottles and formula cans were also shown; there, as in other parts of the world, it is customary to bury the most valued possession with the infant. The film created a groundswell of activity to curb the inappropriate promotion of infant foods and proved to be an effective tool for making many people aware of the problems created by bottle-feeding (Palmer, 1988:203-205; Baumslag and Michels, 1995:154).

⁵ For more details see Maher (1992a) ‘The Anthropology of Breast-feeding: Natural Law or Social Construct.

⁶ The aim of the International Code of Marketing Breast-milk Substitutes is: ... ‘to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breast-feeding and by the proper use of breast milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution’.

The Code includes ten main provisions: (1) no advertising of breast milk substitutes; (2) no free samples of breast milk samples to mothers; (3) no promotion of products through health care facilities; (4) no company mothercraft nurses to advise mothers; (5) no gifts or personal samples to health workers; (6) no words or pictures idealizing artificial feeding, including pictures of infants, on the labels of products; (7) information to health workers should be scientific and factual; (8) all information on artificial feeding, including the labels, should explain the benefits of breast-feeding and the costs and hazards associated with artificial feeding; (9) unsuitable products, such as sweetened condensed milk, should not be promoted for babies; (10) all products should be of high quality, and take into account the climatic and storage conditions of the country where they are used. (WHO/UNICEF, the WHO/UNICEF International Code of Marketing of Breast milk Substitutes, adopted in Geneva, Switzerland, May, 1981 cited in Baumslag and Michels, 1995:164).

‘minimum requirement ‘... to protect infant health (Palmer, 1995; Baumslang and Michels, 1995:163-167; WHO: 1998). Moreover, WHO and UNICEF launched the ‘The Baby Friendly Hospital Initiative’ (BFHI)⁷ in 1991 (WHO, 1998). The BFHI was developed to promote the implementation of the second operational target of the Innocenti Declaration⁸:

Ensure that every facility providing maternity services fully practices all ten of the **Ten Steps to Successful Breast-feeding**⁹ set out in the joint WHO/UNICEF statement ‘Protecting, promoting and supporting breast-feeding: the special role of maternity services’,

.... and aspects relevant to health facilities of the third operational target:

Take action to give affect to the principles and aim of all Articles of the International Code of Marketing of Breast milk Substitutes and subsequent relevant World Health Assembly (WHA) resolutions in their entirety.

⁷ In 1991 UNICEF and WHO launched a worldwide ‘Baby Friendly Hospital Initiative’ (BFHI) in a global effort to encourage and recognize hospitals that had implemented optimal lactation management. By implementing ‘Baby Friendly’ policies, hospitals could give breast-feeding mothers the information, confidence, and skills needed to initiate and continue breast-feeding. The BFHI was designed to remove hospital barriers to breast-feeding and to create an environment in which mothers could breastfeed in an informed and supported setting. The basis of the BFHI was “Ten Steps to Successful Breast-feeding”, a set of guidelines for hospitals that ensured all mothers have accurate information on the benefits, and techniques, of breast-feeding. For a hospital to participate in the ‘Baby Friendly Hospital Initiative’ it must first sign a Certificate of Intent. The staff then receives training and relevant educational materials. After the training, if the hospital implements the ‘Ten Steps to Successful Breast-feeding’ it is accredited as a ‘Baby Friendly Hospital’ (Baumslag and Michels, 1995; WHO, 1998).

⁸ The Innocenti Declaration was produced and adopted by participants at the WHO/UNICEF policymakers’ meeting on “Breastfeeding in the 1990s: A Global Initiative”, co-sponsored by the United States Agency for International Development (USAID) and the Swedish International Development Authority (SIDA), held at the Spedale degli Innocenti, Florence, Italy, on 30 July – 1 August 1990. The Declaration reflects the content of the original background document for the meeting and the views expressed in group and plenary sessions. The Declaration recognises that breast-feeding is an unique process, and (1) provides ideal nutrition for infants and contributes to their healthy growth and development; (2) reduces incidence and severity of infectious diseases, thereby lowering infant morbidity and mortality; (3) contributes to women’s health by reducing the risk of breast and ovarian cancer, and by increasing the spacing between pregnancies; (4) provides social and economic benefits to the family and the nation; (5) provides most women with a sense of satisfaction when successfully carried out. (http://www.infactcanda.ca/innocenti_declaration.htm).

⁹ The Ten Steps to Successful Breast-feeding in any facility providing maternity services and care for newborn babies should: (1) have a written breast-feeding policy that is routinely communicated to all health care staff; (2) train all health care staff in the skills necessary to implement this policy; (3) inform all pregnant women about the benefits and management of breast-feeding; (4) help mothers initiate breast-feeding within a half-hour of birth; (5) show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their babies; (6) give newborn infants no food or drink other than breast milk, unless medically indicated; (7) practice rooming-in – allow mothers and babies to remain together – 24 hours a day; (8) encourage breast-feeding on demand; (9) give no artificial teats or pacifier (also called dummies or soothers) to breast-feeding babies; (10) foster the establishment of breast-feeding support groups and refer mothers to them on discharge from the hospital or clinic (WHO, 1998).

The Innocenti Declaration was adopted by the Forty-Fifth World Health Assembly in March 1992 in Resolution WHA 45.43 (WHO, 1998).

More than a decade has passed since the Code was ratified; and within 3 years of the Code's adoption, 130 countries had taken some form of action on it. Some countries have brought in the Code as a voluntary measure, and only nine countries have introduced the Code as national law. Various excuses for this have been given, such as incompatibility with national constitutions, low priority, or interference by the baby milk industry.

Over the last decade, the steady downward turn in breast-feeding rates has begun to reverse. Public health officials, health organizations, and medical professionals have worked together to counter the bottle-feeding trend. Some areas of improvement can be seen, particularly in labelling and advertising; however, compliance by industry has been pitiful and violations are widespread. Monitoring is difficult. IBFAN¹⁰ accumulates reports of violations and produces *Breaking the Rules*, a worldwide report on violations of the Code, indexed both by company and country. IBFAN also found that the baby milk industry has spent a great deal of effort devising ways to appear to be in compliance with the Code while making maximum use of grey areas. One such area involves getting around restrictions on free samples. Free samples are distributed to every mother in some developing countries, resulting in nearly 90 percent of babies receiving mixed feeding before hospital discharge (Baumslag and Michels, 1995).

Another such area of violation of the Code involves 'follow-up' milks, that is, infant formula marketed for infant six months and older. These were practically nonexistent when the Code was drafted. Now, nearly every company has launched at least one of these types in an attempt to widen the market and evade Code restrictions.

¹⁰ IBFAN or the International Baby Food Action Network is a network of consumer groups from every continent which have banded together to monitor industry's compliance with 'the recommendations' (Baumslag and Michels, 1995:161-162)

The label designs and names of the follow-up milks are often the same as the producer's standard infant formula, simply with the addition of 'II' or 'plus'. The fact, that they are infant foods, given in bottles, with all the dangers of bottle-feeding, takes advantage of the fact that the Code does not specifically restrict advertising of "follow-up" milk (Baumslag and Michels, 1995).

According to IBFAN, Nestlé violated twenty-two sections of the Code in fifty-six countries in just 1990 and 1991. AHP, another formula milk company, violated twenty sections of the Code in thirty-five countries during the same two years. Although some improvements have been made, the companies are still violating almost every section of the Code. Free supplies of artificial baby milk are still widespread, and this is a serious problem. Information materials produced by the formula companies continue to be promotional, and all the companies continue to give a wide range of gifts to health workers, which both explicitly and implicitly encourage the promotion of such products. Improvements have been made in labelling, but some companies, such as Gerber, Snow and Wyeth, still violate the Code by having pictures of babies on some of their labels. Moreover, not a single infant formula company today can demonstrate full compliance with the Code (Baumslag and Michels, 1995).

In this section, I have explored the development of infant formula. There are many reasons that make artificial feeding essential for children. Since the 19th century, experts have developed breast milk substitutes, using cow's milk to produce infant formula. However, by the turn of 20th century, the goal of infant formula companies was no longer to make a product for sick babies but to make a product that could replace mother's milk. To solve the problem associated with this trend, WHO and UNICEF developed the International Code of Marketing Breast milk Substitutes in the 1970s. In the following section, I will examine the economic cost of infant formula.

8.3. The Economic Costs of Infant Formula

According to Weimer (2001)¹¹, in addition to individual health benefits, breast-feeding may provide significant economic benefits in terms of defraying or reducing both direct and indirect costs. The direct costs that might be reduced or averted would relate, of course, to physician, clinic, hospital, laboratory, and procedural fees. Another direct economic benefit to a family is that they will not have to buy infant formula for up to the first year after birth. Ideally, attributing indirect costs to time and wages lost by parents attending a sick child should be considered when estimating the possible economic benefits of breast-feeding. In many places, many mothers return to work before a child is 1 year old (Weimer 2001:3). When these mothers miss work, it often is because their babies are ill. As breastfed babies have been shown to be less likely to catch common infectious illnesses than formula-fed babies, it is possible that mothers who breastfeed may miss fewer days from work to care for a sick child than mothers who feed formula.

An analysis of the costs incurred by the expense of infant formula and the extra costs in health care that result from infant formula-related illnesses around the world indicates that universal breast-feeding could produce estimated savings of over \$333 billion annually¹². In the first year of life, a baby consumes the contents of approximately seventy cans, at a cost of about \$700. A tin of powdered formula concentrate in the United States sells for about \$10.00. Liquid concentrates cost more, and ready-to-feed formula costs even more. There is also the added cost of bottles, rubber nipples, transportation to buy the formula, and fuel to boil water and clean the bottles. For people who live where tap water is not available, the cost of bottled water or ready-to-feed formula must also be included. Based on these calculations, it has been

¹¹ http://www.breastfeedingtaskforla.org/econ_review_bf2002.pdf

¹² <http://www.unicef.org/sowc98/under5.htm>

estimated that at least \$429 million could be saved annually in the US if mothers in the Women, Infants, and Children's supplementary feeding programme (WIC)¹³ would breastfeed for just one month (Baumslag and Michels, 1995:140).

Levine & Huffman (1990)¹⁴ developed and analysed the economic value of breast-feeding and formula-feeding from 4 perspectives: national, public sector, hospital and household. They found that at the national level, the costs of breast-feeding include the potential loss of women's productivity and economic contributions, and the potential loss of revenues from the sale of locally produced breast milk substitutes. The costs of bottle-feeding include the aggregate expenditures on breast milk substitutes and supplies, and the baby and child lives lost because of increased morbidity. Based on this study, estimates for the costs of replacing breast milk ranged from \$1.8 million in Singapore to \$16 million in the Philippines and an estimated \$500 million annually for Indonesia. At the public sector level, the costs of breast-feeding include the costs of breast-feeding promotion and the potential loss of tax revenues from local breast milk substitute manufactures. The costs of bottle-feeding include public expenditures for breast milk substitutes and supplies, public health care costs, family planning costs, and interest on debt incurred by importation of substitutes. Breast-feeding promotion campaigns have been associated with costs of \$1 - \$11 per mother. In Indonesia, \$40 million per year would be required for diarrhoea treatment if breast-feeding prevalence declined by 25 per cent. Moreover, in Indonesia, it is estimated that an additional \$80

¹³ In 1974, the US Federal Government established the Special Supplemental Food Programme for Women, Infants and Children (called the WIC programme) in an attempt to lower the strikingly high US rates of infant mortality and morbidity. WIC serves poor women and children who are at the greatest nutritional risk. Participants in WIC receive food vouchers for eggs, cheese, cereal, juice, milk and infant formula. WIC is made available to selected pregnant, postpartum, and breast-feeding women, as well as to children up to five. When WIC began in 1974, it served 88,000 participants, of whom 26,000 were infants. The WIC food costs were \$8.2 million in 1974 and \$2,335 million in 1994 (Baumslag and Michels, 1995:178). WIC is the largest purchaser of infant formula, buying approximately 40 percent of all formula sold in the United States. The cost of infant formula distributed to WIC mothers in 1997 was \$567 million after formula company rebates of about \$1.2 billion to WIC.

¹⁴ <http://www.paho.org/english/HPP/HPN/BOBN.pdf>

million per year would have to be spent on family planning if breast-feeding were to cease (Levine & Huffman, 1990).

At the hospital level, the costs of breast-feeding include staff training, education, and support of new mothers, and modifications to permit rooming-in. The costs of bottle-feeding include staff time for preparation and feeding; expenditures on breast milk substitutes, bottles, and other equipment; pharmaceutical supplies; and increased health care costs. At this level, direct savings realized from such changes offset the costs associated with changes in hospital practices to promote breast-feeding. For example, the following costs were summarized: lobbying/conferences (\$51 - \$600 per participant); staff training (\$10 - \$860 per participant); lactation counselling \$35 - \$4.00 per participant. On the contrary, for example, a hospital with rooming-in programme, the savings were summarized as follows: reduced staff time because of rooming-in (\$4.20 per delivery in the Philippines, and a 34 percent reduction in personal costs in Chile); less infant formula (\$0.50 - \$0.82/delivery); fewer bottles (0.32 - \$0.60); and less oxytocin (\$0.10 - 0.32/delivery). Finally, at the household level, the costs of breast-feeding include maternal time, lost employment opportunities, and increased maternal food consumption to support breastfeeding. The costs of bottle-feeding include expenditures on formula and other supplies, caretaker's time for bottle preparation and feeding, expenditures on health care for ill children, caretaker's time for care of ill child, loss of the child's potential productivity and economic contribution to the household, and expenditures associated with higher fertility or increased use of contraceptives (Levine & Huffman, 1990).

In accordance with the statistics outlined above, similar studies carried out by UNICEF¹⁵ also show that infant formula is more costly than breast milk, and that these costs should be considered at the national economic level. In other words, the price of

¹⁵ <http://www.unicef.org/sowc98/under5htm>

bottle-feeding is an issue for finance ministers as well. When developing countries import breast milk substitutes, they are exporting scarce foreign exchange that is desperately needed for other priorities (Baumslag and Michels, 1995). For instance, according to UNICEF (ibid) if the 51 percent of Indian mothers who exclusively breastfeed were to stop, replacing all their breast milk with formula would cost about \$2.3 billion. In Indonesia, a study in the 1980s calculated that mothers produced over 1 billion litres of breast milk annually; equivalent supplies of commercial milk would cost \$400 million. The savings in health costs and reduced fertility rates related to breast-feeding were estimated to be another \$120 million (ibid). In Haiti, where just 3 percent of babies are exclusively breastfed, infant formula costs \$10 a week, or more than twice a typical income. Ideally, a mother needs an additional 500 calories a day above her normal diet to enable her to breastfeed properly, which is far cheaper than spending money on formula. In India, for example, five days worth of that extra food costs less than 15 rupees (45 cents). By comparison, a five day supply of formula costs about 130 rupees (\$3.70). In the Philippines, the Jose Fabella Hospital saved more than \$100,000, an astounding 8 percent of its annual budget, within one year of becoming a baby friendly hospital that promoted and supported exclusive breast-feeding (ibid).

In this section I have examined the benefits of breast-feeding and how breast-feeding provides significant economic benefits in terms of defraying or reducing direct and indirect costs. As many other countries, Indonesia also to acknowledged the importance of breast-feeding and have developed policies on infant formula. In the next section I will examine how the government of Indonesia implemented its policies on infant formula.

8.4. Indonesian Policies on Infant Formula

In keeping with the international recommendations of WHO and UNICEF, the Ministry of Health recommends breast-feeding until 2 years of age and beyond (UNICEF, 2000). However, as Hull, Thapa & Wiknjosastro (1989) have already pointed out, the general trend in developing countries is a move away from breast-feeding, and Indonesia is no exception. Moreover, they have also highlighted the fact that, once underway, this trend is difficult to stop or to reverse. Many national and international agencies have been trying to identify ways to promote and maintain the practice of breast-feeding, especially in the modern health sectors, such as hospitals, maternity clinics, and also amongst health providers, such as doctors, nurses and midwives, in developing countries. The modern health sectors need special attention because it is often found that they have an independent effect on the decline of breast-feeding (Rodrigues & Thome, 1984; Majaro & Nines, 1987 cited in Hull, Thapa & Wiknjosastro, 1989:355). At the same time, this sector is also recognized as a potential resource for support for breast-feeding as the method of choice for infant feeding.

About 11 per cent of Indonesian mothers have terminated breast-feeding by the twelfth month of the baby's life. Studies also indicate that about 75 per cent of babies are given small tastes of food in the first hours and days after birth before the mother feels that her breast milk has begun to flow. One study found that 22 per cent of babies received formula, 1 per cent were fed bananas, and 22 per cent honey in some form (UNICEF, 2000). The 1997 multi-site complementary feeding study found that the percentage of infants who had been given formula ranged from 9 per cent in Belu to 41 per cent in Barru, South Sulawesi. Formula feeding in these children was counter productive: babies who were fed formula had a weight-for-age z-score lower than 0.32 between 6-11 months of age, equivalent to weighing about 300g less than babies who had not been fed formula (Sharma et al, 1999; UNICEF 2000).

The latest data from the 2002 Indonesian Demographic and Health Survey (IDHS) show that 32.45 per cent of babies aged less than 12 months are bottle-fed. These data show a marked increase from the 1997 Indonesian Demographic and Health Survey, when there were only 10.8 per cent of bottle-fed babies less than 12 months of age (Untoro, 2004). There are many factors contributing to the decline in breast-feeding in Indonesia, such as lack of support from health providers, lack of knowledge amongst mothers, families and the community about the benefits of breast-feeding, weak law enforcement, and the promotion of breast milk substitutes as more modern and effective than breast milk (Untoro, 2004; Brooks, 2004). Another infant feeding study carried out in Bogor, West Java in 2002 found that half of the mothers who took part in the study stated that they used infant formula, and 62 per cent of them started formula during the first month (Brooks, 2004).

As with many other countries, Indonesia has adopted the International Code of Marketing of Breast-milk Substitutes (World Health Assembly - WHA 1981), and subsequent WHA resolutions on the code (YLKI, 1999). Also, the Government of Indonesia has been committed to supporting breast-feeding in Indonesia for quite some time. In 1985, the Ministry of Health launched an initiative (the Ministry of Health Regulation No. 240/MoH/1985) about breast milk substitutes, which was expanded in 1997 to include the Ministry of Health Regulation No. 237/MoH/1997 concerning the marketing of breast milk substitutes. These regulations are based on the International Code of Marketing of Breast-milk substitutes.

These Ministry of Health bills control the distribution and supervision of infant formula, including registration, distribution and carrying out laboratory tests on samples of each product. This supervision is carried out in hospitals, public health service centres, maternity clinics, etc; and amongst health care providers, such as doctors, midwives, health workers; as well as in market places and within the mass media. The

1997 Ministry of Health legislation (MoH Regulation no.237) also states that the labels of infant formula products cannot show the picture of a baby, or print any statement that suggests that the use of infant formula is ideal for mother and baby, or that infant formula is equal to, similar to, or the same as breast milk.

Moreover, the Government of Indonesia have implemented the Baby Friendly Hospitals Initiative (BFHI) – *Rumah Sakit Sayang Bayi*. To support this programme, the government also launched ‘a rooming-in programme’. Rooming-in means that the baby is placed in the same room as the mother in the maternity clinic or hospital. According to Hull, Thapa & Pratomo (1990) if a mother gives birth in a hospital where ‘rooming-in’ is instituted and where appropriate counselling and support are provided, the mother is likely to choose to breastfeed and continue to breastfeed for considerably longer after discharge from the hospital than a mother in a different kind of health care establishment. Hull, Thapa & Wiknjosastro (1989:361) carried out research in 15 hospitals in 8 major cities in Indonesia and found that most of the maternity clinics applied ‘rooming-in programmes’, which involved placing the baby with its mother right after giving birth to allow the immediate initiation of breast-feeding, followed by the 24 hour rooming-in of the baby with its mother.

However, I found in my research that although there are many maternity services in Semarang purportedly running as baby friendly hospitals with rooming-in programmes, this belied the real picture and the policies were not always implemented correctly. One of my informants, for example, stated that when he went to one district in Central Java Province to supervise the breast-feeding programme in that area, the director of the hospital said that he was still struggling to get funding to build a baby room, since in that hospital they did not yet have a room specifically for babies. My informant was very surprised to hear this because the hospital was certified as running the programme, and should therefore have no need for a special room for the babies.

This suggests that attitudes on the ground as it were may not have changed a great deal in spite of the new programmes. When Hull, Thapa and Wiknjosastro carried out their research in 15 hospitals in eight major Indonesian cities in 1989, they found that although attitudes amongst health providers (doctors, nurses and midwives) towards breast-feeding were very positive, there were gaps in their knowledge and wide variation in the advice given to breast-feeding mothers. Similarly, although the concept of rooming-in received wide support, there were variations in the perception of what rooming-in entails, and some reservations about the possible disadvantages of the practice (1989:362).

Actually, the purpose of the rooming-in programme is to train the mothers to breastfeed the babies on demand. However, during this time approximately 90 per cent of the mothers stated that they felt weak after the birth and that they were not yet producing breast milk. During this time, the maternity services usually gave the baby infant formula. To support the breast-feeding programme, the nurses are supposed to give the infant formula with a spoon, not with a bottle. However, they always used bottles to feed the babies because there were so many babies to care for. Moreover, when the babies were already full from the infant formula, they did not want to breastfeed. One paediatrician commented that the babies would become used to breast-feeding if they were trained to suck the mother's nipples more often. However, since the babies were already fed with infant formula in the baby room, they would not look for their mothers' nipples because they had already been fed on formula and so were not hungry, and usually when the nurses put them in the mothers' rooms they were already asleep.

Non-governmental agencies and organizations have also taken an increasing interest in the decline in breast-feeding. One non-governmental agency, BKPP-ASI (Indonesian Breast-feeding Promotion Foundation), was established as a national

coordinating body for the promotion of breast-feeding in Indonesia. The Indonesian Consumers' Foundation (YLKI) also takes responsibility for monitoring the distribution of infant formula in Indonesia. Surveys carried out by YLKI found that some medical institutions did not support breast-feeding programmes. Data from 1993-1994 showed that amongst 38 maternity clinics, just 15.7 percent of mothers gave breast milk to their babies. The other 84.3 percent gave infant formula or a mixture of formula and breast milk. The survey also found that 40 percent of the new mothers fed their babies the same brand of infant formula that was proposed to them whilst in the clinic. Another survey carried out between December 1998 and February 1999 in two cities also found that producers broke the rules by putting a baby's picture on the label along with statements about the infant formula, both of which are prohibited by the International Code of Marketing Breast-milk Substitutes (YLKI, 1999). Moreover, YLKI also investigated the labelling of infant formula products. Some European companies, such as Lyempf, Nutricia, Dumex, Nuk and Chico, broke the rules since the companies claimed their products were substitutes for or complementary to breast milk. Yet according to the International Code, they are not allowed to make such claims¹⁶.

The latest data from the 2002 Indonesian Demographic and Health Survey show that 32.45 per cent of babies aged less than 12 months are bottle-fed. These figures were a sharp increase from the 1997 Indonesian Demographic and Health Survey, when only 10.8 per cent of babies less than 12 months of age were bottle-fed. In sum, I have analysed that, although the government of Indonesia has adopted the International Code of Marketing Substitutes and also developed infant formula policies to support breast-feeding programme, however, both this research and some previous research shows that these policies are not implemented correctly. In the following section, I will analyse bottle-feeding practices in Semarang.

¹⁶ Kompas, April 16th 1999

8.5. Bottle-Feeding Practice in Semarang

As described in the previous chapter (chapter VII), many factors influence the increasing consumption of infant formula in Semarang, such as the availability of infant formula in maternity clinics, the poor production of breast milk, and the return of mothers to work. Self-motivation and social support are crucial during this period. One respondent from an urban area said that she was willing to breastfeed her baby exclusively. However, she felt that her baby was not satisfied by the quantity of her breast milk, and she felt that her baby was thin in comparison to her friend's baby, who was fed infant formula. Another respondent claimed that she preferred infant formula because her baby was often fussy. She mentioned that compared to her first child, her third child was fussy and that infant formula was more convenient because it meant she could leave her baby with anyone at anytime. One of the respondents stated that she had tried hard to breastfeed her baby but the baby was fussy and cried. When she fed her baby formula, the baby slept well and was less fussy so she and her husband finally decided to feed the baby only infant formula, which helped her feel calm and patient when taking care of her baby.¹⁷

These situations show that mothers perceive that they have to comfort the baby either with breast milk or bottle feeding if the baby is crying, fussy, or hungry. As mentioned in the previous chapter, the mother will feel very embarrassed about her baby's distress. Husbands, relatives (mother, mother-in-law, etc.) and neighbours can offer support to breast-feeding women, although their suggestions are not necessarily followed. Whilst during this research was carried out, I found some maternity services and hospitals in Semarang, even though they joined the baby friendly hospital programme, do not implement the rooming-in policy and the baby is put in a separate room. This is often linked to the pervasiveness of certain attitudes towards and beliefs

¹⁷ Ibu Ita (February, 2002)

regarding what is 'best for mother and baby'. One informant in a private hospital, for example, argued that the policy of putting the babies in a separate room allows the mother to rest and recover quickly from the birth, and prevents the baby from catching any diseases brought in by guests. On the whole, a key rationale behind the reasons why nurses or midwives supported the feeding of infant formula to babies was that the mothers could not or did not seem able to produce sufficient breast milk or were too tired and in need of rest. That most medical staff in this research appeared to encourage the use of infant formula is by no means an issue specific to Indonesia. Indeed, despite the often accepted rhetoric of 'breast being best' which has become relatively prevalent worldwide, I would argue that both within Indonesia and in international contexts, there nevertheless exists a gap between rhetoric and reality. Brooks (2004), for example, who carried out a study of the attitudes of midwives in Indonesia, found that 100 per cent of the midwives agreed that infant formula has a risk of microbial contamination; 58 per cent agreed that infant formula should be given to babies weighing less than 2.5kg; and 89 per cent agreed that infant formula may be given to newborns until breast milk is produced. Brooks' study shows that even though all of the midwives agreed that infant formula has a risk of microbial contamination for the baby, they continued to give it to them based on a range of medically legitimated discourses.

Nevertheless, whilst most of the maternity services visited in this study provide infant formula, the Mawar hospital (a pseudonym) in Semarang does not. The Mawar hospital is the main hospital in Central Java Province, where medical research and teaching is carried out, so they try hard to implement the Baby Friendly Hospital policy. One senior paediatrician in this hospital commented that the patients usually come from the middle and lower classes, and the fact that they consume more beans and vegetables than higher class women affects their breast milk production, since they could produce more breast milk rather than mothers consume less beans and vegetables. Moreover, she

mentioned that the hospital did not want to burden the patients with the cost of infant formula, and thus placed great importance on training the mothers to breastfeed their babies. Thus, it was certainly the case that my respondents in Lintang who gave birth in this hospital commented that they were advised to breastfeed their babies without infant formula. One of the respondents in Lintang, however, mentioned that after she had given birth in this hospital her husband bought one pack of infant formula, since the baby was always crying and they thought the baby was hungry¹⁸. This situation showed that the perception amongst the mothers and their family is that if the baby cries, he/she is hungry or fussy and needs to be fed.

One of the issues I explored in interviews with parents and medical staff in this study was their attitudes towards the availability of infant formula to new mothers. Within this, a range of reactions was expressed with regards the extent of the distribution of infant formula in the maternity clinics. On the whole, however, respondents just accepted the maternity clinic's or hospital's policy. One respondent in Semarang, who had just given birth in hospital, said that she approved of the hospital giving some infant formula to her baby, since she felt weak and did not have enough breast milk. On the other hand, another respondent who gave birth in an expensive maternity clinic claimed that she was really disappointed with the nurses because they didn't encourage the patients to breast-feed their babies. She added that after giving birth, the nurse asked her what brand of formula she wanted to give to the baby.

An important issue here though is that, mothers feel they have little or no choice but to accept the medical treatment for themselves and their babies. In this way, this acceptance of the health provider's prescription of infant formula is a reflection of the relationship between doctor and patient. It is a political culture founded on the assumed

¹⁸ Ibu Siti (November, 2001)

pre-eminence of medical authority in the doctor-patient relationship. As Salter (2003:928-929) pointed out that:

“The authority is derived from the profession’s control of a body of scientific knowledge which is seen by the public as high status, socially functional and, above all, legitimate. As a result the public ‘trusts’ the profession, which, in political terms, can be taken to mean that the public gives doctors the power to exercise a wide discretion in the diagnosis of the condition, the definition of the therapeutic treatment and, in consequence, the allocation of the health care resources required for that treatment. Individual control of the body is relinquished and becomes part of the medical domain, owned and disposed of by doctors.”

Moreover, as Oakley (1993:31) has discussed there is a division of labour in health care, including in perinatal care:

“The most obvious division of labour in perinatal care is between people who are paid to provide obstetric care – doctors, midwives, nurses, paramedics, and so forth – and those who are not paid – so-called ‘patients’ and the families” (Oakley, 1993:31-32).

Oakley added that this division of labour is one example of a general rule observable in all health care, in which a great deal of care is often provided by people who are neither paid nor acknowledged for their performance of this task. One of the consequences of this paid/unpaid division of labour in health care is the hierarchically differentiated status between these groups, both in general and in relation to specific issues such as the evaluation of care. In maternity care policy, as in medical-care policy in general, a clear division holds between clinicians’ autonomy to determine treatment and patients’ attitudes to treatment. It is within this frame of reference that the attitudes of patients have traditionally been accommodated (1993:32). Specifically, Van Esterik (1989) argues that the jurisdiction of the medical profession has expanded to include infant feeding in both developed and developing countries; as it is taken for granted that anything affecting infant health belongs in the medical domain. As Van Esterik argues, the role of the medical profession within infant feeding practice can be problematic. She stated, for example, that:

“Health professionals are involved with infant feeding decisions both at the level of doctor – patient interaction and at the lofty heights of international health policy. Medical knowledge, institutions, and practitioners are powerful determinants of infant feeding patterns. But, however, it becomes clear that the role of the medical profession in the controversy is far from consistent – some would say, far from admirable” (1989:111).

Van Esterik points out that the medicalization of infant feeding refers to the expropriation by health professionals of the power of mothers and other caretakers to determine the best feeding pattern of infants for maintaining maximum health (Van Esterik, 1989:112). According to Conrad and Schneider (1986:129 cited in Van Esterik, 1989:112), medicalization became possible because of the growth of prestige, dominance, and jurisdiction of the medical profession. The process was facilitated by the founding of medical associations to professionalize medicine by constituting and controlling the market for medical expertise, eliminating competition, and creating a medical monopoly.

My study found that there is a relationship between the clinics and the infant formula manufacturers. All of the private maternity clinics in the peri-urban area always gave one local brand of infant formula to the mothers. In addition, the majority most of the midwives always put the same brand of an additional baby food on their information board. I found in my study that the midwives interviewed stated they did not have any special commitment to this particular brand except that it was manufactured locally and therefore cheaper for the patients, many of whom had a low socio-economic status. It was also common practice that when the mothers left they were given a small bag of baby equipment, including soap, shampoo, baby oil, etc, and two cans of infant formula. According to the respondents, they had to pay for one can of infant formula in order to get the rest free.

One of the senior paediatricians commented that it would be very difficult to stop the cooperation that has developed between midwives and infant formula

companies. Firstly, the midwife can access an excellent market for the infant formula companies, and many women prefer the help of a midwife to the help of an obstetrician because the cost is less. Secondly, the midwives are only provided with very brief training in lactation, and thus there may be gaps in their knowledge about this and the breast-feeding programmes. Thirdly, it is easier and cheaper for infant formula companies to collaborate with midwives than with paediatricians; as paediatricians expect much grander and more expensive incentives. For instance, a formula company hoping to woo a doctor at a conference would have to pay for the doctor to travel by plane, whereas a midwife would be expected to travel by train or bus.

It is common knowledge that, in order to market their products, formula companies give donations of breast milk substitutes to hospitals and health centres (Baumslag and Michels, 1995:168). Baumslag and Michels have also documented the way in which free samples, calendars, posters, and promotional booklets are prime marketing techniques of formula companies. Individuals can also benefit substantially from a relationship with the formula milk industry. Formula makers have extended benefits to medical students and paediatricians; these include school loans, grants, and payments for articles, gifts and trips to conferences. One study published in *Pediatrics* in 1991 found that the pharmaceutical industry spends \$6,000 - \$8,000 in promotion per doctor per year in the United States. Expenditures for these special events increased fourteen-fold between 1975 and 1988. In Great Britain, it was found that thirty-one of the government's fifty-nine advisors on health and nutrition policy admitted to receiving payments from the food and drug industries, including the baby companies (Baumslag and Michels, 1995:172).

Such marketing also happens in Indonesia, and in Semarang, as mentioned above. One of the paediatricians stated that it is very common for the pharmaceutical industry, including the formula companies, to pay for research, gifts, articles, and also

costs for attending conferences. Usually the companies ask doctors to use their products for prescriptions, although the paediatrician that I interviewed claimed that he never instructed his patients to use a brand of infant formula which had paid him to use their products. Regarding collaboration between midwives and formula companies, another informant stated that one local brand of formula company offered an incentive of Rp 50,000 (\$4.46) to midwives per birth to recommend their products.

There is, however, no special policy about the brand of infant formula used in the maternity clinics or hospitals. One paediatrician said that he just used whatever brand the clinic or hospital supplied. He mentioned that in some hospitals they change the brand every month. This policy seems to show the collaboration between the formula companies and the hospital for providing formula milk periodically.

As mentioned earlier, the Ministry of Health (MoH) has imposed regulations based on the International Code of Marketing of Breast milk Substitutes, which states that the health provider is not allowed to promote any infant formula or infant food, but this is exactly what seems to be happening in health services in Indonesia. The Indonesian Consumers' Foundation has complained to the Ministry of Health on this matter, but the situation is difficult for the MoH to monitor and much depends on the individual choices made by health providers (YLKI, 1999).

For the peri-urban communities in developing countries, such as Lintang, bottle-feeding is associated with modernity and urbanization. Research has shown that people in poor countries are often persuaded by advertisements that bottle feeding is the modern thing to do. Formula companies' regularly present images of their products as being the modern, healthy 'first world' way to bring up a baby¹⁹. Such advertising is also prevalent in Indonesia, giving out potent and persuasive messages that trade on images of modernization.

¹⁹ <http://www.unicef.org/sowc98/under5.htm>

Consumption, including infant formula consumption, particularly in developing countries, can be categorized as a cultural process – a culture of consumption or consumer culture. As Slater has pointed out:

“consumer culture is in important respects the culture of the modern west – certainly central to the meaningful practice of everyday life in the modern world; and it is more generally bound up with central values, practices and institutions which define western modernity, such as choice, individualism and market relations” (1997:8).

As mentioned above, for people who bottle-feed their babies, bottle-feeding appears to be the ‘modern’ alternative. More respondents from the peri-urban area stated that they were influenced by TV commercials than the mothers from the urban area. They said that TV commercials provide information about the contents of formula milk. Numerous brands of follow-up infant formula - milk given to the baby or child above 1 year old - are advertised on TV, such as Dancow, SGM, Pediasure, Bendera, Vitaplus, etc. Such TV commercials show a middle class family who are happy and proud of their smart child, selling the dream of the perfect family in the commercial. The underlying perception is that viewers can enhance their prestige if they buy the formula milk advertised.

Neighbours or relatives can also influence the mother’s decision. One respondent from the peri-urban area stated that after she visited her sister she wanted to change her daughter’s milk, as her nephew looked so healthy after being fed a certain kind of formula milk. Seeing a bottle-fed baby who is fatter than a breastfed baby seemed to persuade some mothers to feed babies formula milk. One mother said: *“Usually, I gave my child ‘SGM’ milk, but, after couple weeks ago I visited my nephew, he looked very healthy and fatter than before. I asked my sister, and she told me that she gave him one brand of formula milk. Afterwards, I also gave my child the same brand with my nephew. Now, my son also looks healthier than before”*. However, for respondents on a low income, the price often determined their purchase of formula milk.

Respondents in the urban area with higher income levels stated that they chose formula milk for several reasons. One of the mothers stated that she chose formula milk for her baby that was suitable for his age group. For example, Bebelac 1 is usually fed to babies above 1 year old, followed by Bebelac 2, 3, and so on. Enfapro is followed by Enfagrow. Another respondent stated that she chose the formula milk based on surveys in the shops that compared the price of formula milk. Middle class respondents mentioned that they never thought about the price when buying formula milk. They stated that they would economise on other areas of household expenditure, such as leisure or another budget, in order to pay for formula milk. One of the mothers said that her child of 15 months had problems with eating food, which made her afraid her daughter would have nutritional problems. As a result, she gave her daughter Pediasure²⁰ milk. She stated that she had spent a lot of money for this brand of milk and realised that she was influenced by the TV commercial, but felt that it was worth it when her daughter started gaining weight²¹. Approximately 50 – 60 per cent of mothers stated that any information or counselling given by paediatricians was not the deciding factor in their decision. Similarly, one paediatrician stated that only a few of her patients consulted with her about the brand of formula milk.

After Indonesia was hit by the economic crisis in 1997, the price of imported products, such as infant formula, increased sharply. Table 8-1 show the price of infant formula in 2001.

²⁰ Pediasure is follow-up milk for babies over 12 months, and at the moment is the most expensive milk in Indonesia.

²¹ Ibu Rina (January, 2002)

Table 8-1
The Price of Infant formula in Semarang

Brand	Quantity (gr)	Price
SGM I	150	Rp ²² 9,330 (83 cents)
Lactona I	400	Rp 14,225 (\$ 1.27)
Vitalac	200	Rp 13,550 (\$ 1.21)
Bebelac	400	Rp 32,750 (\$ 2.92)
S26	800	Rp 86,250 (\$ 7.7)
Enfamil	800	Rp 80,750 (\$ 7.2)
Promil	800	Rp 75,650 (\$ 6.75)

Source: Primary data based on supermarket prices in Semarang, 2001

In a household, the cost of infant formula is very high. For instance, if a baby in Lintang consumes one pack of even the cheapest formula - SGM I (150gr) - in 1-2 days, the cost of infant formula per month is Rp 279,900 (\$24.99). There may of course be additional costs if the baby gets sick from the illnesses such as diarrhoea, respiratory infection, digestive problems, etc., often associated with formula-fed babies. If one considers that the average salary of working mothers in Lintang is between Rp 300,000 – Rp 400,000 (\$26.78 - \$35.71), it is clear that the cost of infant formula will take up almost all of her salary.

As mentioned earlier, the Government of Indonesia has several policies about infant formula related to the ‘exclusive breast-feeding programme’. According to government regulations, infant formula is milk consumed by babies less than 1 year old and cannot be advertised on TV. However, follow-up milk products are advertised and milk producers also support various kinds of children’s activities, such as talk show for TV programme, any competition for children, etc. Even though the government

²² IDR = Indonesian *Rupiah* (Rp) or Indonesian currency. When this research was carried out, the exchange rate was \$ US 1 = Rp 11,200.

regulation requires that there must be a notice that “breast milk provides the best nutrition for babies”, a picture of a milk bottle often accompanies the advertising or appears at the end of the advertising slot.

Many scholars, as previously discussed, have pointed out that the impact of inappropriate infant feeding is immeasurably greater in developing countries (Maher, 1992a; Dorosko and Rollins, 2003; UNICEF, 2004). Lack of safe water for mixing the formula and contamination of feeding bottles are the main reasons why formula-fed babies die; another is that families cannot afford adequate supplies of formula, so they dilute it too much. A formula fed baby in a developing country experiences higher rates of disease not only because the baby does not receive the protective benefits of breast milk, but also because of exposure to pathogens in contaminated formula milk and bottles (Dorosko and Rollins, 2003:119).

In line with these findings, I found that the mothers in the peri-urban area did not demonstrate great awareness of, or were structurally constrained from delivering adequate bottle hygiene. Sufficient supplies of formula, safe water and fuel to sterilize bottles and synthetic nipples are necessities for hygienic infant feeding, particularly bottle-feeding. The unhygienic environments and relative lack of awareness about healthy living that I found during my research reflects the levels of poverty and structural inequalities in the neighbourhood. The parenting pattern of part-time baby sitters in Lintang village also contributed to hygiene problems pertaining to bottle feeding. During my research, for example, I often saw childminders who left bottles open or lying on a dirty floor. Health behaviour, such as sanitary preparation, including washing hands with soap and water prior to formula preparation; boiling the water used to mix the formula; keeping food preparation areas clean; washing the bottle, the cup or bowl for the baby with soap and water, could all be improved throughout the community as a whole, but was a particular issue in the context of babies being cared

for by people with less emotional attachment to them than their parents were likely to have.

Parents were, however, inevitably constrained or otherwise in their childcare behaviours and patterns by their specific socio-economic circumstances. The mothers in the urban areas, for example, who had the advantage of greater socio-economic and educational capital, stated that they always tried to keep their feeding equipment clean and they never let their servants or baby sitters clean the baby's bottle in order to ensure good hygiene (to avoid unhygienic bottles). In sum, I would argue that socio-economic capital is clearly a primary factor in levels of hygienic feeding practices, but as this section has explored, bottle-feeding practices in Semarang are also significantly influenced by the medical profession. This research found, for example, that most of the maternity clinics in Semarang provide and give infant formula to babies after birth, and, furthermore, that there is a relationship between health providers and infant formula companies.

8.6. Summary

Studies have found that breast milk contains over one hundred constituents. The benefits of breast-feeding for both babies and mothers in terms of nutrition, immunological protection, contraceptive effects, and emotional satisfaction have been widely documented. Many scholars also argue that breast-feeding is particularly needed by babies in developing countries and that through breast-feeding ten million children could be saved from diarrhoeal disease and malnutrition each year. Unfortunately, in developing countries, breast-feeding, especially exclusive breast-feeding, has declined markedly. Studies have also found that it is common for mothers to discontinue breast-feeding and to switch to infant formula (Iskandar, Costello and Nasution, 1992:90; Moffat, 2002; Winikoff and Laukaran, 1988).

Artificial feeding, including infant formula, has been used as infant food for many decades. In the past, the purpose of developing artificial feeding was to save the lives of foundlings and sick babies. But nowadays infant formula companies no longer manufacture a product solely for sick babies or for times when breast milk is not available, but intend their products as replacements for mother's milk. In developing countries, where many people do not have access to sterile water, together with the unhygienic conditions often associated with bottle-feeding, the risk of disease in babies increases with the use of formula milk, making babies more prone to diarrhoea, respiratory infections, and so on. Furthermore, an obvious but nevertheless significant issue is that infant formula costs money that poorer families often lack.

The 'baby-milk scandal' brought to light the fact that feeding infant formula to babies in developing countries had resulted in the death of great numbers of children. To control the booming trade in infant formula in the world, WHO and UNICEF developed this International Code of Marketing of Breast milk Substitutes, and in 1991 launched the Baby Friendly Hospital programme, which promoted a rooming-in policy to increase breast-feeding practice.

Indonesia, like many other countries, has adopted the International Code and many other WHO resolutions. The government has also developed its own regulations to support breast-feeding in Indonesia. Unfortunately, the 2002 Demographic Health Survey showed that bottle-feeding had increased for babies of less than 12 months. Whereas in 1997, 10.8 percent of babies less than 12 months were bottle-fed, in 2002 this percentage had increased to 32.45.

In this chapter I have thus explored the factors which may have contributed to the increase in bottle-feeding in Semarang. One significant issue, for example, is that not all the maternity services in Semarang implemented the rooming-in programme. This policy influenced the motivation of the mothers to practice breast-feeding. Peri-

urban women also tended to introduce infant formula and additional food for the babies too early whilst women in the urban area introduced infant formula early to prepare the babies for when the maternity leave ended. This suggests that maternity leave in Indonesia is too short for working women to practice breast-feeding, especially exclusive breast-feeding. With such issues in mind, the next and final chapter will outline the conclusions of this thesis.

CHAPTER IX CONCLUSIONS

In this final chapter, I conclude by providing an overall summary of the thesis, drawing together both the main research findings and themes and my theoretical analysis of these key issues. Development is viewed as a complex process involving the social, economic, political and cultural betterment of individuals and of society itself (Young, 1997:52). There is no doubt that processes of development and modernization have in some contexts had some positive impacts on women and men's daily lives in terms of, for example, infrastructural development or improvements in social or economic opportunities. However, development processes affect women and men in different ways, and despite practical changes, one could argue that in some developing contexts, little has been done at the structural level to change women's position in society (WHO, 2000; Momsen, 2004). In this sense, many Indonesian women, similar to their counterparts in other developing countries, are labelled the 'poorest of the poor' (Vickers, 1993), because they continue to face economic, social and cultural gendered inequalities and are expected to carry the double burden of both reproductive and productive roles in often difficult circumstances.

This thesis has provided a gendered analysis of reproductive health issues principally from a gender and development (GAD) perspective. According to Young (1997:51) the focus of gender and development is not on women *per se* but on gender relations, i.e. the relations between women and men in a variety of settings. This approach views women as active agents and not passive recipients of 'development'. As discussed in chapter II, the gender and development framework, as developed, for example by Østergaard (1992a), Moser (1993) and Momsen (2004) was used to analyse patterns of breast-feeding practice in Indonesia. In my study, this gender and development framework has proved very useful, since this model facilitates analyses of

class differentiation, health seeking behaviour, the government's policy concerning breast-feeding programmes, and also the dual productive and reproductive roles of women, in this case in the urban contexts. More specifically, on a micro level, from a gender and development framework, I have analysed the health seeking behaviour of women in both peri-urban and urban contexts. I explored where and how they find the health facilities for ante-natal care and also for giving birth, influences upon the practice of breast-feeding and the health status of both mothers and their children. A range of social factors, including experiences of employment, housing conditions, family structures and gender divisions of labour, and also socio-cultural factors, such as attitudes towards children and childrearing, all influence the patterns of breast-feeding. On a macro level, both through gender analysis and from a feminist perspective I have analysed the bottle-feeding phenomenon, including such aspects as government policy, women's attitudes towards and practice of bottle-feeding and also the advertising campaigns of infant formula manufacturers both in the mass media and in maternity services. I argue that, given the conflicting demands placed upon women and through a lack of economic resources and institutional support, it is unrealistic to expect women to be engaged in exclusive breast-feeding for the recommended period of 4 to 6 months as stipulated in WHO guidelines (Huffman, Zehner & Victora, 2001) until such time as wider structural changes are in place.

As I have discussed in the previous chapters, the aim of my research is to analyse and describe the differences in breast-feeding practices between women from apparently different backgrounds. In my study, I used 'area' as a criteria of these differences. A peri-urban and an urban area were chosen as places which could represent the differences between women. Principally, the women I spoke with who live in the peri-urban area tend to have a lower socio-economic status, lower educational attainment and limited access to skilled employment as compared with my respondents

living in the urban area. Lintang village (a pseudonym), which is located on the outskirts of the city of Semarang, was chosen to represent a peri-urban area. This area is undergoing development as an industrial zone of Semarang. However, although the distance between this village and the city centre of Semarang was only 15km, my research found that Lintang village could be described as peri-urban and even rural, based on such conditions as poor transportation, lack of clean water, and an absence of many facilities, including access to poorer quality health services. The urban area used in my study was based within the city of Semarang and in this context, my respondents had a higher socio-economic status, higher levels of education, increased access to better employment opportunities, and had better health services available to them. As stated above, I found that various social factors in both of the areas in which my respondents lived, such as employment, household management, housing, family structures, and socio-cultural attitudes towards children, influence breast-feeding practices amongst women in each area.

The basic unit of the contemporary Javanese family tends to be nuclear as opposed to extended as was more traditionally the case, particularly in rural areas (see Geertz, 1961; Jay, 1969; Koentjaraningrat, 1985; Wolf, 1992). Wolf (1992), for example, found that compared with previous research (Geertz, 1961; Jay, 1969), nowadays there are increasing numbers of nuclear Javanese families than in previous studies. In terms of family structure and household composition, I found that the majority of respondents in both Lintang and Semarang were part of nuclear families. Lintang village is part of an area undergoing development and is composed of migrants moving to the city in search of new employment opportunities. As such, I found in my research that many of the respondents in the peri-urban area were migrants from rural areas, who had come to find work in factories, had started families and had settled in the village. The socio-economic conditions for people in Lintang, such as low levels of

education and poorer economic conditions, seemed to influence their decision to live separately from their parents, as they had moved from their villages to seek jobs, and ended up establishing their own families in Lintang. By contrast, my respondents in Semarang tended to move from their parent's home elsewhere in the city to establish a nuclear family, not due to migration for employment purposes but rather because they wanted to break from traditional extended family forms and live more independently with their own new families.

As Momsen (2004:182) asserts, certain aspects of social, economic and cultural norms determine women's ability to participate in urban employment in developing countries. Modern industry is spatially separated from the home and tends to involve a standard fixed pattern of working hours. Both characteristics cause problems for women with children in terms of childcare arrangements, and, for poor women, the burden of domestic work bears more heavily on those unable to 'buy-in' domestic assistance than women with greater economic resources. I also found that with increasing numbers of working mothers, the housing conditions, i.e. the small house of '*perumnas*' and the changes of family structure caused by the shift from extended family to nuclear family have changed patterns of childcare. In Lintang, as many women are working in the factories and due to the generally poor socio-environmental conditions in the village, this has resulted in the employment of an increasing number of childminders, since houses tend to be smaller in size, which means that only members of the main family can live in the house. Most of the childminders are women around 50 years old or over, who take care of babies in their own houses whilst mothers are working. Some mothers who live in *kost* (rented rooms) and have a lower socio-economic capital ask other tenants or their landlords to take care of their children. On the other hand, for women in the urban area, who had higher socio-economic resources, they were able to and tended to employ dedicated domestic servants or nannies to take care of their children within

their own home. As people in Semarang wanted to live more independently, most of the respondents in Semarang stated that they did not want to ask their mothers or other relatives to help them take care of their children, since they felt that having children and looking after them (or at least arranging their own childcare) was their own responsibility and denoted a style of modern, urban, independent living.

The level of education has also affected the differences in conditions of life amongst women in both areas. Differences in educational levels also hinder women from entry into the best-paid jobs. I found that women in the urban area, with higher levels of educational attainment, could access higher social and economic capital. They could get better jobs, working in careers such as lecturing or in the civil service, could not only hire dedicated childminders, but it also afforded them greater flexibility to rearrange their working hours. As a result of their lower level of socio-economic capital, the situation for women in the peri-urban area is far more constrained. Unsurprisingly, they worked for economic reasons, to improve the family income in response to the increasing the cost of living caused by the economic crisis in Indonesia. As most of them are factory workers, they were often working in factories on 8 hour shifts, sometimes also having to work night shifts, necessitating overnight childcare.

With regard to the cultural context, this research found that people in both areas hold *slametan*, *tingkeban* or *mitoni*, *brokohan* and *selapanan* out of a sense of cultural obligation, since *slametan* is a custom or tradition amongst Javanese people. They believe that during pregnancy and the period around the birth are crucial times during the Javanese life cycle. Nowadays, however, ceremonies have been simplified, particularly amongst respondents in the peri-urban area, because of changing socio-economic conditions. They preferred, for example, to save the money they would spend on elaborate ceremonies, so they could budget for ante-natal care and pay the delivery fees. Further, since they no longer live with their parents, but as a nuclear family, this

means that when they give birth, their parents, relatives, and, most importantly, their mothers, are usually not present. The lack of wider family at hand following the birth can make the holding of traditional ceremonies seen less important. People in the urban area, on the other hand, hold a *slametan* as a ceremony or a party. Even though they are living in a nuclear family, as they tend to have wider family available in the city and higher economic resources, it is still possible to host birth ceremonies. Based on my research findings, however, I would suggest that far more important than these relatively minor differences in cultural practices were differences in terms of women's access to health care, socio-economic position and working conditions.

Østergaard (1992b) has pointed out that development and health are intrinsically interrelated, but, in many cases, development processes have not helped to improve the status and health of poor women, but rather can have negative impacts, for example, many women continue to have little or no access to proper health services, and limited access to gain information about health. Momsen (2004) has also stated that poverty and health are closely related, but economic improvement does not necessarily lead to better public health, and particularly in improvements in women's reproductive health. Similarly, I found that, women in the peri-urban area used the public health centre for their ante-natal care rather than other health services because it was cheaper. However, some of them complained about the poor services in this centre. In Indonesia, particularly in rural areas, the public health centre is supposed to be seen as the main vehicle for decreasing women's health problems, since these centres are highly subsidised by government and other funding. However, poorly trained health staff, including midwives, late referral, and lack of emergency facilities and transportation have kept standards low. UNICEF (2000) reported that in Indonesia, it is estimated that a woman dies every 45 minutes due to complications during delivery, late referral to health services and poor treatment. In these ways it is clear that poverty and health are closely

related and that for poorer women the suffering is usually marked because of their low socio-economic capital, and their relative lack of decision making powers. Women in the peri-urban area are more generally affected since they have a lower socio-economic status and more limited access to better health services than their urban counterparts. As Potter et al. (2004) and Momsen (2004) have pointed out, cities are generally healthier than rural areas because of higher levels of education and income and a concentration of medical services – thus health conditions are generally much better in urban areas in developing countries, since this is where the hospitals, clinics and most doctors are to be found. I also found that women in the urban area with higher socio-economic status had greater access and more choices in health services.

I found that peri-urban and urban women had different attitudes towards post-natal treatment. Mothers in the village still preferred the traditional services of the *dukun bayi* (the traditional midwife) for post-natal treatment, although during the birth process they were assisted by midwives. The Government of Indonesia has developed the ‘Mother Friendly Movement’ programme in an attempt to reduce maternal mortality rates and within this also developed the concept of ‘*pendampingan*’, which under this scheme refers to a trained midwife (*bidan desa*) being called to attend whilst the *dukun bayi* assists at the birth; in this programme the role of the trained midwife is to supervise the *dukun bayi* and to ensure that the proper and sterile tools are used. However, people in villages such as Lintang, even though they have access to the trained midwife, still preferred to ask the *dukun bayi* to treat them during the post-natal period. The *dukun bayis* were seen by women in Lintang to be more friendly, they did not charge a fixed fee and they have some local social status due to their older age and they are therefore thought to have a great deal of experience concerning the birth process and its related treatments. By contrast, none of the women in the urban area had used the services of the *dukun bayi* to treat them during post-natal period, preferring the

services of midwives or obstetricians. There were no *dukun bayis* in the urban area and a higher level of education and income also seemed to influence the women in the urban area to turn away from traditional practices.

As previously stated many scholars have pointed out that breast-feeding is regarded as good practice today, particularly for people in developing countries, since breast-feeding can, for example, save money and reduce infant mortality rates (UNICEF, 2000; Moffat, 2002). Indeed, I found that mothers in both areas have taken on board this understanding and stated that breast-feeding was healthy, cheap and practical. They perceived breast-feeding to be a natural process, part of a women's duty and good parenting, which promotes a good relationship between mother and baby. My respondents also stated that they tried hard to breast-feed the baby as much as they could. However, whilst the majority of the mothers viewed breast-feeding positively, they also said they often encountered many difficulties in attempting to do so. Moreover, I found that there were important differences in breast-feeding practices and experiences for mothers in both areas, differences that can be related to a number of key social issues.

Amongst mothers in the peri-urban area, I found from the qualitative methods, both from the focus group discussions and in-depth interviews, that they lack a complete of understanding of the processes and nutritional issues involved in breast-feeding. This relative lack of knowledge is a result of socio-economic factors, such as limited access to education and lack of adequate counselling in that area. The mothers stated breast-feeding is a mother's responsibility, regardless of whether the quality and quantity of the breast milk are sufficient for the baby or not. A Javanese perception is that, if a baby cries often, he or she is assumed to be hungry, and the mother often feels embarrassed and subject to public pressure to settle her baby down and this is usually done by offering the bottle, supplementary food or the breast.

Building on Hull's distinction about breast-feeding practices amongst Javanese women (Hull, 1984), which include *meneteki* (suck the nipple) and *menyusui* (suckle milk), based on my perceptions arising from my research, I argue that the mothers in the peri-urban area tend to practice a *meneteki* (suck the nipple) form of breast-feeding rather than the *menyusui* form. This practice actually could be seen as good breast-feeding practice according to WHO recommendations, since they appear to breastfeed the baby on demand. However, *meneteki* is not the same as systematic breast-feeding with the primary intention to provide nutrition, rather it is form of comforting a 'fussy' baby. As such, mothers in the peri-urban area tended to see their babies primary nutrition in terms of supplementary feeding (i.e. the introduction of solid foods such as honey and banana) and infant formula, with breast milk used as a form of comfort rather than primary nutrition. Such practices and perceptions, combined with the low socio-economic status of women in Lintang can have a significant affect on the poor nutritional condition both of the mothers and the babies. As a result of the economic crisis which started in 1997, as discussed in chapter IV, malnutrition amongst women has increased significantly in Indonesia. For example, Helen Keller International (2000) found that a year after the onset of the crisis, the mean of Body Mass Index (BMI) amongst women in rural Central Java decreased from 21.5 to 21.0 kg/m². Consequently, the prevalence of maternal malnutrition increased from 15 per cent to 17.5 per cent. These findings showed that maternal malnutrition is caused in part by the tendency of poor women in Indonesia to reduce their own food intake rather than reducing that of their children and husband (Helen Keller International 1998; 2000; UNICEF, 2000). This is not uncommon in developing contexts, in Bangladesh for example, surveys in 1996 – 7 revealed that 52 per cent of women (36 per cent in urban areas and 54 per cent in rural areas) were affected by chronic energy deficiency due to inadequate food (Momsen, 2004:78). Women experiencing chronic energy malnutrition are at a high risk

of having a baby with a low birth weight. In the post-natal phase, a woman's condition often quickly worsens and she can easily face health problems. Production of breast milk will be affected, and the mother may be unable to care for the child or herself, and, furthermore, the baby may face severe malnutrition, which will worsen if she/he is not provided with nutrients to promote immunity which are contained in the mother's milk (Helen Keller International, 1998; UNICEF, 2000).

Conversely, I found that, in the urban area, the mothers were more aware of the distinction between the two forms of breast-feeding and working women particularly, thought their baby might be fussy because he or she was not satisfied with the quantity or quality of their breast milk production. Hence, approximately 70 per cent of them preferred to give their baby infant formula though they still kept giving them breast milk. The higher socio-economic status amongst mothers in the urban area also influenced their access to information. They had more money and were therefore able to choose higher quality health services and also better able to buy infant formula and feed their children formula in more hygienic environments with regular water supplies, the ability to boil the water, and greater access to refrigeration.

The lack of understanding about breast-feeding amongst women in the peri-urban area is closely related to poor counselling. In Indonesia, although the government has in recent years taken steps to promote breast-feeding, leading to a growing interest in the promotion of breast-feeding amongst health professionals, such interest seems not to have taken hold at the grassroots level. The limited budget set aside to promote breast-feeding has resulted in an assumption that the breast-feeding programme is not really important. For instance, at the district level public health centre or *puskesmas*, the midwives who were expected to be in charge of counselling were unable to deliver such service as a result of a lack of understanding of the requirements and a lack of resources.

Kusin & Kardjati (1994), Nordenhall & Ramberg (1998) and Untoro (2004) have indicated that the lower rate of exclusive breast-feeding in Indonesia is due to psychosocial, behavioural and environmental factors. UNICEF (2000) also pointed out that the problem of breast-feeding in Indonesia which is of perhaps greatest magnitude is the premature termination of exclusive breast-feeding due to the premature introduction of complementary foods or liquids other than breast milk. In fact, my research found that just a small number of mothers in both areas breastfeed the baby exclusively. In the peri-urban area, the qualitative data both from the focus group discussions and in-depth interviews show that approximately 70 - 80 per cent of mothers already introduced the baby to supplementary foods when the babies were less than 4 months old. Honey, sugared water, and infant formula were the kinds of food given to babies in the peri-urban area after birth, with soft rice, bananas, and instant baby porridge commonly introduced to babies under 4 months old. In this way, as aforementioned, solid food comes to be seen as a primary source of nutrition, with breast-feeding primarily regarded as a form of comfort. Hence, the qualitative data showed that low levels of education and limited access to information about health and breast-feeding in particular have influenced breast-feeding practices amongst women in the peri-urban area. Some reasons for the introduction of supplementary food and infant formula were that the baby always cried and was hungry, but social pressures from family members such as from mothers, mothers-in-law and neighbours also strongly influenced their decision.

Similarly, based on the quantitative data, 68 per cent of mothers in the urban area did not breastfeed the baby exclusively. This quantitative finding was supported by the qualitative data that show that the mothers employed in work stated that they introduced infant formula when the baby under was 4 months, citing the need to get their babies used to infant formula before they returned to work. From these findings, I

found a strong correlation between full time mothers and exclusive breast-feeding. As discuss in chapter VII, my data show that 23 mothers out of 38 non-working mothers had breastfed the baby exclusively. On the contrary, 64 out of 79 working mothers had not breastfed the baby exclusively. These findings clearly demonstrate that amongst urban women, there was a desire and an understanding of the benefits of exclusive breast-feeding where it was practical and feasible to do so, i.e. when they did not work outside of the home. This is not to advocate that all women should be full time mothers and that women should not be employed in paid work. Rather, what I am suggesting is that if the means are available, i.e. the structural constraints are altered, it seems that many women would choose to exclusively breastfeed.

The 1997 multi-site complementary feeding study in Indonesia found that the percentage of infants who are exclusively breastfed is 63 per cent in the first month of life, 45 per cent in the second, 30 per cent in the third, 19 per cent in the fourth, 12 per cent in the fifth and only 6 per cent in the six month (Sharma et al., 1999). Nordenhall & Ramberg (1998) who conducted research in Purworejo district, Central Java found that the median duration of exclusive breast-feeding stands at 2.1 months. Brooks (2004) also found in his study in Bogor, West Java in 2002, that 62 per cent from half of the mothers who took part in this study stated that they used infant formula during the first month. These findings are in line with UNICEF data (2000) that the median duration of exclusive breast-feeding in Indonesia is relatively brief at only 1.3 months, and is shorter than in many other Asian countries, such as India (4 months) and Bangladesh (6 months).

In Indonesia, as in many other developing and developed countries, there is a large market for infant formula, and one consequence of this has been an increasing infant mortality rate in developing countries. Maher (1992a) has pointed out that 'the baby milk scandal' brought to light the fact that feeding babies with formula milk in

developing countries where the mothers had no access to clean water or refrigeration, had resulted in the death of a great number of babies (1992a:3). However, to stop or to reduce the global marketing of infant formula is not easy, since infant formula marketing is integral to a capitalist system. As Campbell (1984) has stated, breast-feeding programmes and other aid programmes in developing countries are useful for capitalist institutions. In this context, breast-feeding is seen as tool for controlling the fertility of the populations in developing countries. Campbell sees the attempt to regulate the activities of baby milk manufacturers as an accommodation between liberal government and capitalists which actually results in more stable and better profits for infant formula manufacturers. She suggests that 'liberal' pro breast-feeders believe that the regulation of infant formula companies is necessary to support the long term survival of breast-feeding (Campbell, 1984).

Inconsistency in government policies to support the breast-feeding programmes, such as the poor implementation of the 'baby friendly hospital' with 'rooming-in programmes' and also the length of maternity leave for working women, have led to an increase in bottle-feeding practices in Indonesia, including in Semarang. The massive commercial campaigns to promote infant formula and baby foods both in maternity services and the mass media are also responsible for decreasing the trend in exclusive breast-feeding practice. According to WHO and UNICEF (Baumslag & Michels, 1995; WHO, 1998), the purpose of the rooming-in policy is to train the mothers to breastfeed the baby on demand. However, I found in my study that during this difficult period the maternity clinics often gave the baby infant formula. The availability of infant formula in the maternity clinics and the fact that many of the babies had been given bottled milk since birth, suggests that there is a relationship between the health providers and the manufacturers of infant formula. Doctors, midwives and nurses are supposed to be provided with the necessary motivation, support and information not only to support

breast-feeding during the early post-partum days, but also to establish a firm foundation for continued breast-feeding and solve any problems which may emerge once the breast-feeding woman has left the hospital to return home. In the mass media, according to government regulations, infant formula milk targeted at babies less than 1 year old cannot be advertised on TV, however, follow-up milk products are advertised and milk producers also support various kinds of children activities TV programmes, and provide free 'gift packs' in maternity clinics.

I found that many, particularly working mothers, have no choice but to introduce infant formula shortly after birth. Like many women in developing countries, Indonesian women are also facing the double burden of productive and reproductive roles. In this context, breast-feeding becomes more complex because they experience many barriers if attempting to combine the two roles, such as the lack of places to express breast milk in the workplace, limited maternity leave, limited worker control over work schedules and fear of job security. In Indonesia, most workplaces have no nursery or child care facilities. With regards to maternity leave, the government of Indonesia determines maternity leave at three months. Some mothers stated that they took 1.5 months before and 1.5 after the birth. Other mothers took one month before and two months after, so they had a longer time to take care of their babies. However, the length of maternity leave does not support the exclusive breast-feeding programme in Indonesia, since working mothers have to leave their babies before the recommended time of exclusive breast-feeding is over, necessitating the introduction of supplementary baby food, such as infant formula. As mentioned earlier, the burden of productive and reproductive responsibilities impacts more heavily upon peri-urban women than upon working mothers in the urban area. Most women in the peri-urban area are factory labourers which involves working long shifts of 8 or more hours, and can include night shifts. Exacerbating this situation are the poor housing conditions, limited access to

health services and fewer socio-economic resources generally, all of which leads to a greater risk of unhygienic bottle-feeding and poorer nutritional levels for both mother and baby.

To conclude, in line with many women in other developing countries (Maher, 1992a), Indonesian women also perceive breast-feeding to be 'natural', particularly mothers in the peri-urban area who perceive breast-feeding to be a part of parenting. At the same time, however, these mothers also face the conflict between their dual roles as mothers and as working women, and confront real material conditions that not only make it difficult to breastfeed, but also do not provide positive guidance and assistance in enabling them to do so. Whilst I began with the 'socio-biological' frame that breast-feeding is 'natural', a biological function of women's reproductive capacity; based on my research findings, I have critiqued this position for failing to place this biological capacity in the context of socio-cultural factors. In this context, I think it is important to question general statements on breast-feeding policy. In particular, WHO and UNICEF have recommended that because breast milk is sterile and safe, mothers should be breast-feeding exclusively until the baby is 4-6 months old, meaning that the baby receives no other food or liquid, including water during this period. I argue that as a result of a combination of factors, such as the constraints placed upon women as a result of their productive and reproductive roles, the often poor socio-environmental conditions in which they live and the poor health of many mothers and babies in developing countries, such as Indonesia, exclusive breast-feeding for 4 – 6 months is too long. Although agreeing that theoretically breast-feeding is cheap, sterile and safe, exclusive breast-feeding for four to six months for poor people in developing countries may neither be viable or even always desirable under present conditions. More specifically, breast-feeding policy recommendations such as these cannot be separated from wider structural changes that must first occur in terms of ensuring greater

economic equality, better working conditions for women, including the availability of nursery or child care facilities in the workplaces, sufficient time for maternity leave, the provision of adequate health care, raising standards of living, and better education.

BIBLIOGRAPHY

- Abada, Teresa SJ, Trovoto, Frank and Lalu, Nirannanilathu. 2001. "Determinants of Breast-feeding in the Philippines: a Survival Analysis". *Social Science and Medicine* 52, 71-81.
- Anderson, Benedict R. 1983. "Old State, New Society: Indonesia's New Order in Comparative Historical Perspective". *Journal of Asian Studies* 42(3), 477-496.
- Anderson, Margaret L. 1993. "*Thinking about Women: Sociological Perspectives on Sex and Gender*" 3rd ed. New York: Macmillan Publishing Company.
- Aspinall, Edward. 2002. "The Downfall of President Abdurrahman Wahid: A Return to Authoritarianism?". Kathryn, Robinson and Bessel, Sharon (ed) *Women Indonesia: Gender, Equity and Development*. Singapore: Institute of Southeast Asian Studies, 28-40.
- Barber-Madden, R, Petscheck, MA, Pakter J 1987. "Breast-feeding and the Working Mother: Barriers and Intervention Strategies". *Journal of Public Health Policy*, Winter, 531-541.
- Baumslag, Naomi & Michels, Dia L. 1995. *Milk, Money, and Madness: the Culture and Politics of Breast-feeding*. London: Bergin & Carvey.
- Beatty, Andrew. 1999. *Varieties of Javanese Religion*. Cambridge: Cambridge University Press.
- Biro Pusat Statistik (BPS) The Central Bureau of Statistics. 2001. *Population Data in Central Java 2001*
<http://jateng.bps.go.id/b0213.htm>
- Blackburn, Susan. 2001. "Gender Relations in Indonesia: What Women Want". Lloyd, Grayson and Smith, Shannon (ed) *Indonesia Today: Challenges of History*. Singapore: Institute of Southeast Asian Studies, 270-282.
- Bleier, R. 1984. *Science and Gender: a Critique of Biology and Its Theories on Women*. Oxford: Pergamon Press.
- Brenner, Suzanne April. 1998. *The Domestication of Desire: Women, Wealth, and Modernity in Java*. Princeton, New Jersey: Princeton University Press.
- Brooks, Mark. 2004. *The Code of Marketing of Breast-milk Substitutes*. Presented at the Conference of Making the Same Perception Towards Implementation of WHO Code in Indonesia. Jakarta: January, 2004.
- Campbell, C.E. 1984. "Nestlé and Breast versus Bottle Feeding: Mainstream and Marxist Perspectives". *International Journal of Health Services* 14(4), 547-567.
- Carter, Pam. 1995. *Feminism, Breasts and Breast-feeding*. Hampshire and London: Macmillan Press Ltd.

- Cecilia-Ng. 1991. "Malay Women and Rice Production in West Malaysia". Afshar, Haleh (ed) *Women Development and Survival in Third World*. London: Longman, 188-210.
- Cholil, Abdullah. 1997. *The Mother Friendly Movement in Indonesia*. Paper Presented at "Safe Motherhood Matters: 10 Years of Lessons and Progress" an International Event for the 10th Anniversary of the Safe Motherhood Initiative, Colombo, Sri Lanka, 20 October, 1997.
- Davies-Adetugbo, Anita A. 1997. "Socio-cultural Factors and the Promotion of Exclusive Breast-feeding in Rural Yoruba Communities of Osun state, Nigeria". *Social Science and Medicine* 45(1),113-125.
- Dorosko, Stephani and Nigel Rollins. 2003. "Infant Formula Preparation by Rural and Semi-rural Women in South Africa". *Food Policy Journal* 28, 117-130.
- Dyck, Isabel, Nancy Davis Lewis and Sara McLafferty (eds) 2001. *Geographies of Women's Health*. London: Routledge.
- Ebrahim, G.J. 1978. *Breast-feeding: The Biological Option*. London: the Macmillan Press Ltd.
- Fildes, Valerie. 1986. *Breasts, Bottles and Babies: A History of Infant Feeding*. Edinburgh: Edinburgh University Press.
- Fisher, P.J. "Breast or Bottle: a Personal Choice". *Pediatrics* 72(3), 434-437.
- Frankenberg, Elizabeth, Thomas, Duncan and Kathleen Beegle. 1999. "The Real Costs of Indonesia's Economic Crisis: Preliminary Findings from the Indonesia Family Life Surveys". Labour and Population Programme: Working Paper Series, 99-104.
- Gardner, Michele & Amaliah Lila. 1999. *Indonesia: Analysis of Conflicting Crisis-related Research Results*. USAID – Final Report
- Geertz, Clifford. 1960. *The Religion of Java*. The Free Press: Glencoe
- Geertz, Hildred. 1961. *The Javanese Family: a Study of Kinship and Socialization*. The Free Press: Glencoe
- Goderbauer, H. 1987. "New Order Industrial Relations: Managing the Workers". *Inside Indonesia* 12,15-16.
- Grijns, Mies, Smyth, Ines & van Velzen, Anita. 1994. "Women at Work: Overview of the Literature on West Java". Grijns, Mies et al (ed) *Different Women, Different Work: Gender and Industrialization in Indonesia*. Aldershot: Avebury, 17-30
- Guttman, Nurit and Deena R. Zimmerman. 2000. "Low-income Mothers' Views on Breast-feeding". *Social Science and Medicine* 50, 1457-1473.
- Hayman N, Kanhutu J, Bond S, Mark, GC. 2000. "Breast-feeding and Weaning among Aborigin People in Australia". *Aboroginal Law Bulletin* 2(46), 12-14.

- Helen Keller International. 1998. "Have 30 years of Nutritional Improvements in Southeast Asia Disappeared in One Year of the Crisis?", *Indonesia Crisis Bulletin* 1(4) October, 1998.
- Helen Keller International. 2000. "Decreasing Prevalence of Maternal Wasting: Does It Indicate Increased Access to Food?" *Indonesia Crisis Bulletin* 2(4) April 2000.
- Hill, H. 1988. *Foreign Investment and Industrialization in Indonesia*. Singapore: Oxford University Press
- Huffman, Sandra L, Elizabeth R Zehner and Cezar Victora. 2001. "Can Improvements in Breast-feeding Practices Reduce Neonatal Mortality in Developing Countries?" *Midwifery* 17, 80-92.
- Hugo, GJ, V Hull, TH Hull, and GW Jones. 1987. "The Demographic Dimension in Indonesian Development". *East Asian Social Science Monograph*. Singapore: Oxford University Press.
- Hull, Valerie J. 1982a. "*Breast-feeding and Fertility: the Socio-cultural Context*". Prepared for the WHO/NAS Workshop on "Breast-feeding and Fertility Regulation: Current Knowledge and Policy Implications", Geneva, February, 1982.
- Hull, Valerie J. 1982b. "Women in Java's Rural Middle Class: Progress or Regress?" In: P.V. Esterik, ed. *Women of Southeast Asia. Occasional Paper No. 9, Center of Southeast Asian Studies*. Dekalb, III.: Northern Illinois University.
- Hull, Valerie J. 1984. *Breastfeeding and Fertility in Yogyakarta*. Population Study Centre: Gadjah Mada University, Yogyakarta. Monograph Series No. 5.
- Hull, Valerie J, Thapa, Syam and Wiknjosastro, Gulardi. 1989. "Breast-feeding and Health Professionals: A Study in Hospitals in Indonesia", *Social Science and Medicine* 28(4), 355-366.
- Hull, Valerie, Thapa, Syam and Pratomo, Hadi. 1990. "Breast-feeding in the Modern Health Sector in Indonesia: The Modern Health Sector in Indonesia: the Mother's Perspective". *Social Science and Medicine* 30(5), 625-633.
- Husken, Frans and Benjamin White. 1989. "Java: Social Differentiation, Food Production, and Agrarian Control". Hart, Gillian, et al. (ed). *Agrarian Transformations, Local Processes and the State in Southeast Asia*. Berkeley and Los Angeles: University of California Press, 235-268.
- Inch, S. 1987. "Difficulties with Breast-feeding: midwives in Disarray". Report on Meeting of Forum on Maternity and the Newborn, 2 Dec 1985. *Journal of the Royal Society of Medicine*. 80, 53-58.
- Irawan, Purwanto Wahyu. 1995. *The Growth of Exclusively Breastfed Infants*. Master Thesis. Gadjah Mada University.
- Iskandar, MB, Costello, C and Nasution Y. 1992. "Initiation and Duration of Breast-feeding in Indonesia". *Asia-Pacific Population Journal* 5(1), 89-112.

- Islam, Riswanul. 1998. *Issues in Development*. Development Policies Dept. International Labour of Geneva.
- Jaggar, Alison M. 1983. *Feminist Politics and Human Nature*. Brighton: Harvester.
- Jaspan, Helen & Hill, Lewis. 1987. "*The Child in the Family: A Study of Childbirth and Child-Rearing in Rural Central Java in the Late 1950s*". Hull: Centre for South-East Asian Studies, University of Hull, Occasional Papers no 14.
- Jay, Robert R. 1969. *Javanese Villagers: Social Relations in Rural Modjokuto*. The Massachusetts Institute of Technology Press. Cambridge Mass.
- Jerome, NW, Kandel RF, Peltó GH. 1980. *Nutritional Anthropology: Contemporary Approaches to Diet and Culture*. New York: Redgrave Publishing Company.
- Katcher, A.L. & Lanese, M.G. 1985. "Breast-feeding by Employed Mothers: a Reasonable Accommodation in the Workplace". *Pediatrics* 75, 644-647
- Kathryn, Robinson and Bessel, Sharon (ed). 2002. *Women in Indonesia: Gender, Equity and Development*. Singapore: Institute of Southeast Asian Studies.
- Koentjaraningrat. 1985. *Javanese Culture*. Singapore: Oxford University Press
- Kompas, April 16, 2000 "*Promosi PASI Langgar Aturan*" (*Breast milk substitutes Promotion breaks the rule*)
- Kompas, July 31, 2003 "*Penduduk Miskin di Indonesia 38,4 juta jiwa*" (*38.4 million poor people in Indonesia*)
- Koning, J., Nolten, M., Rodenburg, J., & Saptari, R. (ed). 2000. *Women and Households in Indonesia*. Surrey: Curzon Press.
- Kusin, JA & Kardjati S. 1994. *Maternal and Child Nutrition in Madura Indonesia*. Amsterdam: Royal Tropical Institute
- Laukaran, VH, Winikoff, B., Myers, D. 1986. "The Impact of Health-Services on Breast-feeding: Common Themes from Developed and Developing Worlds". Jelliffe, D.B. & Jelliffe E.F.P. (ed). *Advances in International Maternal and Child Health*. Vol. 6. Oxford: Clarendon Press, 121-128.
- Levine, A & Huffman, S.L. 1990. *The Economics of Breast-feeding*. <http://www.paho.org/english/HPP/HPN/BOBN.pdf>
- Lloyd, Grayson and Smith, Shannon (ed). 2001. *Indonesia Today: Challenges of History*. Singapore: Institute of Southeast Asian Studies.
- Magnis-Suseno, Frans. 1996. *Javanese Ethics and World View the Javanese Idea of Good Life*. Jakarta: Gramedia.
- Maher, V 1992a. *The Anthropology of Breastfeeding: Natural Law or Social Construct*. Oxford: Berg.

- Maher, V. 1992b. "Breast-feeding in Cross-Cultural Perspective: Paradoxes and Proposals". *The Anthropology of Breastfeeding: Natural Law or Social Construct*. Oxford: Berg. pp.1-6
- Maher, V. 1992c. "Breast-feeding and Maternal Depletion: Natural Law or Cultural Arrangements?". *The Anthropology of Breastfeeding: Natural Law or Social Construct*. Oxford: Berg, 151-180
- Mannan, HR and Islam MN. 1995. "Breastfeeding in Bangladesh: Patterns and Impact on Fertility. *Asia Pacific Journal* 10(4), 23-38.
- Manning, Chris. 1988. "Rural Employment Creation in Java". *Population and Development Review* 14(1), 47-80.
- Margawati, Ani. 1996. *Determinan Kejadian Penyakit Gondok pada Wanita Berusia 20-35 tahun di Kecamatan Srumbung, Kabupaten Magelang, Jawa Tengah (Determinants of Goiter Disease amongst Women 20-35 years old in Srumbung district, Magelang region, Central Java)*. Master Thesis. Gadjah Mada University.
- Maynard, Mary. 1994a. "Methods, Practice and Epistemology: The Debate about Feminism and Research". Maynard, Mary & Purvis, June (ed) *Researching Women's Lives from a Feminist Perspective*. London: Taylor & Francis Ltd, 10-26.
- Maynard, Mary & Purvis, June (ed) 1994b. *Researching Women's Lives from a Feminist Perspective*. London: Taylor & Francis Ltd.
- Megawangi, Ratna. 1997. *Gender Perspectives in Early Childhood Care and Development in Indonesia. The Consultative Group on Childhood Care and Development. Coordinators' Notebook No.20, 1997.*
- Mexitalia, M and Budihartani, R. 2003. "Hubungan Tingkat Pengetahuan Ibu tentang Pemberian ASI Eksklusif dengan Praktik Menyusui" (*Correlation between Level of Knowledge amongst Women between Exclusive Breast-feeding Practice and Breast-feeding Practice*). Research Report.
- Moffat, Tina. 2002. "Breast-feeding, Wage Labour, and Insufficient Milk in Peri-urban Kathmandu, Nepal". *Medical Anthropology Journal* 21 pp. 165-188.
- Momsen, Janet Henshall. 2004. *Gender and Development*. London: Routledge
- Moser, Caroline O.N. 1993. *Gender Planning and Development: Theory, Practice and Training*. London: Routledge.
- Mulder, Niels. 1978. *Mysticism and Everyday Life in Contemporary Java: Cultural Persistence & Change*. Singapore: Singapore University Press.
- Mulder, Niels. 1996. *Inside Indonesian Society: Cultural Change in Java*. Amsterdam: The Pepin Press.

- Mulder, Niels. 1996. *Inside Indonesian Society: Cultural Change in Java*. Amsterdam: The Pepin Press.
- Newman, J. 1995. "How Breast milk Protects Newborns" *Scientific American Journal* 273(6), 76-79.
- Nordenhall, Charlotta & Ramberg, Sophie. 1998. *The Relationship between Socioeconomic Standard, Knowledge about Breast-feeding and Prevalence of Exclusive Breast-feeding in the Purworejo district*. Gadjah Mada University: Community Health and Nutrition Research Laboratory, Faculty of Medicine. Reprints of the Community Health and Nutrition Research Laboratory No. 25.
- Oakley, Ann. 1993. *Essays on Women, Medicine and Health*. Edinburgh: Edinburgh University Press.
- Oey-Gardiner, Mayling. 2002. "And the Winner Is Indonesian Women in Public Life". Kathryn, Robinson and Bessel, Sharon (ed) *Women in Indonesia: Gender, Equity and Development*. Singapore: Institute of Southeast Asian Studies, 100-112.
- Østergaard, Lise (ed). 1992a. *"Gender and Development: A Practical Guide"*. London: Routledge.
- Østergaard, Lise. 1992b. "Health". Østergaard, Lise (ed). *Gender and Development: A Practical Guide*. London: Routledge, 110-134.
- Palmer, Gabrielle (1988) *The Politics of Breastfeeding*. London: Pandora
- Parawansa, Khofifah Indar. 2002. "Institution Building: An Effort to Improve Indonesian Women's Role and Status". Kathryn, Robinson and Bessel, Sharon (ed) *Women in Indonesia: Gender, Equity and Development*. Singapore: Institute of Southeast Asian Studies, 68-77.
- Parnohadiningrat, HE Sudjadnan. 2002. "Prologue". Kathryn, Robinson and Bessel, Sharon (ed) *Women in Indonesia: Gender, Equity and Development*. Singapore: Institute of Southeast Asian Studies, xxiii-xxv.
- Pearson, Ruth. 1992. "Gender Issues in Industrialization". Tom Hewitt, Johnson, Hazel and Wield David (ed) *Industrialization and Development*. Oxford: Oxford University Press, 188-210.
- Population Council. 1998. *Towards Safer Womanhood: Supporting Safe Motherhood Initiatives and Women's Participation in Development*. The Population Council Asia & Near East Operations Research and Technical Assistance Project.
- Potter, R., Binns, T., Elliot, JA., Smith, D. 2004. *Geographies of Development*. 2nd edition. Harlow: Pearson Education Limited.
- Quandt, Sara A. 1992. "Socio-Cultural Aspects of the Lactation Process". Stuart-Macadam, Patricia & Dettwyler, Katherine A (ed). *Breast-feeding: Bio-Cultural Perspective*. New York: Aldine de Gruyter, 127-144.

- Raphael, D. (ed) 1979. *Breast-feeding and Food Policy in a Hungry World*. London: Academic Press.
- Reddy, Sunita. 1995. "Breast-feeding – Practices, Problems, and Prospects", *The Journal of Family Welfare* 41(4), 43-51.
- Reid, Anthony. 1988 "Female Roles in Pre-Colonial Southeast Asia". *Modern Asia Studies* 22(3), 629-645.
- Rice, Pranee Liamputtong and Naksook, Charin. 2000. "Breast-feeding Practices among Thai Women in Australia". *Midwifery* 17, 11-23.
- Richter, K., Podhisita C., Soonthornhdhada K., Chamratriothirong A. 1992. "Child Care in Urban Thailand". *Journal of Human Lactation* 6(2), 47-48.
- Robinson, Kathryn & Bessel, Sharon. 2002. "Introduction to the Issues". Kathryn, Robinson and Bessel, Sharon (ed) *Women in Indonesia: Gender, Equity and Development*. Singapore: Institute of Southeast Asian Studies, 1-12.
- Robison, R. 1986. *Indonesia: The Rise of Capital*. Sydney: Allen and Uwin.
- Rubin, H J & Rubin, I S. 1995. "*Qualitative Interviewing: The Art of Hearing Data*". London: Sage Publications.
- Salter, Brian. 2003. "Patients and Doctors: Reformulating the UK Health Policy Community?". *Social Science Medicine* 57, 927-936.
- Saptari, Ratna. 2000. "Women, Family and Household: Tensions in Culture and Practice". Koning J, Nolten R, Rodenburg J and Saptari R (ed) *Women and Households in Indonesia: Cultural, Notions and Social Practices*. Surrey: Curzon Press, 10-25.
- Scott, AM. 1986 "Women and Industrialization: Examining the Female Marginalization". *Journal of Development Studies* 22(3), 649-680.
- Sears, Laurie J (ed) 1996. *Fantasizing the Feminine in Indonesia*. Durham & London: Duke University Press.
- Sen, Krishna. 1998 "Indonesian Women at Work: Reframing the Subject". Krishna Sen and Maila Stivens (ed) *Gender and Power in Affluent Asia*. London: Routledge, 35-62.
- Sen, Krishna. 2002 "The Mega Factor in Indonesian Politics: A New President or a New Kind of Presidency?". Kathryn, Robinson and Bessel, Sharon (ed) *Women in Indonesia: Gender, Equity and Development*. Singapore: Institute of Southeast Asian Studies, 13-27.
- Sharma, et al. 1999. *Anthropometric Status is Associated with Child Feeding Practices of Young Indonesian Children*. Working Paper.
- Singarimbun, Masri, and Manning, Chris. 1974. "Marriage and Divorce in Mojolama". *Indonesia* 17, 67-82.

- Slater, Don. 1997. *Consumer Culture and Modernity*. Cambridge: Polity Press.
- Soemantri S. 1997. *Maternal, Child and Infant Mortality in Five Provinces CHN-3*. Presented at Workshop Household Health Survey 1995.
- Soemantri et al. 1999. *Maternal Morbidity and Mortality Study: CHN-3/Household Health Survey 1995, MoH and National Institute of Health Research Development Programme*.
- Stalker, Peter A. 2000. *Beyond Krismon: the Social Legacy of Indonesia's Financial Crisis*. Report for UNICEF. October, 2000.
- Stoler, Ann. 1977. "Class Structure and Female Autonomy in Rural Java". *Women and National Development*. The Wellesley Editorial Committee (ed). Chicago: University of Chicago Press, 74-89.
- Stuart-Macadam, Patricia & Dettwyler, Katherine A (ed). 1992a *Breast-feeding: Bio-Cultural Perspective*. New York: Aldine de Gruyter.
- Stuart-Macadam, Patricia. 1992b. "Biocultural Perspective on Breast-feeding". Stuart-Macadam, Patricia & Dettwyler, Katherine A (ed). 1992 *Breast-feeding: Bio-Cultural Perspective*. New York: Aldine de Gruyter, 1-38.
- Sullivan, Norma. 2000. *Gender and Politics under the Suharto Regime, 1966-1998*. Prepared paper for the Global Network for Women Advocacy & Civil Society. <http://www.ciaonet.org/wps/sun01/sun01.pdf>
- SUSENAS. 2000. *Statistik Sosial dan Kependudukan Jawa Tengah Hasil SUSENAS 2000* (Social Statistic and Population in Central Java, based on Socio Economic Survey 2000)
- UNICEF. 2000. *Challenges for a New Generation: The Situation of Children and Women in Indonesia, 2000*. Civil Society Patterns. Draft paper.
- UNICEF. 2004. *Complementary Feeding of Young Children in Developing Countries: a Review of Current Scientific Knowledge*. http://www.unicef.org/nutrition/index_challenges.html
- UNICEF 1998 *The State of the World Children* <http://www.unicef.org/sowc98/under5.htm>
- Untoro, Rachmi. 2004. *Experience on Exclusive Breast-feeding Promotion*. Presented on Panel Discussion on 'the Roles of Communication on Exclusive Breast-feeding Promotion' SEAMEO – TROPMED, Jakarta: January 15, 2004.
- Utrecht, Artien & Sayogya, Pudjiwati. 1994. "Policies and Interventions". Grijns, Mies et al (ed) *Different Women, Different Work: Gender and Industrialization in Indonesia*. Aldershot: Avebury, 48-70.

- Van der Eng. 2001. "Indonesia's Economy and Standard of Living in the 20th Century". Lloyd, Grayson and Smith, Shannon (ed) *Indonesia Today: Challenges of History*. Singapore: Institute of Southeast Asian Studies, 181-199.
- Van Esterik, Penny. 1989. *Beyond the Breast Bottle Controversy*. New Jersey: Rutgers University Press.
- Vickers, Jeanne. 1993. *Women and the World Economic Crisis*. London: Zed Books Ltd.
- Vincent, Priya. 1999. *Feeding Our Baby*. Chesire: Hockland and Hockland Ltd.
- Weimer, J. 2001. "The Economic Benefits of Breast-feeding: A Review and Analyses". http://www.breastfeedingtaskforla.org/econ_review_bf2002.pdf
- White, Benjamin. 1989. "Problems in the Analysis of Agrarian Differentiation". Gillian Hart, Andrew Turton and Benjamin White (ed) *Agrarian Transformations, Local Processes, and the State in Southeast Asia*. Berkely and Los Angeles: University of California Press, 15-30.
- WHO. 1997. "Women's Health". *WHO Gender and Health Technical Paper*. Geneva: WHO
- WHO. 1998. *Evidence for the Ten Steps to Successful Breastfeeding*. Geneva: WHO
- WHO. 2000. *Women's Health in Gender & Development Perspectives*. Geneva: WHO.
- WHO. 2004. Trends: Reproductive Health Focus – Global Situation in Reproductive and Family Health
http://www.wpro.who.int/themes_focuses/theme2/focus3/trends/trends1.htm
- Winikoff, B & Laukaran, VH. 1988. "Breast-feeding & Bottle-feeding Controversies in the Developing World: Evidence from a Study in Four Countries". *Social Science and Medicine*. 29(7), 859-868.
- Wolf, Diane L. 1986. *Factory Daughters their Families and Rural Industrialization in Java*. PhD diss. Cornell University.
- Wolf, Diane L. 1992. *Factory Daughters: Gender, Household Dynamics, and Rural Industrialization in Java*. Berkeley: University of California Press.
- Wolf, Diane L. 2000. "Beyond Women and the Household in Java: Re-examining the Boundaries". Koning J, Nolten R, Rodenburg J and Saptari R (ed) *Women and Households in Indonesia: Cultural, Notions and Social Practices*. Surrey: Curzon Press, 85-100.
- Woodward, Mark R. 1989. *Islam in Java: Normative Piety and Mysticism in the Sultanate of Yogyakarta*. Arizona: the University of Arizona Press.
- World Bank. 1999. "Indonesia: Facing the Challenge to Reduce Maternal Mortality". *In East Asia and the Pacific Region: Watching Brief*. June 1999, Issue 3.

Yayasan Lembaga Konsumen Indonesia (YLKI) 1999: *Infant Formula & the Government Policy: Review for Breast-feeding Programmes in Indonesia*. Working Paper.

Yimyam S and M Morrow and W Srisuphan.1999. "Role Conflict and Rapid Socio-Economic Change: Breast-feeding among Employed Women in Thailand". *Social Science and Medicine*. 49 pp. 957-965.

Young, Kate. 1997. "Gender and Development". Visvanathan, N. et al. (ed). *The Women, Gender and Development Reader*. London: Zed Books, Ltd, 51-53.

--- The Javanese Family
<http://www.unu.edu/unupress/unubooks/u113se/uul13se09.htm>

--- Understanding Z-Scores
<http://tantaprojects.org/downloads/pdfs/dataanalysis/zscores.pdf>

--- Healthy Mothers, Healthy Babies Child Survival Projects. Guidelines for the Village Midwife and Traditional Birth Attendance Partnership – the *Pendampingan Strategi*". Co-financed by the Government of Indonesia and the Australian Agency for International Development
http://www.developmentgateway.com.au/pdf/health/midwife_birth_attendant.pdf

--- The Innocenti Declaration
http://www.infactcanda.ca/innocenti_declaration.htm

GLOSSARY OF INDONESIAN AND JAVANESE WORDS

Abangan	A social class amongst Javanese, classified by Geertz (1960) based on religious activity, as opposed to <i>santri</i>
Aduh biyung	Ouch mother; usually shouted when an individual gets hurt or feels a sudden pain
Adzan	The formula for the announcement of <i>shalat</i> hours, which includes the Muslim confession of the faith - the <i>syahadah</i>
Agama Jawi	A religious which is followed by Javanese; in principle <i>Agama Jawi</i> is similar with Islam
Anget	Warmth
Ani-ani	Small razor, like knife used by women to harvest rice
Amin	Ending of praying
Apem	Pancake
Babaran	Giving birth
Balita	<i>Bawah Lima Tahun</i> - Children under five years old
Batik	Cotton cloths decorated by wax - resisting and dyeing
Batih	Member of nuclear family
Bayi	Baby
Besekan	Meal box - delivered to the relatives, neighbours, friends on any ritual ceremony or occasion, such as <i>selapanan</i> , etc.
Betara Kemajaya	A male <i>wayang</i> (puppet) figure - symbolised as a handsome man
Bidan	Midwife
Bleketepeng	A peaked roof - consisting of several layers of dried coconut leaves
Bubur ponco warno	Five-coloured porridge
Brokohan	A ceremony, held on the day when the baby's born
Budaya pesisir	Coastal culture
Canting	An instrument used to draw the patterns of batik cloth with molten wax
Dawet	A kind of drink made from sugar, coconut milk and jelly-like pieces of dough, served in the <i>brokohan</i> ceremony
Didadah	A type of massage for the baby
Digendong	Carried a baby in a <i>selendang</i> or shawl looped in sling fashion over the mother's shoulder
Dringin	A motif of Javanese batik
Dukun paes or dukun manten	Bridal beautician
Dupa	Incense
Eling and prihatin	Perpetually concerned
Emah-emah	To wed or to set up a household
Gabug	Barren
Gamelan	Javanese music orchestra
Gedek	Typical of Javanese wall, which is made from plaited bamboo
Gotong royong	Mutual assistance and sharing of burdens
Griya	House; see <i>omah</i>
Grojogan	Water falls
Gudangan	Vegetable salad; see <i>urap</i>
Gula Jawa	Palm sugar

Gulai kambing	Lamb dish
Hajj	Pilgrimage to Mecca
Ibu	Mother; form of address to older woman, usually to married woman
Ikan lele	Fresh water fish
Ingkah nrimah	Accept willingly
Ingkung ayam	Chicken in coconut gravy; served in <i>slametan</i> ceremony as an offerings
Intip	Dried rice
Jagongan bayi	After the birth of the baby, the family holds an open house as soon as food can be prepared for relatives, friends and neighbours for five days and five nights
Jajan pasar	Snack meals bought in the traditional market
Jamu	Traditional herbs
Jarik	Traditional Javanese cloths made from batik
Jenang procot	Thick porridge/ pudding or sweet cake made from glutinous rice
Jogan	Packed earth
Joglo	Typical model of roofs of Javanese houses - this model usually belongs to rich family
Kabupaten	Region
Kader kesehatan	Health volunteer
Kain jarik lurik	Typical of <i>jarik</i> – but its not decorated by wax
Kampung	A residential area for people usually comes from lower socio-economic status in the urban area. In the past, in the <i>kampung</i> wards, most of the houses made from plaited bamboo or <i>gedek</i>
Katu	Leaf - which can increase produce breast milk
Kaum	Member of <i>santri</i> (the sense of Islamic community)
Kecamatan	District
Kejawen	Religion which has followed by Javanese people (<i>Agami Jawi</i>)
Kekahan	A ceremony similar with <i>selapanan</i> , but referred on Islamic principle, which is slathering animal such as goat
Keluron	Miscarriage
Kembang setaman	Five-coloured flowers
Kepel fruit	Fruit that have seeds lying in horizontal line
Kesehatan ibu dan anak	Maternal and child health
Kongres Perempuan	Conference about women
Kota atas	Uptown
Kota bawah	Downtown
Kota lama	Old town
Kotamadya	Municipality
Kost	Rent a room
Kiamat	Judgment day
Krama alus	The highest level of Javanese language
Limasan	One model of shapes of roofs of Javanese houses
Madeking	A rite during subsequent pregnancies
Krama madya	Middle level of Javanese language
Maghrib	Praying scheduled for Muslim people in the late afternoon
Mbak	Older sister; form of address to older sister and older woman
Mbangkaki	In the post-natal phase, when a woman started to breast-feed

	her baby, usually woman's breasts become a bit swollen and feel painful
Mbok mban	Childminder
Meneteki	Suck the nipple
Mess	Dormitory
Menyusui	Suckle milk
Mitoni	A ceremony to celebrate the seventh month of pregnancy; see <i>tingkeban</i>
Modin	Religious official who has been specially invited for the occasion to lead an Islamic praying (<i>ndonga</i>) which consists of one or two chapters of Qoran
Nasi aking	Mixed rice between rice and dried rice
Nasi gudangan	Rice and served with vegetable salad
Nasi Tumpeng	Rice cone
Ndonga	Praying
Ndonyane wong wedok	Women's world
Ngalor-ngidul	Going north and south; used to describe a situation in which a young couple live separately at their respective parents' houses and occasionally sleep together
Ngempeng	Suck the nipple
Ngoko	The lowest level of Javanese language
Nyuwun sewu amit-amit jabang bayi	Really really sorry
Omah	House; see <i>griya</i>
Ora ilok	Taboo, forbidden
Padi	Rice
Pancasila	Five Principles of Indonesian Nationhood
Pangreh projo	Administer of the state
Pamong praja	Foster of the state
Pasar	Market
Pasrah lan sumarah	Surrender and accept the fate
Pembantu	Maid or servant
Pegawai Negeri	Civil servant
Pendampingan	Partnership
Pengajian	Praying together and reading several chapters (<i>ayat</i>) of the Qoran
Perumnas	Housing programme which has developed by the state
Pelita	Five year development programme
Pesisir	Coastal area
Posyandu	Monthly health services
Priyayi	The highest level of social class among Javanese people
Puput puser	The umbilical cord fell off
Puskesmas	Public health centre
Puskesmas rawat inap	Public health centre for hospitalization
Qoran	The Javanese pronunciation of Al Qur'an
Repelita	Country's National Five Year Plan
Rewel	Fussy
Rujak	Fruit salad
Rukun	Harmony
Rukun wilayah	Sub-village; neighbourhood

Rumah sakit saying bayi	The Baby Friendly Hospital
Rewang	Working together amongst the neighbourhood to prepare an occasion such as <i>slametan</i> . In the past, if a family who would like to hold <i>slametan</i> , some neighbours, relatives, friends will come along working together to prepare it, for instance cooking for preparing foods
Rupiah	Indonesian currency
Sangrai	Fried without oil
Santri	Social class amongst Javanese people, classified based on religious activity as opposed of <i>abangan</i>
Sawan	Convulsions
Sayur lodeh	Vegetable dish
Selapanan	A ceremony which held when the baby's 35 days old
Selasa Pahing	Javanese cultural activities are held at regular times, partly based on the seven-day wee: <i>Minggu, Senin, Selasa, Rebo, Kemis, Jemuah, Setu</i> (Sunday, Monday, ... etc), and partly on the Javanese five-day week: <i>Legi, Paing, Pon, Wage, Kliwon</i> , but partly on a combination of the seven- and the five-day weeks, like I mentioned <i>Selasa Pahing</i>
Selendang	A small cloth wrapped around her chest
Senthir	A traditional oil lamp
Sepasar	Five days ; counted based on Javanese calendar
Sesajen	Offerings
Setu Wage	See <i>Selasa Pahing</i>
Sirih	Betel
Sila	<i>Sila</i> is the correct Javanese sitting position on the floor, which consists of folding the legs inward and crossed in front of the body, with the feet hidden under the things
Shalat	Praying according to Islamic law (<i>Rukun Islam</i>); in Islam principle, a Muslim should be praying five times a day
Slamet	Safe
Slametan	Ritual ceremony in Javanese culture
Somah	Household
Srotong	A typical roof of Javanese house
Sungsang	Breach position
Tampah	Large bamboo trays
Tebasan	A practice in which a contractor buys up the rice wholesale on the fields before harvest and then hires labours gangs to harvest it
Tentrem	Calm and peace in the heart
Tingkeban	A ceremony to celebrate the seventh month of pregnancy
Tikar	Traditional Javanese carpet made from bamboo
Urap	Vegetable salad
Weton	' <i>Weton</i> ' is derived from the Javanese word ' <i>metu</i> ', which means come out
Wong cilik	Common people; the lowest social class among Javanese people and as opposed of <i>priyayi</i>
Wilujengan	<i>Slametan</i> in <i>krama alus</i> (the highest level of Javanese language; see <i>slametan</i>)

ABBREVIATIONS

ANC		Ante Natal Care
ARI		Acute Respiratory Infection
BALITA	<i>Bawah lima tahun</i>	Children under five years old
BAPPENAS	<i>Badan Perencanaan Pembangunan Nasional</i>	The National Development Planning Board
BFHI		The Baby Friendly Hospital
BKIA	<i>Balai Kesehatan Ibu dan Anak</i>	Maternal and Children Health Programme
BKPP-ASI		Indonesian Breast-feeding Promotion Foundation
BMI		Body Mass Index
BPS	<i>Biro Pusat Statistik</i>	Central Bureau Statistics
CEDAW		Convention on the Elimination of All Forms of Discrimination against Women
CRC		Convention on the Rights of the Child
DPR	<i>Dewan Perwakilan Rakyat</i>	House of Representatives
FGD		Focus Group Discussion
GAD		Gender and Development
GBHN	<i>Garis-garis Besar Haluan Negara</i>	Broad Guidelines on State Policy
GDP		Gross Domestic Product
GNP		Gross National Product
HHS		Household Health Survey
HIV		Human Infection Virus
HKI		Helen Keller International
IBFAN		International Baby Food Action Network
IDHS		Indonesian Demographic and Health Survey
IFLS		Indonesian Family Life Survey
IGGI		Inter Governmental Group of Indonesia
IMF		International Monetary Fund
MCH		Maternal and Child Health
MMR		Maternal Mortality Rate
MoH		Ministry of Health
MPR	<i>Majelis Permusyawaratan Rakyat</i>	People's Consultative Assembly
NGO		Non Governmental Organization
PDI-P	<i>Partai Demokrasi Indonesia Perjuangan</i>	Indonesian Democratic Party of Struggle
PNS	<i>Pegawai Negeri Sipil</i>	Civil servants
PKK	<i>Pembinaan Kesejahteraan Keluarga</i>	Family Welfare Movement
PMDF		Proportion of Maternal Deaths amongst Females of

PTT	<i>Pegawati Tidak Tetap</i>	Reproductive Ages
RW	<i>Rukun Wilayah</i>	Temporary employee
		Neighbourhood; sub-village; hamlet
SIDA		Swedish International Development Authority
SUSENAS	<i>Survey Sosial dan Ekonomi Nasional</i>	National Socio-Economic Survey
UAC		Upper Arm Circumference
UN		United Nations
UNDP		United Nations Development Programme
UNICEF		United Nations Children's Fund
UNSFIR		United Nations Support Facility for International Development
USAID		United States Agency for International Development
WHA		World Health Assembly
WHO		World Health Organization
WIF		Women, Infant and Children
YLKI	<i>Yayasan Lembaga Konsumen Indonesia</i>	Indonesian Consumers Foundation

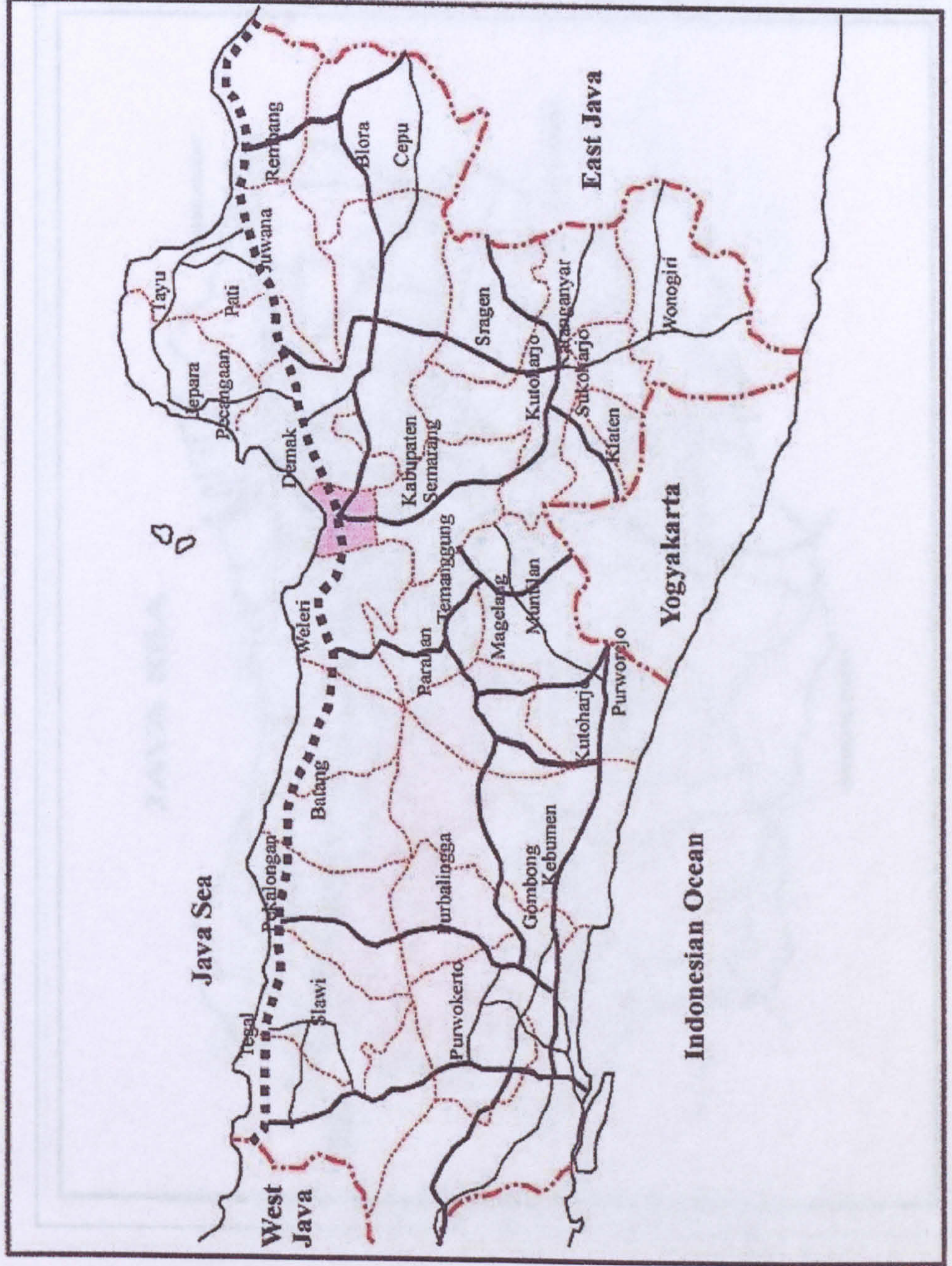
MAP OF CENTRAL JAVA
MAP OF INDONESIA



Case study boundary







MAP OF CENTRAL JAVA

MAP OF SEMARANG



MAP
RESEARCH SITE
(CENTRAL JAVA)

LEGENDS :

-  : Province Boundary
-  : Regent/City Boundary
-  : Train Track
-  : Country Street
-  : Regent/City Street
-  : Case Study District Boundary

SOURCE

North

No. of Picture

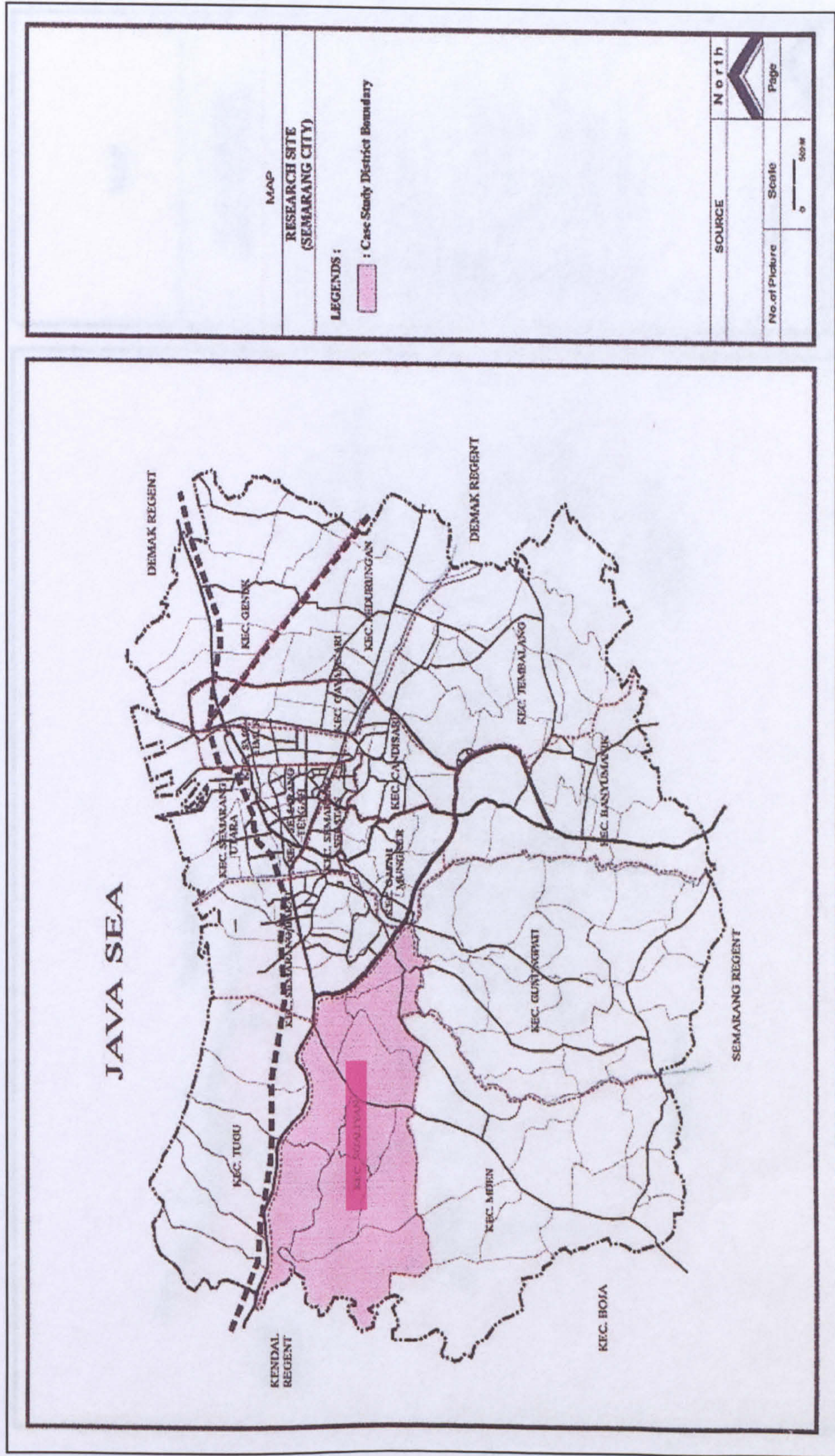
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MAP OF SEMARANG DISTRICT

MAP OF SEMARANG



MAP OF SEKAR DISTRICT

MAP

RESEARCH SITE
(SEKAR DISTRICT)

LEGENDS :

: District Boundary
 : Village Boundary
 : Street
 : River
 : The Capital of District
 : The Capital of Village
 : Market
 : Police Station Tugu Sector
 : Koramil 09 Ngaliyan
 : Case Study District

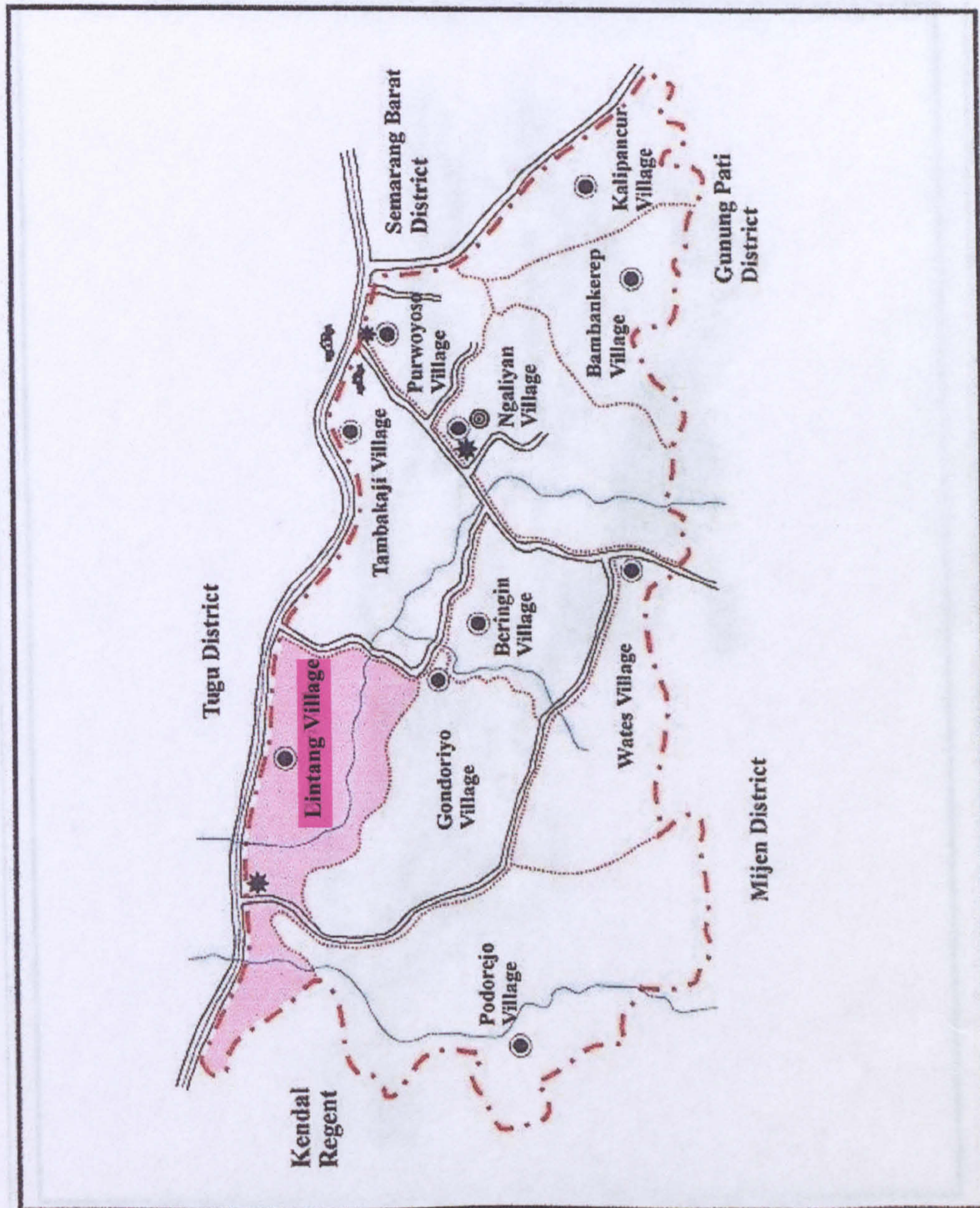
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MAP OF LINTANG VILLAGE

