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Article abstract

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A "Shortage of Women": Gender and Medical Care in the Highlands of Irian Jaya, Indonesia[1]

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Deux aspects distincts des régions montagneuses de l'Irian Jaya sont traités dans cet article: les pratiques locales qui peuvent contribuer au déséquilibre du ratio homme-femme allant jusqu'à 250 hommes pour 100 femmes; et les politiques et les pratiques régionales en matière de santé. Idéalement, les soins médicaux et les besoins de la population se complètent, mais la démographie de la région remet en question l'idée que les programmes de soins essentiels de santé profitent à tous. Ces programmes semblent répondre d'avantage aux intérêts des agents du développement en Indonésie qu'aux besoins de la communauté. Cet article suggère que même si les missionaires et le personnel médical interviennent, notamment lors d'une naissance, ils ont tendance à éviter d'aborder le sujet de la discrimination à longue durée contre les femmes. Le caractère flexible de la notion de «santé» dans le cadre des soins essentiels de santé situe les femmes dans le vide entre la politique et la pratique locale.

This paper describes two distinct features of the Irian Jaya highlands: local practices that may contribute to gender imbalances of up to 250 men for every 100 women; and regional health care policy and practice. Ideally, medical care and local needs complement one another, but the demographics of the region belie primary health care mandates to improve the well-being of all. Healing programmes appear more responsive to Indonesian development agendas than to community needs. This paper suggests that missionaries and medical staff do intervene, notably in events surrounding childbirth, but tend not to address the issue of long-term discrimination against women. The flexible nature of the concept "health" within primary health care allows women to fall into the void between policy and local practice.

Introduction

One of the recurring themes in ethnographic documents from New Guinea is a concern over gender ratios in communities scattered across the island. Recent censuses tally a ratio of 110 adult males for every 100 women in Papua New Guinea (Denoon 1989), and a figure of 112 adult males for every 100 women in Irian Jaya, the western half of the island that is now a province of Indonesia (Biro Pusat Statistik 1986). World populations average approximately 104 male infants born for every 100 females (Sieff 1990). Although more boys than girls are born, by adulthood social and environmental factors conspire to shape ratios into patterns specific to a region. Thus, New Guinea gender ratios are among the most skewed in the world. Social, environmental, biological and psychological factors have all been offered as explanations for the "shortage of women" (Seiff 1990; Miller 1984; Arnold 1991; Scrimshaw 1984; Chagnon 1979; Hill & Kaplan 1987). However, there have been few attempts to look beyond community practice and ecological factors. Ethnographic and demographic material from Irian Jaya offers the opportunity to question what effect other processes, such as available medical care, may have on local behaviour patterns that disfavour women.

The relationship between medical care and gender ratios is not one where, when care is provided, skewed demographics automatically level out. If this were the case, we might expect gender ratios in Irian Jaya to balance out in areas where medical care has been consistently available. This expectation follows from a trend in anthropology and applied health sciences to view traditional systems of care as ineffective — albeit important to local belief systems — and to propose that biomedical care is the most effective way to achieve dramatic improvements in health among Pacific populations. However, this perspective assumes that care is distributed in an egalitarian manner and that everyone benefits equally. A game of assimilation and imposition, health care in Irian Jaya is neither a battery of foreign knowledge and technology imposed on an unwilling population, nor a welcomed set of ideas bringing new hope to lives wracked with disease and mortality. On the contrary, health policies and practices reinforce relations of power. The provision of care exists within an interlocking set of power relations: those in primary health care and those encountered in local ideologies and practice. The question arises, given the egalitarian ethic that motivates the provision of health care, why demographers and statisticians continue to record skewed gender ratios. The ethnographic and demographic literature on the "shortage of women" in the Highlands region of Irian Jaya describes some of the local practices that may affect gender ratios, but does not explain why health systems appear to downplay the broader issue of women's well-being. A review of national health policies suggests that the non-medicalisation of women is a political and economic issue, one that remains unquestioned at least in part because of the malleable nature of the term "health" that lies at the basis of care. Policy makers far removed from the Irianese highlands decide who receives what care, and how to interpret "health." As a result, there is a gap between local actions and national health mandates: this paper proposes that it is mostly women who fall between the cracks.

The "Shortage of Women"

Statistical evidence from recent census reports suggests that long-term discrimination against women in the western half of the island of New Guinea in what is now Irian Jaya, Indonesia, may be the most significant factor affecting women's well-being. Throughout Indonesia, the sex ratio is 99 adult males for every 100 females (Biro Pusat Statistik 1991). In 1985, rural Irianese populations from across the entire island also had a sex ratio of 99/100, but only for infants aged 0 to 4. For children aged 5 to 14, the ratio is 121 males for every 100 females. The figures drop again from ages 15 - 40 to 93 males for every 100 females, a dip Rumbiak (1987) persuasively argues is caused by migration to urban areas. From the age of 40 onwards, the rate rises to 134/100. In the age range 45 to 49 years, the sex ratio is as high as 157/100 across the island (Biro Pusat Statistik 1986). In other words, a study of the demographics of stable rural communities shows that, in the years where the population is stable, gender ratios favour males.

This "shortage of women," and the fear of Melanesian "depopulation," have long been of concern to anthropologists who work in the western half of New Guinea (van Baal et al 1984; Oosterwal 1959; see also Rivers 1922). The apparent surplus of men in many societies in western New Guinea was linked in the early 20th century to fears that entire populations were dying out. Vertenten, a Roman Catholic missionary from the Netherlands, was summoned to Batavia (now Jakarta) in 1919 because of alarming reports from colonial staff that the the population of southwest New Guinea was slowly disappearing. Colonial officials carried out an anti-venereal disease campaign, declared successful, but gender ratios nonetheless remained skewed. When the renowned Dutch colonial official and ethnologist J. van Baal was stationed at Merauke in the 1930's, he noted what he called the "masculinization of the sex ratio in situations of population decline" (van Baal et al 1984:25). He argued this resulted from demoralisation and a loss of interest in life brought about by the onslaught of colonialism on traditional cultural and belief systems. This demoralisation, according to van Baal, simply caused more girls than boys to be born. Psychologically dysfunctional responses to colonialism has since been challenged as a viable explanation for sex ratio imbalances, notably because dramatically skewed ratios continue to be measured in New Guinea societies with little external contact. Still, throughout New Guinea the sex ratio averages around 110, and in some areas reaches 250, giving contemporary credence to colonial worries over "shortages of women."

Among highland populations of Irian Jaya, ethnographic and demographic evidence accumulated over the past 20 years suggests that skewed gender ratios consistently recur. From east to west: the Eipo

of the Mek group have a sex ratio of 190 boys for every 100 live girls (Schiefenhövel 1989); the Yali of the Sela valley average a ratio of 150/100 (Godschalk 1990); the Nduga in the central highlands rate 150/100 (Manembu 1991); the Amungme of the central area a rate of 129/100 (Manembu 1991). Compared to "normal" world rates of 104/100 to 107/100, these numbers place the highland groups listed above as consistently among the world's highest.

What is most striking about the above figures is their consistency. Men invariably outnumber women. If colonial contact does not explain this pattern, we need to look to social practices to examine their potential impact on the well-being of women. Some types of practices which have been analysed as affecting sex ratios occur in most highland populations of Irian Jaya. When life expectancy is less than 60 years of age, and most childhood deaths are caused by infections and parasitic diseases, as is the case in Irian Jaya, girls die at higher rates than boys because they are less well fed and cared for than male children (Arnold 1991; Kumar 1989; Harris 1986). Harris (1986) has also hypothesized that societies that place a high value on male work, that have a marked division of labour, and that have what might be called a hostile attitude towards women, encourage the preservation of boys and the devaluation of girls, especially when the cost of raising a girl is perceived to be high. This cluster of behaviour arguably describes Highland societies in Irian Jaya and in Papua New Guinea. For example, Schiefenhövel (1989) notes that women sustain a devalued status throughout life and that, even in later years when women no longer reproduce, men accuse women of being "witches" and seek to kill them.

Anthropologists have described many forms of human intervention that affect sex ratios: infanticide in the early months of a child's life; long-term discrimination against one sex in terms of access to quantity and quality of food; and concern over the well-being of children of one sex more than children of the other (Hyndman 1989; Schiefenhövel 1989; Harris 1986; Blausfater & Hrdy 1984; Scrimshaw 1984). A woman may induce abortion before birth when she already has the desired number of male children. This can also skew gender ratios in the long run but has considerably less impact than the practices listed above (Arnold 1991).

Of these forms of intervention, one social practice that may affect sex ratios in the Irian Jaya highlands is preferential female infanticide — that is, the deliberate death of female infants and young children. Possibly the best documented case in Irian Jaya is the work conducted in the mid-1970's by Schiefenhövel among the pygmy Eipo in the eastern highlands of Irian Jaya (Schiefenhövel 1989; 1984). Over a two-year period, Schiefenhövel explored a wide range of practices surrounding birth among the Eipo, which included the chance to observe the death of female newborns. Schiefenhövel divides infanticide rates into pre-missionary contact and post-missionary settlement in the area. In the pre-contact phase, he tallies an infanticide rate of 43% of all children born. Infant mortality excluding infanticide is a "natural" low of approximately 50 deaths per 1,000 births, which makes infanticide the most common way to end an infant's life. At birth, the sex ratio was about equal. After infanticide was taken into account, however, gender ratios rose to 190 boys for every 100 girls. By the mid 1980's, an American Evangelical missionary group established itself in the region and actively opposed infanticide. Schiefenhövel returned to examine the impact of their interventions. He noted that, although infanticide rates had dropped, the practice still occurred in almost 30% of all live births.

According to Schiefenhövel, the Eipo justify the decision to end a female baby's life based on a number of factors: on whether the child is born through extramarital affairs; on the number of children they already have; on the mother's assessment of the infant's health; and on child spacing. Male Eipo generally disapprove of infanticide and usually let the mother decide whether to keep the child, but in one case a man encouraged infanticide so that he could avoid the 5-year postpartum sex taboo. In another case a woman was going to kill her newborn daughter but changed her mind when she saw that the baby was strong and healthy (Schiefenhövel 1989). Schiefenhövel seeks to tie these observations into pan-cultural reasons for infanticide and to generate models of probability regarding reproductive behaviour. He links infanticide to higher death rates men suffer as a result of continuous warfare, because he argues the two factors help even out sex imbalances. According to Schiefenhövel, "delayed abortion" is an Eipo cultural practice that ensures a regulated population growth.

Among the Yali of the central Highlands region, Godschalk (1990) has also recorded recently that female infanticide persists despite the discouragement and condemnation of Christian missionaries

and evangelists. Godschalk notes sex ratios of an average of 150 boys for every 100 girls. The 1984 census shows how the sex ratio varies within the Sela valley area. The West Sela sex ratio is 104 males for every 100 females yet in Southeast Sela the ratio jumps to 150 males for every 100 females. In one village in Southeast Sela males outnumber females by 3 to 1. After almost 5 years of observation as a missionary between 1980-1985, Godschark argues that infanticide, though discouraged, is still occasionally practised:

> "In spite of the fact that infanticide is discouraged (and condemned) by the Christian expatriate missionaries and local evangelists, it takes place occasionally within the Christian ambience and has sometimes been carried out by baptized Christians" (ibid:6).

Godshalk theorises that infanticide cannot account for the simple fact that in all the families he studied "a lot more boys than girls were born" (ibid:8). The imbalance continues to grow, he argues, because missionaries encourage couples to sleep together, instead of in separate houses, and the Sela people have taken to imitating this "Christian" behaviour with a concomitant increase in family size and a decrease in spacing between births.

Both Godschalk (1990) and van Baal (1984) do assert that more boys than girls are born. However, their analysis stops at birth. A sex ratio is a social phenomenon, brought about by social practices (Arnold 1991). Birth is part of a life cycle, and the study of births only, albeit an important factor in explaining imbalances, neglects the study of gender relations in the wider community, relations that may also affect the long-term well-being of women.

While infanticide has been relatively well-documented in the Irian Jaya literature, long-term discrimination against women has received virtually no attention in Irian studies. And yet long-term underinvestment in women can include differential nutrition and feeding practices, as well as biases in health care, and may be more widespread than infanticide (Hyndman 1989; Arnold 1991). In the Highlands and fringe Highlands of Papua New Guinea, researchers have established that women generally have a lower nutritional intake than men - they eat less protein, and ingest significantly fewer calories than men (Hyndman 1989). Avoidance of certain foods based on gender is a principal reason for this deficiency. Other factors that influence nutritional status are patterns of food-gathering behaviour and systems of dividing and sharing food. For example, women tend to give small amounts of protein-rich foods to their children yet rarely receive large portions that they can save for their own consumption because men eat first and choose the better food items (Levelink 1991). Lower protein intake makes women less likely to reach adult status, and less able to fight off disease than their male counterparts (Hyndman 1989; see also Arnold 1991). Studies have shown that protein deficiency in itself does not contribute to skewed gender ratios. Young girls are *not* more likely to fall ill with childhood diseases than are boys. They are, however, less likely to receive medical treatment than their male counterparts (Young 1989 1981; Das Gupta 1987; Khan et al 1988).

In many countries with widespread son preference, boys end up receiving more medical care than girls. Parents take boys to clinics more often, and ensure their boy children receive treatment earlier than girls. Medical anthropologists working in Papua New Guinea and the Pacific area have suggested that medical programmes run by missionaries and by government staff alike ultimately help sick boys the most. Michael Young documents how the Catholic missionaries in Milne Bay did little to counteract the tendency for women to allow their sick boys to be hospitalised at a rate of two to one over girls (Young 1989; 1981). Using mission records, he argues that missionary ideology promoted the treatment of boys over girls; and of children over mothers. As a result, some anthropologists have concluded that medical care does little to alleviate the consequences of gender biases in societies (Frankel & Lewis 1989).

These patterns have been recorded in Papua New Guinea, but unfortunately little corroborative evidence has yet been gathered in Irian Jaya. In the Irianese highlands, ethnographers describe the missionary care that predominates in most communities. Without a doubt, missionaries in Irian Jaya try to eliminate all forms of infanticide. Both outsider and indigenous mission personnel attempt to reverse the decision of mothers to reject their newborns, and they occasionally succeed. Levelink (1991), Godschalk (1990) and Schiefenhövel (1989) have all suggested that missionaries working in the Irian Jaya Highlands, whatever their background and whatever the community they work in, take intervention in childbirth as axiomatic. However, from the scant ethnographic material available, it does not appear as though missionaries intervene as readily into patterns of discrimination against women.

Levelink (1991) describes how medical services for the Dani organise nutritional information for women, but rarely dispense it. Child weighing, immunization and family planning are the services most commonly available, and Dani women use them freely. However, no service available to the Dani provides effective intervention or information to counteract local patterns.

Interventions into cultural practices have been a central feature of relations between missionaries and Highland populations since the 1950's when the first missionaries made their way into the Jayawijaya district armed with bibles, schoolbooks and a large supply of hypodermic needles. Yet, the questionable benefit of medical care is a concern that rarely arises in discourse about the provision of services to remote areas such as Irian Jaya. On the contrary, improving access to health care in order to reduce the ill-effects of poverty has been a key rationale behind the increase in provincial medical services. As Keesing and Jolly suggest, policy makers implicated in development are often obsessed with the "exotic savage" and their exotic customs — practices such as infanticide are invariably attributed to "savage" forms of life — because places such as New Guinea "are imagined as places where peoples practicing their ancestral cultures can still be found" (Keesing & Jolly 1991:226).

Health workers may seek out infanticide and other "exotic" practices and try to control and stop them through access to information, medication, and the presentation of a different world view. On the other hand, these workers do not try to intervene in community gender relations in any significant way: perhaps gender inequality does not seem particularly "exotic" to them. Whatever individual caregivers working in the field might think about the people they treat, the boundaries of what "medical care" is in this situation are defined more by political and economic agendas than they are by constructions of people based on ideas about the "exotic." Although many providers in Irian Jaya may have heartfelt convictions that medical care improves community well-being, their good intentions should not disguise the very powerful knowledge base that serves to legitimate healing interventions.

"Health" in the Highlands

The relationship between medical care and community gender relations may at first seem tenuous. The apparent gap between the two arises from a tendency to view healing practices and the discourse that accompanies it as non-political, and as separate from the social world within which it takes place. Yet recent research has suggested that primary health care,[2] like other forms of medical knowledge, is grounded in a body of scientific medical knowledge that is neither amoral nor apolitical (Lock 1988; Justice 1986). The study of primary health care in areas like Irian Jaya is in some sense the study of medicalisation:

> "a process in which the medical community attempts to create a 'market' for its services by redefining certain events, behaviors and problems as diseases" (Lock 1992:100).

Medicalisation not only describes how medical practice creates diseases out of events and behaviours but also underscores how it reinforces social relations and inequalities (ibid). The provision of care to the remote Highlands fits within the general mandates of primary health care as defined and monitored by the World Health Organisation and affiliated agencies (World Bank 1991). As such, primary health care can be seen as a means to create a worldwide market for biomedical care.

Despite the World Health Organization's definition of health as "complete physical, mental and social well-being" (WHO 1978:2), the definition is conspicuous for its lack of qualifiers as to what health might be in a specific context or to the possibility that health varies depending on the personality, gender and politics of the person who is supposed to be healthy.[3] Biomedical models are the gold standard by which the effectiveness of programmes are measured (Justice 1986). In other words, even though health is defined at least in part as a social phenomenon, the social context which may lead to variations in health garners little attention. Not only does a biomedical approach sanction interventions that ultimately help promote a medicalised world view, but it also allows policy makers to manipulate the term "health" to fit in with other political objectives.

In Indonesia, development policy dominates health programmes. In keeping with long term development objectives, the priority for health improvement in Irian Jaya has been the creation of a comprehensive nation-wide primary health care programme. There are over 125 government health centres (*puskesmas*) in the province. There are also over 250 mission health posts. In the highlands, most treatment is given at mission posts or by paramedics

and nurses (mostly trained Irianese or missionary) at health centres. These staff provide treatment for acute illnesses and additionally have set up programmes for maternal and child health programmes, for vaccinations, and for diarrhea disease control (World Bank 1991; Yahya & Roesin ,1990).

There is no denying that in certain situations medical interventions offer extremely effective preventive and curative measures. Malaria, tuberculosis, yaws, influenza, respiratory diseases, and poor nutrition due to inadequate protein intake are ongoing problems. The province's former chief medical officer has suggested that the benefits of a disease-oriented healing programme should be obvious to all (Suriadi Gunawan, personal communication.). However, the value of a disease-oriented campaign has yet to be established, according to standard measuring techniques. Despite continued shortages of equipment and medicine, and communication problems, there is some evidence to support a decline in mortality in some regions of Irian Jaya, but the improvement is scant (Davidson 1990). The results from missionary groups are also encouraging but numbers are too small to take as adequate evidence (Manning and Rumbiak 1989). Additionally, encouraging statistics from the 1990 census that show less poverty and better health in Irianese villages should be regarded as numbers engineered for political purposes to show the positive outcome of a national anti-poverty campaign (Nafsiah Mboi, personal communication).

Medical intervention — education, admonitions, or direct action from health centre staff — that may shape gender ratios is focused on childbirth and on ensuring that infants stay healthy. One reason for the close attention to neonatal care, as opposed to later in a young girl's life, may have to do with the directives the missionaries receive from the Indonesian ministry of health:

> "to meet the special health needs of mothers, pregnant women and newborn children through promotion of attitudinal and behavioural changes conducive to safer delivery and better child health" (Government of Indonesia 1988:68).

Indonesia is a country that sees health as a result of programmes based on medical and technological interventions, as opposed to understanding health as a process that depends on individual knowledge and choice, of which medical intervention is only one part (Rifkin & Walt 1986). In a 1991 World Bank report, Indonesia describes its health care programme:

> "interventions to improve health are an important policy instrument in the government's overall strategy to alleviate poverty and improve the welfare of the Indonesian population" (World Bank 1991).

There is little organised opposition to these objectives from health groups or from political lobbyists within Indonesia. In the case of birth control, for example, previous policies were reversed,

> "following the mid-1960's political shift of power to a military government which was responsive to technocratic advice on economic and social issues and relatively unhampered by conflicting views from other quarters" (Hull & Singarimbun 1989:34).

Countrywide objectives are to lower birth rates, to reduce infant and maternal mortality rates and ultimately to control population growth (Yahya & Roesin 1990; Mboi 1992).

The link between infant well-being, local care and national policy has its locus in Indonesia's Maternal and Child Health programme (MCH). In place since the mid-1980's, the programme operates under the logic that if a child and mother survive childbirth and both remain healthy, the mother will be content with a small number of healthy children (Government of Indonesia 1988). In Irian Jaya as elsewhere in the country, the quintessentially healthy family is a small family.[4]

The majority of missionary services follow these federal guidelines and focus on child weighing, immunisation, and family planning (Levelink 1991; Schiefenhövel 1989). Despite the seeming arms-length relationship between missionaries and state services, missionaries operate in accordance with nationally-defined norms and priorities. Levelink (1991) describes how a missionary devised her own strategies for countering malnutrition among the Western Dani because she considered available programmes ineffective. For all her innovation, the missionary nonetheless worked within existing norms of acceptable health interventions. Conformity occurs in bureaucratic realms as well. A religious non-profit organisation recently assumed responsibility for paying health workers in rural areas (Manning & Rumbiak 1989). Ostensibly as a means to ensure that all workers get paid, the bureaucratization of the religious groups suggests that missionaries function effectively as an extension of government services, and work well as a tool to disseminate government policy. At the same time

that religious groups play an increasingly important role in health provision, both in the government and in the private sector, the Ministry of Health has invested heavily in health facilities in the province of Irian Jaya as a means to foster development in the region (World Bank 1991; Yahya & Roesin 1990).

Within the framework of Indonesian development goals, it is not surprising that the status of women at the local level, and interventions to improve their health, rank low on the priority list for care. One of the most effective ways for nation-wide programmes such as the MCH to legitimate intervention in social life is to manipulate categories of people. Pigg (1992) recently discussed how health development agencies can create a category of person that does not exist within the community in order to set in place development priorities. She uses the example of traditional birth attendants (TBA) as an often nonexistent group of people made real through health care programmes. In many communities in Irian Jaya, there is no such person as a traditional birth attendant. Instead, mothers, aunts, sisters and neighbours attend to childbirth. However, the invention of the category allows health officials to promote normative standards of health — standards acceptable to development objectives (Pigg 1992).

In the case of highland populations, we see the reverse happening: a very real category of person — the discriminated woman — is denied a place in health care programmes because national policy makes no room for variations at the local level. Malnutrition is seen as a province-wide problem, affecting males and females equally, and the half-hearted local programmes initiated by missionaries that try to improve nutrition standards have been, according to recent reports, remarkably unsuccessful. One possible reason for the failure may be because malnutrition is not seen as primarily a woman's problem: "nutrition and hygiene extension training is given to the women because they are responsible for the provision of food for the *family*" (Levelink 1991:21, italics added). It is not concern over women's health that makes Dani women the target of a nutrition campaign, it is their role as food providers for their families. Women are also denied their full status as adults. Levelink (1991) describes a process of "infantilisation" of Dani women when they go to mission clinics — they must bathe, they must dress and they must not take any medication home with them if they want to be served again. While Pigg's example of the traditional birth attendant as an artificial category is a telling one, omissions of categories like the "discriminated woman" are also a frequent occurrence.

How is it that medical workers do not specifically target local practices that discriminate against women if they have little problem intervening in other areas? Keesing has suggested that these kind of blinkers may have to do with what it is that people set out to look for. For example, researchers usually make sure that they find what it is they set out to see. If "exotic" behaviour is expected then exotic writings result (Keesing & Jolly 1991, Keesing 1989b). That what people see often has little to do with what is going on is a striking sociological phenomenon, but a rather dangerous one when it comes to health. Because the term "health" offers such a wealth of images, differences between definitions can almost always be traced to politics, to "who symbolizes and defines significance on whose behalf or at whose expense" (Scholte in Keesing 1987:166). Perhaps for the proponents of MCH and for the missionaries and health workers who carry out the policies, the problem of unequal care does not really exist. As Michael Young (1989) suggests, western beliefs about healing do not allow for preferences; everyone without exception deserves to live. Any yet, ironically, missionaries and MCH programmes both focus on young children, the sick ones that have been brought to them for treatment. Young has suggested that this interest in children arises from a paternalistic assumption that parents could not care for their children as well as the mission. The fact that policy does not explicitly deal with long-term discrimination against women says as much about missionary and Indonesian beliefs as it does about Highland social life. Women are non-medicalised; made to seem unproblematic when statistics suggest that there is indeed a problem worthy of serious medical intervention, according to the standards of primary health care.

Conclusion

"Health" is not a benign concept. As an exceptionally fertile ground for acting out beliefs. Health can be seen as an ideology, and ideologies, according to Keesing (1989b), hide and disguise human and political realities. Health ideologies do indeed mask national development agendas in Irian Jaya. The attitudes of a hundred years ago still prevail: disease is an obstacle to development (Denoon 1989; Foster

1987). Health care has come to be couched in nationalist objectives — that of lower birth rates, first and foremost. The totalizing discourse makes it possible to focus a good deal of attention on development concerns — healthy babies — and comparatively little on women's well-being after birth; on keeping sick children healthy rather than questioning why it is that some children get better care, and more regularly, than others.

The tendency to look only at medical care's potential benefits often overwhelms and distorts analyses of the complexities of health practices. In the Pacific, where many countries have extremely diverse populations (with different genetic, social and political histories), as well as enormous discrepancies in standards of health across very small spaces, we may need to look for the oversights in health policy and practice, and its ties to politico-moral agendas, in order to assess the ways that health care is carried out at the community level. And while the omissions will certainly vary from region to region, they are omnipresent. Health care plays an integral role in any development context; it may be time to give "health" the analytic prominence it deserves by taking off its mantle of benevolence, and by looking underneath it for the subtleties and complexities inherent in all political relations.

Notes

1. This paper arises out of an ongoing debate between the late Roger Keesing and myself. As an advisor for my doctoral research in medical anthropology, Roger had voiced concern about changes in medical practice in Pacific societies. He also challenged my tendency to cynically examine health care as highly politicised practice. I wrote this paper to challenge him — to describe a situation where the motivation to heal may actually play only a a small part in the overall process of providing care. I would like to thank Roger Keesing for engaging me in this stimulating debate. I would also like to thank Margaret Rodman for her generous invitation to present an earlier version of this paper at the 1993 CASCA meetings. Michael Kenny furnished useful critical commentary, and SSHRC and the Asia-Pacific foundation have provided financial support for archival research in Jakarta, Indonesia.

2. Denoon calls Primary Health Care ideology "a virtuous state of mind," a system doomed to remain forever incoherent because it can mean many things to many people (Denoon 1989:105). Parker (1976) found that incoherence does indeed characterise the term. In order to carry out his research, Parker found he needed to invent 92 different definitions of primary health care in order to adequately address everyone's understanding of what it meant.

3. WHO's 1990-1995 General Plan "targets" improved health 48 different ways. Of these, 41 concern the treatment of specific illnesses, and only 7 the social aspects. Not one targets emotional or perceptual issues.

4. In a country of 190 million people, and with such grave concerns about population growth that it began the transmigration programme, the largest social experiment since World War II, it should come as no surprise that Indonesian federal policy explicitly promotes small, healthy families.

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