
Lyn Parker
(The University of Western Australia)

Abstract


Introduction

The ‘moderen’

The international academic discourse of ‘the modern’ often assumes modernity to be universal. This irresistible modernity is associated with the hunger of advanced capitalism, the cultural hegemony of the West, and ways of knowing that are traceable to the European Enlightenment. With such a view, it is hard to see how modernity in postcolonial countries can be other than the mimesis of a Western model. By definition modernity implies the seductiveness of the new, of fashion, change and excitement. However, it also involves loss—of place and environment, of roots and history, of families and communities—and a splitting of new from old, of younger from older.\(^1\)

The harnessing of ‘tradition’ in service of ‘modernity’, for instance in nationalism’s ‘invented traditions’ (Hobsbawm and Ranger

\(^1\) Berman’s *All That is Solid Melts into Air* gets at this aspect of the modern: ‘Modern environments and experiences cut across all boundaries of geography and ethnicity, of class and nationality, of religion and ideology: in this sense, modernity can be said to unite all mankind. But it is a paradoxical unity, a unity of disunity: it pours us into a maelstrom of perpetual disintegration and renewal, of struggle and contradiction, of ambiguity and anguish’ (Berman 1982:5).
1983), shows the instability and malleability of both concepts. Ironically, modernity has also thrown up some reactions—localization, religious fundamentalism, ethnicization, fervent nationalism, terrorism—which effectively work against the expansionist and homogenizing tendencies of modernity. For these reasons many now see, especially in postcolonial countries, the possibility of alternative modernities. 

Modernity is both a condition and an aspiration. The tension between these two is captured in that classic 1960s term, ‘modernization’. Modernization theory assumed that some nations of the world had already reached this desirable condition and others could only work towards it. Thus, while the whole process of becoming modern assumed a linear progression—progress—towards an already-attained Western model, the very setting of this goal defined a set of hopeful, needy, and, therefore, inadequate, nations which had to undergo ‘a set of cognitive and social transformations’ (Gaonkar 1999:2, following Bell 1976):

...the growth of scientific consciousness, the development of a secular outlook, the doctrine of progress, the primacy of instrumental rationality, the fact-value split, individualistic understandings of the self, contractualist understandings of society, and so on; the social transformations refer to the emergence and institutionalization of market-driven industrial economies, bureaucratically administered states, modes of popular government, rule of law, mass-media, and increased mobility, literacy and urbanization (Gaonkar 1999:2).

In New Order Indonesia, modernization—usually called ‘development’ (pembangunan)—held sway as the state unifying discourse for thirty years of imposed social order, steady improvement in living standards, rapid depletion of natural resources and suppression of civil liberties and political expression. The Indonesian version of the modern, ‘moderen’, was and still is always positively valued. Development ‘successes’ legitimized a large range of state interventions at all levels of society, neutralized and enabled rampant corruption and disarmed critics of the regime.

Within Bali, the moderen is a hot issue and much discussed. What is at issue is not the desirability of being moderen—that is assumed throughout all levels and groups within Bali—but the particular form that being moderen in Bali should take. Debates revolve around questions of Indonesian hegemony, Balinese identity, the authenticity of Balinese culture and the threats of globalization (e.g. Picard 1990, 1996 and 1999; Putra and Vickers 2000; Rubinstein and Connor 1999; Vickers 1996:1–36). In the late 1950s the Hindu Balinese feared Islamic domination and learned to present a rationalized version of their religious practice that was acceptable to the Department of Religion (Forge 1980; Geertz 1973). In the early 1960s, the rapid growth of the Indonesian Communist Party (Partai Komunis Indonesia, PKI) collided with the interests of the armed forces, extremist Moslems and ultra-nationalists, producing a crescendo of identity politics that was to climax in Bali with the murder of perhaps one hundred thousand ordinary Balinese. The New Order period in Bali was characterized by [a] political stability, centralized authoritarianism and social order, with the dominant narrative one of development and modernization. Since 1998, the possibility for greater local autonomy vis-à-vis the central government has been seen as a

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2 The journal Public Culture recently ran a four-issue mini-series on alternative modernities, globalization, millenial capitalism and cosmopolitanism. Although the latter three topics would seem to suggest the universalizing tendencies of modernity, the series was designed to interrogate these ‘as defining sites for imagining newness in the world, for marking critically and historically transformative projects, and for the localization of global formations’ (Breckenridge 1999:ix). A recent collection of work on Bali is entitled Staying Local in the Global Village: Bali in the Twentieth Century (Rubinstein and Connor 1999) and in my reading shows the tendency of ‘the local’ to have expropriated ‘the global’ in many ways.
great opportunity by the Balinese. For the time being at least, the Jakarta government is weaker and more democratic, open to negotiation and mindful of Bali’s tourist industry, which it sees as a milch cow. It remains to be seen to what extent and in which ways Balinese relations with the dominant and largely Islamic nation-state, will be significantly altered. The central problem is how to develop, to be healthy, educated and prosperous but still be Balinese.

The development of primary health care

After the WHO conference at Alma Ata in 1978, Indonesia, like many developing countries, adopted the primary health care (PHC) principle as the basis of its health development programme. As part of this, Indonesia claimed to incorporate traditional birth attendants (TBAs) into its primary health care programmes and embarked upon crash training courses for traditional midwives, as well as a host of other measures designed to introduce simple, preventative health care into villages. Then in 1988 Indonesia joined the international ‘Safe Motherhood’ campaign, making the commitment to reduce maternal mortality by 50% by the year 2000 through the National Initiative for Maternal Welfare (Smyth 1996:133). Indonesia’s maternal mortality figures are unacceptably high, and are in the same bracket as those of India and Bangladesh rather than those of its Southeast Asian neighbours. The official rate for Bali is above the Indonesian average.

In Indonesia, the emphasis has been on the top-down provision of adequate biomedical care and on the expansion of biomedical networks to handle obstetric emergencies efficiently (Hull 1990). The state provided a two-tier system of obstetric care in village clinics and town hospitals. As part of its umbrella primary health care policy, the government claimed that it attempted to integrate traditional birth attendants into the modern health care system (Ministry of Health 1990:6). The Ministry of Health boasted that:

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3 However, Hull’s work on health care during the colonial period shows that the principles of primary health care were already being implemented in the nineteenth century, albeit on a small scale, and that the first efforts to train TBAs date from 1807 (Hull 1989; Hull 1990:5). WHO defined primary health care as that health care considered to be essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO 1978 quoted in Saunders 1989:6–7).

4 A figure of 450 deaths per 100,000 live births seems to be commonly accepted. For example, Smyth (1996:132) accepts 450 maternal deaths per 100,000 live births and USAID (1998) quotes this figure. However, WHO/UNICEF (1990) reports maternal mortality rates of 650/100,000 live births for Indonesia in 1990. The average for Asia is 420, for Singapore 45, Malaysia 69, Thailand 100 and the Philippines 162 (various sources quoted in Smyth 1996:132).

5 The figure for Bali is 780, and shows a marked increase recently, but this is probably too high. Wirawan and Linnan (1994:307) report that the increase is partly accounted for by high under-reporting in 1991, and may be due to the mathematical model used to calculate these rates. They suggest that the fixed mathematical relationship between the Total Fertility Rate and the Maternal Mortality Ratio lies at the heart of the apparent increase in the MMR. Using this model, as the TFR falls the MMR rises: as the number of births falls, the obstetric risk per birth will increase unless the risk of death is decreased at a rate commensurate with the birth rate. Thus, they suggest, the apparent increase in the MMR in Bali is a statistical artifact due to the great success of family planning in bringing down the TFR. They tested another model for measurement, the indirect sisterhood method: surviving sisters were asked if they had had any female siblings who died. This study and the experience of other experts suggest that the figure of 718 deaths per 100,000 live births is too high, and that a figure in the region of 331 and 359 deaths may be more accurate (Wirawan and Linnan 1994:308).
Indonesia is one of the first countries to integrate traditional birth attendants into the modern health care system and to train them as family planning motivators.

At present there are about 97,362 TBAs in this country who attend 80–90 percent of all births. They not only deliver babies but also assist women during prenatal periods, give advice on child care, infertility and play important ritual and religious roles (Ministry of Health 1990:6).

It is an integration which has not been without its problems (Grace 1992; Sciortino 1996; Slamet-Velsink 1996). Indeed some have questioned if there has been any integration (Sciortino 1995:233; Hull 1990:6). Despite the rhetoric of primary health care and the integration of traditional birth attendants (dukun bayi), in practice the biomedical model is the only accepted paradigm (Sciortino 1995:232ff). ‘Integration’ is a misnomer: for instance, government survey statistics on personnel attending births carefully distinguish TBAs from doctors, midwives and other medical practitioners. As Sciortino notes, ‘The integration of dukun bayi implies their retraining according to biomedical notions of hygiene and health’ (Sciortino 1995:233). Hull writes, ‘Following such training, traditional attendants are not integrated into the health care system as acknowledged members of the health service team, nor are their ceremonial practices and beliefs accepted as valid elements of maternity care procedures in the local setting’ (1990:6). In fact the use of TBAs has continued but is unmeasurable. Because TBAs generally do not keep written records, the statistics on patronage of TBAs, as well as on infant and maternal mortality associated with their utilization, are unknown.6

In this context, ‘traditional’ means ‘non-government’ is synonymous with ‘dangerous’ and is acceptable only as an interim measure (Achmad 1999:128; Hull 1990:5–6). Although the government includes TBAs in the rhetoric of its health programmes, it is on their biomedical terms. It is seen as a stop-gap measure that will not be necessary once sufficient qualified biomedical personnel are available. In fact, this view of trained doekens (TBAs)—‘to help the people temporarily’—is exactly the strategy taken in a 1937 report: the use of doekens ‘To help the people temporarily’ (Hydrick 1942 [1937]:53 quoted in Niehof 1992:168). TBAs are a ‘necessary evil’:

Due to their ignorance about the physiology and anatomy of the human body, and also not being aware of the state of health of the mothers, mortality is high both for the mothers and the babies. The Ministry of Health would like to end this malpractice. However for the time being it is not possible to prevent them from attending births. Lack of qualified midwives to replace them is one reason why the government cannot yet take steps to lessen the hazards (Subagio 1974, quoted in Sciortino 1995:233).

Tradition versus modernity in health care?

A recent spate of books and papers on birth, maternity, nursing and health care in Southeast Asia, including Indonesia, indicates both a new interest in the topic and the rapidity and extent of the ‘medicalization’ of birth and of health development in the area (e.g. Boomgaard et al. 1996, Hay 1999, Hunter 1994 and 2000, Ram and Jolly

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6 In direct contradiction with the above quote, the Ministry of Health 1999 reports that the national coverage of deliveries by health professionals (i.e. not TBAs, trained or untrained), was 62.3% in 1998; the percentage in Bali was the highest of all provinces, at 92.7%. The national figures seem very high, as under-reporting of TBA-attended births is common. Data from ethnographic and lower-level surveys throw doubt on these high figures. Cameron, for instance, notes that the 100 Villages Survey shows almost a reversal of these percentages, with TBAs attending the majority of births. She reports ‘no systematic change over the period’ [1997–1999], though the table indicates that TBAs attended 65.5% of births in 1997 and this declined to 60.5% in 1999, while professional midwives attended 24% of births in 1997 and this rose to 29.6% in 1999 (2001:57 and Table A1, 64).
The theme of opposition between tradition and modernity is salient in most of these studies. This theme is indicated by titles such as ‘Tradisi and Modern, Village and State: Emergent Tensions in a Sasak Health Quest’ (Hunter 2000) and ‘Birth and the Post-partum in Northeast Thailand: Contesting Modernity and Tradition’ (Whittaker 1999). The studies have highlighted areas of misfit or incompatibility of Western biomedicine with traditional healing (Sarwono in Boomgaard et al. 1996, Slamet-Velsink in Boomgaard et al. 1996), the existence of parallel discourses of curing and caring (Sciortino 1995 and 1996), contradictions between theory and practice (Kollmann and van Veggel in Boomgaard et al. 1996, Sciortino 1995), and tensions between outsiders and insiders (Hay 1999).

Whittaker, like other writers, reported that village women were not averse to using clinics and hospitals and had rapidly adopted a hospital birthing norm. However, she went on to describe how, in north-east Thailand, once out of hospital, new mothers went home and resumed traditional post-partum practices such as ‘roasting’ and resting by a constantly burning fire for a period of from five to eleven days. This was done in order to redress the ‘cold’ condition caused by childbirth, to dry out and cleanse the womb, to benefit from a range of practices such as massage and herbal tonics, to rest from household and work duties, and to mark and perfect the change in social status as a mother (Whittaker 1999:229–235). She suggested that in north-east Thailand,

In birthing and the postpartum period, women move between the spatially separated domains of the hospital and the home and in doing so move between discursive frameworks: the first, where discourses of biomedicine and state development prevail and the second where community discourses and meanings prevail (Whittaker 1999:216).

However, it must be noted that in Indonesia in the field of health, the negotiation of tradisi and the modern in Bali and Indonesia is not perceived by local people as a conflict (Sciortino 1995:236ff). ‘Traditional’ medicine in Indonesia is usually regarded by anthropologists as a much more holistic and integrated system of belief and action than Western biomedicine. The biomedical model is based on ‘the premise that every disease has a specific pathogenic cause, treatment of which can be best accomplished by removing or controlling that cause’ (Lockerman 1984:360 in Sciortino 1995:231). The body is regarded as a machine, and it is the perfect functioning of its parts which indicates a state of health (Sciortino 1995:231). In indigenous Indonesian medicine, the human body is thought to be a microcosm of the social, natural and supernatural macrocosm, subject to but also able to influence the social world, the forces of nature and sources of life and energy (Slamet-Velsink 1996:70). ‘Traditional health care’ assumes that disease is caused by an imbalance or disturbances, either within the human body or in the equilibrium which is believed to exist normally in the micro-macrocosmic relationship between human beings and the social and super/natural environments. The human body is thought to be permeable, the individual self partible and to exist in some sort of continuum with other supernatural beings.7

Observers of the interface between the practice of traditional and modern medicine in Indonesia frequently comment upon the openness of Indonesians in seeking different types of cures, their willingness to consult a wide

7 References on traditional medicine in Bali and Indonesia include Connor (1983); Connor et al. (1996); Lovric (1986, 1987); McCauley (1984); Mitchell (1982); Rienks and Iskander (1988); Ruddick (1980); Sarwono (1996); and Slamet-Velsink (1996).
range of practitioners and the catholic nature of their medical belief (Hunter 2000; Hay 1999; Sciortino 1995). Medical doctors and nurses are often sought early in the process of diagnosing a problem, especially as Western-style medicine is seen as quick-acting, simple and technological compared with indigenous medicine. In this sense, biomedical treatment of disease or ill-health is not seen as competing against traditional medicine but rather as just one in a range of possibilities. The apparent discursive conflict between ‘scientific consciousness, …a secular outlook, …instrumental rationality, …[and] individualistic understandings of the self’ (Gaonkar 1999:2) and a more holistic, religious and personalistic medical theory is not evident in the Indonesian resort to whatever works best.

In this paper I will argue that in Bali there has not been a switch from discourses of tradition to discourses of modernity in birthing practice, despite the ‘medicalization’ of birth apparent in the shift from home birthing in the village to delivery in village clinics and hospitals. I use my own field notes of births in a village clinic and district hospital in east Bali between 1980 and 1994 and intermittently refer to other anthropological sources. Although there are many aspects of birthing practices that could be examined, here I restrict myself to a consideration of the ritual practices of birth, sites of birth and birth attendants. I argue that in the Balinese case, there has not been a rupture between tradition and modernity, and that to represent the medicalization of birth in this manner would be to present a false split. However, the new practice of childbirth in Bali is not that indicated in government rhetoric about the integration of traditional birth attendants. That is, traditional balian manak have not been incorporated into modern birthing practice in Bali. Rather, Balinese village women are now patronising biomedically trained midwives (bidan) in village clinics, a benign community model of birthing that tolerates important traditional ritual elements.

My paper supports one of the key conclusions of Marshall Sahlins in his recent assessment of the contributions of ‘anthropological enlightenment’ in the twentieth century. He argued that anthropology has revealed an important complement of the ‘new global ecumene’: the development of ‘a self-consciousness of …culture, as a value to be lived and defended, that has broken out all around the Third and Fourth Worlds’ (Sahlins 1999:10). This new culturalism is not a naïve attempt to turn back the clock, to recover a world without technology and ‘stay traditional’. Rather it is an active project of the ‘indigeniza-tion of modernity’ (Sahlins 1999:10) which has surprised many development planners. They have found that developing countries have not become clones of the West. They have also discovered that ‘traditional’ cultures are not inevitably vulnerable to development nor are they inevitably incompatible with it (Sahlins 1999:17). ‘The struggle of non-Western peoples to create their own cultural versions of modernity undoes the received Western opposition of tradition vs. change, custom vs. rationality—and most notably, its twentieth century version of tradition vs. development’ (Sahlins 1999:11).

**Village clinic births—an indigenous modernity**

In 1980, I began doctoral fieldwork in a village, ‘Brassika’, in east Bali. I boarded in the Puri, the house of the village head and satria

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8 ‘Brassika’ is a pseudonym chosen by the village head. Fieldwork has been supported by various universities and research funding bodies—The Australian National University and The University of Western Australia, the Australia Research Council and the Spencer Foundation, Chicago. Fieldwork was sponsored by
(high-caste, royal) traditional ruler, Cokorda and his satria wife 'Gung Biyang. She was a fully trained nurse and midwife (bidan), and became a permanent civil servant and the head of the village sub-clinic (Puskesmas Pembantu). She also ran her own thriving clinic and midwifery practice. Her clinic is now housed in a three-room extension of the Puri, one in a line of shop booths on the main bitumen road, across the road from the government sub-clinic. This is her profession and the source of livelihood for herself and her household.

In 1980, most births were home births. A typical birth took place in the couple’s marital quarters in the husband’s natal house-compound. Some labouring women were unattended by traditional village midwives (balian manak), by choice or circumstance; others made some effort to be attended by these traditional specialists; a few were starting to ask for 'Gung Biyang to attend them, though she had no accommodation at this time. Three registered traditional village midwives had just attended a short training course in the use of clean instruments and hands for the delivery of babies. One of them, I Nyoman, was a balian (healer) or tukang urut (masseur); his practice consisted of bone-setting, massage, midwifery and a variety of other interventions including the manipulation of a foetus to turn it head-down. Other traditional village midwives that I came upon in Brassika included two lower satria-caste women, both of whom underwent a short course at the Puskesmas or subdistrict clinic, and three low-caste men, who were unregistered and completely untrained in biomedical midwifery.

During labour, the woman typically sat on a low stool or mat and was physically supported by her husband or other attendants such as a female neighbour, children or female affines. Balinese traditional midwives were unusual in their gender: many were male, perhaps because men dominate the healing profession (as balian) and midwifery was seen as one among many duties. By all accounts, these men usually adopted a ‘hands off’ approach, often remaining outside the building, perhaps bringing herbal or bark drinks (loloh), or oil to make the passage more slippery and hasten birth. In Margaret Mead’s field notes of births in Bayung Gde in the mountains of Bali in the late 1930s, there were experienced women present at all the births but the midwife, Nang Karma, a man, was never actively involved in the delivery. He was often present, in a token sort of way—standing outside the house ‘on duty’ and sporadically calling in to check on progress or to send in supplies—but he never delivered babies. He seems to have enjoyed some status as a source of knowledge and experience. The husband or father of the baby was usually present and centrally important and useful. He was mainly active in holding and supporting his wife from behind in her seated position with raised knees and splayed legs. Husbands frequently tended to their wives’ attire, especially headcloths, and found food, water, rope, cloth and other implements, and ran messages. Several women told me that traditional male midwives and husbands were ‘takut’ or afraid.

* Mead’s field notes of birth are treated more extensively in a forthcoming book (Parker forthcoming). I would like to express my thanks to Mary Wolfskill at the Library of Congress in Washington, for her assistance in accessing Margaret Mead’s field notes (Mead 1936–1938). Danandjaja who worked in the mountain village of Trunyan, not far from Bayung Gde states that ‘In Trunyan and Bali in general, the birth of a child is a matter for men’ (Danandjaja 1980:467, my translation).
Some women reported that they felt uncomfortable being physically exposed to view in their in-laws’ compound. Some, especially those who were reporting first births as young newly-weds, felt isolated and helpless among their affines. They were dependent upon their in-laws’ goodwill and generosity in seeking help if problems arose. One woman felt totally alone (sendirian). She had married into her husband’s Brassika family from north Bali and was quite unsupported by family or close friends.  

Mead’s field notes are valuable sources of information about birth in the 1930s. What pervades her dramatic notes is the pain, danger and uncertainty of birth as it was experienced by the villagers in the mountains of Bali in the late 1930s. The concern of those attending the birth was with the management of the labour—that the parturient woman’s pain was alleviated and shortened by correct seating position, massage, drinks, poultices, and the use of accessories such as rope; that experienced and appropriate people were there to support the mother; and that a new human being was safely delivered by the villagers in the mountains of Bali. 

The rituals surrounding the birth of a child centred on the post-partum period and on the treatment of the Kanda Mpat, or Four Siblings, which are held to accompany the new baby. The blood of birth, the amniotic waters, the umbilical cord, and the placenta embody the Four Siblings. After birth the Kanda Mpat are normally buried in the houseyard near the entrance to the house of the new parents’ meten (sleeping quarters): they are placed in a hollowed-out coconut shell wrapped in white cloth along with various symbolic foods and spices and maybe some magical letters written upon a scrap of white cloth or a piece of palm-leaf (pipit). This is a small, private ritual usually conducted by the new father and perhaps attended by only one or two other family members. A cutting of pandan (pandanus) or large pebble marks the burial spot. At the time of burial the subtle aspects of the Kanda Mpat return to the four points of the compass, where they may be identified with the Panca Maha Bhuta (Five Great Elementals: pretiwi (earth, human flesh, skin and bones), apah (water, blood and bodily fluids), teja (fire, metabolic heat), bayu (wind, breath) and akasa (ether, soul)). 

When the baby is 105 days old, the principal ceremony attached to birth is held: the nelubulanin, or three-month ceremony. This is a small, private ritual usually conducted by the new father and perhaps attended by only one or two other family members. A cutting of pandan (pandanus) or large pebble marks the burial spot. At the time of burial the subtle aspects of the Kanda Mpat return to the four points of the compass, where they may be identified with the Panca Maha Bhuta (Five Great Elementals: pretiwi (earth, human flesh, skin and bones), apah (water, blood and bodily fluids), teja (fire, metabolic heat), bayu (wind, breath) and akasa (ether, soul)). 

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is a large social celebration of a successful birth and contrasts with the actual birth, which is barely ritualized. Neighbours, friends and family are all invited. After this, the Kanda Mpat return to the baby, and from then they normally live in the vital organs of the body until death. The Balinese have considerable feelings of affection for their elder sibling guardians and routinely make offerings to them at life-cycle ceremonies.14

The anthropological literature emphasizes the co-association of the directions, colours, elements, animals, gods and the waste products of birth, the Kanda Mpat. For instance, the most powerful of the Guardian Spirits or ‘Brothers’ is the placenta. It is associated with the northerly direction, with water, with the god Wisnu (lord of water), and with the water buffalo, and bears the name Banaspati Raja. However, it is important to stress the central agency of the Kanda Mpat in the life of the individual. The ability of the Kanda Mpat to mutate is a double-edged sword—if assiduously pandered to they make fine protectors, but if neglected they can be malevolent and violent.15 Tending the Kanda Mpat means ensuring future well-being—hence the seemingly endless offerings, post-partum rituals and apparently infinite multiplication of co-associations.

The elements of the afterbirth literally and cosmologically link a child, via its mother, with its forebears. In the transformation of the Kanda Mpat in the period between birth and three months (105 days), they are considered wild, chaotic and uncontrollable, inhuman. In this period, a baby is considered not yet human; it is entirely dependent upon its mother; and if it dies it is buried with much grief but without ceremony because it is thought that the reincarnating ancestor has changed its mind and the baby still occupies the realm of the ancestors (Filloux 1991:276). The relative importance of the three-month ceremony—a large social occasion—contrasts strongly with the small, private birth ceremony. It marks the end of the baby’s transition to the realm of human beings and the return of the Kanda Mpat to the body of the baby wherein they should remain until death. It is important to understand that these two rituals are conducted as part of a series of life-cycle rituals, the manusa-yadnya, which culminate in the elaborate death rituals. These ceremonies mark ‘the passage from the innocent and inherently godlike child to the duty-bound and vulnerable adult’ (Eiseman 1990:84).

By 1992, the year of my next long stint of fieldwork, childbirth practices had changed dramatically. Nevertheless, birth remained a magically charged event that was managed and interpreted in culturally distinct ways.

By 1992, most births in Brassika occurred in the private clinic owned and run by ‘Gung Biyang. It was possible for her to accept labouring women at the government sub-clinic across the road from her private clinic and the Puri. The government sub-clinic was equipped with a high delivery bed, complete with stirrups, in a separate obstetrics room. As far as I know, this delivery room has never been used. As with her normal nursing practice, villagers preferred to see her in her non-official capacity and in a more home-like setting, and it was easier for her to receive and nurse patients

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14 Before eating, many people put aside a small portion of rice for their siblings; before she begins breastfeeding, a new mother expresses a few drops of breast milk onto the ground to feed the new baby’s Kanda Mpat; before embarking upon a difficult feat, or even before jumping into a river to bathe, children may address their elder siblings, sometimes just attending to them and sometimes asking for help or protection.

15 There is a corpus of work on the Kanda Mpat. See Hooykaas (1974) for a narrative compilation and various lists of these co-associations gleaned from local manuscripts, priestly litanies and the findings of Weck, the Chief Medical Officer in Bali in the 1930s. Eiseman (1990) is a more accessible source.
twenty-four hours a day at her home-based clinic. The women I asked about their choice of site and care during childbirth considered that it was more moderen dan bersih (modern and clean), patut (appropriate) and maju (progressive) to have their babies delivered in the clinic than at home. Although to me the clinic was neither clean, light nor cheery, they preferred it to home—they said they could rest and be well looked after, it was private and clean, and they felt that 'Gung Biyang was more knowledgeable and expert than the balian manak. A couple of women whom I asked about 'Gung Biyang’s reputation for sorcery fended off the insinuation by saying that she would not dare to practise black magic in a proper modern practice—it would be very obvious in the clinic documentation if all the patients died! As for why 'Gung Biyang’s private practice attracted many times more patients than the official government practice, the usual response was that her private clinic was open at times when the patients could come (i.e. particularly in the afternoons and evenings); it was more informal and less ‘official’ (dinas) than the clinic; although not cheaper, it was not expensive and payment was flexible; and she had a greater range of medicines than the government clinic.16

Women in labour arrived at 'Gung Biyang’s private clinic at any time of night or day. One room was a waiting room, another the dispensary and the third room was the delivery room, through which there was access to a tap and cistern. Village women gave birth on a simple, metal-framed bed in this dark and rather dank delivery room. Commonly a new mother stayed here for one night after the birth. For this accommodation and the delivery 'Gung Biyang usually charged Rp15,000 (at that time, AUD$10.00). For the actual delivery, the birthing woman, her husband and 'Gung Biyang herself were the only people that 'Gung Biyang allowed to be present—usually only the two women were there. It was often said, by 'Gung Biyang, traditional midwives and mothers alike, that husbands did not dare (sing bani, tidak berani) to attend.

'Gung Biyang’s routine preparation consisted of fetching a couple of buckets of water, pocketing a tube for sucking out the baby’s airways, placing a stainless steel basin under the bed (for the afterbirth), setting out a towel, blanket, long gauze bandage with strings at the corners (for tying around the baby’s waist), a swab of gauze on the bottle of Betadine (antiseptic), clamps, a bottle of oil, scissors, foetoscope, baby bath and rubber gloves.

Usually the woman laboured and delivered the baby lying on her back, wearing a bra and with her kain (skirt cloth) lying loosely around her. The loosening of clothing was always a precursor to the birth, both in hospitals and in the village clinic. This practice probably derived from a Balinese medical theory of the body which aimed to facilitate the flow of vital life forces and fluids through the channels of the body—hence the importance of massage and the concern with orifices.

An interesting example of the operation of this theory was the alleviation of an obstructed or prolonged labour. The pregnant woman lay

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16 Sciortino (1995:199–225) discusses the contrast between private and public practice by doctors, nurses and midwives in Java. Almost all public employees are also engaged in private practice, and, as in Brassika, private practices are usually much better patronised than government health clinics. Many of the points she makes in explaining the relative popularity of nurses’ and midwives’ private practices are relevant for Brassika. She makes the point that curative private practice is illegal for nurses, though not for midwives; as a result, she says that in private practice nurses are more careful in their diagnoses, take longer to examine and interrogate patients, more solicitous and ‘friendly’, more cautious in their administration of antibiotics, etc. than when practising in public clinics. Unfortunately, she does not consider cases where the nurse is also the midwife, as in Brassika.
on the ground and her mother-in-law touched the pregnant woman’s head with her feet three times, or, in a more highly charged variant, the mother-in-law stepped over the pregnant woman three times. The symbolic humbling of the daughter-in-law was assumed to dissolve the physical obstruction, which had been caused by arrogance or feelings of superiority from the younger women towards the older woman. The ritual restored the proper relationship between superordinate mother-in-law and subordinate daughter-in-law. The tension between parturient women and their mothers-in-law which was made explicit in this practice was obviously partly avoided when women chose the new clinic as the site for birth, though once I saw a woman labouring in ‘Gung Biyang’s clinic walk over to the central crossroads of the village and this ritual was carried out very publicly.

At ‘Gung Biyang’s clinic, the husband often sat by his wife on the bed as they awaited the birth. First-time parents were sometimes embarrassed; one woman resisted ‘Gung Biyang’s attempts to examine her internally. ‘Gung Biyang tried not to leave labouring women alone and was very encouraging, saying ‘Sakit?’ (does it hurt?), as she monitored the contractions, and, in the second stage of labour, she was gentle, encouraging and matter-of-fact, saying mostly, ‘Terus, terus’ (keep going, keep going) or ‘Duweg’ (clever girl). She did not usually administer oxytocic drugs to precipitate the birth or the delivery of the placenta, because, she said, the baby might come too quickly and tear the woman. Episiotomies were not routine and were usually avoided, she said, because she routinely oiled and massaged the genital area and eased the baby’s head and shoulders through the passage. Throughout the birth, women were usually quiet and docile, grimacing with the contractions, sometimes asking how much longer or requesting drinking water or to change positions. Some women cried, most pulled on the bedposts with raised arms. Some women were vocal with the pain—one woman was sheepish and malu (embarrassed) because of it.

After the birth, ‘Gung Biyang oiled and wiped the baby. She clamped, cut and tied the umbilical cord. She weighed and bathed the baby, wrapped the umbilical stub in the disinfected gauze bandage, then she dressed the baby and wrapped it in a blanket. Usually she then handed the baby to another woman—often the new mother’s mother- or sister-in-law. She swabbed the mother, swaddled her abdomen and dressed her. The father took the bloodied kain and towel, and carried home the basin containing the placenta and umbilicus, blood and amniotic waters which ‘Gung Biyang had swished off the vinyl-covered bed.

The mother and father did not usually have the chance to look at or hold their new baby for some time, mainly because the father usually rushed off home to bury the Kanda Mpat. The time after birth was generally relaxed, quiet and happy. The woman who had resisted internal examination was apologetic and expressed disappointment because her first child was a daughter. She was the second wife of an older man whose first wife had had no children. After the birth, ‘Gung Biyang advised her not to use family planning, commenting to me ironically that she was supposed to be the village adviser (pembimbing) on family planning!

The key Balinese ritual of childbirth, the ritual treatment of the afterbirth, survived the move away from home to clinic. The contents of the stainless steel basin—the embodied Kanda Mpat or Four Guardian Siblings—are rushed home by the new father, carefully washed, wrapped and tended, placed inside a coconut shell inscribed with letters, with offerings, and buried with due ceremony. Upon her return home, the new mother should express a few drops of breast milk upon the spot, marked
with a rock or pandanus cutting, where the placenta is buried. There is also no indication that the subsequent rituals that mark the gradual incorporation of both mother and child into the community are dying away: like weddings and cremations, 105-day ceremonies, for instance, are an opportunity for conspicuous consumption and status claims.

**District public hospital births**

In 1992, hospital births were unusual for women in Brassika. Most were problem births that had been referred by ‘Gung Biyang or emergency births transferred mid-course to the district (kabupaten) hospital, 12 kilometres away. Some educated, high-status women such as teachers planned to have their babies delivered in private hospitals in Denpasar, about 40 kilometres distant. Village women were generally too scared to go to hospital—mainly for economic reasons, but also because they were frightened by the unknown and by the stories of the harsh treatment of village women by the staff. Transport problems in getting a birthing woman to hospital were considerable, and families assumed that they would not be able to afford the medical fees and associated costs such as transport and food.

The more glaring aspects of hospital treatment of birthing women were the physical roughness, apparent lack of compassion and inattention to the women’s pain, discomfort and desires. Staff ordered women to lie down and put their legs up in stirrups. Women had to give birth in this position, even if they protested. Staff made all decisions about treatment, interventions, timing and dosages, for example, of antibiotics, vitamins and oxytocin. Episiotomies (cutting from vagina to enlarge the birth opening) were routine for first births. No one other than staff and birthing women was allowed in the labour ward ‘in order to keep everything sterile and so as not to disturb the functionaries’, as one nurse told me. Of course, the birthing environment was a long way from sterile: for instance, the flies could be rather thick, and dropped instruments were re-used. Some nurses would loosen a woman’s clothing, help her manage her hair or assist with sitting up to eat or drink, but generally, women in labour were left alone, were not engaged in conversation, nor were they consulted about action that might help them during sometimes long periods of labour. Nurses watched a lot of television. I have listened to nurses shouting at labouring women, castigating them for taking so long, for not lying down, for putting their legs up, and for not trying. I have witnessed nurses twisting hands and legs into the required position, slapping, poking, scraping, parting and roughly swabbing women.17

Village patients complained about their harsh (keras) treatment at the hands of hospital staff, whom they described as ‘sadis’ (sadists), and vowed not to return. In contrast, one comparatively wealthy hospital patient who had had two children by planned Caesar-ean section expressed satisfaction with the treatment. One reason for this difference was, no doubt, this woman’s known high social status. Another educated, high-satria woman who had lost a baby when 7 1/2 months pregnant blamed the hospital staff for incompetence and procrastination—charges that ill-educated village women would not be in a position to make.

After a hospital birth, and after the baby had been dressed and the mother swabbed and dressed, the mother moved to the general ward.

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17 My records of hospital births are similar to those published by the American midwife, Robin Lim (1994–1998). There are also resonances in my accounts of hospital births of the stern admonitions of birth attendants reported by Mead. The idea that there is a single correct labouring and birthing position is not unique to ‘traditional’ or ‘modern’ childbirth it seems.
and a normal bed, the husband came in and the staff placed the baby next to the mother on the bed. Most couples spent a gentle, quiet half-hour or more alone with the new baby before the father took the plastic bag containing the afterbirth—the contents of the bucket under the bed—home for ritual burial. The treatment of the afterbirth remains the central ritual of birth, even for hospital births. The hospital staff in Balinese hospitals—including Javanese Moslem doctors—have not attempted to rid the Balinese of this practice.

When hospital and higher-echelon health workers talked about, and even to, village people, one of the themes was dirtiness. One woman who arrived at the hospital to give birth, in extremis, was roundly criticized by nurses and midwives for not having cleaned herself after her waters had broken the previous day, and yet none of the staff cleaned her or showed her or her husband where they could get water. The woman was shunned because, the nurses said, she stank. This theme of dirt, poor personal hygiene and bad smell was not evident in 'Gung Biyang's treatment of village women.

One reason for the hospital staff’s perception of the dirtiness and ignorance of village women was that the majority of these women were sent to hospital because their condition was such that local midwives such as 'Gung Biyang were afraid to treat them. They were the emergency cases, such as that woman whose amniotic sac had broken the previous day. One distraught married couple came to 'Gung Biyang’s private clinic one day with a terribly ill baby, more than 35 days old. The mother said a child had given the baby a banana—standard food for a baby that cries a lot—and a common cause of gut obstruction and death in infants. 'Gung Biyang told them to go to the doctor at the subdistrict (kecamatan) clinic. The doctor told them to go to the district hospital. Afterwards, 'Gung Biyang said that she was very worried, that she had not been willing to take the responsibility of giving it an injection or taking any action because it was their only boy—they already had two girls—and that was why she had offered no information or opinion, just told them to go straight to the doctor. Later she went to the hospital—she was worried that she’d be blamed for the death and thought if she went to the hospital the couple would be ‘big-hearted’ towards her. Similarly with problem births—the hospital staff may have been rough or impatient with parturient women because they were left with the high-risk cases. They knew they would bear the responsibility and so they shifted their own fear of blame onto the cause as they saw it: the labouring woman. Sometimes they also blamed the village midwife for having left it so long to get to hospital, for not having cleaned the woman or for her critical condition.

**Conclusion**

Despite this harsh treatment in hospitals, I would argue that women in contemporary Bali should not be seen as the passive victims of ‘technological birth’ (Davis-Floyd 1992). Village women have not been forced to choose between two opposed ‘discursive frameworks’ of tradition and modernity (Whittaker 1999:216). Rather, in deciding against a home birth and presenting themselves at the local clinic, village women chose what they perceived to be a more appropriate site for birth, which offered a safer and more private delivery. In the Indonesian context, ’Gung Biyang was a well-trained, modern birth expert who also understood and accommodated indigenous beliefs about the body, the cosmology of birth and the ritual practices of birth. As a member of the local village community, she offered an affordable, encouraging and appropriate (cocok) environ-
ment, privacy and familiarity. Because husbands and families could visit, bring food, etc., the social character of the event was not degraded, but enhanced.

However, for those women in emergency situations who felt or were persuaded that their condition was such that the new hospital environment offered medical safety, hospitalization did not necessarily augment their birthing choices, enhance the birth experience or improve the medical outcome. Their decision was often undermined by the strangeness of the environment and the inadequate resources, arrogant attitudes and unkind practices of hospital staff.

The medicalization of birth in Bali is just one instance in a worldwide trend. However, even in sites as apparently Western and modern as hospitals, in the 1990s the Balinese play out their increasingly self-conscious discourse of Balinese identity—‘Kebalian’—expressing their unity of tradition, religion and culture (Picard 1999:17). In this paper I have focused on the ritual treatment of the Kanda Mpat and seen their accommodation in clinics and hospitals as emblematic of an inter-weaving of tradition and modernity. The Kanda Mpat have a pervasive influence throughout the life of the individual. Their transformative power, their protective value and their potential for wreaking destruction means that the focus of birth ritual is the care of the Kanda Mpat rather than the mother.

In Bali, the ritual of birth, or, more accurately, of the after-birth, is not as important as the three month ritual to formally welcome, acknowledge and name the new child. After the birth of a first child, the status of the new parents changes dramatically: from dependent, albeit grown-up, children they become adults with full citizenship rights in the village. However, birth is second to death in the number, complexity and social significance of rituals held to mark a transition in human life. Rituals make order out of indefinable chaos, control danger and incorporate natural events via cultural codes and symbols into the realm of the familiar. In the ritual care of the Kanda Mpat we can see something of Balinese attempts to control the danger of birth, albeit expressed as magical rather than physical danger. There is an explanation of the origins and interconnectedness of the universe and its features. We observe the sequestration and gradual restoration of the parturient woman and the incorporation of the new human being into society.

The discourses of metaphysical danger and of pain and possible death are now muted; the voice-over is the eloquent, modern, rational discourse of hygiene and safety. Nevertheless, the resilience of the practices surrounding belief in the Guardian Spirits proves their importance to the Balinese.

In recent years, books on the Kanda Mpat have become common in the bookshops of Bali and there are references to the care of the Kanda Mpat in some government manuals on Hindu Balinese religion. Most contain selected translations of lontar (palm-leaf manuscripts); some consist mainly of pictures of léak (spirits): severed heads, bodies with rearranged body parts or missing parts, magic letters (aksara), grotesque transformations of human figures with ogre heads, etc. When I began fieldwork it seemed that magic was not a legitimate topic for public discussion and the Kanda Mpat were not discussed in public. I

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18 See Hooykaas (1974:125–128). Works include Kanda Pat Bhuta (1981), Kanda Pat Rare (1990) and Kanda Pat Sari (1990). They are usually available in bookshops in Bali. The first government manuals were Badan Pembina Institut Hindu Dharma (1968) and Parisada Hindu Dharma (1967). The publication and distribution of this material raise interesting questions about how and why it became accessible and the role of these books in the process of ‘normalizing’ the Kanda Mpat discourse.
had the impression that it was only by becoming an initiate that one could learn about them. Now, however, information about the Kanda Mpat is openly available. When attending births in hospitals in 1992 I asked about the care of the Kanda Mpat and hospital staff directed me to these published books. Principally through these books, it seems to me, the Kanda Mpat had become a knowable and respectable element of religion (agama), although they do not appear in Balinese school textbooks for religious studies.

This public expression of what was formerly a rather secret, rarely discussed (because dangerous) subject suggests that the Balinese are finding in ‘traditional’ beliefs a symbol of modern identity and difference. The Balinese care of the Kanda Mpat is of no concern to the Indonesian state. The government has apparently deemed this a harmless cultural remnant and relegated it to a bucket under the hospital bed. Given the dogged fight of the Balinese to keep their religion and to have it registered as one of the acknowledged religions (agama) in Indonesia, the respect allowed the Kanda Mpat is significant. Balinese belief in the Kanda Mpat has its parallels in Javanese culture, with widespread belief in the sibling relationship between the baby and the after-birth (Geertz 1961:89; Hull 1990:4), and may even be pan-Indonesian (e.g. Barraud 1990:229, n.10; Niehof 1992:174). Perhaps also the ‘special place’ occupied by Balinese culture within Indonesia combined with the religiosity of Indonesian ‘national culture’—enshrined in the first principle of Pancasila, essentialized in New Order propaganda against Communism and indoctrinated through endless lessons in religious tolerance—disallowed the dismantling of this particular local tradition.

Obstetric practices in Bali changed substantially between 1980 and 1992. It is as mothers, through fertility control and obstetric and post-natal care, that women have been drawn into the net of government health care and its accompanying ideology. According to this ideology, women, as wives, housekeepers, mothers and, finally, as citizens, are responsible for family health and welfare. Government rhetoric states that improvement in family welfare is dependent upon a process of moving the mass of ordinary people from ‘traditional and static to a rational and dynamic way of thinking’ (Republic of Indonesia 1977, quoted in Sullivan 1983:168). In real life, such rhetoric is transformed into the speeches of the powerful, when hospital staff castigate and blame labouring village women for endangering themselves and their families for being dirty, late or slow in labour, or for feeding their children the wrong food. This rhetoric allows an easy but false bifurcation: village births are traditional and dirty, and hospital births are modern and clean. The discourse of Western biomedicine is hegemonic in hospitals. The talk of hospital professionals displays none of the acceptance of TBAs and traditional, holistic medical theory implied by Indonesia’s commitment to primary health care and the principles of Alma Ata.

The three main sites for childbirth—the husband’s home, the village clinic and the state hospital—can be seen to display increasing degrees of the moderen, yet nowhere does the model modern shine clearly. Even at that most modern of state institutions, the hospital, the moderen melds with tradisi in practices such as the loosening of the kain and the treatment of the placenta. Further, inadequate resources and equipment, hospital procedures such as record-keeping and the training and attitudes of the staff present a picture of biomedicine which bears little relation to First World models.

In moving to so-called modern and progressive hospitals to give birth, Balinese village women subject themselves to sometimes considerable vilification as dirty, old-fashioned and
ignorant. Hospital staff only acknowledge as modern and enlightened those higher-class women who submit docilely and in good time to a planned birth by Caesarean section. Hospital staff, and even sometimes villagers, express the ‘discursive split’ described by Whittaker, but this persists alongside practices which suggest that indigenous belief-systems continue to have currency. The ‘scientific consciousness, …secular outlook, …instrumental rationality, …[and] individualistic understandings of the self’ (Gaonkar 1999:2) required by modernity seem elusive.

In village clinics, where midwives and clients are mutually dependent for service, are often known to each other in other contexts, and must operate within a moral community, village women are more likely to be encouraged, not rebuked, during childbirth. In the clinic, birthing women are not subject to impersonal treatment. Indeed, we have seen how one woman’s difficult labour was treated by ritually restoring the equilibrium which is believed should exist in the family relationship. Like hospital staff, village midwives do not want to be blamed when things go wrong, but they are also concerned to appear supportive and ‘big-hearted’ to their clients. In the birthing practice of village clinics the Balinese are creating their own version of modernity.

References

Achmad, J.

Badan Pembina Institut Hindu Dharma
1968 *Pedoman Mengadjar/Tjeramah Agama (Hindu Dharma).* Denpasar.

Barraud, C.

Berman, M.
1982 *All that is Solid Melts into Air.* London: Verso.

Boomgaard, P., R. Sciortino and I. Smyth (eds)

Breckenridge, C. A.

Cameron, L. A.

Connor, L. H.
Connor, L.H., P. Asch and T. Asch  

Danandjaja, J.  

Davis-Floyd, R.  

Eiseman, F.D., Jr.  

Filloux, A.  

Forge, J.A.W.  

Gaonkar, D. P.  

Geertz, C.  

Geertz, H.  

Grace, J.  

Hay, M. C.  

Hobsbawm, E. and T. Ranger (eds),  

Hooykaas, C.  
Hull, T.

Hunter, C.

Kanda Pat Bhuta

Kanda Pat Rare

Kanda Pat Sari

Kollmann, N. and C. van Veggel

Lim, R.
1995a ‘Notes from a Midwife’s Journal,’ *BirthKit* 8 Winter:3+.

Lovric, B.


Parker, L. Forthcoming Birth in Bali. Book manuscript.


Rice, P.L. and L. Manderson (eds)  

Rienks, A.S. and P.Iskander  

Rubinstein, R. and L.H. Connor  

Ruddick, A.  

Sahlins, M.  

Sarwono, S.  

Saunders, P.J.  

Sciortino, R.  
  

Slamet-Velsink, I. E.  

Smyth, I.  
Sullivan, N.

USAID

Vickers, A. (ed.)


Whittaker, A.

Wirawan, D.N. and M. Linnan

WHO/UNICEF
1990 http://www.unicef.org/reseval/maternal.htm#t3 accessed 4.9.00