“HOW TO MAKE THEM STAY?”

Understanding the Challenges and Motivations of Nurses and Midwives Working in the Village Health Posts in Agats, Akat and Sawa Erma Sub Districts, Asmat District, Papua Province, Indonesia

Miladi Kurniasari
Student Number : 5724880

Supervisor : Dr. Winny Koster
2nd Reader : Drs. Erica van Der Sijpt

The Amsterdam Master’s in Medical Anthropology (AMMA)
University of Amsterdam
August 2008
“HOW TO MAKE THEM STAY?”

Understanding the Challenges and Motivations of Nurses and Midwives Working in the Village Health Posts in Agats, Akat and Sawa Erma Sub Districts, Asmat District, Papua Province, Indonesia

Miladi Kurniasari
Student Number : 5724880

Supervisor : Dr. Winny Koster
2nd Reader : Drs. Erica van Der Sijpt

The Amsterdam Master’s in Medical Anthropology (AMMA)
University of Amsterdam
August 2008
ACKNOWLEDGEMENT

This thesis would not have been completed without the generous support, contribution and encouragement of various people and institutions. I would like to address my deepest gratitude particularly to Dr Winny Koster for her advice, patience, close guidance and kindness that significantly helped me to shape my ideas and thoughts throughout the composition of my research proposal, field work and the writing of this thesis. I include Dr Erica van Der Sijpt for her effort to shape the research questions and to strengthen the theoretical concept of this thesis with her detailed input, flexibility and positive support that helped me to improve my analysis. Both of them have maintained my spirit during the hard time.

I have respect for all the AMMA lecturers and staff for providing a warm atmosphere during my study in AMMA. Special thanks for Peter Mesker and Trudy Kanis for all their technical support during the year. My respect to Prof Dr Sjaak van der Geest and Prof Dr Ria Reis who significantly supported my strength and balance during the toughest moments I had in AMMA. I thank all AMMA 11 fellows, for being true friends through all the bad times and good times I had. To Julia Challinor, no words in this world can express my appreciation for her continuous help and input, especially during the writing process of the thesis.

Special gratitude and appreciation to the Governement of Asmat, the District Health Office in Asmat, Puskesmas Agats and Sawa Erna, for their permission and kind cooperation during my fieldwork. Thank you to Dr Amran and Dr Rusmiati at the Indonesian Ministry of Health, the staff at the Center of Health Staff Education in Jakarta for providing me with valuable literature. I thank MSF Belgium in Jakarta and Asmat for all their technical support during the fieldwork. I am grateful to all participants who shared their experiences and thoughts with me. From them I have learned a lot about the family values. They also have broadened my horizon about issues of health human resources.

I thank my beloved family, Bapak, Ebok, Mas Ekky, Mba Dina, Mas Iwan, Mas Alfa, Dyan, Mba Mimin, Mas Dani, Adek Sari dan Aldira for their love, support and inspiration to keep me going on. I love you so much. My second family in Meer en
Vaart, Theo, Ina, Mba Nuning and Rosa, because of them, Meer en Vaart has become a real home for me. Thank you to Mba Nuning for being a friend and psychologist to me.

Finally, I thank the Netherlands Education Support Office, for facilitating the rare opportunity for me to study medical anthropology at the University of Amsterdam. It has been a valuable experience and will allow me to contribute to the health field in my beloved country, Indonesia.
SUMMARY

Asmat is a district in Papua Province, Indonesia, with relatively poor health indicators which relates to the rampant infectious disease (associated with ecological profile of the area) and the poor availability of healthcare services. This healthcare services condition is due not only to difficult geographic access, but also to the socio cultural aspect of the population, as well as the Asmat political and economic factor related to the Government of Indonesia' decentralization policy and Asmat's status as a new district in 2002.

Based on my observation during my work with MSF in Asmat, the village health posts were frequently un(der)staffed. The nurses and midwives who assigned in this posts were usually absent and chose to stay in the capital of the sub district for various reasons. This absence leaves the community without health service, and moreover, complicates the effort to improve Asmat's poor health indicators. Thus, efforts to improve the health staff attendance in the village are crucial to make health services accessible for the beneficiaries. By understanding the experience and motivation of nurses and midwives, who live and work in the village health posts, in relation with the Asmat's context, I try to identified which aspects considered as challenging and motivating by the nurses and or midwives, with regard to their decision either to stay and work in their health post. The critical medical anthropology perspective and the theoretical concept of agency and motivation; are used as a framework to analyse my findings.

The fieldwork were done from the second week of May to the third week of June 2008; and took place in the sub district of Agats, Akat and Sawa Erma, of Asmat District. There were two groups of population participated in the study: (1) the nurses and midwives; who were previously or currently work at the village health posts, and (2) the stakeholders such as governmental officials, health authorities, priests, trader, and MSF staff. Various qualitative techniques were used to generate the datas. Ten nurses and midwives were interviewed to gain understanding about their experiences on staying and working, or leaving the village health post. Participant observatory by living together with one midwife in Pustu Bu Agani provided more insight about midwife' daily life, including her work, at the village health post. The 25 stakeholders provided more information about the context and served to ‘triangulate’ the data from
the nurses and midwives. Participant observatory by living in the capital of Sawa Erna (Pos) and sub district of Agats (Agats) has provided more insight in regard to the challenges to live in Asmat.

The study concluded that the decision making to stay and work in the village health posts of Asmat is influenced by both personal circumstances and structural aspects of Asmat. The personal circumstances of the health staff are their relationships with their family (including their husband, children) and other personal relationship, motivation to pursue the status of a civil servant, and to obtain higher educational degree. They are all tied up in the health staff’s motivation to form a ‘harmonious family’. Furthermore, I argue that all structural aspects that affect the aforementioned personal circumstances and motivations of the health staff are considered important in their decision to stay, and work, or to be absent in the village health post of Asmat.

The environmental aspects of distance, availability of food in the village, and the natural resources of gaharu in the village, which provides business opportunity for the husbands of the midwives, were considered important by the health staff.

The social and cultural aspects; which considered as important by the health staff are educational facilities for the children, the perception about the ‘weird’ culture of the Asmat community, the experience of violent behavior by the villagers, the semi nomadic pattern of life, local language and the existence of traders in the village.

The decentralization and status of Asmat as a new district, provided a rapid infrastructural development and created business opportunities for the husbands of the midwives. The vacant civil servants employment is an important aspect both for the health staff and the husband’s of the midwives. The political status of Asmat has caused the ‘political loss’ for the health system and policy. The current relatively high incentives is motivating, but also creates less motivation, due to the poor transparency of financial management at the Puskesmas (Community Health Center) and Dinkes (District Health Office) level. The cheaper cost of living in the village is a reason for the health staff to decide to stay in the village.

At the level of health system and policy, I provided the aspects considered important by the health staff, including some practical recommendations to improve the motivation of the health staff to stay and work in the village health posts. These recommendations are addressed to the Dinkes, Puskesmas, MSF, and the health staff who works in the village. The recommendations include the consideration of putting back in practice of the old management system before Asmat become a new district,
i.e.; the transportation management, which allow monthly travel by the health staff to the capital, to distribute food/drugs/monthly salary fund from Puskesmas to the villages, conduct regular supervision, even providing support such as stationary, or report template. These are example of practices that can be implemented to improve the working spirit of the staff.

Other recommendation are transparency of the financial management of incentives and training opportunities, improving the drug procurement and distribution system, also improving the housing facilities; are important factors that supports the life and work in the village. Providing entertainment, communication facilities, and posting more than one person in the village; are some options to reduce the feeling of solitude. Organizing better medical service by regulating medical consultation schedule together with the Puskesmas and the head of the village, developing simple guideline for diagnostic and treatment, workshop about the ‘cultural friendly’ delivery care, and enroll the community health volunteers (kadars) as translator during the consultation, are some ways to improve the quality of medical services. Finally, initiating a research project to understand the health and illness beliefs of the Asmat community, including their perception of health, illness, health seeking behavior, perception towards western medical treatment. The result will be useful to define strategy for a ‘culturally fit’ medical service, including referral system, and ensure the drug compliance for the community.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENT</td>
<td>ii</td>
</tr>
<tr>
<td>SUMMARY</td>
<td>iv</td>
</tr>
<tr>
<td>ABBREVIATIONS</td>
<td>xi</td>
</tr>
<tr>
<td>GLOSSARY</td>
<td>xii</td>
</tr>
<tr>
<td>CHAPTER ONE</td>
<td>1</td>
</tr>
<tr>
<td>INTRODUCTION: &quot;WHY ASMAT?&quot;</td>
<td></td>
</tr>
<tr>
<td>Introduction to the problem: Why Asmat?</td>
<td>2</td>
</tr>
<tr>
<td>Research Objective</td>
<td>4</td>
</tr>
<tr>
<td>Research Questions</td>
<td>5</td>
</tr>
<tr>
<td>Critical medical anthropological perspective</td>
<td>5</td>
</tr>
<tr>
<td>Outline of thesis</td>
<td>6</td>
</tr>
<tr>
<td>CHAPTER TWO</td>
<td>7</td>
</tr>
<tr>
<td>FIELDWORK SETTING AND CONTEXT OF ASMAT:</td>
<td></td>
</tr>
<tr>
<td>&quot;A GLIMPSE OF ASMAT&quot;</td>
<td></td>
</tr>
<tr>
<td>The Setting: The ‘Fierce’ of Asmat</td>
<td>7</td>
</tr>
<tr>
<td>Demography, environmental and logistical aspects</td>
<td>8</td>
</tr>
<tr>
<td>Asmat and Papua: economy, politics and historical background</td>
<td>11</td>
</tr>
<tr>
<td>Asmat: Socio cultural aspects</td>
<td>12</td>
</tr>
<tr>
<td>Asmat’s health Indicators</td>
<td>14</td>
</tr>
<tr>
<td>Asmat’s health system and policy</td>
<td>14</td>
</tr>
<tr>
<td>The normative concept of pustu and polindes</td>
<td>15</td>
</tr>
<tr>
<td>The discrepancy of health services: The normative vs. the actual work</td>
<td>17</td>
</tr>
<tr>
<td>CHAPTER THREE</td>
<td>19</td>
</tr>
<tr>
<td>LITERATURE REVIEW: &quot;WHAT IS MOTIVATION ANYWAY?&quot;</td>
<td></td>
</tr>
<tr>
<td>Theoretical concept</td>
<td>19</td>
</tr>
<tr>
<td>Agency</td>
<td>19</td>
</tr>
<tr>
<td>Motivation</td>
<td>22</td>
</tr>
<tr>
<td>Previous studies about motivation among health staff</td>
<td>24</td>
</tr>
</tbody>
</table>
CHAPTER 4 27
METHODOLOGY: "THE JOURNEY OF ASMAT"

- Study type 27
- Study location 28
- Study population and sampling 29
- Data collection techniques 30
  - Review of documents 32
  - Interview with the nurses and midwives 33
  - Interviews with the stakeholders 34
  - Participant observation 35
- Challenges 36
- Data processing and data analysis 36
- Ethical considerations 37
- Reflection on my position in the field 38
- Limitations 40

CHAPTER FIVE 41
"THE CONTINUOUS CHANGE OF ACTIONS INFLUENCED BY PERSONAL CIRCUMSTANCES"

- Life history 1: Family ties of Sondang 41
- Life history 2: Nurdin’s ultimate goal to become a civil servant 47

DISCUSSION 54
- Initial ‘constructed’ decision of the health staff 54
- The ongoing experiences: the subtle change of motivation and behavior of staying and absence in the village health post 55
  - Spouse’s Job 56
  - Children’s Education 56
  - To pursue further study 57
  - Private Emotion 57

CHAPTER SIX 59
"THE INTERRELATED STRUCTURAL ASPECTS OF ASMAT INFLUENCING THE LIFE AND WORK OF THE HEALTH STAFF"
WORKING IN THE VILLAGES
Life in the village as an individual and as family 59
The experience of solitude and entertainment 61
Limitations of food 62
Religion 63
Relation with the villagers 64
The work in the village health post 65
Transportation: The main obstacle 65
Housing and clinic facilities 68
Medical equipment and drugs availability: Distribution and procurement complications 70
Medical consultation 74
Drug preference and compliance 78
Referral complications 79
Assisting deliveries 80
The satisfaction of the community towards the available health service 82
The hunger of “attention” from above 84

CHAPTER SEVEN 88
CONCLUSION AND RECOMMENDATION:
“HOW TO MAKE THE HEALTH STAFF STAY?”
The relation between the health staff and the complex structure of Asmat 88
The relation between personal aspects, motivation and the decision to stay and work in the village 89
Structural aspects influencing the decision to stay and work in the village and the recommendations 90

REFERENCES 99
Annex 1 – Problem analysis diagram “Poor health status of Asmat” 104
Annex 2 – Problem Analysis Diagram: “Absence of Health Staff: Personal and Structural Aspects” 105
Annex 3. Population Figure per Sub District 108
Annex 4. List of Stake Holder included as participants 109
ABBREVIATIONS

Dinkes : *Dinas Kesehatan* means District Health Office
MSF : *Médecins Sans Frontières*
PNS : *Pegawai Negesi Sipil* means civil servant
PTT : *Pegawai Tidak Tetap* means temporary worker

*Puskesmas* : *Pusat Kesehatan Masyarakat* means Community Health Center
SK : *Surat Keputusan* means *Decree Letter* stating the status of civil servant

Pustu : *Puskesmas Pembantu* means A village health post with one or two nurses, and/or midwife, which is responsible only for outpatient medical service

Polindes : A village birth centre, which is staffed by a midwife who attends the deliveries and supports the ante- and post-natal care provided by *Puskesmas* outreach staffs
**GLOSSARY**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bevak</td>
<td>Temporary house in the jungle</td>
</tr>
<tr>
<td>Bidan Desa</td>
<td>Midwife work in the village</td>
</tr>
<tr>
<td>Ganggu-ganggu</td>
<td>Like to irritate</td>
</tr>
<tr>
<td>Minilok</td>
<td>Monthly meeting at <em>Puskesmas</em> to discuss planning and evaluation program</td>
</tr>
<tr>
<td>MSF</td>
<td><em>Médécins Sans Frontières</em></td>
</tr>
<tr>
<td>Niat</td>
<td>True willingness</td>
</tr>
<tr>
<td>Pra Jabatan</td>
<td>Civil servant briefing</td>
</tr>
<tr>
<td>Rezeki</td>
<td>Money, fortunate</td>
</tr>
<tr>
<td>Warung</td>
<td>Shop</td>
</tr>
</tbody>
</table>
CHAPTER ONE
INTRODUCTION
“WHY ASMAT?”

Before studying in AMMA (The Amsterdam Masters in Medical Anthropology), I worked as a medical doctor for Médecins Sans Frontières (MSF) in the Asmat district, Papua province. One of my responsibilities was to organize and conduct trainings to build the capacity (clinical skill and knowledge) of the local health staff especially the midwives and nurses who worked at the village level. Initially it was exciting to conduct trainings and to observe the results but later the health staff resisted and adapted the training in unpredictable ways. One of my main frustrations was the absenteeism of some health staff at the village level. This meant that they did not implement the knowledge and skills learned from the trainings in their clinical practice. At a certain point, I (and even my colleagues) labeled the staff as ‘poorly motivated’ or even ‘lazy’.

Papua is recognized by outsiders as having harsh living conditions. A colleague of mine, a female medical doctor from Java who has been working in Asmat since 2007, once said ‘You know, even the name of this place is Asmat, an abbreviation of Asal Mau Tahan [means as long as you endure]’. When I decided to do my thesis research in this place my father commented, ‘Why did you choose such a difficult and expensive place? Why aren’t you doing it in Java, near our city, Malang, East Java? It’s nearer, easier and cheaper’.

Due the difficult living and working conditions in Asmat, which I myself have experienced, I was amazed that some midwives and nurses stayed and worked in the remote villages for more than ten years. Since then, I have been puzzled with the incongruity: If all health staff experienced the harsh condition as I had, why do they stay? And why have the others left?

---

1 MSF (Médecins Sans Frontières) is an international medical NGO. They have been working in Asmat since March 2006. Since a measles epidemic intervention on March-June 2006, MSF has been supporting the local governmental effort of a 3 year project called ‘availability to Primary Health and Emergency Care with emphasis on Mother & Child Health in the Sub-districts of Agats, Akat and Sawa Erma/District of Asmat Papua/Indonesia’
Introduction to the problem: Why Asmat?

'The most important component of a health system is human resources. This is not just because ...(most) of health system expenditure is on human resources, but also because the nature of health care places great emphasis on the availability and functionality of human resources.'

(Chopra and Sanders 2004: 48)

Asmat is a district in Papua province with relatively poor health indicators, which is illustrated by the extremely high rate of maternal and child mortality. UNICEF (2006) estimates the Maternal Mortality Ratio (MMR) at 400-1100 per 100,000 live births and the Infant Mortality Rate (IMR) at 60-150 per 1000 live births, far above the Indonesian average of 230/100,000 MMR (WHO 2006a) and 47/1000 IMR (WHO 2003). Despite the scarcity of reliable epidemiological data, a Médecins Sans Frontières (MSF) survey in 2006 determined an alarmingly high rate of child mortality. A fertile Asmat woman can give birth 5 to 10 times in her life span, but only half of her babies will survive. The high indicator of mortality reflects the variety of constraints of effective availability and delivery of quality healthcare (Suwandono et al. 2005; UNICEF 2006). MSF (2006) argues that the low health status of Asmat is due to rampant infectious disease (related to the ecological profile of the area) and the limited availability of healthcare. This restricted availability of the healthcare system is due not only to difficult geographical access, but also the socio cultural aspects of the population such as the local health belief and illness as well as Asmat's economy politic situation due to the decentralization policy and status as a new district on 2002.

The health care structure in the villages of Asmat plays an important role as it is the ‘sole and primary’ health center that can be accessed by the community. The village health posts are divided into two categories: Pustu and Polindes. Both are auxiliary units of Puskesmas (working at the sub district level). Each Pustu or Polindes covers one village or more. Pustu is led by a nurse or a midwife

---

2 The survey was done by distributing questionnaire to mothers in 16 villages of the Sawa Erma sub district (79 persons) and in Agats-Akat sub district (106 persons)
3 Pustu is an abbreviation of Puskesmas Pembantu literally means Puskesmas's assistance
4 Polindes is an abbreviation Pondok Bersalin Desa literally means village delivery post
5 Puskesmas is community health center
who is sometimes assisted by another health staff while Polyindes is staffed by one midwife. Based on my observation during my work in Asmat, and also noted by the health authorities, these village health posts are frequently un(der)staffed. The staff is usually absent from the village and stay in the capital of the sub district for various reasons. This absence leaves the community without health service and hinders the work of MSF personnel who do on the job trainings for the health staff in order to support their work. This situation complicates the effort to improve Asmat's poor health indicators. (see Annex.1)

The Asmat government has set a higher salary than the Indonesian standard salary for civil servant for the local health staff to induce them to stay and work there. The District Health Office (Dinkes) and the Puskesmas, supported by MSF, are attempting to increase the availability of (quality) health care including the improvement of midwives’ and nurses’ clinical knowledge and skill capacity by conducting trainings on various topics as well as to improve the work spirit and job satisfaction. Up to now the low availability and quality of health care remains a significant issue, not only for Asmat, but also for Papua in general (Van den Bergh 2008; UNICEF 2006). The ample resources allocated for the health development in Asmat have not been able to resolve the issue of the absent staff in the villages.

During my stay in Asmat, the health officials informed me that this absenteeism was justified by the poor living conditions in the village, the population’s low demand for the healthcare (related to the semi nomadic life of Asmat people) and the nurse or midwifes familial obligation to stay in the capital city.

Franco et al. (2002) point out the scarcity of empirical evidence to define determinants of worker motivation in the context of a developing country. Some international studies have described the cause of absence and low motivation amongst the health staff. In Indonesia, Suwandomo et al. (2005) cite the difficult geography, lack of transportation and infrastructure, the uncertainty of a future career and the difficult working environment as causal factors for the unequal distribution of nurses in the country. Lindelow and Serneels (2006) found that the poor treatment and inadequate services were a source of frustration and affected the motivation of the health workers in Ethiopia. Chen et al (2004), in their
discussion about the crisis of global human resources for health, add one strategy to achieve health staff's motivation. That adequate remuneration, positive work and career environments, and supportive health systems are strategies to achieve health staff’s motivation. Health sector policy makers and managers must recognize the importance of work motivation and understand the links between their current policy and worker motivation. (van Lerberghe in Franco et al. 2004)

To date no study about Asmat’s health staff has been done. So this study, trying to understand the relation between the macro situation of Asmat with the availability of health staff in the village is crucially needed to build an appropriate strategy from every aspect to improve the availability to health care and contribute to the improvement of the Asmat poor health status.

Research Objective

This research is aimed at understanding the experience and motivation of nurses and midwives who live and work in the village health posts. Why do some staff decide to stay while others leave their post? Subsequently, this study is expected to fill the gap of understanding about absenteeism of health staff in the villages of Asmat.

The health staff is the crucial actor to protect and improve the health of the community at the village level. Therefore, efforts to improve the health staff attendance in the village are crucial to make health services accessible for the beneficiaries. It is hoped that the research findings will provide data for recommendations that would address how to keep the health staff in their jobs. Staffs work and so improve the health status of the population of Asmat.
Research Questions

The research focuses on the health staff in the village health posts of Asmat with their multi dimensional challenges. Therefore the main research question is:

What are the aspects considered as challenging and motivating by the nurses and or midwives with regard to their decision either to stay and work or to be absent in the village health posts of Asmat?

This main question is divided into two sub-questions:

1. Which personal aspects do the midwives and nurses considered as important when talking about their motivation and decision to stay and work or not in the village health posts of Asmat?

2. Which aspects of the environment, socio culture, economy politics, or health system do the midwives and nurses perceive as challenging or motivating when talking about their decision to stay and work or not in the village health posts of Asmat?

Critical medical anthropological perspective

In order to answer the aforementioned questions, the interplay between the experience of the health staff and the wider context of Asmat need to be understood. I examine how the macro level context of Asmat and Indonesia may shape and construct the health staffs perceptions and behavior at micro level. This approach, which is known as critical medical anthropology (CMA) is a theoretical and practical effort to understand how large scale determinants, such as the historical and political economic situation, class structure, gender, or health care system can influence and shape the individual’s understanding, decisions and behavior related to health, illness and treatment (Brown 1998; Singer & Baer 2007; Good 1994). Brown (1998) states ‘... this analysis is specifically designed to question the hidden assumption behind the historic, scientific, epidemiological approach to understand disease and international health problems’ (p.16).

This perspective does not take a ‘top down approach’ one that represents the macro determinants pressing down upon people who have little autonomy or
power (Harper in Singer and Baer 2007). It argues that individual decision and action is not a passive action, merely constructed by the macro power influences, but rather that individuals respond to the conditions they face in light of the possibilities created by the context. The process of decision-making and behavior, the experience and 'agency', are "constructed and reconstructed in the action arena between socially constituted categories of meaning and the political-economic forces that shape the context [and texture] of daily life" (Baer et al. 2003:44). To closely understand the process of health staff's decision making and experience, I use the anthropological concepts of 'agency' and 'motivation' as an analytical tool which I will further explain in Chapter Three.

My aim to use the critical medical anthropology perspective in this study is to gain two objectives. First, as a means to understand the construction and reconstruction process of the absenteeism behavior as it relates to the Asmat context and considering aspects of the local environment, politics and economy, health system and policy as well as the socio culture. My second objective is to give recommendations both at the policy and operational level to improve the current situation.

Outline of thesis
This thesis is divided into the following chapters. Chapter 2 includes a description of the setting of the study, Asmat and the context of the health system. A literature review about the theoretical concepts of agency and motivation including an overview of studies that have explored health staff's motivation is presented in Chapter 3. Chapter 4 is describing the methodology of data collection during the fieldwork. The data analysis is divided into two chapters. Chapter 5 includes the personal aspects of health staff to work and stay in the villages of Asmat. This is followed by Chapter 6 which provides a discussion about the structural aspects which staff consider as important with regard to their decision either to stay and work in the village or to leave, respectively. Finally, in Chapter 7 I will answer the main question and discuss it using the theoretical concept and the Asmat context literature and give recommendations about improving the situation.
CHAPTER TWO
FIELDWORK SETTING AND CONTEXT OF ASMAT
“A GLIMPSE OF ASMAT”

Since I use the critical medical anthropology perspective to understand the relation between the behavior of the health staff in the village health posts with the macro situation of Asmat, I shall describe the context of Asmat which covers my fieldwork setting and the relevant aspect related to the theme of this study. This chapter is divided into two sections, first is a picture of Asmat, which includes the demography, environment and logistics, historical and political background, economic situation, social and cultural aspects, health indicators, and the health system and policy. In the second section, I describe the normative concept of health service at the village level as the center background of the midwives and nurse in this study. Subsequently, the discrepancies of the ‘normative vs. actual’ practice of health care are also discussed in this chapter.

The presented information is obtained from a literature review, which is then ‘triangulated’ with my own past experience working in Asmat and findings during the current fieldwork.

The Setting: The ‘Fierce’ of Asmat

There is scant information about the current health system and health policy, economy and political background of Asmat since it’s administration structure is new. Until 2002, Asmat was a sub district of Merauke. Therefore, the following explanation of politics and economy is dominantly about Papua in general with a short description about Asmat. Although I provide the normative concept of the health system from the Ministry of Health, the actual description of the health services in Asmat is based on my past experience.
Demography, environmental and logistical aspects

Asmat, a low-lying region with rivers that flow into the Arafura Sea and dense rain forest is a 23,746 km² district in the Papua Province, the western half of New Guinea. Asmat is situated in the southern swamplands with a population of approximately 79,344 people, divided in seven sub districts and 139 villages. The capital is Agats. This study took place in the three sub districts of Agats, Akat and Sawa Erma. Agats consists of seven villages and Akat has 11 villages. Sawa Erma, the widest sub district, has 36 villages. (Annex 3 provides the population figures of Asmat per sub district).

The picture of Asmat as ‘...one of the largest swamps in the world’ (Trenkenschun in Zubrinich 1997:83) is in agreement with the challenging topography described by Sowada (in Zubrinich 1997:87) who said, ‘the natural environment of the Asmat [people] is severe’.

Figure 1. Map of Papua and Asmat

(accessed on the 5th of May 2008)
The forests of Asmat are thick with palms, sandalwood, pandanus, ironwoods, orchids, creepers, vines and bamboo stands. Due to the almost constant rains, the heat and the badly leached soils, horticulture is not possible in the area. Therefore, sago palm is the main diet and carbohydrate source for the Asmat. Asmat houses are built on poles to make way for the water from the rivers or sea that flood the forest and villages during high tide. At low tide, wide mud banks from the villages and extend for miles into the river or seashore. (Trenkenschuh 1970).

Asmat can only be reached by air or water, as there are few roads. Agats city can be accessed from Timika, the capital of Mimika district in Papua, by traveling 40 minutes by airplane by speed boat four to six hours. The distance from one sub district to the capital varies from 115 km to 240 km (UNDP and
Uncen (2005), a relatively long distance since a speedboat or a canoe are the only means of transportation. Using rivers (up to 1 km in width) as highways, the people may paddle their canoe from a particular village to Agats in days.

![Image](image_url) Figure 3. The Asmat river width may measure up to 1 km
Source: MSF 2004

The rough sea makes access in and around Asmat risky and there have been reported deaths. Until January 1970, the Catholic missionaries wrote about a crocodile, still at large, that killed 55 people in the past years on the river of Kronkel (Trenkeschuh 1972). From 2006 up to now, at least seven people have been reported dead or missing around Agats. (Suara Merdeka 2008a, Suara Merdeka 2008b, Kompas 2008).

Electricity is only available in Agats and Atsy sub districts (Pemda Asmat 2004) on a schedule. The price of kerosene is high, double the national standard price or higher. Rainwater is the only source for a clean water supply. Due to the unpredictable dry season, I have experienced the scarcity of water in Agast several times (March to April 2006 and May 2008). If one has money, mineral water can be used for drinking water instead of boiling the rainwater. Even though I have not witnessed it myself, according to the health staff and officials, the Asmat people

---

6 Uncen is the abbreviation of Universitas Cendrawasih (University of Cendrawasih)

7 The national price of kerosene is 3000 IDR while the Asmat’s price was 6000 IDR, sometimes can reach 10,000 IDR (about 90 cents of euro)
are said to be drinking water directly from the river. The Asmat think that the boiled water is not as fresh as the river water.

School facilities are available in some villages yet do not accommodate the distant ones. Catholic missions have priests, churches and schools in selected villages that have developed their own radio networks (Van Arsdale 1980). MSF also installed radio stations in selected village health posts. Agats city and Ewer village (where the airport is located) are two areas with a mobile phone network.

Food options are problematic for outsiders. Vegetables and fruits are limited and the available ones are frequently quite expensive since they are imported from other districts. However, seafood such as shrimps or crabs, which are a luxury for the outsiders is available at a relatively acceptable price.\(^8\)

**Asmat and Papua: economy, politics and historical background**

UNDP (2005) states that although Papua enjoys Indonesia’s fourth highest level of GRDP per capita of over 11 million IDR\(^9\) largely from natural resource-related industries, such as oil, gold and copper, has not been shared by most Papuans and has not translated into corresponding levels of human development. Musa’ad (in Kazuhisa Matsui et al. 2007), in his analysis of Papua’s special autonomy policy, argues that the centrist government has utilized those resources for the interest of the nation only, without respecting the rights of the local society. He mentions the existence of discrimination and negligence of the human and basic needs of the native people of Papua, which has provoked grievances leading to mistrust of the government.

By the Acts legislative Law 22 and Law 25 1999, Indonesia implemented a new policy of district autonomy, with a decentralization of power to the district level. However, the law only came into effect in January 2002, when the Indonesian government agreed to generous autonomy packages for the province (UNICEF 2006). The Special Autonomy Law for Papua has provisions to change the province name (previously called as Irian Jaya), the return of 70 - 80% of natural resources revenues to the province and to increase in the political

---

8 One medium sized crab is about 5000 IDR. One bag of big shrimp costs 20,000 - 40,000 IDR
9 IDR is the abbreviation for the Indonesian Rupiah
participation of Papuans (UNICEF 2006). UNICEF (2006) states that there is some indication that the Papuan government now receives one third more resources and has achieved regional and special autonomy for general allocation funds and an increased proportion of funds derived from taxes on mining.

The feelings of mistrust have been expressed in various forms, including the wish to be free and independent from Indonesia. Human Rights Watch (2007) published a report stating that there were ongoing violence and human rights violations against Papuans. Several conflicts and rebellions have broken out since the Free Papua Movement or Organisasi Papua Merdeka (OPM) started actively fighting for independence (van Den Bergh 2008). In Asmat itself, which was still a sub district of Merauke, the flag of OPM was flown at the celebration of the World’s Human Rights Day, 14th of July 2000 as witnessed by 2000 people in their traditional clothing (Linggasari 2004). The Bupati and Vice Bupati of Merauke responded to this movement by stating that Merauke is obedient to the principles of autonomy law. On December 2000, Bupati divided Merauke into three districts: Boven Digul, Mappi and Asmat. Since then, there has been no sound of 'Papua Merdeka' and the only flag flown was the merah putih (red and white), the Indonesian Flag (Linggasari 2004). The official year of Asmat became a new district was on 2002.

**Asmat: Socio cultural aspects**

Asmat inhabitants comprise several tribes Asmat, Muyu, Kenyam and Yakhai (UNDP & Uncen 2005). The majority of Asmat people are illiterate (MSF 2006). After the pemekaran, the influx of outsiders increased day by day. Migrants from other districts of Papua, other islands (South Sulawesi and Java) are generally working as civil servants and traders in Agats.

The economic activity from the private trading sectors, such as vendors, restaurants, and construction companies has been mushrooming in Asmat but are dominated by outsiders. Based on interviews with traders and civil servants, they are attracted to Asmat because it offers an easier way to get money. According to traders, they can make a profit of up to 100% in Asmat while back home, in Java or Sulawesi, their profit margin was at maximum 10%.
UNDP (2006) argues that one of the basic problems of Papua is the wide socio-economic inequity between the tribal groups and the outsiders. For civil servants, the opportunity to be accepted is higher compared to their place of origin and their salary is higher than the national average\(^\text{10}\). Some outsiders, including two medical doctors from Java, confessed that their main motivation to stay and ‘hang on’ in Agats was to become a civil servant. Civil servant provides sustainable salary even until retirement.

Papua is believed to be the single most important source, harvested in Indonesia, for exported agarwood (*gaharu*), the resinous, fragrant and highly valuable heartwood that is used as the basic ingredient for incense and perfume (Indonesian Directorate of Forest Protection and Nature Conservation, in Compton 2002). Since the discovery of *gaharu* in 1996 (Linggasari 2002), the Asmat people stay temporarily in the forest to collect the *gaharu*, instead of gathering food, and sell it to the traders for a very high price\(^\text{11}\). Due to this new activity, the semi nomadic style of some Asmat people has drifted into a money economy.

The semi-nomadic existence and local health-illness beliefs and treatment behaviors are generally assumed as causes for the low demand for biomedical services from the health staffs in the village clinics. MSF (2006) and Sowada (2008) argue that the cultural and social dimensions of the Asmat community are considered a serious obstacle for the health staffs. Attempts to change them often result in the frustration of medical officers’. Sowada (2008) states that the Asmat people believe that spirits or humans cause sickness.

*Pemda Asmat* (2004) mentions that there are religious facilities for three religions in the area: the Catholic Church, the Protestant Church and Islam. The Catholic missions were established in 1953 (Trenkenschuh 1972). They have been intensively researching the Asmat language, customs and social structure.

---

\(^{10}\) A civil servant’s salary in Asmat has three additional wages that do not exist in the other areas; profession incentive (*tunjangan profesi*), additional salary (*Penambahan Penghasilan*), and work load incentives (*tunjangan beban kerja*)

\(^{11}\) Good quality *gaharu* is said to be sold for up to five million IDR per ounce.
Asmat’s health Indicators

According to UNDP and Uncen (2005), Asmat doesn’t have data on health indicators. The official data from Dinkes Asmat in 2003, UNDP and Uncen (2005) mentions that malaria, diarrhea and respiratory infections are the most prevalent diseases in the area. MSF (2006) notes that Asmat is a region that experiences frequent outbreaks of diarrhea and that waterborne disease is a big problem in the region. An epidemic of measles emerged from December 2005 to April 2006 and 70 deaths out of 350 cases were reported. Dinkes of Asmat reported a low (59%) coverage of measles vaccination in 2005 this was identified as the cause of the outbreak (MSF 2006).

Asmat’s health system and policy

In general, the health care structure in Asmat is an adaptation of the national Indonesian standard therefore the district health office (Dinkes) is responsible for the health care in the local area. MSF (2006) notes that there is no hospital in Asmat and the Puskesmas in Agats is the referral center of the district. At the moment the Puskesmas in Agats is being upgraded to function as a hospital with an emergency obstetric capacity; (operation theatre and an obstetrician), inpatient and outpatient services, laboratory, transfusion facilities, and radiology. Each sub district in Asmat has a Puskesmas with an inpatient service that is responsible for the primary health care activities; vaccination, mother and child health, general consultation, health promotion, and outreach activities12.

In addition to the governmental structures that provide the community heath services, Asmat is also supported by MSF who have continued their deployment there after the mass vaccination campaign against measles in 2006. In collaboration with the Dinkes and Puskesmas, MSF is attempting to enhance the availability of quality health care; including the clinical knowledge and skill capacity improvement of midwives’ and nurses’ at the Pustu and Polindes (MSF 2006). I have observed some of their activities that include malaria prevention, setting up a referral system and tuberculosis treatment. Beside trainings, MSF also

---

12 There are two outreach activities of Puskesmas. Pusling: a mobile clinic activity for the villages (usually provided by nurses and or midwives) and Posyandu, an EPI activity in the villages with a fixed schedule (provided by the midwives)
does health promotion to the community and community health workers (kaders) about the aforementioned themes.

The normative concept of *pustu* and *polindes*

Based on the MOH Guidelines in Depkes RI (1993), the definition of *Pustu* or *Puskesmas Pembantu*\(^1^3\) is a health service unit supporting *Puskesmas* activity with a smaller scope of responsibility and less sophisticated service. The *Pustu* cover one to three villages with a population of 2,500 to 10,000. The head of *Pustu* is a nurse or midwife assisted by another midwife who assigned to the same village. The *Pustu* is under the coordination of *Puskesmas* and directly supervised by the head of *Puskesmas*. In daily activity, *Pustu* should collaborate with village officials, women’s organizations, traditional birth attendants, etc.

The main activities of *Pustu* are health prevention and promotion without neglecting curative and rehabilitative efforts. Some activities ideally covered by *Pustu* are mother and child health (MCH), family planning, vaccination and the prevention of contagious disease, nutrition, curative treatment, environmental health, community health nursing, health promotion, registration and reporting. *Pustu* works only on weekdays and not on the weekends.

Another sort of village health post is *Polindes* which staffed by a midwife is technically under the supervision of the head of *Puskesmas* too. The role of the village midwife includes promoting community participation in health, providing health and family planning services, working with traditional birth attendants, and referring complicated obstetric cases to health centers and hospitals. She is to serve as a health resource in her community, actively seeking out patients and visiting them in their homes rather than waiting passively until they come to her (Ministry of Health in Frankenberg 2001).

\(^{13}\) *Puskesmas Pembantu* literally means *Puskesmas* supporter
The health staff in Pustu and Polindes

Widaningrum (1999) studied nurses and midwives in Central Java and mentions that the status of health staff working in a community health centre is as a civil servant. Before being inaugurated as a civil servant (PNS\textsuperscript{14}), they must pass a written competency and psychological test (Tes PNS) held once a year at a district level and a national level. Even if a person does not have the PNS status, he may work in a health post as a temporary worker. The temporary PNS status is divided into two. First is PTT (Pegawai Tidak Tetap), which is generally applied to medical doctors and midwives, or honorer which usually applied to nurses. The PTT status has higher salary since it is funded by the central government while the honorer receives less because the salary is going from the local government or institution.

The following is a description of the different levels of the formal educational background of nurses and midwives who, in the context of this study, have a nursing high school diploma (SPK), nursing diploma (D3 Keperawatan), and the Bidan C midwifery. Bidan C is a product of the Indonesian MOH’s ambitious program (Bidan Desa Program) in 1993 to respond to the high maternal mortality rate in the 1990’s\textsuperscript{15}. The objective of this project was to improve the health access by posting a trained midwife in each village, especially in the remote villages (Frankenbergh and Thomas 2001). In Papua, 1000 girls from local villagers were recruited and trained for three years on the midwifery and related subjects, to become Bidan C. Criteria for selection were literacy in Indonesian, unmarried and willing to commit to the program for several years. There was difficulty in finding girls due to a lack of schooling for young girls and the willingness of families from the villages to send their girls away (Van den Bergh 2008).

The Bidan C training’s range of subjects included: anatomy and physiology, general midwifery, general paediatric care, public health nursing, basic public health, epidemiology and basic statistics. In addition to medical knowledge.

\textsuperscript{14} PNS is an acronym of Pegawai Negeri Sipil
\textsuperscript{15} It was estimated at 337 per 100,000 live births (Frankenbergh and Thomas 2001), one of the highest reported among Asian countries.
the midwife received training in communication and managerial skills such as patient registration, reporting systems, and financial management.

Although the subjects of trainings appeared to be comprehensive and complete, I could not draw any conclusions about the true quality of the knowledge and skills of the Bidan Cs in general. Hennesy et al. (2006) in their study about training and development needs of midwives in Indonesia, argue that the training system of these midwives require regular updating, while in reality there has been a lack of follow up evaluation and updated training.

An SPK is a nursing high school graduate asisten keperawatan or nurse assistant (Pusdiknakes 1998). D3 Keperawatan is a higher level of nursing education than SPK but lower than a bachelor degree. The outline of D3 Keperawatan covers more advanced knowledge and skill compared to SPK. In a three year course the curriculum provides basic medical knowledge, nursing skills, nursing attitude nursing management and leadership, sociology, and English.

From the description above, and in accordance with Sciortino’s (1995) argument based on a study about nurses in Central Java, I draw the conclusion that both the D3 Keperawatan and SPK curricula are dominantly focused on a caring domain.

The discrepancy of health services: The normative vs. the actual work

The discrepancy of the educational background and the Indonesian normative concepts of health care for the nurses and midwifes role in the field have been linked to the low quality of health services. I will describe this phenomena based on the literature and my personal observation during my previous work in Asmat.

Sciortino (1995) studied the nurse’s role in the primary health center of Myrad district, Central Java. She found that regular nurses do not perform any health education or health promotion work as conceptualized in their primary health care tasks. What health center nurses actually do is to carry out curative practices exclusively because doctors act as managers and are rarely involved with patients. Nurses are trapped into doing curative work but without legal protection because the local conditions ‘support’ this approach. By doing this, the nurses gain
respect from the community, and sometimes a tips from the community on top of their basic salary.

In regards to the midwives, the Indonesian Family Life Survey\textsuperscript{16} at 1997 (in Frankenbergh 2001) noted that in addition to mother and child care, the great majority of village midwives provide more general curative care and stitch wounds. A relatively similar situation occurs in Asmat, as I have witnessed, where both the Puskesmas and Pustu or Polindes were focused on curative care and ‘neglected’ the disease prevention and health promotion role for the community.

I have described the nurses and midwives in their multidimensional context of Asmat in general and in the setting of their ‘normative and actual work’. The problem analysis diagram, “Health staff experience challenges to work and stay in the village health posts” (see Annex 2), is based on the context of Asmat.

In the next chapter, I describe the ‘how’ I applied this approach by doing six weeks fieldwork as an attempt to understand the challenges and motivation of midwives and in the villages of Asmat.

\textsuperscript{16} The survey was done by doing interviews with 157 village midwives (no place mentioned)
CHAPTER THREE
LITERATURE REVIEW
“WHAT IS MOTIVATION ANYWAY?”

A critical anthropological approach was used to understand the puzzling phenomena of ‘absence’ among the health staff in Asmat: “why do they stay in those villages regardless of the harsh living conditions and why have the others left?”. This approach emphasizes that individual decision-making and behavior is not a passive direct precipitate of a socio cultural construction. As I mentioned in Chapter 2, this process involves the experiences and agency of an individual and correlates with their context. Therefore, this study uses the concept of agency and motivation to analyze the challenges and motivation of health staff to stay and work in Asmat villages. The following section presents a literature review of two themes. First, the theoretical concept of agency and motivation is discussed. Secondly, other studies that discuss motivation among the health staff will be presented.

Theoretical concept
Agency
Since the last quarter of 19th century, Anthony Giddens has criticized the conventional sociological concepts of capitalism and social life. These concepts, mainly functionalist and structuralist, tend to express a naturalistic standpoint. They strongly emphasize the pre-eminence of the macro level over the micro level, overlooking its individual potential (Giddens 1984). Giddens suggests that human agency and social structure are interacting and it is the repetition of the acts of individual agents that reproduces the structure. Giddens (in Long 1992:22) highlights the view that agents are capable of making a difference in a preexisting state of affairs or to a structure and describes ‘agency’ as follows:

The notion of agency attributes to the individual actor the capacity to process social experience and to devise ways of coping with life, even under the most extreme forms of coercion. Within the limits of information, uncertainty, and the other constraints that exist, social actors are knowledgeable and capable. They attempt to solve problems, learn how to
intervene in the flow of social events around them and monitor continuously their own actions, observing how others react to their behavior and taking note of the various contingent circumstances.

Gammeltoft (1999), who studied family planning among women in Vietnam, defined human agency as an *individual* making active choices. The choices are always contextual and challenging which are either endorsed or enabled by the *structure*. In her analysis, Gammeltoft considers two trajectories that impinge on the women decision to have IUDs inserted in their bodies; first, women’s own desires and choices and secondly, the social, economic and political aspects.

This division of trajectories is also employed by Ortner (2005) who reflects on *agency* as a part of what she called a “serious game”, a metaphor of a social life that is actively played and oriented toward culturally constituted goals and projects. ‘Agents’ are actors who are involved and play the game. Ortner distinguishes two modalities of agency. The first is the agent’s enmeshed-ness with power, including both domination and resistance. The second is closely related to ideas of intention, to people’s (culturally constituted) projects in the world and their ability to engage and enact them.

The first concept of agency is what Ortner (2005) labeled as “agency of intention”. People are playing or trying to play, their own serious games regardless of the oppression by more powerful parties. Writing in the “Weapons of the Weak”, Scott (1990) gives an example of agency when the peasants execute hidden resistance acts towards the power of the elite. Koster (2003), who did a study about unwanted pregnancy and abortion in Nigeria, argues that even though the interplay between agency and power often takes the form of dominance and resistance, compliance may also be an active strategic choice. Compliance means obeying or accepting the rules of the structure, such as the state or organization (Moore 1988).

The second notion of agency is a horizontally oriented goal, where *individual* intention and agency come to the forefront. This intention could be related to the solidarity of family, friends, kin, partners, teachers, sponsors, etc. She emphasizes that since agency is individual, ‘intention’ and ‘desire’ come to the forefront and that these personal goals are actually fully culturally constituted.
Ortner notes that the distinction between an agency of power and an agency of intention is subsequently largely heuristic and *inseparable*.

Ortner (2005) points out that the game itself is not simply a relationship between opponents but is built upon power relations at the individual level with the potential to disrupt the game and it continues to a socio and cultural formation and reformation. The same thought is also articulated by Bourdieu’s (in Robbins 2000) in his theory of ‘habitus’, an *interactive* play between the individual and the structure. *Habitus* is defined as:

> an endless capacity [of the agent] to engender products-thoughts, perceptions, actions – whose limits are set by historically and socially situated conditions of its productions, the conditioned and conditional freedom it secures is as remote from a creation of unpredictable novelty as it is from a simple mechanical reproduction of the initial conditionings. (Bourdieu & Nice 1977: 95)

In this theory of practice, Bourdieu attempts to underpin the “subjectivism”, the *strength* of an agent, contrasting the “objectivism” traditions of functionalists who often naively conceived that the structure patterns the social relations or phenomena. In fact, individuals are actively producing the structure in order to save their social condition. Ortner states “that playing the game – as Bourdieu insists- almost always results in social reproduction. Yet ultimately games do change” (Ortner 2005:28).

The dichotomies between individual (agent) and structure or subjectivity and objectivity are construed and reciprocally mutually implicated. We cannot have a concept of one side without a concept of another side. Ortner (2005) argues that this distinction is useful, because having pulled them apart; one can see how they are often interrelated and locked together.

In this research, I am using the individual and structure dichotomy for the convenience of analysis, bearing in mind that these two concepts, as Ortner claimed, are unified. Like Ortner and Gammeltoft, first, I will examine the individual trajectory such as desires, choices, intention and goals, of the nurses and midwives to stay and work in *Asmat*. For the second trajectory, I will look at how the health staff act towards the structure of *Asmat’s* environment, health system and policy, including the economy and politics. I consider all possibilities to see
how the health staff reacts including domination, resistance or even compliance. By exploring the interactive “games” in the two trajectories, I try to understand not only how the health staff as an ‘agents’ act upon the structured situation but also to grasp the “what” and “how” the health staff’s roles influencing the structure, particularly in relation to the Asmat’s health system and services.

Motivation
As described above, in the social life, in and through their recursive activities, human activities are continually recreated via the very means in which humans express themselves as agents (Giddens 1984). Agents are both structured and reproducing the structure. This interaction happens continuously through time. Giddens (1984) argues:

Continuity of practices presumes reflexivity, but reflexivity in turn is possible only because of the continuity of practices that makes them distinctively “the same” across space and time. Reflexivity hence should be understood not merely as a self-consciousness but as the monitored character of the ongoing flow of social life. To be a human being is to be a purposive agent, who both has reasons for his or her activities and is able, if asked, to elaborate discursively upon those reasons (including lying about them). (p. 3, emphasis added)

Giddens (1984) speaks of reflexivity as grounded in the individual’s continuous monitoring of action, which depends upon rationalization, understood here as a process rather than a state or as naturally involved in the agent’s competence. He presents a stratification model of the self action involving “the reflexive monitoring, rationalization and motivation of action as embedded sets of processes” (1984:3).

As Giddens (1984) describes, reflexive monitoring of action refers to a chronic feature of individuals’ daily action, of their own activities and expectations that others will do the same for their own actions. The agents also continuously monitor their action and the context surrounding their action. “Rationalization of action (also done routinely) means that the capabilities competent actors have of ‘keeping in touch’ with the grounds of what they do, as they do it, such that if asked by others, they can supply reasons for their activities” (Giddens 1984:376). Giddens argues that “if reasons refer to the grounds of action, motives refer to the
wants which prompt it" (1984:6, emphasis added). He explains further that if rationalization is directly bound with action, motivation refers to the prospective for the action rather than the form of action itself which is continuously carried on by the agent. In the context of my research, my aim is to understand what reason/s caused the health staff to be staying or to be absent, and what motivation is embedded in it. This model can be represented as in Figure 1.

Figure 1. The Stratification Model

![Stratification Model Diagram](image)

Source: Giddens (1984:5)

While Hastrup (1995) confronts the problem of agency in culture from the particular angle of 'embodied motivation', Mele (2003:16) in the book *Agency and Motivation*, understood that “[agent’s] desires to A, where A is a prospective courses of action, constitute [agent’s] motivation to A.” Clarke (2004) mentions that causalist action theorists treat desires, the etiology of action, as both motivating attitude and reasons for action. Clarke further argues that treating desires as reasons gives us thin and subjective notions of rationality and reasonableness. An agent provided with desire creates a motivated agent (Mele 2003). The term “motivation” in this study refers to a motivated agent who is entrenched with desires.

The idea that all action is fundamentally 'rational' and that people calculate the likely cost and benefits of any action before deciding what to do is the basic approach of “Rational Choice Theory” (Scott 2000). Archer and Tritter (2001)
argue that this is inadequate concept to be use to understand the rational of decision making. Their critique focuses on three core assumptions related to rationality, individualism and temporality. In terms of rationality, the theory is defective because it is restricted to “instrumental rationality” and is not dealing with “substantive rationality”. It cannot explain how the human’s emotionality and normativity, which usually dominate the decision making process, can be incorporated in the rational choice theory. In relation to the individuality, the theory is unsatisfactory in its conceptualization of the interrelation between the structure and agency. It acknowledges the influence of the structure upon the personal goal-information, thus undermining the competence of the agent. At last, the Rational Choice Theory presupposes the possibility of identifying people’s preferences in an atemporal manner, because of their supposed stability. While, on the contrary, preferences have a history and a trajectory. Agents undergo certain experiences in which they reflect upon their preferences. In this process they become different people and are influenced in their motivations, decision-making and action in the future.

Based on the aforementioned limitations, I rather look into what considerations the health staff take into account, what personal traits and what structural factors I can detect from their stories, which influence their decision to be absent or to be staying in the village health post. Based on the idea that rationalization is continuously changing, I provide two life histories in Chapter Five.

Previous studies about motivation among health staff
Health sector performance is critically dependent on health worker motivation. Resource availability, competence, knowledge and skill are essential but not sufficient to ensure desired worker performance regardless the motivation health worker (Franco et al. 2002). Evidence of poor worker motivation can be seen across countries in different forms: lack of courtesy to patients, tardiness and absenteeism, also poor quality during the examination process (Franco et al. 2004). Franco et al (2002) argue that different broad cultural contexts and work environments may lead to a constellation of motivation key determinants.
Franco et al. (2004) who did an exploratory study about health worker motivation in hospitals in Jordan and Georgia, present a determinant framework of health worker motivation. They acknowledge the dichotomy of individual and structure, and divide motivation into the two trajectories. The first one is motivation originated at the level of the individual and their immediate work context such as self-concept, expectations, and experience. The second one is at the level of the cultural context that is composed of two categories of determinants, namely the organizational factors and the social factors. The organizational determinants include health policies, such as payment mechanism, human resource management (including worker performance feedback), community empowerment and organizational culture (such as decentralization). The social factors include community expectation, peer pressure and social values. They claimed that self efficacy, pride, management openness, job properties and values were important in addressing motivational issues in two countries with different cultural and socio economic backgrounds. The result of the study indicates that motivation is a complex play of factors, which operate in a cultural context.

In the following discussion, I will separate the aspects that influence motivation into two categories. First is the personal domain, such as the family, immediate relationships, emotions, personal goals and secondly, related to structure, namely the health system and policy, socio-cultural context, and environmental logistical aspect.

In relation to health policy, a study in Uganda and Bangladesh by Ssengoba et al. (2007) points out that although increased salary created a rise in staff motivation, this didn't equate to the community's satisfaction due to the inadequate drug supply and medical service provision. However, Franco et al. (2004) found that in Indonesia, incentive rewards did contribute to worker satisfaction. This is in agreement with Suwondono (2005), who argues that additional compensation implemented to solve the problem of nurses' placement in remote areas, is not always "big enough" to motivate them.

Suwandono et al. (2005), explain a surplus of unemployed nurses and the uneven distribution to the remote area in Indonesia as due to the uncertainty of a future career and the difficult working environment (namely lack of drug supply,
poor infrastructure facilities, limited monetary reimbursement and a lack of financial incentives). Hamdan and Defever (2002) argue that training opportunities and scholarships can be utilized to motivate, retain and improve the performance of health workers in Palestine. Chen et al (2004), in their discussion of the crisis of global human resources for health, mention that adequate remuneration, positive work and career environments, and supportive health systems are strategies to achieve health staff's motivation. A qualitative study about the performance of health workers in Ethiopia by Lindelow and Serneels (2006) found that the poor treatment and inadequate services (as perceived both by the health workers and the users in the community) were a source of frustration and affected the motivation of the health workers. These authors called for a radical revision of the poorly enforced regional human resources policy in Ethiopia.

Van Den Bergh (2008) observed that the current staff present in Puncak Jaya District of Papua were mostly Indonesian and stayed there for one or two years as part of their training. The health staff didn't speak the local language and lacked awareness of culturally specific practices and beliefs. Three studies done in the same district by Guillard (in Van den Bergh 2008) reported that in 2004 all midwives who should have been working in the 28 village health posts of the Mulia sub district were absent.

Chabal (in Van den Bergh 2008) conducted research about the 'invisible' midwives in Puncak Jaya district and mentioned the following reasons: they did not feel accepted, lacked a feeling of security, solitude, lack of facilities, bad living conditions, late salaries and personal family obligations. Suwandono et al. (2005) cite the difficult geographical conditions and lack of transportation as contributing factors for the unequal distribution of nurses in Indonesia.
CHAPTER 4
METHODOLOGY
‘THE JOURNEY OF ASMAT’

In order to understand the phenomenon of ‘absence’ among the health staff, in relation to the local context described in Chapter 2, in this section I describe the methodological approaches used during fieldwork, including the study type, study location, study population, sampling, data collection techniques and obstacles, data processing and analysis, and some ethical considerations. At the end, reflections of my position as a researcher and limitations of the methodology will be discussed.

Study type
The main focus of this research was to answer ‘how’ and ‘why’ do some health staff stay while others are absent in the village health posts of Asmat. In order to find out how the health staff experienced the challenges and what their motivations were, this study used a qualitative, ethnographic account based on anthropological fieldwork.

As it is the first study about health staff in Asmat, with relatively a small scale and short duration of time it can be considered an exploratory study. Two life histories will be presented in Chapter Five, to describe how motivation and action is changed through time. In Chapter Six, one case study which based on my one week participatory observation in Pustu Bu Agni is used as a frame to describe and analyze a triangulated data from interviews and phenomenon which I have observed and experienced. Through the analysis comparative element regarding characteristic of the health staff may appear as well.

Study location
The fieldwork was carried out over six weeks from the second week of May to the third week of June 2008 in Asmat district, Papua province, Indonesia. I chose Asmat because of two reasons. First, it has a poor health indicators (as it has been
explained in the problem statement) and secondly, because I have worked in the area before.

Instead of covering the whole seven sub districts of Asmat, I chose three, Agats, Akat and Sawa Erma. I chose these places because based on my previous experience, I am already familiar with the environment, the health officials and most importantly, I know some of the health staff in the villages. It was convenient for me that the MSF also covers those three sub districts. I was able to gain technical information and support in terms of transportation, communication and accommodation. The governmental offices including the District Health Office (Dinkes), the referral center (Puskesmas Agats) are located in the capital of the district, Agats city. Two MSF bases are located in Agats and Pos. As most of the informants who should be working in the villages of Agats and Akat sub districts were staying in Agats city during my stay, it was not necessary for me to travel to specific villages to collect information from them. The same situation was present in Sawa Erma sub district, all of the interviews were done in the capital, Pos, except for the participant observations I conducted while staying with a midwife in Bu Agani village.

**Study population and sampling**

There were two groups of study population, the first consisted of the midwives and nurses who work in the village health posts, and the second were the stake holders; government authorities, Dinkes staff, Puskesmas staff, MSF staffs, religious leaders (Catholic missionaries) and traders.

From the nurses and midwives them, I wanted to know what kind of challenges and motivations they have experienced when considering whether to stay and work in Asma or leave. The nurses and midwives were divided into two categories: those who are or were staying in the village health posts and those who are or were absent. In the field, these two categories became problematic. During the study, those who could be defined as staying were not really staying. During my fieldwork I observed some staff of the village health post who stayed in Agats or in Pos (capital of Sawa Erma). According to the health officials and MSF staff, they could be absent in the villages up to two weeks a month for three consecutive
months or 'most of the time'. My findings in the field show that overall, they have experience on leaving the village health post empty without any replacement at a certain duration of time with or without the permit of their supervisors. There was no formal regulation in regards to the duration of leaving the village health post. Below are the conditions regarding the presence of the health staff in their village health post based on different source of information:

Table 1. Presence of the health staff in the village health post based on MSF information, the health staff testimony and my observation in the field

<table>
<thead>
<tr>
<th>Name of the health staff</th>
<th>Sub district</th>
<th>Village health post</th>
<th>MSF information about health staff presence in the village health post</th>
<th>The health staff testimony about their presence in the village health post</th>
<th>My findings based on the observation studying the field</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurdin</td>
<td>Agats</td>
<td>Pusru Osins (previous post)</td>
<td>Rarely stay</td>
<td>Was absent for one month during three months duration of assignment in the post</td>
<td>Working in Dinkes</td>
</tr>
<tr>
<td>Klara</td>
<td>Agats</td>
<td>Pusru Ewer</td>
<td>Rarely stay</td>
<td>Going to Agats twice a month, beginning and end of the month</td>
<td>Has been staying in Agats in the middle of the month, not clear for how long</td>
</tr>
<tr>
<td>Petronela</td>
<td>Agats</td>
<td>Pusru Syaru</td>
<td>Always stay</td>
<td>No testimony</td>
<td>Has been away for three weeks because her father was sick in Boven Digal, Papua (Head of Puskesmas Agats did not know her absence)</td>
</tr>
<tr>
<td>Siti</td>
<td>Agats</td>
<td>Polindes Manep</td>
<td>Always stay</td>
<td>Always stay</td>
<td>Has been away for one week for training and another two weeks for visiting her son in Merauke, than stay in Agats for another two weeks (the Head of Puskesmas Agats was on holiday, no confirmation whether permit were given)</td>
</tr>
<tr>
<td>Merry</td>
<td>Agats</td>
<td>Pusru Pau Dukam (previous post)</td>
<td>Rarely stay</td>
<td>Categorized herself as rarely stay</td>
<td>Working in Puskesmas Agats</td>
</tr>
<tr>
<td>Hendrika</td>
<td>Sawa</td>
<td>Polindes Nekka (previous post)</td>
<td>Always stay</td>
<td>Always stay (in her current post : Polindes Erma Sona)</td>
<td>Staying and working in Polindes Erma Sona</td>
</tr>
<tr>
<td>Ana</td>
<td>Sawa</td>
<td>Pusru Ba Agansi</td>
<td>Always stay</td>
<td>Always stay, but was on holiday for three months (got permit from the Head of Puskesmas Sawa Erma)</td>
<td>Staying in the village health post</td>
</tr>
<tr>
<td>Ester</td>
<td>Sawa</td>
<td>Polindes Manangu</td>
<td>Always stay</td>
<td>No testimony</td>
<td>Has been absent in the village for two weeks waiting for an impending incentive payment in Pus (with the permit of Head of Puskesmas Sawa Erma)</td>
</tr>
<tr>
<td>Sondang</td>
<td>Sawa</td>
<td>Polindes Tonere</td>
<td>Always stay</td>
<td>Always go to Pus every August</td>
<td>Has been absent in the village for one week waiting for an impending incentive in Pus, and another one week in Agats (with the permit of Head of Puskesmas Sawa Erma)</td>
</tr>
<tr>
<td>Fransina</td>
<td>Sawa</td>
<td>Pusru At Atat</td>
<td>Rarely stay</td>
<td>No testimony</td>
<td>Has been absent in the village for two weeks waiting for an impending incentive in Pus (with the permit of Head of Puskesmas Sawa Erma)</td>
</tr>
</tbody>
</table>
Based on this fact, I did not make any categorization which will complicate the further analysis. However, for the endeavor of the following discussion and analysis part of this thesis, I provide the following definition operational which is quite open:

1. Stay and work in the village health posts means currently or previously has been officially staying and working in the village health posts
2. Leave the village health post means:
   - leave the village health post permanently with or without the permit from the supervisor (Dinkes and or Puskesmas)
   - leave the village health post with certain duration of time without any formal working assignment (outside training, meeting, etc) and without any permit from the supervisor

Overall there were 10 nurses and midwives in this study. Due to the aforementioned difficulty to categorize the nurses and midwives, the sampling went different than planned. I had no specific criteria for the sampling method. My main consideration was the availability of the staff, their willingness to participate in the study and feasibility in terms of time, transportation and money, to access the health staff in the field. That is why the method used here is a convenience sampling. In the following discussion and analysis I use the word “health staff” to refer this group. In two tables below I provide information about the village health posts in the three aforementioned sub districts and the total number of participants including the characteristic of the health staff:

Table 2. Number of village health post in Agats, Akat and Sawa Erma and the health staff included as participants

<table>
<thead>
<tr>
<th>Sub Districts</th>
<th>No. of village health posts</th>
<th>No. of village health post in which no staff appointed*</th>
<th>No. of health staff**</th>
<th>No. of Health staff included as participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agats</td>
<td>6</td>
<td>0</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Akat</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Sawa Erma</td>
<td>15</td>
<td>4</td>
<td>14*</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>4</td>
<td>23</td>
<td>10</td>
</tr>
</tbody>
</table>

Note: * Two health posts have two health staff. Other health posts have one staff
** These health staff include those who previously or currently appointed in the health post
Table 3. Characteristic of health staff included as participants

<table>
<thead>
<tr>
<th>Background Category</th>
<th>Number (person)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profession</td>
<td>Nurse 2 Midwife 8</td>
</tr>
<tr>
<td>Sex</td>
<td>Male 1 Female 9</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Married 8 Unmarried/single 2</td>
</tr>
<tr>
<td>Age</td>
<td>20 to 29 y.o 2 30 to 39 y.o 3 40 to 50 y.o 5</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Javanese 2 Papuan non Asmat 5 Asmat 1 Sumatranese 1 Sulawesinese 1</td>
</tr>
<tr>
<td>Place of Origin</td>
<td>Java 1 Sumatra 1 Papua outside Asmat 7 Unknown 1</td>
</tr>
<tr>
<td>Religion</td>
<td>Catholic 5 Protestant 2 Moslem 3 Unknown 1</td>
</tr>
<tr>
<td>Location of the village health post</td>
<td>Walking distance from Agats 1 &lt; 30 minutes by speedboat 2 30 minutes to &lt;1 hour by speedboat 1 1 to 2 hours by speedboat 6</td>
</tr>
<tr>
<td>Duration of staying in the village</td>
<td>≤ 3 months 2 1-10 years 1 ≥ 10 years 2</td>
</tr>
<tr>
<td>Nuclear family members living outside the village</td>
<td>Yes 9 None 4</td>
</tr>
</tbody>
</table>

Remark: * I did not learn her origin, as the method used was informal conversation, with a limited meeting time.

The second group of informant was the stakeholders. The sampling of this group was also mainly by chance and opportunity. The stake holders were included in the study to provide more information about the context of Asmat. Since this information was mainly gathered from literature review and my past experience, interviewing them was a trick of ‘triangulation’. Moreover, the triangulation also applied to check the information that I gathered from the health nurse and midwives in the first group. Overall there were 25 stake holders. The detailed list of stake holders who participated is provided in Annex 4. List of Stake Holder Included as Participants
Data collection techniques

Review of documents

Prior to my travel to Papua, I gathered normative guidelines and books about village health posts and the educational curriculum of midwives and nurses from the Ministry of Health (MOH) in Indonesia. With the help of the AMMA letter explaining my position and my fieldwork, combined with my own request letter, I was able to collect most of the necessary materials. However, the curriculum of Bidan C was said too old and not available anymore in the Pusdikrnakes17 (Center of Health Staff Education) of MOH. During my stay in Pustu Bu Agani, I was lucky that the midwife still kept her modules, notes and photocopies of her midwifery training material.

MSF was helpful by providing a database of village health posts in the three sub districts where I was working. This data was crucial to determine which midwife was where, how to access their post, which posts were empty, etc. The data about the population from Dinkes was gathered secondarily from MSF.

My experience with the Dinkes, taught me that oral approval for getting ‘any’ information from the head of Dinkes did not guarantee that this information would be forthcoming at the lower level. The same thing happened with the human resources department of the Bupati. In both institutions, I could not get information about salary since both implicitly and explicitly stated that it was confidential information.

The Catholic missionary provided many books and documents especially related to Asmat history, environmental information, and socio cultural aspects of Asmat.

Interview with the nurses and midwives

I did two type of interviews with the nurses and midwives, who previously was or currently work at the village health post, namely the in depth interview and informal interview. The interview took place based on the preference of the participants. It could be in their house, or in a private room of the Puskesmas, since

17 Pusdikrnakes is the abbreviation of Pusat Pendidikan Tenaga Kesehatan
they thought that their house where they were staying at that moment were too crowded.

In depth interviews with these nurses and midwives were covering the following topic: 1) background profile including characteristics; 2) their lives as an individual and as a family in the village, considering environmental and logistical conditions, transportation, entertainment, solitude, education for their children, job opportunities for their spouses and the culture of the Asmat people; 3) their professional work experience, in regard to the health system and policy, work demands, job satisfaction, training opportunities and the relevance of their training to their daily work, and the socio culture of Asmat people; especially their local health beliefs and customs. Some questions were sensitive such as religion and salary. These two questions were asked at the end of the interview and only to those with whom I had built a good relationship and rapport.

I did one informal conversation with the midwife of Polindes Syuru. It was not an intentional interview since I was planning to say good bye before I left Asmat. I had visited her a couple of times earlier, but never had the chance to have a conversation. However, the short duration of the final meeting provided me with concise information about her working experience in Asmat (regarding the support of Puskesmas and her training opportunity) and her refusal to be posted in a village health post.

Two of the participants in Agats were interviewed twice or even three times. Two interviews were enriching as the husband was present and provided good information too. All of the interviews were done at the houses of the participants and most of the conversations lasted for 30 minutes to one hour. The appearance of the children sometimes made it difficult to transcribe the interviews since their voice was exceeding the health staff’s voice of in the recorded interviews.

I cross checked the information gathered about the local context of the Asmat health system and policy with the data of my interviews with the health officials, MSF, head of Puskesmas, Puskesmas staff or Dinkes staff.
Interviews with the stakeholders
The objective of interviewing stakeholders was to determine the local context and serve triangulation with the information from nurses and midwives. The interview included both in depth interviews and informal conversations. The interviews which I considered ‘formal’ were recorded. For the others I used jotted notes or wrote the information after the conversation.

The themes of interviews were as follows: 1) personal background, 2) impression about the quality of health care at the village level, 3) opinion about the challenges for nurses and midwives to work in the villages; 4) opinion about the reason why health staff were absent or remained in the village; 5) recomendation to making health staff stay in the villages.

During my fieldwork the themes of my interviews with stakeholders varied depending on with the participant. For example, with the Dinkes staff I went into depth on the theme of health policy, with the traders I went into depth with the theme of their experience with the Asmat people, with the priests, I asked about their experience with the socio culture of Asmat.

Participant observation
I did participant observatory in three different places, in Pustu Bu Agani for one week, and during my stay in Pos and Agats.

Participant observation in Pustu Bu Agani
I was lucky that I could stay with a midwife in Pustu Bu Agani. During my stay in Sawa Erma, the midwife was the only staff who remained in the village, others were staying in Pos. During a one week stay, I could not avoid providing consultation to the community of Bu Agani village. The news that ‘there is a doctor in the village’ was spreading quickly, and patients came to the Pustu requesting to be examined by ‘the doctor’. I did three days of consultation, which provided me with insights about the process of consultation with a limited drug supply and medical equipment, facing Asmat people as patients with their limited Indonesian language and understanding of medical terms. To some extent I was ‘positioned’ as the midwife.
Aside from being ‘involved’ in consultations, I experienced the daily life of living in the village; eating available food, drinking rain water, hanging out with the villagers, and meeting with the head of the village. I also visited the elementary school and chatted with the principal and the teacher.

During my stay in Pustu Bu Agani, I observed the following themes: 1) family life, entertainment, school facilities, the husband’s work, religious practice, water supply, transportation, entertainment, relationship with the indigenous population, daily food etc; 2) the medical service provided by the midwife, the drug supply, condition of the clinic, existing medical equipment, guidelines and standard treatment, referral possibilities, requirements for reports, and the demand of the workload. During the night, I had informal conversations with the midwife and or with her whole family about their life and work. I also shared my life, my study in Holland, previous work and information about my family.

**Participant observation in Agats and Pos**

During my stay in Agats, I lived in a house that belonged to a Catholic sister (even though she was a Catholic sister, she does not wearing a veil since her role was to be part of the community). Since the sister was a youth activist, the house was regularly filled with young people. I frequently hung around with these young adults. I was living simply without support and so I experienced the challenge of scarcity of water, electricity, and food. This differed from my previous stay in Agats when I lived with the MSF staff who provided me with water and food.

In Agats I frequently visited the Catholic missionary compound and chatted with the Catholic priests. Buying food at the small restaurants (warung) and meeting people, chatting with traders and local people about their experience became a source of valuable information for me.

In Pos, I stayed in an MSF house, since I didn’t have any alternative housing and wanted to experience real life there. However, living with the nurses and midwives of MSF also provided me with valuable information in regard to their experience working with the health staff in the villages. The MSF staff provided information about the nurses and midwives availability in Pos, their
absence and their working experience with the health staff in the village health posts.

**Challenges**

In the field, I could not implement my daily and weekly plan. People were often not in their office but out of town, attending training in other district or going to other village. It was not easy to contact them using a mobile phone nor was it easy to find their address in Agats. The streets have no addresses, the houses have no numbers and neighbors sometimes can not give reliable information either. Looking for a house by asking people and walking under the ‘heat’ on a path made from crackly lines of wooden piles (always watching for large fissures or brittle wood), were challenging experiences. Ultimately my daily strategy was to reschedule and meet people by chance.

To gain a good understanding about the experience of the health staff living and working in the village health posts in Asmat, I initially planned to do focus group discussions (FGD) and in depth interviews with the health staff. The FGD was intended for those who were absent and staying in the capital in order to gain insight about their main challenges faced in the village and this information was expected to guide my participant observatory process. However, since the categorization of health staff was problematic and organizing people to gather in one place at one time in addition to the uncertainties of whether the group would be homogenous or not I chose to do in depth interview with nine staff instead of holding a FGD. I sometimes felt as if there was an unharmonious relationship between the health staff when they talk about each other. This was the reason that I cancelled the second FGD which initially planned to be done in the middle of fieldwork.

**Data processing and data analysis**

I performed all data collection by using an audio recorder, and kept my notes using diary and jotting notes. The majority transcriptions were done by two persons who helped me during and after the fieldwork, an MSF nurse and one of my cousins. The importance of confidentiality was emphasized with the two transcribers since
the information could contain a private information for the participants. I did minimal editing while checking the transcriptions. I also did all translation into English.

At the end of each day or on ‘empty’ days, I listened regularly to the recorded interviews. The data was coded and even if the transcription had not yet been done, key quotes were written and categorized. This way, missing data was immediately identified and could be gathered soon in the following days. The data taken from the health staff and the stakeholders were grouped based on the different themes of this research.

I found that writing my findings in an unrecorded conversation and writing a daily diary was a big challenge since I had to fight falling asleep during the night.

**Ethical considerations**

I had to pass different levels of gatekeepers before I could even go to the field. A combination of formal and informal requests for permission was used until I managed to legally set up the study. I openly explained my status as researcher and my study purpose.

Written and oral informed consents were requested from the participants. The written consent was given especially to the nurses and midwives. I requested permission to record interviews before beginning the conversation.

As a guest, I did my best to follow the local norms and customs within the community. The local people show friendliness by greeting people in the street whether you know them or not. While I stayed in *BuAgani*, it was customary to say ‘selamat pagi’ (good morning), or ‘..siang’ (.. day) and ‘..malam’ (..evening). This is an uncommon custom in a metropolitan city like *Jakarta* or even in my hometown, *Malang*, East Java. I did not find it difficult to adapt this habit since during my stay in Amsterdam daily greetings is also customary.

As an Indonesian, I was frustrated with the some of the findings of my fieldwork. The noble legacy of ‘development’ and ‘health improvement’ which was delivered by the government and the Catholic priests for more than 50 years did not result in any significant improvement for the Asmat people. At some points I judge the jargon of ‘development’ as a symbol to kill the culture of Asmat. I
believe that before the intrusion of outsiders, the Asmat people might have had a better life than they have now. This frustration did affect my spirit during the fieldwork, and after reading Scheper Hughes’ (1989) description of critical medical anthropology I have affirmed that it is the responsibility of the medical anthropologist to analyze this issues and bring useful recommendations for a better cultural fit for ‘development’ work.

Reflection on my position in the field

There are four labels of me as researcher which influence my role in the field. These labels are me as a medical doctor, ex MSF staff, and as an unmarried person.

While conducting the fieldwork, I could not separate my position both as a researcher and a medical doctor. Immediately it appeared that people already recognized me as a doctor, calling me ‘Dr Mila’, even when I tried to offset the medical doctor label by introducing myself as ‘Mila’ only. Being a medical doctor was automatically linked with providing consultation. Sometimes people directly asked, ‘Do you have the drugs for this disease or that disease’. There was no place I could separate myself from the fact that I was and am a medical doctor.

As a medical doctor, this status led me to provide medical consultations for three days during my stay in Bu Agani. I was frustrated with the experience of consultation in the limited conditions of Pustu Bu Agani since I had previously worked as MSF staff assisted by two nurses, adequate drug supply and equipment. I could not perform good diagnostics or provide a rational treatment since there were limited drug options.

In addition, I needed to control my impulses to take over immediately when the midwife was providing medical treatment. I did not want to create a bad impression of her in front of the patients. I could not train the midwife explicitly and give the impression that I considered her as having less knowledge and skill. So what I did was show her how I did the diagnosis process, physical examination, and prescribing drugs without overtly imposing my knowledge and skill with her.

In terms of power relations during my fieldwork, I realized that my position as a medical doctor was in a higher social position than that of the midwives and nurses. The formal letters from Dinkes and Puskesmas which stating their
permission for me to collect information in the field may have made the health staff's consent for participation as 'obligatory' (Thorogood 2006). It is possible that the one to one interviews which I performed could have been intimidating to the nurses and midwives since they may have thought they should give an ideal picture of their situation. That is why more than one interview was performed so that I could build rapport and try to offset the power imbalance. The more honest or 'private' information, was eventually revealed after the second or third conversation. Ultimately one nurse was able to call me ‘Mila’ but not until my third visit.

The perception that I was MSF staff was both an advantage and a disadvantage. MSF has provided me the opportunity for transportation support and more importantly served as a reference for medical consultation. I could request MSF help for the diagnostic process for the patients with tuberculosis who I interviewed. They also transported the drugs from Puskesmas to Bu Agani. The disadvantages were that the community of Bu Agani perceive me as MSF. The impression was that I, as MSF, was providing medical services. I worried that the locals might perceive my services as ‘better’ compared to what they had and this perception could harm the integrity of the midwife, Dinkes and Puskesmas.

As a young woman, unmarried and with no children I could also have a relative closeness when having conversations about family and children. It is possible that I was not sensitive enough to recognize the situation or information from the local nurses and midwives. It took time and rapport for I could gather grasp how the participants perceived the importance of their personal and familial aspects of work in the villages.

I felt that being a non-Asmat did not create any difficulties during the fieldwork. I did not feel that the Asmat people had a critical attitude towards me as I had predicted. Furthermore, in terms of language, all my participants were able to speak bahasa Indonesia (Indonesian language), except most of the patients in Bu Agani who have little knowledge of Indonesian language. However, I got some help from the kaders who acted as my translators during consultations.
Limitations

I am aware that some of my questions to the nurses and midwives were about their situation in the past, which might have affected the accuracy of their recall. My position as a medical doctor, could be considered to be higher than the nurses or midwives. This combined with the fact that I was a former member of MSF staff, who were considered as outside the system, might have harmed the integrity of the people or the system and could have caused the information from the participants to be biased.

The methodology of convenience sampling and the cancellation of FGD might provide different perspective on certain topics could which brought the data that culd have been unrepresentative. Additionally, I only did the study in three selected sub districts in a limited duration of time. Therefore, my results should not be generalized.
In this chapter, I will explore the personal aspects that the midwives and or nurses considered important when talking about their motivation and decision to stay and work in the village health posts of Asmat. The personal circumstances discussed here include; personal goals, family including husband and children, and personal relationship and emotion.

I provide two brief life histories with significantly disparate features such as the reason for the staying and working in the village health post and the reason for leaving the post respectively. The first case study is Sondang, a midwife who works in Polindes Tomor (Sawa Erma sub district) and the second is Nurdin, a nurse who had worked for three months in Pustu Uwus (Agats sub district) prior to this study. The life histories were based on information and narratives from our conversations combined with data from other resources, such as MSF staff, Heads of Puskesmas and my own observations.

In the second section I define personal aspects that are considered important by the health staff by doing a chronological comparison of the two stories and insert other information from the other health staff in order to have a representative analysis.

**Life history 1: Family ties of Sondang**

When I was in Pos, Moe (an MSF nurse) told me that Sondang was also in Pos. Moe showed me the house where she was staying, next to the mosque, located just a five minute walk from the MSF base. The first time I visited the house, a young man, the tenant of the house, said that Sondang was out on a business and he advised me to return the next day. The next afternoon I arrived at the house and greeted a middle aged lady wearing a Javanese sarong. I introduced myself explained that I was there to meet Sondang. She said that she was Sondang and we shook hands, a formal way to introduce ourselves to each other. She asked me to
please sit on the bench on the veranda. I could feel her strong character from the way she talked. I explained my purpose and the research that I was conducting. The situation was initially quite formal, especially when I handed her the informed consent. Later on we became more relaxed as we chatted about her experiences with MSF. She confirmed her close relationship with the MSF staff particularly during the MSF monthly visits to the Tomor area. Sondang’s husband, Edi, who is also a Sumatranese, joined our conversation.

Sondang is a 42 year old Bidan C, originally from Medan, North Sumatra who has been working in Asmat for 11 years. The first four years she worked in Sawa village (three minutes by speedboat from Pos) and then until now in Tomor village (two hours by speedboat from Pos). She met Edi, a Sumatranese trader and got married in Sawa Erma. They have two children; the eldest daughter, a 5th grade student in elementary school, has been living separately with a relative in Pos to study and a five year old son who stays with his parents in Tomor. Sondang’s daughter went to school in Pos because although there was a school in Tomor there was no teacher.

Sondang stated several times during our conversation that ever since she can remember she had always wanted to be a midwife. After finishing high school in Medan, she and her family could not afford to pay for her midwifery studies. So, she decided to work as a helper in a midwife’s private practice for two years. Using a letter of recommendation from this midwife, Sondang migrated to Jakarta following her family who had migrated earlier, and tried to look for a job related to midwifery. Her older sister succeeded in arranging a job for her in a clinic. But with only a high school diploma and two years experience as a midwife’s helper, Sondang said that frankly she could only work there as a ‘maid’. In the clinic Sondang met Dr Ike, a female doctor and recent graduate from Yogyakarta, who was impressed with her work. When the doctor needed help she always called Sondang. However, due to her low educational background, Sondang could not find a better work opportunity in Jakarta. She was invited by Dr Ike to go to Papua and was promised an opportunity to join the free midwifery training there.

Convinced that she could pursue her desire to become a midwife, Sondang went to Papua and joined the Bidan C training for one year in Merauke. She
moved to Asmat following Dr Ike who was searching for a challenging work site. Dr. Ike and Sondang stayed in Sawa Erma and Sondang continued with another year of training.

When Dr Ike finished her PTT18 duty, Sondang was already working in Erma village. She was sad and hesitant about being left by Dr Ike, a person with whom she had been close over the years. However, she was agreed to remain in Asmat even though she cried frequently and was terrified of drowning since she could not swim. She convinced herself to remain in Asmat because she has the niat (intense wish) to become a midwife. She felt that perhaps Asmat was her destiny where she could have rezeki19 [money, fortunate].

"Finally she [Dr Ike] went home, I encouraged myself to stay here alone. [...] Even though I didn’t know how to swim. So, I stayed here alone. That was the right thing... I don’t think there were other problems. Because I want to be a midwife, so I have to be one. I already have the niat [...] May be this is the place of my rezeki. "

She further described her personal feelings of solitude and her relationship with the villagers. She mentioned the behavior of the villagers who like to ganggu-ganggu (irritate several times) her by knocking on her windows during the night.

"Sometimes during the night people [the villagers] suka ganggu [like to irritate] me. Yaa.. it’s common here ganggu-ganggu [irritate several times].. knocking on your window.. but well sometimes I remain still.. we could not oppose them, couldn’t we. Finally... [I] accepted it, as long as [they were] not kurang ajar [ill bred]..."

Sondang did not mention why the villagers did this action, but according to other health staff who also heard the story from Sondang, local men were trying to 'offer' her money to have sex with them. After a while this irritating behavior stopped.

Sondang had acute feelings of solitude since the villagers stayed in the forest most of the time and she could not understand the local language. She mentioned that after one week it was not so 'spooky' anymore since she was getting used to the desolation and that the local people started to 'like' her. Furthermore after her marriage and the birth of her first daughter, her feeling of

---

18 PTT (Pegawai Tidak Tetap) is a temporary civil service status. For medical doctors, PTT is an obligatory duty for the recently graduated doctors to work in a Puskesmas for one to three years.

19 Rezeki usually refers to a fortune that comes from God.
sollitude evaporated. At that time her husband Edi was going back and forth from Tomor to Erma to run his business. Edi was selling his brother's trade items (such as food, clothes, etc.) in Tomor and surrounding villages.

After getting the approval from the Head of Puskesmas, the family decided to move to Tomor even though the place was much more remote than Erma. The decision was taken because they want to be together as family and it was more economical to be together than to live separately. Edi explained to me that the decision to move to a more difficult place is important and logic.

"In regards to the [distance of the] place, it should be no problem as long as we stay together... Even, if [you are] assigned in a jungle, as long as there is a chance for business... It is not a problem of location. Anywhere is the same. Family is the first [priority]. So, I need to think about the future, the children, to live decently"

Sondang complained about two aspects of her life in Tomor; the limitation of food and the feeling of discrimination from the villagers. While Papuan midwives got fish from the villagers for free, she had to pay for it, sometimes even at an expensive price. Despite these complaints, Edi said that the family stayed in Sawa Erma because it is the safest place in Asmat. In addition, the area provided the feeling of "fit-ness", as Sondang said:

"If [I should move] to Jakarta, to the cities... [I] don't feel fit, I think. Because here.. I feel calm, comfortable and no body ever hurt me, yet. So we are safe here.. safe.. I think"

Sondang also felt that her work as a midwife was appreciated by the local villagers. People listened to her and accepted her advice. In other places she had worked, Sondang believed that the villagers were more resistant to her practice and advice. Edi mentioned that other Papuan communities had villagers with 'higher brains' compared to the Tomor villagers. He and Sondang concluded that their community in Tomor was relatively 'easier' to serve compared to other Papuan communities.

Sondang casually mentioned that actually she wanted to be posted in the Puskesmas Sawa Erma and that the Head of Puskesmas, had attempted more than once to recruit her to work there. However, Sondang did not think that working in the Puskesmas would be an option. Edi's work was in Tomor which made it
difficult for her to be assigned to the Puskesmas in Sawa Erma, she felt that the Puskesmas staff had feelings of jealousy towards her and she felt job satisfaction since she could work on her own in the village of Tomor.

"Too many jealousy [in the Puskesmas], the jealousy is too high. In Tomor, I'm alone, 100% I have the whole ideas. Cannot use this, I use that."

Sondang said that in the Puskesmas, she was always the *kambing hitam* [black goat]20. One time, she was accused of changing the IV bottle of a patient in the Puskesmas. "How come, I did not know the patient; I did not even go to the Puskesmas, so how come it's me?". Her innocence was finally proven after Sondang asked the patient herself to confirm that she, Sondang, was not the one who changed the bottle. The atmosphere of jealousy among the Puskesmas staff, directed at Sondang, elicited in the following story from Sondang:

“When I’m staying in Pos, people usually call me [for house visit medical consultation]. So I said to them, [I feel] not comfortable with my colleagues here [...] There will be misunderstandings, so please be careful with our feelings, if you want medical consultation, just go to the Puskesmas, I cannot do the house visit. Everyone has their own duty. [...] Still some people rebelled to go to the Puskesmas.”

Despite all the reasons to stay in Tomor, Edi and Sondang shared their current thoughts about moving to Pos. Their daughter in Pos was going to be in the 6th and last grade of elementary school. The 6th grade is the most crucial because in this last year the students prepare for the final national examination which determines graduation and entrance to junior high school. After living apart from their daughter for several years, Sondang was determined to move to Pos:

"Next year I’m coming here to take care of my daughter. [...] We’ve been sacrificing our daughter for many years, so I thought, this year we move here."

Sondang mentioned the consequences they would endure if they moved to Pos. First, Edi would need to travel back and forth from Tomor and Pos, which meant

---

20 *Kambing Hitam* is a metaphor for someone who is always accused of doing something bad or as a cause of disastrous events
spending more money and secondly, they didn't have a house in Pos. The governmental houses for Puskesmas staff in Pos were all occupied.

Every time Sondang’s family stays in Pos, they stay in the mosque’s house. Sondang said the tenant has been so kind and tolerant to give space to her family in his house. When Sondang’s family comes, her daughter who normally stays in the house of Edi’s relatives prefers to come and stay with her mother and father. I sensed Sondang and Edi’s longing to stay together as a family. Edi mentioned that it was convenient for them to stay in Tomor since there is problem with housing.

At the time of my conversation with Sondang and Edi, they were staying in Pos to wait for an impending incentive for Sondang that would be announced by Dr. Gie, the Head of Puskesmas. Sondang also wanted to inform Dr. Gie that she planned to move to Pos. Dr Gie was a new doctor from Sumatra and been staying in Pos for the last two months. Sondang was waiting indefinitely for Dr Gie’s return from Agats where he had gone to manage a patient with obstetrical bleeding. Sondang and Edu needed to arrange their move to Pos this year because next year, Tomor will be an independent sub district, and have its own Puskesmas. By that time arrangements would be more complicated, since Sondang would need to go to Dinkes too for permission to move. This year was the opportunity to request the transfer in a simple way, at the Puskesmas level. Regardless of any constraints, Sondang asserted her determined intention to move to Pos.

“If Dr Gie said it’s not possible [to arrange now], and it has to be next year. Well.. [Whether you] want it or not, I will affirm to move this year.. I feel sorry for my daughter, it’s been enough that I serve the community.. It’s been many years.”

Both Sondang and Edi felt that there was discrimination against them due to the fact that they are not Papuans. They felt that at some point arranging the move to Pos and getting a house was more complicated for them compared to the experience of a Papuan nurse, Feri, who had successfully moved from Munu village and got a house in Pos with no problem. Sondang and Edi implicitly revealed their feelings of discrimination, as Sondang said cynically:

“Where he [Feri] wants to go, [his request] was complied, because here.. people said... dia punya wilayah [this is his area of authority]
My conversation with Sondang and Edi lasted for about two hours. Sondang offered to have me to stay in their health post in Tomor for my research. Both Sondang and Edi said that if I only used information from interviews I would not be able to grasp the real experience of living and working in Tomor.

The story of Sondang reflects how her changing behavior to stay or leave the village health posts was based on a variety of reasons that prompted by her own motivation and familial motivation. Her subsequent actions and reasoning were a result of a continuous process of negotiation between her desires and structural conditions.

A 'niat' to become a midwife, led Sondang to pursue her education and work as a Bidan C. It constructed her to submit herself to work in a challenging place like Asmat. After getting married, she moved to a more remote village since she considered that being together with her husband and being supportive in his work was important. She valued the being a dedicated wife for her husband. Later her daughter's future and education became the main reason to move to Pos despite all odds. At this moment she puts all her efforts to become a dedicated mother.

Throughout the story, I have described some emotions and contradictions which describe the process of decision making of Sondang. She expressed hesitation and her worries when Dr Ike, a close friend who gave her praise and encouraged her to continue with her desire to be a midwife left her in Erwa. Alone in Erwa, she endured the dreadful fear of death and the feeling of solitude although she was able to adapt. There was a feeling that Asmat was her destiny, a place where she might be fated to earn a living. The feeling of discrimination as a non-Papuan came up in her relationships with the villagers and also as related to the health policy in the Puskesmas. This feeling of discrimination contradicts her stated feelings of comfort and safety living in the village.

**Life history 2: Nurdin's ultimate goal to become a civil servant**

Nurdin is a 27 year old male nurse who originated from Solo, Central Java, and the same city where he graduated from a D3 (diploma) nursing academy. He is single but has a relationship with Indah, a Javanese female nurse, his colleague at the
They were planning to get married in Java, after the *Idul Fitri*, which falls in October this year. I knew about Nurdin from a MSF professional who had met Nurdin only once in *Pustu Uwus* (1 hour 10 minutes by speed boat from Agats). Vero, my housemate, happened to be a good friend of Nurdin and gave me his address.

I went to visit Nurdin’s house in the area where Vero had told me to go. Unlike other unnamed streets, this one had a brand new street sign. I could see from the iron plate planted at the T-intersection of the street. The name was *Muyu Kecil* (means small *Muyu*), but the houses had no numbers. Luckily, I only had to ask people once where Nurdin’s house was. A Javanese trader told me, “Ooo, Pak Mantri [means Mr. Nurse]?”, then she pointed to a house in front of her restaurant, “He lives in one of the rooms in that house”.

I followed the lady’s instructions and entered the open front door. It was a house with a big hall in the middle and it had eight rooms in total. One door was open on the right side where I met Indah, Nurdin’s girlfriend. Nurdin was away at that time. Indah said, “He [Nurdin] got slandered the other day, doc. So, at the moment [he is not working at Uwus anymore, [but] is working at the Dinkes. Usually he arrives home after 2 pm.” I met Nurdin the next day and then on two other occasions.

In Nurdin’s room I saw piles of drugs and a row of syringes with needles. Some drugs were antibiotics and based on the name written on the bottle or printed label on the boxes they were *reserpin*, *becarbon* and *CTM*. I could confirm that Nurdin does private consultations in Agats when one day he said, “I have an appointment with a patient this afternoon.” Indah and her sister came to Asmat from Java and brought many different kind of drugs which indicated to me that they intended to do private consultations in Asmat.

---

22 *Idul Fitri* is an annual Islamic festival celebrating the end of *Ramadhan* (the fasting month).
23 *Muyu* is a name of a tribe from *Boven Digul* district
24 *Reserpin* is an antihypertensive drug
25 *Becarbon* is an activated charcoal, an absorbent material which can be used for gastrointestinal complaints or as an antidote for ingested poisons
26 *CTM* is an abbreviation of *chlorpheniramin malic*, an anti histamine drugs. It is usually used for symptomatic treatment of nasal discharge and anti allergy.
The journey to Asmat

On our first meeting Nurdin was open and friendly. After a long walk, for about 20
minutes from the Dinkes office, under the heat, he was sweating in his white
uniform. He smiled and greeted me in Javanese. Indah joined him and the three of
us sat on the floor of his room. He asked me how I ended up studying in
Amsterdam and what kind of study was I doing. After sharing my background and
study I explained my intention to do research in Asmat. He exhaled a long breath
and said, “the only reason [to be here] is social economy factor”. Later on, he
mentioned again “coming here only for the job and income”. He mentioned an
‘extreme’ difference between his current job and his former job since in Java his
salary was 150,000 IDR (around 10 euro) per month but in Asmat, as a civil
servant, he could get up to 6,000,000 IDR (around 450 euro). I sensed from his
way of taking a breath that he was tired and might need lunch and a nap after work.
I offered to meet him again another time when it would be more comfortable for
him. He agreed to continue the chat next time.

At our second meeting, Nurdin told me the history of how he ended up in
Asmat. When he was studying at the nursing academy, there was collaboration
with the Asmat government. He found out from a father of his colleague that Asmat
need human resources including health staff. The man also explained that the
Asmat situation was different compared to Java. Asmat has no roads but wooden
boards for walking and those are the only means of transportation. However,
Nurdin was seduced by the opportunity to become a civil servant in Asmat, this
opportunity would have been almost impossible had he stayed in Java. He said that
even though Indah did not want to join him, he was determined to go to Asmat
after graduating the next year.

Nurdin came to Asmat in October 2004. It took two months for him to
reach Asmat by sea. He complained about the long transit and uncomfortable travel
he had experienced. Once he arrived in Asmat, he realized that the living
conditions were harsh, but he discovered that the salary was very high once a
person becomes a civil servant.

Since Nurdin had only 15,000 IDR remaining in his pocket upon arrival in
Asmat, he worked as a construction worker for about 18 months until he could be
employed as an *honorer* (temporary worker) in *Puskesmas Agats*. The salary of an *honorer* did not fulfill his daily need for food, etc. He then took a site job as a billiard watchman, which he arranged based on his shifts at the Emergency Room of *Puskesmas Agats*. In December 2005 Nurdin took the civil servant test.

After working as an *honorer* in *Puskesmas Agats*, Nurdin wanted to move to *Suator*, a sub district located about six hours from *Agats* by speedboat, where the cost of living is cheaper compared to *Agats*. The geography of *Suator* allows for cultivating vegetables so the price of food is relatively cheap and Nurdin could plant vegetables himself. Nurdin spoke with Dr Steven, the head of *Puskesmas Suator* and requested that he and Indah be transferred there. Dr Steven accommodated him and arranged for Indah to come from Java and with Nurdin. They worked in *Suator* for 18 months.

On January 2007, Nurdin was expelled from *Puskesmas Suator* and went back to Java with Indah. They stayed in Java for four months and worked in a *Puskesmas* as *honorers*. Nurdin implicitly avoided explaining the reason why he was kicked out of *Suator*. He mentioned that this action was related with to the ‘injustice-ness’ treatment he had received even though he had been providing services to the community sincerely from the bottom of his heart. The community in *Suator* has ‘trusted’ him especially when they felt ‘suitable’ with the drugs he gave them. He said that even though he never requested and negotiated any fee the community, especially the outsiders (non Papuans) usually ‘appreciated’ his help by genuinely him tips. He compared himself to a Papuan staff member in *Puskesmas Suator* who stole from the *Puskesmas’* budget, escaped to *Merauke*, and was never reported to the police. Furthermore, this Papuan staff member still had civil servant status including his monthly salary.

The story of Nurdin, led me to Dr. Steven, who is currently the Head Deputy of *Puskesmas Agats*. Dr. Steven told me that Nurdin was ‘trouble’. In *Suator*, he did private consultations and treated people with *diazepam* and *luminal*. The community complained because some patients started to fall off the wooden paths. At one point, the problem became a police case and Nurdin was charged with abusing narcotics. Nurdin was fired.
Nurdin said that initially he did not want to go back to Asmat until he got a phone call from a friend in Asmat telling him that he had passed the civil servant test. He described his consideration to go back to Asmat:

"I was considering like this... because in Java, I was working as honorer with salary of [only] 150,000 IDR per month, plus 20,000 IDR if we replace somebody on the emergency room shift. After the telephone call, I considered carefully.. Shall I take.. or not?... So, I took it."

On June 2007 Nurdin and Indah went back to Asmat. When Dr. Steven saw Nurdin attending the Pra Jabatan (civil servant briefing), he was extremely surprised, "How can a person with a criminal background, pass the civil servant test, and moreover be recruited as a civil servant?" Dr. Steven was laughing.

Nurdin stated that the civil servant position was the reason he stayed in Asmat. He also mentioned his plan to pursue a higher degree probably using the opportunity of scholarship that is provided every year by the government.

"That's why I'm here. I live here because my SK [decree letter stating that someone has become a civil servant] is here. Indeed, I have a future plan. If there is no obstacles, in one or two years I want to continue my study into a bachelor or if possible, for a master degree too"

After his inauguration, Nurdin was recruited as a nurse in Pustu Uwus, by Robby, the Head of Puskesmas Agats. Robby is a male nurse with a bachelors degree in public health. Robby said he recruited Nurdin not only for his high educational background, but also to give him another chance, despite his criminal background. I got information from Robby that actually Nurdin had asked him to assign Indah with him in Uwus. However, Robby said that it had not been possible since Nurdin and Indah were not yet married. Indah was ultimately assigned in Suator. Several times Nurdin expressed his worries that Indah was alone and living far away from him. One time, he strongly stated, "If one day, something bad happens to Indah, I will be very, very angry."

Nurdin stayed in Uwus for only three months and was treated in an "injustice" manner by the Puskesmas being slandered and accused of cutting the fuel hose of Puskesmas Agats' speed boat. Robby explained to me his version of the fuel hose. One day after he had carefully prepared to use the speedboat for important guests he got very angry to find out that the fuel hose fuel was cut. The
community said that Nurdin was the person responsible. Robby mentioned how he was extremely humiliated by the situation. After the incident, the long boat of *Pustu Uwus*, initially provided to Nurdin by *Puskesmas* for transportation in *Uwus*, was withdrawn. Nurdin could not go back to *Uwus* after staying in *Agats* for one month.

Nurdin went to Robby to confirm what was going on and what was the cause of the withdrawal of the long boat. But no clear answer came from Robby who said, “[I] cannot, I have lots of problems. Not only you [Nurdin] who I’m taking care of.” Nurdin said he had tried to confirm the situation but got no answers. Nurdin believed that he was slandered by he doesn’t know who. Robby confirmed to me that later on that he found out that Nurdin was not the guilty person.

Nurdin tried to describe ‘the injustice-ness’ of the situation by comparing his noble intention to work and his disappointment for the hard work he had done:

“The first time I come here was on behalf of humanity. Actually, I have a high sense of humanity. I can not see some body like this or like that. I can’t. Regardless the person comes from particular corner of this earth. But, what make me furious, because of one small mistake, we got dumped, that’s what makes me very furious.”

He also described how the community appreciated his hard work and his concern towards them:

“I asked the community, before I come here, the staff before me, was he willing to serve you every day, 24 hours? [They said] No, no, he didn’t want to, Sir. If he already asleep, he didn’t want to be waken up. [Nurdin said] See how much I love you.. You wake me up at 12 am, or 1 am, somebody needs to give birth, I [always] help you. If others, those staff who doesn’t care, will he do the same thing?”

Nurdin went to see the head of *Dinkes* to explain the unjust treatment he had from the *Puskesmas*. He first explained to the Head of The Dinkes about the hard work that he had done. He said that during the one month of work he had been working hard and in a dedicated way towards the community. However, he also ‘admitted’ his one month absence and mentioned the reason was fuel scarcity in *Agats*. The Head of *Dinkes* gave him a position in *Dinkes* office.
Nurdin described his conversation with the Bupati adjutant who was aware of Nurdin's absence in the village. Nurdin tried to explained to him that he was a 'victim' who was saved by the Dinkes, that it was not his intention to be absent from the village, but that the Puskesmas did not allow him to work there anymore.

Nurdin mentioned that there was food scarcity in Uwus since there were no traders to sell food and unlike Suator he could not do any gardening either. He had to travel regularly to Agats to procure food stock. Due to food scarcity in Uwus, Nurdin described his willingness to help the community trade some goods including food. According to Nurdin, he undertook these trading activities as a moral commitment to the community even though it is prohibited by the law of civil servant to have additional businesses. One day a villager complained that the prices he set were too high and tried to intimidate him by mentioning the possibility that someone could report his activity to the Head of Dinkes. Nurdin said that it was actually the community who had requested him to trade and if they reported him, it would mean that they did not appreciate his noble help.

One day I visited the Dinkes office and I saw Nurdin's new job. He was sitting behind a desk in the front office with a big book on it. He asks guests their names, the purpose of their visit and noted the date and hour. Then he filled the book with that information. Sometimes he cleaned the surrounding area of the Dinkes office. Nurdin said that it was a boring job, actually. By the time I left Asmat, the Pustu Uwus remained unstaffed.

Nurdin's story clearly illustrates his goal to become a civil servant and how he manages different contingencies to reach and maintain that goal. He came to and lived in Asmat despite the tough journey and harsh living conditions. Later on he endured the bad 'stamp' as a 'criminal' and returned to Asmat. The status of a civil servant provides him a firm basis to form a family with Indah. A scholarship opportunity in Asmat will also accommodate his goal to pursue higher education.

As a civil servant and with the humanitarians values he holds, Nurdin was willing to work at the village health post despite his concern about the safety of his future wife. This situation was disrupted by the malfunction of health human resource management which constructed him to leave the village permanently. Subsequently, Nurdin was able to use the malfunction system of health policy and
civil servant regulation to sustain his civil servant status just as when he got the status in the first place.

DISCUSSION

Initial 'constructed' decision of the health staff

Like Sondang who asserted that to become a midwife was her desire and therefore she had had to come and work in Asmat, another six midwives mentioned that they had a 'willingness' or 'wanted to' or 'having a talent' to be a midwife which by chance was accommodated by the recruitment of Bidan Cs in Papua. They heard about the recruitment from friends, family or word of mouth. One person mentioned that it was her parent’s choice since they didn’t have the money to send her to continue her high school education. One midwife did not mention her reason to become a Bidan C. One nurse came to Asmat because her husband was living in Agats. Only Nurdin who mentioned that to become a civil servant was his initial reason to come to Asmat.

For Sondang, who perceived that being a midwife provided a better status compared to a maid, other midwives might also have been absorbed in the ethnocentric discourse of a medical profession as one of the 'elite' professions compared to others. The high maternal mortality in Indonesia during the 1990s has enabled these women to become midwives through a free training, relatively simple educational qualification and subsequently gives them a sustainable job. It offers a 'gold' opportunity especially for those who have economic constraints or limited educational backgrounds. However, as a Bidan C, they are obliged to work in the remote villages. At this point the 'forced compliance' (Moore 1989) of these midwives was created to achieve the objective of Bidan C national program: to improve the access to health care in remote villages.

For Nurdin, the political status of Asmat as a new district offered him and other outsiders who have been swarming over Asmat to become civil servants, a status that can sustain their personal and familial life.

Obviously, all the health staff’s initial reasons to come and work in Asmat; either to pursue their desires, or to follow their familial choices were framed by a
range of broader economic and political circumstances. The structural aspects of Asmat were both constraining and enabling them to pursue their desires.

The ongoing experiences
Sondang’s and Nurdin’s stories represent different personal circumstances that influence the decision making process and action whether to stay or leave their village health post. This is also occurred with other health staff during their ongoing experiences of life in remote Papuan villages.

Spouse’s Job
In Indonesia, the general discourse about the relationship of a husband and wife is conditioned by the family and gender relations that consider the wife as the one who has the moral obligation and responsibility to support and ‘serve’ her husband. Based on this discourse, the job location of a husband impacts the midwife’s decision to stay or leave their post.

In total there were five health staff, including Sondang whose husbands stay with them in the villages. These men usually work as traders doing business with gaharu, selling daily needs to the villagers or producing long boats. These midwives generally stay in their village most of the time and rarely travel to the capital of sub districts as do the other midwives whose husbands work in the sub district. These five midwives need to travel and stay for some period of time in Pos or Agats where their husbands work as civil servants, or in the construction business. However, there were two staff who mentioned that their husbands also travel back and forth to visit their wife in their village.

For the unmarried person, such as Nurdin, his girlfriend’s safety and the possibility to work together were perceived as an important consideration to stay and work in his village health post. One staff had no spouse and I don’t have any information about her personal relationship.

Children’s Education
Even though the husband’s job is considered important, later on the priority for the nurses and midwives to stay or leave their villages depended on their children’s
education. The absence or low quality of educational facilities for children in the villages was mentioned by four health staff in regard to their presence in the village. All of them had to live separately from their children. They sent their children to the capital of the sub districts or to another district for studying. When their children become older, education became a reason for the health staff to leave their villages permanently, as in the case of Sondang,

Sondang's situation is different than Ana, a midwife in Bu Agani (Sawa Erna sub district). Ana thought that even though the quality of the education in Bu Agani was not good, she would take her son (who had been living in Merauke for couple of years) back to live with her and continue his elementary school in Bu Agani.

With the current educational system in Asmat, it can be predicted that like Sondang, other health staff will ultimately decide to move from their villages to the sub districts to be with their children when they move to higher education (above 6th grade).

To pursue further study
In addition to Nurdin, there were three other staff who mentioned that they would like to pursue a higher degree. One of them thought that it would provide more knowledge while the other two indicated that studying could be a reason to leave the village. Their plan would be to officially leave Asmat then come back with higher qualifications. If they were able to achieve the higher degree it would allow them to work in the Puskesmas, or even in Dinkes and not in the village health posts anymore.

Pursuing higher studies for the health staff meant not only gaining higher qualification, or acquiring further knowledge but also was viewed as a tool to leave the village. A scholarship opportunity provided by the government was perceived as a temptation for the newcomers like Nurdin, whereas for others who had been 'stuck' in the village health post, like the Bidan C's, it was seen as a reason to leave the village health post.
Private emotion

Assignment to a remote place with an unfamiliar environment, new language, and ‘odd’ culture of the local people has created a variety of feelings among the health staff. Several times some health staff mentioned feeling ‘frightened’, ‘being comfortable or fitting in with life in the villages’, ‘being too lazy to work in the Puskesmas’, ‘being discriminated against’, and ‘self worthiness’. These feelings were jumbled in the process of decision making and contributed to the decision making of the health staff to stay and work in their village or to leave.

Sondang had a dreadful fear of death which triggered moments of depression for her. The fear of death was also experienced by Petronela, who was assigned to Beriten village (Agats sub district, one hour by speedboat from Agats). She had a traumatic experience when first visiting the village. The long boat was hit by a strong wave and split into two parts. She strongly refused to be assigned there and told me assertively, “I don’t want to, doc. I really don’t want to [stay and work in Beriten].” She was successfully posted in her current village, Syuru, located 20 minutes walking from Agats. Two other staff mentioned their fright of the Asmat community who were famous for their habits of ‘cannibalism’. However, over time these feelings subsided.

Sondang’s feeling of comfort and fit to live in the village was also mentioned by two other staff, regardless of their ethnicity background. They could not explain how they developed such strong and ‘strange’ feelings, because they also mentioned their contradicting feelings such as the local weird community, discrimination, limited food and transportation, etc. All three of these staff developed this feeling over a long time (more than 5 years) of staying in their villages.

Two health staff mentioned their discomfort with the Puskesmas staff as the reason not to stay in the capital of sub district. Aside from Sondang, Ana used the words “too many frictions” amongst the Puskesmas staff to describe her feeling of being ‘lazy’ to visit the Puskesmas.

The feeling of being discriminated as a non Papuan was mentioned by Sondang and Nurdin. If Sondang perceived that both the community and health policy treated her unfairly, Nurdin only mentioned such treatment by his
supervisors. Siti, as the only non Papuan remaining, did not mention the same feeling. This is probably related to her background of having been raised in Merauke despite being Sulawesinese.

Nurdin and Sondang asserted that self worth was determined by educational degrees and job satisfaction contributed by appreciation from the community and their supervisors. They see educational degree both as a ‘pride’ and asset for the future. They were also proud by mentioning how people satisfied with their treatment. For Nurdin, his discourse of being the ‘hero victim’ (Ortner 2005) by blaming the health policy caused him to be absence in the village despite his humanity value and hard work to serve the community were asserting ‘his pride’. He pictured his private consultations in Suator that had become a police case were actually a ‘noble’ effort to help others.

The discussions above demonstrate how the motivation of the health staff underwent a subtle change that was influenced by the structural aspects of Asmat, emotions, the discourse of morality, values and family gender related norms. These motivations strongly influenced the decision making to stay and work in the village health post or to leave.

In accordance with the stratification model by Giddens (1984) and the concept of “habitus” by Bourdieu (1977), I argue that the decision and subsequent actions of the nurses and midwives in regard to their presence in the village health posts in Asmat were the result of active and continuous interaction between the health staff’s individual motivation and the surrounding structural condition of Asmat. They performed creative actions to pursue their goals towards the structures of coercion. The actions were based on a continuous learning, reasoning and negotiating process of their personal motivations, embracing the norms and emotions, with the structural features. As Comaroffs notes (Ortner 2005:3):

“The motivation of social practice... always exists at two distinct, if related, levels: first, the (culturally configured) needs and desires of human beings: and second, the pulse of collective forces that, empowered in complex ways, work through them."

In the following chapter I discuss the structural aspects that are considered by the health staff as important to stay and work in their village health posts.
CHAPTER SIX

"THE INTERRELATED STRUCTURAL ASPECTS OF ASMAT INFLUENCING THE LIFE AND WORK OF THE HEALTH STAFF WORKING IN THE VILLAGES"

In the preceding chapter, I discussed the personal aspects of the nurses and midwives in relation to their motivation and decision to stay and work in the village health posts. In this chapter, I try to define the structural aspects, namely the environment, socio culture, economy politics, health system and policy that are perceived important by the health staff when talking about their decision to stay and work or not in the village health posts of Asmat.

To understand this, I divide my description into two sections that reflect how the structural aspects are interrelated to each other. First, is the life of a nurse or midwife in the village as an individual and as a family, and second their work in the village health posts. In each section, the structural aspects of the lives of the midwives and nurses will appear in the story and will be included in the analysis.

The following stories are framed by one case study of Ana, a midwife posted in Pustu Bu Agani. I stayed with her for one week of participatory observation. This case study is supplemented by additional information from interviews with ten health staff who also work in the villages, stakeholders, documentary review and my participatory observation in Pos and Agats. A complete profile of the nurses and midwives who work at the village health posts is available in Annex 7.

Life in the village as an individual and as family

Initially, I provide an overview of the context of the villages in Asmat. Each village in Asmat has unique characteristics that potentially create different experiences for the local health staff. However, rather than describe all the villages, I will briefly discuss the villages of Bu and Agani to portray the general condition of villages in Asmat.

The Pustu Bu Agani serves two villages, Bu and Agani and usually people call the area Bu Agani for short. They are only separated by a wooden path, an
elementary school and Pustu which is located between the two villages. The total population is approximately 3000 people. The two villages are located along the river and can be reached by speed boat in about 40 minutes from Pos. There are traders from Java and Sulawesi who buy gaharu from the villagers and sell food or clothes. There is one elementary school with six classes taught by four teachers, one of whom is the principal. Every few months, a priest from a Catholic missionary comes to preach at the church. According to Ana, at the time that I was visiting, most of the villagers were staying in the forest to collect gaharu and food.

I met Ana during my visit with the MSF one week before I came to stay at Bu Agani. Ana welcomed me and accepted my letter from Dr Gie, which stating my intention and requested Ana’s permission for me to stay with her. However, Ana was worried that there might be obstacles to my comfort in Bu Agani. She talked to Moe and Irwan, both are MSF nurses about whether I could eat canned food or instant noodles, or would I be bothered about having to bring my own bed, kerosene for cooking and a lamp that could be used for solar energy to provide light in my room. They assured her that I’m an easy person.

Ana began working in Bu Agani in 1996. At that time Bu Agani had two posts, Pustu and Polindes. Initially she worked at the Polindes which was located in the Agani village while the Pustu Bu Agani itself was staffed by a nurse, who at the moment is working in the Puskesmas Sawa Erma. In 2003 she started to work in the Pustu alone. When the head of Puskesmas asked Ana whether she would be capable to handle the double job, Ana said yes. Ana said that formally she only responsible for Agani village, but she doesn’t mind to serve the Bu community also.

Ana is originally from the Nabire district, western part of Papua province and lived in Merauke before working as a Bidan C midwife in Asmat. She married Luki, a Sulawesinese trader and has two sons, Ricardo (seven years old) and Prajab (two years old). ‘Prajab’ was chosen as a name because Ana delivered him during the Pra Jabatan of civil servants, a status she had been waiting for after serving in the village as a PIT for 10 years. The PIT period normally is only three years. Tamen, a 13 year old boy originated from the Agani village was living with them.
also. He helped with the daily activities of the family and went to school everyday with Ricardo.

I experienced closeness with Ana’s family, by daily chatting with the whole family and sharing such tasks as helping to sweep the floor, making plastic bags for dispensing drugs by cutting a plastic roll and burning one side with a candle. However, throughout my visit and until I returned to Pos, Ana and her family still treated me like a ‘doctor’. They kept called me ‘doc’, prepared my meals, water for shower, and never allowed me to help Ana cook.

The experience of solitude and entertainment

Due to the semi nomadic lifestyle of the villagers, six health staff experience solitude at the beginning of their assignments. Normally, when the villagers go to the forest the villages are left empty with the exception of the old people and old dogs. Some health staff described this situation as ‘dead silence’ or ‘like a cemetery’ or ‘spooky’. According to Esco, the most senior nurse in Puskesmas Sawa Erma, some midwives rationalized their absence in the village and stay in Pos for several weeks by saying, “the village is empty, why should I stay there?” Two out of the six health staff mentioned language as other reason for solitude.

The solitude was decreased over time because the health staff started to know the villagers. The feeling of solitude also evaporated when the midwives got married and had families in the village, like the experience of Ana who said, I don’t feel lonely anymore, my children is my entertainment.” Only Klara did not mention solitude as a constraint. She is a midwife who originally came from the same village where she works now (Ewer village). Her parents and relatives were also living in the same village.

One midwife in Sawa Erma, Hendrika, said that she couldn’t handle the deserted situation in the village anymore, even though she had gotten married and lived in the village with her husband (Jivak village, four hours away from Pos). She used this reasoning to convince the head of the Puskesmas Sawa Erma to

---

27 However, I found that in some villages, like Bu Agani and Manep even though most of the villagers went to the forest, some villagers were actually stayed behind.
transfer her to another village, near Pos, where there is more of a crowd due to the presence of outsiders. In villages where gaharu can be found in the forest, outsiders are attracted to live there to run their businesses. The health staff considered these traders as friends and that they helped to relieve their boredom. In Bu Agani, I observed that Ana only made friends with the traders and rarely spent time with the indigenous people.

Four health staff said that at the beginning, using a radio or communication means, such as SSB radio or HT were one of the forms of entertainment to cease the feeling of loneliness. This was also a mean for communication for the nurses and midwives to contact colleagues in other villages or Puskesmas. The HT that had been provided by the Puskesmas (when they were initially employed in the villages) was broken and never repaired. Ana mentioned that when she was feeling stressed due to loneliness, Dr Ike sent another midwife or nurse to provide her with company.

The head of Puskesmas Sawa Erma and other stake holders were aware of the solitude problem and limited entertainment facilities. Some of them ‘justified’ this as a logical reason for the health staff to be absent in the villages.

From the description above, I conclude that feeling of solitude is influenced by the original place and ethnicity of the health staff, the socio culture aspect of the Asmat people, namely their semi nomadic life style and language, the communication and entertainment means. The current implementation of health policy which places only one nurse or midwife in the village, especially in the special context of Asmat also contributed this feeling. The effort to provide a radio and HT was applied at the beginning of the Asmat health program but there have been no signs of follow-up. However, the fact that the natural resources of Asmat have attracted outsiders to do business there enables the staff to make friends with the outsiders and diminishes their feeling of solitude.

Limitations of food

Although in the capital, food options are limited, the situation in the villages is even worse; not only in terms of options and availability but sometimes also the price. Six health staff complained the limitation food of food in the village.
Ironically, since the food is so bad it actually provides a cheaper cost of living and therefore some health staff mentioned it as a reason to stay in the villages. First, the health staff is forced to eat whatever is available, not craving for the expensive food sold in the capital. Their children do not demand snacks from vendors. Families consume less kerosene when cooking because cord wood is available in the villages and not in the capital. So finally the health staff is able to save their money.

Similar to my experience in Bu Agani, traders provide basic food for the health staff such as rice, sugar, coffee, canned food, and offer a convenience that means less frequent travel to the capital, except for the nurses and midwives to receive their salary. Ana said usually they travel every three months. In the villages where there were no vendors, for example in Nurdin’s Uwus village and Merry’s Pau Dalam village, nurses and midwives needed to travel regularly to the capital. Merry mentioned that even though by ethnicity she is an Asmat, she grew up in Merauke and was used to eating rice and therefore she had difficulty suddenly having to eat sago instead. This was different from the experience of Hendrika, who is originated from Mappi district, south west of Asmat who had no problem eating sago, sago termites and cassava. This difference could also be related to the different generations of the two nurses; Merry is 25 years old, born in a modern era, while Hendrika, 46 years old, came from a generation that still ate traditional food.

It can be concluded that even though the limitation of food contributed to the reasons for some staff to travel regularly to the capital, it also enabled some staff to remain in their villages since the scarcity of food afforded a relatively cheaper cost of living. Younger staff had a harder time adapting to local food compared to the older staff. The traders had a positive impact as they relieved boredom and provided daily food.

Religion
There were only two persons who mentioned their concern about religion. First, Ana, as a Protestant, did not feel comfortable with the way the Catholic priest preached using the local language and sometimes performing Asmat rituals in his
worshipping ritual. And second was Sondang, a Moslem who complained about how the villagers regularly ate pork.

Even though they mentioned their concern about practicing their religion, there was no strong indication that it was an important issue for them to decide whether to stay or leave the village.

Relation with the villagers
Most of the health staff, the stake holders perceived that the Asmat people have a strange way of life. This was confirmed by my observations in Bu Agani, Pos, and Agats. They said that they could not understand why the Asmat people spend their money instantly, or think about food all the time and not think about the basic needs of life, such as education, housing and clothes. The most frequent descriptions used by the health staff were that the Asmat people were ‘stupid’, ‘unique’, ‘primitive’ or ‘weird’.

Ricardo and Prajab were not allowed to play with other Asmat children, who usually play barefoot in the swamp or used a machete as a daily playing tool. One day, Ricardo and Prajab were playing with Asmat children and they ate a cherry-like fruit from the forest. The following night, both of them were vomiting. Ana was angry with them and said to me “that is when they play with the Asmat children”.

Six health staff mentioned the behaviour of the local villagers towards them, which most of the time was contradictory. They could be irritating and kind at the same time and sincerely treat them like family. There was a ritual where the health staff was asked to suck the breast of an old lady in the village as a sign that they were considered as the village’s own daughter. Ester experienced the ritual where she was bathed by the villagers and given a mark on her face with sago as an initiation that she had become a foster child of her Papa piara. Ester, Siti and Ana mentioned that they have Mama Piara (forested mother) or Papa Piara (forested father) with whom they have close relationship. They sometimes helped the health staff manager transportation issues.

However, the nurses and midwives also had irritating experiences. Siti had a quarrel with the villagers, because she did not allow the villagers to increase their
debt in her shop. Ana felt welcomed when she first arrived in the village but experienced having her chickens stolen when she and her family were away for holiday. Fransina mentioned the negative behavior of the villagers as her excuse to get out of the village:

"They wrecked the building. They stole my clothes and cooking utensils. [...] the glasses were broken with the axe, I was still [endure to] staying. Now I want to get out."

Siti and Ana told me that they actually wanted to leave the villages but instead the village authorities and community requested them to stay longer.

From the description above, both the positive and negative behavior of the villagers contribute to the decision whether the nurses and midwives decided to stay or leave their villages. However, the behavior of the villagers was also strongly related to the community’s satisfaction with the health services provided. The discussion about this will be described later.

The work in the village health post

Transportation: The main obstacle

Ana and Luki firmly mentioned that transportation had been their main obstacle for living and working in the village. In total there were six health staff who argued that the cost of transportation to the capital to receive their salary, handing in reports or to pick up drugs and buy food was expensive and used up most of their salaries, especially when the fuel costs in the village rose due to scarcity. Even if the staff doesn’t have the means for transportation, they use other alternatives by rowing themselves or by paying the local people to row the kole-kole. Some of the husbands of the midwives, such as Edi (Sondang’s husband) and Alex (Siti’s husband) has businesses and could effort to buy a boat and fuel. This could technically support the transportation for their wives. Two staff did not perceive transportation as important since their posts were relatively close to the capital. Klara stays in Ewer village, 15 minutes away from Agats and Petronella stays in Syuru village, 20 minutes walking from Agats.

---

28 The return trip from Agani to Pos with a long boat could reach at least 1,000,000 IDR or even more. This takes about 70% of the gaji pokok (main salary of civil service).
Formal requests for transportation have been sent to the Puskesmas and Dinkes with no result, as Sondang said:

“We have spoken with the Head of Dinkes, and head of Puskesmas too. They said there is no fund,[...] We have requested a boat but they did not gave us any.”

Sondang justified her action of charging the villagers for medical consultation as necessary to cover the cost of fuel:

“They didn’t violate Bupati’s directive, but they do violate my regulations. [...] I got a warning for charging patients, they must provide me the fuel. I had discussed with the community, I told them that the drugs, indeed belonged to them, the government provided the drugs, the drugs are theirs. [...] [Sondang said to the villagers] You guys wanted me to come and work here, you pay for the consultation fee or you provide me fuel [...] They said, they don’t want to [provide the fuel], so they pay [the consultation fee].”

Ana and Hendrika compared the current situation with the early years they worked as midwives. During the early years, they didn’t worry about transportation since every month they were picked up and brought home by a nurse from Puskesmas for the Minilok. After Dr Ike (the Head of Puskesmas that time) left, this system was never implemented again.

---

29 According to one Dinkes official, there has been a regulation decreed by the legislative board about giving a free of charge medical consultation for the indigenous population.

30 Minilok is a monthly meeting of Puskesmas staff including the staff from the village health post to evaluate the past activities and plan the future activities.
The transportation management system in the area of Puskesmas Agats (that time Akat sub district still covered by Puskesmas Agats) was apparently different compared to Sawa Erma. Siti, Klara and Ida, a midwife from Puskesmas Agats confirmed that there had never been a system of picking up or dropping off the staff from the villages. However, there was a budget called 'operational money' that could be used for transportation costs. At present, the operational cost allocated by the Puskesmas cannot cover the rising price of expensive fuel. So currently, Puskesmas Agats provides boats for Pustu Uwus and Pustu Ewer and a certain amount of money for the fuel costs.

For Ida, who was assigned in Uwus during the 1990’s, the long distance from the village to the Agats, made her feel lazy to travel to Agats. So her monthly reports were sent through the villagers who by chance were traveling to Agats. She said that the current health staff, at least those who worked under the supervision of Puskesmas Agats, were luckier as they are now helped with transportation.

Wim, the Head of Sawa Erma District confirmed to me that transportation has been the main obstacle for the midwives since he frequently receives complaints from them. He could not understand the arbitrary health policy that although equipped with plenty of money, hinders a solution to the critical issue. At a certain point, he justified the behavior of midwives who are frequently absent in their posts because the midwives do not have any means of transportation.

The Vice Bupati was also aware of the transportation problem and noticed that food and salary were the main reasons for the health staff to travel to the capital. He mentioned his idea to give their salary not in the capital but to distribute it directly to them in the villages. Ana heard about that plan and thought that was a convenient solution. But to date the idea has never been implemented.

I asked Dr. Helen, who previously worked at Puskesmas Sawa Erma with her husband Dr Sandri (the ex-Head of Puskesmas Sawa Erma) about their experience related to transportation arrangements. She felt sorry for the health staff but said there was nothing they could do as there was no budget allocated by the Dinkes.
The limited food in the villages, the payment of salary in the capital of sub district, handing in reports and taking drugs supply are structural aspects which have constructed the need for the health staff to travel regularly to the capital. However, the lack of transportation and long distances also ‘force’ the health staff to stay in the village.

The health staff, their supervisors and governmental officials have been aware that transportation has been a chronic and major problem faced by the staff in the villages. There was a feeling of frustration among the health staff in Sawa Erma when they compared the current situation with the period of Dr Ike.

**Housing and clinic facilities**

Complaints about housing conditions and lack of furniture were noted by five health staff and mentioned as a constraint from the beginning when they were posted to the village health posts. Ana, Nurdin and Siti had to buy and bring their own furniture, i.e., chairs, beds, tables, etc. Ana told me that when the first time she moved to Pustu Bu Agani, the building was located ten meters from the main road and connected by thin wooden boards. She was wondering why the Dinkes only built the building and not the connecting road. Ana lobbied the head of the village to build the bridge and she succeeded in having one built.

![Figure 5. The thin wooden path (left) and the current wooden path of Pustu Bu Agani.](image-url)
In the house and clinic of Ana, rain water was contained in three water tanks of 1,100 liters and a couple of water basins. We used the water for showers, drinking, cooking and washing. There was a shallow well on the side of the Pustu to provide water for flushing the toilet. Ana said that they never experienced a lack of water, because every time they started to run out of water rain would come. No health staff complained about water at their current post. Hendrika mentioned how she got helped by the water container provided by Puskesmas Sawa Erma, the same container I saw in other village health posts.

Edi, the husband of Sondang mentioned that the relative scarcity of water in Agats was one consideration not to stay and work there. Sondang and Edi refused an offer to work in Agats from the previous Head of Dinkes, a Sumatranese, with whom they had a quite close relationship.

Ana and Luki built a veranda with rows of wooden banks in front of the clinic using the family’s private money and spent approximately 3,000,000 IDR (around 210 euro), approximately 70% of her monthly salary. According to Ana, now she can at least breathe fresh air during consultation days because the patients can use the veranda as a waiting room. This is unlike before when patients all waited in the overcrowded registration room (2,5 m x 1,5 m). Ana said that the people were smelly and sometime flies got in and flew around inside the clinic.

Hendrika, described her house as underbuilt when she was working in Jivak. She described her efforts to have at least a ‘decent’ house:

"[My house] was not complete, the windows, the doors, I took care of that myself, sometimes [I] bought hinges, latches, for the door, the hand lock, I bought and put them on myself, I bought myself. The most important thing is that the house was erected, covered and roofed."

Furthermore, Hendrika described how she did medical consultations there with only a carpet for many years, until a contractor came to build a school in Jivak and helped her by making desks and chairs. When she got transferred to Polindes Erma Sona in 2006, together with her husband they renovated the building and bought the materials themselves.

---

1 Dry season happens more frequent in Agats
Ester, a midwife currently work in Mumugu village (Sawa Erma district) mentioned that her current house was dangerous to live in. The pillars were rotten. She and her husband slept at the certain site where she considered still safe. This information was confirmed by one MSF nurse. Like Ester, I found that the health staff could stay for certain time in Pos and Agats by staying in their family’s or relative’s house, except Sondang who stayed at the mosque’s house. Ana could not stay in Pos because she did not have relatives there. She mentioned that previously, Dr Ike provided the midwives a guest house where the staff from villages could stay over for the monthly Minilok.

From the description above, the lack of housing facilities has existed for a long time and in both Puskesmas areas. For the midwives, there was no rebellion action since that was their first job and there were no options for them to demand better conditions. The health staff has also figured out their own way to tackle their issue. Even though they perceived that housing was a big constraint, unlike transportation, which caused a chronic problem and continuous frustration. Most of the health staff seemed to have managed the issue by themselves and no longer felt that it was still a big or urgent constraint except Ester who perceived that her life was in danger due to the condition of the house. The poor housing condition in the village contributed to the reason to stay in the capital. The lack of housing in the capital also contributed the health staff to stay in the village.

Water was never mentioned as a current issue by the health staff to work in the current village. This may due to the water containers that were provided by Puskesmas. Relative scarcity of water became one reason which enable them not to stay in Agats but to remain working in the villages.

Medical equipment and drugs availability: Distribution and procurement complications

When I first visited Pustu Bu Agani in 2007 for a mobile clinic activity, I could see the lack of medical equipment. The MSF donated a sphygmomanometer\(^2\), stethoscope\(^3\) and a thermometer. At that moment, I was wondering, “How did she

\(^2\) The equipment to measure the blood pressure
\(^3\) The equipment to examine and listen to the internal organs, such as lungs, heart and bowel system
manage to examine and diagnose the patients without that basic equipment?" Ana said she already had made a request to *Puskesmas* but had had no response. I confronted Dr Helen who said, "Even *Puskesmas* don’t have enough sphygmomanometers." Overall, no health staff mentioned that the lack of equipment hindered their job.

The midwives, however, were initially equipped with a *bidan kit* (delivery and child resuscitation equipment) when they graduated from the *Bidan C Training*. During my study, I observed that MSF has been donating medical equipment related their on the job trainings, such as sterilization and waste management, delivery sets, weighing scales and height measurement tapes to assess the nutritional status of the children.

Drugs at the village health posts are distributed every month. During *Posyandu*, the *Puskesmas* staff usually brought the drugs to the health posts in the village. Ideally, the estimated amount and kind of drugs is based on the drug consumption report. In reality, this does not happen. Drugs were distributed based on the stock in the *Puskesmas*. According to Dr Helen, the stock in the *Puskesmas* was also based on the *Dinkes* stock, not by their formal request. In *Bu Agani*, during my second day of consultation, we were running out of drugs. A couple of days before, Ana had ordered the drugs from the responsible pharmacy at the *Puskesmas*, but could not yet find a way to bring the drugs to the *Pustu*. Subsequently, through radio communication I made the request to MSF to assist with drug transport to *Bu Agani*.

In the *Pustu Bu Agani* the drugs generally included oral generic antibiotics, antiparasites (antihelminthes, antimalarias, and antiamoeba drugs), symptomatic drugs (antipyretic, analgesic, antihistamine and anti diarrhoea), corticosteroids, vitamins and minerals, *ORS* (Oral Rehydration Solution). Some injection drugs included antibiotics, antimalarias, vitamins, corticosteroids, anesthetics, and analgesics. I saw syringes, antiseptic solutions and wound dressing materials (bandages, tapes, and hand gloves), one container of antipruritus talc, some antibiotic salve for eyes and a bottle of antibiotic drops for ears. The drugs were the standard drugs for *Puskesmas* that I have seen in other parts of Indonesia, including Java. These drugs are used to treat simple complaints and diseases, such
as respiratory infection, malaria, diarrhea, simple eye, ear or skin infection, antenatal care and wounds.

There were five health staff who mentioned limited drugs quantity as a constraint for their work. Ana complained that the distribution of drugs was not a problem during Dr Ike’s era, in terms of quantity and distribution. Now, she frequently lacked drugs. Irwan, an MSF nurse shared his experience about the complaint from the midwives in Sawa Erma who sometimes use expired drugs remaining in the shelves to treat patients. Waluyo, a senior nurse in Agats informed me, that even one year ago, the Puskesmas Agats was running out of Paracetamol, a basic drug. At that time the doctor went to buy the drug in the shop.

Klara said she usually runs out of drugs when the incidence of diarrhea increases. When it happens she refers the patient to Agats since the distance from Ewer is quite close (15 minutes by speed boat). Siti sometimes treated patients from other villages also. Usually patients from Sawa Erma district came to look for gaharu in her village, Manep. When this happens, Siti runs out of drugs quickly. Merry related her unforgettable moment, that when working in Pau Dalam village, when she treated a patient with a tear injury, the result of an axe accident, without anesthetic drugs.

Sondang complained that she had promoted the family planning program of hormonal injection contraception to the community. Since the program was no longer running she procured the drugs herself through a friend who regularly travels to Java. She did not provide information regarding the price.

I brought my question about the distribution of drugs to Richard, a nurse who is the Head of Communicable Disease Control at the Dinkes and earlier had been in charge of the pharmacy because there was a lack of human resources when the Dinkes was just formed. Richard was one of the most reliable and cooperative professionals in Dinkes, especially during my work with MSF. I told Pak Richard that during my medical consultation in Bu Agoni, I could not treat malaria patients with Primaquine because we didn’t have that in the stock. He was aware of the lack of drugs and late delivery problems in the village health posts and explained that the chain of the general drug distribution problem does not end at the Dinkes.
After Asmat became a new district, the Dinkes procured their drugs separately from the Merauke. The planning of the drug order and procurement is done by a team in Dinkes which is later assessed by the legislative board. This process takes quite a long time. Starting from 2007, the procurement is done by a private company, which normally is not permitted to procure drugs in large quantities. Drug procurement normally should be done by companies that have PBF, a license decreed by the Ministry of Health to procure and distribute drugs in large amounts. According to Richard, Asmat at that moment was cooperating with a company from Timika that doesn’t have the license. He said that the Bupati chose the company and not the Dinkes. The person had taken his initial payment to buy drugs but never returned. After talking with Pak Richard in one of the most expensive restaurants in Agats, and enjoying the nice fresh expensive pineapple juice, I got the point of what a medical doctor in Puskesmas Agats told me once, that there is a business ‘played’ in the Asmat’s drug procurement process.

The lack of medical equipment seems to be a chronic problem and there is no difference in the conditions of the two Puskesmas areas. The equipment of Bidan Kit was the only equipment the Bidan C had, and there was no sign of follow-up in regard to the equipment. Nevertheless, even though equipment was lacking, I could see that the health staff were not longing for it unlike the need of transportation. This could be related to the habit of “ghost examination’, diagnosing and treating people by their complaints. A description of this phenomenon will be described further in the following section.

The health staff perceived the issue of drug availability as a recent problem. The lack of drugs in the health post, including its chaotic system leads to low job satisfaction. There is an indication that the problem of drug procurement is related to the political economy situation of Asmat. There was a strong system implemented during the Merauke era, which was not continued after Asmat became a new district. This is also sign of ‘political loss’ related to a policy of decentralization.

Before decentralization, 75% of the health budget came from the central government (Gani 2006). All programs were designed with a top down policy, by

---

4 PBF is the abbreviation of Pedagang Besar Farmasi, which means Big Pharmacy Trader.
the central or provincial level and merely left the district level officials in the role of practitioner 'only'. After decentralization, the 'practitioners' had to define their own health priorities, planning advocating to the legislative board for their individual budget allocations. The lack of capacity in the district levels led to poor health management, planning and implementation of the program.

The fact that Asmat is a new district has made the situation worse. If other districts experience decentralization as a 'big bang' (Lieberman and Marzoeki 2002), a process of restructuring the existed government including the health structure into an independent actor, Asmat is weighed with double burden. Asmat must nurture its new born governmental structure into a solid one. And at the same time, with a relatively limited 'guidance' and 'control' from any party, this remains an unstable premature system. Dinkes Asmat was officially formed in 2004 and must perform all programs independently. Furthermore, the political loss combined with the full authority and independence can be used by stakeholders, with their own special interests, as a power of political tool (Lieberman and Marzoeki 2002). The process has resulted in a chaotic system in every aspect of Asmat including the drug procurement system in Asmat.

Medical consultation
In Chapter Two, I described that the work in the community health centers is dominated by therapeutic activities, undermining the normal role of the nurses and midwives for preventive and health promotion activities. This is in accordance with the experience of my one-week stay in Pustu Bu Agani when I conducted medical consultation work only, including some antenatal care. I did not have the opportunity to join the monthly Posyandu activity, which according to Ana includes immunization and nutritional activities.

The Pustu Bu Agani was equipped with desks, chairs, benches, and an examination bed. There were two cupboards for keeping the drugs and medical equipment. The place was clean and well ventilated. A poster of a Rapid Diagnostic Procedure for Malaria including the treatment protocol was hung on the wall.
During the consultation days, the villagers sat on the veranda. There was no arrangement for waiting in order, so people had to be tolerant and get into the consultation room based on the time they arrived at the *Pustu*. Some people had no patience and came in the room, waited inside, hoping to get a consultation sooner. Ana was trying to ask the people to wait outside. She said, “Otherwise it would get too hot inside and the doctor could not breathe”. But they did not care, and stayed inside. I could see that Ana got upset but there was nothing she could do.

![Picture. A mother with two children waiting for consultation](Source: Pia Engebrigstein)

Similar to the usual system in other village health posts throughout Indonesia, I registered the patients in a big book with tables for their name, sex, age, address (name of the village), old or new patient, diagnosis, treatment, and remarks while doing the consultation. This daily data provide the number of patients and the morbidity profile based on age and whether they were new or old patients. This data was compiled weekly and reported monthly. There was no compilation of a patient’s medical history. The only way to trace the history was to look one by one on the list for the same name. That is why it was difficult for me to do follow-up on particular patients. Luckily, Ana remembered each patient and provide me the needed information. Usually, patients did not know their age but Ana estimated by their face. For the children, Ana counted from the year they were born and did an estimation of their age by looking at their erupted teeth.
There were three kaders (community health worker) from both villages. From Bu, there was a guy, named Rolly and the wife of the head of the village. While in Agani, there was Agnes, a Muyu lady who had been staying in the village since childhood. All were capable of speaking Indonesian and were literate. Sometimes the three kaders appeared on my consultation day to help me translate my conversations with the villagers. Agnes was the only one who appeared regularly each day. Based on my experience, most villagers didn’t really understand the Indonesian language and kaders gave significant help for translation.

I had, on average, 30 to 33 patients per day, varying from babies, adults, elderly and pregnant women. Doing all the steps by myself, registration in the book, weighing on the weigh scale, anamnesis, medical examination, defining the treatment, dispensing the drugs, putting the label on each package of drugs, and telling the patients how to take them, was a big challenge. According to Ana, when the villagers come back from the forests, the number of consultation can reach 75 or even more than 100 a day. However, she also mentioned that those days most of the villagers stay in the village and she did not have a single patient for weeks. She said sometimes the Puskesmas questioned her empty report, so she replied “Well, that’s the reality. What can I say?”

**Diagnostic and treatment process**

The physical diagnostic and treatment part of the medical examination became a way for me to experience the complex problems related to medical consultations. Luki concluded based on his observation of the patients who were waiting in the veranda, “they are very happy, doc, when you check the blood pressure, because they never experience that.”

When pregnant women arrived for antenatal care, Ana showed me her excellent skills. She also reminded me of a skill I barely remembered since medical school. I refreshed my knowledge by learning from her about how to check the position of the baby, predicting the pregnancy age and how to define whether the baby has entered the pelvic ring or not. On the other hand, my presence did not create a good impression of Ana with the local villagers. It was obvious that the
service I delivered was ‘different’ from the one usually delivered by Ana. Ana was trained as a midwife and had less training to perform a complete medical examination. In the middle of a consultation, Ana informed me that a patient said to her, “You [Ana]. . be quiet, I’m gonna talk only with the doctor.” She was asserting the fact that the community appreciated the doctor ‘more’ than her (Ana).

After the diagnostic process, there were at least two chronic diseases that I found problematic in terms of treatment options. Those three cases included a suspected hemorrhoid and extensive fungal skin. There were no drugs on hand to treat hemorrhoid and the fungal skin infection. A symptomatic treatment was the least thing that Ana and I could provide.

One afternoon I saw Ana serving a villager who complained of shortness of breath. She directly put some pills in a plastic bag and gave it to the patient, without performing any examination. Another day, I saw Ricardo and Tamen dispense drugs for a patient while Ana was busy cooking for me.

Language is a problem faced by every health staff who originated from outside the area. A good anamnesis can be improved by the help of the kader. There was a clear indication of “ghost diagnosis and treatment” for medical consultation performed by the health staff. This is a ‘habit’ which I have observed especially at the community health centers in Indonesia, performed by nurses, midwives or even medical doctors. The diagnostic process was mainly based on the complaint without proper a diagnostic process, followed by a treatment composed of symptomatic drugs. However the limited drugs and equipment, and discrepancy between the knowledge and actual work in the field were also constructed this behavior. I have no data to make any conclusion whether background or level education of my participants influencing their performance.

Village health posts are designed to treat patients in simple and basic procedures. This is also the reason for minimum variety of drugs in the Pustu. The normal regulation affirmed that the staff has no facilities to provide treatment for complicated cases and must refer them to the Puskesmas. The complexities of referral also hinder the health staff to facilitate better treatment for the villagers. A further discussion about referral system will be described later.
Drug preference and compliance

Before the consultations started, Ana warned me not to be surprised if some patients requested to have an injection or prefer capsules to treat their complaints. Apparently Ana recognized the culture of ‘injection as the real treatment’, a phenomenon amongst patients that happens in other parts of Indonesia and the world. Whyte et al (2002) noted that it is an enormous and widely used mode of treatment. Even though Ana was aware of the ‘irrational treatment’, she also faced a dilemma, “If they don’t get an injection, they will come everyday.” Since I did not perform any injections during consultations, Ana once said to the patients, “Those who want an injection come the day after tomorrow [a day after I leave the village].” In addition to injections, there was some kind of ‘fanatic’ belief that capsules were the best oral drugs.

In regard to drug compliance, I experienced that it took a lot of patience to explain drug regulations. Putting the labels on the drugs doesn’t help a lot since most of the villagers are illiterate. The kaders helped to give better explanation. The understanding of drug usage cannot be assumed to be automatic and to lead to compliance. When I prescribed antibiotics for five days, Ana sometimes reminded me that the villagers would not finish their drugs so it was better to give fewer pills. Moreover, if I prescribed five days worth of medication, the stock would be finished quickly.

Doctors at the Puskesmas have expressed concern about low drug compliance. In relation to TB and malaria, they argue that finding and diagnosing patients was possible although difficult. But ensuring compliance was perceived as a heavy responsibility due to the semi nomadic pattern and illness beliefs of the Asmat people. If compliance cannot be achieved, this may lead to drug resistance.

I could not objectively define the level of drug compliance among the Asmat people. Nevertheless, giving clear information and assuring understanding about drug usage is a tough job, I assume that there is a risk of low compliance in Asmat. Drug resistance can emerge in Asmat if drug compliance is proven to be low. The phenomenon of injections as therapy is perceived as unavoidable and related to the socio cultural aspects of the community.
Referral complicacies

During three days of consultation, there were two patients with abdominal tumors. I contacted MSF to see the possibilities of referring the patients to Agats. Apparently the gynecologist was on holiday and it was uncertain when he would return. Another issue was how the patient would go to Agats, where they could stay in Agats and what money was available to pay for the food of the family who would accompany them. In the end I could only give them Paracetamol to ease their occasional pain. Subsequently, the patients went to Agats but could not see the gynecologist since he was out indefinitely.

Food has been frequently mentioned as the reason to not go or leave the Puskesmas before treatment is completed. Puskesmas Agats has allocated a fund to provide food for the patients but not for the family. This has also been implemented in Indonesian hospitals in general. The context of Asmat is more complicated because the family cannot simply provide food by eating in restaurants. The Catholic Mission Hospital in Bayun sub district provides firewood and the family can bake their own sago there.

Five health staff mentioned referrals as a constraint for their work. Out of all the health staff who worked in the village, only Klara who perceived that a referral wasn’t a problem for her, due to the short distance to Agats (Ewer is located 15 minutes by speedboat from Agats). Siti stated that sometimes she provided the money to the patient and the family to cover the fuel and meals. Fransina, a Bidan C in As Atat village (Sawa Erma sub district), described her experience with deaths due to the referral issue:

“That’s how it is, the patients became the victim.. What can we do about it.. there was no transportation means [...] Once there was a bleeding case... I inserted IV line, injection.. [because] the placenta was retained.. [I]would like to refer.. can not.. so she died. Because there was no transportation and I could not push people to lend their boat to the patients [...]So finally, the patients became the victim.. It has frequently happened.”

Sondang mentioned that she never refers patients, because of the complexity. First, many family members would accompany the patient, and second even though she was told by the head of Puskesmas that there is a budget to refer patients, she was disappointed by the following experience:
“Because one time when we were staying here [in Pos]... a child... 3rd grade of elementary school was going to deliver... It was three days already but the baby had not come out, so they called me here. I spoke with the doctor, I said I’m going there but there is no transportation. [Sondang said to the doctor] There is fund, isn’t it? So let me use it, I will go there and help them, I said. [...] He said can not. From there I never refer patients because it’s a set of my own emotion, moreover the villagers also died... so when something came up, I tackle it myself, up to now there has been no problem.”

The general referral system seemed to be chaotic and arbitrary. Deaths were reported by the health staff due to the poor functioning of the referral system. The system gets more complicated due the far distance and socio cultural aspects of the community. Referring a patient to the capital does not simply mean the referral is executed. The health staff must also consider the family’s sustainability in the capital. Sondang firmly stated her emotion of frustration by saying that her persistence in treating the patient by herself was preferable to dealing with the disorganized referral system.

Assisting deliveries

Four midwives mentioned that Asmat women are rarely willing to deliver at the health post and have a weird way to deliver. The midwives frequently attend these deliveries at the traditional houses. Delivering women are usually assisted by their female relatives. Whole families including children can witness the delivery process. There is no traditional birth attendance. Ana mentioned her struggle to walk on the thin wooden boards in the middle of the night to attend to a woman who was delivering. Siti excitedly described her experience falling down in a tumbled house after the baby was delivered. She could save the baby but needed to search for her instruments for three days in the mud.

Siti never performed an episiotomy procedure, which usually done during the delivery process, especially for those women who are delivering their first child. She said this was because the women refused the procedure. She found that based on her experiences, “the women deliver easily here”, asserting her agreement that it was okay not to perform an episiotomy because there might be no need for

\[Episiotomy\] is a surgical incision through the \[perineum\] made to enlarge the \[vagina\] and assist childbirth
The first delivery which Siti experienced was said to be unforgettable moment because the husband got very angry with her:

“I was assisting a delivery. Here when we help a partus [delivery], soon as the baby delivered, we directly clamp it and than cut the cord. Then the husband of the mother whose I was assisting, got angry [and said] My child [refers to Siti], you can not do that, why do you have to cut it so quickly.. I said, Sir, this is how we do it at the hospital, so soon after the child is born, we cut it, then we take care of the baby, we wrapped it to keep it [The husband said] we have the custom here is not like that... It’s not allowed... He got furious.”

Ana also expressed her perplexed reaction about this tradition which was completely different than the skill she had learned during her training. I was also amused to hear their stories. The Asmat tradition is to delay cutting the placental cord and is exactly the same as the recommendation I heard in a lecture I had during the Children’s Module of AMMA. The delay in clamping and cutting the placental cord proved to decrease the risk of anemia for the newborn. I explained to both Ana and Siti that according to the lecture I had in Amsterdam, what the Asmat people do is actually recommended by current scientists. They were also astonished and commented, “So, the Asmat people, they are actually not stupid.”

Furthermore, Sondang described how the women took an unusual position when they delivered a baby, like squatting or diving. Sondang said if usually in the hospital; the health staff gives the instructions to the patients but in Asmat, the health staff is the one who ‘must’ do the patient’s instruction.

I juxtaposed the above stories with the educational material of a Bidan C. and found that the two instances were actually mentioned in their training materials. Based on this, I argue that the educational training of the Bidan C was actually culturally appropriate for the midwives who work in Asmat. But, since there was no continuing training about it perhaps this was the reason why they forgot about the lesson and perceived that such local behaviors were not ‘normal’.

---

6 The lecture was given by Bernard Brabin, a Professor of Tropical Pediatrics of University of Amsterdam.

7 The placental cord was mentioned in A VISENA, a media newsletter for Puskesmas at Jayawijaya District, September 1996 edition (Special Edition for Village Midwife Inauguration). Secondly, the mother’s position during delivery was described and explained in a paper titled “The Comfort of The Delivery Mother”, written by Dr Ikc and Dr Budi. The content of this paper is re-explained in a new protocol for Normal Delivery Care (Asuhan Persalinan Dasar), a national standard guideline for normal delivery that was decreed in 2002 by the Ministry of Health.
Assisting deliveries for the midwives, especially if they could perform it successfully and the community appreciated them, provided job satisfaction and self-esteem for the midwife. However, the ‘misperception’ about the traditional delivery in Asmat which was thought to contradict western medicine was perceived as a problem.

The satisfaction of the community towards the available health service

Similar to what Siti also experienced sometimes during my stay in Bu Agani patients came and wanted to have consultation outside the consultation time, for example during lunchtime, when we were cooking, or when we were resting. Ana said, that she has several times announced to the people that they can knock on her door only for emergency cases such as a mother who is delivering, or diarrhea or severe complaints. However, sometimes the villagers came with coughs, or runny noses; symptoms that could be postponed.

During my stay there, Ana explained with patience several times that they should come back the next morning because we were resting or having meals. However, later on I observed her treated a patient in a harsh way after the whole day consultation with me. A man brought his daughter, with a wound in her foot because she was playing with a machete. Ana was tired and said to the man with the tone of being fed up, “You, came here in such a late afternoon. How come you let your daughter playing with a machete?” She put some antiseptic on the wound without giving any bandages, and gave her four tablets of Amoxicillin while saying quickly, “Here, drink one.” without further explanation.

Based on the information that I got from MSF and the Catholic priests, the impression that the health staff in the villages treat the patients roughly seemed to be quite common. The Catholic priests mentioned how the villagers often refused care because the health staff was too busy. They also provided drugs without any explanation which caused some confusion. MSF frequently received reports from the community about their dissatisfaction with the health service. Sarah, a Belgium midwife described the complaints received by the MSF staff:

“We often heard complaints of patients being refused especially when they were coming from outside the village where the Pustu or Polindes are
located. They were refused because according to the staff, it is not an emergency, because it’s too late, because it is in the weekend.”

Sondang explicitly mentioned that she was a mean midwife since she sets hours for medical consultations. Once, an MSF nurse reported to me that Sondang frequently sent the patients away.

Aside from the timing, Ana, Sondang and Siti mentioned that the patients rarely said thank you after they receive their treatment. There were other behaviors which were perceived as less respectful or even irritating by the health staff. Klara, who was described by MSF staff as staff who rarely stayed in the village, said she felt the pain when the community reported her absence to the head of Puskesmas Agats:

“[...]when I came back [to Ewer] then returned again to Puskesmas later I will hear from the Puskesmas that the community reported that I was not dong my job in Ewer while I was just spending my time here only for couple of days, that’s all what made me feel the pain, poignant.. but yaa.. the community.. “

Some violent behaviors were also experienced by the health staff due to the villagers’ dissatisfaction with the treatment they had received. Ida mentioned her experience of being threatened with an axe, just as Fransina who told her story:

“When we treated a patient then he was not cured sometimes they got suspicious [...] [They] came with a sharp instrument.. now [I] got kind of like immune with that.. not afraid any more.”

Despite the negative behaviors, the health staff also had positive experiences that showed an appreciative expression from the community. Some midwives mentioned that this is what kept them staying in the village. I felt the bind of family when during consultations old people called me “Anak Perempuan” (means daughter). Hendrika described how the villagers were not so happy with her at the beginning but this changed later on:

“When I told them not to stay too long in the forest, they got angry and said, Hei you are coming here not to tell us what I should do. Later on they started coming to me. [...] On September 2000, one delivering mother had already the hand of the baby out. They saw with their own eye how difficult it was to deliver a mother and a baby [...] even though the baby died but the mother survived. They acknowledge me there. They approached me and hugged me while crying and saying Oooo... you are kind.”
In total two health staff experienced negative behavior from the villagers due to the unsatisfactory treatment they had received and five staff mentioned the villagers’ positive behavior towards them. It can be concluded that the behavior of the villagers who came outside scheduled hours were perceived as demanding by the health staff. However, I should be careful when stating the ‘demanding’ part, since there were times that the health staff also had minimal patients or even none at all during the whole week. I determined myself that the ‘demanding’ perception here is constructed by the absence of formal and firm regulations about the schedule of consultation.

The stories above also show no indication that the community treated the health staff based on their ethnicity. Even an Asmat midwife who came from the same village perceived that her community did not appreciate her. I can not provide any analysis to understand the irritating or stealing behavior of the villagers because in the different villages health staff also perceived the area as safe (see Sondang’s story).

The hunger of “attention” from above
Complaints related to the support from the Puskesmas were briefly mentioned several times in the previous section and chapters. Here I describe specifically work appreciation, trainings and supervision.

Work appreciation and the work of the Puskesmas staff
There were two persons who complained that their work was not appreciated by the Puskesmas. Ana mentioned how furious she was when her monthly reports of mother and child health activities (KIA) were not found in the folder in the Puskesmas. The report was important since the number of deliveries she attended would serve as proof of how many deliveries she had performed and would be used to determine the amount of incentives she could receive. Ana was fortunate that she made an archive of her report. I observed the papers of reports she had to make every month, in total nine kinds of reports plus two reports for MSF (malaria and obstetrics reports). As there was no template for the Puskesmas reports, she
has to manually make the tables. She said that previously, Dr Ike provided the template. However, no staff stated that the reporting was a heavy duty. They said during the empty days they could make and fill the tables little by little so that there was no enormous burden at the end.

Nurdin referred three patients from Uwus, after mentioning how complicated it was to refer a patient and he felt disappointed that he did not get any feedback from the Puskesmas. A nurse in Sawa who I met during my work with MSF in 2006 had the same complaint. He rarely got any reply from the Puskesmas about the patients that he referred in his referral letters. He said, “How would I know the patient’s disease when the patient returns to the village and needs some follow up”. MSF who have been supporting the set up of a referral system, also developed a referral letter together with the Puskesmas, since the Puskesmas did not have any templates. I have found out in the report files of Ana that Dr Ike had already developed the template.

Both Sondang and Ester said that they are not happy with how the Puskesmas is working at the moment, especially when the staff do outreach activities ‘haphazardly’. Lately, mobile clinic activities were rarely done. Even if there was one, they are always in a hurry, not spending enough time to look per village. Poor appreciation towards the health staff from the Puskesmas also reflects how they are not happy with the work of the Puskesmas staff.

**Training Opportunity**

In regard to the training opportunities, the health staff perceived the ‘real’ training as the formal one, when they are sent to the capital of a sub district or another district, and receive a certificate from the Dinkes or Provincial health office. Both Ana and Sondang perceived that the MSF on job trainings are not a ‘real’ training. Even though some health staff said that they need training to update their knowledge and that the training from MSF has been supporting their work, especially in regard to malaria or normal delivery health care, there was no indication that they have been consistently implementing the new knowledge in their work. One reason for this inconsistency was because of the limited facilities, for example incomplete malaria drugs in the field, or when the training did not ‘fit’
with situation in the field. Sondang mentioned the side effects of ACT, the new malaria drugs that cause vomiting and general weakness. The community accused her as ‘going to kill them’. Another example is delivery care which does not fit with the delivery practice of Asmat women.

Ana said that she had never received any training. She heard rumors that when the staff in the villages were listed for training by the Dinkes, it was always the Puskesmas staff who departed. Petronella (from Syuru village) whom I visited only once was very happy to hear from Robby, who accompanied me, that she would be appointed for the next training. She was saying, “I hope this time I really get in. Before, my turn was always sabotaged by the other nurse, who lobbied at the Dinkes level. She’s an Asmat.” In total three staff mentioned about the limited opportunity of the ‘real’ training.

Incentives and visit from the doctor
Esco, the nurse in Puskesmas Sawa Erma, mentioned ‘attention’ as the payment of incentives. He assumed that there might be hidden incentives that were not distributed to the health staff. According to him, giving the staff their rightful incentives would serve as a way to show appreciation. Even though Nurdin mentioned that the incentives were the reason he stay in Asmat two other health staff perceived that incentives alone did not improve their spirit of work.

Ana compared the current situation with the previous situation when there were no additional incentives and said the work environment was better previously. At that time Dr Ike was supervising them closely. Every month she came to the Pustu, and spent the night there before continuing her rounds to the next village. She checked the reports, and went to see the head of the village to investigate how the midwife was doing serving the community. Petronella was surprised to see me meeting with Robby, her supervisor. She said that this is the first time her supervisor ever visited her. Ronny asked Petronella what kind of furniture she need for her Polindes. Then she smiled at me while mentioning the items she needed. Klara also compared the current situation with the previous time of Puskesmas leadership:
“Since the replacement... there has never been a visit o the villages, During the year of 1997 or 1998, they did, the doctor and head of the Puskesmas. Now... not anymore”

Siti stated a similar comparison by mentioning the opportunity of direct communication with the doctor:

“Yes, it was clear that previously we got the attention,, seriously.. For instance, the obstacles we faced in the field, we consulted using HT,, directly to the doctor.. like this.. like that.. We could directly talk and we could execute the treatment based on what has the doctor informed”

The health staff perceived the different levels of ‘attention’ between the previous management and the current situation. Currently they felt the lack of appreciation from the Puskesmas as reflected by missing reports, referral cases with no response, limited training opportunities and poor supervision from their supervisors. Incentives were mentioned as one of the reasons to stay and work in Agats, but did not always mean an improvement in performance.

A visit from the supervisor who closely checks on their quality of work was considered as work appreciation. It also meant a feeling of ‘close’ relationship and could be a way to consult directly with a medical doctor about important cases. Moreover, the health staff who never got any ‘real’ training from the Dinkes perceived that current training opportunities were unfair.
CHAPTER SEVEN
CONCLUSION AND RECOMMENDATION
“HOW TO MAKE THE HEALTH STAFF STAY?”

The objective of this research was to understand the challenges and motivations of nurses and midwives who live and work the village health posts of Asmat. By using the dichotomy of agent and structure, I explored the health staff’s experiences in relation to the macro context of Asmat. I have separated the discussion into two trajectories to understand the aspects considered as challenging and or motivating by the nurses and midwives in regard to their decision either to stay and work or to be absent in the village health posts of Asmat; the health staff’s personal aspects and the structural aspects of Asmat.

The relation between the health staff and the complex structure of Asmat
Ortner (2005) has written agency and structure are principally inseparable. I found this to be true from the stories of the health staff that I heard in Asmat. The relation between the health staff and the surrounding context of Asmat did not merely construct the health staff’s behavior, but the health staff themselves were capable of influencing and changing the structure. The structure of Asmat has conditions that are both challenging and motivating to the health staff in regard to their decision to stay and work in the village health posts, or to leave, respectively. But in contrast, the health staff’s behaviors, such as private consultation, charging patients, continuing a family planning program, trading in the village as a site job, playing the power relations in the Dinkes and Puskesmas, self procurement of drugs, irrational treatment, and subsequently their presence in the village health posts are all ‘active’ actions. As others have noted (Bourdieu and Nice 1977; Ortner 2005) these actions by the health staff influenced the structural aspects of Asmat, particularly the health system and policy and most importantly the health staff held a strategic position to influence the health status of Asmat people.
The relation between personal aspects, motivation and the decision to stay and work in the village

Using the Stratification Model of Agent (Giddens 1984), I argue the health staff continuously develop creative actions by learning the surrounding context, rationalize their actions and negotiate this process with their own motivation. The whole process is embedded in their actions. The three study cases presented in this research show precisely that the motivations of the health staff are supporting their overall plans, decision-making and actions whether to stay and work in the village health posts or to leave.

The personal circumstances of the health staff such as their relationships with their family, including their husband, children, partner (future wife), pursuing the status of a civil servant and educational degree are all tied up in the health staff’s motivation to form a ‘harmonious family’. This motivation is framed by their deepest desire to make a family, the Indonesian discourse of family and women’s roles in family, the value of being together as a family, and the value of being an educated person.

Although the nurses’ and midwives’ motivations are relatively stable, the decision making and actions themselves are continuously changing. This study, tried to “rationalize” the health staff’s actions but could not rank the aspects or explain their order based on the health staff’s narratives. I argue that this is due to a methodological limitation. One cannot study rationalization of action chronically, in day to day actions (Giddens 1984:347). Moreover, one cannot study the complex process of rationale when it involves someone’s emotions. (Hastrup 1995; Archer and Tritter 2001).

"Beyond intention and the individual rationalization of particular actions lie deeper motives that do not belong to the explicit and empirical but to the implicit and receding order of incorporated culture. [...] The acting person is not only a rational, intentional ‘person’ but a deeply motivated body-in-life.” (Hastrup 1995:94)

Our world, in particular the health system in Asmat, is influenced by the broader political and economic situation and views health staff as a pure ‘objects’ fixed in a constant motion when in reality they are active subjects moving in a social space of time and continuous action. That is why I argue that the current
The health system in Asmat does not 'culturally fit' into the context of the Bidan C produced during the 1990's when the midwives were all unmarried. By time the midwives changed into agents with multiple identities, they were not people who were constructed to serve the community in the villages. The health staff cannot be defined as individual agents. Each man or woman is embedded in his or her multiple identities; a wife, a husband, a parent and a heath care agent. If one speaks of their motivation one must speak about their family's motivation. Speaking about their work is to speak of the livelihood of their family. Their motivation to stay or to leave the village health post, which has changed over time, has been a learned and negotiated process grounded on family values. He or she has the power to pursue this value by executing all the possibilities towards the structure through compliance, resistance and domination.

**Structural aspects influencing the decision to stay and work in the village and the recommendations**

I have committed my self to perform this study as applied research. Therefore, I draw my conclusion and recommendations based on the empirical data I have collected combined with my critical analysis of the complex context of Asmat. I conclude that all structural aspects that affect the aforementioned personal circumstances and motivations of the health staff are considered important in their decision to stay and work or to be absent in the village health post of Asmat. In the following paragraph, I summarize each structural aspect and make recommendations for the Dinkes of Asmat, Puskesmas, and the health staff who work at the village health posts.

**The environmental aspects**

Two health staff had extreme fear of death by drowning in the river of Asmat. One person mention water scarcity in Agats as the reason to remain in the village. The general topographical conditions of the area require long distance travel by speed boat to leave the village. Six health staff mentioned food scarcity in the village as a constraining aspect to live there. However the long and difficult journey and food scarcity (which paradoxically also provides a cheap cost of living in the village)
could also be enabling factors for the staff to remain in the village.

The existence of gaharu in the forest around villages of Asmat has contributed to the decision of five health staff to stay in the village since it provides their husbands a job opportunity. The current scarcity of gaharu which is threatened with extinction may influence the health staff decision to leave the village permanently because their husbands’ job opportunity will disappear.

The social and cultural aspects

Educational facilities for the children
Four health staff mentioned that school facilities for their children in the village were an important issue in their decision making process to stay or leave the village. To improve the educational facilities in the villages is a long process for Asmat. However, the Dinkes and Puskesmas could post unmarried staff or staff without school aged children at the village health posts.

The behavior of the Asmat people
The semi nomadic pattern of the villagers and language barrier were mentioned as a cause of solitude by eight health staff. The positive (kind, familial) and negative attitude (stealing, violent threats) were pointed out as affecting the decision to stay and live in the village by nine health staff. These behaviors were also related to the community’s satisfaction with the existing health service.

Economy and political aspects
The status of Asmat as a new district has created the development of infrastructure and human resource recruitment for all governmental departments. This has created rapidly increasing business and civil servant opportunities in Papua, especially in Agats, and specifically for the husbands of two of the nurses and midwives. These opportunities were the reason for the nurses and midwives to travel frequently to Agats or even to leave their health posts permanently. One health staff mentioned that his status as a civil servant was the main reason for him to stay and work in Agats.
The current political situation has created the opportunity for scholarships to pursue higher degrees. This was mentioned by four health staff as a consideration to stay or leave the village health post.

**The health system and policy aspects**

**Leadership at the Puskesmas level**

Temporary medical doctors who are assigned to PTT duty as the head of the Puskesmas face complex situations in the field. The educational system at the medical faculty educates doctors as clinicians (Sathyamala 1986:26) teach minimal managerial skills to manage staff at the Puskesmas level. Therefore, below are some recommendations for the managerial process at the Dinkes level:

- Combine the current conventional training from the Dinkes, including briefings from the health officials in every Dinkes department with a detailed introduction to the situation in the field. This should include information about daily life, working environment, the staff of the Puskesmas, the culture of Asmat community, etc.

- A report from the departing medical doctor who was the head of the Puskesmas could provide insight for the situation in the specific village.

- The two to three year duration PTT work is too short to establish a successful managerial system. Choosing somebody inside the Puskesmas with long experience and a good performance history could be an option.

**Transportation**

Five health staff mentioned transportation as a dominant problem not only because it affected their work but because it involved salary and food; basic needs of their whole family. The health staff felt de-motivated as they were not only paying for fuel but also had to arrange for the frequently scarce fuel themselves. This situation caused one staff to charge the patients to pay for his fuel costs. Below are recommendations directed to the Dinkes:

- Allocate a special budgetary fund for monthly transportation for the health staff in the villages.
- arrange a sustainable fuel stock for the Puskesmas including their village health posts by coordinating with the related department.

Recommendations at the Puskesmas level:

- discuss the best solution with the health staff in the villages to arrange for monthly transportation. The method created by Dr Ike to pick up and drop off the health staff could be considered.
- Organize a system of rolling shifts or assign two persons to one health post to avoid the absence of health staff in the villages. This would also reduce the health staff’s feeling of solitude.
- organize a regular visit to each village to distribute salary, food and pick up the monthly report from the village health post.

Recommendation for MSF:

- Investigate the possibility of supporting the transportation issue at Puskesmas level since MSF is equipped with the means for transportation including drivers.

**Salary and incentives**

Even though one health staff in this study mentioned incentives as the main reason to stay and work in the village, other two staff perceived it as ruining their spirit of work due to poor transparency of the program. The recommendation at the level of Dinkes and Puskesmas is to be transparent about financial management.

**Reward and punishment system**

There were two health staff who mentioned feeling discrimination towards them since they were non Papuan. The recommendations to improve the reward and punishment system are directed to the Dinkes and Puskesmas level are:

- give special rewards to the health staff who have been working for a certain number of years in the village
- negotiate a consistent punishment system between the Dinkes and Puskesmas
Training opportunity

Three health staff mentioned training opportunities in relation to their work appreciation from the supervisors. There was a feeling of prejudice that the opportunities had been unfairly distributed. Below are the recommendations for the Dinkes and Puskesmas:

- **be transparent with the health staff in the village about training opportunities, including the prerequisites**
- **perform a follow-up for training that has been done and equip the staff with the necessary materials to implement their new knowledge**
- **collaborate with MSF to provide official training**

Recommendation for MSF:
- **Perform training and follow-up together with the Puskesmas staff. The follow up could be done during the monthly minilok**

Supervision

Five health staff perceived that a visit from the head of Puskesmas was a form of attention towards them. Historically, this visit may have included feedback on the health staff reports, quality control of their work in the village, the opportunity to consult on difficult cases and develop a close relationship between the health staff and the supervisor. Below are recommendations for the Puskesmas and MSF in regard to supervision:

- **make a regular visit to the village**
- **hold a monthly minilok at the Puskesmas**
- **the regular visits of MSF to the villages could be the opportunity for the head of Puskesmas to also visit as a convenient method of transportation**

Drug stock

Five health staff mentioned limited drug stock as a constraint in regard their work. Drug availability is an important basic tool for treating villagers and as an indicator for the community’s satisfaction towards the health service. There is an indication that drug procurement and distribution involves the political power of the
government. Below are the recommendations for the Dinkes:

- advocate for the urgency of drugs procurement at the governmental and legislative level
- strengthen the drug chain from the Dinkes to Puskesmas level

Recommendation for the Puskesmas level:

- strengthen the means for regular drug transportation to the village. This is linked with the management of transportation
- improve the available drug reporting system and request new drugs based on the need at the village level

Referred system

Five health staff mentioned referral system as a constraint in performing their job. This is also related to the transportation system, communication means, and socio cultural aspect of the community. However, MSF is developing a system with the Puskesmas and Dinkes and work with the kader and health staff in the village. Hereby are the recommendations for MSF and Dinkes:

- assess the community's understanding of referrals and strengthen the existing strategies to develop a referral system at all levels, from the Puskesmas level up to village level (including kaders)
- communicate with the Catholic missionaries who already have developed a ‘cultural friendly’ hospital in Bayun sub district and learn from their experience

For the health staff in the village:

- consult with the head of the village to convince the families to agree to travel when referred to the capital and arrange a support system for the families who will be staying in the Puskesmas

Housing facilities in the village

Five health staff mentioned housing facilities as an issue especially the first time they arrived at the villages. Below is my recommendation to the Dinkes and Puskesmas:
- Assess the health post conditions and improve the facilities
- Cooperate with the village authorities to improve the available conditions if necessary

**Solitude, communication and entertainment means**

Six health staff experienced solitude at the beginning of their stay in the village due to semi nomadic behavior of the villagers and the language barrier. Four of the health staff mentioned that communication means (HT and SSB) and radio were the tool they used to entertain themselves. The traders at the villages were considered as friends to hang out with. Based on this finding, below are recommendations for the Dinkes and Puskesmas:

- Provide entertainment facilities such as radio, HT or SSB
- Monthly minilok could serve as a monthly meeting and as entertainment to see other colleagues and share stories
- Consider the availability of outsiders, a friend in the village, when assigning only one health staff to a village

**Stationary**

Although no one mentioned reporting as demanding, providing stationary, plastic drug bags, registration books and report templates were seen as a form of ‘attention’ from the Puskesmas towards the health staff.

**Organizing better medical service**

Three health staff said that unclear schedules for consultation were a constraint. Clear regulations in individual villages are difficult to implement and have caused low satisfaction from the local communities. The recommendation for the Puskesmas and the village health staff is to arrange a formal agreement with the heads of the villages to develop a defined regulation for a consultation schedule.

Four health staff mentioned the language barrier as a constraint to perform medical consultations. Kader and or villagers who speak Indonesian have helped health staff. The help of the kaders could be useful especially for new staff assigned in the village
Developing simple diagnostic guidelines and treatments focusing on the most frequent diseases seen in the field is important to ensure good quality of treatment. The effort to improve the health staff's clinical skill and knowledge has been an ongoing activity of MSF in cooperation with the Puskesmas.

Infant deliveries in Asmat are considered 'weird' by the four health staff, including the habit of delivering at home and using 'unusual' positions. These habits are considered as positive by the current western concept of deliveries. Considering that assisted delivery is a specialty of the midwives, a workshop about the 'cultural friendly' delivery habits together with a gynecologist is a strategic way to broaden their horizons to improve quality of service and community satisfaction. This workshop could be arranged by Dinkes, Puskesmas and MSF.

Nine health staff experienced a positive or negative reaction towards the health service. The recommendation directed to the Dinkes and MSF is to initiate a research project to understand the health and illness beliefs of the Asmat people, including their perception of health, illness, health seeking behavior, perception towards western medical treatment. Use this information as a tool to define strategy for a 'culturally fit' medical service for the community.

Finally

The health staff is the crucial actor to protect and improve the health of the community at the village level in Asmat. Therefore, efforts to improve the health staff attendance in the village are crucial to make health services accessible for the beneficiaries.

During this study, I learned the importance of the health policy maker and managers recognition of the health staff's motivation and the need to accommodate this motivation within the health system and policy, especially in the complex situation of Asmat. The contribution of medical anthropology in this field is a stimulus to suggest that motivation is an important determinant of health staff's behavior and performance to stay and work in the village.

I chose the quote below from the book of “Death Without Weeping” (Scheper-Hughes 1992), which reflects my consideration that the health staff have been silenced, in particular those who work in the villages Asmat:
The anthropologist is an instrument of cultural translations that is necessarily flawed and biased.... Nonetheless, like very other master artisan (and I dare say that at our best we are this), we struggle to do the best we can with limited resources we have at hand-our ability to listen and observe carefully, empathically and compassionately. .... This research is an opportunity to tell a part of their life history..... I believe there is still a role for the ethnographer-writer in giving voice, as best as she can, to those who have been silenced.... (1992:28)
REFERENCES

Archer, M.S. & J.Q. Titter

Baer, H., Singer, M. & I. Susser
2003 Medical Anthropology and The World System, 2nd ed. Westport, CT: Greenwood

Batra, V.

Brown, P.J.

Brubaker, R.

Chen, L., et al

Chopra, M. & D. Sandres

Clarke, R.

Compton, J.
2002 Agarwood (Gaharu) Harvest and Trade in New Guinea [Papua New Guinea and the Indonesian province of Papua (formerly Irian Jaya)]. Paper presented at the Twelfth meeting of the Plants Committee, Leiden (The Netherlands), 13-17 May 2002

Depkes RI (Departemen Kesehatan Republik Indonesia)
Doul, L. & F. Campbell

Dwyer, P.D. & M. Minnegal

Fleischhacker, M.B.

Frankenberg, E. & D. Thomas
2001 Women’s health and pregnancy outcomes: Do Services Make a Difference?. Santa Monica USA.

Gammeltoft, T.

Giddens, A

Good, B. J.

Hamdan, M. & M. Defever

Hardon, A, et al.

Harvard University Gazette
2008 Never-before-seen Rockefeller photos at Peabody Museum. 

Hastrup, K.
Hennesy, D., Hicks, C., Hilan, A. & Y. Kowanal.  

Hennesy, D., Hicks, C., Hilan, A. & H. Koesno.  

Human Rights Watch  

ICG (International Crisis Group)  

Ikatan Bidan Indonesia  

Long, N. & A. Long (eds)  

Mele, A.L.  

Musa’ad M.A.  
2007 Papua Special Autonomy: Impact of General Election and Direct Local-Head Elections. In K. Matsui et al. Regional Development Policy and Direct Local-Head Election in Democratizing East Indonesia, pp 125-152.  

Kompas  

Koster, W.  
Kuntjoro, T.

Ladkin, D.

Suradji, M.A.

Lindelow, M. & P. Serneels

Linggasari, D.

Long, N.

Medecins Sans Frontieres (MSF)

Moore, H.L.

O'Meara, J.T.

Ortner, S.B.
2005 Power and projects. Paper presented in lecture at the University of Amsterdam.
Pemda Asmat

2005 *Medical anthropology. Understanding public health*. England:London School of Hygiene and Tropical Medicine.

Pusdiknakes


Robbins, D.

Sciortino, R.

Scott, J.C.

Scott, J.

Shand, A.

Singer, M. & H. Baer.

Smith, H.F.

Sowada, A.A
Strauss, C.  

Suara Merdeka  
2008a *Speed Boat Kandas: Dua Mahasiswa Hilang di Timika*  
2008b *Pencarian Kru Jefak Petualang Terhambat*  

Suwandono, A., Muharso, A.A. & K. Aryastami.  

Strauss, C.  

Thabrany, H.  

Thorogood, N. & G. Judith  
2006 *Qualitative methods for health research*. London: SAGE publication/Ltd.

Trenkeschuh, F.  

UNDP and Uncen (Cendrawasih University)  
2005 *Local government capacity needs assessment in selected districts of Papua*. Jayapura: UNDP and Lembaga Penelitian Universitas Cendrawasih  
2005 *Community livelihoods and civil society organizations in Papua, Indonesia, A Snapshot by Local Non-Governmental Organizations*. Jayapura: UNDP  
2006 *Sintese Kapasitas Pembangunan Papua*.  

UNICEF  
2006 *Women’s and child health program in Papua*. Jayapura: UNICEF
Van Den Bergh, S.
2008 Make babies not war: Social-cultural factors influencing maternal and newborn health among the Lani people in Puncak Jaya, Papua, Indonesia. 
Master Thesis. Amsterdam: University of Amsterdam

Weiner, B.
1992 Human motivation: metaphors, theories, and research. SAGE
http://cf.uba.uva.nl/nl/handle/googlescholar/ (5 May 5. 2008)

WHO
2003 Indonesia and family planning: An overview
2006a Mortality country fact sheet 2006
2006b Working together for health. The world report 2006
2008 Indonesia: National health system profile

Whyte, S.R., Van Der Geest, S. & A. Hardon

Widaningrum, Ambar
2005 Street level bureaucracy: Dilemmas of providers in health centers.
Yogyakarta, Indonesia: Gadjah Mada University.

Zubrinich, K.
Annex 1 – Problem analysis diagram “Poor health status of Asmat”

POOR HEALTH STATUS OF ASMAT

Environmental aspect (prone to infectious diseases)

Limited availability of health care

The village health posts are frequently under(staffed)

Decentralization

Asmat is a new district

Political economy aspect

Limited function of health system

Notes: = Focus of the research
Annex 2 – Problem analysis diagram: “Experience of health Staff: Personal and Structural Aspects”

Social and Cultural Aspect

- Local health-illness belief and behavior
- Semi-nomadic population
- Population poor satisfaction toward the health service
- Sensitivity of the non-Papuan towards the non-Papuan

Environmental Aspect

- Lack of water supply
- Limited communication
- Limited educational facilities (for the children)
- Religion
- Limited carrier/formal job opportunities for the spouse

Familial Aspects

- Too many responsibilities

Human resources policy

- Poor functioning of referral system

Health System and Policy Aspect

- Limited regulatory work (clinical guidelines and standard treatment)
- Not clear job description
- Limited guidance and supervision
- Limited medical instrument and supplies
- Limited drug supply
- Limited training opportunity

Health Authorities

- Limited training opportunity

EXPERIENCE OF HEALTH STAFF

- Low demand of health care utilization
- Low personal job satisfaction
- Limited guidance and supervision
- Limited medical instrument and supplies
- Limited drug supply
- Limited training opportunity

Professional World Aspect

- Limited training opportunity
- Diverse target indicator and report
- Educational background (Limited skill of knowledge of clinical and community health management)
Annex 3. Population Figure per Sub District

<table>
<thead>
<tr>
<th>No</th>
<th>Sub District</th>
<th>Name of the Puskesmas</th>
<th>Population Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Suator</td>
<td>Suator</td>
<td>7,937</td>
</tr>
<tr>
<td>2</td>
<td>Kamur</td>
<td>Kamur</td>
<td>17,906</td>
</tr>
<tr>
<td>3</td>
<td>Basim</td>
<td>Basim</td>
<td>6,939</td>
</tr>
<tr>
<td>4</td>
<td>Atsy</td>
<td>Atsy</td>
<td>15,310</td>
</tr>
<tr>
<td>5</td>
<td>Akat</td>
<td>Akat</td>
<td>6,643</td>
</tr>
<tr>
<td>6</td>
<td>Agats</td>
<td>Agats</td>
<td>8,349</td>
</tr>
<tr>
<td>7</td>
<td>Sawa Erma</td>
<td>Sawa Erma</td>
<td>16,260</td>
</tr>
<tr>
<td></td>
<td>TOTAL</td>
<td></td>
<td><strong>79,344</strong></td>
</tr>
</tbody>
</table>

(Source: Dinkes Asmat 2008)
Annex 4. List of Stake Holder included as participants

<table>
<thead>
<tr>
<th>POSITION</th>
<th>NO OF INFORMANTS</th>
<th>METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of Dinas Kesehatan</td>
<td>1</td>
<td>In depth interview</td>
</tr>
<tr>
<td>Staff of Dinas Kesehatan</td>
<td>1</td>
<td>In depth interview</td>
</tr>
<tr>
<td>Head of Puskesmas</td>
<td>6</td>
<td>Informal interview</td>
</tr>
<tr>
<td>Staff of Puskesmas</td>
<td>2</td>
<td>Informal interview</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>In depth interview</td>
</tr>
<tr>
<td>Eks Head of Puskesmas</td>
<td>2</td>
<td>Informal interview</td>
</tr>
<tr>
<td>Government Officials</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Vice Bupati</td>
<td>1</td>
<td>In depth interview</td>
</tr>
<tr>
<td>- Human Resource Department Officer (Kepegawaian)</td>
<td>1</td>
<td>In depth interview</td>
</tr>
<tr>
<td>- Head of the sub district</td>
<td>1</td>
<td>In depth interview</td>
</tr>
<tr>
<td>- Head of the village</td>
<td>1</td>
<td>Informal interview</td>
</tr>
<tr>
<td>Traders</td>
<td>1</td>
<td>Informal interview</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>In depth interview</td>
</tr>
<tr>
<td>Priest</td>
<td>1</td>
<td>In depth interview</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Informal interview</td>
</tr>
<tr>
<td>MSF staff:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Field coordinator</td>
<td>1</td>
<td>In depth interview</td>
</tr>
<tr>
<td>- Midwife coordinator</td>
<td>1</td>
<td>In depth interview</td>
</tr>
<tr>
<td>- Nurses</td>
<td>1</td>
<td>In depth interview</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td></td>
</tr>
</tbody>
</table>
Annex 5. Data Collection Tools

1. General Profile of Nurse and Midwives included as informants

1. Name (optional)
2. Age, Sex
3. Marital Status
4. Number of children (if any)
5. Family members living together in the village (if any)
6. Family members living outside
7. Occupation: Nurse or Midwife
8. Level of Education
9. Training received: Theme of the training? Duration? Who recruited you? How did you get selected?
10. Religion
11. Origin (Papua or elsewhere)
12. Normal place of residence
13. Residence of Village Health Post (currently or assigned to)
14. Location of village
15. Duration of stay in the village health posts (since date or between dates ... and ...)

2. Topic List for Nurses and or Midwives

This topic list was used for in depth interview, informal conversation and observation

When did you begin working in Asmat?

How did you decide to work in Asmat? Did you move from your home town to work here?

What was your first position? How was your experience working in Asmat, did you face any challenges? What are they?

How are the personal and/or familial aspects experienced by the nurses and or midwives? (Specification described below)

How are the environmental and logistical aspects experienced by the nurses and or midwives?

For these 2 topics above which relate to each other, the following list were asked:

1. job opportunities for the spouse
2. availability of school for the children
3. the distance of the place with the capital
• transportation means
• communication means
• entertainment
• clean water supply / water for washing clothes etc
• the feeling of solitude

How is your daily working experience in the village as a midwife or nurse?

How are the aspects of local health system and policy experienced by the nurses and or midwives?
For these 2 topics which relate to each other, the following list will be considered:
• target and report requirements
• the diverse tasks (outpatient, mother and child health, refer emergency cases, health promotion, house visits)
• training and the actual work in the field
• the presence and functioning of early warning system and referral system
• the regulatory work (clinical guidelines and standard treatment)
• job description
• guidance and supervision
• (constant) availability of drugs, medical supply and instruments
• raining opportunity
• the quality of healthcare
• job satisfaction
• the salary (and satisfaction with the level of salary)

How are the social and cultural aspects of the Asmat community experienced by the nurses and or midwives?
1. The local health belief and treatment behavior (are they in accordance with views of health staff)
2. The villagers are temporarily staying in the villages. The rare exercise of the job.
3. The populations’ demand of healthcare and for which services
4. The population’s satisfaction with the healthcare (reasons for high or low satisfaction)
5. The behavior of the population towards them (especially towards the non Papuan) related to their security

According to your opinion, what are the challenges and motivation for the health staff to stay? Why do you think some people stay and the other leave?

3. Semi Structured Questions for Interview with The Stakeholder

- How long have you been working in Asmat? What is your position?
- How do you think about the availability and quality of health care of Asmat,
especially at the village level?
- What are the challenges for nurses and midwives to work in the villages?
- How do you think about the role of nurses and midwives who are working in the village health posts?
- Why do you think the nurses and midwives remain working in their villages?
- Why do you think the nurses and midwives are absent in the village health posts?
- How do you think we can improve the healthcare at the village level? I particular – how can we make the nurses and midwives stay
Annex 6. Sample of consent form

In the field this form was translated into Indonesian language.

**CONSENT FORM**

Hereby I state:

1. I have been given information about the study being conducted by Miladi Kumiasari Margaret of the Department of Medical Anthropology at the University of Amsterdam, The Netherlands.
2. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.
3. I am aware that I have the option of allowing my interview to be audio recorded to ensure an accurate recording of my responses.
4. I am also aware that excerpts from the interview may be included in the thesis and/or publications to come from this research, with the understanding that the quotations will be anonymous.
5. I was informed that I may withdraw my consent at any time by advising the researcher.

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

☐ YES ☐ NO

I agree to have my interview audio recorded.

☐ YES ☐ NO

I agree to the use of anonymous quotations in any thesis or publication that comes of this research.

☐ YES ☐ NO

Participant Name: ______________________ Researcher Name:

____________________

Participant Signature: ______________________ Researcher Signature:

____________________

Date: ______________________ Date:

____________________

(adapted from sample found at: http://iris.uwaterloo.ca/ethics/human/application/samples/B4_InfoLetter_Interview.htm)