The Mother-Child Bonding in Pregnancy, Childbirth, and Postnatal

An Ethnographic Study of Birthing among the Sasak People in Lombok

Saki Tanada

December 2018

The Mother-Child Bonding in Pregnancy, Childbirth, and Postnatal:

An Ethnographic Study of Birthing among the Sasak People in Lombok

Saki Tanada

December 2018

Doctoral Dissertation

The Mother-Child Bonding in Pregnancy, Childbirth, and Postnatal:

An Ethnographic Study of Birthing among the Sasak People in Lombok

Division of Human and Socio-Environmental Studies, Graduate School of Human and Socio-Environmental Studies, Kanazawa University

Student ID Number: 1621082005

Author: Saki Tanada

Primary Supervisor: Haruya Kagami

Abstract

Drawing on my anthropological fieldwork in Lombok Island, this paper aims to illuminate the Sasak women's perspectives of bonding in pregnancy, childbirth and postnatal and the social significance of the healing practices in contemporary rural Indonesia.

In the former half of this paper, we will see the general background of the shifting birth settings in Reragi village (pseudonym) in East Lombok (Chapter 2), the Sasak concepts of being, spirits, and things (Chapter 3), and the rituals and treatments in pregnancy, childbirth, and postnatal (Chapter 4). In the latter half, we explore specific cases in which women cope with pains of maternity in the critical moments of birth, sickness and losses as well as in everyday lives (Chapter 5).

This ethnographic study discusses three primary questions (Chapter 6). First, situated in the shift of birth settings from traditional midwifery to modern medicine, how do women in Reragi village acquire and value the local healing practices? Second, how do the birthing mothers and people surrounding them understand the relationship between pregnant women and the unborn as well as the one between postnatal women and their children? Finally, how, and for what purpose, do the women in Reragi continue turning to the ancestral notions of illnesses and healing in the contemporary context of medicalization of childbirth?

Based on the village women's voices about their experiences of birthing, I argue that people in Lombok perform the local rituals and treatments of pregnancy, childbirth, and postnatal as the essential effort to nourish the whole of the baby's being. In such aspect of the daily cares, the mother-child bonding is equivalent not to the formation of the attachment between individuals but to the existence of a dimension of the partly shared bodies of the persons.

Keywords: body; childbirth; healing; Indonesia; Lombok; materiality; postnatal; pregnancy.

Contents

List of Illustrations

Chapter 1 — Introduction

Chapter 2 — Reragi Village: Birth Settings and the Background

Chapter 3 — Sasak Concepts of Being

Chapter 4 — Rituals and Treatments of Pregnancy, Birth, and Postnatal

Chapter 5 — Giving Birth in a Lombok Village

Chapter 6 — Bringing Babies into Being

Notes on Transliteration and Names

To protect the privacy of the informants and the anonymity of the field village, pseudonyms replace the names of all informants and the site village throughout this paper.

In the field of linguistics, there has not been an established analysis on the geographical variation of the Sasak language in Lombok, while there are five currently recognized dialects named *Ngeno-Ngene*, *Ngeto-Ngete*, *Meno-Mene*, *Merarik-Meriku*, and *Ngene-Mene* (Wouk 1999: 92). Most of the Sasak spelling in the ethnographic data of this paper presumably belongs to *Ngeno-Ngene* dialect as spoken in the field village in East Lombok.

There has neither been a grounded agreement among researchers in transliterations of Sasak words pronouncing the sharp, almost inaudible sound of '*k*' or '*q*' at the end of words (e.g., mandi*k*, or mandi*q*: bath). The difference between the two spellings does not bother the informants in the field village, and they use those interchangeably in writing. This paper follows the spelling check of the informants in indicating '*k*' or '*q*.'

In addition, people in the site village use accented words of Indonesian origin in the Sasak phrases while changing accents from '*i*' sound to '*e*' sound (e.g., In., ba*i*k; Sa., ba*e*k (good, kind) and from '*u*' sound to '*o*' sound (e.g., In., sab*u*k, Sa., sab*o*k (written as sab*o*k and pronounced as sab*o*k): belt, sash) and, vice versa, use Sasak words in accented Indonesian phrases.

Most of the informants speak both the Sasak language and Indonesian fluently and often with hybrid words and sentences of the two, and some of them

speak basic English. Interviews were mostly conducted in Indonesian since I was less competent in the Sasak language. Some interviews with older informants, who were more comfortable to speak in Sasak than in Indonesian, involved the assistance from native speakers of both, who were mostly the extended family members of the informants.

In translation from Sasak to English and from Indonesian to English, changes were made in the word order so that sentences make sense in English. Complimentary words are also added in brackets to indicate the dropped subjects, objects, verbs and tense and the descriptions of gestures.

Throughout the paper, English translations follow each word in the first time it appears. The language distinctions are indicated in the following manner:

(1) Sasak words: italics. e.g., spirits (*bakeq*) / *bakeq* (spirits)

(2) Indonesian words: italics with the abbreviation 'In.' e.g., village (In., *desa*) / *desa* (In., village)

(3) Words appearing in both Sasak and Indonesian contexts: italics with the combined abbreviation 'Sa./In.' e.g., pain, sickness (Sa./In., *sakit*) / *sakit* (Sa./In., pain, sickness)

(4) Words of Arabic origin in Sasak or Indonesian contexts: italics with combined abbreviations of 'Sa.', 'In.', 'Ar.' e.g., prayer (Sa., *solat*; In., *shalat*; Ar., *salat*) / *solat* (Sa., prayer; In., *shalat*; Ar., *salat*)

The indication of the language differences is omitted when words appear as of dialogues.

Acknowledgments

First and foremost, I gratefully acknowledge people in Lombok who generously accepted my persistent observation and interviews. I am deeply indebted to my host family and the extended relatives who were always so helpful in numerous ways, but especially for taking care of me in times of sickness.

My sincere thanks also go to Dr. Agusdin, who provided me with an opportunity to visit the University of Mataram and the access to the site of field research. Without his precious support, it would not have been possible to collect the first-hand information in the region.

I would like to express my gratitude to my supervisor Prof. Haruya Kagami for the continuous support of my Ph.D. study. Besides my primary advisor, I would like to thank the rest of my thesis committee, the faculty, and my colleagues at Kanazawa University for offering critical feedback on earlier drafts.

Last but not least, I express my deepest regrets to the victims of the massive earthquakes that hit Lombok in July and August 2018. My prayers are with the survivors who have been struggling in the aftermath of the earthquakes.

This research was supported by JSPS Research Fellowships for Young Scientists and JSPS KAKENHI (Grant Number 17J00441).

The work and any errors are my own.

Figure 1.1 A mother and a child. Kissing on the cheek is a common gesture of affection between mothers and children in Lombok as in many other regions in the world. Lombok, 27 February 2018 (photograph by author).

• 1 •

Introduction

> Don't you dare be naughty, because you are my urine, you are a part of my body, you had the breastmilk the most!
>
> *Dendek mek bangga karena penekku anta, bagian awakku anta, anta paling koat mek nyusu!*
>
> —— A woman's expression of lecturing one of her children.

1. Research Objectives

(1) The subject of the study

Bonding as the focus of ethnographic writing

This paper launches the ethnographic study of the birth practices with an analytical focus on the local women's perspectives of bonding in the processes of pregnancy, childbirth, and postnatal in Lombok Island, Central Indonesia.

Drawing on my anthropological fieldwork, it aims to illuminate how the two generations of women in the site village strengthen and make sense of the bodily and emotional connections between mothers and children as they engage in self-care and care exchange through the maternity and (grand-) motherhood.

It is essential to explore the local perspectives of the mother-child bonding processes in daily context surrounding birth in Lombok for three reasons. First, the focus on the lived realities of birthing mothers allows us to rethink the social significance of rites and treatments surrounding human birth by considering the women's perspectives of maternity, the body, and genders at the center of discussion.

This re-examination will add new methods and materials to the previous ethnographies of birth rituals that predominantly aimed for the structured abstraction of symbols and cosmologies of reproduction on the representational level.

Second, such redirection of the focus illuminates the ways women in contemporary Indonesia deal with the pervasive but relatively new model of childbirth and parenting by reckoning the bonding process as an important aspect of birthing. The modern model is that typically imposes the gender roles on women as the principal carers for children and naturalizes maternal bond as a biological system.

Third, the ethnographic study on the social concerns of birthing and bonding in Lombok can contribute to the critical discussions of the broader context of women's well-being in Indonesia and Southeast Asia. The empirical accounts in the research will provide the first-hand material on the question of how the new generations find it meaningful, or necessary, to turn to the local cares and notions of birth, sickness, and loss in the otherwise medicalized procedures of reproductive healthcare.

In regards to these three defining aspects of the importance of the issue, I argue that Reragi villagers embrace the beginnings of life as the beginnings of relationships, in the nexus of which the bonding process entails constant interaction among people and things working with daily maternal and infant cares.

(2) Purposes of the research

This paper presents the ethnographic case study with Sasak people, the indigenous population of Lombok Island located in Central Indonesia.

The core purpose of this research is to illuminate the cultural understandings of birthing and the social significance of the local healing practices in the emerging

context of medicalization of childbirth in Reragi village (pseudonym) in East Lombok. In particular, the case study aims to illustrate the bonding process with an emphasis on the ways the village women cope with pains and illnesses surrounding childbirth.

More generally, through this paper, I aim to propose that much is to be gained by grounding the analysis of birth rites not necessarily on the representational domains but on the more ambiguous, diverse concern for birthing in family lives. Revisiting the rituals and treatments of birth from the perspectives of women will allow us to capture the humanity of the local self-care and care exchange in the way it reflects people's experiences of being situated under the increasing impact of modern medical interventions in rural Indonesia as elsewhere in the world.

(3) Research questions

Considering the research purposes as mentioned earlier, the discussion of this paper explores three broad questions of:

(1) How people in Reragi acquire the local healing practices in the shift of birth settings from traditional midwifery to modern medicine;
(2) How the birthing women and people surrounding them interpret the processes of pregnancy and childbirth in regards to the mother-child relationships, and;
(3) How, and for what purpose, they continue turning to ancestral notions of illnesses and healing in the context of medicalized birth settings.

To discuss these three research questions, the descriptions and analysis of specific cases primarily concern with subordinate questions listed as the following:

- How pregnant women and family members acknowledge the existence of embryo/fetus during pregnancy?
- How the gestational period and fetal development are understood?
- When, and how the unborn or newborn children become regarded as a human being?
- How are the boundaries of the body-self between mother and child drawn, blurred, or crossed in pregnancy and after birth?
- How is the relationship between child and mother in the context of childcare?
- How is their relationship to the world understood during pregnancy, at birth, and in postnatal?

2. Method and Material

(1) Method

Methods of data collection

I conducted the field research in Reragi, a village located in the East Lombok Regency (In., *Kabupaten Lombok Timur*), the West Nusa Tenggara Province (In., *Provinsi Nusa Tenggara Barat*), the Republic of Indonesia (see Figure 2.1 and Figure 2.2, for the maps).

I collected the ethnographic materials of this paper through anthropological fieldwork in Reragi and the neighboring villages in Lombok Island. During my field research, I collected the data through participant-observation, interviews, and text research. Detailed empirical data used in this paper was written on field notes or

recorded at times of events. The transcription process included the additional interviews and the native check of my spelling of the Sasak words.

All interviews and observations depended on the voluntary acceptance and participation of the informants whom I met through the informal contacts during my stay in Lombok.

The duration of field research

I conducted the field research from 2014 until 2018 going back and forth, in approximate total for 12 months.

I selected the site village during my first visit to Lombok in 2014. During the three-week stay on the island, I visited four villages in the central, eastern and northern regions to conduct the initial survey of my MPhil thesis that concerned the local weaving traditions as well as the gift and the use of cloth among women. After going back and forth the four villages, I ultimately prospected that only Reragi village would enable me to research the weaving culture, considering the largest weaving population. During my ten-day stay in Reragi in September 2014, I conducted a participant-observation on the birth rituals for children and learned that villagers weave, succeed and use certain kinds of local healing cloth in childbirth.

The family who hosted my initial stay agreed to accept my three-month stay from May until August 2015 to conduct the field research of master thesis about the ritual use of the healing cloth. I continued my fieldwork in Reragi in March 2016, from August until October 2016, from June until October 2017, from January until March 2018, and from October until November 2018 to collect data for the doctoral research project. The same family hosted me throughout my visits.

(2) Material

Sources of data

The informants of the master and doctoral research projects included over 200 women and men from a range of age groups, professions, and indigenous healing knowledge and skills. However, the present paper mostly focuses on the data collected through semi-structured interviews with just 50 women who had given birth in the region recently or in the past. The other relevant data was collected through in-depth interviews with six indigenous healers, three indigenous midwives, three clinic midwives, two hospital nurses, and one Islamic religious leader.

The key informants of the participant-observation included three women of my host family and their female relative living next door with whom I regularly interacted throughout my visits to Lombok. Much of the related data used in this paper was confined to the material of my first-hand fieldwork with limited numbers of people. By all means, any ethnography ultimately belongs to specific and unique actors behaving in their particular ways.

With these in mind, in the next section, we turn to the conceptual framework underlying the content of this paper. Rather than attempting to give extensive reviews on the range of theoretical considerations on childbirth, I aim to further narrow down the scope of this research by pointing out the definitions of specific conceptual terms used in the present paper.

3. Definitions and Delimitations

(1) From the cosmology of reproduction to the experiences of childbirth

The preceding studies of the cosmologies and the symbols of reproduction

Paradoxically, although there is an abundance of ethnographic writings on the diverse understandings of the mechanism of human birth, there are little empirical accounts underpinning how women talk (or do not talk) about their appreciations and experiences of the reproductive processes.

In the field of the cross-cultural studies, anthropological literature has long depicted that the rites of conception and birth vary across regions and time. The sustained comparative studies in the pre-industrialized societies provide the evidence of customs of pregnancy, childbirth, and postnatal, which are socio-culturally diverse and yet hold some commonalities.

Some of the significant examples of the commonly observed notions and behaviors surrounding birth in Indonesia and broader Southeast Asia include, but not limited to: (1) food and behavioral restrictions on pregnant women; (2) pregnancy food cravings; (3) the couvade of men imitating the cravings and behavioral restrictions of their pregnant partners; (5) the burial of the placenta as the sibling of the newborn; (6) the separation of postpartum women from daily activities, and; (7) rituals marking the return of postpartum women and the inclusion of children to the society.

Among many studies of the distinct care practices in Southeast Asia, Laderman (1983) significantly offers a comprehensive analysis on traditional midwives' practices in humoral terms in rural Malaysia, illustrating how 40 days

after childbirth constitute the recovery phase in which postpartum bodies should be warmed, healed, and protected from invasive spirits through various treatments such as massage and herbal tea. Laderman (1983) also explains the local model of conception concerning the behaviors of couvade where men in advance to their female partners are supposed to conceive the child in the brain for forty days and have pregnancy cravings during the process.

Further, Obeyesekere (1963) reports how the norms of pregnancy cravings in rural Sri Lanka serve the local women to temporarily escape the male dominance during pregnancy by depending on the sin imposed on men for their rejection of obtaining the food that the pregnant craves. By demanding on the men and consuming various kinds of food that symbolize masculinity, wealth, and power, the local pregnant women fulfill the desire rather than nutrition in the otherwise male-dominated social structures of the village (Obeyesekere 1963).

As witnessed in the studies of the distinct customs of pregnancy, childbirth, and postnatal in South and Southeast Asia, non-western societies in the pre-industrialized times widely appreciated reproduction as dynamic processes that in various ways involve the physical and moral engagement of women, men, healers, and other people as well as their spiritual and cosmological relations with the world.

Feminist critique on the alienation of women in anthropology

As we have seen in the previous sub-section, the anthropological studies of childbirth in pre-industrialized societies were mostly directed to the understanding of the diverse cosmological representations of reproduction often from the analysis on the abundant elements of symbolism composing the local beliefs.

Besides few exceptions (e.g., Obeyesekere 1963, Laderman 1983), however, the cosmological studies on childbirth tend to dismiss the problems of how, if any, such representational domains of birth in the non-western societies matter to the lives and experiences of women in maternity and motherhood.

Broadly, such scholarly indifference toward women's lives seems to come from the institutional background of anthropology where women, in general, were marginalized. As Tanaka puts, there has long been a lack of enough anthropological studies about women or the world surrounding women because: (1) there were only overwhelmingly small numbers of female anthropologists; because (2) anthropologists used to take the low status of women in the research site at face value; because (3) it was difficult for male anthropologists to contact women in the field; and most prominently, because (4) the climate where anthropologists had grown up despised women and imagined the world of women as something unimportant (2005: 14).

Since the feminist critique in the 1970s and the 1980s, the anthropology has witnessed both the development and limitations of the approaches in the women studies focused on their social statuses as well as the more recent growth of broader attention to gender and sexualities including the queer studies and the studies of masculinity. It is no longer a marginal fact that the social realities of women, alongside gender minorities, had long been disregarded in the historical conventions of anthropology.

Medical anthropological studies on the reproductive health of women in Asia

Despite the change, there is yet little in the way of ethnographic studies directed explicitly to the description of women's experiences surrounding pregnancy,

childbirth, and postnatal. Instead, and as it is significant in its own rights, the most profound impact that the feminist critique had on the anthropology of childbirth was the development of critical approaches to the problems of maternal and reproductive health rights.

In that research context, anthropologists tend to focus on evaluating the medical risks and effects of the local birth rites by counting those among the traditional healing behaviors competing with the new biomedical practices. The accumulating medical anthropological studies critically witnessed the post-colonial context of childbirth in Asian societies, where the local birth settings with indigenous midwifery dramatically transformed under the impact of Western biomedical technologies, national and international health policies as well as the broader factors of social and economic changes (Rice and Manderson 1996).

As Samuel puts, 'under pressure from international health organizations and foreign-aid donors,' the governments in Asia promote the medicalization of childbirth and 'regard the replacement of traditional practices by procedures derived from Western biomedicine as virtually unqualified good' (2002: 3). As witnessed by anthropologists in the second half of the last century and onward, the Indonesian government has also enforced the national strategies of health improvement and population control, disempowering traditional midwifery and endorsing the health control with modern medicine (see Chapter 2 - Section 3, for more discussion).

In Lombok, medical anthropological studies critically report the persistent obstacles of the local reproductive healthcare improvement in pluralistic medical conditions in the 1990s. These ethnographies particularly detailed the mostly unsuccessful introduction of modern medicine with the objectifying and

psychologically distant aspect to the local childbirth settings that were previously dependant on traditional midwifery and close social relations (e.g., Bennett 2014; 2015a; 2016; Hay 1999; 2001; 2005, Hunter 1996a; 1996b; 2002).

As such, the prominent anthropological studies of childbirth after the feminist critique share their concerns directed to the improvement of maternal and infant health, the protection of women's dignity, rights, and social status in the transitions of birth settings from the local context of traditional midwifery to the national and international context of modern medicine.

Bonding as a focus of ethnographic writing

Indubitably, the growing medical anthropological studies critically exposing the problems and the local conditions of reproductive health in the non-western societies are significant in its own right. However, when it comes to the matter of illuminating the lived realities of birthing, one of the remaining limitations in the anthropology of childbirth is that they often describe women as patients in the modern medical terminology and overlook their abilities and efforts as the subject of self-care and care exchange outside the clinical settings.

In Lombok, the earlier ethnographies also tend to describe the non-specialist women the patients as powerless sufferers confused and trapped in the desperate system disorder emerging medical pluralism (e.g., Hay 1999; 2001; 2005). While such accounts critically present medical landscapes of rural Indonesia at the time of events, this paper suggests that those are limiting insofar as they further entrench the notions of women's health and well-being as being predicated on the medical interventions by experts, either traditional or modern (see Sub-section 3 of this section, for more).

Further, when the anthropological studies of childbirth in the post-colonial Asia explain the local healing rituals as a part of disappearing (or resisting) traditional medicine in its power dynamics to biomedicine, the focus of the investigation is often set on its immediate effects and problems regarding the local health conditions. At the same time, besides few exceptions (e.g., Bulloch 2016), not enough attention has been drawn toward the broader context of daily activities of the women during the long processes of pregnancy and childbirth that does not always link to the critical medical concerns.

The lack of empirical accounts specifically detailing the everyday lives of pregnant and postpartum women is a loss to the anthropological discussions of childbirth in at least two aspects. First, it restrains us from examining how the existing notions and practices surrounding childbirth that continued from the pre-industrialized times matter to the women today except when those affect their health in distinct ways. Second, the lack of attention to the existential questions of birth in the quotidian of maternity and motherhood prevents us from rethinking the previously studied rites of pregnancy and birth from women's perspectives in the way those reflect social meanings arising in the significant shift of birth settings in the non-western societies.

Considering those, I suggest that much is to be gained by addressing how women talk about their experiences of birthing, especially about the bonding, in the longer, transformative processes of pregnancy, childbirth, and postnatal. In this paper, I aim to launch an ethnographic study that reframes the analysis of rituals and treatments surrounding childbirth with an emphasis on the problem of how the bonding process is embedded in people's specific experiences of birthing rather than

the problem of how the mechanism of reproduction is symbolized in abstract belief systems. More generally, by shifting the focus from the cosmology of reproduction to the experiences of birthing and bonding, I join Appadurai in revisiting the notion of culture not as a substance but as 'a dimension of phenomena, a dimension that attends to situated and embodied difference' (1996: 11-12). This broad notion of culture as a dimension is pertinent to the present paper about contemporary rural Indonesia, the site where the indigenous cultures, world religions, and modern scientific worldviews converge.

As an attempt to outline the contours of the mother-child bonding process that has been largely overlooked by scholars, generalization is inescapable. The philosophical problems such as the notions of the self and the other in the emerge of the fetal and newborn personhood in pregnancy, childbirth, and postnatal encompass the vast and complex field left for further investigations than one ethnographic case study can explore.

This paper, therefore, sets the analytical focus on just one but prominent matter of the mother-child bonding, namely the continuity and connectedness between mothers and children. To define the scope of the present paper in more detail, the next sub-sections will introduce the recent philosophical and historical discussions of the discourses of conception and pregnancy, the approaches to the concepts of the body in anthropology, and the previous ethnographies of childbirth practices and the indigenous worldviews in Lombok.

(2) Theoretical considerations for the inquiry of the bond

General conceptions of the pregnant organism: the container model

As we have seen in the previous sub-section, we can identify at least two primary contexts of anthropological literature about childbirth in Southeast Asia. Those include the cross-cultural comparison of rituals and worldviews in pre-industrialized societies and the critical medical anthropological studies of the transition from traditional to modern medical birth settings.

We have also seen that in either context, the problems of how the birthing mothers make sense of their relationship with the unborn/newborn remain mostly unexplored. In this sub-section, I address the modern imagery of mother-child relations as pointed out in the recent philosophical studies of the metaphysics of pregnant organisms that Kingma (2015, 2018) launched.

Indeed, not only within the field of anthropology but also in the public controversies over pregnancy, the questions of the mother-child existence arise as an issue almost only when those immediately link to the ethical problems surrounding the practice of technologies of reproductive health. The ethical problems involve, for instance, the conflicts of the rights between pregnant women and the unborn in determining the validity of induced abortion as well as in the emerging variation of the parental roles and responsibilities that come along with the new biomedical technologies transforming the reproductive process itself.

As Kingma critically points out, in the field of philosophy, the relationship between mother and fetus often come into question when it concerns with: (1) the reproductive choices such as prenatal screening and embryo-selection; (2) the moral obligations of pregnant women towards their offsprings, and; (3) the obstetric ethics

in making priorities between the health of the fetus and the one of the gestating women (2015: 1-2). Besides these contexts of philosophical debate, the culturally dominant construal of pregnancy remains mostly untouched (Sidzinska 2017; Kingma 2018).

In such tendencies of discussion over the mother-child relationship in pregnancy, philosophers premise the abstract representation of the pregnant organism in the model that Kingma calls as the 'fetal container model' (2015: 2). In the container model, pregnant organisms involve the twofold relationships where the gestator and the fetus are neatly separated physically as the container and the content and morally as two individuals (ibid) (**Figure 1.2**).

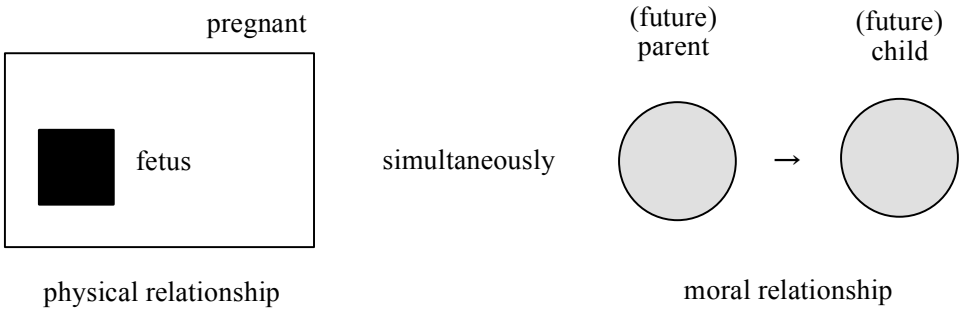

Figure 1.2 The container model of pregnancy. The fetus and the mother have the twofold relations, in which they relate to each other physically and morally as two separate individuals. (Illustration by the author).

In the container model, the fetus and the pregnant woman are separated physically as the content and container and ethically as two individuals (Kingma 2015, Sidzinska 2017). As Kingma puts:

> (T)he discussion tends to characterise the physical maternal-foetal relation as one of container and content; life-support machine and subject; or even "fortress" and prisoner (Phelan, 1991). The *moral* relationship between gestator and foetus, meanwhile, is often analysed as one between two distinct (but specially related) individuals: (future) parent and future child (e.g., de Crespigny & Savulescu 2007). Both conceptions keep foetus and mother neatly separated in space and moral analysis: as distinct, non-overlapping individuals, with only spatial *containment*, the nature of *parental obligations*, and the 'moral status' of the developing foetus considered as posing complicating constraints for our philosophical analysis. This is the *foetal container model*. (sic., Kingma 2015: 2)

As such, the viewpoint that presupposes the pregnant as the gestating container and figures the pregnant and fetus as wholly separated individuals are pervasive in contemporary societies. Problematically, the container model of pregnancy remains mostly unquestioned in the field of philosophy and in general (Sidzinska 2017), while it continues shaping the central premises of the more practical debates over the reproductive choices and parental obligations in modern medical and social discourses (Kingma 2015: 2).

Historical conventions of the container model: the modern marginalization of women's bodies in conception and childbirth

Despite its penetration in the vast fields of medicine, laws, media, the history shows that the concept of the embryo/fetus as the unborn human being is nothing other than the product of modern society (Duden 1993), aspects of which have been largely overlooked by scholars.

Indeed, as anthropologists have long witnessed in the non-western societies, many pre-industrialized societies, the definitions of the fetal and newborn personhood vary across regions and times, and '(t)o be born and to be embodied do not in themselves guarantee social membership' (Turner 2008: 174). The various birth rites were performed as the necessary procedures for communities to accept the newborn into the context of daily lives, or to initiate the birth in the society, as anthropologists observed in many societies.

As Suzuki (2005) elaborates in her historical analysis of the reprints of "Aristotle's Masterpiece," which was the popular manual of healing, sex, midwifery, and childcare directed to both men and women as well as the birth and childcare attendants, the discourses of reproduction transformed in the West since the book's first publishing in the 17th-century England. Under the influence of the establishment of modern obstetrics and the Christian ideologies at times of reprints, the book repetitively changed its explanations of the mechanism of conception and pregnancy including the time points of the fetal development and ensoulment until its last reprints the early 19th century (Suzuki 2005).

As Suzuki puts, the book long supported the significance of the sexual satisfaction of women with the idea that the successful conception requires both male and female 'seeds' at equal importance (2005: 170). It was only since the reprint version of the year 1831 in the United States when the "Masterpiece" began to describe the male 'seed' as the only material that determines the substance of the child and to diminish the womb as the field to grow the seed (ibid). Significantly, it was also when the modern tendencies began to appear, where the balance of the roles of women and men in conception and childbirth is lost, women's sexual desires are

silenced, and instead, the images of women as modest and asexual "passionless mothers" are praised (Suzuki 2005: 170-171).

As a reminder, while many societies in the past long recognized the sexual intercourse between men and women as the necessary act for having a child, it did not bother the beliefs that regarded the conception as the occasion in the cosmos (Suzuki 2005: 174). Conversely, as Suzuki critically points out, it is clear that the contemporary perspectives and practices of childbirth and parenting among the modern families are rather peculiar when compared to the historical conventions before those (2005: 167).

Launching an anthropological approach to the bonding process in the ordinary context of pregnancy, childbirth, and postnatal

As seen in the studies of philosophy and history surrounding women and birth as mentioned above, in contemporary societies we are observing the worldwide penetration of the modern discourses of conception and pregnancy reframing roles of women physically as the mere gestational container and morally as the parent.

Such tendencies also penetrate popular notions of the mother-child bonding, which deeply relate to women's experiences of their bodily and psychological transformations, pains, and vulnerability as well as their awareness of the beginnings of the relations to the unborn/newborn and the beginnings of fetal and newborn personhood.

In contemporary societies, bonding generally refers to the attachment that forms between a parent and a child, and its significance is often emphasized by scholars and media concerning its long-term influence on social and cognitive development as well as mental health of the child. While it is known that the bond

may develop in cases where the child is unrelated, such as adoption, the maternal bond associated with pregnancy and childcare is most typically discussed.

Health institutions and media coverage encourage women to form the bond self-consciously throughout pregnancy by talking, singing, and reading to the unborn. The First Nations Health Authorities' resource booklet about bonding exemplifies such tendencies, where they put as 'Connecting starts before birth. Let your baby know you care, even before they arrive!' (NCCAH 2013: 10). In the field of nursery, scholars regard the biological mother as 'the safe haven for the establishment for the first emotional attachments of the child, which will reflect on all future social relations' (Perrelli et al. 2014: 258).

The discussions of healthcare and childcare clearly show the modern medical conceptions of pregnancy as pointed out by Kingma (2015), where a mother and her unborn/newborn is presumed as two separate individuals. Further, based on the model of modern nuclear families, these discussions tend to expect the biological mother to take central roles concerning the child's bonding with others and his/her social inclusion. Such tendencies are seen in instructions by the First Nations Health Authorities such as 'Encourage your partner to get to know your unborn baby' (2013: 10) and also in the aforementioned definition of the maternal bond as 'the first emotional attachments of the child' (Perrelli et al. 2014: 258).

Regarding these tendencies, it is essential for the present case study of the birthing practices in Lombok to readdress the matter of mother-child bonding without being bounded by the modern discourses of mother-child-as-two-individuals. In doing so, I join the anthropological approaches that identify the human body in a processual term.

Before we look into the particular notion of the body adopted in this research, it should be beneficial first briefly to turn to the previous anthropological literature about the body. By doing so, I clarify the difference between the anthropological concepts of the body and the notions of pregnant organisms in the recent metaphysical approaches that exclude social and human-specific factors of pregnancy from considerations before we look into the particular notion of the body adopted in this research.

The body as a field in anthropology:

Anthropology of the body examines diverse aspects of the human body, entailing conceptions of personhood, subjectivity, and social relationships. It reflects on the persistent anthropological premises of the long-standing Cartesian dualistic model of analysis on cultures and societies that prioritizes mind over the body and discourses over experiences.

Over decades since Merleau-Ponty (1970), the accumulating scholarships have continued questioning the existential qualities of the human body as being universal and neutral and rethinking its self-evidence as being diverse and contextual. As Van-Wolputte puts, '(t)he history of the body in anthropology is a history of notions of self, person, and subject' (2004: 252).

The body as a field in anthropology concerns diverse topics, including, but not limited to the post-colonial criticism, psychoanalysis, cultural images of body shape, commodification of the body, alterations and scarifications, the disabled body, sex and gender, affect, embodiment and trauma, phenomenology and praxeology.

The anthropological approaches to the body in anthropology vary tremendously. Among these, the most influential theoretical grounds include the

concepts of: (1) the social body as a representational medium of social systems (Douglas 1978); (2) the 'three bodies' (Scheper-Hughes and Lock 1987) as individual, social and political; (3) the body as being the existential ground of culture and embodiment as being situated on the level of lived experience (Csordas 1990, Weiss 1999), and: (4) the fragmentary, decentered, multiple body-selves (Csordas 1994, Mol 2003).

On the one hand, the previously mentioned cultural anthropological studies of childbirth in pre-industrialized societies tend to share the interest with the body symbolism in the representational realm. On the other hand, those in medical anthropology more often interpret the local practices concerning embodiment and disembodiment, as well as regarding women's bodies as a site of social processes and political change, on which disciplinary strategies of bio-ideology increasingly imprint.

Significantly, Terence Turner (1994) warns against the centrality of a consumerist and medicalist representation of the body in social theory. According to Turner, the Foucaltian approaches configure the human body as a distant, abstract, ahistorical and self-contained 'antibody' (1994: 47) and endorse rather than challenge the mainstream Western philosophy and political thought by emphasizing the individualistic dimensions of bodiliness (Turner 1994, as cited by Van-Wolputte 2004). Similar critiques argue that the turn toward the body remained deeply embedded in a representational paradigm, in which the body appears not as an agent but as an outcome of social praxis, and the bodiliness equals empty box for the mind.

Considering the birthing bodies as a locus of relationships:

As Van-Wolputte puts, anthropology of the body is increasingly directed to explore the 'moments during which the body and bodiliness are questioned and lose their self-evidence and on the experience or threat of finiteness, limitation, transience and vulnerability' (Van-Wolputte 2004: 263). Here, it is essential to note that despite such tendencies, the anthropological discussions about the concepts of the body mostly presuppose non-pregnant bodies. The ethnographies concerning women's experiences of living with/as the bodies remain marginal even in the anthropological literature devoted to understanding, identifying, contextualizing, criticizing and deconstructing those very conceptions of bodies, persons and selves.

In this paper, I draw on Turner in rethinking the body as 'material process of social interaction' (1994: 29) to approach the problems of bonding for two reasons. First, during pregnancy, childbirth, and postnatal, women experience the unique processes of the transformation of the body and selves where the child emerges as the other but yet as a part of themselves (c.f. Kingma 2018). Therefore, it is pertinent to consider the birthing bodies in the processual terms with consideration into the ongoing social interaction.

Second, the particular focus on the birthing bodies and its material process of social interaction will bring close attention to the blur borders between the human corporeality and the object materiality. As Warnier puts, 'it is not possible to divorce material culture studies from the study of the body, and vice versa, as is largely the case at present' (2001: 10). Such debate is especially pertinent as people not only express but also create themselves with the support of materials (Miller 2008). Turner's viewpoint of the body will allow us to explore the dimensions of the human

bodies in its complicated relationships not only with the bodies of others but also with the material surroundings.

By considering the birthing bodies as a locus of relationships and by paying attention to its material process of social interaction, this paper aims to address the fundamental questions of: (1) what constitutes the beginnings of the human personhood; (2) what determines if the embryo is a life, and; (3) what separates or unites the body and material substance such as food and nourishment in the ways it reflects the women's lived experiences of maternity.

In the final sub-section, I will introduce the previous anthropological literature related to the topics of childbirth and the body in Lombok Island, the site where my fieldwork took place, to confirm the scope and the context of the present ethnographic case study.

(3) Childbirth and the body as topics of ethnographies in Lombok Island

Anthropological case studies of maternal and reproductive health in Lombok

As I mentioned previously in this section, medical anthropological studies of maternal health flourished alongside the feminist critique in the 1970s and the 1980s directed to the traditional anthropological accounts on women in the non-west.

While Lombok Island was long overlooked in anthropological literature in the shade of its western neighbor of Bali (few exceptions include Cederroth 1981, for example), it was since the 1990s when the region gathered special attention of female medical anthropologists who kept critical eyes on the local reproductive health conditions.

In Lombok as elsewhere in Indonesia, rural populations experienced the rapid change of birth settings through the 1980s and the 1990s as the state promoted biomedical interventions and clinic birth to replace the previously popular practices of traditional midwifery and home birth.

What medical anthropologists found in peasant communities in East Lombok in the 1990s were the health disadvantages that the indigenous Sasak people suffered during the dramatic changes in medical landscapes and its relative underdevelopment among regions of Indonesia.

Those include, but not limited to: (1) severe discontinuities and tensions emerged between the village social relations and the state-oriented modern medical settings (Hunter 1996a; 1996b; 2001); (2) the functionless medical pluralities led to fatal cases, in which biomedical technologies were desired but distanced because of financial difficulties, patronization and isolation, lack of explanations and options (Hay 1999: 269); (3) the inaccessibility to the reproductive care among unmarried Sasak women as they were stigmatized, disadvantaged, and deprived of life options other than adolescent marriage and early motherhood under the cycle of poverty (Bennett 2005; 2014; 2015a).

Hay (1999), among others, reports that the national healthcare implementations during the 1980s and the 1990s had limited effects in decreasing the island's devastating maternal mortalities — despite the family planning and birth control, hygiene education for traditional birth attendants and the dispatch of biomedical midwives in villages.

As Hunter points out, in the field of healthcare in contemporary Indonesia, 'government or politics, or both, create the institutions and discourses through which

the state controls its population' (1996a: 110). For the majority of residents in East Lombok, the clinical settings became the place where '[t]he social context is replaced by a biomedical, cartographic and objective reality in which persons become things' (Hunter 2002: 294).

Revisiting the quotidian context of maternity and motherhood: the scope and the limitations of the present case study

These preceding studies in various ways depict the healthcare problems surrounding reproductive safety and discuss its complex factors in the juxtaposition of the local traditional medicine and the modern Western medicine. Most of such medical anthropological studies in this area, however, for entirely understandable reasons, tend to premise that the increase of biomedical interventions and the decline of midwives' authorities equals the loss of social contexts.

Accordingly, pregnant women and new mothers in Lombok as elsewhere in Southeast Asia are often allocated as powerless, suffering, mere 'patients' trapped in the disorders between the two competitive sets of expertise. While the previous studies present significant aspects of social realities, this paper suggests that such accounts are limiting insofar as they further entrench the notions of corporeality, subjectivity, and communality of maternal bodies as being predicated on medical interventions.

Despite, or perhaps given, that the medical dominance of birth settings involve the objectification of maternal organisms, the ways women face and treat the pains, emotions, and vulnerability surrounding pregnancy and childbirth remain deeply embedded in the context of social life. Indeed, it is 'precisely because the

embodied person is the ultimate object of medical treatment that the state is unable to fully control the body of the citizen' (Kumar 2005: 14).

Although the case study of this paper substantiates much of their argument as the socio-medical background of the area, it is thus not the purpose here to rehash criticisms of the local clinical conditions or to make further suggestions for healthcare improvement in Lombok. Instead, in this paper, I aim to counterbalance the dominant scenario in which women suffer the socially configured disadvantage of reproductive health. In doing so, I emphasize the importance of depicting the quotidian of the lives of pregnant and postnatal women in a way it captures the dilemma, joy, and struggles that women face not only as a patient but also as the subject of decision-making and care exchange.

As I mentioned previously, in attempting to outline the broad contours of the local perspective on the process of bonding that has been largely overlooked by scholars, generalization is inescapable. I, therefore, set the scope of this research around the fundamental questions about the ways people acknowledge and work with the personal persistence of birthing mothers and the fetal and newborn personhood in crucial moments of pregnancy, childbirth and postnatal, including cases of pregnancy loss, premature birth, maternal and infant mortality.

Admittedly, the episodes of pregnancy and childbirth discussed in this paper are the cases in which people desired and loved children as they were conceived and born. The reason why the present case study does not consider the other cases in which children were not expected is that no such case was collected in the research project. It is possible that the informants kept silence about the incidents of premarital sex and induced abortion both of which are highly stigmatized in the

region. It is also possible that those among the villagers imposed of social shames avoided me when they knew I was visiting people's houses randomly and via informal contacts to hear their stories of pregnancy and childbirth.

Regarding the limitation of time, numbers of informants, and available statistics, it is impossible to assert the conditions of the welfare of women and children, including the problems of domestic violence. Given the limited scope of the data collection, the present case study exemplifies the loving and supportive aspects of childbirth and parenting in the site village but does not represent the whole picture of the social realities.

This research thus delimits the scope of discussion by putting aside considerations on the vast domains of other practical problems surrounding reproductive health and its improvement. Serious investigations into reproductive health rights exist in the preceding and growing studies in Lombok as elsewhere in Southeast Asia. Those include the topics such as: (1) the high maternal mortality rate due to physical and psychological inaccessibility to the proper healthcare and knowledge (Grace 1996, Hunter 1996a; 1996b, Hay 1999; 2001; 2005); (2) the stigma, shame, isolation and morbidity surrounding premarital sex and abortion in Lombok (Bennett 2001; 2005; 2014; 2015b); (3) the lack of local regulations and the public debate to implement reproductive right as international human right in terms of law (Nilsson 2005), and; (4) broader concerns for sex, sexualities and gender in contemporary Indonesia (Bennett and Davies 2015).

The description of the Sasak notions of the body, self, and persons in the previous ethnographies: persons = body + soul?

Inquiring into the birthing bodies, which remains marginal in the anthropological

approaches to the body, bring us back to the conundrum circulating the anthropological studies of the body: 'To what extent, and through what means, can we grasp the emotional and sensorial life of another person or people' (Desjailais 1992: 14)?

In preceding studies in Lombok, anthropologists agree that in Sasak conceptions, the material body (*awak*) and the intangible life (Sa./In., *nyawa*) compose persons.[1] As Telle describes in her study of Sasak mortuary practices, '(d)uring life, the body houses the spirit' and '(t)he spirit's bodily connection is only permanently severed upon death, after which the spirit gradually becomes associated with the grave, provided proper rites are performed' (2000: 777). The intertwinement of the body and life may sound dualistic when juxtaposed as such, but it begins to show the more holistic aspects in regards to the problems of the selfhood and relationships.

Relations between persons and things

Medical anthropologists correspondingly argue that the integrated notions of the body-self pervade the Sasak conceptions of personhood in the way it directly

---

[1] Sasak terms and transliterations referring to the local concepts of body, soul, and life differ from one scholar to another. In her study in Central Lombok, Telle mention 'the spirit soul (*nyawa*)' and 'the material body (*awak*, *perane*)' as two broad components of the person while noting that her informants use '*ruh* and *nyawa* more or less interchangeably to refer to the soul-spirit complex' (2000: 777). In her study in West Lombok, Bennett mentions a person's '*bayu*' (Balinese) as 'life force or spiritual essence' (2016: 5). In her study in East Lombok, Hay mentions '*epe*' as a person's soul or spirit (2001: 217, 318). In this paper, I use the terms '*awak* (body)' and '*nyawa* (life)' following my informants.

counters Cartesian duality defining the two as a separate entity (e.g., Bennett 2016, Hay 2001, Hunter 2002).

Most explicitly, Hay points out that 'Sasaks, like Balinese, are not bothered with a Cartesian duality' (2001: 101), and therefore 'knowledge and thinking are intimately bound up with hearts, stomachs, experience, and illness' (2001: 164). Similarly, Bennett briefly mentions that 'an integrated notion of the self prevails for both Sasak women and their traditional female healers' (2016: 5). As Bennett puts, in the Sasak cultural context of fertility care practiced by indigenous midwives:

> Not only is the whole body positioned as the locus for healing, but personally undergoing the bodily experiences involved in reproduction is understood as essential knowledge. Here we see a distinct privileging of embodied epistemology, directly counter to the biomedical model that privileges knowledge generated by the rational (disembodied) mind. (2016: 9)

Besides health concerns, Telle further examines the prominent cultural sensibility to the human experiences of vulnerability among Sasak people in regards to the constant relationships and intersubjectivity between people and the environment (2007, 2009).

In her study of the locally perceived relationships between persons and the house, Telle illustrates that the Sasak conceptions of sociality involve materiality (2007: 199). As Telle puts:

> Rather than operating with a stark dualism between subjects and objects, of people on the one hand and inanimate things on the other, Sasak conceptions are somewhat more fluid... In such a world, people are continuously affected by their reciprocal engagement with the various beings, more or less person-like or thing-like, with which they come into contact. (2007: 199-200)

Through the argument in the present study about the relationships and the bond between mothers and children, I join Telle (2007) in acknowledging the importance of material interaction in the understandings of relationality among Sasak people. What is of interest here are the specific ways in which people bring babies into being in the children's relations between birthing mothers, which lies at heart of this paper.

4. Chapter Outline

(1) Overview of the chapters

The following chapters of this thesis are composed of three broad parts: the background (Chapters 2), the research findings (Chapters 3 - 5), the discussion (Chapter 6), and the conclusion (Chapters 7).

The background

Chapter 2 — Reragi village: birth settings and the background

By way of introduction, Chapter 2 outlines the general background of the village site where the field research took place. This chapter offers schematic accounts with graphic details on the places and demographic, social, and medical contexts where the subject people of the case study are situated.

The research findings

Chapter 3 — Sasak concepts of being

Chapter 3 offers a general picture of the Sasak concepts of being to approach the local sensorial lives in which maternal-child relations are concerned to emerge.

It particularly illuminates the intersubjective relations between humans and other-than-humans such as spirits, the dead, materials, and other invisible beings.

Chapter 4 — Rituals and treatments of pregnancy, birth, and postnatal

Chapter 4 of this paper illustrates the general flow of rituals and other local treatments in Reragi village primarily concerning the fertility as fortunes in marriage lives as well as the health of mothers and children in the phases of pregnancy, childbirth, and postnatal. The descriptive details and graphic images in this chapter draw on participant-observation at times of events come with oral information collected through interviews with people in the village.

Chapter 5 — Giving birth in a Lombok village

In Chapters 5, I deliniate Lombok women's voices related to their own experiences of pregnancy, childbirth, and postnatal. This chapter illustrates the processes and moments in which people in Reragi acknowledge the presence of life in the womb, the beginning of personhood, and the connection between mothers and children extending to material things and the body of others.

The discussion

Chapter 6 — Bringing babies into being

Chapter 6 discusses the central argument of this paper by way of summary and analysis of the research findings presented in Chapters 3 - 5 in close dialogue with the theoretical considerations pointed out in Chapter 1.

The conclusion

Chapter 7 — Conclusion

Chapter 7 offers a brief summary and concluding remarks on this research.

• 2 •

Reragi Village: Birth Settings and the Background

1. Chapter Introduction

This chapter outlines the general background of the village site where the research took place. The first section gives the general background of Lombok, including the geography, administrations, the people, religions, and industries. The second section presents the village of Reragi with a focus on economic, religious, family and social lives. The third section describes the birth settings in Reragi, its recent background, and the general flow of maternal and child health care. Overall, this chapter offers schematic accounts with graphic details on the places and demographic, social, and medical contexts where the subject people of the case study are situated.

2. Land and People of Lombok

(1) Geography, administration, and industry

Location and climate

Pulau Lombok (Sa./In., Lombok Island) is a volcanic island of the Lesser Sunda group in Indonesia, between Bali and Sumbawa (**Figure 2.1**) (**Figure 2.2**). Lombok Island is surrounded by many smaller islands locally called *Gili*. While the Lombok Strait separates Lombok from Bali to the west, the geographical line of Java, Bali and Lombok shares similar fauna and flora (Cederroth 1981: 26).

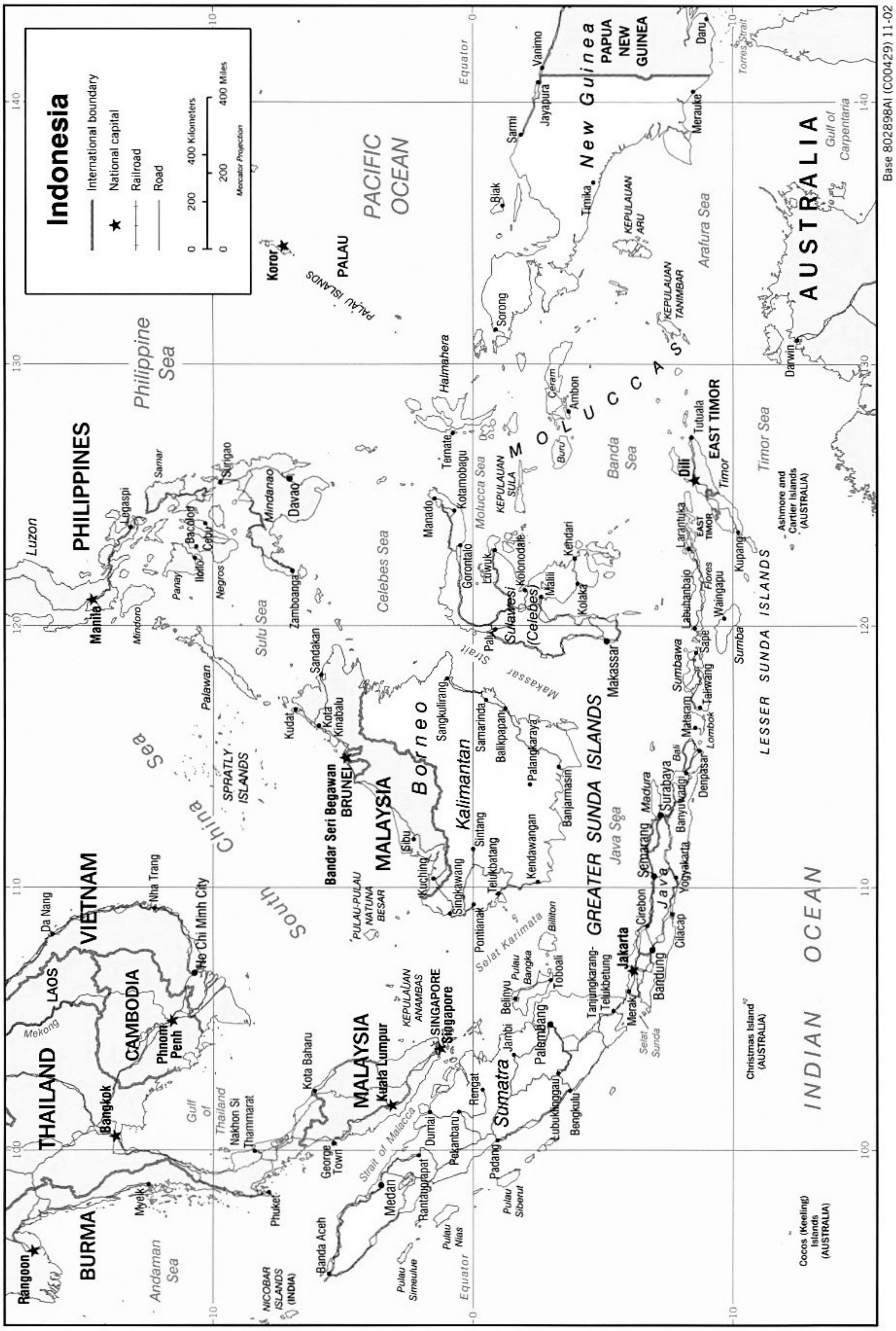

Figure 2.1 Map of Indonesia. Image from the University of Texas Libraries. http://www.lib.utexas.edu/maps/middle_east_and_asia/indonesia_pol_2002.jpg, accessed 30 September 2018.

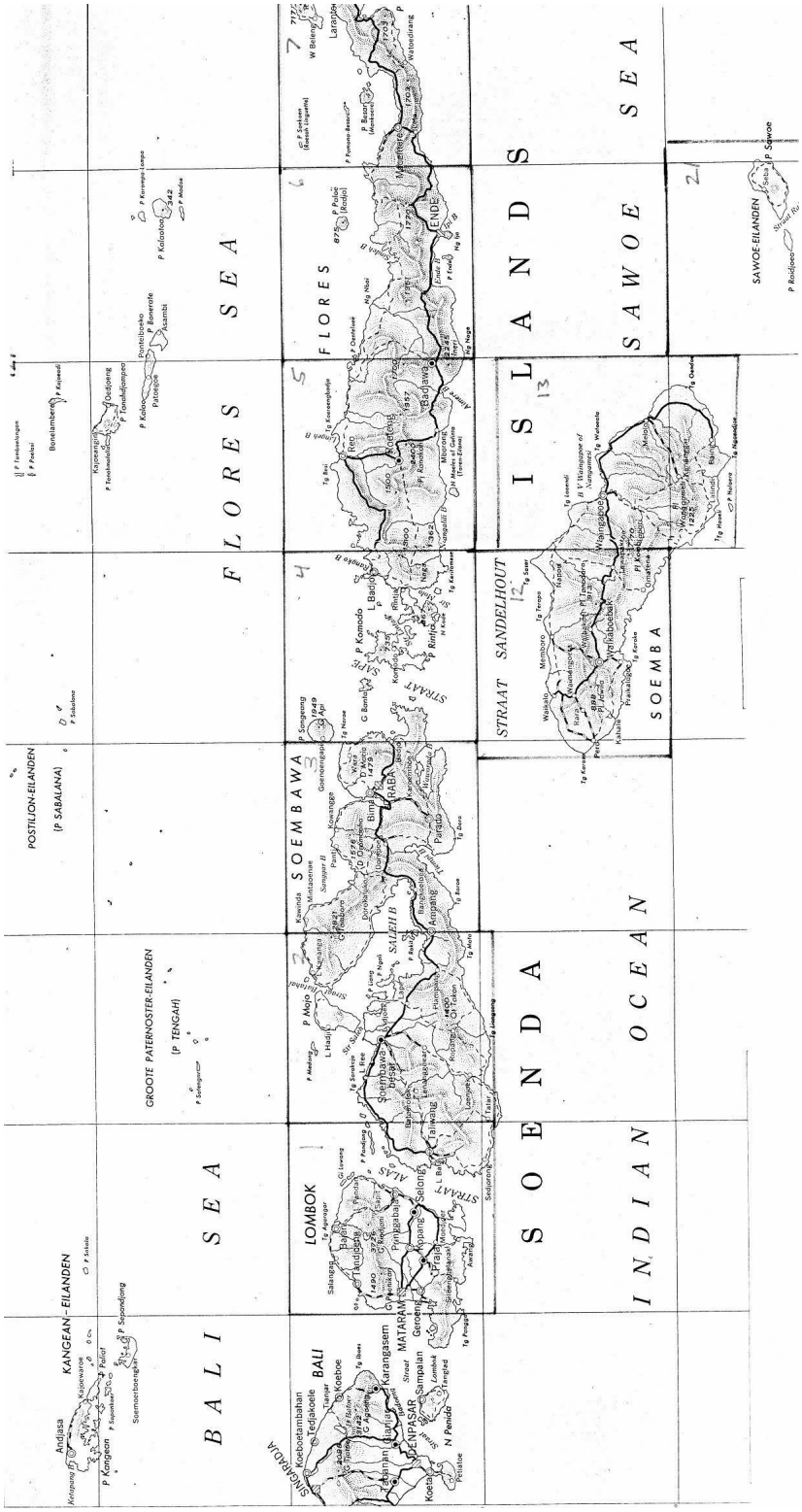

Figure 2.2 Lombok, Sumbawa, Flores, Sumba. Image from the University of Texas Libraries. http://www.lib.utexas.edu/maps/ams/lesser_sunda/index1.png, accessed 30 September 2018.

Located in the torrid zone right in the south of the equator, the residents generally recognize that Lombok two seasons of 'hot season (Sa./In., *musim panas*)' or dry season from around May until September and rainy season (*musim ujan*; In., *musim hujan*) from around October until April. As of 2016, Mataram weather station in West Lombok observes 2934mm of total rainfall within a year, 76.8 percent of which is occupied in October until April, as shown in the data of Badan Pusat Statistik Nusa Tenggara Barat (BPS NTB) (2018a).

Three geographical features compose the island: '(1) the northern mountain complex, (2) the southern mountain range, and (3) the central plain' (Haridas et al. 1980: 1). While some northern and southern parts are dry, the central island has rich rainfalls from the 3,726-meter high Rinjani Mountain. Lombok Island lies on the tectonically active margin between the India and Australia plates converging with and subducting beneath the Sunda plate. M 6.9 earthquake occurred in Lombok on August 5, 2018, and the region experienced six other events of M 6.5 or more massive earthquakes in the 20th century.

Population and administration

Four *Kabupaten* (Regencies) and one *Kota* (City) constitute the administrative subdivision of Lombok under the governance of *Provinsi Nusa Tenggara Barat* (West Nusa Tenggara Province).

The provincial capital *Kota Mataram* (Mataram City) belongs to the small area of the west coast, while the vast rural area spreads across *Kabupaten Lombok Timur* (East Lombok Regency), *Kabupaten Lombok Barat* (West Lombok Regency), *Kabupaten Lombok Tengah* (Central Lombok Regency), and *Kabupaten Lombok Utara* (North Lombok Regency). As of 2014, Lombok Island has the population of

3,352,988 people, over 80 percent of which scatters across the central plain from the west to east regencies while only 13 percent lives in Mataram (BPS NTB 2016).

Primary industries and occupations

As of 2018, the primary industries of the Nusa Tenggara Barat province including the regions of Lombok and Sumbawa islands are agriculture and trade, occupying 38.27 percent and 19.39 percent of the local workforce respectively (BPS NTB 2018c). As of 2015, the major vegetable crops in the province include red onions, chili, tomato, cabbage, cucumber, kale, eggplant, red chili, yardlong beans, mustard, potato, and spinach (BPS NTB 2018d) other than the primary agricultural products of white rice paddy.

The other significant workforce kinds include the processing industry (7.82 percent), education services (6.19 percent), and construction work (5.62 percent) while remaining 22.71 percent belongs to other minor industries (ibid).

The international tourism market has continued to grow in Lombok Island centering around the Western and Southern beach areas. The only airport in Praya (central Lombok) recorded roughly over 7,000 international passengers entering Lombok regularly every month in 2017 (BPS NTB 2018e).

In 2017, the most significant construction projects in Lombok began in the southern region nearby Kuta beaches, where the government designated the vast land of 1.175 hectares as an intensive focus of Mandalika Special Economic Zone (In., *Kawasan Ekonomi Khusus Mandalika*) by the executor of the Indonesian Tourism Development (Persero) or ITDC (in accordance with Government Regulation No. 55 of 2018 and No. 33 of 2009).

(2) The people and religions

The people

The population in Lombok Island is ethnically and religiously diverse, while it has the Sasak people, most of whom are Muslims, occupying the predominant 93 percent and the most prominent minority of Balinese Hindus, living in Lombok across generations and often intermarried with the Sasak (Telle 2016: 422).

The Sasak people are defined as the native habitats of Lombok, and currently, the majority speaks both the national language of Indonesian and the native language of Sasak. Linguistically, the Sasak language is the Sasak-Sumbawa branch of the Bali-Sasak-Sumbawa subgroup of Western Austronesian, and it has at least four confirmed regional variants though more careful geographical survey has not been conducted yet (Wouk 1999: 92). Regarding the rapidly increasing mobility, migration and inter-ethnic marriages, not all Sasak descendants speak the local language, and being a Sasak appears as being a part of diverse Indonesian citizens rather than as the homogeneous ethnic identity.

As Cederroth (1981) notes, the lack of solid writing limits us from getting to the early history of Lombok. What is known is that this small Island went through three considerable foreign impacts. The long history of constant foreign impacts on the island include the strong Javanese cultural influence seemingly dating from the 15th and 16th centuries, the Balinese and Macassarese political influence in the 17th century, and the consolidation of Balinese political control from the beginning of the 18th century and afterward (Haridas et al. 1980: 2).

Losing Praya Wars against by Balinese occupation in the 19th century, Sasak people had a hope in a better life on the coming outside dominance of Dutch from

the end of the century as well as from Japan during the World War II, only to suffer from more of exploitation (Cederroth 1981: 32-35).

Regarding the local religions, people from Java seem to have caused a significant impact to Islamize Sasak people in the 15th century or the beginning of 16th century (Cederroth 1981: 32, Haridas et al. 1980: 2). The pioneering settlers fell apart under the oppression of Javanese kingdoms and the later generations in the new east settlement established *Selaparang* kingdom (Cederroth 1981: 32).

Religions

Islam has continued to be the dominant religion on Lombok Island. According to the data of Badan Pusat Statistik Nusa Tenggara Barat (BPS NTB 2018b), average 93.62 percent of the population in the four regencies and the city of Lombok is registered in Islam as of 2016.

The region with the highest percentage of Muslim population in the island is East Lombok Regency, where the field village resides, recording percent in Islam, with 0.06 percent in Hinduism, 0.02 percent in Protestant, 0.01 percent in Catholic (ibid). The region with the lowest percentage of Mulsim population in Lombok was Mataram, yet recording 82.00 percent in Islam, while marking 14.47 percent of the Hinduism population, the second biggest religion on the island, as well as 1.60 percent in Protestant, 1.06 percent in Buddhism, and 0.86 percent in Catholic.

The provincial capital of Mataram is a center of the religions as mentioned above, withholding many Balinese neighborhoods and Chinese towns (**Figure 2.3**).

Figure 2.3 Mataram Islamic Center of Nusa Tenggara Barat Province. Lombok, 24 February 2018 (photograph by author).

Socio-historical background of Islam in Lombok

In the history of the indigenous Sasak people, researchers observed three different religious groupings *Waktu Lima* and *Waktu Telu,* and *Bodha* (also known as *Buda*). According to Haridas et al., the *Bodha* might have been 'the descendants of the people who…fled into the mountains in order to escape Islamization' (1980: 3) and inhabited in a small number around the most remote northern and southern areas, remaining rich animistic beliefs.

The classification of *Waktu Lima* and *Waktu Telu* is the colonial categorization of the local Islamic groups in Lombok, literally meaning five times (*Waktu lima*) or three times (*Waktu telu*) with connotations of prayer frequency. However, the difference between those two did not bother the rural Sasak people until the 1950s when Islamic teachers (*Tuan Guru*) from other parts of Lombok began to visit the communities and urged people to change local ways (Telle 2000:

775). In the islandwide socio-religious developments, 'there has been a gradual decline in Waktu Telu practices and institutions and ascendancy of a self-consciously orthodox form of Islam since Indonesian independence, particularly since the rise of the New Order' (Telle 2000: 775, in reference to Cederroth 1981 and Ecklund 1979).

As Telle summarizes, '(i)n the aftermath of the alleged communist coup of 1965 and former President Suharto's rise to power, the conflict between orthodox Muslims and Waktu Telu become entangled with national politics' (2000: 775-776, in reference to Kipp & Rogers 1987; McVey 1995), in which the orthodox Muslims accused Waktu Telu as being communists. In 1968, the categories of Waktu Telu and Waktu Lima were officially abolished in the court, and since then all the Sasak people were 'to be simply Muslims, belonging to the Indonesian and worldwide community of believers' (Telle 2000: 776).

More recently in the 1990s, the Muhammadiah movement influenced Lombok as 'a pan-Indonesian modernist Islamic organization that has established schools and introduced welfare programmes,' and 'many Sasak are prepared to recognize that many of their practices are rooted in Sasak custom rather than Islamic law' (Telle 2000: 776). Simultaneously, 'the Waktu Telu now appear less as a deviation from Islam's straight path and more as the beginnings of Sasak understandings of Islam' (Telle 2000: 776).

The so-called oldest mosque in Lombok remaining in the Northern villages of Bayan has become a popular tourist attraction of both domestic and international tourists (**Figure 2.4**). According to oral reports in the area, the residents built and has been using a new mosque nearby the old mosque while the old mosque is occasionally opened and used for ritual purposes.

Figure 2.4 The old mosque in Bayan. Lombok, 10 July 2015 (photograph by author).

3. Reragi Village

(1) Geography, population, and administration

Location, climate, population and administration in East Lombok Regency

Desa Reragi (Reragi Village, in pseudonym) is in the central east of the vast fertile plain of Lombok Island and roughly 350 meters above the sea level (BPS KLT 2018a: 12). The climate of East Lombok is relatively dry, recording total 109 days of rainfall as of 2017 (BPS KLT 2018a: 25). Months with more than ten days of rainfall included January until April as well as December in 2017 (ibid).

Reragi village is under the administration of East Lombok Regency which has the total population of 1,183,204 persons (BPS KLT 2018a: 95), 20 *Kecamatan*

(Sub-districts) encompassing 239 Villages (*Desa*), 1,269 *Dusun* (Sub-villages) and 6,367 *Rukun Tetangga* (Neighborhood Associations). Reragi village has the municipal center of *Kecamatan Reragi* (Reragi Sub-district, in pseudonym) consisting of Reragi and the other nine villages. As of 2017, Reragi Sub-district has the population of around 54,000 people in the total area of 134 square kilometers, which indicates population density of roughly 400 persons per square kilometers (BPS KLT 2018a: 96).

Village population and administration

As of May 2017, Reragi village has the population of 9,140 persons (4,416 men and 4,724 women) with 2,261 heads of households (Kantor Desa 2018), indicating that one household is composed of approximately four persons on average. The village consists of five Sub-villages each of which consists of several Neighborhood Associations, each of which has boundaries by creeks or small artificial ditches that webs the village along the roads.

In Reragi as elsewhere in Indonesia, the municipal leaders of the village compose the pyramid structure. At the top, *Kepala Desa* (Village Chief) exercises authority over the village administration, and at the bottom *Ketua RW* (Leader of Community Association) *Ketua RT* (Leader of Neighborhood Association) leads each smallest unit of neighborhood in cooperation with *Kepala Keluarga* (household headmen), while *Kepala Dusun* or *Kadus* (Sub-Village Chief) as the mediating figures in the middle.

Reragi Village has the administrative subdivision of five sub-villages composed of total 37 Neighborhood Associations and eight Community Associations. However, the villagers often refer to the areas following the old terms classifying the

village neighborhood into four hamlets (*Gubuk*) according to the directions, including *Gubuk Daya* (North Hamlet), *Gubuk Lauk* (South Hamlet), *Gubuk Timuk* (East Hamlet), and *Gubuk Baret* (West Hamlet). The chiefs of those former hamlets were called as *Keleyang* in Sasak.

The four *gubuk* are subdivided by the two main roads intersected at the center. Those crossroads are wide enough for cars and motorcycles to pass by in both directions. Those two roads intersect with the other main roads that surround the central part of the village. This central Reragi is the dense residential area which has primary public space such as the Mosque, the village office, *Puskesmas* (primary clinic of the sub-district), police station, the market, and two elementary schools.

The interviews and observations took place in the central part of Reragi mostly in the walking distance from the house I stayed during my fieldwork. Outside the main roads spreads the vast rice paddy fields with irrigation systems, while there are increasing numbers of houses built on the former rice fields and rainforests.

Other than the representatives as mentioned earlier with their roles defined on the district basis, volunteer-based community organizations including Youth Association and Tourism Promotion Association show an essential presence in planning and executing events of gathering (community festivals, charity events, disaster relief) often in coordination with the village and sub-district municipalities.

(2) Work and education

Economic levels and primary occupations in the region

As of 2016, 18.46 percent of the population in the East Lombok Regency is defined

as the Poor People (In., *Penduduk Miskin*) who live with an average expenditure below the Poverty Line (In., *Garis Kemiskinan*) of Rp.382,861 per month, determining the economic inability to meet basic food and non-food needs (BPS KLT 2018a: 229).[1]

Except for a minority of elites including biomedical professionals, government officials, and successful business persons, the most of Reragi villagers are far from well-to-do and live without a stable income, although there is no official record available about the issue. As of 2016, each of 2,201 households recorded had access to electricity (BPS KLT 2018c: 138). Among the total 2,336 houses in Reragi village, the majority (2,196 houses) is constructed for permanent or semi-permanent residence, while 150 houses remain as make-shift buildings (BPS KLT 2018c: 49). Also, 1,909 houses have access to an undrinkable water source (water well pumps) (BPS KLT 2018c: 51), while there is no available public source of systematic distribution of clean water (In., *Perusahaan Daerah Air Minum*; PDAM) (BPS KLT 2018c: 133). In regards to the mobility of the villagers, there are 2,105 motorcycles, 90 cars, nine trucks or mini trucks, and two mini bans in Reragi village (BPS KLT 2018c: 168), indicating that the primary method of transportation among the villagers is the motorcycle.

According to the data shown by Kantor Desa (2018), as of May 2017, the most primary occupation in the village is farming, counting the population of 2,301 farmers. Other occupations of Reragi villagers include rental services (538 persons), construction workers (205 persons), merchants (168 persons), Civil Servant Teachers (In., *Guru Pegawai Negeri Sipil*) (105 persons), carpenters (104 persons), Honored

---

[1] As of 31 December 2016, Rp. 382,861 is equivalent to USD 28.47.

[2] The productive population is defined as the population over the age of 15 years old.

Teachers (In., *Guru Honorer*) (55 persons), retired persons (35 persons), Civil Servants (In., *Pegawai Negeri Sipil*) (25 persons), divers (25 persons), self-employed (15 persons), policemen (14 persons), midwives or nurses (10 persons), and others (538 persons) (Kantor Desa 2018).

However, it is worth noting that people in Reragi most likely do not limit their work to a single occupation. For instance, farmers may run small shops, and teachers may have rental services. It is thus impossible to determine the number of actively working productive population or the percentage of occupations by the kinds mentioned above. However, the numbers listed above the general tendency in Reragi village that agriculture remains as the predominant source of subsistence, the primary production of which is rice farming.

Located in the upper southern foot of Rinjani Mountain, the land of central Reragi is fertile with irrigation systems drawing on multiple sources of spring water. Reragi Sub-district, where Reragi village resides, has nearly 4,300 hectares of rice fields and total around 23,800 tons of rice harvest as of 2015 (BPS KLT 2018a: 253). The documented primary vegetable harvesting areas in Reragi sub-district in 2014 include the ones of chili, red chili, eggplants, tomatoes, yardlong beans, cucumbers, cabbages, potatoes, and kales (BPS KLT 2018b), while smaller plantations of much more various vegetables and fruits can be observed.

Also, though the details of number per village are not available, there must be a significant number of migrant workers who work in neighboring islands and countries as roughly over 760 men and 40 women in Reragi sub-district is recorded as transmigrant labor as of 2017 (BPS KLT 2018c: 147). In the same year, total 13,241 men and 1,065 women departed home in East Lombok Regency to work

abroad, including Malaysia (13,643 persons), Brunei Darussalam (304 persons), Taiwan (123 persons), Hongkong (120 persons), and Singapore (116 persons) (BPS KLT 2018a: 135).

Among those migrant workers, 13,445 persons are engaged in agriculture, occupying 87.25 percent of the entire migrant labor force from East Lombok, while others as janitors, helpers (In., *pembantu rumah tangga*), construction workers, factory employees, drivers, and others (BPS KLT 2018a: 136). The population of migrant workers abroad occupies approximately 2.55 percent of the active workforce of 560,936 persons in the productive population of East Lombok Regency (BPS KLT 2018a: 127).[2]

It is important to note here that generally in East Lombok as many societies in Indonesia, the predominance of men over women is widely evident in productivity and education. As of 2017, the productive population of 827,584 persons in East Lombok Regency is composed by 44.7 percent of men and 55.3 percent of women, according to the data shown in BPS KLT (2018a: 128). 67.8 percent (total 560,936 persons) of the entire productive population is working, and the work participation rate has a significant gender gap of 82.9 percent for men and 55.6 percent for women.

Levels of education

As of May 2017, 3,183 persons out of the total village population (9,140 persons) have primary education or less, while 1,072 persons graduated from middle school level, 1,974 persons graduated from high school or vocational school level, according to the data shown by Kantor Desa (2018). Also, 693 persons graduated

[2] The productive population is defined as the population over the age of 15 years old.

from undergraduate programs in college or university level, and 16 persons graduated from master's programs in graduate school level (ibid).

The literacy rate in the population of the ages over ten years old in East Lombok Regency is approximately 85.7 percent, whereas it is 89.2 percent for men and 82.8 percent for women (BPS KLT 2018a: 159). However, the school participation rate of both men and women in the current youth is much higher than older generations.

As seen in the data between 2014 and 2017, East Lombok Regency achieved the school participation rates of approximately 99.5 percent of youth in the ages of 7-12 years old, 98.8 percent in the ages of 13-15 years old, and 75.4 percent in the ages of 16-18 years old (BPS KLT 2018a: 160). The ages shown here correspond to the typical age groups enrolling in primary schools (In., *Sekolah Dasar; SD*), middle schools (In., *Sekolah Menengah Pertama; SMP*), and high schools (In., *Sekolah Menengah Umum; SMU*) or vocational schools (In., *Sekolah Menengah Kejuruan; SMK*) respectively.

Under the compulsory education program, Indonesian citizens are required to attend 12 years of school, and they can choose between state-run, nonsectarian public schools supervised by the Ministry of National Education or private or semi-private religious, mostly Islamic, schools supervised and financed by the Ministry of Religious Affairs.

Reragi sub-district as of 2017 has 35 primary schools (32 public and three private schools) (BPS KLT 2018c: 164), eight middle schools (five public and three private schools) (2018c: 168), one public high school (2018c: 176), and two vocational schools (one public and the other private) (2018c: 179). Among these, the

participation rates of students in compulsory education in Reragi subdistrict are below the average of East Lombok Regency, with the numbers of 96.2 percent for participation in primary schools (2018c: 167) and 78.3 percent in middle schools (2018c: 170). The ratio of high school participation is not available.

(3) Religion

Religious facilities

As mentioned previously, East Lombok is a predominantly Islamic region where 99.92 percent of the population is Muslims (BPS NTB 2018b). The entire population of Reragi Sub-district is Muslims without exceptions as of 2017, according to the data shown in BPS KLT (2018a: 225). Islam is an indubitably and fundamentally important part of daily lives in the communities of Reragi village.

Reragi village has five mosques (*mesigit*; In., *masjid*) and 16 prayer houses (*wakab*; In., *musholla*) (BPS KLT 2017: 127). One of the mosques in the village is also the principal mosque of Reragi sub-district, where or imams (Sa./In., *imam*) or Religious Leaders (Sa./In., *Tokoh Agama*) lead prayers every day as well as in occasions of people's death.

The Reragi Mosque also takes a central role as a facility of public announcement in the village. Upon requests, the mosque staff uses loudspeakers attached to the top of the minaret to notify subjects, dates, time, and places of gathering often in the early morning of the day of the events. The subjects of notice vary. It includes death notice (name and age of the deceased, the date, time, and place of death, names of his/her family members, the date, time, and place of the funeral).

Besides, the Mosque announces the places and timings of the meetings of chiefs of sub-villages, monthly integrated health care services of *Posyandu*, occasional health programs such as group injections at the *Puskesmas* sub-district health center and weekly exercises (In., *senam*) for senior citizens in school playgrounds.

Imams at the mosques and other Ustads (Sa./In., *Ustad*) engage with the community by leading prayers and preaching and guiding the study of the Qur'an at prayer houses for small children and other voluntary participants from the neighborhood on a daily basis before and at the sunset prayer (*magrib*; In., *maghrib*).

It is worth noting here that although there is none of them in Reragi village currently, Islamic teachers called *Tuan Guru* in other regions of Lombok are not only the central representative of any religious activities but also the influential leaders of the communities on Lombok.[3] In essential events of life cycle such as *akikah* (In., ritual giving names and shaving the hair of the newborn or young child) and circumcision, some villagers call and ask Tuan Guru to lead prayers at the time of events.[4]

Community events in Islamic years

In general, people in Reragi village as Muslims elsewhere follow both the Gregorian

---

[3] Muslims in Lombok significantly respect not only local Islamic School teachers but also nationwide teachers as Tuan Guru. See Fahrurrozi (2018), for the study of the socio-religious roles of Tuan Guru in Lombok.

[4] A Tuan Guru whom I interviewed in 2017 mentions that he receives requests of lectures, prayers, and consultations from Mosque staff and community mostly via Whatsapp, the instant messaging service for all major smartphones.

calendar (solar calendar) and the Islamic calendar based on the cycle of the moon. The Islamic calendar is consistently shorter than a solar year, and thus shifts approximately 11 days every year concerning the solar calendar. Reragi villagers work with and celebrate the religious months and holidays with local variations below:

(1) Fasting month (Sa./In., *Puasa*; Ar., *Ramadan*): the 9th month of the Islamic calendar, during which Muslims fast daily from dawn to sunset as part of an effort towards self-purification and moral excellence. The fasting month is also the lively month of sales and shopping where people prepare for new attire and presents to wear on the day of breaking the fast. In central Reragi, night markets of clothing (*dagang kelambi*; In., *pasar malam*) open on the main streets every night over the last two weeks of Ramadan, where people enjoy shopping at temporary stands of clothing and food and occasional fireworks and karaoke until around midnight.

(2) Festival of breaking the fast (*Lebaran Belo*; In., *Idul Fitri*; Ar., *Eid al-Fitr*): the holiday commemorating the completion of Ramadan and lasts for three days during which Muslims celebrate with special prayers, meals, sweets, presents for children, and community festivities such as parades. In the morning of Idul Fitri, all men and women in Reragi except for sick people and women in menstruation, postpartum bleeding, or guardians of small children gather at the Reragi Mosque and streets surrounding it to perform prayers. That is also the time when Reragi villagers dress up in new clothes and visit relatives to send regards (*siarah*; In., *salam*), and also visit the graves (Sa./In., *kubur*) (**Figure 2.5**).

Figure 2.5 A scene of the grave visit. Lombok, 17 July 2015 (photograph by author).

(3) Steamed-rice festival of breaking the fast (*Lebaran Topat*): the Sasak tradition widely performed six days after the day of (2) in Lombok, where people cook, buy, and consume steamed rice wrapped with palm leaves commemorating the completion of Ramadan (**Figure 2.6**).

Figure 2.6 A woman making wraps (*topat*). Lombok, 23 July 2015 (photograph by author).

(4) Annual Pilgrimage to Mecca (Sa./In., *Haji*; Ar., *Hajj*): The *Haji*, or annual pilgrimage to Mecca, consists of several rituals which symbolize the essential concepts of the Islamic faith, such as devotion to God, brotherhood, and unity. Hajj is required once in a Muslim's lifetime if s/he is financially and physically able, and those are limited among Reragi villagers, only counting nine of them as of 2016 (BPS KLT 2017: 128).

(5) Festival of the Sacrifice (*Lebaran Pontak*; In., *Idul Adha*; Ar., *Eid al-Adha*): the holiday that takes place on the third day of *Haji* and lasts for four days. The holiday commemorates Abraham's willingness to sacrifice his son, who was miraculously replaced by a lamb. The holiday is celebrated much like (2), and additionally, people sacrifice a goat or cow and share the meat. Imam takes roles to slaughter the animals upon people's requests (**Figure 2.7**).

Figure 2.7 A scene of the sacrifice. Imam (center, holding a banana leaf and a knife in his left hand) gives prayer after slaughtering a cow while the crowd surrounds to watch. Lombok, 2 September 2017 (photograph by author).

(6) Islamic New Year(In./Ar., *Muharram*): the Islamic New Year marks the beginning of the new year on the Islamic calendar. On the day of Islamic New Year, people in Reragi gather at the mosque and the prayer houses to give prayers without as much festivities seen in (2), (3), and (5).

(4) Kinship

Family lineage, titles, and classes

There are three classes in the Sasak hierarchy called *wangsa*: *perwangasa* – descendants of Sasak kings, *triwangse* – descendants of noble families, and *jajarkarang* – ordinary people (Fadly 2008: 81). People who belong to the upper two classes possess titles before their names: In the *perwangasa* class, men have a title of *Raden* and women have a title of *Dende*. In the *triwangse* class, men have *Lalu* and women have *Baiq* as a title.

Nowadays, few among Sasak people encounter those in the *perwangasa* class because the number of its population is minimal. On the other hand, *triwangse* people scatter across the central plain including several in Reragi village. Villagers take *triwangse* people essential and speak to them in a respectful language.

Family heads with Lalu title are called as *Mamiq*, meaning a king, whereas those who without a title is called as *Amaq*. Married women with a title of *Baiq* are supposed to be called as *Memeq*, but nowadays they are called in the same title *Inaq* prefixing name of married women of the common class. Older men and women in the common class lineage are referred to with the calling title of *Papuq* (grandfather/grandmother) that comes before their names, while those in the aristocrat family lineage are referred to with the title of *Niniq*

(grandfather/grandmother). Specifically, to call government workers such as staff at the village office and clinics, people use Indonesian titles such as *Bapak* for men and *Ibu* for women.[5]

Kin relations

Sasak descent is 'bilateral, with a patrilineal emphasis' (Krulfeld 1972: 66). It stands on heterogamous marriage that takes a form of kidnapping of a wife. The heterogamous kinship is called as *kadang jari* while homogamy is called *kadang waris* or *waris wirang* (Kantor Desa 2014).

The extent of closeness among extended family members has three broad categories: *keluarga rapet* (the closest relatives), *keluarga jok* (the less close relatives) and *kerabat* (Sa./In., distant relatives, neighbors). The closest relative members include the ego's grandparents, great-grandparents, cousins, second cousins, parents' cousins, and grandparents' cousins. Those people usually have a moral obligation to help the ego's nuclear family for *adat* events. The less close relatives are the even less related ones, including grandparents' cousins' children.

Male family members inherit the land, and the house and female members receive the rest of heritage such as clothes, gold, and silver. When men get married, they usually live in their parents' houses until they earn enough money to build a new house nearby. So, the houses of male members of families gather close and eventually shape the neighborhood of the whole village.

---

[5] In this report, people's names are mentioned according to those local categories of titles including *Mamiq, Amaq, Inaq, Niniq, Papuq, Bapak* and *Ibu*.

Food and other daily consumptions

The outdoor market (*peken*; In., *pasar*) in Reragi is open every morning after the time of the dawn prayer (*seboh*; In., *subuh*) until around 9:00 am (**Figure 2.8**). It supplies a wide range of goods such as fresh, dry or canned food as well as daily utensils such as cooking tools and clothes, including school uniforms, sarong skirts, and underwear.

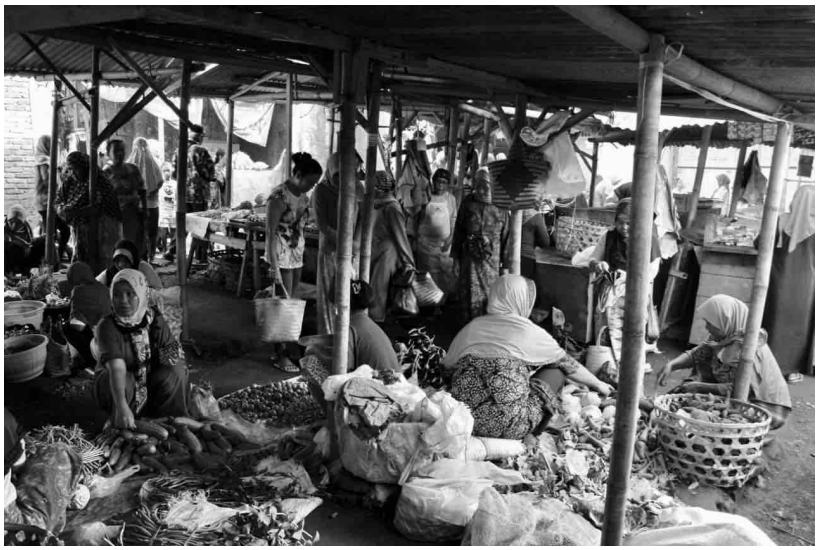

Figure 2.8 A scene of the morning market (*peken*). Lombok, 16 May 2015 (photograph by author).

Mostly, adult women go to the morning market to collect ingredients and cook twice a day for three meals and men do not take charge of those. The village also has numerous tiny shops that operate during daytime to sell fresh food and snacks in a walking distance, and several sellers who carry vegetables, eggs, snacks to seek customers door to door on a daily basis.

From around sunset until around 9:00 pm or 10:00 pm, a take-out food shop opens in the central crossing of the village and helps women to provide sudden guests with snacks. There are three grocery shops around the central crossroads where villagers usually buy shampoo, soap and bottled water for big feasts and other occasions of receiving guests. According to oral reports, it has only since the 2010s that some people began business on electric supplies and communication and give a place for villagers to pay for phone and electricity bills.

Events of the family gathering: gawe

Gawe or the feasts in any significant occasions such as marriage, pregnancy, childbirth, circumcision, death, memorial, and other crucial moments of life consist essential part of the daily family, and village lives in Reragi. The *gawe* feasts are held throughout the year except for the Islamic month of fasting. Gawe functions for the family hosting the feast as a mean to strengthen the bond with extended family members and the neighbors through the week-long preparation process and the exchange of gifts.

For instance, at times of death, the family members of the deceased would let know people close to them or to the deceased about the event. One of them would also ask the staff at the mosque to make a death notice on the speakers by visiting them, making a phone call or leaving a note at the door. Typically many close relatives immediately gather to help the family of the deceased to lead the preparation for the feast, as those bereaved family members are in too much pain and sorrow to do work on it by themselves.

In the meantime, those who find themselves distant enough to the bereaved family members, and thus not obligated to participate in the preparation process

would join the feasts as visitors. Those visitors, including distant relatives, neighbors, and friends, would 'bring the gifts (*belangar*)' to the hosts of the feasts as they hear the news in person or from the announcement from the mosque.

The gift bringing is often the role of adults, including both men and women. Men usually married men brings enveloped cash typically ranging from Rp.5,000 to Rp. 50,000. Those male visitors would take seats (the most typically on plastic chairs borrowed from the village office and lined up on streets) and have freshly cooked dishes of the feast as soon as they give the cash and greet the hosts of the feast. On the other hand, women bring a bowl of husked rice (typically more or less than 3.0kg for celebrations such as wedding and childbirth, and more or less than 1.5kg for mourning such as funerals and memorials) (**Figure 2.9**). Also, they typically more or less than 1.0 kg of refined sugar only for celebration, as well as other suitable materials such as used glasses and plates for funerals, new glasses, pillows, and bedspreads for weddings, and detergents and soaps for birth rites.

Figure 2.9 A set of gift for the funeral feast. Lombok, 26 September 2016 (photograph by author).

As soon as those women arrive at the place of the feast, they would first give their presents to the hosts in charge, greet the bereaved family and see the deceased in case of funerals, the newly married couple in case of weddings, and the newborn child in case of birth rites (**Figure 2.10**). In the meantime, those in charge of the feast meals quickly clear the contents and fill the bowl with ready meals, typically including cooked rice, jackfruit curry, meat soup, homemade sweets, and fruits. Those sets of food are immediately brought home by the visiting women and consumed among their family members at home.

Figure 2.10 A scene of gift-bringing at the funeral feast. Women (right) visit and give the gifts to the hosts of the funeral feast. The hosting women (left) collect the gifts of rice (center), used glasses, and used plates (bottom left). Lombok, 28 September 2016 (photograph by author).

As of 2014, Reragi village recorded 142 incidents of birth and 13 incidents of death (BPS KLT 2017: 41). Further, although there is no further available data about the

amount of certificate issued for marriages in Reragi village, the data shown in BPS KLT (2018a) indicates that average 468.8 marriage certificates issued in Reragi sub-district between 2013 and 2017 (2018a: 69). Those numbers hint the potential frequency of events of feasts and people's constant participation in them.

4. Birth Settings in Reragi: The Local Medical Conditions

(1) Maternal health and health facilities in East Lombok and Indonesia

Background

At Independence in 1945, the Government of Indonesia had 'a weak and unevenly distributed health system to which much of the population had only limited access,' in response to which they 'decided to increase the number of facilities and to locate them closer to the people' (Heywood and Harahap 2009: 1). In 1951, a new health program for the city of Bandung (Bandung Plan) was introduced with a principle to integrate preventive and curative medicine to the existential health systems that were mostly government owned and curatively inclined (Heywood and Harahap 2009: 2).

Based on the Bandung Plan, the government implemented a new national system from the mid-1950s to establish a network of public health facilities throughout the country with a health center at each of the more than 7,000 sub-district and a hospital at the regency level (ibid). By the launch of the First Five Year Plan in 1969, Indonesia already had 1,058 health centers, 7,590 treatment clinics (In., *Balai Pengobatan*; BP), and 5,620 maternal and infant health clinics (In., *Balai Kesehatan Ibu dan Anak*; BKIA) (ibid).

Indonesia rapidly established the network of health centers at the sub-district level and hospitals at the regency level, and by the mid-1990s there were more than 7,000 health centers and over 20,000 health sub-centers (ibid). During the 1980s, the government also started the Village Midwife (In., *Bidan Di Desa*; BDD), a program that allocated trained midwives at the village level as a new type of facility.

The rapid increase of health facilities demanded a large number of human resources of doctors, nurses, and midwives. The government introduced obligatory assignments for all new graduates in medicine, nursing, and midwifery to work at the various health facilities for the first three years in Java or shorter periods in areas outside Java and to make them permanent civil servants, while there were also a limited number of private sector facilities (ibid).

As Nababan et al. puts, significant among 'the maternal health programs and health-financing strategies to achieve the highest possible standard of health for all women' were 'the village midwife program, the insurance program for maternal and child health, and the placement and incentive programs in underserved areas' (2017: 12). Between 1986 and 2012, the utilization of any antenatal care increased from 81 percent to 95 percent, the use of four or more antenatal care increased from 61 percent to 85 percent, while institutional birth rose from 22 percent to 73 percent with a sharp increase after 1998, and cesarean-section birth increased from 2 percent to 16 percent in Indonesia (Nababan et al. 2017: 14).[6]

---

[6] World Health Organizations (WHO) recommend the inclusion of any antenatal care to ensure the delivery of effective and appropriate screening, prevention, and treatment of complication around pregnancy at the fundamental level.

Numbers and types of health facilities in East Lombok

According to the data shown in BPS KLT, East Lombok Regency has total three hospitals (In., *Rumah Sakit*), 31 health centers (In., *Pusat Kesehatan Masyarakat*; *Puskesmas*), 1,736 integrated health service posts (In., *Pos Pelayanan Terpadu*; *Posyandu*), 20 clinics (In., *klinik*), and 240 village birth facilities (In., *Pendok Bersalin Desa*; *Polindes*) as of 2017 (2018a: 199).

All the three hospitals of East Lombok Regency are located in the city of Selong, holding total 80 doctors, 1,973 nurses, 91 midwives, and 55 pharmacists (BPS KLT 2018a: 201). Overall, the hospitals in Selong occupy 50.0 percent of total 160 doctors, 63.7 percent of 3,095 nurses, 38.5 percent of 1013 pharmacists present in the entire East Lombok Regency, and 10.0 percent of the total population of 1,013 midwives, while the other 90 percent of midwives scatter under the administrative distinction of total 915 *Puskesmas* across the region (ibid).

Those numbers also indicate the severe lack of medical experts in the regency of East Lombok, where there are approximately only 0.14 doctors, 2.6 nurses, 0.9 midwives, and 0.9 pharmacists for every 1,000 people. It is worth noting here what kind of diseases the dense population of East Lombok are at high risk.

According to BPS KLT, the ten most common causes of diseases detected in East Lombok include:

(1) Common cold (acute nasopharyngitis) (44,429 cases);
(2) Infectious diarrhea (gastroenteritis) (21,847 cases);
(3) Primary hypertension (20,594 cases);
(4) Upper respiratory tract infection of unknown origin (16,461 cases);
(5) Influenza with other manifestations, virus not identified (14,631 cases);

(6) Influenza with identified virus (13,145 cases);

(7) Fever of unknown origin (12,459 cases);

(8) Non-acute lower respiratory tract infection (10,283 cases);

(9) Gastritis of unknown origin, and;

(10) Typhoid fever (8,977 cases) (2018c: 2019).

Overall health status indicators improved in Indonesia with the rising life expectancy of the country population, also showing the fall of under-five mortality from 52 to 31 deaths per 1,000 live-births as well as the fall of infant mortality from 41 to 26 per 1,000 live-births between 2000 and 2012 (Nababan et al. 2017: 12).[7] On the other hand, the maternal mortality rate remained high, recording 210 deaths per 100,000 live-births in 2010 and showing a persistent inequality across regions (ibid).

As of 2017, East Lombok Regency recorded total 26,860 incidents of birth, 97.2 percent (26,110 incidents) of whose medical procedures were performed in approved health facilities (BPS KLT 2018a: 205). Among those, 26,131 birth incidents were reported, and 798 among the infants had low birth weight while 72 had nutritious problems (BPS KLT 2018a: 210).

In the same year of 2017, among the total number of 28,139 reported pregnant women, 100.0 percent utilized any antenatal care (In., *Kunjungan 1*; K1), 98.1 percent utilized four or more antenatal care (In., *Kunjungan 4*; K4) to health

---

[7] According to Human Development Index (In., *Indeks Pembangunan Manusia; IPM*), life expectancy at birth in East Lombok Regency is slowly improving with the approximate average of 62.8 years in 2015, 63.7 years in 2016, and 64.4 years in 2017, while all the numbers are below the approximate average of the Nusa Tenggara Barat province or broader Indonesia (United Nations Development Programme 2018).

services, 11.1 percent showed Chronic Energy Deficiency (In., *Kurang Energi Kronis*; KEK), and 97.6 percent received Iron Supplement (In., *Zat Besi*; Fe) (BPS KLT 2018a: 211).

(2) Maternal and child health care services in Reragi

Health facilities currently available to people in Reragi village

Puskesmas Reragi, which is the sub-district level health center aimed for the population of 10 villages in the Reragi Sub-district, opens every day from 8:00am until 1:00pm as regular working hours, and operates an 24-hour emergency service unit (In., *Unit Gawat Darurat*; USG) in the presence of two nurses and two midwives as well as one ambulance. Overall, *Puskesmas* Reragi serves the main center that administrates the health information of community, implementing various health programs including the integrated service posts of *Posyandu* and providing ambulance services to send patients and clients in the sub-district to hospitals in Selong as needed such as in cases cesarean-section birth is necessary.

Puskesmas Reragi has three doctors (In., *dokter*), 33 nurses (In., *perawat*), 29 midwives (In., *bidan*), and three pharmacists (In., *farmasi*) (BPS KLT 2018a: 200). Among those, two out of the three doctors are medical interns, and one out of the 29 midwives are also a midwifery intern (BPS KLT 2018a: 135). The staff mentioned above does not include obstetric doctors or nurses.

Puskesmas Reragi has only one delivery room with two beds, and the team of midwives work in shifts regularly and has two midwives to treat the clients in the delivery room while other members do counseling, administration, and other tasks in the office room located next to the delivery room (**Figure 2.11**).

Figure 2.11 A scene of morning consultation at *Puskesmas*. The midwife (left), a medical student (center) and clients (right) talk in the office of midwives. Lombok, 3 August 2015 (photograph by author)

People in Reragi most commonly have access to multiple facilities of general as well as maternal and child health, including the *Puskesmas* Reragi, private clinics of midwives and nurses, hospitals or obstetric clinics in Selong and Mataram or *Polindes* in neighboring villages, depending on their conditions of finance and mobility.

There is one private sector facility of midwifery in Reragi village among total 12 private facilities run by individual midwives (BPS KLT 2018c: 137). Other than midwives' clinics, there are 22 private paramedics and four private doctors in Reragi village (ibid), none of whom has expertise in obstetrics. Other than at health centers, people in Reragi have an walking-distance access to medicine at two drug stores (Sa./In., *apotek*, *toko obat*) located in the village and one drug store located in the

neighboring village, which are the only three drug stores operating in the Reragi sub-district (BPS KLT 2018c: 136).

According to the data shown by *Puskesmas* Reragi (2014), Reragi sub-district recorded 1,177 incidents in 2012, 1,049 incidents of birth in 2013, 1,037 incidents of birth in 2014. The sub-district also had 12 incidents of infant death in 2012 and ten incidents of infant death in both 2013 and 2014 in less than one year of age, as well as two incidents of maternal death in 2013 and one incident of maternal death in 2014 (ibid). The total number of birth incidents and the exact maternal and infant mortality rates in the regions of Reragi village and Reragi sub-district are unknown due to the lack of available data.

Means of contraception and abortion

As Bennett puts, '(w)hile induced abortion is widely and routinely performed throughout Indonesia, it is illegal unless the woman's life is at risk' (2001: 38). However, in Lombok as elsewhere in Indonesia, induced abortion is not uncommon for either single or married women and performed in private practices and family planning clinics maternity hospitals and women's homes, with the principal method of menstrual regulation and vacuum aspiration as well as with traditional and popular methods (Bennett 2001: 38).

Abortion policy in Indonesia, which became a major issue of controversy inside and outside the country, sets that abortion is permitted only to save the life of the woman with additional requirements. The fundamental conditions required include the '(t)he medical procedure must be performed by a health worker possessing the necessary skills and authority, under the guidance of an expert team,' and the '(c)onsent of the pregnant woman, her husband or her family for the

procedure is necessary and it must be performed in an approved health-care facility' (Population Division of the Department for Economic and Social Affairs of the United Nations Secretariat 2018).[8]

According to Bennett, providers of reproductive health care in Mataram show compassion for married women who had two or more children and unplanned pregnancy as a result of contraceptive failure regarding that the women's choice of abortion as prioritizing the family's welfare by limiting family size, which accords with the official ideal of 'small and prosperous family' (Bennett 2001: 41).

In Reragi sub-district, the use of contraceptive methods regulated under the Family Planning programs (In., *Keluarga Berencana*; KB) count 2,073 as of 2016 (BPS KLT 2018c: 140). The most popular method among those were birth control injections as utilized for 937 times, birth control pills as utilized for 468 times, and birth control implants as utilized for 415 times (ibid). Besides, 126 intrauterine devices (IUD) and 100 condoms are utilized, and surgery for men (In., *Medis Operatif Pria*; MOP) and surgery for women (In., *Medis Operatif Wanita*; MOW) were operated 17 times and ten times respectively (ibid).

While there is no available statistics, the mixed use of the aforementioned contraceptive methods is generally found common in Lombok as elsewhere in Indonesia, including the use of traditional herbal medicine and massage (Bennett 2001: 37).[9]

---

[8] See Chapter 5 - Section 3, for the cases of induced abortion in Reragi village.

[9] See Chapter 5 - Section 2, for discussion of the local understandings of the process of conception and pregnancy as well as the cases of the use of contraceptive methods in Reragi village.

Monthly maternal and child health services of Posyandu

In the current programs of universal health coverage implementation, the Government of Indonesia is implementing the Posyuandu health services that integrate free monthly maternal-and-child health services closely located to clients at the village level with the involvement of community volunteers.

The *Posyandu* is not a physical building, but temporary opened posts that provide essential elements of preventative maternal and child health services at the village level, including family planning, birth monitoring, monthly birth weight, nutrition (distribution of vitamin A) and diarrheal disease control, and immunizations (if health worker is present) (**Figure 2.12**) (**Figure 2.13**).

As of 2017, *Puskesmas* Reragi operates a total of 87 *Posyandu* in the sub-district, eight among which are held in every five sub-villages of Reragi village typically in the first week of each month. Midwives, nurses, and immunization specialists visit the houses of the female volunteer cadres (Sa./In., *kader*), mostly the members of Applied Family Welfare Programs (In., *Pembinaan Kesejahteraan Keluarga*; PKK).

Those volunteers open up their houses, set up the places, operate receptions of the clients and record the date and place of attendance, the weight and height of children under six years old as well as the weight of pregnant women, and sometimes sell homemade sweets and snacks while the medical staff focus on treating the clients.

Figure 2.12 A scene of *Posyandu* maternal and child health care services. A *Puskesmas* midwife (center) sees a pregnant woman (left) in the house of volunteers. Lombok, 3 August 2015 (photograph by author).

Figure 2.13 A scene of *Posyandu* maternal and child health care services. Women crowd to have children to receive check-up of the weight and the height at the *Posyandu*. Lombok, 3 August 2015 (photograph by author).

The clients, including pregnant women, postpartum women, and children under six (with guardians) usually walk to the *Posyandu* opened closest to their houses in the morning when they hear the notice from the Mosque about the time and place of the event. However, when they miss the notice or when they prefer to make the occasion of *Posyandu* to visit their natal family living in a walking distance, they can participate in other *Posyandu* than the one held nearest to their current residence.

(3) The shift of birth settings in Reragi: the 1980s-2000s medical landscapes

Introduction of Puskesmas Reragi in the village context of childbirth

The *Puskesmas* Reragi began operating in 1984 in the central area of Reragi village. As mentioned previously, it was the timing when the Government of Indonesia was rapidly increasing the health facilities at the sub-district level and also dispatching the village midwives to improve the population coverage of national healthcare services. However, as Hay (1999) among other medical anthropologists report, the national healthcare implementations during the 1980s and the 1990s had limited effects in decreasing the devastating maternal mortalities in East Lombok despite the family planning and birth control, hygiene education for traditional birth attendants.

According to oral reports in Reragi village, in the 1990s, medical professionals struggled to promote clinic birth at *Puskesmas* as women in the village preferred home birth as conducted by local traditional midwife-healers (*belian beranak*; In., *dukun bayi*).

Ibu Hale, a woman in her late forties, was the first nurse who was born and raised in Reragi village and graduated from the three-year *Sekolah Perawat Kesehatan* (SPK) program, which is equivalent to senior high school level of training

in healthcare and nursing. Ibu Hale graduated the Mataram National School of Health and Nursing in 1992, worked in *Puskesmas* of neighboring villages of East Lombok Regency from 1993 until 1997 and shifted to *Puskesmas* Reragi since 1998. Currently, Ibu Hale works both in *Puskesmas* Reragi and at her private nurse clinic that she newly opened at her house in central Reragi.

According to Ibu Hale, when she began working in *Puskesmas* Reragi in 1998, *Puskesmas* Reragi only had one Javanese doctor who did the administrative job as the head of the health center, three nurses including Ibu Hale, and two midwives, and two trainees of immunization (In., *juru immunisasi*; *Jurim*). Although people were willing to attend *Posyandu* health services free of charge when Ibu Hale and midwives visited them door to door, no one wished to give birth at the *Puskesmas*. Therefore, as she puts, child delivery was conducted usually in the homes of people in the presence of the midwife-healers although Ibu Hale urged people to come to give birth at *Puskesmas*.

Ibu Hale recalls that when she showed up, midwife-healers did not want to see her and became upset saying 'Really, such a child as you can do (the assistance in childbirth)? (*Masak, kamu si becik to*?).' At least for the first three years since 1998, according to Ibu Hale, people immediately sought assistance from midwife-healers at times of childbirth, and often it was too late when they decide to call Ibu Hale or other young female medical professionals.

Ibu Hale understands that the proximate and direct causes of maternal and infant mortality in those times were hemorrhage and infection because:

(1) Midwife-healers tied and cut the umbilical cord (using cotton threads and bamboo knives) only after the placenta spontaneously came out of the birthing mother's body;
(2) It made birthing mothers keep bleeding while newborn children were left naked in cold air;
(3) The healers made women in labor to bear down hard in the sitting position when it was too early to urge, leading to the death of children before birth;
(4) Relatedly, there was no access to cesarean-section birth when it was needed, and;
(5) The healers left the vaginal wound by covering it with ashes, and new mothers refused midwives to stitch up the wound.

As Ibu Hale puts, it took a very long time for postpartum women to recover and they were afraid to walk because there were vaginal wounds not having been treated properly. There was no concept of mobilization (In., *mobilisasi*) among the midwife-healers or the other villagers, and postpartum women immediately lay down on the bed and did not move from there.

In those early years, Reragi villagers could not even tell who was a doctor, a nurse, or a midwife, according to Ibu Hale. 'Perhaps I was the only one (among medical experts) who got called (by people),' Ibu Hale recalls, because 'I was from here (Reragi village) and people were happy when I visited' when someone was about to give birth, or already gave birth.

After childbirth, midwife-healers remained at the home of new mothers and newborn children, typically helping with bathing both the baby and the mother. When possible, Ibu Hale remained in their house to observe the postpartum bleeding

for two hours and also to provide immunization for the newborn. Ibu Hale also made visits to check if the navel of the newborn children were dry enough and to see if they were not showing any symptoms of infections. 'Now it is forbidden (to assist people at their homes),' and it is out of her duty as a nurse, Ibu Hale emphasizes, while she laughs off that people still seek her to ask for assistance in childbirth.

Inclusion and exclusion of local midwife-healers in birth settings

The disempowerment of local midwife-healers and the replacement of birth attendants by medical experts have been the key theme of the successive government strategies aimed at improving the devastating infant and maternal mortality rate in the country (Hunter 1996a, 2001).

In the course of the evolving health policies, the Government of Indonesia in the 1980s implemented programs in which they trained midwife-healers (In., *dukun terlatih*; *dukun bersalin*) with short biomedical lecturing programs and distributed medical kits for child delivery assistance with primary goals to improve the hygiene and to decrease hemorrhage.

As of 2017, the presence of 19 trained midwife-healers, none of whom are permitted to perform assistance in child delivery, are acknowledged by Reragi sub-district, and zero among those is reported in Reragi village. However, interviews with two midwife-healers unrecognized in Reragi village and the neighboring village show that there are at least a few or more midwife-healers continuing their treatments in limited but various ways.

For instance, Papuq Rin, in her seventies, participated in the program of *Puskesmas* Reragi when she was a midwife-healer in the neighboring village back in the 1980s. After marrying a farmer, she succeeded in the role of a healer from her

mother to help people with difficulties. Papuq Rin and her mother worked together until the mother passed away in the 1980s or earlier. At that time, Papuq Rin already had grandchildren. After the death of her mother, Papuq Rin joined the training program and learned child delivery skills from a male nurse. She went to *Puskesmas* Reragi with her friend who was also a midwife-healer, listened to instructions about the kits, which she found easy to handle.

Papuq Rin claims she used to cooperate to work with midwives on occasions of child delivery. She quit visiting people's homes to assisting with child delivery as she got older and began to have problems walking. However, Papuq Rin still receives pregnant women who seek massage to ease abdominal pains, families of birthing mothers who bring bottles of water to seek her healing formula (*jampi*) to be breathed into, as well as others with various need related or unrelated to maternal health.[10]

On the other hand, another midwife-healer called Papuq Apit in her seventies or eighties did not participate in the program.[11] Papuq Apit did not dare to go at the clinics or to work with midwives for child delivery. When the Training for Healer project began, she heard that other healers were visiting *Puskesmas* but did not follow them. That was because once she caught a glimpse of child delivery at *Puskesmas* and was terrified to see midwives inserting hands into the body of the pregnant woman. She also felt uncomfortable to be in the crowded room of around ten midwives. Since then, she has not visited *Puskesmas* Reragi. Refraining from the unfamiliar clinical practice, Papuq Apit continued to help women with giving home

---

[10] See Chapter 3 - Section 4, for further discussion of healing formula and healing powers.

[11] Papuq Apit and her family members did not keep track of her exact age.

birth until she got an injury on the right leg and became unable to walk much, in 2010.

Since the early 2000s, East Lombok Regency has been carrying out a project that encourages traditional midwife-healers to take their patients to clinics by promising them a payment for each recommendation that the healers give to the clinics. In the following decade, clinic birth became no longer strange to the women in Reragi. As of 2014, the *Puskesmas* Reragi counted 257 incidents of birth as being facilitated the *Puskesmas* (which occupies 24.8 percent of the total incidents of birth in Reragi sub-district), and more than 80 percent of those as being accompanied by midwife-healers (Puskesmas Reragi 2015).

In such circumstances, women in Reragi village experience the access to multiple sources of the maternity and child health care on a daily basis, engaging both with midwife-healers for consultation, including abdominal massage and ritual performance, and with the government-trained clinic midwives for child delivery as well as the *Posyandu* for antenatal care, postnatal care, and more. Also on the occasion of childbirth, midwife-healers, other kinds of healers, or their remedies are often present at the health facilities including the *Puskesmas*, hospitals, private clinics of midwives, and the *Polindes*.

Currently, the local medical professionals in Reragi often choose not to interfere with people's persistent reliance on midwife-healers or other kinds of traditional healing unless they judge that those had risks of endangering a patients' health. For instance, the taking of healing water during a difficult birth. In order to prevent the spread of contagious disease, midwives do not allow healers to blow the magical liquid onto the patient's genitals.

In contrast, midwives do not mind if the healer applies the water to the patient's forehead or lets her sip it, assuming it no threat to maternal health. They tend to see those as only supplementary alternative medicine and neither encourage nor discourage their patients from using it. As we will see in Chapter 5, there are also cases in which medical experts themselves visit traditional healers to seek massages to ease abdominal pains during pregnancy.

It is thus fundamentally essential for the present case study of the healing behaviors surrounding pregnancy childbirth, postnatal to explore the contexts of birth beyond the clinical scenes of the institutional medical procedures. In the next chapter, we will turn to the Sasak concepts of being that show the local perspectives on human vulnerability and specifically the vulnerability of pregnant women and their unborn children as well as new mothers and their young children.

• 3 •

Sasak Concepts of Being

1. Chapter Introduction

This chapter presents a general picture of the Sasak concepts of being to approach the sensorial and social dimensions of the village lives in which mother-child relations are to arise. While specific cases of such intricacies are to be examined later in this paper, this chapter delineates how people acknowledge and deal with continuous relationships between a human being (Sa./In., *manusia*) and other beings such as evil spirits, the dead, material things, and other forces affecting health.

The brief episodes of illness interpretations include infants' being affected by the encounter with their dead relatives as well as by the presence of their younger unborn or newborn siblings. It is fundamental to delineate the local sensibility and vulnerability in the world for the present study of the maternal-infant bonding because that is the world where children are born into and come to gain social memberships. As we will explore the specific rituals, treatments, and cares in Chapter 4 and Chapter 5, the local perspectives of the mother-child relations are entangled into people's concerns for the broader assemblages of various beings as they cope with vulnerability, pains, and losses in pregnancy, childbirth, and postnatal.

2. The World of 'Onion Skins'

(1) Various beings in the multidimensional world

The coexistence of the multiple worlds

In the Sasak-Muslim worldview, humans live in the tangible world (Sa./In., *alam nyata*), and the dead persons (*dengan mate*) exist in the grave world (Sa./In., *alam kubur*) until the day of judgment, while unborn children are in the womb world (Sa./In., *alam kandungan*) before they are born to the tangible world.

Telle (2000) draws on the Sasak mortuary practices to argue the transition from the mortal world to another as the principal theme of death. However, as we will see in this chapter, at least in the context of everyday life, those multidimensional worlds are perceived as a co-existential entity rather than as different stages of the linear progressive time of individual life cycle.

When villagers talk about the worlds, they tend to describe that unborn babies belong to the womb world inside each pregnant body while the pregnant persons live in the tangible world and the womb world exists as a universal entity. Similarly, the dead persons belong to the grave world that resides in each grave (*kubur*) while the grave world itself is one. In general, Reragi villagers describe the multidimensionality of the world as of onion skin (Sa./In., *kulit bawang*). Among those, only the material world where the living exists is tangible (Sa./In., *nyata*), and the other dimensions where other-than-human beings belong are intangible (*endek nyata*; In., *tidak nyata*).[1]

---

[1] See Chapter 5, for further the examination of the statuses of the unborn.

Alam bakeq: the world of the unseen

The world of onion skins also includes the realm of spirit being. That dimension of the worlds is commonly referred to as *alam bakeq* (the world of *bakeq*, or the world of spirits) in Sasak language, *alam jin* in Indonesian, or *alam gaib* in Arabic.

People regard the spirit world as the residence of various kinds of spirits which can be divided roughly into two groups of demons (Sa./In., *setan*) and angels (Sa./In., *malaikat*), or of evil spirits (Sa., *jin lenge*; In., *jin jahat*) and good spirits (Sa./In., *jin bagus*). To my knowledge, Reragi villagers do not divide angels or good spirits into smaller groups, while they refer to evil spirits in specific categories with different names and characteristics. As the Sasak words *alam bakeq* represents, the spirit world most typically matters to people as the residence of *bakeq*, one kind of various evil spirits.

People consider *bakeq* as invisible, uncanny neighbors who prefer living in quiet or dark places such as vacant houses, shady streams, rice fields, and forests. Although the spirits and the spirit world is supposed to be intangible, some local healers and ordinary villagers claim to have seen them and can describe their appearances in detail.

In the familiar local imagery, *bakeq* appears human-like but with extremely thin (Sa./In., *kurus*) body, pale (*bodak*) skin, straight, red hair (*bulu abang bareng lurus*) covering the face, barefoot, and only wrapping a piece of white sarong (*kereng putek*) around the waist.[2] The size of *bakeq* varies from as small as thumbs to as big

---

[2] Some features of the appearances of *bakeq* correspond with the media representation of demons in Indonesian horror movies and television shows, including the pale skin, straight hair, and a thin body. In one of my interviews about *bakeq*, a local healer

as the minaret, and the bigger the size more powerful and harmful *bakeq* is. *Bakeq* lives, dies, becomes sick, gives birth, and works (*begawe*) like humans with their own social lives, but their lifespan is long, ranging from hundreds of years to thousands of years.

Habitually, *bakeq* is considered to float in the air and not walking on the soil, as the spirit world itself exists a foot above the ground level. It intakes food by inhaling with nose and not by eating with the mouth. It can go through walls and other tangible things. Things in the spirit world work oppositely from the tangible world: the night in the tangible world is the morning in the spirit world, and what smells sweet (such as flowers) here smells terrible there.

3. Being Vulnerable in the Multidimensional World

(2) Landscapes co-habited by persons and spirits

Keeping distance from bakeq

In the level of daily life, however, villagers acknowledge the presence of *bakeq* by cautiously guessing (*badek*; In., *menebak*) or feeling (*rasak*; In., *merasa*) it rather than seeing (*gitak*; In., *melihat*) it. The most common behaviors of precaution against *bakeq* are spitting (*betusik*) on the ground, by which people express the gesture of salutation (Sa./In., *salam*) toward *bakeq* in a superior manner to warn it inexplicitly not to disturb them.

---

pointed out the television screen showing horrors and commented, 'It (*bakeq*) looks like that!' However, the relation between the local imageries of evil and contemporary media representations of Satan is out of the scope of this research.

The spiting behaviors are commonly found among adults in the village, especially in times before going out of the house and entering other people's homes, as well as when getting closer to rice fields, streams, and forests. When people find it bothering or inappropriate to spit, they can make it simple into the gestures of puckering the lips and giving off exhaling sharply without leaving saliva on the ground.

Reragi villagers precautiously avoid *bakeq* also in less aggressive manners by keeping a certain distance. Pregnant women and infants are considered especially vulnerable to *bakeq*.[3] Pregnant women and guardians of children typically prepare to keep a clove of garlic (*bawang putek*) with them so that it keeps *bakeq* away with the scent it dislikes. Children are warned to return from rice fields and streams before twilight (*sendikala*), which is the morning and thus busy time in the spirit world so that they do not encounter with *bakeq*.

People also take more polite manners to *bakeq*. For instance, when Reragi villagers hold the exorcizing day for newborn children, they typically prepare a small portion of rice paddy and other various kinds of food so that the child and people attending the event would not be disturbed by the unseen (**Figure 3.1**). Similarly, when villagers deconstruct old houses or build new homes in an empty field, carpenters would have special rituals offering bananas and incents so that they do not offend *bakeq* by invading their residence.

---

[3] Reragi villagers typically believe that being touched by *bakeq* or illnesses of the bakeq touch (*sedut bakeq*) during pregnancy have risks of severe damage leading to inflammation of the infant or stillbirth. The case of stillbirth is explored further in Chapter 5.

Figure 3.1 A set of food offerings for the unseen. The food set was prepared in the corner of the room, nearby the door, at the house of the newborn on the day *molang malik* (exorcizing). Lombok, 6 September 2014 (photograph by author).

Numerous illness episodes of encountering with *bakeq* include it passing by a young man leaving his ear skin burnt black, and it pushing an old woman on the ground when she hurriedly climbed the house roof to take her laundry before thunderstorms. Such encounters with the *bakeq* are explicitly referred as illnesses of *bakean* or *sedut bakeq* (*bakeq*'s touch) and typically associated with the extreme heat (*beneng*) endangering the proper coolness (*mel*) necessary for health.[4]

While people consider themselves vulnerable to *bakeq*, they also regard illnesses of *bakean* or *sedut bakeq* as preventable if they take the cares mentioned above to keep an appropriate distance from the spirits. Such illnesses interpretations

---

[4] Hay spells '*mul*' (2001: 218, 319) and Telle spells '*embal*' (2009: 294) to indicate the transliteration of the Sasak word for 'coolness.' In this paper, I follow my informants in spelling the coolness as '*mel*.'

and preventive behaviors of *bakean* demonstrate that in the Sasak ontology, the spirit beings can immediately and physically affect the body of humans in the tangible world regardless of their intangibility, and conversely, a human being can defend themselves against them materially and keep a distance spacially.

In the next sub-section, we will examine the Sasak notions of being by further looking into interactions between tangible and intangible dimensions of the world. More specifically, the following section focuses on the cross-border interactions between the living and the dead to shed light on the sociality and conviviality of the Sasak sensorial lives. As we will see in Chapter 5 of this paper, the collective assemblage of various beings is also the ground of human and social experiences where people embrace and acknowledge the presence of the unborn in pregnancy.

(2) Neighborhood co-habited by the living and the dead

Ketemuq: illnesses of coming across the dead

In the Sasak sensorial lives, people find themselves being vulnerable in the multidimensional world where they occasionally come across various kinds of spirits and implement preventive strategies as seen in the previous sub-section. In similar yet different manners, the villagers' sensibilities toward the presence of the dead persons further illuminate the existential qualities of human being.

The interaction between the living and the dead most explicitly appears as the local illnesses of meeting the dead (*ketemuq*). In Reragi, people diagnose and heal a variety of sudden symptoms as being triggered by an unexpected encounter with the dead. The interactions between the living and the dead seem contradictory to the Islamic beliefs that part the souls of the deceased and ancestors irreversibly from the

mortal world. However, regardless of the indubitable religious faith shared in the community, the vernacular gestures surrounding the illnesses of *ketemuq* demonstrate that the dead appears in the village social lives as affectionate, touchy and subjective figures.

Although there is almost no anthropological literature focusing on the phenomenon, Hay (2001) briefly mentions *ketemuq* in her medical anthropological study in East Lombok. Hay regards ketemuq as 'the illness that results from meeting a ghost' (2001: 204) and describes it as 'one instance of many in which a single illness name is used for multiple, disparate cases' (2001: 207). 'It could be that ketemuq has such a wide variety of symptoms because the name is based on experience, a sensation of meeting a ghost, rather than on physical symptoms' (2001: 206), as Hay puts in an unsure manner.

Although Hay (2001) defines *ketemuq* as a sensation of meeting a ghost, it is crucially misleading to presume the dead equals ghosts (which does not) in the Sasak ontology. In Reragi, *dengan mate* (dead persons) and *hantu* (Sa./In., ghosts) refer to different kinds of beings, and *ketemuq* as common illnesses refers to meeting the identified familiar deceased persons, not the uncanny demons.

In the Sasak language, *ketemuq* generally means 'encounter,' and mainly refers to the interaction with various beings other than humans, such as dead persons, *bakeq*, and *ilmu* (secret knowledge, talent, and strength that operates itself beyond the control of the person who possesses it).[5] Among those other-than-human beings, the most common kind of *ketemuq* is the encounter with the dead, and illnesses of coming across *bakeq* are called explicitly as *bakean* as we have seen in the previous

---

[5] See Section 4 of this chapter, for the description of the notions of *ilmu*.

section. Therefore, when villagers talk about *ketemuq*, they tend to refer to occasions of meeting the dead as well as the inevitable pains and sickness that follow the encounter. In this paper, accordingly, I refer to *ketemuq* as the illnesses of meeting the dead.

In contrast to *bakeq* or other uncanny things, the dead are not considered as an evil being that enforces harms. Instead, Reragi villagers understand the illnesses of *ketemuq* as an inevitable consequence of the cross-border social interaction, in which the dead persons call and beckon to the living. The sickness is healed by identifying the source of waving (who among the dead persons called the living) by way of hair-pulling (*pertuk*).

Cross-border interactions between the living and the dead

Significantly, the local behaviors of the self-care against the illnesses of *ketemuq* underpin the point that people habitually sense vulnerability and admit the presence of the deceased persons in the houses of their lifetime or the places they were dying.

When Reragi villagers receive guests at home and try to serve some drinks and snacks, the hosts typically use fixed phrases such as 'Drink (it) so that you don't meet (the dead)! (*Ngenem, antek endak ketemuq!*)' to persuade them to receive the offer. This expression derives from the logic that the guest can prevent encountering with the dead persons present in the house by showing them that he is welcomed, not intruding, by receiving the hospitality of the hosts. Also when people are about to leave someone else's house they visited, they might speak out or say by heart phrases such as 'For goodness sake, (I) will not meet (the dead)! (*Mudahan endek ketemuq!*)'

According to oral reports, pregnant women and infants are particularly vulnerable to the encounter because babies, both unborn and newborn are those

whom the dead persons 'miss too much (*kangen lalok*).' For instance, if a pregnant woman is diagnosed as having *ketemuq*, it is often supposed that the dead person called her to detain her from going out of the house late in the afternoon so that she would not meet the *bakeq*. Therefore, pregnant women and the guardians of infants are supposed to pay attention to their daily behaviors instead of the children themselves who cannot take care of themselves yet regarding this matter. With this in mind, we will turn to the case of an infant's first encounter with his ancestor to examine the vulnerability of infancy in which children begin to explore the neighborhood while simultaneously becoming in touch with the intangible surroundings and the dead who exists there.

The case of an infant's first encounter with his late grandmother

As I mentioned previously, people in Reragi find pregnant women and infants as especially being vulnerable to the illnesses of meeting the dead as they are often the ones that the dead persons miss too much. This sub-section delineates the characteristics of symptoms and treatments of the illness by detailing the incident of an infant's encounter with his ancestor. It is the case of Yom, an 18-month-old boy (at the time of the event) who lives with his parents and seven-year-old brother next to the house I stayed during fieldwork. Inaq Tip, the subject child's mother in her mid-thirties, permitted me to conduct a close participant-observation, interviews, and a video recording at times of the event.[6]

In the late night of 12 March 2018, Inaq Tip awoke to find that Yom, 18-month old and still breastfed at that time, was vomiting on the bed that they shared.

---

[6] Relatedly in Chapter 5, Inaq Tip's episodes of pregnancy and childbirth are depicted.

Inaq Tip's husband was away at a fishing pond as usual, about which she often complained. The mother immediately picked up her child, wiped his mouth, changed his clothes, gave water and pacified him until he fell asleep. In doing so, Inaq Tip recited verses from *Ya Sin* (In./Ar., the 36th chapter of the Quran) wishing that nothing serious would happen to her baby.

Although vomiting is not rare for infants especially after meals, Inaq Tip was confused because it was unusual for Yom to vomit 'suddenly (*selun-selun*)' in the middle of the night. Also, she knew that Yom's behaviors change if he is about to be sick, losing the will to play and laugh, and clinging to his mother. Inaq Tip caught none of these signs the day before, and Yom seemed healthy and energetic until he went to sleep.

In the following morning on 13 March, Inaq Tip told me about the event above while she was still concerned about Yom's health, wondering why he suddenly vomited at midnight. It seemed to me that Yom was in good health, retaining appetite, the average body temperature and willingness to play and laugh. In the time of Azan in the late afternoon, after spending an uneasy half day of uncertainty, Inaq Tip told people chatting in front of her house that Yom perhaps met the dead. Inaq Tip claimed that the day before she found Yom toddling into the narrow corridor toward the back door of the neighboring house by himself to visit his favorite three-year-old cousin. Inaq Tip assumed that it was when Yom met his ancestors who had lived in that house.

At around 5 pm, Inaq Tip went to see her neighbor that can diagnose the illnesses of ketemuq. The neighbor, Inaq Po in her fifties, lived across the vacant lot behind the houses of Inaq Tip and her neighbors. Inaq Tip carried Yom, while I led

his three-year-old cousin by the hand to visit Inaq Po. The following dialogue describes the exchange between Inaq Tip and the Inaq Po:

Inaq Tip, walking to the house entrance, stepping up the stairs:
Hello! Where are you, Auntie?[7] It's your grandchild (that I brought with me). (*Asalamu'alaikum! Embe Inaq kaka? Papu ene.*)

Inaq Tip, opening the door, speaking to herself, knocking on the entry:
How come (there is no response)?
(*Kumbek a ene?*)

Inaq Tip, seeing Inaq Po as she showed up:
Ah, give us a little yank!
(*Kah, pertuang ita sekedik.*)

Inaq Po, coming out of the house, undressing the prayer clothing:
Yeah, yank!
(*Aok, bertuk!*)

Inaq Tip, sitting down on the entrance terrace, taking off her hijab:
(Is it) me (to yank)?
(*Aku si?*)

Inaq Tip, wearing hijab again, noticing that Inaq Po also took off the clothing:
You (to pull)? Let's (do it)!
(*Sida? Teh!*)

Inaq Po, sitting down at the terrace, holding up a small bundle of her hair:
To whom am I going to give a yank? Who has *ketemuq*?

---

[7] Inaq Po is not related to Inaq Tip as kin. However, as any other respected figures in the village are habitually called with statuses such as 'Uncle (*Paman*),' 'Grandfather/Grandmother (*Papuq*),' 'Great-Grandfather/Great-Grandmother (*Balok*),' Inaq Po is often referred to as 'Auntie (*Inaq kakak*).'

(*Si bebertuk? Si ketemuq ene?*)

Inaq Tip, looking at Yom:

Oh, it's Yom, the sweetie!

(*Oh, Adik Yom!*)

Inaq Po:

Oh, poor thing!

(*Oh, kaya!*)

Inaq Tip:

(He was) throwing up.

(*Ngutak-ngutak ono.*)

Inaq Po, twisting up the bundle of hair with both hands:

Oh! (It's) my role (to treat Yom). Let's! Let's! Let's! Let's!

(*Oh! Bagianku! Teh! Teh! Teh! Teh!*)

Inaq Tip, brushing the leavings off Yom's chest:

(He was) playing there.

(*E-e bekedek lek ito.*)

Inaq Po, further twisting up the hair, talking to Yom:

Eaten? Have you eaten?

(*Mangan, kah? Wah mangan aku?*)

Inaq Po, still twisting up the hair, talking to Inaq Pit:

Is it likely that Papuq Jumain that met (Yom)?

(*Ya ketemuq si Papuq Jumain?*)

Inaq Tip, affirmingly, gazing away:

Well, (Yom was) throwing up...

(*Epe, ngutak-ngutak nganyan...*)

Inaq Po, murmuring while covering the front of the head with the left palm, and using the right fingers to pinch and pull up some of the twisted hair loosely for seven times:

(Inaudible incantations or the name of the dead)

Inaq Po, giving a hard yank to the hair, and hearing the consequential popping sound:

Hmm, yes!

(*Mmm ya!*)

Inaq Tip, turning her head to Inaq Po:

(Is it) yes?

(*Ya?*)

Inaq Po, leaning forward, and spitting on the ground:

Yes, (it's) the female!

(*Ya, nina ono!*)

Inaq Tip, leaning forward and spitting on the ground.

Inaq Po tried murmuring and yanking again to see if Yom had also encountered his late great-grandfather. As there was no popping sound of yanks still, Inaq Po commented that it was not making the noise, and concluded that Yom only came across his late great-grandmother called Papuq Jumain (Grandmother Jumain). Papuq Jumain can be referred to either of Inaq Tip's husband's matrilineal grandparents who used to live in the neighborhood of the current house of Inaq Tip, but the one who met Yom was confirmed as 'grandmother (*papuq nina*).' Inaq Tip left the house of Inaq Po with a brief salute of thank you ('*Makasih, endeh!*') and quickly returned home with the children. Several relatives and neighbors, including Inaq Tip's mother-in-law, who is the daughter of Papuq Jumain, were still chatting in front of the house. They casually asked if it was indeed *ketemuq*. Inaq Tip sat down

with them, let the child off her arms, and explained it was Papuq Jumain. She also repeated that Yom had suddenly vomited the night before. As they watched him toddling around, people affirmatively repeated her comments and compassionately added that the child became healthy right away after the hair-yanking. The mother agreed and echoed that Yom was already healthy, putting an end to the incident for the time being.

As the case of Yom's encounter with his late great-grandmother demonstrates, the physical symptoms of *ketemuq* are generally characterized by the unexpectedness. In general, while signs of *ketemuq* vary tremendously, the villagers follow the single pattern of the hair-yanking diagnosis called *pertuk* as long as the symptoms are sudden and showed possibilities of *ketemuq*. By doing *pertuk*, the living identifies and acknowledges precisely who among the dead called the subject of illness (**Figure 3.2**).

Figure 3.2 A scene of the treatment of the illness of meeting the dead (*ketemuq*). A mother and an infant (right) visit a woman (left) to ask for the diagnosis and treatment of the illness. Lombok, 13 March 2018 (photograph by author).

If necessary or desired, the villagers typically do not hesitate to seek biomedical treatment to ease the pain and help with recovery. In any case, they tend to consider *pertuk* as an essential process of healing for the illnesses of *ketemuq*. Even if doctors diagnose different disease, the villagers regard that it is crucial to perform *pertuk* as early as possible and that its delay can lead to fatal consequences.

It is worth noting here that in cases of adults coping with *ketemuq* in Reragi, the felt symptoms are understood to resemble the pain (*sakit*) that struck the dead in their lifetime. As a woman in her fifties puts, 'If we meet (the dead), what the person felt before dying is what we feel. Let's say (he) died because of headaches. That is what we feel when we meet (him/her)! (*Mun ta ketemuq ja apa si idap a sik dengan pas na gin bilinang ato mate ya rasaang ta. Misal a, mate karena sakit otak ono wah rasaang ta pas ta ketemuq!*).' It is also worth to note that the sensed similarity of sickness refers to the resemblance of the felt pains but not the diseases. For instance, one informant claims she had the sudden uterus pain but not the hemorrhage when she met a woman who had died of hemorrhage during childbirth.

In contrast, as we have seen in this section, people who consider infants as suffering from *ketemuq* tend to guess the source of calling according to the locations rather than symptoms. That is partly because people often find it impossible to specify what kind of pains babies are suffering as they cannot explain that in the way adults can.

In the case of Yom's encounter with Papuq Jumain, *ketemuq* came up as a possibility as the mother found no other reasonable explanations for why the child vomited in the middle of the midnight. The mother remembered that Yom recently began to toddle around in the longer distance than before, and also she imagined that

he met his ancestors on his way to the neighboring house. Inaq Po raised the name of Papuq Jumain according to the report from Inaq Tip that Yom had been playing next door. While the reactive popping sound of the hair-yanking proved that to be positive, Inaq Po tried yanking again to check if Yom also met another ancestor, for which the silence proved to be negative.

Inaq Po, along with many others, explains that *pertuk* is the act of asking the dead whether or not he or she had beckoned to the subject of sickness. Before giving the hard yank, people in charge of pertuk calls the names of the suspected dead persons by heart (*ate*), while they count seven or nine times of looser preparatory hair-yanking according to the gender of the deceased under suspicion. In case people do not remember the names of the dead under consideration, they can call the ancestors by titles in kin relations, such as a great-grandparent (*baloq*), a great-great-grandparent (*mbiq*), or an ancestor (*toker goneng*).

In almost every neighborhood several people can perform *pertuk*, and there is no exchange of money or other forms of the fee expected for the treatment. People tend to seek the older women for the procedure, as they can assume that the elderly to know who used to live in the neighborhood, and also they can expect women to have the hair long enough for yanking.

What is intriguing in the case of Yom's encounter with his late grandmother is how his mother's concerns about *ketemuq* accompany her concerns about the rapidly increased mobility and spontaneous walks of the infant who started toddling recently. In the neighborhood co-habited by the dead and the living, infants' solo exploration of the surroundings begins as they become acquainted with the unseen world embedded in daily life. Simultaneously with her awareness of Yom's being on

his long walks, Inaq Tip carries Yom to the diagnosis and treatment of ketemuq, where she spits on the ground and prevent further disturbance from any other-than-human beings in substitute of the infant who cannot spit by himself.

As we have seen in this section, the Sasak people consider that spirits and the dead exist in different dimensions of the world, and yet find themselves and their children at the constant risk of coming across those beings in the neighborhood where they live everyday life.

In the next sub-section, we turn to the relationships between human and other-than-human being in the dimension of the tangible world. In this domain, significantly, people and things have everyday interactions, as Telle points out in her study of the Sasak house that '[r]ather than operating with a stark dualism between subjects and objects, of people on the one hand and inanimate things on the other, Sasak conceptions are somewhat more fluid' (2007: 199).

(3) Things and persons in the tangible dimensions of the world

Personification of things

In Reragi, the flexible interchange of subjects and objects appears most casually in people's verbal personification of things.

For instance, Inaq Nir, who was my host mother, she often notified me the noise of kettle as the sign of boiling water by saying, 's/he (kettle) is crying (*nangis (kocor) a*).' When she explained to me how to use the washing machine, she described the function as 'works by itself (*begawean mesak*)' in substitute of us (human). When toddlers and infants occasionally fall on the ground or hit the head or body parts against furniture, adults surrounding them would immediately yell, 'Hit

him/her (*Pantok a*)!' and stamp on the ground or slap on the furniture at the point the child was hurt.

Putting aside the problem of whether people rationally recognize it or not, those verbal expressions hint that a kind of subjectivity and autonomy of material things assert itself as a premise of everyday communication. Significantly, the point that things occasionally become subjects interacting with people matters most to the villagers when things are supposed to affect health.

Pepedaman: illness being affected by various 'things'

In Reragi, people interpret various symptoms of pain and sickness as a consequence of deficiency of things and refer to that condition as *pepedaman* or *pedam* (Sa., deficiency; thirst; desire). Almost anything can be the source of *pepedaman*, including the least mysterious stuff such as accessories and one's hair as well as the more critical things such as gravestones, sacred knives, and ancestral cloth.

For instance, sometimes people in Reragi suppose the possibilities of *pedam pepek* (thirst of vagina) for a married man or *pedam lesek* (thirst of penis) for a married woman. According to the villagers, the thirst for the partner's genital does not always relate to sexual desire but appear as various symptoms of sickness. People might guess the possibilities of the unfulfilled sexual desire if a husband and a wife becomes sick while living apart, and the sickness eases after the couple met again whereas it did not heal with the previous medication. To be polite, many villagers feel more comfortable to communicate with substitute phrases such as '*pedam senina*' (yearning for his wife) '*pedam semama*' (yearning for her husband) instead of directly pointing out the illness names of *pedam pepek* and *pedam lesek*.

One of the most common cases of the illness is *pedam* of pillows (*pedam galang*). When Reragi villagers get a crick in their neck or other body parts while sleeping, they might consider it as *pedam galang*. People deal with *pedam galang* by sun-drying (*kendang*) a pillow a half day until it becomes warm and fluffy, and tapping the sick person on the body part in crick for seven or nine times.[8] The pain might not go away immediately, but Reragi villagers widely practice the process of sun-drying and tapping as an appropriate healing method.

In another instance of similar occasions, Inaq Nir remembers that Ati, her 19-year-old daughter, became sick for deficiency of gold (*pedam emas*) when she was four years old. At that time, as Inaq Nir recalls, she was caring for Ati because she had a fever and kept crying for days. As the mother was wondering why the child kept crying even after the fever was reduced by medication, she noticed that the girl had lost gold earrings that she had worn every day.[9] The mother asked the daughter if she was sad about and missing the lost earrings, to which Ati answered no. Inaq Nir guessed that Ati was unconsciously suffering from a gold deficiency, and bought a new pair of earrings as a substitute. As she found Ati healing afterward, Inaq Nir came to understand that her daughter was suffering from *pedam emas*.

Episodes of *pedam* reragian demonstrate the other typical cases of *pepedaman* that is autonomously caused by potent things. For instance, *Reragian*

---

[8] The tapping counts seven times for women and nine times for men. In Sasak ritual context, the numbers of seven and nine are often attributed to female and male persons respectively, as other researchers observe it (e.g., Hay 2001: 111).

[9] In Reragi as elsewhere in Lombok, girls typically get their ears pierced and wear gold earrings as soon as their parents can afford it. The piercing used to be done at home but is currently more often conducted by clinic midwives at Puskesmas with the fee.

refers to a handwoven, natural-dyed, and typically stripe-patterned healing cloth succeeded by ancestors in the village (**Figure 3.3**). At least several *reragian* cloths remain in Reragi village and are often used in various bathing rituals at weddings, in pregnancy and for the cure of multiple symptoms such as itchiness of ears and eyes, bruise, swelling, and stomachache.[10]

Figure 3.3 An ancestral cloth of *reragian*. The photograph was taken when the clothe and other tools were prepared for the ritual of a wedding bath. Lombok, 12 June 2015 (photograph by author).

---

[10] The textiles in Lombok Island have not drawn as many scholarly remarks as they deserve, possibly given its geographical marginality neighboring the picturesque islands of Bali and Sumba. While fragmentary, however, the earlier Dutch records suggest the development of stripe-patterned, tubular-shaped sacred cloth for rites of passage, healing rituals and agricultural ceremonies in Lombok before the *Majapahit* influence in the 14th century and Islamisation in the 16th century (Utsumi 1994). Significantly, Cederroth (1999) reports that under the syncretic *Wetu Telu* Sasak *adat* (customary laws), people used a variety of the sacred tubular cloth for preventing the future children's madness and sicknesses. It hints that the *reregian* in Reragi Village is one of the few variants of the Sasak healing cloth crafted in Lombok until today. The use of *reragian* and other healing cloth is illustrated further in Chapters 4 – 5.

In contrast to the *pedam* of pillows and gold, in case of *pedam reragian* and other potent materials such as inherited knives, people find more particular causal relationships between the sick person's treatment of the object and the sickness he or she is suffering. Such cases of the illness can be exemplified by the episode of Amaq Udin in his forties.

One night in 2017 when he returned from Malaysia after ten years of migrant labor, Amaq Udin suffered from sudden stomachache as if being squeezed around the waist so severe that he could not sleep. When his father heard the incident the following morning, he suggested that it must have been the symptom of *pedam reragian*. Amaq Udin's father guessed that the night before, in coming back to the room after a long time, Amaq Udin accidentally crossed the basket in which the cloth was stored.

In other households of those who have *reragian* typically store the cloth in the wardrobe or on the garret to avoid such incidents of improper contact with *reragian*. In Amaq Udin's house, the room where he slept had long been used as a storage, and the cloth had been secured there. Amaq Udin's father explained to his son that possibly the *reragian* took his act of crossing as disrespect and transformed into an invisible snake during the night to call for proper treatment. He gave Amaq Udin the healing ritual by dipping the fringe of the *reragian* cloth into a bowl of water and tapping the water on the forehead and the abdomen of Amaq Udin and letting him sip the remaining water.

After the incident, Amaq Udin kept away from the room in awe of *reragian*. Such behavior of maintaining a certain distance toward *reragian* and other potent materials is quite typical among villagers. People who own the healing cloth

typically claim that they cannot and must not sell, throw away or give away the fabric for any reason because it can lead to death, referring to the old story of a man that they believe died from severe illness after he had thrown away the cloth.

Pedam adik: sibling rivalry between infants and unborn children

Further, the local understandings of *pepedaman* extend to the notions of the presence of unborn children in women's body emerging as infant illnesses of '*pedam adik*' or 'being affected by a younger sibling.' *Pedam adik* is considered as an illness in which young children are 'fussy (*nyelek*),' meaning that they tend to 'become sick easily, cry easily, get angry easily (*girang sakit, girang nangis, girang gedek*)' during the pregnancy and postnatal periods of their mothers. While being fussy, the children having *pedam adik* are also said to show symptoms of frequent fever and refusal of becoming separated from their guardians and especially from their pregnant or lactating mothers.

The villagers understand that the illness does not derive from the unborn or newborn children but that it comes from the infants' anxiety of losing their mothers' love and attention because of the new presence of younger siblings. It was the case of Ani's newly weaned 23-month-old daughter (at the time of the event) who was diagnosed as *pedam adik* in March 2018 when she had a fever and the other symptoms above.[11] People found the infant as had been 'knowing that his/her younger sibling is present' (*tok arak adik na*) and 'fearing that his/her mother's love was going to be taken away (*takut endek ta kangen malik isik inaq a*)' even before Ani or people around her came to know her conception (**Figure 3.4**).

---

[11] The episode of Ani's first childbirth is described in Chapter 5.

Figure 3.4 A child being fussy (*nyelek*). The child became to be diagnosed as having the illness of *pedam adik* (being affected by a younger sibling) within a few weeks the photo was taken. Lombok, 20 February 2018 (photograph by author).

Ani's pregnancy was confirmed around two weeks after the infant had been showing the symptoms mentioned above and waking everyone in the house with bursts of cry a few times every night. Inaq Nir, who is Ani's natal mother, was taking care of the baby the most while Ani worked away, was convinced that the child had *pedam adik*. Inaq Nir called a healer (*belian*) in her extended relatives who breathed a healing formula (*jampi*) into the opened plastic bag of the child's favorite snacks so that the child would calm down as she intakes the healing formula by eating the snacks. Simultaneously, Ani kept giving her child oral medicine until the fever was reduced.

As we have seen in this section, Reragi villagers find themselves and persons they care for as being vulnerable to illnesses and pain that people experience in relationships and occasional contact with various beings in the tangible and intangible dimensions of the world, including the spirits, the dead, and material

things. We have also seen that the villagers habitually keep a distance from potential harms in space and in a manner to prevent the contact and that they not only seek medication but prefer to enact specific forms reconciliation as a method of healing.

In the next section, I further shed light on another kind of beings acknowledged in Reragi, namely *ilmu* or the power of healing and harms possessed by individuals. By doing so, I aim to capture the fluid dynamics of the local sensorial life in which people sense the vulnerability and strength of the self and others through kin and social relations.

In the next section, I explore the local notions of *ilmu*, which can be defined as secret knowledge, talent, and strength that operates itself beyond the control of the person who possesses it. The notions of *ilmu* illustrate the fundamental principles of healing strategies for the human body that exists in the multidimensional world.

4. Personal Competence as a Being

(1) Ilmu as the power of healing and harms

The hot ilmu and the cold ilmu

In the Sasak context of health concerns, *ilmu* can be transliterated as the power of hurts or healing that affects the human body, health, and emotions. In Reragi, *ilmu* is broadly divided into two categories: *ilmu* of fire (*ilmu api*) and *ilmu* of water (*ilmu aik*), or put in other words, hot *ilmu* (*ilmu beneng*) and cold *ilmu* (*ilmu nyet*), and black ilmu (*ilmu bedeng*) and white ilmu (*ilmu putek*), respectively.

In Lombok, as in many societies in Indonesia and the Malay world, the heat is typically associated with sorcery or other forms of harm while the coldness is considered as the healing and protective power against those. In the Sasak context,

the coolness (*mel*) or being neither extremely hot or cold is essential to health as observed by Telle (2002, 2007, 2009) and Hay (2001: 218), and as echoed by people in Regagi.

The hot *ilmu* may include hypnotism (*serep*) by which one might sneak into houses and steal properties, love magic (*senggeger*) by which one might poison food to target someone in mind to be in love with him/her or others, and black magic (*seher*; In./Ar. *sihir*) by which one might kill or leave crucial health damage on the targeted person. The cold *ilmu* includes any protective or detoxifying power against the hot *ilmu*.

In this context of healing, people regard that the *ilmu* of heat and coldness battles against each other, and that the *ilmu* of higher competence wins the battle. If the cold *ilmu* successfully defeats the hot *ilmu*, the person in pain or sickness can heal. In other contexts of healing, the cold *ilmu* can refer to any therapy for illnesses and pains unrelated to the hot *ilmu*, such as massage for the body pain.

The mastery of *ilmu* must be unspoken, but the matter of who has what kind of *ilmu* is a public secret in Reragi, and that the villagers learn to be cautious with and sometimes ask help from those who have *ilmu*. People whisper the names of supposed masters of sorcery, love magic, and other kinds of potential harms as 'knowing the hot *ilmu* (*tok ilmu beneng*),' and more publicly mention the master of the cold *ilmu* as a healer (*belian*) or 'user of the formula' (*tukang jampi*).

In my interviews with healers and non-specialist villagers, I collected 79 names of those capable persons who are known to have abilities to enforce either or both of the hot and cold *ilmu*. In other cases, some people in Reragi also refer to a

few of the local Ustad as the master of the cold *ilmu* and rely on their prayers as a healing formula.

Although people habitually distinguish the hot and cold *ilmu*, some healers in Reragi emphasize that the matter of harms and healing is the matter of personal intentions who enforces or asks to apply the *ilmu*. Paman Si, a farmer and a renowned healer in his early twenties, describes that there is no bad *ilmu* and there are only wicked intentions.[12] For instance, while hypnotism can be used as a method of manipulating others to succeed in stealing and robbery, it can be used for easing the severe pain of an ill person into sleep.

(2) Ilmu as personal competence

The power, words, and formula of healing

This sub-section explores more abstract conceptions of *ilmu* in the Sasak healing practices. In her medical anthropological study, Hay explores the Sasak concept of *ilmu* as a secret knowledge for health concerns (see Hay 2001: 159-168). Although my observation in Reragi disagrees to some specific details of analysis of local narratives of *ilmu* by Hay, it corresponds to her overarching definition of *ilmu* as a tangible, limited, hidden, agentive entity of learned knowledge that individuals own and succeed as 'their wealth, their protection, and their pride' (2001: 167).

In general, '*ilmu*' as Indonesian and Malay terms can be translated into English as 'knowledge' or information. Citing Ferzacca (1996), Hay further notes that the term *ilmu* began to refer to scientific or academic knowledge in urban Java

---

[12] As it was the case for Inaq Po, some people in Reragi are regarded as socially senior regardless of the biological age.

(2001: 159). As of 2018 in Lombok, most Sasak residents are bilingual in Sasak and Indonesian, and *ilmu* refers to this general sense of knowledge in the broader contexts of public education. Nonetheless, *ilmu* in the context of local health concerns is not shareable, and it is something that enters and becomes integrated within one's entire body and being (Hay 2001: 164).

Hay elaborates on this point by regarding *ilmu* and *puji-puji* (mantra) almost interchangeably, and asserting that the incantations are never written down not only because most people in her field village are illiterate but also because '*ilmu* must enter (*tama*) a person to be potent' (2001: 164) and thus there is no use of writing.

To my knowledge, however, *puji-puji* are the words used in the formula of enforcing *ilmu* (both hot an cold) and are not equivalent of *ilmu* itself. Reragi villagers generally find no necessity and avoid to write or speak *puji-puji* to secure the secrecy of *ilmu*. However, some of the informants did not hesitate to teach me theirs, and one woman let me take a picture of her smartphone screen showing the typed *puji-puji* she learned from her grandfather who is a massage therapist (*belian urut*).

The formula for healing and protection is locally referred to as *jampi*.[13] *Jampi* is the specific act of enforcing the cold *ilmu* by way of whispering the words of *puji-puji* for cure or protection of sick persons. The healers apply the matching *jampi* for the ill person by breathing onto the spot of the upper forehead (*semanget*) or breathing into other materials such as water, betel leaves and food to be absorbed by the sick person from the mouth or the skin (**Figure 3.5**). Various forces of

---

[13] See Hay (2009), for analysis of *jampi* in the field of psychological anthropology.

healing and harms are supposed to permeate through the *semanget* spot on the upper forehead.[14]

Figure 3.5 A healer and a client. The healer (left) breathes the formula on the upper forehead (semanget) of the client (right) who asked the treatment of his headache. Lombok, 15 October 2015 (photograph by author).

Ilmu as the personal competence of healing

In any case, unlike the ordinary preventive self-care behaviors against harms such as spitting on the ground and bringing cloves of garlic, significantly, the mastery of *jampi* and the ownership of *ilmu* are in the limited domain of specialists. One of the preconditions is the family lineage, meaning that there must be the owner of the specific *ilmu* in older family members or extended ancestry.

In general, one learns the spells of *puji-puji* and the ways of formulating *jampi* from a healer in their family lineage while the healer is alive. When healers

[14] See Chapters 4 – 5, for the descriptions in which *informant*s mention the semanget.

sense that they are nearing their end, they typically allow those as the heritage for their close family members, including children, children-in-law or grandchildren, depending on their judgment of trustworthiness of their offsprings.[15]

On the other hand, it is often the case that those who directly learned the spells and formula from a highly capable person do not inherit *ilmu* as the whole competence but do so only partially. Instead, ilmu as the high competence of healing can be transmitted directly to another offspring who was born after the death of the healer and thus did not have a chance to learn specific *jampi* (**Figure 3.6**). In the context of cross-generational transmission, *ilmu* embodies the personal competence of healing as a whole, which operates itself beyond the control of the owner.

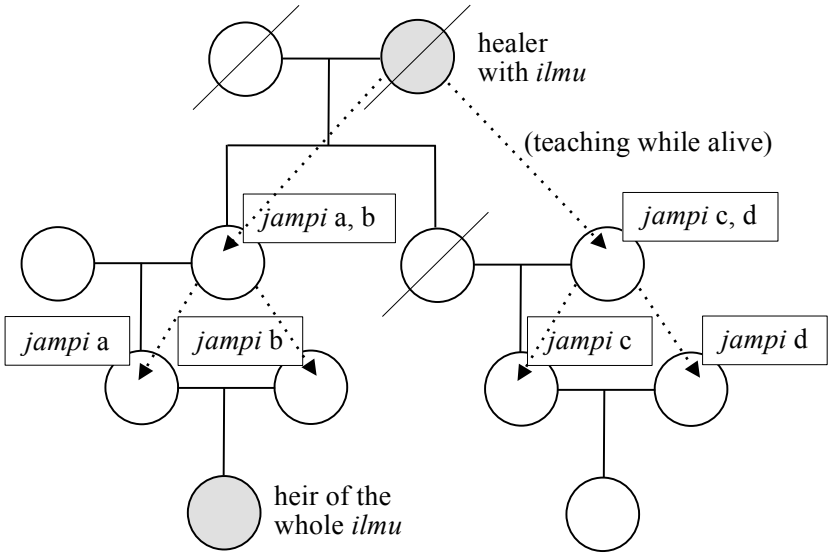

Figure 3.6 An example model of transmissions of *jampi* (healing formula) and *ilmu* (personal competence). The heir of *ilmu* does not need to learn from others how to enact *jampi* to enforce the *ilmu*. (Illustration by the author.)

---

[15] In the respect that the healing formula and the personal competence of ilmu transmit between persons and enter bodies as an alieanable essence, the Sasak personhood can be considered in terms of dividual (Marriott 1976).

(3) Ilmu as a being

Ilmu as an agency coming in and out of persons

The reason why individuals cannot seek *ilmu* in the way they seek information or education lies in another precondition of its ownership.

In Reragi, people do not have a choice in obtaining what kind of *ilmu* to what extent, although they might train and prepare themselves to be capable of receiving it through meditation and other forms of self-empowerment. Instead, it is *ilmu* itself that chooses the person to enter into.

The prime candidates for the ownership of *ilmu* must be capable of enduring absorption of the *ilmu* into themselves, according to Paman Nawa. This point is echoed by healers' narratives of the severe sickness and pain, bodily changes and behavioral restrictions that they received when *ilmu* entered (*tama*) them.

For instance, Paman Nawa, the renowned healer of all kinds, describes the moment when he was 17 years old that he met his late great-grandfather and a big, thick book entered his body while his body was paralyzed. Since then, Paman Nawa finds himself highly sensitive toward the sunshine and wears long-sleeves to go out anywhere.

Paman Si, also a healer of all kinds, claims that he was gifted with a jewel as a key (*seserek*; In., *kunci*) to *ilmu* while he intuitionally knocked one of the rocks at nearby creeks.[16] Since then, Paman Si understands that he must not travel out of the island or otherwise his *ilmu* will be gone.

---

[16] On this experience of receiving *ilmu*, Paman Si regards that jinn keeps the *ilmu* of ancestors in the secure place until the right person appears.

People in Reragi thus understand *ilmu*, the personal competence of healing or harms, as an entity that comes in and out of the human body-self with its autonomy and agency. This existential quality of *ilmu* is pertinent not only in the specific context of its transmission between particular persons but also in the broader context of people's health and vulnerability.

As I mentioned previously, victims of the hot *ilmu* can heal when the cold *ilmu* defeats the hot *ilmu*. As local healers elaborate on this, it is not the humans (*manusia*) using *ilmu* that fight, but it is the hot *ilmu* and the cold *ilmu* itself that battles against each other.

For instance, to detoxify the black magic causing severe abdominal pain with an iron nail, the cold *ilmu* enters the target victim so that the hot *ilmu* or its material substance (the pin) will come out of his/her body. When a healer enforces his or her cold *ilmu* by enacting the matching healing formula of *jampi*, and its power surpasses the harming force of hot *ilmu*, the hot *ilmu* would go away (*lalo*), the nail would be excreted, and the abdominal pain would vanish.[17]

The perceived mobility of *ilmu* that comes in and out of persons is also evident in the local interpretations of illnesses of *ketemuq* (encounter) in which people accidentally come across the force of *ilmu*. For instance, if figure A enforces curse to figure B who also owns higher competence of *ilmu* with which (s)he can shield (*ende*; In., *tameng*) him/herself against it, figure C who happened to be

---

[17] Similar mechanisms of *jampi* are also illustrated in Hay (2001; 2009) and Bennett (2004).

situated defenselessly nearby B might be involved in the battle and become sick beyond the intention of A and B (**Figure 3.7**).[18]

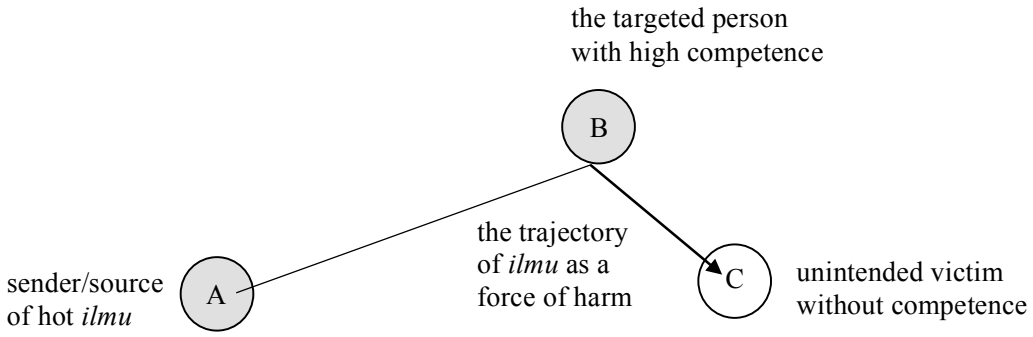

Figure 3.7 An example model of the illness of coming across a person's *ilmu*. If the targeted person of curse has higher competence than the source person, the *ilmu* of the target will repel the force of harm. Unrelated, defenseless individuals are at risk of being involved and becoming sick if they are nearby the target at the moment of battle. (Illustration by the author.)

In the respect that Reragi villagers find themselves vulnerable to the illnesses of coming across someone else's *ilmu*, there should be no exaggeration in saying that *ilmu* is considered as an agentive force. This point is underpinned by the healers' narratives for their experiences of *ilmu* entering themselves, and their explanations of the battle between *ilmu* that go beyond their intentions and control. At the same time, as we have seen in this section, *ilmu* is understood as a person's talent, knowledge and strength of healing and harms, which can be inherited in the family lineage.

---

[18] The point that an individual with enough *ilmu* can repel the curse is also observed by Hay (2001: 121).

Those aspects of *ilmu* demonstrate that in the Sasak sensorial experiences of vulnerability and strength, one's competence operates itself as an autonomous being. This personal competence is not confined to the self of the person in suffering and healing, and conversely, one's essence extends to the body of others in space and over time. Regarding that, I conclude this chapter by remarking on further implications of the sensed intersubjectivity of the Sasak body-self that extends to the social construal of the maternal-infant relation and its complications.

5. Chapter Summary

As we have seen in this chapter, the Sasak sensorial lives involve persons' intertwined relationships not only with other individuals but also with other-than-human beings that permeate multiple dimensions of the world.

The various beings that inhabit the world of 'onion skins' and affect human health include uncanny spirits such as *bakeq* that share the landscape, and occasionally see or touch people with evil intentions. Similarly, the affectionate dead inhabits the neighborhood of the living, once in a while beckoning the missed offsprings, bereaved family members, or random people in the community as they come nearby the houses of the dead persons lived in their lifetime.

In the tangible dimension of the world where people live their daily life, material things call for people's attention, triggering temporary illnesses until their need for human respect is fulfilled. Importantly, such constant relationship with various beings often surfaces people's concerns in regards to the vulnerability of pregnant women and their unborn babies, new mothers, and newborn children, as well as infants in the weaning period or older children.

Reragi villagers perceive the three broad kinds of other-than-human beings (spirits, the dead, and materials) as an external entity, and learn various behaviors of illness prevention to keep a physical and social distance from those and avoid contact. In contrast, *ilmu*, the personal competence of healing or harms, appears as a more ambiguous entity that is neither wholly external nor internal to the human being. Although *ilmu* is owned by individuals and inherited by family lineage as personal property, it does not immediately confine *ilmu* as the object.

As we have seen in the previous section, *ilmu* is considered, enacted, and experienced as an agency that autonomously chooses the owner, and comes in and goes out of the body occasionally beyond the control of the person who enforced it. The permeable qualities of the material and immaterial substance, as well as the transmission of those through human bodies, offer further implications concerning the mother-child relationships before, at, and after birth.

In the Sasak sensorial lives, the human body is often profoundly entangled in the fluid relationships with various beings in the multi-dimensional world. Further, as we will see in the next chapter, the awareness of such relaionships penetrate the local rituals and treatments surrounding the processes of pregnancy, childbirth, and postnatal.

• 4 •

Rituals and Treatments of Pregnancy, Birth, and Postnatal

1. Chapter Introduction

This chapter illustrates the general flow of rituals and other local treatments in Reragi village primarily concerning the health of mothers and children in the phases of pregnancy, childbirth, and postnatal. The descriptive details and graphic images in this chapter draw on participant-observation at times of events and are complemented with oral information collected through interviews with people in the village.

I first mention the wedding rite of bathing in which people wish for fortunes and fertility in the coming marriage life. Second, I describe another bathing ceremony in pregnancy securing healthy childbirth, pain-reducing massage conducted by local healers, and other treatments concerning health in the later period of pregnancy. Finally, I delineate the rites of birth and other postnatal therapies regarding the health of new mothers and the newborn and infants.

The primary purpose of this chapter is to delineate the general processes of the local rituals and treatments during pregnancy, childbirth, and postnatal. Those descriptions compose an essential part of this paper on enriching the empirical data about the cares securing the health of birthing mothers and their children in Lombok today. To note, the general description of the rites and treatments in this chapter is not to diminish people's diverse lived realities of pains, loss, and healing. Chapter 5 is devoted for the detailed case study of such aspects.

2. Marriage and Conception

(1) Wedding bath for fortunes and fertility

This section begins with describing the events of bathing rituals typically performed at weddings in Reragi. I first put a brief enumeration of the wedding bath (*mandiq penganten*) because marriage is generally considered as a necessary procedure for reproduction and couples are typically expected to have a child soon after marriage in the predominantly Islamic society of Lombok and Indonesia.[1]

General procedures of marriage ceremonies

There are two broad types of marriage (*merarik*; In., *perkawinan, penganten*) in Lombok that is locally referred to as 'marriage on stealing' (*memaling*; In., *kawin lari*) and 'marriage on request' (*ngendeng penganten*). Marriage in stealing is a kind of kidnapping of wife found in many traditional societies in Southeast Asia. According to oral reports, marriage on stealing used to be the common way of marriage and remains popular in rural Lombok until today, as the Sasak term of marriage (*merarik*) draws on 'running' (*berari*).[2] More recently, people have

---

1 As I briefly mentioned in Chapter 1, research on women's reproductive rights requires another argument on its own and is out of the scope of this paper. See Bennett (2005), for the discussion of the modern courtship, women's sexual autonomy and reproductive health in Mataram; Bennett (2014), for moral state of premarital sex and unmarried women's inaccessibility to reproductive health care, and; Bennett (2015a), for women's reproductive choices and social status in young marriage.

2 Pre-marital romantic relationships with or without parents' permission are commonly seen in the region. Many among the 50 informants of my semi-structured interviews indicated that their marriage was by stealing (*kawin lari*). Some were the cases in which women were deprived of chances to reject the men in their courtship (*midang*),

marriage on request typically when the groom lives in a different village from the bride and when the groom's family can afford the cost of formal events and gifts of the proposal.

In either case of marriage, Reragi villagers typically hold a series of the following ceremonies on the day of the wedding under the Islamic laws and Sasak *adat* marriage laws called *nyorong*:

(1) *akad nikah* (In., swearing): an Islamic tradition in which the marriage is religiously solemnized and administratively registered;
(2) *gawe*: a few hours of the feasts or wedding reception that immediately follows the *akad nikah* ceremony;
(3) *mandiq penganten*: a short bathing ritual after the *akad nikah* ceremony and the *gawe* feast;
(4) *bejango*: rituals in which a groom's family visits the bride's family's house after the events mentioned above, typically in the late-afternoon.

The wedding ceremonies are typically held at the groom's house, streets, or school playground in the neighborhood. The groom's family is expected to pay for all or the majority of the cost of the wedding, including domestic animals for sacrifice the feast and the rental set-ups of the wedding hall, each of which cost around one million rupiahs as of 2018, according to oral report. The capacity of the ceremonies depends on the affordability of the groom's family, and the extent of permissible

---

and others included a planned elopement in which the unmarried couple secretly arranged to meet and marry. Several cases are detailed in Chapter 5 of this paper. See Bennett (2005), for the discussion of the changing modalities of courtship in Lombok.

simplification is negotiated through face-to-face discussion between the families of the groom and the bride before marriage.

Mandiq penganten: wedding bath

The ritual of wedding bath remarks a short, joyous conclusion of the wedding day, after the solemn religious ceremonies and the celebratory feast. The wedding bath is held on the street in front of the groom's house, where the wedding ceremonies also typically take place. The following description of the service draws on my participant-observation on 12 June 2015 and other several events of wedding bath.

In advance to the wedding day, the groom's family prepares for a bundle of wooden parts of weaving loom (*kayuk sesekan*), an old *reragian* cloth, a gold-lacquered bronze bowl (*bokor*), flower petals, small coins, and the source of water.[3] The groom's family also appoints one or two person(s) with high competence (*ilmu*) for assistance with the ritual performance. This typically involves the participation of either or both of an older female relative who can give the proper formula (*jampi*) or a male, Islamic religious leader (Sa./In., *Ustad*) who can provide prayers.

After the *akad nikah* ceremony and the *gawe* feast, both of which typically involve dozens or hundreds of guests, the wedding bath is performed with a small number of voluntary participants among close family members and neighbors without any invitation or preparatory announcement.

When the ritual tools are set ready, and the ritual performer arrives, the newly married couple comes out of their freshly shared home where they were resting after the ceremonies and sits down side by side on a new, unused rush mat (*teper*; In.,

---

[3] The loom parts include a pair of the foot braces, the warp beam, and the nonskid stick.

tikar) that bundles the loom parts with the single *reragian* cloth wrapping the shoulders of both. While breathing *jampi*, the ritual performer applies the yellow soap on the upper forehead (*semanget*) to wish for marriage life blessed with fortunes (Sa., *riski*; In., *rizki*). (**Figure 4.1**).[4]

Figure 4.1 A scene of the wedding bath (*mandiq penganten*). A woman (center) applies turmeric soap on the forehead of the groom (left). Lombok, 12 June 2015 (photograph by author).

Several women (typically the older female relatives from the groom's family) stand behind the couple and help the ritual performer with spreading the soap over the head and shoulders. After having enough of it, the ritual performer pours abundant water onto the couple by lifting the golden bowl over the head and flipping it upside down for several times each. She then cuts a little bit of the couple's hair near both ears. Finally, she scatters the chopped herbs and flower petals onto the head and body of

[4] The yellow soap paste is made by scraping turmeric, grinding husked rice and mashing candleberries and commonly used to deodorize goats and cattle before sacrifice.

the couple and pours water again on their heads and shoulders until the soap is washed off.

During the bathing ceremony, the crowd on the street, predominantly women and children, go wild for another event called coin showering (*serogot kepeng*) that is recurringly performed in other life-cycle rituals. The coin showering constitutes a kind of exorcizing routine, in which those who could catch many coins would be blessed with fortunes. Usually, the mother of the groom (if not, other female members of the groom's family) throws away a dozen handfuls of coins and husked rice in the air. As she continues, the crowd shout for excitement ('*Ampoq* (More)!'), open arms and jump to reach out their hands to the showering money, and hurriedly crouch on the ground to collect dropped coins.

On the other hand, some of the participants in coin showering weave their way through the crowd to play pranks. They sneakily touch the dirty pot used in the *gawe* feast and joke sooting up people's faces (it is said that the soot keeps *bakeq* away). The growing chaos of delight tempts the marrying couple to laugh aloud, which is also supposed to chase away misfortunes.

The crowd cools down when the golden bowl of coins becomes empty. The bathing ceremony is done by the time, and the drenched couple enters the groom's parents' house to change clothes. The groom's family gives the ritual performers a gift set of cash and husked rice called *andang-andang* to show their gratitude. As the crowd scatters to make their way home, the extensive series of ceremonies are all settled down to mark a prosperous and fertile marriage.

(2) Change of women's social statuses from a bride to a pregnant mother

In Reragi, there are no particular social events organized at the time of conception.

While people tend not to hesitate to let know family members and friends about the pregnancy once it is confirmed, the matter itself is more likely reserved as a private issue rather than as a public concern.

From the time of marriage until pregnancy turns out, newly married men and women are typically called by their social status as the 'newlywed' (Sa./In., *penganten*), 'groom' (*penganten mama*) for men, or 'bride' (*penganten nina*) for women. Since the time the bride's pregnancy is confirmed, family members switch the way of reference to 'pregnant mother' (*Inaq ebon*) for the pregnant woman and 'pregnant father' (*Amaq ebon*) for her husband (while the wife and husband call each other by the first name). This is often when and how more numbers of neighbors and relatives casually notice that the couple is expecting a child, and they typically join in referring to them in the same way.[5]

Reragi villagers today usually confirm the conception with commercially available pregnancy test (In., *tes pek*) from the drug store or free pregnancy test at the *Puskesmas* (sub-district health clinic). As we will explore later in Chapter 6, the acknowledgment of *ngidam* (pregnancy sickness and food cravings) as experienced by the pregnant mother or the expectant father sometimes serve as a motivation other than the delay of menstruation for women to take the pregnancy test.

---

[5] People are called by the name of the first child after s/he is born and named. As we will see in detail in Chapter 5, when they are expecting another child, people around them often switch again to call them 'pregnant mother' and 'pregnant father' until s/he is born. Once the other child is born, people switch back to refer to the couple by the name of the newborn.

3. Pregnancy

(1) Rite of first pregnancy

Mandiq besembet: pregnancy bath for smooth childbirth

During women's first pregnancy, another bathing ritual called *mandiq besembet* is performed similarly to the wedding bath.[6] While the wedding bath is generally intended to wish for prosperity and fertility of the married couple and their families, the pregnancy bath particularly concerns the health and the safety of childbirth. The first child is supposed to open the path (*langan*; In., *jalan*) from the womb to the outer world. In securing its journey, people typically hold the bathing ceremony in which the pregnant woman and her husband are cleansed with the river water.

The pregnancy bath is typically performed in the seventh month of pregnancy and requires the ritual participation of both the 'pregnant mother' (*Inaq ebon*)and the 'pregnant father' (*Amaq ebon*) as well as the person who can give *jampi* and/or the religious leader. The bathing ritual may stage at rivers or beaches, but most people choose the shallower edges of nearby creeks.

Similarly to the occasion of wedding bath, the couple expecting sits down side by side on the bundle of the loom portions with a rush mat rounding it, receiving prayers, *jampi* using the turmeric soap, bathing, and the hair-cutting, while their shoulders covered with their shoulders with the *reragian* cloth (**Figure 4.2**).

---

[6] Hay (2001) observes events similar to *mandiq besembet* as '*besumbut*' ritual in which 'the prospective parents are ritually cleansed, the health of the child is ensured, and the pain and danger of birth are prevented.' (2001: 109). I use the term '*mandiq besembet*,' following the spelling of my informants in Reragi.

Figure 4.2 A scene of the pregnancy bath (*mandiq besembet*). The seventh-month pregnant woman (central left) and her husband (middle right) sit down on the loom parts set on the riverbed and receive the cleansing water as it is being poured over the head by an older female relative. Lombok, 19 July 2015 (photograph by author).

After that, the pregnant mother smashes several things, including candlenuts, a saffron corm, a bamboo joint, and a coconut shell, and the expectant father crushes a chicken egg under the water and lets it float along the stream. Meanwhile, other attendants are all in the creek except the couple, ritual performer and several assisting women enjoy the ritual of coin showering.

In the end, the ritual performer cuts off the long tassels of home-woven birthing belts (*sabok beranak*) with scissors (**Figure 4.3**).[7] A fistful of the trimmed threads are thrown into the stream so that a child will come out of the womb smoothly (Sa./In., *lancar*) like the flowing of streaming water. As people gather

[7] The craft, use, and social roles of birthing belts are explored further in Chapter 5.

things to bring home, the rush mat on which the couple sat down is also thrown along the creek for the same purpose.

Figure 4.3 The birthing belt (*sabok beranak*). Lombok, 19 July 2015 (photograph by author).

The Sasak word '*besembet*' refers to the act of cutting the belt tassels (*bulu sabok*). The families of the pregnant woman can omit the ritual if they cannot afford feasts. In such cases, they usually conduct the belt-tassel-cutting (*besembet*) ritual later at the time of exorcizing for the newborn child.

(2) Treatment of abdominal pain

Massage easing the abdominal pain of pregnant women

Typically in the eighth and ninth months of pregnancy, women in Reragi visit local female midwife-healers (*belian beranak*) or female massage therapists (*belian urut*)

who have skills and competence (*ilmu*) of pain-reducing massage (*urut-urut*).[8] The massage is not considered a mandatory rite or a social ceremony but widely performed as a method to ease the abdominal pain of pregnant women. According to my informants who sought the massage from local healers, they asked the massage as a substitute to painkillers (In., *parasetamol*) because they cannot take painkillers during pregnancy.

The purposes and processes of massage vary from one therapist to another and depend on the condition of the pregnant woman they see. To put broadly, however, the clients consider the abdominal pain in the last few months of pregnancy as the consequence of the slanting movement (*poter*) of the baby (*bebeak*) inside the womb. Those women thus seek the massage to reposition the baby in the womb to the center of the abdomen and in the right direction (the head at the bottom and the feet on the top) to ease her pain as well as to avoid breech birth.[9]

Local therapists detect the baby's position by asking the pregnant woman it hurts and by touching and rubbing the abdomen. According to midwife-healers, if the location of the baby is slanted to the left, the left part of the pregnant woman's belly is felt stiff (*tegel*; In., *keras*), and if the baby is tilted to the right, the right part of the abdomen is touched stiff. The therapists either directly rub the pregnant

---

[8] Those healers in Reragi also engage in a variety of reproductive treatments, including infertility cares, contraception, and postpartum cares. The following sections and chapters of this paper will explore specific examples of their care practices in order.

[9] People in Reragi consider the proper repositioning of the baby in the center of the womb as essential. They also consider it essential for healthy hutching of chicken. In occasions of earthquakes, people gently sway chicken eggs on the flat colander for a few minutes so that the 'baby chicken (*bebeak manok*)' in the eggshell can take balance and return to the central part of the egg.

woman's abdomen by both hands from the side to the middle top over and over or slowly shake the whole upper body of the woman by lifting it with a towel (**Figure 4.4**).

Figure 4.4 A scene of pregnancy massage therapy. In the early morning, a local midwife-healer (*belian beranak*) (upper center) gives massage to a ninth-month pregnant woman (center) to ease the abdominal pain. The woman gave birth to her second child on the same day. Lombok, 7 August 2015 (photograph by author).

Pregnant women would receive the massage care once or for multiple times as they wish. As it is the case with any other local treatments and healing formula using *ilmu*, the massage is expected to be done on a volunteer basis. However, it is most common that women bring the small gift set of *andang-andang*, typically one kilogram of rice paddy and small cash between 4,000 rupiahs and 30,000 rupiahs.

4. Childbirth and Postnatal

(1) Treatment for postpartum recovery of new mothers

Cross-wrapping of the postpartum abdomen with the birthing belt

Reragi villagers bring the home-woven birthing belts (*sabok beranak*) used in the ritual of pregnancy bath to the delivery room alongside other essentials, including drinking water, food, pillows, maternity pads, and a dozen change of sarong cloth. After childbearing, female family members, typically the natal mother or mother-in-law of the new mother, often cross-wrap the abdomen of the new mother with the birthing belt (*sabok beranak*) a few hours after childbirth (**Figure 4.5**).

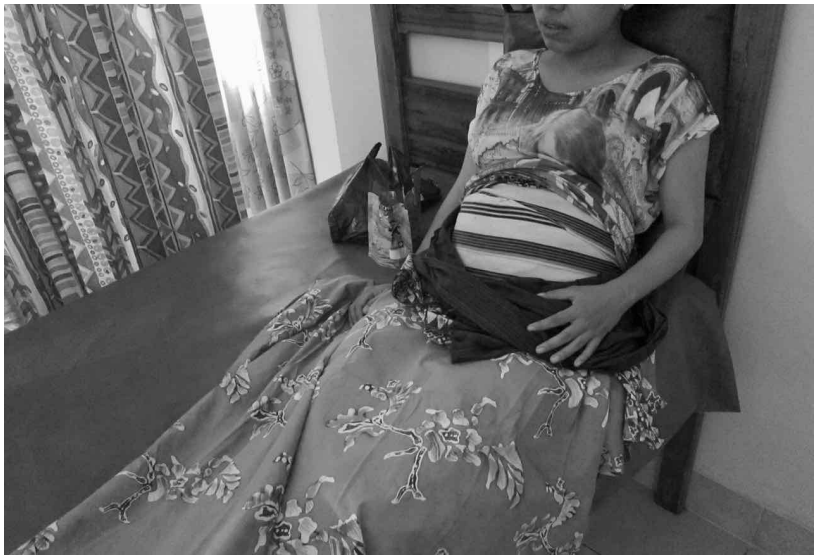

Figure 4.5 A scene of the resting hours on the day of child delivery. In the midwife's clinic, a new mother reclines on the child delivery bed with the birthing belt cross-wrapping the abdomen. Lombok, 30 July 2017 (photograph by author).

In some families, a kind of herbal medicine is tied into the belt tassels and placed

under the navel to apply to heal for the womb. During the post-partum recovery, the woven stripes of the cloth are also said to help the wearers by alleviating lochia, quickening the involution of the uterus, and smoothing stretch marks. However, not everyone attributes such specific functions to the weaving patterns.

In Reragi, where almost every household has the back-strap weaving loom, women's weaving skills are transmitted from mothers to daughters. The birthing belts are reproduced and succeeded across generations as an essential item of pregnancy, childbirth and postpartum recovery. The birthing belts are five-meter long, stripe-patterned white cotton sashes. The two side stripes include colors such as black, orange, red and green, while the central lines are in black. Typically, village mothers prepare the belts for their daughters immediately after marriage, with the expectation that they will soon become pregnant (**Figure 4.6**).

Figure 4.6 A woman weaves the birthing belt with the back-strap loom. Lombok, 22 June 2015 (photograph by author).

The weaving patterns of the belts itself are said to help the delivery process. In

Reragi Village, people associate the risks of birthing with the extreme heat, and the straps are supposed to secure childbirth with its coolness (*mel*).[10] According to oral reports, when the villagers practiced a sitting birth at home, the birthing belts were hung from the interior beam of the bamboo-woven houses so that women in labor could hold on to them. As a local midwife-healer (*belian beranak*) puts:

> If (it was) the long time ago, people held onto the sash while giving birth and we have (the birthing mothers) sit down on the stool.
>
> *Lamun lek ja beranton-anton dengan beranak dit suruk ta ya tokol ngadu tokolan.*

Since people rebuilt houses and the birthing style shifted toward a lying birth at the clinics, the belts no longer give support in the process of child delivery.

As we will examine further in Chapter 5, despite the changes in birth settings, most women bring the belts to the biomedical facilities to wear the belts immediately after birthing and continue to cross-wrap the abdomen, as they feel '*miq* (comfortable),' for anywhere ranging from one month to one year. In many cases, people double the wrap in combination with *stagen* (In., girdle), which refers either to thinner home-woven cotton sashes or mass-produced elastic girdles.

Birthing belts are not used in case doctors deliver women of a child by operation (*bebedel*; In., *operasi*). Postpartum women are advised at hospitals not to stimulate the stitched wound of cesarean section at least for a few weeks, and neither new mothers nor their families dare to hurt the wound by corsetting the abdomen

---

[10] See Chapter 5 - Section 2 and 5, for the discussion of the local humoral understandings of pregnancy and childbirth.

with sashes or girdles. In case of cesarean delivery, those who can afford would purchase mass-produced cotton sashes (In., *gurita*), which are specially produced for patients of cesarean delivery and sold at local hospitals.

Urut-urut massage for new mothers

On the third, fifth, and seventh day of childbirth, many but not all new mothers receive the whole body massage from midwife-healers or massage therapists. According to the healers, this is aimed at straightening (*melombok*) the vessels (Sa./In., *urat*) of blood and other liquid that become collapsed (*petok*) and loose (*kendur*) at childbirth. Forty-four vessels running through the inner body, according to Inaq Naca, become tight (*kenceng*) in pregnancy until delivery, and the vessels are at once come loose when the baby comes out of the vagina. The healer explains that she gives massage on the entire body of postpartum women from the bottom to the top because in the head there is the root of all the vessels, including the tiny ones, gather and often become congested. As she puts:

> The head is where the root of all small vessels gather, yes, (so) we massage from the bottom to the top. If it (feels) stiff we rub along the vessels so that the congestion of the vessels will disappear (and the postpartum body will quickly heal). We straighten the loosen vessels, and we fix the collapsed vessels so that *dadang* (remaining afterbirth) must not go up to the head. If the *dadang* goes up to the head, it makes the person (who had given birth) cannot see, feel dizzy, and have a headache.
>
> *Lek otak ta tok akar selapuk urat lantong si becik-becik, ya ampok ta urut lengan bawak aning atas. Dit endah lek mudin keketut ta tok a girang macet urat, jari tono tok a kumpul terus harus ta urut antek a gagar urat ta. Ono angkak ampok ta urut a mun na wah jera beranak ja ta melombok urat si*

kendur o dit ta meriri urat si petok. Antek endak tek dadang a aning otak ya miak dengan saru penggitak a dit peneng sakit otak.

As we will examine in the case study of postnatal care in Chapter 5, the *dadang*, the Sasak definition of afterbirth excluding the placenta and the umbilical cord, continues to concern some new grandmothers until their daughters' postpartum bleeding but not the new mothers themselves.

(2) Placenta burial

Ariq-ariq placenta burial

A newborn child and the placenta (*ariq-ariq*) are considered as twin siblings (Sa./In., *adik-kakak*) whose susceptibilities to harm are in sync. Reragi villagers generally consider the placenta as the baby's big sibling (Sa./In., *kakak*) as it helps the child, who is its little sibling, to come out of the 'baby's house (*balen bebeak*)' or the womb (In., *rahim*).[11] During pregnancy, the placenta assists the baby as a baby's sitting stool (*tokolan bebeak*).

To prevent *pedam ariq-ariq* or the illnesses of being affected by the placenta, the placenta must not be thrown anywhere (*gelamparang*) but be wrapped white cloth (*bokos*), put in the coconut shells (*jeji*) and buried underground.

By the day of baby's due, ingredients for the placenta burial, including a de-husked coconut shell, white cotton gauze, a bamboo joint, betel leaves, and dried tobacco, are prepared by a midwife-healer (*belian beranak*) or otherwise by a skilled female relative. According to oral reports, the placenta burial has been a part of the

---

[11] With the same logic, when Reragi villagers have twin children, the first child is regarded as a younger sibling and the latter one as the older sibling.

childbirth treatments by the local midwife-healers. As the number of active midwife-healers decreased, more and more non-specialist family members, typically older and female, began to take the role.

On the day of childbirth, the placenta is brought back home by midwife-healers or family members who attended the birth at the clinic or hospital. The ritual performer washes the placenta carefully with running water, puts it in coconut shells and buries it in front of the house of the newborn child within a few or several hours after childbirth (**Figure 4.7**).

Figure 4.7 A scene of the placenta burial (*Ariq-ariq*). A healer wraps the placenta (*ariq-ariq*) with white cotton gauze (*bokos*) placed in the dehusked coconut shell. Lombok, 15 July 2015 (photograph by author).

The ritual performer puts the soil back to the large hole that she had made for the burial, places the large stone, heaps the dirt into a hemisphere and organize the shape by pouring adequate water and smooth the clay by pressing the surface with both hands. She then inserts the small bamboo joint vertically into the mount so that the

placenta can breathe air through the pipe.

The ritual performer also gives gifts such as rice roll as food, herbal leaves, tobacco and flower petals as the aroma, and lit the candle to secure the placenta from the attack by *bakeq* spirits (**Figure 4.8**).

Figure 4.8 The mount of the placenta burial. Lombok, 15 July 2015 (photograph by author).

After the candle fire goes out, someone among family members covers the mount with a chicken basket (*gorong*) or otherwise a plastic laundry basket to prevent cats and chickens from kicking or stepping on it accidentally. It is the local saying that if the bamboo pipe is displaced, it robs air for the placenta to breathe, which would cause breathing problems to its sibling newborn child. However, despite the careful treatment of the placenta on the day of birth, the mounted soil soon and quietly fades from people's attention and gradually weather through the following years.

In rare cases, the placenta is not buried underground in front of the house but thrown into the river or to the sea. According to oral reports, parents or family

members wish that the newborn child would travel away from the island in the future, they throw the placenta into the river or the sea. Conversely, if they wish the child would stay with them and continue to live in the village, they conduct the placenta burial. Besides, some villagers report that they bury certain items together with the placenta in case they make specific wishes, such as a lipstick to wish for the girl's beauty and a pen or a notebook to wish for the child's intelligence.

(3) Birth rituals

Calling names for the newborn children and new parents

As I mentioned previously, since the confirmation of the conception until childbirth, pregnant women and their parents are casually called by their liminal parental status of '*Inaq ebon'* (pregnant mother) and '*Amaq ebon*' (pregnant father). People traditionally did not discuss names of children until childbirth, and until today there are no Sasak terms that refer to embryo, fetus, or gestation. As we will explore that point further in the next chapter, people address the unborn children only generally as '*bebeak*' (baby), the term used to refer to children anytime until around six years old, depending on the context.

On the other hand, the newborn children are specifically referred to as '*kesek*' (newborn), and especially '*lok kesek*' for boys and '*lak kesek*' for girls. Accordingly, new parents are called as *'inaq kesek*' (newborn's mother) and '*amaq kesek*' (newborn's father). People in Reragi often use those calling names for newborns and new parents until the day of '*molang malik*' (throwing harms away) and the following night of *ngurisang* (hair-cutting), in which children are officially named, as we will see below. However, nowadays some parents or their family members

discuss names of children before birth, and their children are called by the given names from the day of delivery.

Molang malik: exorcizing day of the big feast

The first big event after childbirth is the day of *molang malik*, literally meaning 'throwing harms away' in Sasak. The Sasak *adat* custom instructs to hold the event the seventh day after the birth of girls and ninth day after the birth of boys, but currently, the date bothers only a few people in Reragi. *Molang malik* is held anytime from one week to several months after childbirth, depending on the affordability of the host family and the health condition of infants and new mothers. *Molang malik* is essential for the village social lives as the day family members and extended relatives organize the event of gathering (**Figure 4.9**).

Figure 4.9 A scene of the day of exorcizing (*molang malik*) of the child. Extended family members gather to see the child. Lombok, 22 May 2015 (photograph by author).

Adults typically give the child *sembek*, a gestural form of blessing in which they touch the upper forehead (*semanget*) of the child with the right index finger while making a wish such as for the healthy growth of the child. According to oral reports, the currently common form of *sembek* is a simplified version, the original of which includes the person making a wish touch his/her heel first to put a small portion of the soil on the forehead, through which the child is kept away from disturbance (*ganggu*; In., *gangguan*) including *bakeq* spirits.

The day of *molang malik* is also a day of celebratory feasts of *gawe*. The gawe feasts on the day of molang malik, as in the other occasions such as the wedding, pregnancy bath, funerals, and circumcision, are a week-long project in which dozens of close family members. They get together to cook and prepare the meals, snacks, and drinks for hundreds of guests, typically including white rice (*nasik*), jackfruit curry (*sayur nangka*), meat soup of sacrificed animal (chickens, goats, or cattle, depending on the affordability of the host), bananas, cupcakes and/or rice cakes, coffee and tea.

During those few days of preparing and hosting the *gawe* feast of *molang malik*, extended female family members and female neighbors bring gifts (*belangar*) of three-kilogram rice paddy, one-kilogram sugar, and postnatal essentials such as soaps and detergent, all of which are put in the large bowl. Those who brought gifts before the feast revisits the hosts to receive and bring home the set of cooked rice, bags of soup and snacks the host family put in the bowl they had used to transport the gift. Those who brought gifts after the feast had begun immediately receive the souvenir set and go home after chatting, seeing and giving blessing the child.

The host family of the feast and their neighbors, including both men and women, thus spend all day relaxing and waiting for people who come to greet and exchange gifts, while they also work on cleaning up the yard and the house. Many family women hold the newborn child in turn in the terraces and the kitchen, except for breaks of breastfeeding, cradling, naps, and bath. In the late afternoon, they typically perform the ritual of coin showering (*serogot kepeng*) (**Figure 4.10**).

Figure 4.10 A scene of coin showering (*serogot kepeng*). Women and children look for coins that fell. Lombok, 6 September 2014 (photograph by author).

Ngurisang: hair-cutting, naming, and cleansing

In the evening of *molang malik*, people hold a hair-shaving and name-giving ritual called *ngurisang*, which can also be referred to as *akikah* (In./Ar.) ritual widely performed in Muslims communities.

In the *ngurisang* ceremony, the child receives the name, goes through the ritual shaving the hair and becomes purified with aromatic flowery water that keeps

harmful spirits distant. Before the shaving ritual starts, people go back home to take a shower, change clothes, and pray. The newborn child also bathes in lukewarm water and changes in new clothes. Several dozens of the invited adult-male relatives make two long lines along both sides of the catering table, help themselves with mineral water, rice, soup, stew and fruits, and take seats on the plastic chairs in the yard or floor-mats in the terraces or living rooms (*Perasmanan*, or supper feast).

Several younger men among the hosts as well as all the women and children wait for them to finish meals, having casual conversations in the kitchen or the back of the house. Around a half an hour later, men end their meals and women take all the empty plates back to the kitchen. The master of ceremony on the microphone announces the start of the ritual. The father of the newborn child holds his baby in his arms and sits down in front of the religious leader.

Assisting family members bring the Quran to the front of the religious leader, securing it on the elaborate satin cushion. They also carry other essential things such as scissors (put on a ceramic plate), and a golden water bowl filled with flower petals and herbal leaves on the tray. The master of ceremony chants Quranic phrases (In., zikir) while using loudspeakers. The male attendants typically sit in a lotus position, place hands on the knees with palms up and follow chanting.

Soon after the master of ceremony announces the name of the child, the religious leader cuts a tiny bit of hair behind ears of the baby and give blessings to the father and child by scooping some fragranced water from the golden bowl, putting it onto their foreheads and quietly breathing softly upon them.

Finally, everyone stands up to give the blessing to the father and child in turn while continuing to chant. The father or other male guardians carry the baby around

the rooms, terraces and the yard so that all attendants can breathe onto the upper forehead of the child to give words of blessings and can apply the water with flowers and herbs (**Figure 4.11**). Soon later the solemn ritual is over, as the father and child finish receiving blessings from all the adult male attendants.

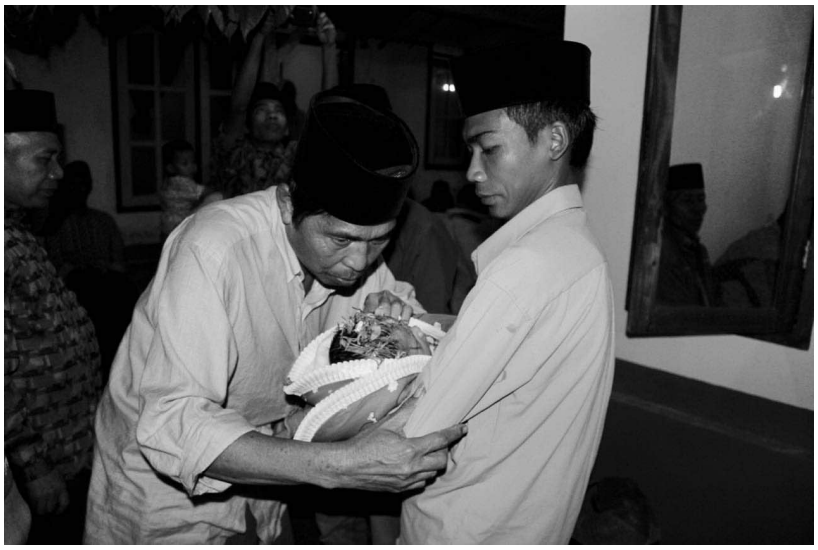

Figure 4.11 A scene of the hair-cutting (*ngurisang*) ritual. An invited male relative (left) gives fragranced water and breathes words of blessings onto the upper forehead of the newborn child (center) who is carried by his uncle (right). Lombok, 6 September 2014 (photograph by author).

Male guests make their way home, lining up toward the exit, greeting each other with soft smiles and receiving a small package of homemade rice cakes as souvenirs. Women and children who were waiting for the whole hour on the backstage can have their dinner feast from then. They take their time to enjoy eating and talking in very casual manners, clean up the tables, the chairs, and the floor mats back and take the rest of the food home.

(4) Applying various protective materials for newborn children

Tying the wrists, anklets and the waist of infants

Regardless of the proper introduction to the surroundings through the rituals of *molang malik* and *ngurisang*, infants are considered as very vulnerable toward illnesses and disturbance. Typically on the following day of *molang malik* or soon later, children wear the protective thread trimmed out of the birth belts in the pregnancy bath and then braided by a parent or other senior family members to relieve light, frequent illnesses.[12] Children wearing such bracelets are considered as '*wah besembet*' (already '*sembet*'), denoting the completion of the chains of defensive acts that started with the bathing rituals.

The threads are referred as *teken* (wrist) and take various forms such as bracelets, anklets or longer string for the waist, each of which is believed to effect on the child's illness such as nose bleeding, vomit, diarrhea, and gas. For example, one of the common kinds is *utaq-utaq* (cocoon), a braided bracelet that goes through a fragmental piece of the envelope of bagworm moth that is said to help with soothing the symptom of vomit.

Other accouterments include *jeringo*, braided threads that go through either a sphere-shaped lace of rattan or a line of tiny wooden beads to ease dizziness and injuries (**Figure 4.12**). For male children, there is also a braided string called *embet* that is tied onto the waist with a tassel dangling to ease excessive gas passing.

---

[12] In my fieldwork in 2015, I found the thread treatment for the sickness of children not only in Reragi but also in villages of Bayan in North Lombok, where the names and the illnesses to cure with the braids vary from the ones in Reragi.

In addition to protective threads, there are metal bracelets, and anklets called *selaka* (silver) that are believed to heal diarrhea. If children have diarrhea, adults typically let them wear either or both of silver metal bracelets or anklets that they to inherit from older generations. Those protective accessories of bracelets, anklets, and belts must not be undressed until the child demands it.

Figure 4.12 A child wears rattan-braided threads on the wrist (*teken*). Lombok, 4 August 2015 (photograph by author).

Bubus chalk powder for newborn children

Another kind of popular home remedies concerning infants' health includes white chalk powder called *bubus* that parents or grandparents apply on a spot of the upper forehead (*semanget*) of newborn and young children continuously on a daily basis for a few weeks.[13] According to oral reports, the *semanget* of babies is still open

[13] Hay translates the Sasak word '*bubus*' as 'the forehead' as she describes the ritual of putting betel chew on the forehead (2001: 152). However, as mentioned previously in

(*masih ngangak*; In, *masih terbuka*), as we can see it sometimes twitching slightly, and so people apply the chalk powder to strengthen the spot (**Figure 4.13**).

Figure 4.13 A mother and a child. The white chalk powder (*bubus*) is put on the upper forehead of the child. Lombok, 23 March 2018 (photograph by author).

As I mentioned previously in Chapter 3, pregnant women and young children are considered as especially vulnerable to attacks from *bakeq* spirits surrounding them, and people typically recommend them and their guardians to bring garlic to keep *bakeq* away when they go out. According to a healer, pregnant women attract *bakeq* because they 'still have stench' (*masi ngeru*), the smell that *bakeq* likes.

On the other hand, children are vulnerable to *bakeq* because their *semanget* is 'still soft a bit not tough yet' (*masi embok dit endek man tegel*) and easily disturbed by *bakeq*. *Bubus* is thus applied to cover the weak point of newborn and young children so that the child would stay healthy and safe from spiritual disturbance.

Chapter 3, people in Reragi use '*semanget*' in the Sasak to refer to the upper forehead. By saying '*bubus*,' the villagers refer to the chalk powder applied onto the *semanget*.

The notion that infants' body is permeable in regards to spiritual disturbance and thus have to be covered by materials such as *bubus* and accessories is also reflected by common gestures of baby carriers who cover the open mouth of newborn and young children with the back of middle finger when they yawn. According to oral reports, this is to prevent *bakeq* sneaking into the baby's body as the baby inhale the air deeply.

5. Chapter Summary

As we have seen in this chapter, social concerns for birthing are expressed explicitly in ritual forms as early as on the wedding day, when newly married couples go through the bathing ceremony for fortunes of fertility. While the event of conception remains in a private domain of family life, people casually acknowledge the transition of the social status of the married couple by hearing and joining to refer them no longer as 'the newlywed' but as 'pregnant mother' and 'pregnant father.'

Typically in the seventh month of women's first pregnancy, the pregnant mother and the expectant father go through another bathing ritual that is aimed at easing the process of childbirth by helping the first child to smoothly open the path from the womb to the outer world. In the last few months of pregnancy, pregnant mothers also tend to receive massage therapies from local healers to ease abdominal pains, which are said to be caused by babies slanting and moving around. The local massages are also aimed at preventing breech birth.

On the day of childbirth and during the postpartum recovery phase, new mothers except those who have been through cesarean section would wear the homemade birthing belts used in the ritual of pregnancy bath. Some of them also

receive the massage from local healers to prevent illnesses such as dizziness and headaches that are caused by the locally defined 'afterbirth' remaining in the woman's body until the postpartum blooding stops. In the meantime, the placenta is considered as a big sibling of the newborn child and is mostly buried in front of the house to prevent illnesses of infants, including *pepedaman* and breathing problems.

Parental statuses of couples shift from 'pregnant mother' and 'pregnant father' to 'newborn's mother' and 'newborn's father' on the day of birth. Children tend to be called as 'newborn' until the day and night of birth rites where they are exorcized, named, and spiritually cleansed. Those rituals are traditionally held on the seventh day after the birth of girls and the ninth day after the birth of boys but can be postponed depending on the health conditions of the newborn and new mothers.

After the celebratory birth rites, children continue to be protected on a daily basis with the use of various materials covering the weak points of newborn and young children such as wrists, ankles, waist, and the upper forehead of *semanget*. Along the gesture of baby carriers covering the open mouth of them to prevent bakeq entering the body of infants, the use of protective materials reflect the local understandings of the body as being porous of external harms.

Those rituals and treatments illustrate that people's concerns and cares for the health and security of birthing women and their children are deeply embedded in the daily social context of Reragi village. The local healing practices during pregnancy, childbirth, and postnatal also immediately associate with the Sasak concepts of being that relates human vulnerability and strength to the interaction with various spirits and things. Considering that, in the next chapter, we will look into the specific cases in which women in Reragi talk about their diverse experiences of maternity.

• 5 •

Giving Birth in a Lombok Village

1. Chapter Introduction

This chapter illustrates specific cases in which people in Reragi acknowledge the presence of life in the womb, face vulnerability and loss in pregnancy, and nourish the bond between birthing mothers and their children.

I begin with describing the general mechanism of pregnancy as a local healer explains it and then proceed with examining specific episodes of illnesses, pains, transformations, loss, and healing surrounding birth that partly matches or otherwise vary from the general description. Second, I launch the case study by inquiring into the ways women acknowledge the presence of a living thing inside their bodies in their experiences of quickening. Third, I explore the cases of two women's miscarriage and stillbirth and ask the statuses of the children lost to them.

Fourth, I look into episodes of sickness and food cravings of pregnancy in which birthing mothers and their husbands perceive the nourishment as connection their emotions and vulnerability with the ones of their children, continuing to the bond after childbirth through breast milk. Finally, I examine the cases of postpartum care. The case will show the sense of gratitude, reluctance, and muted frictions between new mothers and their natal mothers in determining how much the 'new grandmothers' should interfere with the body of their daughters who are now mothers, vice versa how and in what way the new mothers would acquire their mothers' cares through the postpartum body that they own.

2. The Presence of the Living Thing

(1) The processes of pregnancy: a general description by a healer

Interviews with healers and women in Reragi

In this section, I summarize the general mechanism of pregnancy (Sa., *betian*; In., *hamil*) as described by a local massage therapist (*belian urut*) and midwife-healers (*belian beranak*) who take primary roles to help pregnant women to ease the abdominal pain by massage (*urut-urut*) and formula (*jampi*). I first draw on the narrative by Inaq Naca, a female massage therapist (*belian urut*) (**Figure 5.1**).[1]

Figure 5.1 A massage therapist (*belian urut*) showing her hands. Lombok, 17 March 2018 (photograph by author).

As a massage therapist, Inaq Naca treats both women and men who seek to ease or

[1] The lack of document makes it impossible to determine the exact age of Inaq Naca. Although she does not keep track of her age, Inaq Naca claims that she was born before the independence of Indonesia in 1945.

reduce various health problems, including the pregnancy massage we have seen in Chapter 5. I selected Inaq Naca as a key informant of this matter because I found a dozen among 50 women in my semi-structured interviews about their experiences of childbirth report that they sought and received her massage to ease the abdominal pain during pregnancy and to stimulate the postpartum recovery.

According to Inaq Naca, she received *ilmu* of massage from an unknown, invisible person (*dengan alim*) when she was walking to the Mosque decades ago. She felt the person touched the upper forehead (*semanget*). After the incident, she found abnormal changes of her body such as her teeth falling on the ground, her back bending, and scissors can not cut hair. She understood those as the bodily reactions to the strong *ilmu* that entered her body. When Inaq Naca gives the massage, she claims, it is not her that provides massage, but the invisible person does.

It is worth noting here that while Inaq Naca and other healers' skills and the competence (*ilmu*) of healing are regarded as expertise, fragments of general descriptions of the conception and pregnancy were heard recurringly from other non-specialist villagers, including the women who asked massage from Inaq Naca. Therefore, although only Inaq Naca and a few midwives (*belian beranak*) bothered themselves answering my questions ('Could you explain how is pregnancy?') in a structured manner, I regard the following explanation about the process of pregnancy represents much of common knowledge among the village women (who found themselves less obliged and more reluctant to offer lengthy description to me).[2]

---

[2] However, as we will see later in this chapter, the details of how and when pregnancy sickness begins, and the baby begins to have the life significantly vary.

The first thing that struck me during my interviews with (both specialist and non-specialist) women in Reragi was the fact it made little sense to them when I asked 'Could I ask you how the baby develops in the mother's abdomen during pregnancy? (*Bu ke ku ketoan sida bagaimana cara bebeak berkembang didalam perut Ibu ketika hamil?*).' I had to rephrase by saying 'how *is* pregnancy from the first day until birth? (*bagaimana cara kehamilan itu dari hari pertama sampai melahirkan?*),' to which most of the women would kindly begin answering my questions and telling their experiences of pregnancy.

Reragi women's reactions do not indicate that they have not heard of or do not understand the terms such as fetal development (In., *perkembangan janin*). In the village as elsewhere in Indonesia, the biomedical processes of embryo statuses and fetal development are informed with the visual aid in the widely distributed state-initiative maternity health-record books (In., *Buku Kesehatan Ibu dan Anak*). Those also appear in lectures by the clinic midwives and visiting obstetric doctors (sent from Selong) at the sub-district health center aimed at informing people about the necessity to behavioral restrictions and proper treatments for pregnant women.

What women's strange look and refusal of answering my first question indicated was the situation in which the concept of fetal development was irrelevant to pregnancy and childbirth *she* experienced, and thus my initial question was irrelevant to both of us because I was supposed to be there to listen to her personal stories of pregnancy and childbirth. For some women in Reragi, as one of the informants puts, 'babies do not develop (*bebeak endek berkembang*).' As we will see in the healer's description of pregnancy below, physical changes surrounding the processes of pregnancy is always emerging as it *is* in here and now.

The general flow of conception, pregnancy, and birth explained by Inaq Naca

The unity of the male person's liquid and the female person's egg:

According to Inaq Naca, the first day of pregnancy is when male person's liquid (*aik dengan mama*), also known as the chicken liquid (*aik manok*), and female person's egg (*telok dengan nina*) is united (*besopok*). At this point, the 'pregnant mother' (*Inaq ebon*) has not felt yet (*endek man rasak*) anything happening inside the body.

The baby as liquid:

In the first and second weeks of pregnancy, the baby (*bebeak*) is still liquidy (*masi cair*). In these weeks, both or either of the pregnant mother and the 'pregnant father' (*Amaq ebon*) might begin *ngidam* (pregnancy sickness and food cravings). In the first and second months of pregnancy, the baby is still blood (*masi darak*). The abdomen (*tian*) of the pregnant mother is still small (*masi becik*).

The baby as flesh:

Around the third month of pregnancy, the baby becomes flesh (*jari dageng*). It begins to have solidity and shape, around the size of areca nuts (*buak*; In., *pinang*) or craws of chicken (*kendodok manok*; In. *tembolok ayam*). At this point, the abdomen of the pregnant mother is still soft (*masi embok*), and she still has to be very careful to prevent miscarriage.

According to Inaq Naca, as echoed by many others in Reragi, women in early pregnancy with still-small abdomen should especially refrain from wearing skinny jeans and riding motorcycles and bicycles. The local customs also assign pregnant women with other various and behavioral and food restrictions such as avoiding the

hot food (Sa./In., *makanan panas*) like durians and or the strong drink (Sa./In., *minuman keras*) like carbonated drinks throughout the entire pregnancy.

The baby as a life:

Inaq Naca puts that in the fourth month of pregnancy, the baby has life (*benyawa*) as 'written in the Quran,' and the baby is very big (*semakin belek*), around the size of a fist (*regem*; In. *kepalan*). Pregnant mothers sometimes can feel the movement (*kadang bu rasa begerak*).

Although Inaq Naca refers to the Quran here, the Quran does not provide an assertation about the status of human embryos, and Islam has no central authority that determines it (Neaves 2017: 2542). In Indonesia today, there are different views among Muslim leaders about when the soul (*roh*; In./Ar., *ruh*) enters the fetus, but this time point of ensoulment is generally recognized as 120 days after conception while some Islamic scholars have argued that ensoulment could happen as soon as 40 days after fertilization.

The baby wanting to become a human:

In the fifth and sixth months of pregnancy, the baby 'wants [is about to] become a human' (*mele jari manusia*). The pregnant mother feels strong moves (*rasa begerak keras*). In those times, 'parents (*dengan toak*) must pray well (*harus na berdo'a si bagus-bagus*)' so that the baby can become a human.

The baby as a ripe human:

In the seventh month, the baby's body already exists entirely (*awak bebeak wah selapuk arak*), already ripe (*wah toak*), and the baby has already become a

human (*bebeak wah jari manusia*). At this point, the abdomen of the pregnant mother is already big (*wah beleq*), and 'vessels (*urat-urat*)' of the blood and other body liquid are tight (*kenceng*). If the baby is born in the seventh month, it is 'normal (Sa./In., *normal*),' and the baby would become smart.

The baby as an unripe human:

In the eighth month, the baby is still unripe (*masi odak*). The abdomen of the pregnant mother sometimes hurts (Sa./In., *kadang sakit*). If the baby is born in the eighth month, the born baby is often considered as less healthy (Sa./In., *kurang sehat*) and weak (Sa./In., *lemah*).

The baby coming out (as a ripe human):

Within nine months and ten days, as 'written in the Quran,' the baby is already ripe (*wah toak*), and the baby comes out (*sugul*). The baby is already complete (*wah sempurna*) at this point, meaning that the nose (*idung*), eyes (*penenteng*), hair (*bulu*), and everything is ready. The pregnant mother gives birth (*beranak*). The vessels become loose (*kerut*) as those are cut (*petok*, In., *putus*) at the time the baby comes out.

In Inaq Naca's description, the mechanism of pregnancy is put in chronological order with the presence of multiple subjects for simultaneous conditions (**Figure 5.2**).

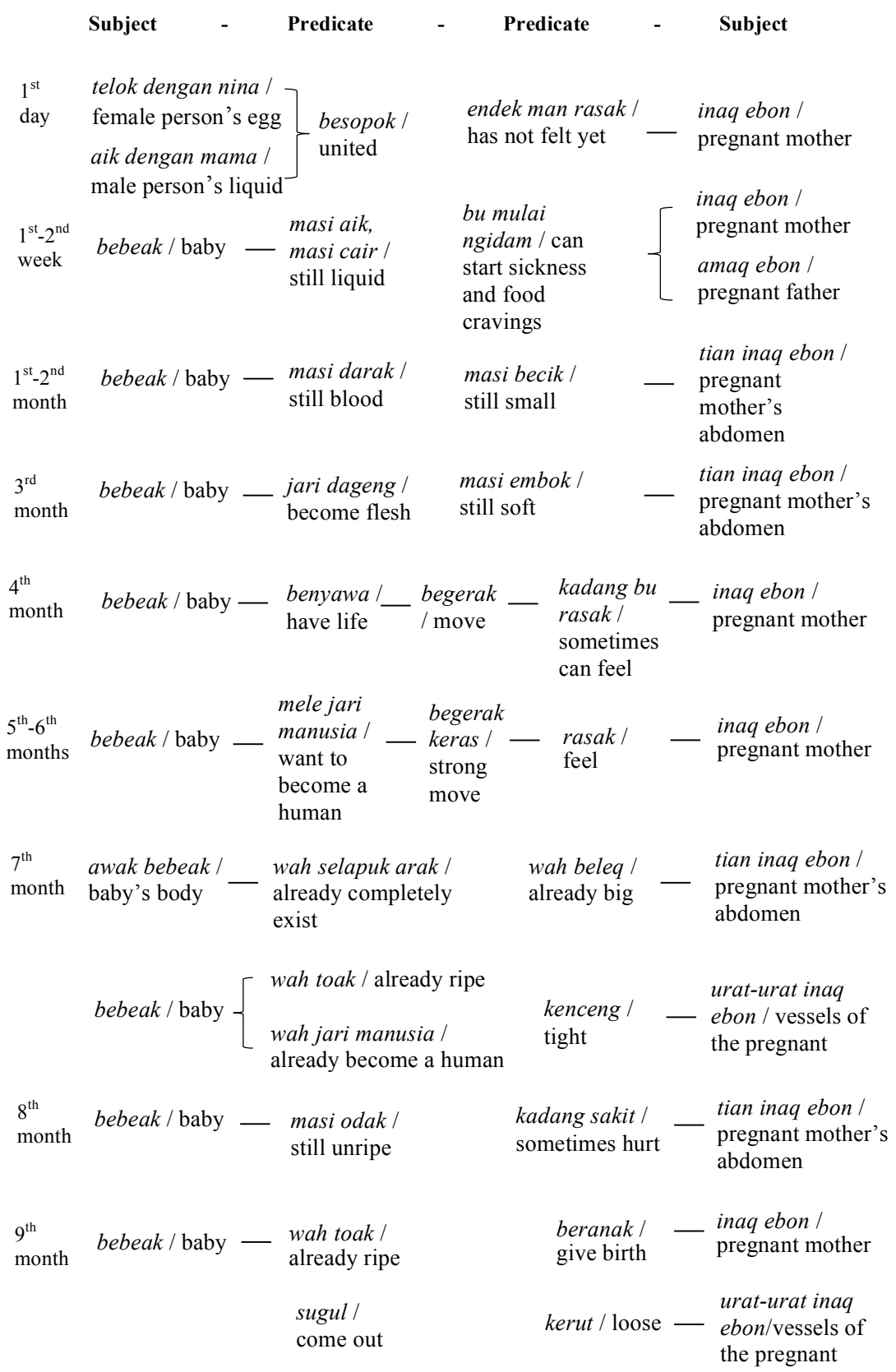

Figure 5.2 Outline of pregnancy as described by a healer (Illustration by author).

Beginnings of the life

In her explanation of the process of pregnancy, Inaq Naca makes clear divisions in acknowledging the moment of fertilization, the time point of ensoulment, the beginning of human personhood, and the day of birth.

According to Inaq Naca, babies (*bebeak*) appear as a figure as early as the moment of fertilization. That is also the time point when the nine-month process of pregnancy begins to count, and women start to have a parental status of a pregnant mother (*Inaq ebon*). However, as Inaq Naca puts, the baby is still liquid (*masi aik*; *masi cair*) and still blood (*masi darak*) for the first two months of pregnancy, and it only begins to become flesh (*jari dageng*) in the third month. The baby is neither life nor a person yet in the meantime.

As Inaq Naca puts, in the process of pregnancy, the child begins to 'have the life' (*benyawa*) first in the forth mouth, which corresponds to the Islamic understanding of the beginning of personhood. Significantly, this is also the initial stage in which pregnant mothers 'can feel movements' (*bu rasa begerak*), and followingly they would feel strong movements as babies 'want to become a human' (*mele jari manusia*). As we will explore later in this chapter, this point of 'feel' (*rasa*) of movements is where many non-specialist women in Reragi subjectively and varyingly acknowledge the presence of life according to their experiences and not necessarily referring to the Quranic knowledge.

For Inaq Naca, babies do not count as human (*manusia*) until all the body parts complete in the seventh month. Conversely, people in Reargi do not necessarily regard birth in the seventh month of pregnancy as premature birth but instead positively consider it as 'mature' (*toak*) and 'normal.' On the other hand,

childbirth in the eighth month of pregnancy is understood as dangerous as the child is still immature (*odak*) and soft until the ninth month comes. Also, Inaq Naca puts that there are people who continue to be pregnant up until 11 months. In those cases, the child is still immature if born in the tenth month, and is already mature if born in the 11th month. Many women in Reragi echo such notions of maturing of babies. Interestingly, the villagers widely use the biomedical term of premature (In., *prematur*) without negative connotations of abnormality. Although it typically requires weeks of hospitalization and medication, people in Reragi tend to consider premature birth as usual (Sa./In., *biasa*) and healthy (Sa./In., *sehat*) (**Figure 5.3**).

Figure 5.3 A mother and a child looking into each other after breastfeeding. The photograph was taken on the day of *molang malik* (exorcizing), which was postponed for a month until the discharge of the child from hospitalization after premature birth. Lombok, 12 August 2017 (photograph by author).

(2) Infertility care and contraception

Massage for infertility care and contraception

Generally in Reragi as elsewhere in Muslim communities in Indonesia, the matter of having a child (Sa./In., *anak*), having a marriage partner (In., *jodoh*), and coming to death (*kematean*; In., *kematian*) are understood as being 'on the hands of the God' (*izin nenek epenta*; In., *atas izin Allah*) and out of human manipulation.

From the fatalistic point of view, having a child is not under human control but is to be blessed (*riski*; In., *rizki*) with a child. However, as an Imam in Reragi puts, although God gives fortunes such as children and health, humans can make efforts to seek them. The fatalistic views shared among women in Reragi do not merely fall into submissive attitudes regarding their fertility concerns, and they often try to examine causes and seek available cares of infertility *bangkol* (male or female infertility) as well as to access multiple methods of contraception in need.

In her study of the local infertility care in West Lombok, Bennett reports that Sasak midwife-healers use massage as a primary means of infertility care and birth control by that they lower or raise the physical location of the womb so that it meets or goes beyond the reach of sperm (2016: 6). Similarly, in Reragi, Inaq Naca and two midwife-healers (*belian beranak*), as echoed by many other village women, regard that it is because the 'baby's house' (*balen bebeak*), or the womb (In., *rahim*), is on the side that some people have difficulties to have children. According to Inaq Naca, the problem is that the male person's liquid (*aik dengan mama*), or the sperm, cannot reach the womb because the womb is on a different side. Inaq Naca and other healers in Reragi offer abdominal massage to move the position of the uterus to the center and the front, just below the navel (*poset*; In., *pusar*).

For instance, Inaq Naca claims that she has successfully treated a clinic midwife (In., *bidan*) who had difficulties in conceiving a child. The midwife was from Yogyakarta and was working at a hospital in Selong. It was difficult for her to have a child even though all her sisters could have nine or ten children. As Inaq Naca touched the abdomen of the midwife, she found that it was hard (*tegel*; In., *keras*) on the left side, which meant that the womb was sliding on the left. Inaq Naca recommended her to check with ultrasound (In., *USG*; *ultrasonografi*) first, and it turned out correct (*kenak*; In., *benar*). Inaq Naca then gave her abdominal massage to bring down the womb to the front. According to Inaq Naca, the treatment can be done within two days (one set of massage per day) if the person is 'thin' (Sa./In., *kurus*), while it takes longer if she is 'fat' (*lemu*; In., *gemuk*).

Shared understandings of the pregnancy mechanism among women in Reragi

The Sasak fertility massage is 'most often vigorous and deep, lasting at least an hour,' and when pains occur during the massage, 'belian talk their patients through it, explaining what the pain means and why it needs to be removed from the body' (Bennett 2016: 6).

Non-specialist women who receive the massage in Reragi, as mentioned previously in this chapter, thus share the fundamental understandings of the mechanisms and treatments of infertility and contraception. The shared beliefs of the local traditional contraceptive methods are exemplified by an experience of Niniq Tuan in her mid-fifties, who received both of treatments from Inaq Masulah, the late midwife-healer (*belian beranak*) in Reragi.

Niniq Tuan, she was married to her late husband back in October 1985 when she was 22 years old. They did perform the ritual of the wedding bath, but she could

not conceive a child for a long time. After four years of waiting for the conception (since the time of marriage), there was a healer called Inaq Masulah who asked her: '(Do you) want a child (*mele bedue anak, ke*)?' Niniq Tuan answered yes, and Inaq Masulah gave her abdominal massage and got her to drink a glass of coconut juice mixed with herbal remedies (Sa./In., *jamu*) made from turmeric (*kunyit*), pepper (*sang*; In., *merica*), and black threads (*benang bedeng*). A month after the treatment, Niniq Tuan felt pains while passing urine a little, and noticed that she was not having menstruation (*het*; In./Ar., *haid*; In., *bulan*, *mens*) for two months. Niniq Tuan took a pregnancy test at the *Puskesmas* sub-district clinic and found out that she was pregnant. Niniq Tuan gave birth to her first child in October 1989 and had twins (*pada*; In., *kembar*) in January 1993. All were boys.

Raising three boys, Niniq Tuan 'wanted to rest for a while (*mele mentelah semendak*).' Niniq Tuan began to take birth control pills (In., *PIL*) that she asked and received for free at the sub-district clinic, but it 'did not suit (*endek cocok*)' her, and within a month she became sick (Sa./In., *sakit*) with dizziness and headache.

According to Niniq Tuan, she was also concerned that she might forget to take medicine every day and also that it might induce infertility as people rumored.[3] Since Inaq Masulah was dead by then, Niniq Tuan went to see Inaq Naca and asked for a massage to raise the womb to the upper position to avoid another conception. After ten years, Niniq Tuan found herself being ready (Sa./In., *siap*) to have another child. She went to see Inaq Naca again to lower the womb to the center, and she gave birth to her fourth boy in April 2003.

---

[3] As Hay (2001) reports, rumors about contraceptive pills as having side-effects producing sterility were also evident in other villages of East Lombok in the 1990s.

Episodes of others in Reragi echo experiences of Niniq Tuan, indicating local women's preference to the local healers' treatments as an alternative means of infertility cares and birth control besides the state-initiative biomedical care and their shared perspectives on the mechanism of pregnancy.[4] In the next sub-section, we explore the commonality and variations in the local understandings of the process of pregnancy in Reragi by mainly asking how the villagers acknowledge the presence of a living thing.

(3) The heartbeat, throbbing, and quickening: feeling the life of the unborn

The context of interviews with non-specialist women in Reragi

As we have seen, Inaq Naca explains that unborn babies (*bebeak*) in the womb are ensouled in the fourth month of pregnancy by making specific reference to the Quran. It is worth noting that her reference to the Quran connoted her quick defense to a perhaps skeptic and thus awkward question of mine to ask a highly competent person (person with *ilmu*): 'How do you know that (the baby is ensouled in the fourth month)? (*Ngumbe angkun da ngetok a?*).'

In my semi-structured interviews with 50 non-specialist women in Reragi, I casually included similarly awkward inquiries: 'When the baby begins to have a life? (*Piran bebeak mulai bedue nyawa?*)'; 'How do you know that? (*Ngumbe angkun da*

---

[4] Bennett points out that the possible reasons of a preference for consulting traditional healers over doctors for Sasak women include the lack of dedicated infertility clinics in Lombok, the relative poverty of most Sasak families, and the enduring respect for and trust in traditional healers among the Sasak (2016: 3).

ngetok a?); 'When the baby becomes a human? (*Piran bebeak jari manusia?*),' also again; 'How do you know that?.'

In the in-depth interviews with Inaq Naca, she was informing her knowledge and experiences of helping people with expertise and *ilmu*. In contrast, the interviews with 50 women were understood by each informant as her voluntary contribution to my collection of 'stories of giving birth (In., *cerita melahirkan*).' The questions mentioned above thus did not impose on them negative connotations of challenge toward her knowledge but rather conveyed my decent curiosity as an unmarried woman. This tendency is underpinned by the comments that often followed their answers to my questions as mentioned above about the beginning of baby's life and personhood: 'Saki would also feel that when Saki is going to have a child (in the future) (*Saki juga akan merasakan itu kalau Saki mau punya anak*).'

The interview comments about the beginning of life

In such contexts of interviews, the informants' stories expose certain tendencies in Reragi where women address the beginning of the life of unborn babies to the first moments in which they feel the active, animated presence in the body other than themselves.

The vast majority of informants in various ways made an immediate reference to their experiences of bodily changes during pregnancy. In particular, the primary source of reference made to answer my inquiry of 'when the baby begins to have a life in the womb' was the feeling the throbbing (*nguit-nguit*, *mut-mut*, *duk-duk*) of the heartbeat or the kicking (*begerak*; In., *bergerak*; Sa./In., *nendang-nendang*) of the unborn child ranging from the second to the seventh month of pregnancy. As we can see in the short excerpts of interviews:

Around the fifth month, (the baby) begins to move. Gurgle-gurgle, it feels!
Sekitar lima bulan, mulai begerak. Ngemput-ngemput, rasanya!
— Inaq Azah in her early thirties, a mother of two children

Around the fifth month, when (the baby) begins kicking, (it has a life).
Sekitar lima bulan, pas (bebeak) mulai nendang-nendang (dia punya nyawa).
— Inaq Istikoma in her mid-forties, a mother of five children, one of whom is dead.

When (the baby is) the five-month-old (in the womb), she began throbbing. Maybe that is (when she started to have a life).

P*as umur lima bulan dia mulai nguit-nguit, itu mungkin (dia mulai mempunya nyawa).*
— Ais in her early twenties, who had stillbirth of her first baby.

She begins moving, around the seventh month. Our abdomen feel gummy and painful!

Dia mulai nendang-nendang, sekitar tujuh bulan. Bergetar rasa perut kita dan sakit!
— Inaq Azari in her late twenties, a mother of one boy.

The throbbing is felt at the age of two months (of pregnancy). For instance, (it's like) feeling (our) own heartbeat.

Terasa nguit-nguit usia dua bulan. Misal, kaya merasa jantung diri.
— Inaq Dewi in her early thirties, a mother of three children.

Beginning from the forth or the fifth month, (the baby) throbs eventually.
Mulai empat atau lima bulan, baru nguit-nguit.
— Niniq Air in her mid-forties, a mother of two children.

Around the fourth month, (we) know (that the baby has the life because) s/he moves in sort of a butterfly. [raising and fluttering the right hand]

Sekitar empat bulan, (kita) tahu dia begerak semacam kupu-kupu.
— Inaq Mariati in her early forties, a mother of five children.

Around the fourth month, the heartbeat is already throbbing in our abdomen, (and) we feel that. [gesturing with the right fist loosening and tightening quickly and repetitively]

Sekitar empat bulan, wah jantungnya duk-duk-duk-duk di perut kita, kita rasain.

— Poiani in her early thirties, a mother of one natal child and one adopted child

While the majority of the informants refer to the times when they feel the movement in the body, some women also mention the experiences of hearing the heartbeat through the use of biomedical tools by doctors and midwives:

Around the third or fourth month, (the baby) already moves. Happy, we are! Much more if we go to see a doctor and we hear the heartbeat!

Pas telu atau empat bulan, (bebeak) sudah begerak. Senang kita! Apa lagi diperiksa di dokter dan kita dengar jantungnya!

— Mama Sire in her mid-thirties, a mother of two children

At the age of two months (of pregnancy), (it was) checked at the maternity health check, the midwife heard the sound of the heart '*duk-duk-duk-duk.*' In the second month, (it) can already be heard. (If in) the fourth month, (it is) already shown in the echograph.

Umur dua bulan dicek di Posyandu, bidan dengar suara jantung 'duk-duk-duk-duk.' Dua bulan sudah bisa didengar. Empat bulan udah bertanda di USG.

— Inaq Haditia in her late twenties, a mother of two children

44 days after (conception), becomes a fetus. Around the second and the third month, (there are) heartbeats. Some midwives have the tool, '*duk-duk-duk*,' the heart sounds like that.

44 hari setelah (hamil) jadi janin, denyut-denyut sekitar dua sampai tiga bulan. Ada bidan yang punya alat, 'duk-duk-duk,' suara jantungnya.

— Inaq Anguraini in her mid-thirties, a mother of two children

Besides many of those mentioned the precise movements of something other than *hers* in the body, including the 'heartbeat,' felt by themselves or heard by the midwife, there was a minority among the informants.

The minor responses included the simple refusal saying 'I don't know (*Endek ku tok a*)!', the opinion that the baby is already a living human from the first day of conception, and another opinion that the day of birth on the ninth month and ten days is the day of having a life. Also, one person mentions throbbing in the fourth or fifth month as the time point of the baby having a life and also becoming a human as visible in the ultrasound. She does so while she conceptually distinguishes miscarried embryo as 'blood (*darak*; In., *darah*)' or fetus (In., *janin*)' that could not become a 'child (Sa./In., *anak*)' in giving general explanations of food restrictions to avoid miscarriage.

Overall, the interview excerpts of mentioned above demonstrate the mostly empirical understandings of the beginning of new life during pregnancy. While there is a particular local tendency of addressing the first moments of movements felt by themselves or heard by biomedical specialists as the beginning of life, the time points and the ways of acknowledging those differ from a person to another. Also, the comments of the minority also suggest that the matter of the beginning of life does not have to be addressed in a singular generalizable form and mostly remains in the domain of personal insights and experiences.

In the next section, we examine the cases of how people treat the babies lost in miscarriage and stillbirth, where social concerns about the beginning of life and the beginning of personhood come into light in the form of deciding whether to conduct funeral rites for the baby.

3. Pregnancy Loss

(1) Coping with pregnancy loss

The context of interviews

In my semi-structured interviews with 50 women in Reragi village, I collected 14 cases of miscarriage (*nyelok*; In., *keguguran*) and two cases of stillbirth (*lahir mate*; In., *lahir mati*) from 11 informants, among which three women experienced miscarriage twice. Besides the semi-structured interviews, I also conducted in-depth interviews with two women with a focus of inquiries into their experiences of miscarriage and stillbirth.

As mentioned in Chapter 2, abortion policy in Indonesia sets that abortion is permitted only to save the life of the woman. That comes with requirements that '(t)he medical procedure must be performed by a health worker possessing the necessary skills and authority, under the guidance of an expert team' as well as '(c)onsent of the pregnant woman, her husband or her family for the procedure,' and 'an approved health-care facility' (Population Division of the Department for Economic and Social Affairs of the United Nations Secretariat 2018).

However, the regulations are not always enforced. For instance, one informant in her early twenties tells her experience of miscarriage in the sixth week of pregnancy in 2016.

When she found a small spot of blood on her pants, she was frightened and immediately went to see an obstetric doctor, where the doctor got her ultrasound, said 'fetus cannot develop (In., *janin tidak bisa berkembang*),' and suggested her to 'clean (In., *bersihin*)' the womb, an implicit way of recommending her to have

abortion. 'I was not brave (*endek ku rani*),' and 'did not want (*endek mele*)' to do that, the woman puts. She went home, went out again to seek abortion-inducing herbal paste (In., *jamu*) from a Javanese healer, went home again and mixed *jamu* with a bottle of water and took it until all the blood 'came out by itself (*sugul mesak*).'

This subsection primarily draws on the two in-depth interviews to describe how specific events of pregnancy loss are treated among Reragi villagers. As the strikingly large number of 11 out of 50 informants reporting miscarriage and two out 50 informants reporting stillbirth indicates, pregnancy loss is no rare occasions in Reragi. In this section, I delineate women's narratives to grasp their personal experiences and social contexts of the pregnancy loss on which the statuses of being of the babies surface people's concerns.

(2) The case of Ais

Stillbirth of the first child

This subsection describes an episode narrated by Ais, a 21-year-old woman who had stillbirth of her first child on 16 February 2018. I had not been acquainted with Ais before the interview, but I heard of Ais on the day of the incident from Inaq Nir, my host mother, who is an aunt of Ais' mother-in-law, and Inaq Tip, my neighbor.

Two weeks later on 6 March 2018, I went to see Ais in the form of a visit (*bejango*) accompanying her close relative who introduced me to Ais as a research student and as an adopted child of Inaq Nir. After I asked her if she would mind my inquiries about her pregnancy and childbirth, which Ais generously accepted, we proceeded the interview with the presence of her relative who remained there to interrupt me on Ais' account in case I was in any way to interfere with her.

In March 2017, when Ais was 20 years old, she was married to her current husband seven years older than her and became a housewife. Ais lived with her husband in a newly built house while her big sister-in-law (Sa./In., *kakak ipar*) and her widowed mother-in-law (Nana's natal mother) lived next door.

In July 2017, her husband had two days of a severe headache (*sakit otak*) and craved *pelemeng* (a steamed rice cake wrapped in a bamboo leaf), which her mother-in-law guessed was the symptoms of 'pregnancy sickness' (Sa./In., *ngidam*).[5] Ais waited and saw as she was not sure yet if her husband was sick indeed because of her pregnancy. Later as she realized that her menstruation was delaying for a month Ais bought the pregnancy test, confirmed her pregnancy, and went to the *Polindes* village clinic where the 'doctor' (In., *dokter*) had a blood test and told her that she has been pregnant for three months and prescribed medicine (In., *obat*).[6]

She had pregnancy sickness with nausea (*oler*; In., *mual*), dizziness (*peneng*; In., *pusing*), weakness (*lemes*; In., *lemas*), loss of energy (*endek arak balung*), and food cravings for fruits such as custard apples (*buak srikaya*; In., *buah sirsak*) and pears (In., *buah pir*). Although Ais could not bare to eat rice because its flavor stimulated nausea initially, the sickness related to food began to ease within around a month.

---

[5] See Section 4 of this chapter, for further explanations of the local understandings of *ngidam* that refers to sickness and food cravings during pregnancy typically experienced by both pregnant women and their husbands.

[6] As we have seen in Chapter 2, there are no obstetricians in the village-level health facilities of *Polindes* (In., *Pondok Bersalin Desa*) or the sub-district-level health centers of *Puskesmas* (In., *Pusat Kesehatan Masyarakat*). The *Polindes* clinic where Ais used has a solo-provider village midwife, who presumably Ais referred to as a doctor. In this section, I use Ais' reference to the village midwife as a doctor with brackets.

At the same time, from around the third and fourth months of pregnancy, Ais found herself often being sick with fever (*benengan*; In., *demam*), a headache (*sakit otak*; In., *sakit kepala*), coughs (*batok*; In., *batuk*), and running nose (*selesma*; In., *pilek*).

Both the first time she went to the Polindes clinic for the pregnancy check-up and the second time she went there to consult with her symptoms, Ais only received medicine and was told that she should rest a lot and should not carry heavy things while she was not provided with the explanation about the causes. Sometimes Ais went to see a local healer (*belian*) receive healing formula (*jampi*) on the head. Ais thinks that she was just 'fatigued' (Sa./In., *kelelahan*, *kecapean*). She did not have abdominal pain and thus did not receive massages on the body.

As Ais puts, 'when (the baby is) the five-month-old (in the womb), she began throbbing (*Pas umur lima bulan dia mulai nguit-nguit*),' which she guessed the timing when the baby began to have a life (Sa./In., *nyawa*).[7] By the sixth month of pregnancy, Ais' husband named the baby as 'Lily Salsabila Khair.'

As Ais puts, 'there was a feeling that my baby was a girl (*rasanya anakku nina*)' although they had not checked the gender of the baby yet. In the seventh month of pregnancy, instead of holding the pregnancy bath, Ais' husband and mother-in-law invited orphaned children from the asylum in Reragi and hosted an event of reading *Ya Sin* to wish for healthy birth.[8] The birthing belt was not ready.

---

7 See the interview comment in the previous sub-section of this chapter.

8 In Reragi, *Ya Sin* ceremonies with orphaned children to pray for blessings are widely performed in various occasions but typically at the significant juncture in lives, including weddings, death anniversary, and the start of new business. The ceremony often lasts at least an hour, and in the end, Ithe hosts typically gift the children with a

Ais also went to have ultrasound at an obstetrician clinic in Selong in the third month and the eighth month of pregnancy to see baby's health (In., *kesehatan bayi*), sex (In., *jenis kelamin*), and 'whether (the baby) is active or not (In., *apakah aktif atau tidak*).' At both times, Ais' husband took her to the clinic by motorcycle and accompanied her during the checkups. At the second ultrasound, the obstetrician told that the baby was healthy (In., *sehat*) and that the due was on 20 March 2018.

In the midnight of 16 February, however, 'pains suddenly came (In., *tiba-tiba datang sakit*).' Before 3:00 am, Ais' husband immediately took her the Polindes village clinic by motorcycle. Ais' natal mother and older sister also followed them by motorcycle. Although the *Puskesmas* sub-district clinic is closer to her house, Ais chose the Polindes clinic in the neighboring village because she was 'not brave (*endek rani*)' to trust the staff at *Puskesmas* as she sees many of them are trainees.

As Ais puts, the birthing process was 'normal childbirth (In. *melahirkan normal*)' and for just a while, did not take so long. Although nothing could be heard when the midwife (In., *Ibu bidan*) checked the heartbeat (In., *suara jantung*) of the baby, the midwife initially did not let her know about the condition so that Ais would not be shocked (In., *stres*; *kaget*) and have difficulties in birthing. As it is in the dialogue between Ais and the author:

Author:

> So, what were the words of the midwife there?
> *Terus apa kata bidan di sana?*

---

box of packed rice (In., *nasi bungkus*) with meats, vegetables, fruits and small cash as each child gives regards (Ar./In., *salam*) by holding their right hand with both hands and placing on the forehead.

Ais:

She [the midwife] said… After that? (When we) just came? After (the midwife) heard the heartbeat, uh, of the baby, you know, '(It) wasn't heard,' (the midwife) said like that. Then, already checked for three times but (the heartbeat) wasn't heard. Then, the last time, neither yet, the heartbeat couldn't be heard.

Katanya… Pas anu itu? Baru datang itu? Pas dengarin datak jantung, e, si bayi kan, 'Ndak dia kedengaran,' katanya gitu. Terus sudah tiga kali diperiksa ndak kedengaran. Terus terakhir kalinya itu, ndak masih juga ndak dia kedengaran datak jantungnya.

Author:

The sound of the heart (wasn't heard)?
Su… suara jantung?

Ais:

Hm… Checked for three times, meanwhile (it) huuurts, and then like that, you know, like stomachache, so (the baby) came out by herself, you know, (I) wasn't injected or anything else, like that. She [the midwife] didn't say if the child had already passed away, she didn't say that. Only after (the child) was out, (we) were told that the child was dead, like that, she didn't say that (before).

Hm… Tiga kali diperiksa, sampai-sanpai kan sakiiit, terus seperti itu kan, mules-mules gitu, jadi keluar sendiri, tanpa diberikan suntikan atau apa, gitu. Tak dia bilang kalau anaknya sudah meninggal gitu tak dia bilang gitu. Pas keluar aja, dikasih tahu anaknya udah meninggal, gitu.

Author:

After (the child) came out… (you) were told?
Pas keluar… dikasih tahu?

Ais:

Yeah, we wouldn't have been brave (enough) if (we) were told about that while (the child is) still inside, you know, the concern is that we get shocked or anything, like that, (so) we weren't told. So, 'Can (the child) be born,' uh, 'Can (I) give birth now ma'am?' the mother [Ais] said, you know, (I) asked. 'Yes, possible, if she is born,' uh, 'tonight,' uh, she [the midwife] said, 'the baby won't be so healthy.' 'If the baby is born two weeks later, if Allah wills it, the baby would be healthy,' (the midwife said). But, uh, the reality is that we gave birth that night, so yeah, Allah willed another way, like that.

Ya, kan ndak berani kita dikasih tahu pas masih didalam kan, takutnya kita itu stress atau gimana, gitu, ndak dikasih tahu kita. Jadinya, 'Bisa dilahirkan,' e, 'Bisa melahirkan sekarang, Ibu?' katanya Ibu kan, bertanya. 'Iya, bisa, kalau dia lahir,' e, 'malam ini,' e, katanya, 'bayinya kurang sehat.' 'Kalau dia lahir tinggal dua minggu lagi, Insya Allah, sehat bayinya.' Tapi tahu-tahunya kan kita melahirkan malam itu, jadinya, ya, Allah berkehendak lain lah, gitu.

It was her first pregnancy, and thus Ais did not know the child was 'unhealthy' (Sa./In., *kurang sehat*). Ais had noticed that the baby was not moving for three days before the stillbirth. However, there was a movement as if something was sticking out (In., *muncul*) in the abdomen in the night before the stillbirth, so Ais talked with her husband 'Wow, what's going on? (*E-e, apanya ini ya?*),' 'Maybe it's her hand! (*Mungkin ini tangannya!*).' As Ais and her relative continue conversations:

Ais, speaking fast:

(We) thought the baby was healthy, but it turned out not. At the time of ultrasound before, 'Woo, the baby is healthy (and) active!' (the doctor) said like that, 'amniotic fluid is good!,' (the doctor) said.

Kirain kan sehat bayinya, ternyata nggak, gitu. Kemarinnya pas USG, 'O-o, sehat, bayinya, aktif!,' katanya gitu, 'air ketubannya bagus!,' katanya.

Ais' relative interrupting her, trying to give her a chance to elaborate on the properness of her behaviors during pregnancy by answering his question:

Haven't (you) carried heavy things (during pregnancy)?
Endek wah angkat si berat-berat?

Ais answering immediately:

No, I haven't!
Endek ku wah!

Relative:

Um...
Hm...

Ais while giggling:

(It [the stillbirth] was) supposed to happen...
Mulan mele a...

Relative, interrupting:

Yeah, (it) wasn't our fortune yet!
Aok, endek man riskinta!

Ais:

(It) wasn't our fortune yet!
Endek man riskinta!

Author while hesitantly:

Not (blessed) yet?
Masih belum (rizki)?

Ais interrupting the author while giggling and saying aloud:

Not blessed yet! Not yet trusted by Allah!
Belum riski! Masih belum dipercayai sama Allah!

After a tea break of the interview, I asked Ais if the midwife did explain the causes of stillbirth ('*Pernahkah bidan, a, a, apa, menjelaskan, a, penyebabnya?*'), to which she responded that '(It) wasn't explained (*Tidak dijelaskan*.).' I did not wish Ais to receive my question as suggestive of any accusation, so I added that I had heard from a midwife that it is not because of the mother if the child is born deceased ('*Saya per-per-pernah dengar dari bidan, a, itu bukan karena ibu kalau anak, a…a, lahir, a, meninggal. Itu bukan karena ibu.*'). Ais agreed to my comment by immediately saying 'No, No (*Bukan, bukan*).'

As Ais informed me, 'Many times people say, well, in Sasak language, it's the "slap of *bakeq*." ('*Kebanyakan orang bilang, e, bahasa Sasaknya itu "tepes bakeq," gitu.*'). By saying 'people' Ais is referring both generally to people in Reragi and specifically to her husband's family members living in the neighborhood. According to Ais, her extended family members said that bakeq did the stillbirth as the child's 'skin color (Sa./In., *warna kulit*) was 'burnt black (*motong*; In., *gosong*).'[9] As Ais and her relative continue:

---

[9] As we have seen in Chapter 3, a kind of evil spirits called as *bakeq* is often associated with dangerous heat in Reragi. The villagers typically experience their contact with

Ais, speaking to the author:

The thing is that, when she comes out, the skin color is like that, like burnt? Like black-ish, like that.

Soalnya kan, dia keluar itu, warna kulitnya itu kayak gini kan, gosong? Kayak hitam-hitaman gitu.

Relative, responding agreeably:

The slap of spirits… Maybe burnt… because this child… that baby died in the abdomen, right? Of course burnt, for sure.

Tepes bakeq… Laguk gosong…Karena kan anak ini… bebeak o mate lek dalam tian, kan? Wajar na gosong, sebenar a.

Ais:

Yeah, so… more likely people say so.

Ya si… kebanyakan ngeno dengan muni.

Relative:

Yeah, maybe depends on beliefs.

O, laguk o lin-lin keyakinan kah.

Ais:

And (it) depends on beliefs.

Dan menerut keyakinan.

Ais concluded that it 'depends on beliefs' and did not commit herself to the account. I casually asked whether she also believed that or not ('*Ah, ibu juga percaya?*'), Ais

---

invisible *bakeq* by getting scalded and believe that *bakeq*'s attack on pregnant women would involve risks of stillbirth.

giggled and said: '(I) believe here, don't believe there. Both, yeah, (I) don't know! (*Percaya di situ, nggak di situ juga. Dua, ya, ndak tahu!*).'

What 'people' said, according to Ais, is that Ais often went to visit her natal mother at around the time of sunset prayer and it (stillbirth) was the consequence. As Ais puts, at the time of sunset prayer, or the time of *sendikala* in Sasak, a lot of bakeq comes out and thus pregnant women and postpartum women are not allowed to go out of the house.[10] From the beginning until the end of pregnancy, Ais visited her natal home almost every night before or after the sunset prayer until around 9:00 pm or 10:00 pm, being fussy (*nyelek*) and often disobeying her mother-in-law even when she reminded her not to go out at around sunset. As Ais puts:

> (I did) not feel at home, (I) wanted (to be) at (my) mother's house because (I was) also lonely here, you know. Over there are (my) nieces and nephews, (my) sisters, many. Like that, there were friends. Look, if here, there are no, just mother(-in-law), sister-in-law, and husband only, like that. So (I was) lonely. (I) felt lonely, so (I) wanted time off, hanging out to mother's house.
>
> *Nggak betah di rumah, pengen di rumah ibu karena sepi juga kan disini. Disana ada keponakan, ada kakak, banyak, gitu, ada teman. Nah, kalau disini nggak ada, cuma ibu, sama kakak ipar, sama suami aja, gitu. Jadinya kesepian. Merasa kesepian, jadi pengen ada liburan, main-main ke rumah ibu.*

Lily, the baby, was buried in the morning of 16 February 2018 nearby the grave of Ais' father-in-law. Ais did not attend the burial as she had to rest at the *Polindes* clinic that morning. She has not visited the grave within two weeks following the event because she was 'not clean yet (In., *belum bersih*).'

---

[10] See Chapter 4 - Section 2 of this paper for the general description of sendikala.

It is not allowed for women to visit the graveyard or the Mosque during the periods of menstruation or in postpartum blooding, so Ais had to 'wait 44 days (In., *nunggu 44 hari*)' until the blooding ends. Ais did not know of who attended the funerals or if the religious leader was called for prayer, but she knew that they gave prayers on the first, third, and seventh nights following the burial.

According to Ais, the name of Lily was not written down on the gravestone (In., *mesan*) as it is the norm for the tombs of small children (*anak becik*) up to around five years old. Statements of many who lost their infants echo Ais' words. The graves styled for infant death are distinguishable in the graveyard (**Figure 5.4**).

Figure 5.4 A grave of an infant. The photograph was taken with the permission of the parents of the child. Lombok, 17 July 2015 (photograph by author).

When an infant dies, people carry his/her remain to the graveyard with the baby's head on the right chest of the carrier and the feet on the left in the opposite direction from carrying a living child (carried with the head on the left chest of the carrier), according to oral reports.

It is worth noting here that parents who went through the pregnancy loss of the first child are typically referred to by their first name or by their status as 'bride' or 'groom,' shifting back from the calling names of 'pregnant mother (*Inaq ebon*)' and 'pregnant father (*Amaq ebon*)' and not referred to by the name of the lost child. On the other hand, parents who lost their first child in the postnatal phase continue to be called by the name of the child after his or her death in the same way as parents with their living children are called.

Although I was unable to conduct more interviews with Ais in later period, her family members told me later in October 2018 that Ais was pregnant again expecting due in March 2019.

(3) The case of Nana

Stillbirth of the first child and miscarriage of the second child

This episode describes the incidents and treatments of stillbirth and early miscarriage as experienced by Nana. It will offer a further glimpse into the intricacies surrounding pregnancy loss, the ontological and social statuses of unborn and miscarried 'children (Sa./In., *anak*)' and their mothers.

Nana is a 30-year-old woman (as of 2018) who had stillbirth of her first baby in 2010 and miscarried her second baby in 2012. Nana is an older sister-in-law of Ais, and Nana's natal mother is Ais' mother-in-law that Ais repeatedly referred to, while it is unknown if Nana was also the sister-in-law that Ais mentioned. The interview was conducted on 2 September 2017 at her house with the presence of her husband.

In 2009, when Nana was 20 years old, she 'was stolen' (*dipaling*) by and married to her current husband, Zas, who is eight years older than Nana. They knew

each other from childhood as neighbors but never had a rigid courtship before marriage. Zas had become a migrant worker in Borneo Island back in 2004 and returned to the village only once a year for a few weeks following the fasting month of Ramadaan.

Zas secretly planned to kidnap Nana, asked assistance from his best friend and his wife, and took her to the house of his best friend's grandparents by motorcycle after casually asking her to join them to eat together at a meatball (In., *bakso*) stand. Nana only realized Zas' intention of marriage only after she was already arriving at the house. The weeks following the fasting month is a 'marriage season (*musim merarik*),' Nana added laughingly, 'many (women) are stolen (*luek dipaling*)' around that time of year.

Nana and Zas began to live with Zas' widowed mother in her house but shortly after marriage Zas went back to work in Borneo. As she soon conceived a child, Nana left her work at the take-out food stand while she continued to spend daytime at her natal home in the neighborhood to assist her natal mother with preparing the food for sale.

In 2010, the baby was 'six-month-and-half-old,' which means approximately after 26 weeks of Nana's pregnancy, the baby was 'dead in the womb (*mati didalam kandungan*),' and it was 'premature birth (*beranak odak*).' Zas was away working in the rainforest of Borneo and had no signal on his cell phone while his family members tried to let him know about the incident.

As Nana had severe abdominal pain in the early morning, she was immediately brought to the *Puskesmas* sub-district clinic in the village. To have her treated by obstetric doctors, the clinic midwives and nurse tried to take her to the city

hospital in Selong by ambulance, which typically takes around 15-20 minutes, but the baby 'came out' (*sugul*; In, *keluar*) on the way. The medical staff told her that 'the womb was weak' (In, *lemah kandungan*) and that Nana had to 'rest the abdomen' (In., *istirahat perut*), meaning that she should not conceive a child, for the following six months. They went back to the *Puskesmas* where Nana was rested two nights with necessary medication. While Nana was in the clinic with her natal mother and mother-in-law, the baby was immediately brought home by relatives.

The baby was a girl, Nana's natal family members named her as 'Isti Apriani' and buried her in the graveyard after wrapping her with white cotton gauze with the attendance of Zas' uncle. They conducted prayers (*sikir*; In., *zikir*) at the grave at the time of burial and in the house in the night of burial.

As Nana puts, infants immediately 'enter the heaven (*tama sorga*; In., *masuk surga*)' because there is no guilts (In., *dosa*) and thus they do not need the eight nights of prayer as performed for funeral rites of adult persons. Nana's natal mother and mother-in-law took care of Nana and comforted her during the hospitalization and afterward, saying:

> Maybe she has not wanted to live with us (but) later we would be given a good one (by the God)!
> *Sang mungkin endek man mele idup bareng ita, jemak na embeng ita si bagus!*

Zas received a phone call only four months after the incident.

Later in 2012, when she was 23 years old, Nana miscarried (*nyelok*) her second baby in the fourth month of pregnancy. She found the blood dripping down from the uterus while she was giving the noon prayer at home. As Nana puts, '(The baby was) still small, still a chunk of blood, like a flesh, and unknown (whether it

was) a girl or a boy (*masih becik, masih bergumpal darak, segumpal dageng, endek man tok nina mama*),' around the size of a fist (*sekepel*; In., *segenggam*).

With the severe uterus pain, Nana went to the sub-district clinic, where the midwives gave the 'uterus medicine' (In., *obat kandungan*) to take orally and had her go back home while telling that the baby had to come out and otherwise she would have been in danger and that she had to avoid moving around.[11]

While Nana rested at home, she still had an unendurable uterus pain. In the late afternoon, Nana went to see a private clinic of an obstetric doctor, seeking further diagnosis and medication. However, the doctor only had her to go back home, where she could not eat because of the severe pain.

In the following morning at around 6:00 am, still suffering from unbearable pains, Nana visited a private clinic run by a licensed midwife in the neighboring village. The midwife immediately provided her with 'light surgery' (In., *operasi ringan*), gave her a drip (*impus*), had her rest for one day on the bed of the clinic. With the pain eased finally, Nana went home in the late afternoon.

On the same day as Nana was resting at the clinic, the miscarried baby was being buried in the grave nearby the grave of Isti. In the funeral, the burial did not include all the rites performed for Isti such as naming and praying at the Mosque, but the miscarried one was only wrapped with a piece of white cotton to be buried.

That was because, as Nana puts, '(It) was still flesh (*masih dageng*) ' and 'has not become yet (anything) (*endek man jari*).' Nana felt the throbbing (*nguit-nguit*)

---

[11] Since Nana did not give specific details of medical procedures in the interview, names, and terms of medicine are written in this sub-section with the exact words used by Nana.

when the baby was ‘still a chunk of blood like flesh’ in the third month of pregnancy, and that was when the baby ‘already had a life (*wah benyawa*).’ However, ‘if s/he is still blood (*kalau dia masi darak*),’ as Nana puts, ‘s/he has not yet felt living in the world (*dia belum merasakan hidup di dunia*),’ and the burial does not require prayers.

Although Zas was still in Borneo on that occasion of miscarriage, he was out of the rainforest and thus had signal on his cell phone. As she reproduced, Nana called him from the midwife’s clinic and yelled on the phone, saying ‘I’m in pain! (I) am not at home (*Sakitan ku! Endek arak lek bale*)!.’ As soon as he received her call, according to Zas, he flew back to Lombok, hugged her and comforted her by saying ‘Calm down, calm down, okay? (*Sabar, sabar ya?*)’ (**Figure 5.5**).

Figure 5.5 A husband and a wife. Lombok, 2 September 2017 (photograph by author).

As they were relaxed at the end of the interview, Zas also reproduced the scene by hugging Nana, to which Nana gave a big smile and commented that her husband was a loving man (‘He is the one that loves his wife! (*Setia isteri kalau dia!*)’). Nana

resolved her storytelling by saying:

> We are patient and (we) always protect our heart. If we don't, then we would go mad. Must be patient. Always be patient. We must be patient.
>
> *Kita itu sering bersabar, terus jaga hati. Kalau tidak, jadi kita akan jogang. Harus sabar. Selalu sabar. Kita harus sabar*.

Later in October 2018, Ana and Zas had an idea of adopting the youngest child of Ana's older sister living in Jawa but it has not been realized due to unknown reasons.

(4) Pregnancy loss: what was lost?

The distinctions of funeral rites

The previously summarized two women's episodes reveal striking sets of reality in which young married women in rural Lombok suffer pregnancy loss without having informed consent on the medical treatments they receive adequate institutional support to prevent or grieve the loss.

Although there are much of injustice to be resolved in regards to their maternal health rights in further discussions, this section remains sets focused on asking how the two individual episodes concern the ontological and social statuses of the 'baby (*bebeak*).' What was lost to them? Most explicitly, the illustrations of burial practices give some insights into the ontological problems surrounding unborn children: whether embryos or fetuses are considered as a living thing.

According to oral reports, if the baby is still the size of a fist or 'the size of a mouse (*sebesar tikus*),' it might come out while the mother is urinating and she might not realize if it was the child. As one woman puts, 'If we realize (that it is the

child), we bury her/him (*kalau kita tahu, kita kuburkan dia*),' but there is no problem with not being able to conduct burial in the house yard or the graveyard.

Some women see it better to bury the miscarried baby in the grave and not at the house because, as one woman who experienced early miscarriage puts, 's/he wanted to be a human (*dia mau jadi manusia*)' even though s/he had not become yet. Others see remains of early miscarriage as just 'flesh (*dageng*) ' without life and miscarriage as the consequence of the absence of life by saying, 's/he (the baby) is miscarried if (s/he) does not have life (In., *dia keguguran kalau tidak punya nyawa*).'

As it was in either case of Ais or Nana, if a miscarriage happens later when the sex of the child is known, usually the baby is named and buried like an adult, meaning that the attendants give the prayer during the burial and the following first, third, fifth, and seventh nights. However, as it is also seen in both women's episodes, funeral ceremonies are not announced in public in case of pregnancy loss like those are in the times of death of adults. It is worth noting here that it is also common in case of infant mortality that the funerals are held quietly. That is both because small children do not have any sins and thus their souls do not need constant prayers to be lifted to the heaven and because those children are 'not acquainted (*endek man kenal*)' socially with people around, according to oral reports.

When the life of the unborn babies was lost, what is also taken away from the former 'pregnant mother' is their bond to children that they nourished throughout the process of pregnancy and the future that they expected to spend together as a mother.

As we will see in the next section, the unique bond between mothers and children is embedded in the processes of marriage, conception, and pregnancy, often extending to the body of others. Such aspects of the mother-child connectedness

most explicitly surface people's concerns at times of pregnancy sickness, food cravings, and breastfeeding.

4. Pregnancy Sickness and Cravings

(1) Ngidam: pregnancy sickness and cravings

The characteristics of pregnancy sickness and food cravings in Reragi

This section explores the sense of togetherness between children and their parents as evident in the local perspectives of pregnancy sickness and food cravings referred to as *ngidam* as well as an emotional attachment between new mothers and children in the postnatal.

In Chapter 1, I mentioned that sickness and cravings during pregnancy are widely recognized and variously interpreted as *ngidam* in many societies of Indonesia and the Malay world. Also, in the medical field and the general public elsewhere, a variety of nausea and vomiting of pregnancy, as well as appetite changes, is a commonly known to affect women onsetting around the fourth or fifth week and lasting until around the 16th week of pregnancy.

Nonetheless, besides a few exceptions (e.g., Obeyesekere 1963), the local understandings of pregnancy sickness and food cravings itself are mostly unexplored by scholars and remains as a marginal fact in ethnographical writings. This sub-section sets a focus on observation and interview findings to delineate how the sickness and cravings are experienced and treated by men and women in the village as something brought from unborn babies.

The sickness of 'pregnant fathers (Amaq ebon)'

As mentioned previously in this chapter, both pregnant women and their husbands in Reragi experience the pregnancy sickness and food cravings called *ngidam*. In case of first pregnancy, men's pregnancy sickness remarks the time point where husbands as grooms (*penganten mama*) experience the transition of his social status to the liminal stage of 'pregnant father (*Amaq ebon*)' between grooms and fathers until their wives' childbirth. It is widely considered in the village that 'men become sick first (*Mama juluk nyetan*)' in advance to their pregnant wives.

In the interviews with 50 women, I asked the informants questions such as: 'Have your husband already had pregnancy sickness? (*Wah ngidam ke suami side?*),' 'When did it start? (*Piran mulai itu?*),' 'Where did work then? (*Lembe suami side begawean waktu itu?*),' and 'At that time, did (you) know then it (his sickness) was the pregnancy sickness? (*Wah tok a itu ngidam waktu itu ke?*).' As a result, 25 out of 50 women reports that their husbands had pregnancy sickness with various symptoms and typically before their own experiences of pregnancy sickness or even before the consciousness of pregnancy. For instance:

> Yes (my husband had pregnancy sickness), (he) wanted to eat sour things. He (had *ngidam*) first, around one week. (I) immediately knew it was pregnancy sickness.
>
> *Ya, maunya makan yang pedis-pedis. Dia dulu, kira-kira seminggu. Langsung tahu itu ngidam.*
>
> — Papuq Asin in her sixties, a mother of eight children one of whom died as an infant.

> He (husband) had pregnancy sickness, at first, he had a fever. He was the one who had pregnancy sickness first.
>
> *Ngidam dia pertama sakit benengan. Dia duluan ngidam.*

— Inaq Akid in her forties, a mother of three chidren.

At the time of (pregnancy of) the first child, (husband was) sick with fever, vomit! He (was) first, but we didn't know that it was pregnancy sickness! So, we gave (him) healing formula against *bakeq*, but it didn't have effects, and then (we) knew it was pregnancy sickness! At the time of the second child, soon after coming back from (working in) Malaysia, he became sick (because of pregnancy sickness)!

Waktu anak pertama, sakit panas, muntah! Dia dulu, tapi kita belum tahu itu ngidam! Jadi kita kasih jampi bakeq tapi tidak berhasil, terus tahu itu ngidam! Waktu anak kedua, baru pulang dari Malaysia dia sakit!

— Inaq Azah in her thirties, a mother of two children.

Pregnancy sickness he had, (my husband was) sick! He was ill first, had a fever for one week, and given healing formula. It was *bakean*, symptoms of those who met *bakeq*, (the tongue feels) bitter and the food does not taste good.

Ngidam dia, dingin! Dia sakit dulu, panas satu minggu, terus dijampi. Bakean itu, ciri-ciri orang bakean, pahit, tidak enak makanannya.

— Inaq Noid in her thirties, a mother of three children.

Yes, he (husband) had a headache first, sick for a week. He did not heal until (he was) injected at the place of a nurse! Also, (he) wanted to eat a mango. 'Oh, this (should be) pregnancy sickness!,' parents also said like that.

Ao, juluk sakit otak a, dingin-dingin seminggu. Disuntik di perawat baru sembuh! Terus mau makan mangga. 'Oh, ini ngidam!' orang tua juga bilang gitu.

— Inaq Easum in her thirties, a mother of one child.

On the other hand, 15 women answered 'No (*Endek*),' and ten answered 'I'm not sure! (*Endek ku tok a!*)' often with reasons such as their husbands were migrating abroad during pregnancy and thus their sickness at that time is unknown, such as: '(I) don't know because (my) husband (is) in Malaysia (*Ndak tahu karena suami di Malaysia*),' 'I'm not sure! He was not at home. He had work (away)! (*Endek ku tok!*

Endek a lek bale, begawean ia!).'

In one interview in the presence of her husband, one woman reversed his denial of having pregnancy sickness by himself by saying that he was strange during her first pregnancy in which he always wanted to sleep with his head on her arms until childbirth. Similarly, in instances of discussing whether the man had reasoning the lack of pregnancy sickness, Ibu Air, 29-year-old (as of 2018, a former part-time school teacher and a mother of three-year-old son) puts gigglingly that her husband always accompanied her and insisted on having her head resting on his arm when Ibu Air missed her natal home and stayed over there ('(My husband) did not become sick, (he) just didn't want to separate from Ibu Air (me) (*Ndak sakit, cuma tidak mau pisah sama Ibu Air*)').

While I was talking with Ibu Air, Bapak Air (Ibu Air's husband, a former middle-school classmate of Ibu Air and a current owner of a kiosk selling small electric machines) was chatting with his male friend in the other corner of the booth. There Bapak Air elaborated on how he could not be bothered by his health conditions because he had little money and was working hard to provide for his pregnant wife.

As seen in their explanations about why the men did not have pregnancy sickness or why the fact was unknown, not only those who acknowledge their husbands' pregnancy sickness but also those whose husbands did not have it consider sickness and food cravings of unborn babies' male parents as a common phenomenon. Also as the most reported cases show, men's sickness or appetite changes are often interpreted as symptoms of pregnancy sickness by their wives or

other close family members living together in combined guesses about the possibility of conception and related changes of physical conditions of their wives.

Also, the beginning of pregnancy sickness often becomes the occasion in which the news of conception is spread mouth-to-mouth among family members neighbors, after which a 'newly married couple (*penganten*)' becomes 'pregnant mother (*Inaq ebon*)' and 'pregnant father (*Amaq ebon*).' Such situation is exemplified by a case of the 'newlywed (*penganten*)' in my host family, Mamiq Lifa, my older host brother, and Kakak Amu, Lifa's wife, which I observed.[12]

(2) Pregnancy sickness of husband and wife

The case of Mamiq Lifa and Kakak Amu

In December 2017, Mamiq Lifa, a 33-year-old (as of 2018) son of Inaq Nir (my host mother), got married to Kakak Amu, a 24-year-old college student from Reragi village. Kakak Amu confirmed her first pregnancy in February 2018 as described followingly, and she gave birth to her first child in October 2018 at *Puskesmas* Reragi.

As they began a courtship (*midang*) only since October 2017, Amu hoped to get married Lifa after her college graduation expected in 2018. However, Mamiq

---

[12] The father and his children in my host family are the descendants of aristocrat lineage while the mother is from common people. The two men in the family are thus entitled with '*Mamiq*' (father of aristocrat family lineage) instead of '*Amaq*' (father of common family lineage). I refer to Lifa here as 'Mamiq Lifa' (Father Lifa) following Kakak Amu who regularly call her husband as 'Mamiq Lifa' to show respect regardless of the absence of his parental status. Similarly, I refer to Amu as 'Kakak Amu' (Big sister Amu) following the way my host sister biologically older than me regularly called her new sister-in-law with respect.

Lifa persisted in his request of marriage to be resolved as soon as possible, to which Kakak Amu and her parents ultimately agreed. On 17 December 2017, Lifa and Amu had an elaborate wedding ceremony. Amu recalls that she and her mother were 'shocked to sickness (*sakit kaget*)' and fever for several days before the wedding day. While Amu eventually recovered by the wedding day, Amu's mother was still sick and could not attend the ceremonies.

Amu married into my host family's house, lived in Mamiq Lifa's room which became the 'couple's room (*kamar penganten*),' stayed away from college, and became a housewife, working with Inaq Nir every day. Lifa continued working in the farming factory, going back and forth to West Lombok every day taking two hours in one way by motorcycle, while he had day-trips to Sembalun region in North Lombok every week.

Mamiq Lifa had nausea three weeks later on 7 January 2018. Kakak Amu went to ask for sickness pills (In., *obat mual*) at the sub-district health center of *Puskesmas*, which takes around five minutes by motorcycle. According to Kakak Amu, nurses in *Puskesmas* knowing that Mamiq Lifa and Kakak Amu just got married in December suggested her to take pregnancy test there, which Kakak Amu declined to do because she remembered that she had the last day of menstruation on 26 December and guessed that it was too early to get accurate result of the pregnancy test. Inaq Nir guessed that Lifa had pregnancy sickness, but Kakak Amu thought that her husband's nausea had unrelated causes such as fatigue of riding motorcycle two to three hours a day back and forth from his workplaces in West and North Lombok.

Around a month later on Sunday 3 February, Mamiq Lifa and Kakak Amu for the first time together as a couple attended a wedding ceremony of Kakak Amu's

female friend, to which I accompanied Kakak Amu. Kakak Amu was dressed up and excited to see her close friends, or her 'gang (Sa./In., *geng*)' in Kakak Amu's reference, which is the popular calling name in Reragi to mention members of a group in which they hang out the most often. Kakak Amu had a long talk with her gang from around 11:00 am until she came home at about 1:00 pm.

On the following day (4 February 2018), Kakak Amu claimed that she had a headache (*sakit otak*) and had a hard time getting up from the couch of the living room (*sesangkok*) until late. It was a rare occasion because she usually gets up before the time of daybreak prayer (*solat suboh*; In., *shalat subuh*) to cook breakfast for her husband and work with Inaq Nir to do house chores the whole morning. At around 9:00 am, one male relative who occasionally visited the house and saw Kakak Amu reclining shared his quick guess with her by commenting 'Oh, maybe you are in pregnancy sickness (*sang ngidam sida*)' to which Kakak Amu only responded with a faint smile. Kakak Amu told me that maybe she was fatigued (Sa./In., *kecapean*) from the hangout at the wedding because it was hot the day before.

While Inaq Nir was away going to Mataram City with her husband until around noon, Kakak Amu for the first time after marriage called her natal mother and older sister-in-law (Amu's older brother's wife) to do washing and cooking in substitute for herself. When she came back in the early afternoon, Inaq Nir was both surprised and embarrassed with Amu's mother for coming over and doing house chores in her absence. In the kitchen where just two of us were present, I meddled in Inaq Nir's cleaning by suggesting it 'maybe pregnancy sickness (*sang ngidam*)' to make sure that she was not feeling like blaming her daughter-in-law about her

dependence on natal mother. To my relief, Inaq Nir modestly whispered me back by saying, 'Yes, hopefully! (*Ya, mudah-mudahan!*).'

By the time of sunset prayers, women in the house gathered quietly in the absence of Kakak Amu and discussed in a low voice that it might be pregnancy sickness. Those included Inaq Nir, Inaq Tip (who is the neighbor and Inaq Nir's a close relative who has two children), Ati (Inaq Nir's unmarried third child that appeared in the episode of *pedam emas* in Chapter 3) and the author. As Inaq Tip commented informatively, 'Maybe Kakak Amu has pregnancy sickness like mine. The head huurrrts if (it is) pregnancy sickness (like mine)! (*Mungkin ngidam kayak saya, Kakak Amu. Sakiiiit kepala kalau ngidam!*).'

Kakak Amu lacked appetite and energy throughout the day. Inaq Nir asked her what she could eat and had bought steamed rice (*ketupat*) as she wished. As I comforted Kakak Amu while she was reclining on the bed ('Rest a lot, okay? (*banyak istirahat, ya?*)'), she repeated that she was fatigued.

In the following morning (5 February 2018) before leaving for work, Mamiq Lifa prepared and brought a mag of hot tea to Kakak Amu who could not get up from the bed again. Knowing that Kakak Amu had vomited in the early morning, Inaq Nir was already confirmed by herself and asserted that it was pregnancy sickness to me ('This is pregnancy sickness! She cannot get up, she is sick! (*Ngidam, ini! Dia tidak bisa bangun, sakit dia*)').

When Kakak Amu came out of her room to give the leftover pieces of pancakes (*terang bulan*) to Inaq Nir, Inaq Nir affirmingly told her that Kakak Amu had pregnancy sickness ('*Ngidam!*'). Soon later, Inaq Nir's husband called Tana who was visiting Ani, her married older sister in the neighboring village, and yelled

that Kakak Amu had pregnancy sickness. In the late afternoon, Tana and Ani came home with Ani's two-year-old daughter Kia and yelled with a happy smile, 'Pregnancy sickness! (It's going to be) Kia's younger sibling! (*Ngidam! Adiknya Kia!*),' to which Kakak Amu responded with an open-mouth big smile.

Around the time of evening prayer (*Isa*; In., *Isha*), Kakak Amu's natal mother, older brother and his small child came to visit (*bejango*) and spend time with Amu in her room in the presence of Mamiq Lifa. According to Ani, it was the norm that natal mothers visit their daughters at times of pregnancy sickness 'because their child is sick (*karena anaknya sakit*).'

In the morning of 6 February, having her infant being looked after by Inaq Nir, Ani came back from her night shift as a nurse at the city hospital in Selong and brought back two kits of pregnancy test and Vitamin B complex that she purchased at a drug store on the way back.[13] Kakak Amu received both but hesitated to take the test by saying she did not have the desire to urinate. On the other hand, Ani took the pregnancy test by herself as she had been doing weekly for the past month, expecting to conceive her second child. To her disappointment, Ani's pregnancy test turned out negative.

Kakak Amu, while having sugared hot water that her husband prepared for her, complained to me that she had vomited twice and could not have slept the night before. As I asked her about her menstrual cycle, Kakak Amu said that her last menstruation was in December. I commented that it had been more than a month

---

[13] As we have seen in Chapter 2, Vitamin B complex is the widely used medicine by pregnant women in Reragi as those are distributed free of charge at monthly maternal health check of *Posyandu*. Vitamin B complex is among the few biomedicine that is acquired as safe to be taken during pregnancy in the village.

and that there was a possibility that her condition was pregnancy sickness. 'So be it (Sa./In., *Amin*),' Kakak Amu answered, and I repeated her utterance. Kakak Amu went to the bathroom with the pregnancy test while Ani and I were waiting, but she came back saying that she just vomited and could not urinate yet. It was in the late afternoon that Kakak Amu finally took the pregnancy test. As Kakak Amu came back to the living room from the bathroom, Ani casually asked if it was done ('Already? (*Wah?*)') and Kakak Amu answered yes ('Already (*Wah*)'), putting the result of positive reaction down on the floor (**Figure 5.6**).

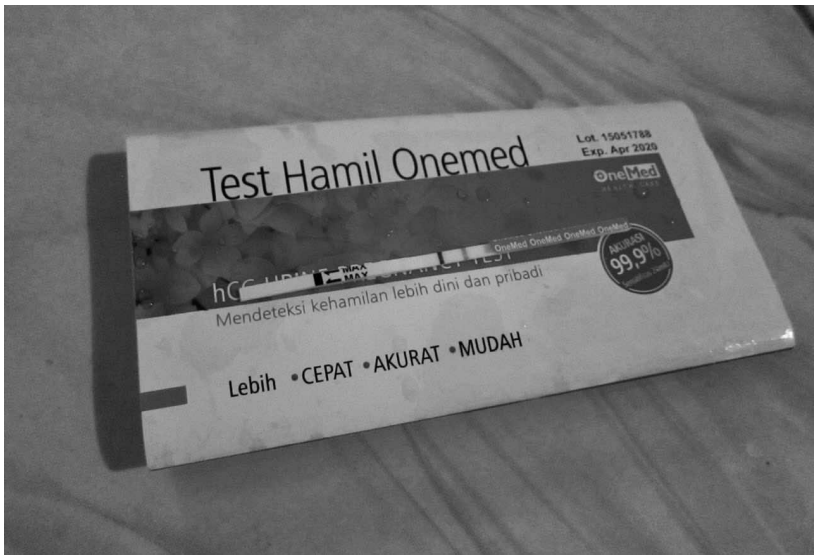

Figure 5.6 The used kit of the pregnancy test. Lombok, 7 February 2018 (photograph by author).

Inaq Nir was busy all day taking care of Kia, but the used kit on the floor confirmed her about Kakak Amu's pregnancy when she passed by the living room. Mamiq Lifa heard the news as soon as he came back from work after sunset.

From the following day (7 February), Kakak Amu was no longer referred to as 'Bride (*penganten*)' but began to be called most often as 'Pregnant mother (*Inaq*

ebon).' Mamiq Lifa continued to be called most often as Mamiq Lifa while he was sometimes called as 'Pregnant father (*Mamiq ebon*).'

Kakak Amu continued suffering from nausea, vomiting, and lack of appetite but she slightly recovered in the following week and increased her house chores of washing, cooking and cleaning to the extent before the beginning of pregnancy sickness while she maintained her habit of reclining down on the couch or the bed as necessary. Mamiq Lifa made it his morning routine to care for her before leaving for work by cooking hot water and bringing a glass of cocoa milk which nutrient for pregnant women. I made it my daily routine to give Kakak Amu head massage when she asked me to ease a headache and dizziness (as I often volunteered to give massage to my host family members upon their request to ease pains), which soon became Mamiq Lifa's evening routine as the couple relaxed in the living room after dinner.

It was not until 22 February, over two weeks after the pregnancy test at home, that Kakak Amu decided to go to the *Puskesmas* to go through the medical procedures, to which I attended. Kakak Amu was waiting for her dizziness to be reduced so that she was 'strong enough (In., *cukup kuat*)' to walk to *Puskesmas* which is around 300 meters away. She explained that pregnant women are not allowed to ride a motorcycle to avoid miscarriage while the week before she had no problem in riding on the back seat of Mamiq Lifa's motorcycle to visit her natal home if it was slow (*adeng-adeng*).

At the *Puskesmas*, amongst other a dozen of women, *Inaq ebon* took the urine test and the blood test, waited for the results for more than an hour, received quick oral questions by a female nurse about the menstrual cycle and physical

conditions. The nurse told her that her hemoglobin content was enough and that instructed her to receive and take Vitamin B complex and oral iron preparation (In., *Tablet Tambah Darah*) if she feels dizzy and to attend the forthcoming *Posyandu* maternity health check. Kakak Amu expected to receive the maternity health book (*Buku Kesehatan Ibu Dan Anak*), but the nurse said that the item was out of stock and told her to accept the book at *Posyandu*.

On 5 March, Kakak Amu went to her first *Posyandu* in the neighborhood, where she received an injection and the measuring of weight and blood pressure by a male nurse as well as the checking of the width of her waist and questions by the female midwife. There had been no communication about the lack of stock of maternity health book between the *Puskesmas* nurses and the midwives. The midwife recorded the data about Amu on a piece of paper and told her to come to *Puskesmas* soon again to receive the book with her record (which Kakak Amu volunteered on 14 March).

Around the time of sunset prayers on 7 March, Mamiq Lifa came back from business trip in Sembalun as usual. As soon as he parked his motorcycle and put down his helmet, he was called and went out again to take Kakak Amu's aunt from high school in the North Hamlet (*Gubuk Daya*) to her house in South Hamlet. When he came back home, Mamiq Lifa skipped dinner while *Inaq ebon* accompanied him in their room. As Inaq Nir and I talked to them from behind the half-open door of the couple's room after dinner, *Inaq ebon* said that Mamiq Lifa was already 'feeling strange (Sa./In., *merasa aneh*)' when he came home, and now with nausea, stomachache, and dizziness.

Kakak Amu immediately guessed that Mamiq Lifa had the illness of *ketemuq* and tried diagnosis by herself for the first time. Inaq Nir asked *Inaq ebon* where Mamiq Lifa supposedly had *ketemuq* ('Where did he meet? (*Ketemuq lembe*?)') and *Inaq ebon* answered that it should be spirits in Sembalun ('Sembalun spirits! (*Bakeq Sembalun!*)'). As she told me later, it was the first time Amu attempted the diagnosis of the illness of *ketemuq* after she saw and learned its method from her mother.[14]

After the evening prayer, while not knowing that Kakak Amu already diagnosed Mamiq Lifa, Inaq Nir (and I) visited a neighbor in the back of the house to ask for diagnosis whether Mamiq Lifa had *ketemuq* or not and if so with whom he had met. Inaq Nir explained to her neighbor that Mamiq Lifa became sick after coming back from Sembalun and picking up Amu's aunt from the North Hamlet, elaborating on how immediately he went out after coming home without rest.

The woman confirmed that Mamiq Lifa was called by his late grandmother (Inaq Nir's mother) who had lived with them in the house and passed away eight years ago as well as bakeq residing in the high school in the North Hamlet. It was also Inaq Nir's guess that her late mother had beckoned Mamiq Lifa to suggest him to take a rest ('Rest first! (*Mentelah juluk!*)'). As it is regarded that illnesses of ketemuq can heal as long as it is properly diagnosed, Mamiq Lifa was left unmedicated while *Inaq ebon* took care of him. He eventually recovered and went to work in the following morning as usual.

In case of Mamiq Lifa and Kakak Amu, Inaq Nir and Kakak Amu count both events of Mamiq Lifa's sickness on 7 January and 7 March 2018 as his pregnancy sickness. Kakak Amu's physical symptoms including nausea, vomiting, headache,

---

[14] See Chapter 3, for the detailed descriptions of the treatment of the illness of *ketemuq*.

and appetite changes were also considered as her pregnancy sickness by Kakak Amu herself and people around. Her heavy nausea and headache eased by the end of March 2018 while she craved to eat *ketilmus*, a kind of Lombok black plums.

The case of Mamiq Lifa and Kakak Amu exemplifies the tendency in Reragi where any sickness experienced by a pregnant woman and her husband especially in early pregnancy is interpreted as a part of *ngidam*. In the excerpts of episodes of husbands' ngidam and the case of Mamiq Lifa, we saw that men's sickness that happens in the early period of their wives' pregnancy tend to be referred to as *ngidam* at any symptoms including appetite change (3 persons), fever (2 persons), headache (1 person), vomiting (1 person) or potential causes such as *bakean* (2 persons) and *ketemuq* (1 person). Those also show that men's pregnancy sickness is occasional and temporary and does not necessarily imitate nausea and vomiting of pregnancy that typically affects women for months.

In the next sub-section, we explore the local understandings of pregnancy sickness further by looking into the ways people in Reragi regard both men's and women's pregnancy sickness as being derived from their unborn children but with an emphasis on the physical and emotional connections between mothers and children. As we will see in women's episodes of their own experiences of pregnancy sickness, the inclusive idiom of pregnancy sickness is not only referred to as the explanations of various symptoms during pregnancy but also drawn on as the ways of deepening pregnant mothers' special bond with their children that continues to last even after childbirth.

5. Feeding Mothers and Children

(1) Ngidam of 'Pregnant mothers (Inaq ebon)'

Nausea and vomiting, appetite changes, and increased sensitivity in pregnancy

The semi-structured interviews with 50 women included questions about their experiences of pregnancy sickness, such as: Did you have pregnancy sickness? (*Wah ngidam sida?*); what did you feel while you had pregnancy sickness? (*Waktu ngidam, apa yang Inaq rasakan?*); What did you crave (to eat)? (*Apa ngidam side?*); Could all the cravings be fulfilled? (*Semua keinginan bisa disampaikan?*), and; Could you tell when pregnancy sickness started and how long it was? (*Apakah boleh Inaq cerita kapan mulai ngidam dan berapa lama?*)

According to the interview results, compared to men's ngidam during their wives' pregnancy, pregnant women's pregnancy sickness is understood as more lengthy, repetitive, and intensive conditions of nausea, vomiting, headache, appetite changes, and increased sensitivity toward the light, smell, flavors, and touch.

Such conditions are not unique to Reragi village and widely experienced and acknowledged by women elsewhere in the world with individual variations. For instance, Ibu Air, the 29-year-old woman who commented that her husband did not have sickness during her first pregnancy in 2015, puts:

> My pregnancy sickness was ordinary. When I had pregnancy sickness, (it was) like dizzy, vomiting, and wanted (to eat) spicy stuff. Inaq Air (I) didn't want (to taste) sweet things. And I couldn't stand smells of garlic and shallots, like that. (So I) couldn't enter the kitchen, you know (because there are always garlic and shallots there), so Niniq Air (my mother-in-law) cooked (instead of me), until around the third month (of pregnancy). If (I was) sick, (we) just let it

be because we knew it was pregnancy sickness, (I) just drank milk if I felt like vomiting, just like that.

Biasa ngidam saya. Kayak pusing, muntah, kalau saya ngidam, terus mau yang pedas-pedas. Ndak mau makan manis-manis kalau Inaq Air. Terus saya tidak bisa bau bawang putih, bawang merah, gitu. Tidak bisa masuk dapur kan, jadi Niniq Air yang masak, gitu, sampai sekitar tiga bulan. Kalau sakit, dibiarin aja karena kita tahu itu ngidam, cuma minum susu kalau mau muntah, cuma gitu.

While Ibu Air describes her pregnancy sickness as usual (In., *biasa*), some women perceive their pregnancy sickness as being 'tough (In., *keras*),' 'strange (In., *aneh*),' or different from other people. The case of 'tough pregnancy sickness' is exemplified by the case of Inaq Tip, my host family's neighbor who commented on 4 February 2018 that Kakak Amu's headache might have been similar to the symptom of pregnancy sickness that she had experienced, as I mentioned previously.

The case of Inaq Tip

Inaq Tip was married (marriage by stealing; *penganten dipaling*) and became a housewife in 2006 when she was 22 years old. She conceived and gave birth to her first child in 2010 soon after almost four years of long-distance partnership with her husband who works in Malaysia. She became pregnant for the second time in January 2016 and gave birth in early October 2016. Both were boys and were born by cesarean section at the general hospital in Selong city.

Inaq Tip remembers that at the time of her first child, she was often dizzy, had a headache, and lost appetite because it did not taste right from the first three months of pregnancy. She craved guava (In., *jambu merah*) but there were only bitter ones because it was out of season. So, Inaq Tip's older sister went out seeking

guava across the island until she finally found it in Mataram. Inaq Tip's husband was already back in Malaysia when her pregnancy turned out. Instead of the husband, her older sisters, natal mother and mother-in-law helped Inaq Tip during her pregnancy.

When she was pregnant for the second time, her pregnancy sickness was even harder, as Inaq Tip recalls. While she 'forgot (Sa./In, *lupa*)' her husband's pregnancy sickness when he was in Malaysia in her first pregnancy, she remembers that her husband had pregnancy sickness in advance to her in the time of the second pregnancy: he craved to eat *rujak* (Sa./In., a kind of fruit slices dipped with spicy brown sugar cream). She did not dare to smell garlic, shallots, and the perfume of shampoos and skin care oils for the first five months. She could not dare to touch cold water and wanted to use hot water for bathing, or otherwise, she would vomit. So, Inaq Tip had to boil water and take a bath only once a week (because it was too much trouble to cook a lot of water every day). Inaq Tip also could not stand sunshine so she could not go out of the house. She craved avocado (*jeliman*) and red grapes (In., *anggur merah*). As her husband was back from Malaysia in 2016, he covered the windows of their bedroom with the remnants of plastic posters and sought the craved food for her ease.

Inaq Tip remembers that sometime in her second pregnancy, she 'did not have the energy (*tidak ada tenaga*)' and wanted to get a drip at the *Puskesmas*. However, as Inaq Tip puts, the health center was full of patients, and there were no beds available for her. To her disappointment, Inaq Tip just received additional Vitamin B complex and oral iron preparation and returned home. Inaq Tip did not take medicine because it tasted bad and she knew she would vomit even if she has

one. As she confessed laughingly, Inaq Tip hid the tablets behind the curtains instead.

According to Inaq Tip, it was only after she had a blood test at *Puskesmas* in the eighth month of pregnancy where Inaq Tip knew she had anemia (with the hemoglobin concentration decreasing to 8g/dL) that she began to take medicine regularly three times a day. Inaq Tip also considers that her pregnancy sickness was already finished and she was already healthy by then so there was nothing that disturbed her to take medicine.

Around the same time in the eighth and the ninth month, Inaq Tip went to visit Inaq Naca twice to receive massage and reduce the waist pain. Inaq Naca told her that the baby's position was good ('*Bagus posisinya!*'). In the eighth and ninth month, Inaq Tip and her husband went to see a private obstetric doctor to get the ultrasound. At the time of the second ultrasound, the doctor recommended them to go to the city hospital to give birth.

However, considering the cost of hospitalization and the troubles of calling everyone to come to the city, they went back home first and stayed at *Puskesmas* for one night. In the following morning, Inaq Tip was moved from *Puskesmas* to the city hospital and gave birth by cesarean section. According to Inaq Tip, her husband, who had been slightly disappointed for not being able to have the first daughter, attended the operation and immediately became extremely happy and loving toward his second son as soon as he was born.

While there are tremendous individual variations in how one goes through sickness, pains, and vulnerability during pregnancy, the case of Inaq Tip

demonstrates much of self-care, communal care exchange, and biomedical interventions that can be entangled into the local women's experiences of those.

Particularly in regards to pregnancy sickness, the first striking thing in the interviews was the diversity of the experienced conditions of pregnancy sickness and the commonality of its mechanism as being derived from the child in the womb. As I casually showed sympathy for what she had to do to deal with 'tough pregnancy sickness (*ngidam keras*),' Inaq Tip immediately responded by saying 'It's nothing, let the child be healthy! (*Endek ngumbe-ngumbe, antek anak sehat!*).'

As one woman puts, in the local understandings in Reragi, 'everyone has pregnancy sickness because of the child (*semua ngidam karena anak*).' As we will see next, this is the point where pregnant women's specific demand for food and care are tolerated, and its fulfillment becomes regarded as the moral obligation of people surrounding them.

(2) Synchronizing with the child through the food and the nourishment

Fulfilling the desires of the child

It is a clear assertion and the shared understandings among many women that pregnancy sickness derives from the unborn child. In this context, *ngidam* refers to the various changes that happen to the body of pregnant women, including nausea and vomiting, appetite changes and high sensitivity toward odors, noise, and things they touch, as mentioned earlier.

Most explicitly, the local expressions in Reragi indicate the food cravings of pregnant women as the food cravings of the unborn, whose desires must be fulfilled immediately or otherwise, the newborn child would be slobbering ('If we want (the

food) it has to be fulfilled quickly. If not, the child that comes out would be slobbering (*Mun ta meleang a, harus becat na sampeang mun endek ja eloran bebeak o pas na sugul*)').

Many people refer to such expressions as 'parents' words (*engkat dengan toak*)' and not necessarily as their own opinions. Rather, it would be more accurate to put that the sense that the child craves the food surfaces and articulates the women's unknown feelings or emotional changes beyond their control. An episode of food cravings of Inaq Nir's pregnancy of her first child (who died at the age of four-month-old) back in 1984 exemplifies such processes of realization. To add the background, Inaq Nir was born in a poor peasant family of Reragi Village, eloped with her middle-school teacher in her teenage, and raised three children as a housewife and a weaver. As Inaq Nir puts:

> If me, when (I was) pregnant, I did not feel anything, every food tasted good while I had pregnancy sickness. However, one thing I desired was the leftover of other people. For instance, someone passed away, and Mamiq [Inaq Nir's husband] went to pray for remembrance (and joined the feast). I had him to wrap the leftover after they finished eating because, in the past, dishes of those who had feasts were the best meal because back then there wasn't as much food as today. So if (the leftover) was not brought home, you know, tears welled up my eyes already like this [Inaq Nir slowly trailing down the cheek with fingers]. 'Why-y-y?' (I wondered). I was not hungry but I desired (the food) so much, and that's how I knew it was the baby that wanted to eat... The important thing is that the food is brought. Even if (the food) is a little bit, we would taste if it was brought home. We think we would eat it a lot of it, (but) in the end we are (already) good by just looking at it... Only that (the leftover of the feast) was what I desired so much until I craved it. Other than that, things were usual, you know.

Aku ja lek pas ku betian endek ku ngidap apa-apa selapuk pepa mik sik ku ngaken a nyekang ku ngidam. Laguk arak skek so melet ku kaken sisa-sisa dengan, misal a arak dengan mate terus mamik lalo sikir suruk ku wah ya merimbun berkat jerak a si ngaken a no, karna lek ono kakenan dengan paling bagus karna lek endek luek kakenan mangkun si nengka. Terus mun endek encuang aku ulek sugul so aik matang begini. 'Kenapa-a-a?' Endek ku lapar ja laguk angen-angenangku terus ono ampok ku tok a bebeak o mele ngaken... Si penting na encik kakenan o, padahal ara sekedik kaken ta mun na wah enciang ulek, kenan ta na buek isik ta ngaken a sok ta gitak-gitak bagus so angen ta... Ono so meletang ku si sampe angen-angenangku mun si lin lekan ono ja biasa so.

People in Reragi generally understands that 'usually pregnancy cravings are weird (*biasanya ngidam itu aneh*).' As the narrative of Inaq Nir that counts her cravings of people's leftovers as out of the 'usual cravings (*ngidam biasa*)' suggests, food cravings are recognized and remembered with specific items involved, and some of those the pregnant women or people surrounding them find unusual or unfamiliar tend to be characterized as 'weird cravings (*ngidam aneh*).'

Many informants refer to their food cravings of pregnancy as usual (Sa./In., *biasa-biasa*) in case they preferred to sour (*pedis*; In., *kecut*) or sweet (Sa./In., *manis*) fruits (e.g., grapes, apples, pears, coconuts, black plums, guavas, avocados, mangos, custard apples, bananas, baby jackfruits, oranges, starfruits, duku fruits) (28 persons), noodles (4 persons), marine fishes (3 persons), chicken wings (3 persons), snacks (3 persons), clay (3 persons), spicy vegetables (2 persons), sugar (2 persons), areca nuts (1 person), coffee powder (1 person), *pecel* (In., boiled vegetables with spicy peanut butter) (1 person).

Family obligations to fulfill the food cravings in pregnancy

When I asked if the husbands or people around the pregnant woman would not see her as being dependent (Sa./In., *manja*) when she craves food, each informant would assert 'No,' and repeat that people understand because the cravings must be fulfilled quickly for the good of the unborn child.

Instead, when I had interviews with individual women in the presence of their children, husbands, sisters, and neighbors, the most common immediate expressions from the adults watching us and commenting on the informants' descriptions of food cravings was a joyous cry, something like 'Hey, the cool thing this child wanted! (*E-e-i, kren melen a kanak ene!*),' especially in cases that the items craved are expensive.

As one man tells his episode of seeking food, once when his older sister-in-law was pregnant in 2010, his brother (the husband of the pregnant woman) called him on the phone at around 2:00 am and had him to seek oranges to meet the cravings of his pregnant wife. As markets and kiosks are closed during the nights, the young brother went to search the neighborhood for orange trees with ripe fruits.

He did not find the tree until he ended up in the house of strangers in the neighboring village. He knocked the door, and the resident looked very scared when he came out to see what was going on with the sudden visitor in the middle of the night ('What's wrong with this kid? (*Arak apa kanak ene?*)'). He told the man that 'Excuse me! I have someone craving oranges! Can we ask for your oranges? (*Permisi! Mene arak dengan ngidam jeruk! Bu ke ta ngendeng jeruk da?*),' and the man immediately agreed, saying 'Yeah, okay, if so! (*O bu a, na ngeno ja!*).'

An episode of strange cravings narrated by men also exemplifies the local people's tendency of attributing the source of the food cravings) to the unborn.

During her first pregnancy in 2012, Paman Nawi's wife craved young coconut fruits picked from trees in the graveyard. As Paman Nawi and his twin brother saw no difference between the coconuts in the graveyard and other coconuts, they bought usual coconuts from somewhere and gave her without indicating where he picked those.

However, when Paman Nawi's pregnant wife tasted the fruit, she was unsatisfied and immediately said 'Not this (*Endek ya ene*).' Paman Nawi's twin brother visited his friend's house, where he could find coconuts harvested from the middle of the graveyard. He asked his friend for the coconut, brought it to the pregnant woman, and she was content. That was when the twin brothers were reassured that the child 'could feel/taste (*tok a rasa a*)' and 'know (*tok*)' if his cravings were fulfilled.

(3) The permeable bodies of mothers and children

Food and feelings permeating through the body

The articulations of pregnancy food cravings vividly describe the local perspectives that acknowledge unborn babies inside the body of pregnant women as a being that can feel/taste (*tok rasa a*). In such contexts, the feelings (Sa./In., *perasaan*) of unborn children are perceived as present wherever pregnancy cravings are evident at any stage of pregnancy regardless of whether the baby is already a human or not, the status of which tends to be measured by maturing of the body parts of the child. How, then, children's desires appear as the cravings of their pregnant mothers?

The common understanding of the phenomenon of food cravings of pregnancy in Reargi is that feelings of pregnant mothers and their children transmit

(*nyambong*; In., *nyambung*) via food (*kakenan*; In., *makanan*) given to the children from mothers through the umbilical cord. This is the point where Nana, while going through the pregnancy loss twice, mentions that 's/he (the baby) joins her/his mother (*milu inaq a*; In., *dia ikut ibunya*)' for everything and that 's/he cannot feel alone yet (*endek man tok rasa mesak-mesak*)' during pregnancy. As Nana puts:

> If the mother sleeps, s/he sleeps. If we sing, s/he sings. If we are sad, the child is sad. If we are happy, so is s/he happy... Children cannot feel alone yet, (and) join his/her mother because the food is given... If (it is about) pregnancy cravings, it's the child that wants to eat this and that, and his/her mother directly knows the child's feelings... People say that if (they) already have a child, and if the child wants to be breastfed, it also transmits. The mother immediately knows the child's feelings (that s/he wants breast milk).
>
> *Mun na tindok inaq ja ya endah tindok, mun ta menyanyi menyanyi ya, mun ta sedih bebeak o sedih, mun ta seneng seneng ya, bebeak endek man tok ngerasak mesak milu-milu le inaq lonto karna makanan Lengan inaq. Mun ngidam, bebeak mele ngaken ene ono terus inak a langsong tok perasaan bebeak, engkat a mun wah arak anak terus anak a mele nyusu ono endah nyambong, inaq a langsong tok perasaan anak a.*

Nana describes that the sensed continuity of food and feelings between mothers and children are supposed to last even after childbirth by referring not only to her own experience of pregnancy but also other women's saying. The sensibilities to the mother-child connectedness in breastfeeding are something that Nana she has not had a chance to experience the sensed continuity of food and feelings between mothers and children. Nana's reference seems to come from the collective knowledge in the village.

Breastfeeding and the transmission of the food and feelings

As Inaq Tip puts, 'our food enters the body of children because of breast milk' even after birth. Inaq Tip says that she weaned Yom from the breast when the series of massive earthquakes hit Lombok Island in August 2018 because she was afraid that breastfeeding would transmit her constant fears (*taget*; In., *kaget*) to Yom and make him uneasy (*endek nyaman*).

It is worth noting that, in the region, women are recommended to breastfeed the baby up until two-year-old. Yom was 22-month old at the time of the first earthquake, and Inaq Tip found his age a little too early for weaning but decided to wean him. When he pestered for milk, Inaq Tip applied lipstick around the areola to surprise Yom and repeated saying '*Mimi, yek!* (Dirty milk; Milk is dirty! (in baby talk)).' Applying lipstick or other material of color such as coffee paste is a common trick of weaning in Reragi.[15]

Importantly, women find the continuing permeability of their bodies and the bodies of their infants in both directions even after the umbilical cord is cut. As Nana puts and as many echoes, women are supposed to know when infants desire breast milk as their feelings synchronize. Conversely, as in the case of Inaq Tip, women often find the need to be emotionally prepared before breastfeeding their children so that their negative feelings would not affect the child.

---

[15] One of my informants who is a female healer (*belian*) specialized in the infant matters including weaning and the improvement of fussiness (*nyelek*) explains that although she treats clients if they visit her, her healing formula (*jampi*) of weaning functions with the trick of scaring the infant with unusual color rather than by her exercise of healing potency (*ilmu*).

Mothers and children sharing the body and emotions

The sense of mother-child continuity through nourishment, or the sense that what enters the body of mothers becomes 'a part of the child's body (*bagian awak anak*),' also extends to the sense of connectedness to the 'pregnant fathers.'

Such sense of togetherness is reflected by the common expression that describes children as 'being urine (*penek*)' of parents as 'humans are born like the way of urination (*manusia di lahirkan seperti saat menek*),' 'coming out between the thighs of the mother (*sugul lengan langkang inaq*).' For instance, Rizki, a man in his mid-thirties who lost both parents in his twenties, recall his childhood when his mother often scolded him by saying 'Don't you dare be naughty, because you are my urine, you are a part of my body, you had breastmilk the most! (*Dendek mek bangga karena penekku anta, bagian awak ku anta, anta paling koat mek nyusu!*).'

According to oral reports, men use such metaphors drawing on that their semen ('liquid (*aik*)') take part in the fertilization process. Meanwhile, women use the same metaphors because children are 'born like urine (*sugul mangkun penek*),' 'coming out between the thighs of mothers (*sugul lengan langkang inaq*).'

While people in Reragi acknowledge the connectedness between children and their fathers in times of pregnancy sickness and cravings, they tend to emphasize the bond between mothers and children as being stronger and more direct because the child is in the body of the mother for the nine months of pregnancy and is breastfed for the following two years. One woman puts that she reassured herself that she is still connected to her 16-year-old. The woman says she knows she can feel what he is feeling by just being around him. One day, the woman had an occasion in which she received a phone call from her son as soon as she had sudden uneasy feelings,

and turned out that he got injured in a traffic accident in Selong. When I asked random groups of women chatting about the length of their continuity to the child, their answers would always be 'until whenever (*sampe piran-piran*)' even after the death parts the two.

However, the continuity between mothers and children do not make mothers as figures that knows everything about the children or has control over their feelings. Parents and other guardians of infants in Reragi as elsewhere in the world confront the messy everyday realities of early nurturance where they are not only pleased but also confused, exhausted, and filled with constant questioning: why my child keeps crying?; how come is s/he suddenly sick?

In such contexts of daily life, people make efforts to save young children against a variety of potential danger not only with the access to biomedicine but also by practicing remedies, rituals, and *ilmu* of healing and protection. The guardians cope with illnesses resulting from their interactions with various beings such as the dead and even their unborn siblings, the cases that we have seen in Chapter 3.

In the next and final section about the research findings, I describe the further details of the local postpartum cares previously mentioned in Chapter 4. In doing so, I put a particular focus of attention to the ways the young mothers and their natal mothers interact concerning how to use the birthing belt to support the health and recovery of the postpartum women.

The daily negotiation and the muted frictions between the two generations in the postnatal phase is the especially pertinent material to discuss the present temporality of the birth settings because this is the period when the village women begin to cultivate the selfhood as new mothers and new grandmothers.

6. Postnatal: The Cares of New Mothers and New Grandmothers

(1) The gift of the birthing belts from mothers to daughters

The new grandmothers' solicitude for their birthing daughters

As briefly mentioned in Chapter 4, the birthing belts (*sabok beranak*) are reproduced in Reragi as an essential item of pregnancy rituals and postpartum recovery. The cross-wrap of the abdomen with the birthing belts often requires the helping hands. Older female family members often help new mothers to cross-wrap the abdomen with the cotton sash, taking a few minutes to complete (**Figure 5.7**).

Figure 5.7 Women cross-wrapping the abdomen with the birthing belt. A woman (right) stretches the birthing belt to cross-wrap the abdomen of her daughter (center) who had given birth to her first child ten days before the photograph was taken. Lombok, 8 July 2017 (photograph by author).

After the shift of birth settings from homes to biomedical facilities, it has become the norm in Reragi that the attending family members of birthing mothers bring the belts to the delivery rooms so that the new mothers can wear the belts there. The postpartum women continue to cross-wrap the abdomen, as they feel '*miq* (comfortable),' for anywhere ranging from one month to one year. In many cases, people double the wrap in combination with *stagen*, which refers either to thinner home-woven cotton sashes with a color variation or to mass-produced elastic girdles, as we have seen in Chapter 4.

The next sub-sections illustrates how women in Reargi practice the home remedies of maternity care for their daughters in the postpartum recovery phase. It reveals that, for those women who now became grandmothers (*papuq*, *niniq*), it is vital to support their daughters' reproductive phase, and particularly in the present case to encourage the proper use of the birthing belts, in extending their past experiences of the pain and vulnerability to the bodies of their birthing daughters. The new grandmothers are also in tribute to their past caregivers when they hold onto the 'old ways' of solicitude, maintain the long-term relationships with their old cloth, and apply the successive cares to the next generation.

(2) New grandmothers and the cloth that cares

The case of Inaq Nir

As we have seen in Chapter 4, it is the norm in Reragi Village that either a natal mother or mother-in-law of the pregnant women prepares the birthing belts for the newlywed daughters if affordable. Not surprisingly, Inaq Nir, my host mother, considered it her responsibility to prepare for the cloth for Ani (my older host sister).

Inaq Nir had happily expected her first grandchild, prepared the belt, and kept it in the top shelf a few months before Ani's marriage in May 2015. Just 20 days after the wedding, Inaq Nir was deeply upset as her husband forced her to sell it expensively to visitors from another village, who sought the birthing belt for their newly married daughter. On the same day in her husband's absence, Inaq Nir informed me educationally, frowningly:

> A mother has to prepare the birthing belt for her child when she [the child] is getting married, and then the child gives birth, then if that born child is a girl, she will prepare the belt for the child when (her child) gets married. That's the way (it should be)!
>
> *Inaq harus nyiapang sabok untuk anak a si nina pas na nikah, terus anak a beranak, terus mun anak si lahir ono nina ya gin nyiapang sabok untuk anak a ono saat nikah. Ngeno angkun na!*

Eventually, Inaq Nir ordered her cousin another belt, and the cloth was ready within a month. The price of the birthing belt within the village was Rp300,000 as of 2015, much higher than the local cost of regular woven sarong cloth (Rp200,000) because of the relatively long process of weaving the former takes, according to Inaq Nir. She also added that the bride's mother or other appropriate female guardians such as aunts and older sisters must prepare the belts, but it does not require them to weave on their own. If she finds herself busy and can afford it, she can ask her relatives or neighbors for the labor.

Protecting the auras of potent materials

The mother was concerned about selling the birthing belt also because she feared

such inappropriate treatment of the cloth might cause sickness to her or other members of the house.

As we have seen in Chapter 3, people in Reragi consider that mistreating various objects, including both potent things like the old healing cloth and old knives, and more ordinary materials such as earrings, pillows, and even one's hair would cause illnesses called as pedam with diverse factors, symptoms and healing processes. For instance, there are numerous episodes of sudden stomach ache and snake nightmares that are caused by the ancestral healing cloth called reragian in return to people's reckless behaviors such as leaving the fabric unwrapped on the floor, stepping over that unintentionally, or touching the material without the owner's permission.

The birthing belts are widely considered to react in similar ways to the ones of the ancestral cloth that calls people's attention by making them sick when mistreated. Inaq Nir recollects that she once had a terrifying experience of a python (*sawak*; In., *ular sanca*) huge snake coming to her dream, triggered by her birthing belt woven by her natal mother. As Inaq Nir puts while holding her birthing belt:

> 'Can I borrow your belt?' (my niece asked). 'Yes, (you) can,' I said. Then (she) borrowed it for months, so I was not looking for it [the belt]! But I dreamed the very long python, the python that chased me, long like this belt, so long the python that chased me, it was! Then I was tired, running and saying 'Please, please, help!' suddenly I woke up! 'Wheeeeeew! What happened to me?,' (I asked myself,) and then I remembered, that belt might not have been stored well, perhaps, it was why I had the dream. Then I was looking for (the belt), (and my guess was) right, it was not the place to store (where I found the belt). Then, I kept it here (in the wardrobe), and since then I haven't had the dream, the snake we didn't dream anymore. This (belt) is the only one I was given by great-grandmother [Inaq Nir's natal mother].

> '*Bu ke ta singgak sabok da?,*' '*O, bu,*' *ningku terus ampok singgak a pira bulan ya be kah, jari endek be ku peta-peta a kah, endak ku ngimpi sawak mara belo apa sawak ini si malek aku ngeno ja belo sabok ini ngeno belo sawak ini si malek aku! Terus lelahku ngeno* '*Tulong-tulong berari,*' *tangi-tangi aku.* '*Huuuuuu! Wah ku ngumbe ene?*' *Ampok ja enget-enget ku, kan ku ngimpi badek ku ja sabok ono rua endek bagus isik a meriri a rua a ito ene ampok ku ngimpi. Ampok ku peta a terus peta-petangku tetu endek keruan tok a nolok a. Ampok ku sempem a ite terus lengan ono so endek ku wah ngimpi, ta endet ular o endek ta ngimpi. Enggak sekek ene so piang a aku si balok mek.*

She has stored the belt secure in between the layers of sarong cloth in her wardrobe until today, as she is determined to keep the fabric as long as the life continues. Inaq Nir's episode exemplifies some of the common concerns for the harms and the careful treatment of the birthing belts in Reragi. After the use, the cloth is more often wrapped with plastic bags in a layer, and stored in the wardrobe or the rattan basket, avoiding abundance or selling.

Caring for the body by caring about 'everything'

Significantly, the moral obligations surrounding the birthing belts are embedded in the broader notions of cares for the body, which is considered especially important in the process of pregnancy, childbirth and postpartum recovery.

The recollection of Niniq Air in her late 40s, who is the mother-in-law of Ibu Air that shared her story of pregnancy sickness previously in this chapter. Niniq Air, the mother of two adult sons and the grandmother of a three-year-old boy, Air, portrays the interconnection between the proper use of the cloth and further carefulness:

> In the time of our parents, we were careful with everything since we start cravings (from conception) until we give birth! For example, after we get the belt cutting (during pregnancy) and we finish childbirth, we were not allowed to lie down for 44 days. Usually, after delivery, we had to sit up on the bed (for 44 days) so that the *dadang* (vaginal blood after childbearing) does not go up (to the body and the head). Also, we wore the belt for a long time, yeah, sometimes until one year, but if now, after finishing childbirth, all (the young people) immediately lay down before the time comes and wear the belt only a while like three months. Long ago, also, while we gave birth, yeah, we hang the belt and then we were advised to sit on the stool while we gave birth, yeah.!
>
> *Mun dengan toak ta lek ja selapuk perhatiang a lengan ta mulai ngidam sampe ta jerak beranak. Endek sade ita sembarang missal a pas ta molong sabok, ono endah jerak ta beranak endek sade ita tindok biasa harus 44 jelo ta tindok tokol na marapang tek dadang ta dit endah lek ja sue ta besabok jerak ta si beranak, o, kadang sampe setahon lamun nengka ja endek ya jerak lonto beranak langsung tindok dit ngadu sabok ara semendak ara telu bulan. Lek ja endak nyekan ta si beranak o, gantungan a ita sabok ta ya tok ta berentik ya si ke lekin a beranton-anton o, terus suruk a ita tokol ngadu tokolan pas ta beranak o!*

The use of the birthing belts in Reragi village, as emphasized by Niniq Air's statement, thus associates with the reminder for the necessity of the continuous and constant self-care of the pregnant and post-partum body. Niniq Air expresses respect for her late mother and the women of her times by describing their carefulness with 'everything,' which most notably refers here to the ways to protect the postpartum body by avoiding the lie-down position and wearing the belt until lochia ends.

In the interviews about their childbirth, Niniq Air, Inaq Nir and other grandmothers elaborated on the importance of self-care with gestures demonstrating how they had been careful so that the vaginal bleeding does not flow back to the body and the head. Inaq Nir comments that if they wanted to pick up cloth on the floor, they had to squat without leaning forward. The essential thing is the upper

body remains straight up all the time, and wrapping the abdomen with the birthing belt gives necessary support to the posture.

Notably, such depiction by the new grandmothers about the self-care that they had enacted upon the instructions from their mothers often advances from or to their frustration toward daughters' recent attitude that does not follow 'words of our parents (*engkat dengan toak ta*).' '*Dengan toak*' in Sasak language refer to parents and ancestors, not necessarily clarifying the distinction between the two in every context.

Becoming a grandmother

The juxtaposition of the past and present self-care is made explicit in an enthusiastic side-talk of Inaq Inure in her late 40s, the widowed mother of six daughters and the grandmother of four infants. Her statement evolved as she tried to convince her nephew and her married daughter who were present in the interview about Inaq Inure's birthing experience. The exact year of the incident in her narrative is unknown both to Inaq Inure herself and the researcher, but it seemingly took place later than 2010, when her first daughter got married. As Inaq Inure puts with a persuasive intonation:

> I will tell you (name of the nephew), you think I had never *dipedam* (become sick) by the belt of my mother-in-law (who had left behind the cloth when she moved out of Inaq Inure's house). My stomach and my head felt, maybe one week, hurt! Then, she (the mother-in-law) laughed, coming to the dream. Then, the following day, I went there (where the mother-in-law lived) and asked for water and the *jampi* (incantation). 'You, even if you think we do not become sick with your cloth,' she said, 'it is the same thing (you still become sick even if you do not believe in it)'! Even though I had been let know, been told (by the mother-in-law), not to leave the belt underneath, (the cloth) must be (put) on the

upper part, like on the wardrobe. But, to name it, we forget, and we do not believe (in *pedam*), and we just put (the belt) wherever. My mother-in-law, even though she was hard-of-hearing, but she could *bejejampi* (give incantations). So you know these kids (Inaq Inure pointing to her third daughter breastfeeding the baby), I scold (her), of course, if (she) does not want to wear the belt long, at least for six months I told (her to wear the belt). If it was in the old days, we wore the belt until one year after we finish childbirth. Also, I told her to sit-sleep, but kids now are stubborn. (They) don't want to listen to our words, so that is why I am often angry. We worry that the *dadang* goes up to the head, you know, it takes long (time and process) to be cured if that (lochia) already went up.

Ku ceritaang anta, kena mek endek wah aku pedam a si sabok mentoak ku, tianku barengku otak idapku arak so seminggu ku dingin, terus ngingik ja ya datengin aku le impingku, mara jemak a ketok so aku terus ngendeng aik dit bejejampi, kamu po banuk dakak kereng o kenanbi endek a padam ita ning a ngenok aku! Padahal wah badak a aku suruk a dendek nolok sabok a le bawak harus le atas, misal le atas lemari. Laguk aran endek ta enget a terus endek ta percaya lalok terus gelomparang ku ja tolok, mentoak ku dakak kekedokan laguk ceket ya bejejampi. Terus tok mek kanak-kanak ene remongang ku lonto mun endek mele ngadu sabok sue ja minimal ono enam ulan ku suruk a mun lek ja sampe seton ta kadu sabok jerak ta si beranak o. Di endah suruk ku ya tokol tindok laguk kanak nengka bekeh-bekeh endek mele denger engkat ta ya ampok ku remon lonto o ta marapang dadang a si tek aning otak a o kena mek sue peririan na mun wah tek ja.

Inaq Inure's extended family smilingly interrupted her to calm her down by asking her daughter, who was breastfeeding her three-month-old child at that time, how many months she (Inaq Inure's daughter) wore the birthing belt after childbirth ('*Pira bulan da besabok jerak da si beranak o?*'). As Inaq Inure's daughter answered calmly, she wore it 'more or less than five months, because mom becomes angry if we wear the belt only for a while (*kurang lebeh enam bulan, pepa Inaq silik*

a ita ngadu sabok semendak-mendak).' That was when Inaq Inure eased into a smile, by concluding:

> All these children of mine, I made the belt for each, because, you know, we live by (weaving) cloth. It (cloth) is the only thing that we can give to children. Also (I wove the belts for all of them) so that they are comfortable, (so that they) don't need to borrow from each other.
>
> *Selapuk a kanak ene piangku sabok pada sekek-sekek aran ja ita usaha kereng ba enggak a ta sade a pada. Dit endah antek a molah endak pada saling singgain.*

Inaq Inure's conversation with her nephew and her daughter exposes a keen sense of unease and irritation about the carelessness and effortlessness that she finds in her daughters' behaviors after childbirth such as the casual lie-down and the removal of the birthing belt. From Inaq Inure's perspective, being careless about the birthing belts means at the fundamental level being careless about herself, as mistreatment of the birthing belts directly affects the body that needs the cloth for postpartum recovery.

Further, Inaq Inure eloquently draws on her episode of the self-care, illness, and dreams to ensure that her mother-in-law was right in telling her to take care of the belt, and to express her regret of having dismissed the mother's knowledge by not believing in what she had told her. As she emphasizes how angry she becomes with daughter for not listening to her, this regret is embodied in Inaq Inure's efforts to extend herself to her late mother-in-law.

Inaq Inure acknowledges the parallel of the contexts of maternity and grandmotherhood that she and the mother-in-law went through in the past and that she and her daughter is experiencing at present. The new grandmother tries to act on

her emotions by putting caregiving into practice for her daughters, particularly in this case by weaving the birthing belts and pushing each child to wear them properly. Her last comment further hints that Inaq Inure expects them to appreciate the gift of the cloth, considering her hardworking motherhood as a widow.

Notably, despite that the narratives vividly reveal the new grandmothers' frustrations and desires surrounding their own experiences of treating the postpartum body with the birthing belts and the contrastive attitudes of '*kanak nengka* (kids today),' the friction with the daughters remain mostly suppressed, at least on the surface of daily family lives. Further intricacies surrounding the local maternal cares can be explored from the perspectives of their daughters, who are now young mothers.

(3) New mothers and the 'old ways' of the solicitude and the cares

The unproblematic traditions

Although the belts are no longer expected to function as a holding strip during labor as it used to be the case in times of home birth, the belts still appear as the essential tool in the child delivery. People in Reragi bring the birthing belts to the clinic birth alongside other essentials, including drinking water, food, pillows, maternity pads, and a dozen change of sarong cloth.

As we have seen in Chapter 2, the *Puskesmas* Reragi began operating in the 1980s, but the clinic birth became norms approximately only since the 2000s. In the process of maternal and child health care implementation, the local biomedical professionals gradually gained the authority and power in the village community to

assist in child delivery, interfering with healers' treatments that they judged it as endangering the patients' health.

In contrast, such authoritative censures on indigenous medicine have tolerated much of the presence of birthing belts alongside other ordinary materials of healing, including the incantatory water, protective garlic, and wrist-tying threads. Currently, clinic midwives do not interfere with its use in biomedical birth settings, recognizing 'no problem (In., *tidak apa-apa*)' with it.

Their toleration is not surprising in the sense that these materials do not interrupt the actual procedures of child delivery as conducted with biomedical facilities. In the present local birth settings, child delivery thus takes place not only in professional attendance of clinic midwives with biomedical facilities but also often in the presence of family members with their tools and techniques of childbirth support.

For the current youth in their 20s and early 30s, many of who are making new families inside or outside the village, clinic and hospital birth and various maternal and child health care programs compose much of the standard procedures of pregnancy, birth, and postnatal. In such situations, pregnant women and new mothers face the practical questions and options surrounding cares in significantly different ways from the previous generation.

Generally, the young women in Reragi Village prefer to try whatever available care that they find preferable to take, including the ultrasound, Vitamins, traditional massages, and the birthing belts. The question is, then, how the young women, in the recent context of the institutional superiority and tensions depriving indigenous midwifery and medicine of its authority, prefer to take in the 'old ways

(*cara lek*)' of birthing support and cares? What kind of desires and dilemmas lie in the choices they make being engaged in, instead of being divorced from, the past knowledge and advice?

In answering these questions, I explore the case of the postpartum recovery support with the birthing belts with an analytical focus on its cross-generational aspect. The following episodes from observation and interviews will illustrate how new mothers carefully negotiate the ways to understand and treat the postpartum bodies from different perspectives through the gift of birthing belts and other attention and treatments from their older generations that they receive in pregnancy, birth, and postnatal.

The case of Ani

Ani is a woman in her late twenties, a hospital nurse, a mother of two daughters, the first of whom was born in March 2016 and the second of whom in October 2018.

Admittedly, with the college education, stable income, and mostly supportive families, Ani figures one of the most well-to-do in the area, where many women and men struggle with economic instability and work away from home island. However, her case is important as it shows the stark contrast of perspectives on pregnant and postpartum organisms shared among the younger generations and the everyday context in Reragi where the current new mothers negotiate the ways to respond to their older generations.

Ani has been working at the nearby city hospital as a nurse since college graduation. She got married to a colleague from a neighboring village in June 2015, gave birth to her first child, Kia, in March 2016 at the same hospital that they work. Though Ani moved out to her husband's village during the early stage of the

fieldwork, her frequent returns to old home after Kia's birth enabled close observation of continuous interactions between Ani and her natal mother, Inaq Nir.

The primary motivation for Ani to bring Kia to her natal home almost every other two days seemed that the frequent visit allowed her to have a relaxing time away from her new home with her husband and his parents. Ani often complained to Inaq Nir that her husband is unwilling to share the house chores and she is becoming thin due to the fatigue of overworking as a nurse while doing all the house chores and taking care of Kia by herself without the helping hands.

For Ani, the first experience of reproduction began and ended with sharp pain. She became pregnant soon after marriage, as she and her family members had expected. Within a week after the wedding, Ani called her parents (and me) to visit her as she had a severe genital pain from urinary tract infection, to which no one else but Ani and I were shocked. As soon as we found Ani lying down on the bed, Ani burst into tears and extended her arms to me for hugs.

Inaq Nir remained calm and repeated saying 'it's nothing (okay) (*endek ngumbe-ngumbe*)' and informed me that the illness and pain were 'usual (Sa./In., *biasa*)' for the newlyweds. Ani obtained drugs on a doctor's prescription and also received cups of incantatory herbal tea that her grandfather-in-law made for her to ease the pain. Her pregnancy turned out about a month later by the commonly used urine test, which Ani had bought at drug stores and tried almost every week during the past month.

During her pregnancy, Ani continued to work at the hospital until a month before her due date. In this period, instead of going to the monthly *Posyandu* health posts in the neighborhood, Ani chose to go to see an obstetrician in the city to get an

ultrasound every month, a popular option for those who can afford the extra cost. She visited her old home once or twice a week and sometimes stayed over.

From the sixth to eighth months of pregnancy, Ani also sought massage to reduce the abdominal pain from Inaq Naca, who is also her older distant relative. Ani tried to receive the same kind of massage from her husband's village, but she did not as she found out that the healer asked for lots of money and thus not 'sincerely (In., *ikhlas*)' helping people. In the seventh month of Ani's pregnancy, Inaq Nir organized the *mandiq besembet* bathing ceremony to wish for smooth childbirth.

Ani and Inaq Nir had planned to give birth at the small Polindes health post where Ani's older female cousin works as a clinic midwife. However, they ended up following Ani's husband's suggestion to go to the city hospital for some reason that they did not know. Ani preferred the village health post because it allows several family members to accompany the delivery process while the hospital accepts only one attendant.

In March 2016, Ani went through painful labor over two nights. Inaq Nir, her husband, Ani's mother-in-law, and other female family members stayed at the hospital giving the foot and hand massage. Ani's mother-in-law also took a local healer with her in disguise as one of the family members to provide Ani with the incantatory water (*aik jejampi*) on the upper forehead (*semanget*) and for sipping to ease the pain. After the child delivery in the separated room, Ani was allocated to the patients' room full of new mothers and infants. After a few hours of rest, Inaq Nir helped her to wear the birthing belt, to which Ani complied relaxingly.

Ani's child was born healthy. However, her husband's family gossiped that the difficult delivery was her fault, according to Ani's complaints. They judged that

the umbilical cord was tangled because Ani violated taboos during pregnancy, such as wrapping towels around the neck and eating squids. Ani and her husband overheard the rumor but did not mind it. According to Ani, she understands that the cord was entangled because the child moved around in the womb and that what her mother-in-law says is superstition. As Ani puts:

> Mythos! (It's not allowed to) eat squids, wear the towel, sit down in the doorway. So many! So much myth here!
> *Mitos! Makan cumi-cumi, pakai handuk, duduk di pintu. Banyak! Banyak mitos disini!*

Ani continued that she does not believe in such taboos. The reason was that nothing happened to her child, for instance, even though her husband broke a taboo by getting a haircut during her pregnancy, which is said to leave burns to the newborn. They shared this reasoning quietly between the two of them and avoided face-to-face disagreement toward with the family members.

On the other hand, Inaq Nir interpreted that the problematic birth was due to spiritual disturbance. Ani's child, as it is for other children in the village, was considered particularly vulnerable to such beings because she was born in the sunset hours (*sendikala*) when spiritual beings are most active.

Later as the child grew up, when the child cried through the nights or when she got sudden fever without any apparent reasons, Inaq Nir often self-quoted this interpretation that the child is the one who is easily disturbed by various beings. It was also the case of *pedam adik* (illness being affected by a younger sibling) that Inaq Nir supposed that Kia was disturbed by Ani's pregnancy, as we have seen in Chapter 3 of this paper. When Kia was sick, Ani usually did not openly oppose her mother on such statements and gave prescribed drugs to the child simultaneously

while Inaq Nir gave incantatory water or other forms of healing to the child's as healers had suggested.[16]

In the meantime for the first two months after Kia's birth, Ani was also wearing the birthing belt prepared by Inaq Nir. Ani was never stressed about wearing the birthing belt, remarking the '*miq* (comfortable)' abdominal support that it gives for the two months after childbirth. Ani knew from her mother that she is supposed to wear the belts for up to one year, but she stopped wearing as she returned to work in the third month of post-natal recovery. Ani claimed that she could not continue wearing the belt because it did not fit the nurse uniform, which Inaq Nir understood and agreed.

Maternity and motherhood in the everyday context of family lives

Other young mothers echo such excuse of abbreviating the belt-wearing period. For instance, Ibu Air, who is the daughter-in-law of Niniq Air, says that she wished she could wear the belt for a long-term, but she stopped in the first month because her skin became itchy with sweat. Inaq Patik in her mid-20s, the natal daughter of Inaq Inure, said in the absence of Inaq Inure that she stopped wearing it in the second month because she no longer felt weak and did not need to use the belt anymore.

The variety of casual excuses in rejecting the new grandmother's advice to wear the belt long enough suggests the young women's suppressed dilemmas and

---

[16] The combined use of biomedicine and traditional healing exemplifies the current norms in Reragi that regard biomedicine and ethnomedicine as being compatible with one another. It shows an overall dramatic contrast to the anxiety and confusions in the area in the 1990s when the fear of incompatibility between the two medicines prevented proper treatments and led to fatal consequences (see Hay 1999; 2001; 2005).

desires in retaining autonomy for what kind of cares they accept and deny without causing any troubles in everyday family life.

Once in 2017, when Inaq Nir carried the child to the healer for incantations, I challenged Ani if she believes in the potencies of the weaving patterns on the birthing belts. Ani smiled slightly and said frankly: 'sometimes yes, sometimes no (In., *kadang ya, kadang tidak*),' such ambivalent comment echoes Ais' indeterminacy about the cause of stillbirth that we have seen previously.

Figure 5.8 Women and a newborn child on the exorcizing day (*molang malik*). The grandmother (left) of the child applies a portion of rice on the upper forehead (*semanget*) of the newborn while the mother (right) of the child watches. Lombok, 6 September 2014 (photograph by author).

Overall, for those young mothers, using the birthing belt serves as an essential ground of showing the appreciation to the solicitude from the older generations whom they interact on a daily basis. Such social aspects of cares also pervade other various remedies and treatments of healing and protection on their bodies and the bodies of children that are typically facilitated by older family members (**Figure 5.8**).

Acquiring the cares serve the young women to explicitly demonstrate their mothers and other older family members that she listens to 'parents' words (*engkat dengan toak*)' and appreciates their childbirth support. In this respect, whether or not to believe in the efficacy of the rituals and remedies is an irrelevant issue for the new mothers as they employ the 'old ways (*cara lek*)' of solicitude to deepen connections to their parents and not necessarily for medicinal purposes.

7. Chapter Summary

In this chapter, we have explored the ways men and women, but mostly women, articulate their unique experiences surrounding birth in Reragi. Those statements and episodes included the understandings of mechanisms of pregnancy, fertility, and infertility shared by healers and non-specialist women in the village.

We have also seen the tendencies and variations of the viewpoints on the life and personhood of embryos and fetuses. Those most explicitly appear in the moments when individual women acknowledge the presence of a new life in the womb, when and how the entity becomes a human with the heartbeat, throbbing, and quickening, as well as the local definitions of premature birth and mature birth.

Further, we have explored the cross-generational aspects of the postnatal recovery treatments, considering the muted frictions and exchange of cares between new mothers and grandmothers. The detailed accounts of pregnancy loss spoken by two young women would lead to tough a question: what was lost to the women? Most explicitly, the illustrations of burial practices give some insights into the philosophical problems surrounding unborn children: whether embryos or fetuses are considered as a life or a human being. The burial practice in case of early

miscarriage and stillbirth as described Nana exemplifies accounts of other women who went through pregnancy loss. Nana perceives her second miscarried child as having possessed life as she already felt its throbbing inside the body.

The distinction and omission of funeral rites in pregnancy loss and infant mortality thus reflect the different social and existential statuses of embryos, fetuses, stillborn children and infants concerning their social and bodily liminalities. However, such abstract underpinnings of the modalities of burials in the absence of the postpartum women are far from representing the tremendous weight dragged by Ais and Nana as they narrate miscarriage and stillbirth as their stories of the pregnancy loss.

The questions on the articulated beginning, existence, loss, or absence of life entangle further inquiries into the relations between pregnant mothers and unborn children. The local perspectives on nourishment offer a glimpse into the matter, in which the mother-child connectedness enables people to convey and fulfill the need of unborn babies through the treatments of pregnancy sickness and cravings of *ngidam* that often extends also to the body of male parents or 'pregnant fathers.' The special bond between parents and children, but mostly mothers and children, persist in the postnatal and beyond because people in Reragi understand children as being born 'a part of the body' of the parents and also sharing food and feelings with their mothers through breastfeeding.

In the processes of postnatal recovery, the middle-aged women who now became new grandmothers strive to participate in the cares of their daughters' postpartum recovery. They engage in the long process of the craft or purchase of the belts from the times of marriage of their daughters or even before. Regarding the gift

and use of birthing belts, new mothers negotiate how and to what extent they acquire the solicitude of their natal mothers as they try to retain their comfortableness and convenience in treating their own bodies.

As we have seen in the previous section, young women in Reragi are barely hesitant in making easy excuses for being unable to follow their mothers' advice to wear the belt up to one year. However, in doing so, the new mothers are careful not to let the new grandmothers feel dismissed, and conversely, the new grandmothers also remember and show the respect for their mothers' cares for them. The interaction between new mothers and new grandmothers thus hint the rather covert motivation of the practices of the 'old ways' of solicitude that women attempt to express a token of their esteem toward older generations. The biography of the Sasak birthing belts thus demonstrates the processes of the cross-generational coordination of cares surrounding maternity and (grand-)motherhood in Reragi.

Regarding the research findings summarized above, the next chapter turns to the core research questions into the social meanings of the rituals and treatments of pregnancy, childbirth, and postnatal and the ways the mother-child bonding is understood in Reragi.

• 6 •

Bringing Babies into Being

1. The Points of the Discussion

In previous chapters of this paper, we have seen the background and the shifting birth settings of Reragi (Chapter 2) and the Sasak concepts of being, including the notions of personhood and person's relationship to various beings in the world (Chapter 3). We have also witnessed the ongoing rituals and treatments in pregnancy, childbirth, and postnatal (Chapter 4) and specific cases in which women suffer and cope with sickness and pains that accompanied their different experiences of maternity both in the critical moments of losses and the broader context of everyday social lives (Chapter 5).

Drawing on the descriptive accounts presented previously, this chapter discusses the findings in regards to the three broad questions of the research: (1) after the shift of birth settings from traditional midwifery to modern medicine, in what kind of context Reragi women acquire the local healing practices; (2) how the birthing mothers and people around them understand birthing in regards to the mother-child relationships, and; (3) how, and what for, they continue referring to ancestral notions of the mother-child relationships and strive to practice the local maternal cares in the emerging context of medicalization.

In the following sections, I first review the emerging local context in which the local healing practices surrounding pregnancy, childbirth, and postnatal are observed. Second, we look into the ways people understand the statuses of the

unborn through the body. Finally, we will explore how, and what for, people in Lombok continue to engage themselves in the local rituals and treatments of pregnancy, childbirth, and postnatal in the otherwise medicalized procedures of birthing.

2. Cares in Daily Lives of Pregnancy, Childbirth, and Postnatal

(1) The shift of birth settings from homes to clinics and hospitals

Transitions from home birth to clinic/hospital birth in the 1990s and the 2000s

While the social history of childbirth tends to be described as the linear progress shifting away from midwifery and moving forward to medicine (Suzuki 1997), the ways people respond to the introduction of modern obstetrics are often more complicated than it seems.

As we have seen earlier in Chapter 2, two generations of women, namely new mothers and grandmothers, are situated in the shifting birth settings in Reragi. The local medical landscapes dramatically changed since the first sub-district-level health centers launched in the 1980s, the first village midwives increasingly intervened with home birth as previously directed by traditional midwives in the 1990s, and the birth settings shifted to clinics and hospitals in the 2000s.

In East Lombok, the available health facilities include the sub-district-level health centers of Pusksemas, the public and private hospitals in the nearby city of Selong, and smaller private sectors of midwives, nurses, and doctors that scatter across the village communities of the region (BPS KLT 2018a: 199). Compared to the situations observed in the 1990s in the region of East Lombok, the rural

population's accessibility to the modern medical facilities dramatically increased physically, economically, and emotionally while critical problems such as the lack of enough doctors per population and treatments without informed consent persist.

The emerging context of local healing practices in everyday social lives

In Reragi, the current youth in her twenties is mostly the last generation of children who were born at home by the attendance of traditional midwives. They grew up taking both biomedicine and traditional remedies in their childhood and now face their life stage to get married and have children. For those new mothers, it is the matter of course of women to seek the help and support from the health clinics, drugstores, families, and healers in the neighborhood to reduce pains and ease sickness during the maternity.

Further, with the increased literacy and school participation rates (BPS KLT 2018a: 159-160), for many of those who have or expect to have children today in rural Lombok, the practical mainstay of knowledge and livelihood has always been based on public education and national citizenship. The so-called traditional lifestyles operating on *adat* traditional customs, its conflict against the modern institutions and their ideologies, and the process of marginalization belong to the past stories of grandparents and ancestors.

In such recent context, young generations in their twenties find access and familiarity in both home remedies and biomedicine. As they newly come to the life stage of building a new home and become a mother, their experiences of vulnerability show specific differences from that of the older generations. Such tendencies are particularly evident in the two generations' narratives and practices of postpartum cares in which the new grandmothers are extremely concerned about

their birthing daughters' postpartum bleeding while the new mothers do not share their humoral understanding of postnatal recovery. While some suspecting views toward biomedicine remain in the communities of rural Lombok, including the local rumors that the use of birth control pills could induce infertility among women, birthing mothers as well as people in Reragi, in general, depend heavily on nearby medical professionals with various health concerns.

(2) Two generations of women in the shift of birth settings

The different experiences of postpartum recovery among new mothers and grandmothers

As mentioned earlier, clinic and hospital birth became common in East Lombok only recently, in the 2000s. Almost three decades after the first trained midwives and nurses arrived and promoted biomedical interventions of childbirth, the region of rural Lombok has two generations of women who experienced the shift of birth settings from homes to the clinics and hospitals. In such situations, young women in their twenties acquire the cares from the older family women, whose health concerns for their birthing daughters could differ from the youth's perceptions of their birthing bodies.

One instance in which such generation gap distinctively appeared was the experiences of postnatal recovery and the perspectives about the sense of vulnerability of the postpartum bodies. As we have observed in the daily interactions and conversations between new mothers and grandmothers in Chapter 5 - Section 6, the older generation of women remember and make self-reference to their own experiences of vulnerability and pains after birth when they try to care for their

birthing daughters. The new grandmothers share the humoral understandings in which they consider the blood of the postpartum bleeding as the afterbirth (*dadang*) and fear its regurgitation.

The older generation's humoral understandings of the postpartum bodies directly link to their experiences of the uterus pains, dizziness, and headache after childbirth as well as the various behavioral restrictions they acquired to prevent these symptoms. The postpartum self-care of the older generations included the constant sit-sleep, the long-term use of the birthing belt (*sabok beranak*), and the careful avoidance of risky postures such as reclining on the bed, bending the upper part of the body and lowering the head that could induce the regurgitation of the postpartum blood.

These behaviors correspond to the oral report of Ibu Hale as depicted in Chapter 2 - Section 4. As the first female nurse originated from Reragi, Ibu Hale attended home birth directed by traditional midwife-healers, and she observed the maternal health problems in the late 1990s and the early 2000s. As Ibu Hale puts, in those times 'it took a very long time for postpartum women to recover and they were afraid to walk because there were vaginal wounds not having been treated properly.'

As now they newly become grandmothers, the older generations of women are eager to take care of their birthing daughters. As we have seen in the case of Inaq Nir and Inaq Inure, new grandmothers concern about their daughters' health to a great extent and bother themselves prepare for the birthing belts soon after daughter's marriage, hold rituals of its tassel-cutting, and give helping hands for the new mothers to wear the belt every day (see **Figure 5.8**).

On the other hand, the new generation of birthing experiences their postpartum recovery in very different situations. As seen in Chapter 2 - Section 3, their bodies are under health control that follows standardized procedures of stitching and postnatal mobilization at clinics or hospitals on the day of childbirth. As we have also seen in the cases of Ani, Ibu Air, and Inaq Patik, the new mothers do not find themselves in dire need of sit-sleep, rest, postural attention, and the long-term use of the birthing belt. Cesarean section is not rare, and in such cases, new mothers would not have an opportunity to wear the birthing belts. Overall, we can observe that these new mothers acquire the cares and advice from their mothers with intentions of maintaining harmonious family lives rather than for solely medicinal purposes.

The older generations and particularly the mothers of the birthing women tend to regard it as obligations of pregnant women and new mothers to take care of themselves by following the 'parents' words' in addition to that they follow medical procedures of the maternity cares and childbirth process. For those new grandmothers and other people around, it is also vital that they engage in support of the birthing mothers. In that context, it is often just not enough for them to give 'parents' words' of advice, consolation, or frustrations to their daughters and wives. They need to work through it by extending themselves to the body of the women, be it by giving the food to fulfill their pregnancy cravings or by giving the birthing belts to support the abdomen of postpartum women.

The succession and the continuity of the healing practices in daily family lives

The older generation's health concerns for their birthing daughters is evident not only regarding postpartum recovery but also throughout the long processes of

pregnancy and childbirth. As we have seen Chapter 4 and Chapter 5, the pregnant women and their 'babies,' as well as the new mothers and their infants, live with higher risks of illnesses and harms as they attract the attention of the spirits that favor attacking them and the affectionate dead persons that miss and often beckon them.

The number of rituals and treatments exemplifies various ways in which the older family members take central roles to enact the inherited maternal cares. These include when they host events of celebration and healing for the newlywed as well as for pregnant mothers and pregnant fathers, transmit the knowledge of ancestral taboos for pregnant mothers and pregnant fathers, and give the more practical and constant support for the young couples by substituting for the house chores of cooking and washing during their pregnancy sickness).

Conversely, for new mothers, various kinds of ancestral notions and successive cares they acquire through the processes of pregnancy, childbirth, and postnatal are deeply embedded in everyday lives at home and in the neighborhood. As we will see in the next two sections, such quotidian context of maternity care is the dimension where people in Reragi strive to build and share the communal experiences of maternity in the otherwise medicalized procedures of childbirth.

3. The Holistic Understandings of the Mother-Child Relationships

(1) Coming into existence

The bodies of mothers and children

In this section, I explore the core questions about the existential statuses of children and their connectedness to the body of mothers in pregnancy, birth, and postnatal.

How pregnant women and people around them acknowledge the conception? How the embryo/fetal development are understood? When, and how, unborn children come to be regarded as a living thing or as a human being? How are the boundaries of the mother and the child drawn, blurred or crossed?

In answering these questions, this section explores Reragi women's narratives related to the matter, including the local healers who give massage easing the abdominal pains of to pregnant women and securing the postpartum recovery of birthing mothers.

The statuses of the unborn and the beginnings of parental statuses

As we have seen in the explanations from Inaq Naca, the massage therapist, the processes of pregnancy is understood with several particular and distinct stages of conception, the beginning of the life of the child, the condition of the unborn's becoming a human, and the moment of being born.

In her description, Inaq Naca puts the baby (*bebeak*) as a subject as early as the moment of fertilization when the 'female person's egg (*telo dengan nina*)' and the 'male person's liquid (*aik dengan mama*)' becomes united (*besopok*). That is also the time point when she parallelly attributes a parental status to the pregnant woman as being a 'pregnant mother (*Inaq ebon*)' who has 'not felt anything yet.'

Inaq Naca puts that the baby is still liquid (*aik*) or blood (*darak*) for the first two months, and it becomes flesh (*dageng*) in the third month, both in the absence of life (*nyawa*). The pregnant mother and her husband, or 'pregnant father (*Amaq ebon*)' could begin mourning sickness and food cravings around this time.

However, as we have observed in the case of Mamiq Lifa and Kakak Amu, in the realm of everyday lives, social statuses of men and women change from the

'newlywed (*penganten*)' to the 'pregnant father (*Amaq ebon*)' and 'pregnant mother (*Inaq ebon*)' only after the woman confirms the conception by using pregnancy test. That is also often the time point when either or both of the husband and the wife show the symptoms of pregnancy sickness and food cravings.

As soon as the beginning of the parental statuses, older family members typically start to expect the 'pregnant mothers' to follow the local food taboos and behavioral restrictions to protect themselves against potential harms, as shown in the cases of Ais, Kakak Amu, and Ani.

The parental obligations for the survival of the unborn

Some among many food taboos include the 'strong drink (*minuman keras*) ' such as carbonated drinks and the 'hot food (*makanan panas*)' such as durians whose bubbles and heat could destroy the embryo or the fetus leading to miscarriage. The other food taboos include the octopus and squids that could entangle the umbilical cord in the womb causing difficult birth or stillbirth.

The behavioral restrictions include the avoidance or limiting of riding motorcycles and bicycles or in the early period of pregnancy. The fear is that the pregnant mother could fall (*jatuh*) and thus the baby could 'fall together' (*milu jatuh*) with the mother, causing miscarriage. Pregnant women in Reragi are also expected to follow the curfew during the sunset hours (*sendikala*) to avoid the risks of being attacked by *bakeq* spirits that could 'burn' the child resulting in stillbirth. Pregnant women are also supposed not to carry heavy things nor wear jeans because or the 'baby's house (*balen bebeak*),' or the womb (In., *rahim*), cannot endure the pressures of the weight or tightness, also leading to pregnancy loss.

Although unexamined in the case study of this paper, there are also other numerous restrictions and obligations of pregnant women. For instance, pregnant women are urged to take a shower with running or stream water if they hear the news of maternal death so that the misfortune does not infect them.

The obligations of cares and protection often involve people around the pregnant women, including the taboos of hair-cutting of pregnant fathers as well as the moral actions to help to ease pregnancy sickness and to fulfill the food cravings of both women and men (but mostly women).

Feeling the animated presence of the baby

According to Inaq Naca, the baby carries life in the fourth month, and the pregnant mother feels it from the movement (*begerak*), including the heartbeat, throbbing, and quickening. For the healer, the movement signifies that the baby a living thing but not yet a human being. As she puts, the movement itself is the sign that the unborn wants to become a human and thus the parents had better pray well as the movements increase from the fourth and the fifth month of pregnancy.

The interview results with 50 village women show similar tendencies in Reragi where women address the fetuses as a living thing as they recognize the active presence of those by feeling the throbbing, the heartbeat, throbbing, and quickening of the unborn.

The comments of the majority among 50 women illustrated their experiences of the start of throbbing and quickening as the time point when they knew that the baby began to have the life. There are minor viewpoints in which individual women see that the baby as being alive from the day of conception, and conversely that the

baby's life begins only on the day of birth. Besides, two women declined to introspect by saying that they do not know.

Also, while many draws on the perception of the throbbing and the heartbeat as their bodily experiences, three women address the occasion of receiving stethoscope or ultrasound from midwives and doctors in earlier months. Such instances of the medical intervention of visual or auditory aid are still minor. However, these show the significant new variation of the sensory experiences for the local women to acknowledge the presence of life in the womb as clients of health services alone with the medical professionals or together with their attendants, who are often their husband or other family members.

Overall, the interview results demonstrate the mostly empirical understandings of the beginning of new life during pregnancy. While there is a particular local tendency of addressing the first moments of the felt, heard, or seen movements as the sign of the beginning of the unborn's life, the time points and the ways of acknowledging those differ from a person to another. Also, the comments of the minority also suggest that the matter of the beginning of life does not require an agreement or general standard to share.

Most explicitly, the ways to understand the matter of the beginning of the life of the fetus remains in the domain of personal insights and experiences and not confined to the local healers' explanations nor bothered by Muslim leaders' viewpoints on the matter regarding the controversy over induced abortion.

(2) The beginnings of the human personhood

The bodily maturity as the parameter of the statuses the unborn

In regards to the problem of whether the unborn is a human or not, the most common views were that the unborn is a human being (*manusia*) when all the body parts exist entirely in the seventh month of pregnancy. Women in Reragi describe the body of the baby not in processual terms regarding development but in conditional terms concerning whether 'already (*wah*)' or 'still, not yet (*masi, endek man*)' matured, corresponding to the present-tense depiction given by the local healers.

According to the local healers, the seventh month of pregnancy is when the unborn becomes a human. The baby is mature (*toak*) with all the body parts and thus ready to be born. On the other hand, she considers that the children become immature and soft again in the eighth month as thus often unhealthy if born. Inaq Naca puts that children are born in nine months and ten days, as written in the Quran, while some are born later in the tenth or the 11th month. In cases of longer pregnancy as well, she considers the odd number of 11 months and the even number of ten months as the times when the babies are mature and immature respectively.

While people in Reragi generally consider the usual length of pregnancy as being approximately nine months, they often do not count earlier birth incidents as premature birth (In., *prematur*) as long as the newborn children survive. As one woman puts, some children can be born in the seventh month because the baby is already a human and only happen to be born earlier than others. The babies are already 'mature (*toak*)' in this context, and do not correspond with the local notion of 'premature birth (*beranak odak*)' that often connotes the incidents of stillbirth or infant death concerning the softness or the incompleteness of the body parts.

The burial practices in cases of pregnancy loss and infant death also imply the ways people see and distinguish the status of children concerning the body. As it was in either case of Ais or Nana, if a miscarriage happens later when the sex of the child is known, usually the baby is usually named and buried like an adult, meaning that the attendants give the prayer during the burial and the following first, third, fifth, and seventh nights.

However, as seen in both women's episodes, people do not announce funeral ceremonies in public in case of pregnancy loss like those are in case of death of adults. That is both because small children do not have any sins and thus their souls do not need constant prayers to be lifted to the heaven as they and because those children are not acquainted socially with people around. The distinction and omission of funeral rites in pregnancy loss and infant mortality thus reflect that the statuses of embryos, fetuses, stillborn children and infants varyingly reflect the body.

(3) The holistic understandings of the mother-child relationships

Feeding the unborn

In the interview results, we have also seen the clear assertion and the shared understandings among women in Reragi that pregnancy sickness and cravings called *ngidam* derive from the unborn. In this context, *ngidam* refers to the various changes that happen to the body of pregnant women and their male partners but mostly women, including nausea and vomiting, appetite changes and high sensitivity toward odors, noise, and things they touch, but most especially the food cravings.

Both women and men in the village acknowledge the moral obligation to care for the symptoms of pregnancy sickness and food cravings to fulfill the need and

desires of the unborn. One man's episode of seeking the items desired by pregnant women shows the pervasive commonality of virtues fulfilling the food cravings as he sought oranges in the middle of the night and could obtain an immediate agreement and generosity from a stranger to provide the items for pregnancy cravings.

While they remember the rationale of the 'baby's cravings (*ngidam bebeak*)' by referring to older generations that the newborn child would be slobbering unless they bring the food immediately, people often embrace and realize the necessity to fulfill the pregnancy cravings in more practical manners. Pregnant women and people around them make sense of the food cravings as a message of the demand from unborn children most explicitly when the women experience the often unexpected, unfamiliar, random, and unrestrained emotions and desires along the transformative processes of pregnancy.

Inaq Nir's episode of her cravings for the leftovers of people's feasts communicate the incident dramatically, saying that she realized that 'it was the baby that wanted to eat' when she was craving even though she was not hungry. The given specificity, diversity, and strangeness of the food craved among women in the village as well as fewer episodes of the particularly 'strange cravings (*ngidam aneh*)' such as the coconuts from the graveyard also convey that the unborn have desires, preferences, and tastes for the food demanded by pregnant women.

The transmission of food and emotions between mothers and children

The local interpretations of pregnancy sickness and food cravings demonstrate the three broad aspects of the mother-child relationships with which Reragi people work.

First, in the context of actually going through pregnancy sickness, appetite changes, and other diverse transformative experiences, people find that unborn

babies inside the womb have the ability to *rasa* (feel, taste). They encounter such moments of realization without being bound to the range of statuses of the babies being a 'chunk of liquid,' 'blood,' or 'flesh' in the absence of life, or as the living thing that wants to be a human, or as the complete human being.

Second, for people in Reragi, birthing mothers and their children have permeable bodies and emotions that synchronize via food. The pregnant women's cravings and intake of food and the consequential nourishment of children via the umbilical cord shape the material processes in which the mother and people around communicate and interact with the child with the food as a medium of exchange. Reragi people's perceptions of such permeable qualities of the birthing bodies also appear in the local food restrictions mentioned previously, where the food qualities physically affect the safety of the unborn.

Finally, the awareness of the food and emotional transmission between mothers and children also entails the sense that they belong to each other as they share a part of the body. In everyday lives of pregnant women, Nana describes while going through pregnancy loss twice that the unborn always 'joins mother (*milu inaq*)' for doing everything like sleeping and singing and that the baby cannot feel alone yet. In a rather particular context of lecturing a child, the inseparability between parents and children is appreciated by both men and women when they call their children as 'a part of my body (*bagian awakku*)' and 'my urine (*penekku*).'

Those empirical understandings of the synchronization and permeable connectedness of feelings between mothers and children via material substance demonstrate a holistic dynamics of the mother-child relationship (**Figure 6.1**).

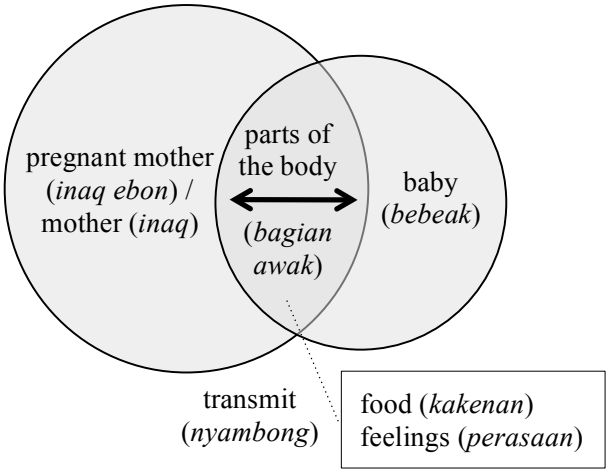

Figure 6.1 The holistic model of the mother-child relationship. The mother and the child belong to each other and influences each other in both ways in pregnancy and after that, as they share the parts of the body (Illustration by author).

In the holistic model of relationships, the mother and the child in pregnancy belongs to each other and influence each other in both ways as they share the parts of the body through the transmission of the food and feelings.

The dynamics of interaction and belonging shown here illustrate the local perspectives of mother-child relationships in Reragi that directly counters the modern medical conventions of the container model that neatly separates the pregnant mother and the fetus physically as a container and content and ethically as two individuals that is seen in the container model (see **Figure 1.2**).

Further, such multi-directional interaction continues after the umbilical cord is cut at birth, as we have seen in the narrative of breastfeeding and weaning. Women in Reragi often acknowledge that they can feel what their children feel, including when the child wants breast milk. Vice versa, they try to be emotionally prepared at times of breastfeeding to prevent their negative feelings from entering the

body of children and making them feel uneasy as we have seen in the case of Inaq Tip.

As we will discuss in the final section, such holistic understandings of the mother-child relationships forming through feeding persist through the local healing practices surrounding pregnancy, childbirth, and postnatal. Importantly, this embodying aspect of maternity shows greater significance today as it encourages people to sustain their recognition of the birthing bodies in the relationship with the body of others, material things, and the invisible beings in the otherwise medicalized birth settings.

4. Bonding as a Dimension of Being

(1) Embracing the beginnings of life as the beginnings of relationships

Embodying the baby with care

People in Reragi constantly engage in the various rituals and treatments of pregnancy, childbirth, and postnatal in the village social lives. In the context of the quotidian, such performance is fundamentally important for the villagers in order to nourish the baby materially and emotionally. The villagers perceive mothers and children in pregnancy and after that as being in direct connections and synchronization to each other. Such perspectives most explicitly appear as the pregnant women and people around concern for the sickness, food cravings, and strange feelings experienced both by pregnant women and their husbands but mostly women.

In Reragi people's communal effort to nourish the child with care, the mother-child bond forms the long, dynamic processes of social interaction where the

baby is gradually embodied with food as well as emotions that the food transmits. In this respect, the local people acknowledge and form the mother-child bond as an internalized dimension of the baby's existence itself. Such appreciation directly counters the notion of the maternal bond as an attachment between two individuals.

Being vulnerable in a relationship with the surroundings

Significantly, the holistic understandings of the mother-child relations acknowledge and entangle the existence of mothers and children in the broader assemblage of persons and things. The assemblage composes the world of 'onion skins (*kulit bawang*),' where various beings including the unseen, ancestors, potent materials, and agentive competence of people co-habit while continually affecting each other.

The harms and hardships in the multi-dimensional world could come to newlywed couples as infertility or the lack of fortunes to conceive a child, to pregnant mothers and pregnant fathers as a difficult birth of the first child that needs to open the path to the outer world. The family members, therefore, work to perform bathing rituals for the man and woman to wish and help for them to ask for the God's blessings and secure the first child's birth, gather prayers from others.

When children show 'sudden (*selun-selun*)' symptoms of those of unknown origins or other conditions such as 'fussy (*nyelek*)' with constant and frequent bursts of cry, people also make guesses about the risk contacts with various agentive beings. Such tendencies appear in the case of *ketemuq* (illness of meeting the dead) of Yom and the case of *pedam adik* (illness of being affected by a younger sibling) of Kia. Thus, those whom infants begin to have relationships encompass the multiple dimensions of the world, including *bakeq* spirits, the dead persons, potent things, and the unborn children, requiring particular methods of defense and healing.

The local midwife-healers and massage therapists treat women in the late period of pregnancy to ease the abdominal pain by listening and talking to them, giving massage on the body, and 'moving the baby' in the right position. The healers also give massage for new mothers to restore the broken vessels and stimulate postpartum recovery. New grandmothers, or the mothers of new mothers, also try to assist their daughters in postpartum recovery by recommending them to wear the birthing belts and also to be careful about the postures and 'everything' to prevent the backward flow of 'afterbirth (*dadang*).'

As such, people in Reragi share and work with their concerns for the vulnerability, health and the safety of mothers and children during pregnancy, childbirth, and postnatal as they find these mothers and children as being present in the world of 'onion skin' where both harms and healing can permeate through the body. As we will see in the next sub-section, it is precisely such context of everyday cares that add an important dimension to the lived realities of pains and losses surrounding maternity in the otherwise medicalized birth settings.

(2) Being the body and relating the world the way 'it could be'

New mothers' ambivalence toward cares and concerns of new grandmothers

As we have seen previously, it is essential for everyday social lives of people in Reragi to perform various rituals and treatments concerning the health and the safety of mothers and children. In this sub-section, I point out that the young generation's ambivalence toward the older generation's cares and concerns for them.

As we have seen earlier in Chapter 5, Nana and Ais, both of who experienced pregnancy loss, express the tremendous weight of loss as they find themselves

bereaved of their babies. Whether being buried as a remain of human body or a chunk of blood that has had 'not become yet (*endek man jari*)' to live, the existence lost to Nana and Ais is their babies who shared the body with them, tasted food with them, and felt with them during the period of pregnancy.

In the bereavement with their beloved babies, what both women and their family members found as comforting was not the concluding remarks from medical professionals that attempt to determine the cause of loss as seen in Nana's case where a nurse told her that her 'uterus was too weak.' Instead, what Nana and Ais needed was the alternative angles to see the loss not the way 'it is' but the way 'it could be.'

For instance, when she expresses herself in the bereavement, Ais communicates that she is not blessed yet and Allah has not trusted her yet as the ways to make sense why the baby had to be deprived of her although the baby had been healthy according to the obstetrician. At the same time, such fatalistic remarks are not conclusive in its own right.

Ais also refers to 'people's words' that it could have been because of the attacks from *bakeq* spirit, which Ais had not been bothered in advance to the incident of stillbirth. In the context of the interview, what Ais was referring here as the source of claim about spirits' attack was that mother-in-law (who is widowed and thus the only parent-in-law of Ais), although she intentionally blurred it by saying 'people here' to avoid pointing her out by name.

Ais takes an ambivalent, hesitant attitude toward the claim of her mother-in-law and the neighbors about the *bakeq* attack, by saying that '(I) believe here, not there, both, yes, I don't know!.' In remarking that it 'could have been' because of

bakeq, Ais not only considers her possible contact with the unseen but also reflects on her attitude that she was fussy (*nyelek*), disobedient toward her mother-in-law during pregnancy, not listening to her, and often breaking the pregnancy curfew.

Ais' ambivalence toward the cares and concerns of the older generation for her vulnerability as a birthing mother is echoed by many other young women's narratives of their experiences of maternity.

As we have seen in the case of Ani, a hospital nurse in her late twenties, Ani denies the validity of local pregnancy food taboos and her mother-in-law's accusation on her for breaking the taboos and for inducing difficult birth of her first child. At the same time, Ani also assertively sought massage therapies from traditional specialists who possess healing competence to reduce the abdominal pains during pregnancy. When I asked Ani whether she trusted in the ancestral interpretations of illnesses and healing, Ani frankly answered 'sometimes yes, sometimes no.'

As we will see in the final sub-section, such ambivalence the young generation expresses toward their parents' cares and concerns is especially meaningful in the recent context of medicalized birth settings.

(3) Enriching birth and the bond with indeterminacy

The social significance of the local cares in the medicalized birth settings

As we have seen previously, in the recent context of medicalized birth settings, local midwifery, and traditional healing are primarily deprived of its institutional authority by biomedical institutions, and as the child delivery processes are separated from homes to the exclusive domain of clinical settings. The systematic arrangement of

health control also marginalized potent materials such as the birthing belts.

Nonetheless, the healers' knowledge retains a part of the conventional knowledge about pregnancy mechanism in Reragi that continues regardless of the institutional disempowerment of local healers in child delivery and the changes of birth settings. Women's episodes of receiving infertility care and contraception from the local midwife-healers and massage therapists suggest that healers and their clients share the understandings of the mechanism of pregnancy.

One of the most apparent notions shared between healers and non-specialist women found in the cases was the local 'afterbirth (*dadang*)' that the healers and the new grandmothers claimed to affect women's health during the postpartum bleeding. The women's episodes about their practices in the past childbirth such as avoiding to move around and twist the body during the postpartum bleeding phase correspond with the local situations in the 1990s that the first female nurse that was born in Reragi depicted. What she witnessed was, according to the nurse, the ignorance of traditional midwives that delayed or lacked the treatment of the postpartum body and of the patients that prevented her to stitch the wound, as we have seen in Chapter 2.

In contrast to those new grandmothers, the younger generations do not find the physical and humoral necessity to wear the birthing belt for up to one year and to be 'careful about everything' as they live everyday life in the postpartum recovery process. In the present clinical scenes, families of the birthing mothers prepare and use the belts as childbirth essentials. To the medical professionals, and perhaps to the new mothers as well, the birthing belts might appear as a mere, apparent piece of cloth that physically supports the postpartum abdomen.

Nonetheless, for young women as well as for older generations in Reragi, it is essential to participate in various daily treatments and ritual activities surrounding pregnancy, childbirth, and postnatal. Why?

The narratives of young mothers show that their decisions of following 'parents' words' are made not necessarily on their approval or disapproval of therapeutic efficacy for certain rites. Instead, as I pointed out in this chapter, such ritual performances and daily solicitude are necessary because babies' coming into existence entails the processes of nourishment - the processes of feeding that requires people's conscious effort to care for the baby through the care for the birthing mothers.

Simultaneously, we can observe that the local rituals and treatments of pregnancy, childbirth, and postnatal are increasingly significant in the recent context of medicalized birth settings precisely because those inherited maternal cares allow women to be aware of their birthing bodies and its relationship to the world the way 'it could be.' As it is clear in Nana's case of pregnancy loss where medical professional told her that her uterus was weak, but instead she joined her mother in understanding that 'maybe the baby did not want to live with us,' the indeterminacy and ambiguity of the local solicitude enrich an abundance of possible nuances. Such aspects of local care practices undoubtedly help people cope with various pains of birthing and strive to lead the trajectories of their lives in a meaningful way.

Thus, the social significance of the local rituals and treatments of pregnancy, childbirth, and postnatal is amplifying despite, or perhaps because of, the institutional peripheralization of the '*cara lek* (old ways)' of care and the penetration of modern medical objectification of maternal bodies. Conversely, in the emerging

context of medicalized birth settings, what those communal cares deal with is the vast realm of vulnerability, sorrow, and grief that the local medical practices are unable to reach out yet.

In the context of daily lives, new mothers take in the ancestral notions of illnesses and healing as they try to maintain harmonious relationships with new grandmothers and to the world surrounding them but preferably not until their autonomy yields. In the middle of medicalized birth settings where women's bodies are often objectified, that flexible and resilient aspect of the quotidian amplifies its social significance of enriching the ground on which people make empathetic effort to build communal experiences of birthing by extending the self to the body of others.

• 7 •

Conclusion

Based on my ethnographic fieldwork, this paper aimed to illuminate the Sasak women's perspectives of bonding in pregnancy, childbirth and postnatal and the social significance of the healing practices in the shifting birth settings in Lombok.

The case study was primarily concerned with the following three questions. First, after the dramatic shift of birth settings from traditional midwifery to modern medicine, in what kind of context do Reragi women acquire the local healing practices? Second, how do pregnant women, postpartum women, and people surrounding them understand the processes of birthing and bonding in regards to the mother-child relationships? Finally, why do they continue turning to the ancestral notions of illnesses and healing, and how do they strive to engage in the local maternal and infant cares in the emerging context of medicalization of childbirth?

Drawing on the Lombok women's particular voices about their experiences of maternity, I argue that people in Reragi village perform the local rituals and treatments of pregnancy, childbirth, and postnatal as the fundamentally essential empathetic effort to nourish the baby materially as well as emotionally. In such respect of cares in everyday family lives, the mother-child bond forms as a dimension of the existence of a mother and a child in the gradual becoming of their partly shared bodies. Such appreciation directly counters the modern medical view of bonding that presupposes separate individuals to be attached to one another.

As we have seen, in Lombok, the holistic understandings of the mother-child bond persist through the birthing mothers' awareness of being the permeable body in

daily activities, especially at times of pregnancy sickness, food cravings, and breastfeeding. The sense of fluid continuity and connectedness with the child can arise and strengthen regardless of whether the unborn can count as a person or not.

Even if the unborn still cannot be regarded as a living thing or as a human being, people in Reragi consider that the unborn can feel what the pregnant feels, including joy, sorrow, and taste. Whether it exists as life and whether it is human or not, the unborn may desire specific food and may be contented or discontented by the taste of the food that its mother eat. According to the villagers, those who breastfeed can tell when their babies desire milk and infants may share the feelings of fear that transmit from their mothers via breast milk.

In such holistic understandings of the relationships between mothers and children, feeding the baby is equivalent to the embodiment of the mother-child bond. Significantly, the mother-child bonding is the open, inclusive, dynamic process of interaction in that people around pregnant and birthing mothers should involve themselves. When mothers and children share the food, bodies, and emotions, it is mandatory for family members to take care of the bodies and emotions of pregnant and postpartum women in order to secure the survival and the healthy growth of their children.

Conversely, for those family members, particularly new fathers and new grandmothers of the children, it is often just not enough to give advice and consolation. They need to work through it by physically taking part in the long processes of feeding the baby with care as they pursue food and satisfying the pregnancy cravings as well as by substituting house chores of pregnant and postpartum women. Such daily activities and ritual acts as the physical means of

nourishing the baby have been increasingly valuable for Lombok families, who are situated in the medicalized birth settings where the scientific worldviews and the ideas of modern nuclear family are increasingly pervasive.

In the marginalized domains of the quotidian, people in Lombok engage in the local healing practices and daily cares for the survival and the nourishment of the baby. Simultaneously, the new generation of birthing mothers strives to cultivate the ground on which they share a part of the body with the baby, belong to each other, and relate to the world not the way 'it is' but the way 'it could be.' It is essential for women in Reragi to turn to the ancestral notions of illnesses and healing precisely because it amplifies the choice of meanings that they need to cope with the pains and losses of birthing.

This paper, therefore, proposes that further anthropological approaches to childbirth are to gain much from paying close attention to the long-term daily activities in pregnancy, childbirth, and postnatal in contemporary birth settings.

Despite, or perhaps given, the impact of modern medicalization that powerfully segregates childbirth from jammed homes to delivery rooms and fix mothers and children as two separate individuals, the young and older generations in in Lombok find the ancestral notions of birthing and bonding as their necessary and helpful resources to live with the body and relate to the world as a continuous human existence. In their empathetic effort of bringing babies into being, people in Lombok embrace the beginnings of life as the beginnings of relationships that they desire to join with their vulnerability and strength.

References

Appadurai, A.

1996. *Modernity at Large: Cultural Dimensions of Globalization*. Minneapolis: University of Minnesota Press.

Badan Pusat Statistik Kabupaten Lombok Timur (BPS KLT).

2018a. *Kabupaten Lombok Timur Dalam Angka 2018* (East Lombok Regency in Figures 2018). Electronic document, <https://lomboktimurkab.bps.go.id/publication/2018/08/16/8b4701edcb6750999424f0b2/kabupaten-lombok-timur-dalam-angka-2018.html> Accessed 18 September 2018.

Badan Pusat Statistik Kabupaten Lombok Timur (BPS KLT).

2018b. *Luas Panen Sayur-sayuran Menurut Kecamatan di Kabupaten Lombok Timur Tahun 2014* (Harvesting Area of Vegetables by Sub-District in East Lombok Regency in 2014). Electronic document, <https://lomboktimurkab.bps.go.id/dynamictable/2016/01/07/29/luas-panen-sayur-sayuran-menurut-kecamatan-di-kabupaten-lombok-timur-tahun-2014.html> Accessed 18 September 2018.

Badan Pusat Statistik Kabupaten Lombok Timur (BPS KLT).

2018c. *Kecamatan Dalam Angka 2017* (Sub-district in Figures). Unpublished electronic document.

Badan Pusat Statistik Nusa Tenggara Barat (BPS NTB).

2016. *Jumlah Penduduk dan Rasio Jenis Kelamin Menurut Kabupaten/Kota 2014* (Number of Population and Sex Ratio By Regency / City 2014). Electronic document, <http://ntb.bps.go.id/linkTabelStatis/view/id/154> Accessed 8 January, 2016.

Badan Pusat Statistik Nusa Tenggara Barat (BPS NTB).

2018a. *Jumlah Curah Hujan Menurut Bulan di Mataram, Sumbawa Besar, dan Bima Provinsi NTB, 2012-2016.* (Number of Rainfall by Month in Mataram, Sumbawa Besar, and Bima Nusa tenggara Barat Province, 2012-2016). Electronic document, <

https://ntb.bps.go.id/dynamictable/2016/07/20/19/jumlah-curah-hujan-menurut-bulan-di-mataram-sumbawa-besar-dan-bima-provinsi-ntb-2012---2016.html> Accessed 18 September 2018.

Badan Pusat Statistik Nusa Tenggara Barat (BPS NTB).

2018b. *Persentase Penduduk Menurut Kabupaten/Kota dan Agama yang Dianut di Provinsi Nusa Tenggara Barat 2016* (Percentage of Population by Regency / Municipality and Religions in Nusa Tenggara Barat Province 2016). Electronic document, <https://ntb.bps.go.id/statictable/2017/11/15/189/persentase-penduduk-menurut-kabupaten-kota-dan-agama-yang-dianut-di-provinsi-nusa-tenggara-barat-2016.html> Accessed 18 September 2018.

Badan Pusat Statistik Nusa Tenggara Barat (BPS NTB).

2018c. *Indikator Makro Triwulan 1 -2018* (Macro Indicator Quarter 1- 2018). Electronic document, < https://ntb.bps.go.id/backend/images/INDIKATOR-MAKRO-TW1-2018-ind.jpg> Accessed 18 September 2018.

Badan Pusat Statistik Nusa Tenggara Barat (BPS NTB).

2018d. *Luas Panen Tanaman Sayuran Menurut Kabupaten/Kota dan Jenis Sayuran di Provinsi Nusa Tenggara Barat, 2015* (Area of Vegetable Crop Harvesting by Regency / City and Vegetable Type in West Nusa Tenggara Province, 2015). Electronic document, < https://ntb.bps.go.id/dynamictable/2016/08/24/50/luas-panen-tanaman-sayuran-menurut-kabupaten-kota-dan-jenis-sayuran-di-provinsi-nusa-tenggara-barat-2015.html> Accessed 18 September 2018.

Badan Pusat Statistik Nusa Tenggara Barat (BPS NTB).

2018e. *Wisatawan Mancanegara* (Foreign Tourists). Electronic document, <https://ntb.bps.go.id/backend/images/WISMAN-DES-2017-02-ind.jpg> Accessed 18 September 2018.

Bennett, L-R.

2001. Single women's experiences of premarital pregnancy and induced abortion in Lombok, Eastern Indonesia. *Reproductive Health Matters* 9(17): 37-43. DOI: 10.1016/S0968-8080(01)90006-0

Bennett, L-R.

2005. *Women, Islam and Modernity: Single Women, Sexuality and Reproductive Health in Contemporary Indonesia*. London & New York: Routledge Curzon.

Bennett, L-R.

2014. Early marriage, adolescent motherhood and reproductive rights for young Sasak mothers in Lombok, Eastern Indonesia. *Wacana, Journal of the Humanities of Indonesia* 15: 20-42.

Bennett, L-R.

2015a. Young Sasak mothers – "tidak manja lagi": transitioning from single daughter to young married mother in Lombok, Eastern Indonesia. In K. Robinson (ed.), *Youth Identities and Social Transformations in Modern Indonesia*. Leiden: KLTIV/Brill, pp. 238-261.

Bennett, L-R.

2015b. Sexual morality and the silencing of sexual health within Indonesian infertility care, In L-R. Bennett & S.G. Davies (eds.), *Sex And Sexualities in Contemporary Indonesia: Sexual Politics, Health, Diversity and Representations*. London & New York: Routledge, pp. 148-166.

Bennett L-R. & S-G. Davies (eds.)

2015. *Sex And Sexualities in Contemporary Indonesia: Sexual Politics, Health, Diversity and Representations*. London & New York: Routledge.

Bennett, L-R.

2016. Indigenous healing knowledge and infertility in Indonesia: learning about cultural safety from Sasak midwives. *Medical Anthropology*, DOI: 10.1080/01459740.2016.1142990

Bulloch, H-C.

2016. Fetal personhood in the Christian Philippines: the view from a Visayan island. *Philippine Studies: Historical and Ethnographic Viewpoints* 64-2: 195-222.

Cederroth, S.

1981. *The Spell of The Ancestors and the Power of Mekkah: A Sasak Community of Lombok*. Goeteborg: Acta Universitatis Gothoburgensis. [Gothenburg Studies in Social Anthropology 3.]

Cederroth, S.

1999. *A Sacred Cloth Religion? Ceremonies of the Big Feast Among the Wetu Telu Sasak (Lombok, Indonesia)*. Copenhagen: NIAS Reports, No. 10 (revised edition).

Csordas, T-J.

1990. Embodiment as a paradigm in anthropology. *Ethos* 18: 5-47.

Csordas, T-J.

1994. *Embodiment and Experience: The Existential Ground of Culture and Self*. Cambridge, UK: Cambridge University Press.

Desjailais, R.

1992. *Body and Emotion: The Aesthetics of Illness and Healing in the Nepal Himalayas*. Philadelphia: University of Pennsylvania Press.

Douglas, M.

1978 [1970]. *Natural Symbols*. New York: Praeger.

Duden, B.

1993. *Disembodying Women: Perspectives on Pregnancy and the Unborn*. Translated by Lee Hoinacki. Cambridge MA: Harvard University Press.

Ecklund, J-L.

1977. Sasak cultural change, ritual change, and the use of ritualized language. *Indonesia* 24: 1-25.

Fadly, M-A.

2008. *Islam Lokal: Akulturasi Islam di Bumi Sasak* (Local Islam: Acculturation of Islam in Sasak Society). Lombok: Staiiq Press.

Fahrurrozi.

2018. Tuan guru and social change in Lombok, Indonesia. *Indonesia and the Malay World* 46(135): 117-134. DOI: 10.1080/13639811.2018.1452487

Grace, W-J.

1996. Healers and modern health services: antenatal, birthing and postpartum care in rural East Lombok, Indonesia. In P-L. Rice and L. Manderson (eds.) *Maternity and Reproductive Health in Asian Societies*. Amsterdam: Harwood Academic Publishers, pp. 145-167.

Haridas, S-A. et al.

1980. Lombok: conquest, colonization and underdevelopment, 1870-1940. In S-A. Haridas, S. Anand, P. Drake, J-D. Legge, J-A-C. Mackie, W. Gungwu and A. Reid (eds.) *Asian Studies Association of Australia: Southeast Asia Publications Series* 5. Singapore: Heinemann Educational Books (Asia), pp. 1-15.

Hay, C.

1999. Dying mothers: maternal mortality in rural Indonesia. *Medical Anthropology* 18(3): 243–79.

Hay, C.

2001. *Remembering to Live: Illness at The Intersection of Anxiety and Knowledge in Rural Indonesia*. Ann Arbor: The University of Michigan Press.

Hay, C.

2005. Women standing between life and death: fate, agency, and the healers of Lombok. In L. Parker (ed.), *The Agency of Women in Asia*. Singapore: Marshall Cavendish, pp. 26-61.

Hay, C.

2009. Anxiety, remembering, and agency: biocultural insights for understanding Sasaks' responses to illness. *Ethos* 37(1): 1-31. DOI: 10.1111/j.1548-1352.2009.01029.x

Haywood, P. and N-P. Harahap.

2009. Health facilities at the district level in Indonesia. *Australia and New Zealand Health Policy 2009* 6(13): 1-13. DOI:10.1186/1743-8462-6-13

Hunter, C.

1996a. *Sasak Identity and the Reconstitution of Health: Medical Pluralism in a Lombok Village*. PhD thesis, University of Newcastle.

Hunter, C.

1996b. Women as good citizens: maternal and child health in a Sasak village. In P-L. Rice and L. Manderson (eds.) *Maternity and Reproductive Health in Asian Societies*. Amsterdam: Harwood Academic Publishers, pp. 295-328.

Hunter, C.

2001. Sorcery and science as competing models of explanation in a Sasak village. In L. Connor and G. Samuel (eds.) *Healing powers and modernity:*

traditional medicine, shamanism and science in Asian societies. Westport CT: Bergin & Garvey, pp. 152-70.

Hunter, C.

2002. Embracing modernity: transformations in Sasak confinement practices. In S. Rozario and G. Samuel (eds.), *The Daughters of Hariti: Childbirth and Female Healers in South and Southeast Asia*. London: Routledge, pp. 279-97.

Kantor Desa

2014 *Gambaran Umum Lokasi Penelitian* (General Description of the Study Area). Unpublished manuscript of survey data collection, Kantor Desa (Village Office).

Kantor Desa

2018. *Daftar Sumber Daya Manusia* (List of Human Resource). Unpublished document of survey data collection, Kantor Desa (Village Office).

Kingma, E.

2015. Better understanding the metaphysics of pregnancy (BUMP): organisms, identity, personhood and persistence. *ERC Starting Grant 2015 Research Proposal (Part B2)*. Electronic document, <http://www.southampton.ac.uk/assets/imported/transforms/content-block/UsefulDownloads_Download/E13065820B804133816196D2A525E89B /Kingma%20BUMP%20ERC_StG_2015%20B2FINAL.pdf>, Accessed 28 September 2018.

Kingma, E.

2018. Lady parts: the metaphysics of pregnancy. *Royal Institute of Philosophy Supplement* 82: 165-187. DOI:10.1017/S1358246118000115.

Kipp, R-S. and Rodgers, S.

1987. Introduction. In R-S. Kipp and S. Rodgers (eds.) *Indonesian Religions in Transition*. Tucson: University of Arizona Press, pp. 1-31.

Krulfeld, R.

1972. Sasak. In F-M. Lebar (ed.) *Indonesia, Andaman Islands, and Madagascar: Ethnic Groups of Insular Southeast Asia*, vol, 1. New Haven: Human Relations Area Files Press, pp. 65-69.

Kumar, D.

2005. Introduction: the politics of culture and medicine. In J.S. Alter (ed.), *Asian Medicine and Globalization*. Philadelphia: Pennsylvania Press, pp. 1-20.

Laderman, C.

1983. *Wives and Midwives: Childbirth and Nutrition in Rural Malaysia*. Berkeley: University of California Press.

Marriott, M.

1976. Hindu transactions: diversity without dualism. In B. Kapferer (ed.), *Transactions and Meaning: Directions in the Anthropology of Exchange and Symbolic Behavior*. Philadelphia: Institute for the Study of Human Issues.

Merleau-Ponty, M.

1970. *Phenomenology of Perception*. London: Routledge & Kegan Paul.

Miller, D.

2008. *The Comfort of Things*. Cambridge, UK: Polity Press.

Mol, A.

2003. *The Body Multiple: Ontology in Medical Practice*. Durham: Duke University Press.

Nababan, H., M. Hasan, T. Marthias, R. Dhital, A. Rahman, I. Anwar.

2017. Trends and inequalities in use of maternal health care services in Indonesia, 1986-2012. *International Journal of Women's Health* 2018(10):11-24. DOI: 10.2147/IJWH.S144828

National Collaborating Centre For Aboriginal Health (NCCAH).

2017. *Family Connections*. Electronic document, <http://www.nccah-ccnsa.ca/Publications/Lists/Publications/Attachments/91/family_connections_EN_web.pdf>, Accessed 9 December 2018.

Neaves, William.

2017. The status of the human embryo in various religions. *Development* 2017 (144): 2541-2543. DOI: 10.1242/dev.151886

Nilsson, J.

2005. *The Right to Reproductive Choice in Lombok, Indonesia: A Minor Field Study on National Implementation of International Human Rights Law*. MA thesis, Lund University.

Obeyesekere, C.

1963. Pregnancy cravings (dola-duka) in relation to social structure and personality in a Sinhalese village. *American Anthropologist* 65: 323-342.

Perrelli, J-Z., F-Z. Carla, A. Cantilino, and E-B. Sougey.

2014. Mother-child bonding assessment tools. *Revista paulista de pediatria : orgao oficial da Sociedade de Pediatria de Sao Paulo* 32(3): 257-265. DOI: 10.1590/0103-0582201432318.

Rice, P-L. and L. Manderson, eds.

1996. *Maternity and Reproductive Health in Asian Societies*. Amsterdam: Harwood Academic Publishers.

Samuel, G.

2002. Introduction: the daughters of Hariti today. In S. Rozario and G. Samuel (eds.) *The Daughters of Hariti: Childbirth and Female Healers in South and Southeast Asia*. London: Routledge, pp. 1-33.

Scheper-Hughes, N. and M-M. Lock.

1987. The mindful body: a prolegomenon to future work in medical anthropology. *Medical Anthropology* 1(1): 6-41.

Sidzinska, M.

2017. Not one, not two: toward an ontology of pregnancy. *Feminist Philosophy Quarterly* 3(4) Article 2: 1-22. DOI: 10.5206/fpq/2017.4.2

Suzuki, N.

1997. *Shussan no Rekishi Jinruigaku* (Historical Anthropology of Childbirth). Tokyo: Shinyosha.

Suzuki, N.

2005. Giving birth: changing concepts of procreation and children. In M. Tanaka and A. Nakatani (eds.) *Studying Anthropology by Exploring Gender*. Kyoto: Sekaishisosha, pp. 166-186.

Tanaka, M.

2005. Anthropology of gender and sexuality. In M. Tanaka and A. Nakatani (eds.) *Studying Anthropology by Exploring Gender*. Kyoto: Sekaishisosha, pp. 1-19.

Telle, K.

2000. Feeding the dead: reformulating Sasak mortuary practices. *Bijdragen tot de Taal-, Land- en Volkenkunde* 156(4): 771-805. DOI: https://doi.org/10.1163/22134379-90003829

Telle, K.

2002. The smell of death: theft, disgust, and ritual practice in Central Lombok. *Social Analysis* 46(3): 75-104.

Telle, K.

2007. Entangled biographies: rebuilding a Sasak house. *Ethnos* 72(2): 195-218.

Telle, K.

2009. Spirited places and ritual dynamics among Sasak Muslims on Lombok. *Anthropological Forum* 19(3): 289-306.

Telle, K.

2016. Ritual power: risk, rumours and religious pluralism on Lombok. *The Asia Pacific Journal of Anthropology* 17(5): 419-438. DOI: 10.1080/14442213.2016.1206614

Turner, T.

1994. Bodies and anti-bodies: flesh and fetish in contemporary social theory. In T-J. Csordas (ed.), *Embodiment and Experience: the Existential Ground of Culture and Self*. Cambridge, UK: Cambridge University Press, pp. 27-47.

United Nations Development Programme.

2018. Human Development Reports: Human Development Data (1990-2017). Electronic document, < http://hdr.undp.org/en/data> Accessed 19 September 2018.

Utsumi, R.

1994. Romboku Tou Sasakku Jin no Senshoku to Ishou (Textiles and Costumes of the Sasak People in Lombok Island). *Minzoku geijutsu (Ethnic arts)* 10: 125-40.

Van-Wolputte, S.

2004. Hang on to your self: of bodies, embodiment, and selves. *Annual Review of Anthropology* 33: 251-269.

Warnier, J-P.

2001. A praxeological approach to subjectivation in a material world. *Journal of Material Culture* 6(5): 5-24.

Weiss, G.

1999. *Body Images: Embodiment as Intercorporeality*. New York: Routledge.

Wouk, F.

1999. Sasak is different: a discourse perspective on voice. *Oceanic Linguistics* 38(1): 91-114. Electronic document, <http://www.jstor.org/stable/3623394> Accessed 15 December 2016.