



THROUGH THE BODY OF THE MIDWIFE: Ethos, Labor, and the Cultivation of Trust in Health Care in Yogyakarta, Indonesia

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Yanti shuffled out from the back room and placed the small aluminium toolkit on the table between us.¹ “It’s small, isn’t it?” she said with some concern in her voice. We both looked down at the UNICEF-branded toolkit. She continued: “Back then we thought that this was everything we needed. Now we think we need all of this.” Yanti chuckled and gracefully swept her arm in a wide circle, gesturing around her house and Independent Midwife Practice in a village about a two-hour drive from the city of Yogyakarta in Indonesia. The rooms around us were filled with overflowing filing cabinets tucked under tables and stacked on top of each other; folders full of paperwork filled shelves to the ceiling. The birthing room, emergency room, and pharmacy counter faced onto the courtyard just outside, as did several bedrooms, bathrooms, and a kitchen for women waiting to give birth. Yanti’s self-funded ambulance was parked in the driveway in the front yard, where she had removed a large section of the fence so that people could more easily access her house and Midwife Practice. We were sitting at her dining room table, drinking tea, eating steamed bananas, and talking about her days as part of Indonesia’s Village Midwife Program, when she was expected to meet all the health needs of her village with the rudimentary equipment included in the toolkit in front of us, supplemented with a good dose of her own tenacity. Now

the kit was empty and redundant, but Yanti had kept it as a souvenir to remind herself of her time as a brave young village midwife.

In this article I take up the life histories of midwives like Yanti to examine the critical problem of how interpersonal trust between a practitioner and their patient might translate or fail to translate into a deeper, more generalized trust in health care. In interviews with thirty midwives in the Special District of Yogyakarta in 2019 and early 2020, midwives like Yanti frequently gave evocative accounts of their experiences during the Village Midwife Program to illustrate how midwives, over about thirty years, came to be seen as a group of highly trusted health-care workers who play expanded and atypical roles in the health system and in their communities. Interviews with thirty-five women confirmed that midwives are widely perceived as trusted and trustworthy health-care workers. But village midwives like Yanti did much more than passively supply health services or even fill gaps in the health system. By being highly responsive to community needs and improvising diverse forms of health and social care in a resource-poor environment, they over time came to embody a distinctive ethos that continues to characterize the professional identities of midwives in Yogyakarta today. This ethos acts as an affective and ethical orientation binding midwives together, guiding their relationships to communities and the health system, and characterizing the culture of their practice. This ethos sees midwives take on high levels of personal risk and responsibility to remain alert and responsive to the evolving needs of their communities and continually improvise and expand their skills to compensate for shortcomings in the health system. As such they provide forms of health and social care that go well beyond their official role as maternal and reproductive health providers. At times this ethos takes the form of subtle gestures of reassurance and attuned forms of care, but it often involves high levels of risk-taking, physical exertion, and an ongoing vigilance concerning the social environment.

In addition to illustrating the prominent and atypical roles midwives play in the health system, this article examines how this ethos acts as the object of a substantive generalized trust in the culture of midwifery. Cultivating trust in health care marks no small feat, and the problem of trust and distrust is one faced by health-care workers around the world. While it is broadly acknowledged that trust constitutes an important component of just and effective health systems, much remains unknown about how interpersonal trust in a particular health-care worker does or does not translate into a generalized trust in cultures of medicine or health systems. While trust operates on interpersonal, epistemic, and sociopolitical levels (Marková, Linell, and Gillespie 2007), it is also a deeply corporeal experience,

“an embodiment of expectations that vulnerabilities will be protected rather than exploited” (Abelson, Miller, and Giacomini 2009, 64). Given the corporeal vulnerability and power imbalances often present in clinical encounters (Grimen 2009; Hamdy 2008; Høybye and Tjørnhøj-Thomsen 2014; Smith-Oka 2012), this focus on embodied vulnerabilities and the anticipation of either protection or neglect seems particularly pertinent for understanding (dis)trust in health care.

Indeed, many anthropologists have illustrated distrust in health care as a destabilizing and traumatic dynamic that amplifies suffering, reproduces health inequities, and undermines the efficacy of health care. Distrust in medicine may result from abuses of power by practitioners, especially if there is a lack of accountability (Dixon 2015; Sadler et al. 2016; Smith-Oka 2012). It can also result from the complicity of medical institutions in structures of racism, gender-based violence, political violence, and other dynamics of social oppression (Briggs and Mantini-Briggs 2003; Davis 2019; Varley 2010). However, distrust in medicine also develops indirectly, as a result of histories of colonization or social oppression that generate widespread distrust in the state, intensify embodied suffering, deepen health inequalities, and inform social imaginaries of medicine (Blair, More, and Tsai 2017; Briggs and Mantini-Briggs 2003; Hamdy 2008; Smith 2015). This raises the question of the extent to which health-care workers are able to counter these powerful social forces to create a more stable, generalized trust in health care.

Although trust in medicine is strongly mediated by perceptions of the state and the same sociopolitical histories that structure health inequities (Briggs and Mantini-Briggs 2003; Hamdy 2008; Smith 2015), in seeking to promote trust in health systems, the tendency has been to rely heavily on the goodwill of health-care workers, encouraging them to embody forms of speech and behavior that signal integrity and competency (Gilson 2003; Mechanic 1998). In addition to being an important site of interpersonal trust, clinical encounters often carry sociopolitical ramifications that shape perceptions of medical knowledges, cultures of medicine, health systems, or the state itself (Andaya 2010; Briggs and Mantini-Briggs 2003; Hamdy 2008), including processes mediated through the bodies of health-care workers (Cooper 2015). To understand how to deepen generalized trust, we need to examine how trust or distrust becomes directed toward a particular object—which might be limited to the individual health-care worker, but when more stable extends to medical knowledges or technologies, cultures of medicine, the health system, or a sociopolitical order anticipated to provide (or deny) care (Calnan and Rowe 2006; Gilson 2003; Mechanic 1998). The question then becomes: What kind of sociopolitical order is signified through a clinical encounter? And to what extent

can we expect health-care workers to resignify the place of health care within that sociopolitical order, to promote the embodied anticipation of protection that characterizes generalized trust in health care?

This article investigates these questions through ethnography that illuminates trust's tendency to morph between an affective, interpersonal dynamic and an embodied anticipation of protection within the broader sociopolitical realm of healthcare. I bring ethnographic perspectives to debates around trust in health care by showing how a group of health-care workers came to embody an ethos that over time became the object of a substantive generalized trust in a culture of medicine. This ethos was enacted by midwives gradually over several decades as they improvised, adapted, and responded to the demands of the broader institutional and social landscape, demonstrated their trustworthiness through strenuous labor, personal dedication and risk-taking, and slowly expanded the scope of their practice. Their life histories show trust's historical progression from distrust, to a transactional form of trust, to interpersonal trust, and then to a generalized trust in the ethos shared and continually enacted by midwives. They also show the fragility of trust, where trust remains contingent not only on the conduct of health-care workers but also on the ways that their actions are perceived to reflect particular sociopolitical orders that may or may not produce feelings of corporeal protection (Cooper 2015; Hamdy 2008; Smith 2015).

I focus on this positive case study of trust not to downplay ongoing problems in the health system but with the aim of contributing to efforts to build trusted and trustworthy health systems (Gilson 2003). My own motivation to research trust in health care comes from having previously carried out ethnographic research in the Indonesian province of Aceh, where health systems faced deep distrust as a result of protracted structural and political violence and widespread distrust of the state, and where I observed the highly distressing consequences of entrenched distrust in health care (Smith 2015). I have placed midwives at the center of this research to show how health systems are shaped by the health-care workers within them, who navigate an ever-shifting social field to respond to emerging challenges and care for communities. This becomes particularly apparent in resource-poor settings, where health-care workers need to be highly adaptive and innovative (Langwick 2008; Livingston 2012; Street 2011). Although health systems rely heavily on the resilience of health-care workers, the complex forms of labor they carry out remain problematically underrecognized, as does the highly feminized nature of the global health workforce (Birn 1999; WHO 2019a). In addition to offering recognition to midwives, this article shows the labor of health-care workers as a

generative force that shapes cultures of medicine and animates the social realm of health care.

After illustrating how the midwives of Yogyakarta came to embody an ethos and to cultivate trust in their culture of medicine, the article concludes by observing that although the depth of trust in midwives is quite remarkable, it is also contingent on midwives' continual efforts to sustain this ethos through extraordinary levels of vigilance, responsiveness, and improvised forms of care. This has both positive and negative effects for midwives and for the stability and depth of trust in health care. Taking up [Lucy Gilson's \(2003\)](#) observation that building trust-based health systems ought to be a high priority given that trusted health systems generate wide-reaching social benefits and can even work to deepen trust in the state itself, I conclude by arguing that the responsibility for generating trust in health-care ought to be more equitably shared between health-care workers and other health researchers and professionals, both to deepen institutional trust and to alleviate the burden currently placed on our health workforces.

MIDWIVES: The Backbone of the Indonesian Health System

One of the distinctive features of the Indonesian health system is the prominent and atypical role played by medically trained midwives. Although home births are discouraged, Indonesia has always had a policy of midwife-led care. Partly a consequence of Indonesia's shortage of doctors ([World Bank 2009](#)), midwives significantly outnumber doctors and are a visible presence within hospitals and community health centers (*puskesmas*), where they lead maternal, sexual, and reproductive health care, while also supporting other medical staff to triage patients and perform many other duties. Like Yanti, many midwives operate Independent Midwife Practices (*Bidan Praktek Mandiri*), where they perform even more diverse roles. Usually attached to the homes of midwives, Independent Midwife Practices are physically and socially embedded in neighborhoods and villages, forming important nodes in the health system. Midwife Practices serve as birthing centers and major providers of maternal, sexual, and reproductive health care ([Anindya et al. 2020](#), 14). Midwife Practices are also important points of primary health care through which midwives respond to accidents and emergencies, attempt to offer mental health care, stay vigilant to signs of domestic violence and abuse, promote vaccination and nutrition, and offer highly diverse forms of health care that go well beyond the typical role of midwives. While perceptions of the health system and maternal health experiences vary radically across Indonesia ([Alesich 2008](#); [Anindya et al. 2020](#); [Bennett 2017](#); [Hildebrand 2009](#); [Fitzpatrick 2022](#); [Munro, Katmo,](#)

and Wetipo 2022; Newland 2002), and while the health system is continually expanding (Witoelar and Utomo 2022), even in the relatively well-serviced area of Yogyakarta midwives carry out diverse and expanded forms of health care.

The expanded and atypical role that midwives play has its historical roots in the Village Midwife Program, a major public health program that saw tens of thousands of young women trained and posted to work in remote communities, usually as the only trained health practitioner. The Indonesian government established the Village Midwife Program in 1989 in response to persistently high levels of maternal mortality, which at the time stood at 400 deaths per 100,000 live births (Shankar et al. 2008, 1226). The program emerged as one of Indonesia's primary responses to the World Health Organization's Safe Motherhood Initiative, which saw an increased emphasis on the medical management of birth (AbouZahr 2003; Langwick 2012; Pigg 1997). In many countries, traditional birth attendants were prohibited from attending births, and norms around birthing changed rapidly in this global policy environment (Berry 2006; Jenkins 2003; Whittaker 2002). While Indonesia also suppressed traditional birth attendants during this era (Hildebrand 2009; Newland 2002), the Indonesian government departed from the global trend by building a large workforce of trained midwives, known as *bidan*. The Village Midwife Program aimed to place a skilled birth attendant in every village in the archipelago. Village midwives were to oversee maternal and child health, and sexual and reproductive health care, and they made major contributions to Indonesia's highly regarded family-planning program (Hildebrand 2009; Hull 2003). The government hoped that midwives would stay long term in their villages, become financially self-sufficient after their initial three-year contract and acting as a first point of care in a decentralized system of village-based health care (Hull et al. 1999).

Over the first seven years, some 54,000 women were trained and posted to remote villages, providing coverage to more than 96 percent of Indonesia's large and geographically dispersed population (Shankar et al. 2008, 1227). The minimum training required to be a licensed midwife has changed many times over the years, but in the original program village midwives were nurses with an additional year of midwifery training.² In principle, all village midwives were associated with a community health center (*puskesmas*). However, they were posted to remote villages some distance away from their affiliated health centers, so in practice village midwives frequently operated as the only trained health-care worker in their assigned villages.

Although the Village Midwife Program continues today, references to the program usually point to the 1990s, when the program was most active and formed an important element of the Indonesian government's efforts to expand primary health care. Although the program led to improvements in women's health, the reductions in maternal mortality were not as significant as anticipated (Hatt et al. 2007; Frankenberg and Thomas 2001; Shrestha 2010; Trisnantoro et al. 2010). While maternal mortality has steadily decreased over time, it remains elevated at 177 deaths per 100,000, and a range of complex social and health system factors continue to contribute to maternal deaths, which are inequitably distributed across provinces and social class (Hay 2015; Saraswati 2022; WHO 2019b, 101). While access to health care continues to improve, marked inequities and systemic complexities persist, affecting both midwives and those in their care (Anindya et al. 2020; Hay 2015; Wilopo et al. 2020).

Earlier accounts show that many village midwives struggled to adapt to life in their new villages. Terence Hull and colleagues describe that in the mid-1990s, midwives were "neither respected enough by the people to replace the *dukun* [traditional birth attendant], nor skilled enough to provide a level of primary health care comparable to that given by general practitioners" (Hull et al. 1999, 48). Ethnography from diverse parts of Indonesia during the 1990s suggest that midwives struggled to meet the conflicting expectations of communities and the government, while also often failing to meet their own desire to support the health of their communities (Alesich 2008; Hildebrand 2009, 190–93). This observation resonates with the recollections of midwives I interviewed in Yogyakarta in 2019. However, sometimes the social implications of development interventions unfold over a much longer period of time. The life histories below show how midwives in Yogyakarta eventually overcame these obstacles and over a period of decades went on to establish themselves as a group of highly respected health-care workers with significant social influence who create a sense of safety in health care (Bennett 2017). This trust was cultivated gradually, as midwives responded to their challenges and came to embody a distinctive ethos that continues to characterize their practice today.

THE MAKING OF A MIDWIFE: A Case Study

Siti, now in her early forties, runs an Independent Midwife Practice in a tobacco-farming village about forty-five minutes outside Yogyakarta. Like most Independent Midwife Practices, Siti's practice is a hybrid clinical-domestic space inside her family home. Siti and her family live upstairs, while the ground floor

serves as her practice. In addition to the consulting and birthing rooms, bedrooms, and kitchens for guests, Siti runs a small shop from her garage, stocked with basic pharmaceuticals. Siti is known as a friendly and skilled midwife, so that about twenty women from surrounding villages give birth in her practice every month. Siti lives with her three children and her husband Arief, who serves as the principal of the local primary school and doubles as the unofficial village ambulance driver. Siti adopted one of her children after the girl was left abandoned by an unmarried woman who fled late at night after giving birth.

Siti was born in Central Java in “a tiny village far in the mountains.” She said that when she was a child, her mother was often called to support the traditional birth attendant. Although Siti sometimes joined her mother at these births, she said that her mother didn’t encourage her to become a midwife, but that “the path of her life” drew her to midwifery:

Actually, I didn’t intend to become a midwife. When I was a girl, I wanted to be a dancer, I liked Javanese dance. I used to perform when I was in school, but the nursing college was run by Muhammadiyah. I had to wear a headscarf, I had to live in a dormitory, the rules were very strict, so I couldn’t practice. Later they thought it was pretentious for a nurse to dance. So, I thought, “Well, OK, I’ll follow the path of my life with a happy heart.” So, I became a midwife, which is humanitarian, right? Let alone in [the rural district I was posted to]. It was remote. It was poor.

As a young woman she moved alone to Yogyakarta to study nursing and midwifery. Soon after graduating, Siti was posted to a village about two hours outside of the city. She recalled her formative experiences as a midwife as follows: “After I had been working for just a year, the monetary crisis hit [1998]. [The district I was posted to] was always dry, always poor, the farmers had always struggled there because there is no water. So even in the community health center the patients were bathed with a washcloth, just one dip of water. We had to order the water to be sent up from Yogyakarta in jerry cans, and it was slow to arrive.” I asked her: “And who paid for the water, the government or the midwife herself?” She replied, surprised, “Oh, the midwife herself must pay, that’s clear. And the electricity too.” She continued:

So that’s what I encountered when I arrived in [this rural district] as a young girl. It was dry, the farmers were poor, there was the monetary crisis, and

there was a lot of suicide, lots of suicide. People would commit suicide if for instance they had a sickness that didn't heal. They felt despair to the point that they would hang themselves. So that's what I encountered as a young girl in the village. Before I arrived in the village, I was thinking about hygiene, what to do if there is a complicated birth. But when I arrived in the village and I saw the despair, the suicide, I realized that the responsibilities of midwives included all the needs of the people.

Observing suicide, poverty, and general suffering deepened Siti's sense of compassion and social responsibility.

As a young woman and an outsider to the community, Siti realized she would need to gain the trust of the people. Her key strategy was to participate in the everyday events of village life. Although part of her role meant convincing people to take up "modern" and hygienic health practices, Siti did not try to assert her authority, but rather carried herself as an ordinary woman "at the same level" as the people. Siti explained: "The main thing is that we give back to the people. We can't be indifferent, we have to be friendly, join in gatherings, the [Quranic] recitation gatherings that are organized by the village head, games and competitions. . . . Yes, [I felt] happy, so if anything happens, I always joined in the gatherings. [This meant that] asking for help [from villagers] was also easy. So, if something happened people would come to me, listen to me, help me."

In the beginning, her attempts to build trust proved essential to gain acceptance:

From when I was a girl, whenever I was in the village, I felt close [*akrab*] with the people. I only owned a television. I didn't have any wealth. I could go out and leave my door open, leave the key, go to the neighbors whenever I wanted. In the next village there was another village midwife from Jakarta, and she was egotistical. She went into Yogyakarta and left her house unlocked. All her appliances were stolen. Even her iron, her fan, her television, all of it. Everybody knew who stole it, but they wouldn't tell the police. That was because she wasn't close to the people. So even though I was in a poor, remote village, I adapted quickly, so that I would get used to it and I would be close to the people.

Siti observed the social environment, approached people with humility, and prioritized building trust with the community. She agreed to all requests if at all pos-

sible. She often worked in exchange for rice or bananas, or for nothing at all. She befriended the traditional birth attendant and never scolded anybody if they didn't follow the health practices she promoted. Instead, she waited for opportunities to gently demonstrate her skills without criticizing others or drawing attention to herself. Over time, Siti built confidence in her own ability and strengthened relationships with the community.

Siti moved back to the city after her three-year placement as a village midwife and became a hospital midwife. After Yogyakarta was struck by a major earthquake in 2006, she moved to her husband's village and opened her practice. But she still has strong connections with the village in which she worked as a village midwife: "Even now if there is a wedding or celebration I'm still invited to join. More than fifteen years later I'm still invited. They know my children, and my husband too. I still feel like I'm family with that village."

Siti still now often offers services for free, or finds ways to offer generosity, such as having her husband drive people into the city. Her practice is open from around 7 AM to 10 PM, or twenty-four hours if there is a birth or if somebody knocks on the door seeking urgent care. In the evenings, after her practice closes, Siti lies in bed and scans through the messages in the WhatsApp message group she organizes among women in her area, answering questions and offering health advice. She also reads the tone of the messages, to see if anybody seems at risk of post-natal depression, or to detect if any are having marriage problems, which could lead to domestic violence or emotional distress. I asked her about the long hours she works.

The point is that midwives have to work with sincerity. We have to struggle. It's good for us to struggle. The struggle is the way that we care for women. For instance, we can't focus on our own families. Sometimes our families feel neglected. We can't promise to spend time with our own children, this means our families also need to have sincerity. It's different from a doctor who practices from this time to this time. Midwives need to be ready twenty-four hours. We can't plan the time of a birth. We can't plan the time of an emergency. That means that midwives and their families must be sincere and enthusiastic. We need to stay healthy. Sometimes even if we are sick or in pain, we need to help others.

The dedication and responsiveness of midwives like Siti is not only admirable but has become productive of an ethos guiding the culture of midwifery and shaping the dynamics of trust in health care.

EMBODIED LABOR AND THE IMPROVISATION OF HEALTH CARE

The midwives of Yogyakarta have been remarkably successful in creating a trusted sociopolitical realm in which health encounters can occur, cultivating substantive levels of trust in the culture of midwifery. While they were originally mistrusted, midwives like Siti cultivated progressively deeper levels of trust by carrying out both subtle and strenuous forms of labor and by staying highly responsive to the shifting social and institutional landscape. These efforts gradually took the form of a recognizable ethos that shaped the culture of midwifery, became the object of trust, and promoted the embodied anticipation of protection that characterizes generalized trust in health care. Like Siti, many of the midwives I interviewed looked back on their capabilities as young women with some surprise, but most notably with pride. Since village midwives were sent alone into remote villages, they needed to improvise and dig deep into their own resilience, including by responding to accidents and attempting to prevent suicide. Building trust in the early days was strategic and necessary. This was a transactional form of trust sometimes described as “thin trust” (Nootboom 2006), and yet it was this transactional trust that allowed midwives to adapt to life in an unfamiliar setting, develop their skills, persuade people to accept their support, and establish the foundations for deeper forms of trust to emerge over time.

For some, the hardship they faced as freshly trained midwives felt challenging. One recalled the first birth she attended: “When I arrived, I could see there was fluid on the dirt floor. I thought: ‘Is this amniotic fluid, is this blood? It’s so hard to tell in the dark.’ There was no electricity back then, we only had a lantern. Every time the wind blew, the flame would flicker, and I prayed to God, ‘please don’t leave me alone in the dark with this woman’s life.’” No doubt, many midwives did not manage to adapt or feel a sense of satisfaction in their work, as captured by Vanessa Hildebrand (2009). But others recalled this period of their lives with exhilaration and pride.

Rini, for instance, now runs a clinic in a village about an hour outside of Yogyakarta. When I explained that I was researching trust in health care, she smiled and began talking enthusiastically about her experiences as a village midwife:

[The village I worked in] was in a mountainous area. It could only be accessed using a motorcycle or a bicycle at the time. And there was no midwife in the village where I lived. When I arrived, I was regarded as an angel. I mean people thought ‘Oh, there are capable midwives who can help! There is a midwife who can solve all our problems.’ What happened is, —you know I still remember until now, —the village where I worked was on the edge of a river. The river had no bridge. Well, the first thing I experienced when I arrived in the village was to be called to a birth in the village on the other side of the river. The village was in a different district but they had no midwife, so I had to help, right?

She sat forward on the edge of her seat, grabbing my knee: “The river had no bridge. So, what happened? I needed to walk across the river in the middle of the night. I grabbed my equipment, my village midwife kit, and a change of clothes, and carried it all on my head.” She elongated her back and gestured elegantly, as if picking up her midwife kit and placing it on the top of her head: “The people were shouting out ‘quickly, quickly she’s already in pain.’ I walked across the river in the middle of the night with everything in a bundle on my head. The water was up to my shoulders.” Rini reached her chin upwards, as if she were struggling to keep her face out of the water: “The current was strong, it was cold. Woah! I still remember it very clearly.”

Rini narrated her experience enthusiastically, smiling and shaking her head as she remembered how capable she was as a young woman. I asked about her responsibilities as a village midwife: “It wasn’t our [official] responsibility, because it’s not within our competency. But when I was there, the community assumed that ‘you have to be able to do anything, you have to be able to solve all of the problems that exist in this village.’ There is an injury. Yes, I’m there. Somebody fainted, I must be able to help. Anyway, if anything happened in the village, people ran straight to me.” I replied: “You must have learned a lot about health, right?”

Yes, from three years living in the village, I feel like I gained about ten years’ worth of education. Yes, it felt like ten years, because I was working twenty-four hours. It was also difficult because there were cultural particularities that were different from my [upbringing]. The problem was I was still very young, very young, but I was positioned as the person who was responsible for everything. That’s what was extraordinary in my opinion.

I continued: “And how did you feel back then, proud or scared, or . . . ?” “Proud, very proud,” she exclaimed, “because thanks to God, I was given my abilities by God, and I was given the opportunity to make the most of them, and thanks to God I was able to help people and I didn’t have many problems, so I think this was a big achievement. Even though other people don’t consider this an achievement, I think it’s an achievement, so I’m proud.”

Most of the midwives I interviewed in their forties and older had similar stories. Many counted on their fingers the multiple roles they carried out. Ratna recalled: “Somebody fell off the roof, lots of people fell off the roof. There was somebody who was electrocuted, somebody who drowned, people coming with fevers, with all kinds of illnesses, elderly people who were lonely and felt sick but really, they just needed somebody to talk to.” Similarly, Dewi described: “Yes, people had accidents, lots of accidents, motorcycle accidents, people cut themselves, once somebody fell out of a tree.” Siti explained: “Yes, of course, we had to do everything. If people had a fever, if people fell off the roof, once there was a guy who cut his leg from here, [she pointed to her foot] all the way up to here [pointing to her inner thigh]. There was blood everywhere and everybody was screaming . . . Yes, the point is we needed to accept everybody, whether it was in our competency or not.” Although all affirmed that it was their proud duty to respond to the needs of those around them, some also expressed how difficult this was as a young midwife with little or no support. Many used the phrase: “I was still a little girl [*gadis kecil*]!” while describing their experiences. One said: “It’s like the government said to us, oh, you can ride a motorcycle, why don’t you fly this aeroplane.”

While the decision to send young, freshly trained midwives into unfamiliar and remote areas seems to depart from gender norms since midwives were usually alone, unmarried, and with limited institutional support, this policy reflects an enduring tendency within Indonesian state-building to naturalize the unpaid labor of women and to then instrumentalize that labor within processes of state-sponsored development (Marcoes 2002; Newberry 2006; Suryakusuma 1988). During the Suharto era, such efforts focused on mobilizing “housewives” into large, women-based volunteer movements that implemented development agendas, including many health activities, and that played a major role in animating state-building (Newberry 2006). Although midwives are trained health care workers—and not volunteers—similar sensibilities also likely rationalized the high expectations placed on village midwives to carry out extensive forms of labor beyond their assigned roles. However, the mobilization of women’s labor is a common feature of health systems globally. The highly feminized nature of health workforces is rarely

made visible in academic or policy literature, and the unpaid labor of women within global health remains largely taken for granted and unrecognized (Birn 1999; WHO 2019a).

Nevertheless, my midwife interlocutors emphasized their pride in the contributions they made and continue to make to their communities. While there is a certainly an extraction of women's unpaid labor at work, it is analytically useful, and aligned with the sensibilities of my midwife interlocutors, to focus on how this labor gradually generated an ethos that orients midwives to their practice and stands as the object of trust in the culture of midwifery (Gilson 2003; Mechanic 1998). Former village midwives, many of whom later moved to the city, and the younger generation of midwives who work under their guidance, continue to share and recreate this ethos, even as the health system continues to grow and expand.

SUSTAINING THE ETHOS OF MIDWIFERY TODAY

Yogyakarta is no longer a sleepy town and has grown into a small but bustling city with traffic jams, air pollution, and shopping malls. Yogyakarta is a university town with a vibrant youth culture, set within an old Javanese city proud of its traditional arts, its sultanate, its pluralistic healing traditions, and its cultural codes of speech and conduct (Ferzacca 2001). Yogyakarta city has some of the best health infrastructure outside of Jakarta, with nine major hospitals, smaller specialized hospitals, decentralized emergency services, and, according to my interviews, "more than one thousand" Independent Midwife Practices. While Yogyakarta has a growing middle class, high levels of socio-economic inequality persists. Just beyond the ring road that forms the perimeter of the city, the urban atmosphere is quickly replaced by rice fields and mountains. The farming communities that Siti worked in still struggle to make ends meet. Many villages have distinctive identities as micro-communities. These days, most youth will leave to live in the city. Others stay and seek work on the tobacco farms, cigarette factories, or other factories that dot the rural landscape.

Although there are established health services, midwives in both rural and urban areas of Yogyakarta still hold strongly to their ethos. For instance, one of the district's senior midwives, Ida, was deeply moved when she heard a story of a young, unmarried university student who took her own life when she realized she was pregnant. Ida now goes door to door to the boarding houses of Yogyakarta: "I tell them—if a young woman becomes pregnant, don't shame her, don't scold her. Make sure you call me and I can talk to her. I can make sure she has the care she needs. Don't shame her to the point that she kills herself." Although this departs

somewhat from social norms, Ida makes it known that she welcomes unmarried pregnant women, fearing that they might hide their pregnancies and give birth alone, or worse yet die by suicide. Like Siti, Ida also adopted a child that was left abandoned at her practice. Despite her age and her own health problems, Ida dedicates herself to protecting the health of women in Yogyakarta, including by seeking to influence sensitive social issues such as suicide and the sexual health of young and unmarried people.

Like Ida, many described the vigilance they feel observing the lives of those around them, scanning for hidden health needs. For instance, Ayu explained: “When I’m out in the streets, wherever I am, I’m always looking around to see: ‘Is this woman happy, does she have enough money for food, does her husband come home late at night?’ I’m always looking to see if there is a problem that later might turn into a health problem.” Midwives still attend neighbourhood events “like ordinary women,” even as they take on extraordinary responsibilities. Like Siti, many midwives run WhatsApp message groups, allowing them to be on the lookout for potential problems.

Government agencies also call on midwives to carry out a broad range of activities. A senior midwife told me:

When there is a government program, there are always midwives involved, whatever it is. For example, it’s clear that [midwives will be involved in] any maternal and child health programs, health promotion, infectious diseases, non-communicable diseases [programs]. Then there is nutrition, family planning, and programs for schoolchildren. But actually, midwives can be involved in anything. For example, when they build a new housing project for the poor, they invite the midwives to open the building . . . and I agree. Because it’s always an opportunity to enter the community. We can enter people’s homes, and say, ‘stop smoking,’ ‘that toilet needs to be cleaned,’ ‘don’t warm up your motorcycle inside your house if your wife is pregnant.’ . . . We can look for signs of domestic violence, violence against children. These are opportunities to promote health and to become closer to the people.

I asked her whether she agreed that midwives should take on this broad range of responsibilities:

Yes, well it is our responsibility, because we are sworn-in healthcare workers. Even though legally it’s not our responsibility. But if we don’t help the people,

who will? . . . Once there was a situation where somebody was electrocuted. People called the midwife to come to help. And the midwife said: ‘Well, I can’t, that’s not my job, that’s the doctor’s job, it’s not my job call the doctor.’ And then the person died. The villagers wanted to burn down the midwife’s house, chase her out of the village. People came to her house with flaming torches, some carried machetes, other weapons. We are community officials, like it or not, we have to help, we have to do it. We can’t say: ‘Oh, it’s not my job, oh, it’s your job, oh, I can’t.’ We have to be ready to embrace all levels of society.

While this ethos is primarily generated through their ongoing expanded labor, senior midwives also socialize their junior colleagues into this ethos. For example, Siti told me: “Sometimes young women come to me, and they say they want to be a midwife because babies are cute, because it’s nice to help women. But they don’t want to work, they’re afraid of work. They say they’re tired, they want to go to meet their friends. I won’t accept it. You cannot become a midwife because babies are cute. You must only become a midwife because you’re ready to serve your community.” The Indonesian Midwives’ Association regularly holds gatherings at which senior midwives give speeches to their younger colleagues, emphasizing that midwives should be ready to work 24/7, stay alert to the needs of their communities, and look out for signs of domestic violence, hidden pregnancies, or women at risk of post-natal depression. Midwifery is demanding work for little pay, with junior midwives in private practices starting at the minimum wage of 2 million rupiah (USD 140) a month. “The same as a factory worker,” one junior midwife said to me with tears in her eyes. “But I’m proud,” she quickly added, “I’m proud to be a midwife.” Young midwives who do not share these values are directed to seek other paths in life.

RECOGNIZING THE FOUNDATIONS OF TRUST

While my research centered on the experiences of midwives themselves, I interviewed thirty-five women about their experiences interacting with health services, and found that many described midwives’ friendliness and sincerity, their integration into local communities as equals rather than elites, and their willingness to carry out extensive forms of labor around the clock as signs of their trustworthiness. As we saw in Siti’s account, the imperative to be friendly and calm, to accept and treat everybody, and to agree to requests whenever possible, was recognized as the foundation of trust. As Indah emphasized: “Anything that we

need, the midwife will give. If I want advice, if I'm feeling uncertain, I just talk to the midwife, and straight away, I feel calm again. Midwives are ready to help us, enthusiastic to help us, twenty-four hours."

Many interpreted midwives' strategy to situate themselves as ordinary women and part of the community as a sign of humility and integrity. This was particularly prevalent in villages, and among low-income women in the city, where the hierarchical nature of the health system felt pronounced. Fitri, described this as follows: "They live in our villages, they are our neighbors. I'm scared to ask a question if I'm at the community health center. The staff there are elites, I'm embarrassed to talk openly with them. If I'm with the midwife, I can be more comfortable, chat for a while, we know each other, I don't need to worry about being scared." Many recognized midwives' willingness to work well beyond their official duties to respond to community needs. Although this behaviour was expected and often taken for granted, participants frequently admired this dedication and generosity. As Atikah described:

Midwives are very friendly, very friendly, especially to poor people like me. We don't have to worry about paying. If we can give just a little bit [of money], yes, just a little bit [is enough]. If we can't give a little bit [of money] we can just give rice. Midwives are very friendly. Even my husband goes to the midwife to have his blood pressure checked because he's too lazy to wait at the community health center, and she is always happy to help.

In the instances where participants expressed a dislike for a particular midwife, it was because they did not adhere to the expected ethos. This is expressed through a narrative that holds that midwives in independent practice are friendly, while hospital or community health center midwives are fierce (*galak*). Since it is financially difficult for midwives to run their practices, a midwife might go out of business if they are seen to be fierce. Some midwives burn out or wish to spend more time with their own families, which might lead them to work in a hospital or community health center, which is also demanding but with better working conditions. In these institutional settings, however, it is more difficult for midwives to demonstrate their ethos. Many hospital midwives operate practices from their homes in the evenings, sometimes limited to contraception and reproductive health advice, to stay connected with their communities. However, the high expectations are also a reason why some midwives close their practices to work in hospitals, where they have a "shared responsibility" for the lives of the people in

their care. Hospital midwives enjoy better working conditions but enjoy a lower social status and sometimes experience less satisfaction, since midwives themselves are deeply invested in their ethos. While midwives have been remarkably successful in generating trust, they must remain vigilant and responsive to community needs to sustain this ethos, retain this trust, and to satisfy their own sense of duty. This means taking on high levels of risk and responsibility for little pay and only partial recognition, in return for good social standing and a rewarding career that many approach with deep dedication.

CONCLUSION

Health systems are one of the most intimate and vital manifestations of the state, and the task of understanding institutional trust in health care has important implications for improving health systems and for building trust in the state. Although trust in health care is mediated by a range of sociopolitical processes that shape the anticipation of either protection or neglect in a clinical encounter, the responsibility for building trust is frequently carried by health-care workers themselves. While this perception of trust as an interpersonal, affective dynamic no doubt promotes important forms of care, and while the midwives in my research certainly embraced this responsibility, in many cases the efforts of health-care workers do not suffice against the backdrop of long histories of sociopolitical oppression (Briggs and Mantini-Briggs 2003; Hamdy 2008; Smith 2015). In other cases, trust may remain limited to the interpersonal realm and fail to generate a more stable generalized trust in health care (Calnan and Sanford 2004). While trust is an affective and interpersonal experience involving the anticipation of corporeal safety and protection, to become more stable it needs to shift beyond the interpersonal realm, to situate health care in what is perceived as a legitimate sociopolitical realm that generates an anticipation of corporeal protection.

This article has offered ethnography to show what the cultivation of trust looks like in practice, in a resource-poor situation where health-care workers take on the responsibility for building trust in health care. In the present case, midwives successfully built not only interpersonal trust but also trust in the culture of medicine, since they gradually embodied a distinctive ethos that acted as the object of trust and successfully established midwifery practices as important and trusted nodes of the health system. The ethos enacted by midwives came to define their culture of medicine, stand as the object of trust, and create a trusted sociopolitical realm in which health encounters could occur. The cultivation of trust involved extensive and demanding forms of labor, high levels of risk-taking, and

the improvisation of forms of health care well beyond their field of training, in addition to gentle acts of kindness and empathy. Generalized trust requires an object. In this case, the object of trust is the ethos, continually generated and mediated through the bodily labor of midwives, whether they are smiling gently, swimming across flooded rivers, running to respond to accidents, or answering their door 24/7 to those in need.

However, even this relatively successful case study shows the precarious nature of trust in health care. While the efforts midwives have made to build trust are admirable and a source of pride for the midwives themselves, this cultivation of trust through strenuous and complex labor comes at a high cost to midwives, who work under demanding and poorly paid conditions with only partial recognition. It may also come at a cost to the health system, since health systems that rely heavily on the goodwill of health-care workers are also more vulnerable to the failings of health-care workers, and to fluctuations in levels of trust as its conditions change over time. Trust might be lost if a health-care worker cannot meet the high expectations placed on them, or if they do not manage to compensate for either institutional or broader sociopolitical shortcomings. If health-care workers abuse their power or act in ways that reproduce social oppression (Davis 2019; Smith-Oka 2012; Varley 2010), this can extend to a distrust of medicine more broadly. Trust can easily revert to an interpersonal dynamic of care confined only to an individual health-care worker, or even fail and lead to an active distrust of medicine more broadly.

To recognize the multidimensional labor of health-care workers means not only to support better labor rights, but also to see health systems as social institutions that rely heavily on health-care workers to establish institutional legitimacy and trust. While I completed my fieldwork in January 2020 in the early weeks of the COVID-19 pandemic, the demands placed on midwives intensified greatly during peak periods of the pandemic, to the point that even the deeply dedicated midwives I worked with were pushed to their limits (Hazfiarini et al. 2022; Smith 2020). As Gilson (2003) argues, the creation of a trust-based health system has wide-reaching social benefits not only because trust is essential for quality health care but also because health systems constitute important institutions for the establishment of political legitimacy and trust in the state itself, as well as for the creation of the broader values of mutual care and social responsibility. If our goal is to develop trust-based health systems, then should move beyond the tendency to rely heavily on health-care workers to build trust through their labor and willingness to take high levels of risk. Instead, we should recognize that the development

of trusted health systems requires an ongoing social and political process and share responsibility for the creation of trust in medicine more equitably across health-care workers, public health professionals, and health social scientists.

ABSTRACT

The question of how to build trust in health care is one that faces health-care workers and public health actors around the world. This article illustrates how midwives in Yogyakarta, Indonesia, have over time generated a distinctive ethos that characterizes the culture of their practice, and that stands as the object of a substantive generalized trust in midwives. In bringing attention to the multidimensional forms of labor carried out by health-care workers in a resource-poor setting, this article shows how cultures of medicine are generated and embodied by health-care workers in ways that mediate the dynamics of trust in health care. It offers a case study of the successful cultivation of trust in health care, while also reflecting on the problematic implications of the tendency to rely heavily on the labor of health-care workers for the development of trust-based health systems. [trust; health care; ethos; culture of medicine; midwives; Indonesia]

ABSTRAK

Bagaimana cara membangun kepercayaan terhadap layanan kesehatan merupakan masalah yang dihadapi petugas kesehatan dan profesional kesehatan masyarakat di seluruh dunia. Artikel ini menggambarkan bagaimana para bidan di Yogyakarta, Indonesia, telah membangun etos khas yang mencirikan budaya kebidanan, sehingga yang menjadi objek kepercayaan masyarakat terhadap bidan secara umum. Selain membahas pekerjaan multi-dimensi yang dilakukan oleh petugas layanan kesehatan di lingkungan dengan sumber daya yang terbatas, artikel ini menunjukkan bagaimana kebudayaan kedokteran dihasilkan dan diwujudkan oleh petugas layanan kesehatan dengan cara yang membentuk dinamika kepercayaan dalam layanan kesehatan. Artikel ini menawarkan studi kasus atas kesuksesan terwujudnya kepercayaan dalam layanan kesehatan, secara bersamaan juga memberikan refleksi terhadap implikasi bermasalah dari kecenderungan untuk sangat bergantung kepada tenaga kesehatan dalam pengembangan sistem kesehatan berbasis kepercayaan.

[kepercayaan, layanan kesehatan, etos, budaya kedokteran, bidan, Indonesia]

NOTES

Acknowledgments This research was funded by a Discovery Early Career Researcher Award (DECRA) from the Australian Research Council (DE180101214), with additional support from Macquarie University. I am deeply grateful to the Indonesian Midwives Association, especially Nunik Endang Sunarsih, Sutarti, Christina Pernetun Kismoyo, and all the midwives who participated in interviews and showed me kindness and hospitality. Sincere appreciation to Siswanto Wilopo and Amirah Wadhi at the Center for Reproductive Health at Gadjah Mada University for their collegial guidance, and to Atik Triratnawati, Gama Trioni, Dian Lestariningsih, Nefiani Puji Astuti, Rizka Rachmawati, and Linda Bennett for their generous assistance.

Rebekah Plueckhahn, Jane Palmer, and Annemarie Samuels offered insightful feedback on earlier drafts, and Vida Asrina Dhulst kindly edited the Indonesian abstract. Sincere thanks also to the three peer reviewers, and to the *Cultural Anthropology* editorial collective for their nuanced and supportive feedback.

1. All names used in this article are pseudonyms.
2. Shifting guidelines over the years have produced significant variation across midwives' levels of training. In 2020, the minimum requirement for licensed midwives was a three-year diploma from a specialized midwifery college, although some midwives are also nurses or hold other qualifications. New guidelines stipulate that by 2030 midwives will require a bachelor's degree to work independently.

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