

# Papuan Perspectives on Family Planning, Fertility and Birth Control



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Over a decade ago, anthropologist Leslie Butt (2001, 2005) documented indigenous resistance to the Indonesian state's family planning (or fertility control) agenda in the highlands of Papua Province. Butt's work showed the extremely political nature of indigenous perspectives on birth control, referred to as KB (*keluarga berencana*), and documented some of the experiences that led locals to assert that 'KB kills'. Indonesian fertility control practices were criticised by men and women who argued that birth control was supporting the state's genocidal intention of eliminating indigenous people, and because KB interfered with the cultural ideal of producing as many healthy descendants as possible (Butt 2001). Women described painful experiences with birth control implants that were inserted in the upper arm, where the device would often shift and become painful as they carried out strenuous gardening activities. Men expressed that KB would give both men and women the freedom to engage in extramarital affairs, challenging the norm of clan influence on marital and reproductive domains.

Family planning is coming back in style globally. John May, a demographer, blogged from the Center for Global Development in 2012:

After 20 years of neglect, family planning is back at the heart of the global development agenda. Thanks to the vision and courage of the Bill & Melinda Gates Foundation and the UK Department for International Development (DFID) to reposition this crucial issue, the July 11 Family Planning Summit in London is expected to raise pledges of approximately \$4 billion to provide family planning services to 120 million women over the next eight years. (May 2012)

Indonesia, where family planning efforts are said to have 'stagnated' (Kapoor 2014), is one of the 10 focus countries of the new Bill & Melinda Gates Foundation family planning initiative. Family planning activities promoting long-acting and permanent methods of contraception (LAPMs) are scheduled to begin in Papua Province in 2014 (AFP 2014a). As such, it is timely to ask how this revitalised family planning agenda might be received by Papuans, and consider whether Papuans have shifted their views and practices regarding state-run fertility control. In 2012, Kirana Pritasari, Director for Child Health at the Indonesian Ministry of Health, suggested that geography and infrastructure are the main barriers to maternal and newborn health in Papua and West Papua, referring to the continuing high rates of maternal and infant death in these provinces compared to the rest of Indonesia (Faizal 2012). There is no question that Papuans' use of family planning reflects access-related considerations, including cost, quality and availability (BKKBN et al. 2009), although these are not my main concerns in this paper. Rather, by discussing political, cultural, gendered and religious facets of family planning, this paper corrects the notion that 'access' in Papua can be primarily understood in terms of geography or infrastructure. More importantly, it points to ways that family planning agents might rethink their motives, modes and standards of intervention in local places.

This paper focuses on perspectives on fertility, family planning and birth control among Papuan men and women, mainly Dani from in and around the town of Wamena in the central highlands of Papua Province, and a group of coastal Papuans (originally



from Manokwari, Biak, Arfak and Sorong) in Manokwari, the capital of West Papua Province.<sup>1</sup> It draws on interviews conducted with over 100 Dani and other central highlands university students during 16 months of fieldwork in 2005–2006, and more recent interviews with approximately 60 nurses, health workers, HIV-positive mothers, young women and sex workers as part of a broader study on HIV/AIDS in Manokwari and Wamena. I also rely on observations and casual discussion during multiple trips to Tanah Papua from 2006 to 2013, and participant observation in public health clinics.

After describing the cultural context and health indicators that are relevant to the imminent resurgence of family planning in Papua, I explore the perspectives of indigenous youth, then consider conservative moral views that shape young peoples' engagements with family planning, and finally examine the ongoing political tensions surrounding family planning from the perspectives of Papuan health workers. My research reveals that while some aspects of the former 'KB kills' reaction have subsided and shifted, there remain important unanswered questions, and opportunities for dialogue, that define the ideological space of the family planning revival in Tanah Papua.

### The Global Family Planning Agenda in Indonesia

Indonesia has pledged to use the village-level public health apparatus to expand family planning throughout the country by 2014, 'especially in poorer regions, through the strengthening of all public and private clinic services and provision of preferable long-acting and permanent methods' (AFP 2014b). According to the World Health Organization, LAPMs include the intrauterine device and the progestogen implant, as well as male and female sterilisation. LAPMs are promoted on the grounds that women should have more choices available to them (WHO 2012). It is important to note that in Indonesia, only married women and men are legally entitled to access contraceptives. So far, pledges to expand family planning have not extended to greater changes in reproductive health, such as opening up contraceptive access

for unmarried youth or changing laws that specify that abortion must take place prior to the sixth week of pregnancy and is legal only under certain circumstances (Diarsvitri et al. 2011).<sup>2</sup>

In September 2014, Advance Family Planning, which describes itself as 'an evidence-based advocacy initiative' of the Bill & Melinda Gates Institute for Population and Reproductive Health with the Johns Hopkins Bloomberg School of Public Health, announced that its Indonesia activities will include districts in Papua Province. This seems to be the first concrete local expression of the revitalised interest in family planning among global health agencies and donors. The initiative, in which 'Participants will learn how to establish and operate working groups of district-level stakeholders committed to family planning issues and to create a draft family planning strategic plan for each district' (AFP 2014c), will be implemented through the various levels of the Indonesian National Population and Family Planning Board (BKKBN). Given that this flagship initiative emanates from Jakarta-based agencies and will be enacted through the state's bureaucratic apparatus in Papua, it appears to repeat top-down, external population control agendas that Papuans have resisted strongly in the past.<sup>3</sup>

Officials at the Ministry of Health continue to see the challenges of fertility control in Papua as primarily related to terrain, remoteness and infrastructure, rather than the approach of the global and national institutions that promote it. However, the view of Indonesian health authorities draws directly on the dominant global public health discourse that holds that 'uptake of modern contraception is constrained by limited access and weak service delivery' (Tsui et al. 2010, 152), with limited regard for cultural or other considerations, either local or national. Following Vincanne Adams and colleagues (2014, 180), this rendering of the notion and practice of 'uptake' reflects the tendency for global health to dismiss local specificities as 'variables that cannot be included in problem-solving ... because such differences would demand a host of responses that are unique and tailored to specific communities'. Indeed, it is important to reflect on the extent to which the new global family

planning agenda is based on assumptions such as a universal desire for modern contraception, a shared view of how many children are appropriate and at what temporal intervals, and that 'unintended' or 'unplanned' pregnancies do in fact result from lack of access to modern contraceptives (Koenig et al. 2006; Santelli et al. 2003).

The science that lies behind these public health operations typically reduces beliefs, experiences and local values to 'myths and misconceptions' about contraception (Meskele and Mekonnen 2014; WHO 2012). The research behind the new push for LAPMs among the poor draws strictly on 'globalizable metrics' (Adams et al. 2014, 181), and the need to provide generalisable research recommendations based on scientifically replicable methods that can be applied systematically and similarly in most countries, often to the exclusion of qualitative and contextualised understandings. The conclusions that Meskele and Mekonnen (2014), among others, come to about the 'broad acceptability' of LAPMs (WHO 2012) and the so-called fertility intentions of women and men cannot be assumed to accurately represent local realities. A number of scholars have argued that such a standardised approach does not allow for the diverse research needed to respond to public health problems (Bhutta 2002; Lambert 2006).

The case study of Papua raises questions about the continuing challenges that global family planning agendas, insofar as they reflect the mainstream principles of global health interventions and globalisable datasets, encounter in local contexts. Looking at Papuan reactions and understandings can help us to develop recommendations for how and why family planning might be leveraged, even in complex local contexts, to support the broader goals of improved sexual, maternal and reproductive health.

### Family Planning in Tanah Papua

Tanah Papua is culturally diverse and politically complex. Rich in natural resources, but with poverty levels that rank far above the Indonesian national average, development practices have struggled to come to terms with diversity, inequality and ongoing political tensions. Human

Development Index rankings place Papua Province last in the country, while West Papua Province sits at 29 of 33 provinces (Hadar 2013).

Cultural change in Tanah Papua relates to diverse local histories and different connections to global capitalism, especially extractive resource industries (Kirksey 2012; McKenna 2012; Timmer 2007). State, education and missionary influences on the coast began in the late 1800s, while in the mountainous interior, foreign missionaries and administrators did not make a permanent presence until the 1950s or later. A sweeping set of political changes came to locally organised cultural groups with the incorporation of what was then West Irian (formerly Netherlands New Guinea, part of the Dutch East Indies) into the Indonesian state in 1963. Indonesian control has been defined by an aggressive development agenda and state violence, especially via the entrenchment of security personnel, who are also involved in the resource sector. The politics of this incorporation were contested from the start, and indigenous groups continue to assert Papuans' right to self-determination, some violently, but most in peaceful ways. The Indonesian state views Papuan grievances as primarily related to poverty and underdevelopment rather than the political processes by which Indonesia controls Tanah Papua (Widjojo et al. 2008), or the failure of the government's 'special autonomy' policy, which has backfired to generate enhanced conflict and resentment (Bertrand 2014).

A major concern for many Papuans is the in-migration of Indonesians (Chauvel 2005). From the early days of incorporation, Indonesian migrants received financial and logistical concessions to help them build new lives as settlers in remote, rural and urban parts of Tanah Papua. The official transmigration program remains in effect, and Papua also attracts other migrants who are not part of this program. Tanah Papua ranks first among eastern Indonesian destinations where migrants can make a new life, occupy a better job, earn more money, or build business alliances. In-migration poses a challenge to indigenous economic and social systems, and is seen by many Papuans as an effort by the government to displace

them from their lands (Upton 2009). On the other hand, a degree of peace and order is maintained amid simmering ethnic tensions, and wealthier migrants provide different models of cultural and sometimes religious identities, perhaps even 'modern' personas, to which Papuans may aspire in spite of coexisting resentments (Braithwaite et al. 2010; Richards, in press). With increasing access to mobile phones and satellite television, Papuans are more connected than ever before to global media and popular Indonesian culture, and mobile within Indonesia and beyond (Slama and Munro, in press). In addition to these facets of social change, education and literacy levels are rising, and a critical mass of educated youth may represent the family planning acceptors or resisters of the future.

Family planning in Tanah Papua is thoroughly infused with the notion of modern progress and development. As in Indonesia more broadly, in Tanah Papua family planning starts with the Indonesian state, and has been institutionalised through various bureaucratic structures and invoked in the nationalist sentiments of development. As Bennett (2012) writes, 'Indonesian women have been expected not only to become mothers, but to control their maternal desires by limiting their family size to two children for the good of the nation'. Reproductive rights were of minimal concern until after 1998, Bennett notes. Rather, 'during the New Order regime, state policy treated women's health as synonymous with maternal health, and maternal health was conflated with the use of modern contraception' (Bennett 2012).

Leslie Butt adds, 'Indeed, the regulation of intimate domains was targeted as a necessary step in the successful control of population growth, itself the cornerstone of national development policy' (2005, 164). Reproductive and contraceptive choices make a statement about women's orientation to 'modernity' and 'development' (Dwyer 1999). In Papua, Indonesian migrants have played the role of so-called modern exemplars, including KB users and promoters, especially in remote and rural areas (Butt 2005). Family planning officers and the bureaucrats above them privilege conservative,

middle-class Indonesian values regarding sex and view Papuan sexual practices as 'free sex' (*seks bebas*). Sexuality and pregnancy have become categories, in addition to skin colour, racial features and cultural practices, through which Indonesians may denigrate or deem Papuans inferior.

Development, in-migration, Papuans' own mobility, and increasing connections to the rest of Indonesia and beyond foster changing values and practices in the domains of sexuality and the family. Researchers have found that, as in the rest of Indonesia, youth in Tanah Papua are having sex at a younger age than the previous generation (Butt et al. 2002; Diarsvitri et al. 2011). Marital practices are changing, as bride price norms are tested by or combined with other modes of legitimising a relationship, such as a church wedding or, for some youth, the birth of a child (Munro 2012). Varied traditional understandings of sexuality in Tanah Papua are meeting with starker religious and cultural value systems dominated by ideas such as chastity, honour and sin. These are not only religious moral values but the cultural values of the state which, for example, legislates that a pregnant high school student must leave school, promoting a culture of shame and secrecy (Bennett 2005a, 2005b). Cultural norms regarding premarital sex and pregnancy in Tanah Papua are diverse. In the highlands, there has been more emphasis on how to legitimise the pregnancy or how to maintain control over the clan's line and its interests, but this is tested in part due to the rising prominence of Indonesian perspectives that emphasise shame (Butt and Munro 2007). In urban, coastal areas such as Manokwari, discourses of virginity and chastity are more prevalent and longer standing (Hewat 2008). To the extent it is possible to generalise about shifting conditions, views of premarital pregnancy as a mortal sin and a moral crisis that can bring shame to an entire family are displacing views of premarital pregnancy as inappropriate but manageable.

Adolescent birth rates, or the number of babies born to women aged 15–19, ranges from 44 per 1000 female adolescents in Manokwari to 145 per 1000 female adolescents in Jayawijaya district, where Wamena is located (BPS 2012, 13).

In Jayawijaya district, 37 per cent of women aged 20–24 surveyed by the Indonesian Bureau of Statistics (*Badan Pusat Statistik*) had given birth before they turned 18 (BPS 2012, 13). Early marriage corresponds to adolescent birth rates. Thirty per cent of women surveyed by BPS in Manokwari were married before the age of 18 (BPS 2012, 24). In Jayawijaya, 47 per cent of women were married before the age of 18. Women who are married before the age of 18 tend to have more children than those who marry later in life. Pregnancy-related deaths are known to be a leading cause of mortality for both married and unmarried girls between the ages of 15 and 19, particularly among the youngest of this cohort.

Family planning usage among married women ranges from 16 per cent of women in Jayawijaya to 52 per cent of women in Manokwari (BPS 2013). In Papua Province, data collected by nurses suggests that 24.5 per cent of married women aged 15–49 years report using KB (BKKBN et al. 2009, 9). In West Papua Province, 37.5 per cent of married women aged 15–49 years report using KB, compared to a national contraceptive rate of 57.4 per cent (BKKBN et al. 2009, 9). For both the national and provincial rates, these coverage estimates are likely inflated because they include women who stated that they use condoms as a mode of birth control.

Use of contraceptives certainly relates to knowledge and awareness of contraceptives. On this point, studies present different conclusions about the level of knowledge Papuans have about KB, ranging from minimal knowledge and information (Butt et al. 2002) to ‘relatively high,’ according to the 2007 Indonesia Demographic and Health Survey, meaning that women surveyed knew of at least three methods (BKKBN et al. 2009). The 2012 Indonesian Demographic and Health Survey found that almost all of the unmarried youth surveyed had heard of at least one method of modern contraception (BPS et al. 2012). Information and awareness about KB will be essential in a revitalised family planning effort. However, information, education and communication are not sufficient to address or engage with Papuans’ views, practices and beliefs.

Ethnicity continues to be a factor in KB uptake, and in the utilisation of antenatal services. Government figures show that within West Papua Province, most KB acceptors live in the provincial capitals. These areas are also home to the most non-indigenous people, who in some cases make up the majority. Women’s engagement with antenatal care and delivery options varies according to education and ethnicity. Rural, uneducated, poorest women and those where the head of the household is Papuan are less likely to have their babies delivered by skilled personnel (BPS 2012, 16). Women who live in urban areas, who have higher education, who are non-Papuan and are wealthier tend to deliver in public or private health facilities (BPS 2012, 16).

Family planning is an important issue in Tanah Papua because maternal death and morbidity rates are extremely high, which speaks not only to birth spacing and number of births, but more broadly to antenatal care and primary health care access, including place of delivery and the availability of appropriate, desirable, delivery assistance. For Papua Province, maternal mortality is estimated at 362 per 100,000 live births compared to a national average of 220 per 100,000 live births (IPPA 2013). Moreover, of critical importance for exploring Papuan perceptions of family planning are the figures that affirm Papuans’ experiences of health disparity in relation to non-Papuans. A multiple indicator cluster survey (MICS, a UNICEF-developed survey program) conducted by the Bureau of Statistics in 2011 indicated an infant mortality rate of 79 per 1000 live births in Papuan-headed households compared to 21 per 1000 in non-Papuan households in Papua Province (BPS 2012, 9). In West Papua Province, the survey showed infant mortality rates of 70 per 1000 in Papuan-headed households and 21 per 1000 in non-Papuan headed households (BPS 2012, 9). The authors caution that these estimates may be unstable and cannot be used to derive population-level statistics, but these patterns are confirmed by other small-scale surveys (i.e. Peters 2012). In fact, household surveys based on individual reporting may more accurately capture infant mortality data in contexts where deaths are often not reported to the authorities.

At the same time, the family planning agenda in Tanah Papua must work with overstretched health systems and services. Despite increased funds to the provinces enabled by Special Autonomy laws of 2001, health services are still inaccessible and ineffective for many people (Butt 2013; Rees et al. 2008). All health services are further strained by the current HIV epidemic among Papuans (Butt, in press; Munro 2014b). Counselling in antenatal care, or in relation to HIV, has been shown to be inadequate, which tests a core assumption of the new family planning agenda, namely that counselling will take place in 'an environment free of coercion and in a way that ensures the client has sufficient knowledge about the full range of contraceptive options to make an informed choice of the method that optimally suits her needs' (Credé et al. 2012, 198).

In Tanah Papua, the government's vision for family planning still revolves around 'creating small, prosperous, happy families', but this vision has done little to replace the former motto, 'two children is enough', which still circulates widely (BKKBN et al. 2009, 30). In October 2013, the National Family Planning Agency announced that in Papua, 'The family planning program is not aimed at limiting the number of children, but rather at birth spacing and family prosperity'. This approach is said to be a specific response to the resistance of indigenous Papuans towards the family planning program (Metrovnews 2013). What, then, are some of the factors that shape Papuan responses to family planning?

### Education, Gender and Fertility Values among Youth

Demographers predict that as education levels rise among Papuans, especially girls and women, acceptance of family planning ought to be increasing, and fertility decreasing (Kim 2010; McNicoll 2011). The demographic transition in Indonesia is facilitated by social pressures. For example, young people are expected to delay marriage to undertake secondary education or tertiary training, which may take them into their mid-twenties (Robinson and Utomo 2003). Delaying marriage for educational attainment

creates an expectation that sexual activity will also be postponed well into adulthood. Premarital relationships are highly stigmatised, viewed as a violation of national cultural and religious norms, and may be punished by ostracism and shaming (Bennett 2001; Utomo and McDonald 2009). The nationwide call for young people to develop themselves into good quality human resources (*sumber daya manusia*) stands out as a form of moral regulation that promotes education and technical skills packaged with values of piety, patriotism, health and abstinence (Munro 2009, 2012). Premarital sex, perhaps especially among highly educated adults, is emerging as a practice that divides those who are seen to be contributing to national modernisation and population improvement from those who are not.

Research with highlands Dani university students living in North Sulawesi, a province of eastern Indonesia, showed tensions between the competing priorities of education, adulthood, marriage, and norms of young marriage and parenthood (Munro 2012). Young people's understandings of unintended pregnancy and, indeed, marriage strongly test global public health assumptions about fertility. Ika,<sup>4</sup> a 22-year-old woman whose two older cousins had recently had babies while at university, summed up the belief that students should refrain from sex, saying, 'Our parents send us to study, not to have sex'. Indeed, it was perhaps the biggest fear among parents who had sent a daughter away to study that she would *kawin* (get married, 'shack up', have sexual relations) and become pregnant, thus interrupting her studies perhaps indefinitely. As Ika and other students explained, relatives might withdraw financial support for a daughter who became sexually involved with men while studying. Still, relatives and other sponsors were not always consistent in financially supporting students in the first place, which reduced the impact of parents' threats. In most cases women continued to receive some support from home, indicating that relatives largely supported marriage and childbearing if it became a reality for their son or daughter.

Yet many other students argued that sexuality was an inevitable part of growing up and living

independently, regardless of education ambitions. Yuli, a 20-year-old female, stated, 'It is normal to have a girlfriend or boyfriend; it is just part of life.' Daniel, a 25-year-old male, said he doubted that local people followed moral advice about sex either, and commented, 'Around here it is the locals who are having promiscuous sex, just go down to the boardwalk and they are there every night'. Students thus questioned the feasibility of being abstinent adults, as well as the idea that sexuality was necessarily destructive to educational goals.

Descriptions of premarital sex frequently evoked the concept of marriage, as students argued that pregnancies were not casual mistakes caused by unrestrained desire, but were often part of established love relationships in which the participants felt ready to become parents. Minke, a female student who married a recent graduate and left university to be with her husband, explained premarital sex as follows:

Sometimes we use the term *cari anak* [literally, looking for a child] when people have sex, because we understand that sex causes pregnancy. If someone has sex, the woman might become pregnant, but if people are married [*sudah kawin*] then they will most likely make a child. They know this and can't deny it.

Premarital sex was also described as resulting from mutual desire, using the expression '*mau dengan mau*', literally 'want with want', but it was clear that pregnancy was an expected outcome of frequent sexual relations.

Pregnancy was most likely to become a problem if the mother was seen as changing sex partners frequently, or if one or both of the parents refused to take responsibility for the child. Regarding a baby born in North Sulawesi who was taken to Wamena to live with relatives, a number of students said things like, 'that child has many fathers', or 'that child belongs to many people', meaning that the child's mother was perceived to have had sex with different men before the baby was born. Pregnancy was never described as accidental because of the notion of mutual desire and the belief that many acts of intercourse are

needed to produce a pregnancy. Views of pregnancy as a necessary risk for couples having sex limited the significance of birth control, but birth control was not accessible to female students anyway, as is the case for unmarried women generally in Indonesia.

There was thus a strong positive discourse on fertility among students, reflecting the cultural significance of reproduction in constructions of adulthood, and the perceived appropriateness of pregnancy within the context of marriages that they formed out of love, on their own, rather than in the traditional highlands style of an arranged marriage formalised by the payment of bride price. Looking at how women reacted to premarital pregnancies further illustrates emerging understandings of fertility among educated youth.

### Premarital Pregnancies

Pregnancy was common among Dani university students in my research. Over half of the 26 women I interviewed were in overt relationships that they described in marital terms although they were not legally married nor had they been married according to highlands cultural practices. Some informants undoubtedly chose not to reveal relationships, or were not in a relationship at the time of the research but had been in previous relationships. Of the women who described themselves as married, nine had children and three were pregnant in 2006. Women's relationship status shaped how they felt about pregnancy. Those who had been in a relationship for a short time, or who were not certain about the paternity of the baby, described huge amounts of shame and typically left their studies and returned to the highlands, gave the baby to relatives to raise, or sought an unsafe abortion.

Women who considered themselves married, and who were planning on having an official ceremony and/or expected their partner to pay bride price at some point back home, expressed positive feelings about their pregnancy. These women were likely to invoke importance of educational and employment success. For instance, 24-year-old Anny graduated with a bachelor's degree in economics in 2006 and was seen taking

photographs around campus in her graduation gown after the ceremony with her one-year-old daughter Mei by her side. Her partner had graduated in 2005 and was employed as a teacher in Wamena. Anny said that with childcare help from her sister and female cousins who lived with her, she was able to graduate and would soon be returning home. Anny laughed at the idea that her parents might be disappointed: 'What do they have to worry about? My husband is a teacher, I have just graduated, and the baby and I are going home soon!'

Similarly, Lavinia, aged 25 years, said she got pregnant on purpose to strengthen her relationship with her husband. She pointed out that as a biology student she had learned more than most young people about sexual reproduction and her pregnancy was no accident. She described her experience of pregnancy:

People usually say, finish [studying] first, but I think you can do both. I have a husband, he helps me by sending money, I had a baby and I finished as well, I just got my degree. Some girls could be ashamed, but I say we are not in high school anymore. We are university students (*mahasiswa*). I am married, so why can't we have a baby? Even when I was pregnant I went out as usual. I went to campus and I went to the city, even though people stared at me. We planned to have this baby so that I would have the baby after he graduated and went back to Puncak [a district in the highlands], and so our relationship was clear. He takes responsibility.

She concluded:

I think as long as I finish my studies, my relatives will not be too angry that I have a child. They will be extra happy — a diploma and a descendant! Wamena people love children, we love descendants (*keturunan*), so why should we be embarrassed?

These results raise themes of notions of responsibility and constructions of adulthood which seem critical in shaping decisions around pregnancy and the context in which family planning decisions might be made, if in fact birth

control or sexual health services were available to women like Lavinia and Anny. Whether or not young women plan to become pregnant is certainly not clear-cut, and their feelings about the pregnancy change depending on how the relationship with the baby's father pans out. Their educational achievements, coupled with the achievements of their partners, help to normalise an otherwise unorthodox journey to motherhood. Fertility is viewed positively, so long as the paternity is clear and there is a marriage-like relationship that supports the pregnancy. Achievement indicates adulthood and responsibility, and can thus offset parental concerns about legitimacy and marital arrangements. Education, sexual relationships and parenthood can proceed simultaneously in these cases, and fertility need not be postponed indefinitely for the sake of tertiary studies. But the views of highlands men and women are not generalisable to all Papuan youth. Manokwari offers a case study in which to explore the confluence of religious morals and cultural politics for the acceptability of family planning.

### Religion and Conservative Moral Views: Family Planning for Unmarried Youth?

Indonesia is a majority Muslim country where, officially, conservative views prevail in the domains of sex and sexuality (Bennett 2005a, 2005b). Sexuality is normatively deemed shameful and sex should not be discussed publicly. The association of sex with shame has pushed sex among unmarried couples 'underground' (Hewat 2008) and into 'secret' (Bennett 2005a; Butt 2007). While the official view among political and religious leaders is that sex is borderline immoral, even within the bounds of marriage, ubiquitous, not-very-secretive practices of pornography, sex work and affairs coexist with this idealised view of moral sex. The official, public view of sex tends to inform what education and health services are formulated and enacted, less so the realities of sexual practices. As a result of these values, family planning officially caters only to married women both in Indonesia and in Tanah Papua. The language of KB policy that is provided at health centres usually describes



‘couples of childbearing age’ rather than ‘legally married couples’, but national guidelines do limit the provision of family planning only to married couples (Diarsvitri et al. 2011).

Manokwari is a good case study in which to explore the converging impact of religious, cultural and moral conservatism on sexual health understandings and family planning accessibility. Manokwari, located on the bird’s head of New Guinea, is mostly inhabited by coastal Papuans originally from Biak and other islands of Cenderawasih Bay who moved to the area after the Dutch established a colonial outpost in 1902. The local category of coastal people stands in contrast to the mountain people (Arfak, among others). Coastal Papuans may more often identify with Indonesian migrants than with mountain inhabitants, who are seen as ‘dark, aggressive, and simpleminded’ (Hewat 2008, 154). These perceived affinities may shape responses to family planning, as more migrants are KB acceptors than Papuans, and what migrants do sends a socially powerful message to Papuans who may aspire to be more like members of this dominant economic class. Structural conditions have historically facilitated a degree of contact, trade, intermarriage and affinity in Manokwari (Hewat 2008, 154) in spite of the violence employed by Indonesian forces to rid the area of freedom aspirations in the 1960s and the persisting inequalities between migrants and Papuans.

Manokwari is celebrated by Christian Papuans as the site of the first mission in Tanah Papua — German Lutherans from the Utrecht Mission set up camp on nearby Mansinam Island in 1854. Today known as the Gospel City, Papuans in Manokwari are mainly Christian Protestant. Churches include the evangelical Christian Church of Indonesia, the Pentecostal Church, the Bethel Family Church, the Kingdom of God, the Gospel Tabernacle Church, and the Catholic Church. Manokwari has undergone rapid social, religious and economic transformation in the past decade since it became a provincial capital in 2003. Rapid change and powerful religious dynamics shape views of family planning. In Manokwari, Richards (in press) has

used the term ‘sex panics’ to characterise Papuan convictions that premarital sex and pregnancy and extramarital affairs are increasingly prevalent and disconcerting. These concerns form part of a wider problematisation of Indonesian and foreign influences on an increasingly idealised traditional and Christian Papuan culture. Christian Papuans see their religious practices and values as threatened by increasing Muslim migration, as well as by the rapid pace of development in the area, including commoditisation, media and internet, and mobile phone technologies. The response to premarital sex within religious domains has been oriented towards moral policing and punishing illegitimate sex (Hewat 2008, 157).

Christian responses to family planning in Tanah Papua are diverse (BKKBN et al. 2009). A common Christian teaching that asks followers to take responsibility and provide for their children leaves the specifics of family planning up to individuals. Another view is that moral damage to the good name of the family and the church can be limited by the provision of contraceptives to adolescents to prevent pregnancy (BKKBN et al. 2009). Most churches accept that it is reasonable, indeed desirable, for married couples to limit the number of children they have and space out births by some method; it is the methods themselves that are the subject of disagreement. Some churches promote primarily natural methods and oppose medical interventions. Condoms are seen as facilitating illicit sex with sex workers or lovers, and not for marital sex. Further research is needed to ascertain the different ways that family planning values might be promoted or criticised in different local denominational contexts.

Nonetheless, a key factor that increases the acceptability of family planning even in religious contexts that are pro-fertility and anti-intervention is that in Tanah Papua, and in other parts of Indonesia (see Aragon 2000), conforming to state development ideals is, generally speaking, considered a morally appropriate religious practice. National values promote piety, and religious organisations promote state values. Religious leaders say they feel obliged to come out in favour of family

planning (BKKBN et al. 2009). Christian discourses promote family planning within marriage as an aspect of moral citizenship, family propriety and gendered responsibility.

Even against a conservative moral backdrop, the actual practice of KB delivery may take liberties that defy conservative guidelines. In Manokwari, churches go so far as to facilitate the mass provision of contraceptives to women at community events, particularly in rural areas where health services are limited (BKKBN et al. 2009). Even though birth control is legally available only to married couples, in my experience in health clinics in Manokwari, I have yet to see a nurse or KB assistant demand to see a marriage certificate (or a marriage book, for Muslims) before providing KB. Yet neither would even the bravest among unmarried youth be likely to approach a nurse and ask for KB, a fact corroborated by high adolescent birth rates. The emphasis on providing KB to couples is also subject to the providers' interpretation. Husbands are, in principle, expected to approve their wife's use of family planning, but this may not be enforced. Nurses said that they often know their prospective KB clients personally, and are thus aware of their marital situation. Married women described their alliances with KB nurses to acquire injections without their husbands' knowledge, often if the couple had many children, or the husband was away from home frequently and was suspected of having sex with other women. Officially, nurses do not provide such services because it may cause a violent reaction from a husband (BKKBN et al. 2009). Nurses' subjective interpretations of the marital or moral circumstances matter in the provisioning of KB, thus those who have the most difficulty accessing KB, if they wish to, is young or adolescent women perceived as promiscuous or clearly of school age, and young couples engaging in more-or-less clandestine relationships.

Again, while nurses' practices of KB might skirt some moral codes and national guidelines by providing birth control to couples who are not married, or to wives without the consent of their spouse, young people are estranged from family planning because of this emphasis on couples and families. The idea that pregnancy is just something

one deals with when it arises is prevalent among Papuan youth (Munro 2012), and reflects their exclusion from the domain of birth control. As part of a collaborative HIV program evaluation in 2012, I conducted in-depth interviews with eight young Papuan women engaged in transactional sex in Manokwari. These women ranged in age from 17 to 22 and were known locally as 'naughty women' (*perempuan nakal*) who would be invited around to hotels or cars with dark tinted windows for sex, eating and drinking, and who always received money or gifts on their way out the door (see also Hewat 2008, 160–61). None of the women in the research had ever tried to access KB or been tested for any sexually transmitted infections, and they had all been pregnant.

Pregnancies created significant consequences for them. Some of the women had given birth to babies that were either willingly fostered to relatives or taken away by relatives. A few spoke of getting drunk with the intention of aborting their pregnancies. A few had been beaten by a boyfriend who wished to get rid of the pregnancy. Abortion is illegal under Indonesian law except in cases of life threatening pregnancy, severe genetic disorder, or pregnancy due to rape, and even then it must be carried out by the sixth week of pregnancy. All religious traditions in Indonesia condemn abortion. Self-induced abortion appears to be a common reaction to pregnancy among young unmarried women in some parts of Papua (Diarsvitri et al. 2011, 1053). Although the young women in my research were known to a local non-government organisation (NGO) that could have facilitated access to health services, they were reticent about accepting advice or assistance, and described the public clinic as a space that made them 'scared' (*takut*). 'I don't need any help', said Elena, 'I'm just having fun and being happy'. Health workers categorised the women as 'mobile phone sex workers' because of the way that men would get in touch with them, and deemed them 'too difficult' to find and engage (Munro and McIntyre n.d.).

Renewed global attention to reproductive rights and sexual health is meant to address realities like unsafe abortion practices, violence against young

women experiencing pregnancy, and HIV risk. But, condensed and simplified locally as family planning, there is little evidence that the returning KB agenda will matter much for these young women and men, or that using contraceptives will significantly alter the broader conditions of their lives. Will information about sex, and birth control and reproductive health services, be made available to young unmarried Papuans? In urban coastal areas like Manokwari, young unmarried Papuans seem likely to embrace birth control if it can be offered in a way that protects their privacy and dignity because of the difficult task of living up to moral expectations of chastity coupled with potent fears of premarital pregnancy and early parenthood, which are perceived to largely ruin a young woman's moral, social and economic future (see Hewat 2008). First, young people have to see sexual health and birth control as something that is a legitimate option for them, not just for married couples. For their contemporaries in the highlands, politics plays a stronger role in shaping reactions to family planning, as do competing desires to produce culturally valuable descendants and also to thwart other cultural expectations (Butt 2007).

### Politics and Family Planning

Papuan youth, particularly educated young people from the highlands, continue to view family planning in highly political terms. Petrus, a 25-year-old male student, indicated that having children could be a way of responding to Indonesian dominance.

They want to get rid of the black people, the Melanesian race, so they can claim all of the riches of Papua for themselves. They want the land, not us. *Orang putih* [literally, white people, a reference to Indonesians] regard *orang Papua* as the most primitive of all people. They look down on us and they would be pleased if we all were taken into custody or just died. But we do not want this, so we continue to struggle through whatever means.

It was common for Dani students and others to speak of the impact of Indonesian governance

in terms of fear of elimination due to migration, HIV/AIDS, military killings and marginalisation (Butt 2005; Munro 2012). Black, a 27-year-old male, stated:

Indonesia does not want us to have more children so that is why they give birth control and they send prostitutes with AIDS. The men sleep with them and bring AIDS home to their wives. This ruins their womb. They want our black skin to be finished; they want to eliminate our race. So we think it is important for our race to keep the blood line going by having children.

It was male students who primarily espoused the racial value of reproduction, an idea which has deep links to Papua's nationalist movement. The racialised aspects of today's nationalist movement relate to European ideologies and the distinctions they drew between Melanesians and Malays, which influenced colonial missionaries and administrators (Ballard 2008; Rutherford 2012). The ongoing racialised exclusions that Papuans experience, including stigma and stereotyping, also contribute to the formation of a politicised, racialised identity among educated highlands youth (Munro 2012; in press). Male students were typically more overtly political in their comments than women, but women also expressed strong views of Indonesian oppression, especially regarding conditions of poverty and feelings of discrimination. These assessments of reproduction emphasise the political and cultural contributions of childbearing in the Dani and Papuan contexts rather than the possible ways that pregnancy and sexuality may threaten educational achievements or lead young people into sin. As Butt (2001) found over a decade ago, family planning may still be rejected on the grounds that it furthers the Indonesian state's alleged genocidal intentions and contributes to the demise of the indigenous population.

The continuing linkage of politics and family planning emerges clearly in the simplistic framing of family planning by government agencies as a matter of creating a 'quality family' (*keluarga berkualitas*). The foundation of the Indonesian government family planning program was the

'development of prosperous families' (Herartri 2004, 2). Since 2000, the vision has been 'Quality Families by 2015' (BKKBN 2001) and, specifically, 'to create small, happy, and prosperous families' (BKKBN 2011). This particular way of framing birth control may hold little traction among many Papuans, who are asking different questions about quality and prosperity. My informants have described an education system that does little for improving family prosperity (Munro 2013), and the government's apparent lack of interest in the widespread illegal production and consumption of home-brewed alcohol that is perceived to be destroying the young generation (Munro 2014a; Munro and Wetipo 2013). During discussions of alcohol that I facilitated in the highlands in 2012, Darius, an older male subsistence farmer stated:

Indonesia knows our weaknesses so they brought in alcoholic drinks to finish off (*habiskan*) Papuans ... this is Indonesia's covert politics (*politik halus*) you know that they keep on practising to this day.

Welem, a male youth, stated:

I did not experience the old days (*zaman dulu*) but according to the stories of the elders/parents (*orang tua*), in the old days there was not yet a government and we lived quite simply and even old people lived a long time ... but once the government came in, all kinds of foods and drinks came in and were imported to Jayawijaya and people started to learn. From there arose an awareness among us Baliem people, a desire to try things (*ingin coba*) and a desire to drink so these days ... it is a tradition, a modern tradition, and this is destroying us (*merusakkan kami*).

Hannah, a 28-year-old female university graduate, argued, 'Up until recently Indonesia gave us ignorance education so they could cheat us and steal our lands' (Munro 2012, 1019).

These are just a few indications of the ways that any family planning agenda that is based on the premise that the government deeply cares about the welfare, wellbeing and prosperity of Papuans is likely to be tested, at least in the highlands and among more politicised individuals.

Alongside concerns about the impact of HIV and alcohol or violence-related deaths on population growth and quality, Papuans express concerns about uncontrolled migration and the lack of policy leadership to address problems arising from this flow of migration, including competition over land (urban and rural), and feelings of exclusion, alienation and marginalisation among indigenous youth (Munro 2014a). Political violence, much of it undocumented, also adds to the perception that the Indonesian state is not interested in Papuan welfare.

Similarly, promotions of KB on the grounds that birth spacing decreases maternal mortality will face criticism from Papuans who point to all of the more obvious reasons why women might die in childbirth in Tanah Papua: unhygienic hospitals, limited or no surgical facilities, lack of essential medications, and a two-tier system where those who can afford it pay high prices to give birth at private clinics, even in small towns. During my recent work in Manokwari, I found critical discussions in multiple locales questioning what Papuans perceive to be the increasing practice of delivering babies by caesarean section and the risks this presents to mother, baby and future fertility (Munro and McIntyre n.d.). These are the sorts of questions that a family planning agenda must respond to if it is to gain traction among those many Papuans who see reproduction and fertility, indeed indigenous welfare more broadly, in political terms.

### From Women's Trauma to Men's Pleasure: KB and Condom Promotion

Family planning trauma continues to shape understandings of reproductive and sexual health problems among the indigenous population. Timo, the director of an HIV NGO, reflected on the implications of family planning trauma for condom promotion:

Here in Wamena, especially among Baliem Valley people, we have ongoing trauma from KB that rendered women infertile. As a result, we who are working on HIV have trouble promoting condoms on the grounds that it is a method of prevention ...

To circumvent the issue of prior family planning trauma, the NGO tried to follow revised international models that now promote condoms as pleasurable, not as KB or HIV prevention:

Our staff finds it more effective to promote condoms on the basis of increasing sexual pleasure by adding variety (*variasi*). This is especially influential for men. Women who suspect their husbands are cheating, or HIV positive, or who are HIV positive themselves, they often suggest using condoms not because of KB, or prevention, but to add variety to their sex life. (Timo)

Similarly, Mina, an NGO worker, described providing HIV information sessions in which marital harmony was promoted as preventive and protective on the grounds that a harmonious marital (and sex) life would keep husbands from straying into extramarital affairs. Being from the coast, Mina might not have realised in her promotions that harmony is not the norm in Dani marriages, where gender antagonisms remain salient, and a degree of segregation persists in women's and men's roles and household activities. Nonetheless, these practices indicate how the politics of family planning may be shifted, though not in a positive direction, by engaging with emerging gendered constructs, particularly the notion that sexuality is primarily a male domain, where male pleasure is promoted and 'served up' (*dilayani*) by women.

Although NGOs are active in spreading the word about condoms, it is often public health nurses who are the key promoters of birth control, mainly the injectable variety. Nurses had also used male pleasure discourses to promote family planning, albeit somewhat differently from NGO workers. Female Papuan nurses asserted that it was difficult to promote KB. Yolanda, from Manokwari, described a recent experience while making home visits to promote family planning:

I went to this neighbourhood. There was a husband and wife both at home, so I spoke to them together. I said 'I'm here to talk about KB'. Right away, the husband started getting annoyed, and he said to me, 'Are you

a Papuan? Can you come here as a Papuan and ask us Papuans to use KB? You know we are going to be finished (*habis*), right? We need more children, not less!' He went on for a while. I sat there quietly while he talked. He talked until he was totally satisfied and had nothing more to say. Then I said, 'Sir, look at your wife. She is tired. Wouldn't you like your wife to be pretty and energetic again? Wouldn't you like to enjoy (*menikmati*) your pretty wife?' And you know what, they agreed to use KB.

Among married Dani women, infertility was described as much more of a crisis than having too many children. During a recent visit, I was surprised to learn that Nelly, a government employee with two children, had been punched in the face by her husband in the context of a dispute over her fertility. I had not realised that either of them wanted more children, assuming that they had chosen to stop at two because in so many ways they seemed dedicated to prevailing development principles, including the belief that more than two children was likely to inhibit family prosperity. Apparently, it was Nelly's husband's view that she had secretly taken KB at some point after the birth of their youngest child and, if she was not currently still taking it, it had rendered her infertile. Nelly did not dispute the fact that she may have taken KB in the past, but had defended the decision on the grounds that it was best for the family. Both parties were clearly distressed by the current situation, in which they might want to have more children but seemed unable to do so. Similarly, Maria, a subsistence gardener, described the effects of infertility on her life. She had never been married, but said she used KB in the past and since then had sex with different men but never became pregnant. She expressed sadness and likened herself to an abnormal child who was unable to grow up. 'Look at me, I have no children, no husband, in fact, I still live with my parents!' These views affirm that family planning in Papua might gain more traction if its sole aim was not to limit or space births but that it also provided treatment for involuntary infertility, as the World Health Organization advises (Cui 2010).

## Conclusion

Family planning still clearly raises political concerns for Papuans, ranging from prior trauma to questions about why Papuans should limit their population growth while in-migration contributes to rapid population growth. In Tanah Papua, they ask, overpopulated or underpopulated? While Papuans are still the ethnic majority and outnumber both new migrants and Papua-born Indonesians, this is a perspective we would expect to find among a minority that feels threatened and questions the state's commitment to indigenous rights, care and protection. Reproductive and sexual health in Papua cannot wait for the Indonesian state to prove its commitment to Papuan rights, but the reality of these interconnections must be an important consideration for policymakers, development practitioners and donors. Family planning agents must recognise that political conditions, ethnic tensions and state-minority/indigenous relations shape community responses to global health interventions; minimising these complexities inhibits effective implementation.

However, whether the state or international agencies have any business getting involved in matters of reproduction and sexuality seems to be less of a question for Papuans than it was a few decades ago. This indicates that Papuans are more accustomed to government intervention in personal and cultural domains than ever before even though they also see health services as poor quality and ineffective. Papuan acceptance of government services in these cultural domains suggests that the Indonesian state has a compelling presence, rendered visible in myriad ways even where physical manifestations of infrastructure, services, technology or organisational powers are not visible. The prevalence of Papuan nurses who try to do the 'translational work' (Wardlow 2012) of public health among Papuans likely also contributes to this new level of acceptance of state intervention.

At the same time, as young educated Papuans have been largely excluded from sexual and reproductive health domains, we can read both

resistance and pragmatism in their views of premarital sex (it just happens), and tenuous faith in the cultural networks that may support and value infants produced from less-than-ideal relationships. Particularly for this cohort, family planning efforts need to be aware that delaying parenthood (a critical marker of adulthood) in favour of educational attainment is regarded as implausible, even undesirable. What is desirable is delaying parenthood in cases where young peoples' relationships are still fluid and undefined, or where pregnant young women feel they will face punishment or ostracism. Despite practices that are testing the boundaries of cultural and legal understandings of marriage in Papuan society, young people also know well and fear the consequences of premarital sex and pregnancy, including HIV risk, shaming and ostracism, having infants taken away, and unsafe abortions or self-induced miscarriage (see also Djoht 2005). Caught between what 'just happens' and what might happen, youth are cornered into denial and secrecy even as sex and relationships hold an important place in their social world.

Family planning seems to be more acceptable when it invokes emerging discourses that promote sexuality as a healthy part of a successful marriage. Locally, however, this idea has underpinned practices of promoting men's pleasure, variety in marital sex, and women's attractiveness to their husbands. The importation of the ideology of a successful marriage and its local features requires further investigation, but in relation to family planning it means that KB can be promoted on the grounds that fewer pregnancies and children keeps wives youthful and energetic so that they can 'serve up' sex to their husbands. These practices amplify prevailing gender inequalities in marriage and sexual relationships.

There are specific social and ideological spaces at which family planning, as part of a sexual and reproductive health agenda, might be targeted to gain leverage in Papuan society. Papuans' desire for personal and family health and wellbeing, or preference for schooling not to be disrupted by marriage or pregnancy, are examples of ideological

spaces in which family planning may be warmly received. Religious values overlap with these views on education, moral wellbeing and health, although they may have differential influences on strategic approaches for achieving these goals, with some churches refusing to instruct men and women on the modes of family planning. Religious values and practices will continue to have an important effect on the way Papuans see and practise family planning, thus the government and donors should engage with these ideas and practices in the formulation of policies and programs. On the other hand, the government's messages that sexual health and family planning creates small, prosperous families or healthy human resources do not seem to resonate very deeply with Papuans. While there is thus a dire need for original thinking and fresh expressions for sexual health, these ideological achievements mean little without the practices to back them up. On some level, it comes back to basic health care and trust in the system: when toddlers who live a few blocks from a public clinic no longer die of diarrhoeal disease, Papuans might begin to have faith in more controversial practices of health care, which long-acting and permanent contraceptive methods clearly represent.

Papuan views on family planning continue to raise important questions that will determine the success or acceptance of family planning, which has follow-on effects for maternal and child health, including the important need for preventing mother-to-child transmission of HIV in a generalised epidemic. Family planning has an unshakeable, unanswered legacy in Tanah Papua that not only facilitates the exclusion of youth but also invokes the unanswered questions that remain important today. This affirms the view of Vincanne Adams and colleagues, who write, 'Community decisions about global medical interventions do not occur in a vacuum. They partially occur in response to previous medical and political practices' (Adams et al. 2014, 183; Whitmarsh 2009). The rebranding or re-messaging of KB is not a

solution to these complex reactions. Any simplistic messaging almost certainly bypasses core concerns that form the basis of Papuan interpretations of family planning.

By discussing political, cultural, gendered and religious facets of family planning, this paper corrects the notion that 'access' in Papua can be primarily understood in terms of geography or infrastructure, and points to other factors that may shape Papuans' uptake of family planning. It is critical that these considerations are addressed in order to improve access, appropriateness, and desirability of family planning and sexual and reproductive health services. But rather than just ask how Papuans are likely to react to a new global family planning agenda, we also need to ask what the imposition of this (new, but also old) family planning agenda means in Papua, where it seems much more appropriate to develop locally owned policy ideas and implementation practices. What, I wonder, would a Papuan-designed sexual and reproductive health strategy look like, and is there the political will to facilitate and support it? Given that global family planning advocates emphasise the importance of local leadership and locally driven agendas, the revival of family planning in Tanah Papua presents a compelling opportunity to explore these questions through rigorous contextualised research and community-based policy dialogue.

### Author Notes

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## Endnotes

- 1 In this paper I use the terms 'Papua' and 'West Papua' to indicate the relevant province. To refer to the whole territory that makes up the western half of the island of New Guinea, I follow indigenous usage: Tanah Papua (Land of Papua).
- 2 There is currently a youth policy being considered by legislators in the West Papua provincial parliament that would see HIV and life skills education guaranteed for youth along with access to sexual and reproductive health services that are normally accessible only to married couples (Grainger 2014).
- 3 Like other sexual health agendas, most notably efforts to address the HIV epidemic in Tanah Papua (Munro and Butt 2012), the family planning strategy does not make use of Papuan research on health, culture and sexuality (e.g. Djoht 2004; Kayame et al. 2014).
- 4 All names of research informants are pseudonyms.

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