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## The Recovery of Healthcare: A case study of Javanese medical practices and related discussions about pluralism in healthcare

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**Article history:** Submitted June 7, 2020. Accepted in revised form December 7, 2020.

**Published online:** December 10, 2020

**Citation:** Weydmann, N., (2020). The Recovery of Healthcare: A case study of Javanese medical practices and related discussions about pluralism in healthcare. *Visions for Sustainability* 14, 66-82.

**DOI:** <http://dx.doi.org/10.13135/2384-8677/4561>

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**Competing Interests:** The author has declared that no competing interests exist.

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### Abstract

The use of 'traditional' medicine is a common phenomenon throughout Indonesia. In today's Indonesian healthcare system 'traditional' and complementary medicine coexist with globalized biomedicine and even urban, educated households are still more likely to use 'traditional' than biomedical healthcare. This paper explores the fundamental differences between Western and Javanese understandings of health, illness and healing. It highlights first the Javanese relational perspective on healing, which involves resonance with the surrounding whole. It contrasts this with the entanglement of biomedical knowledge and economic interests, which is identified as a major problem of governmental healthcare services, as it enables overshadowing the medical objective of helping health-seeking persons with the objective of generating profit. Relationships with biomedical experts are described as shaped by monetary considerations, while rejecting non-biomedical treatment methods is suspected of being a way of protecting the interests of biomedical businesses. Based on these categorical and structural barriers between different medical traditions, the nationally structured and formally recognized system of healthcare is contrasted with a common informal, socially and culturally rooted way of navigating healing. Therefore, against the formal background of these conceptual differences, the paper highlights health seekers' sensual experiences, embodied realities, and their common routines of tinkering and combining healthcare practices between conceptual differences. This provides glimpses into everyday informal cooperation between distinct medical traditions, which easily bridge categorical, structural and economic barriers.

**Key words:** Healthcare Bricolage; Indonesia; Jamu Medicine; Javanese Tradition Medical Degrowth; Medical Pluralism; Primary Healthcare; Traditional Knowledge; Traditional Medicine.

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### Introduction

The Covid-19 pandemic and related questions of accessibility of healthcare services have exposed the fault lines of both the human right to health and current medical realities in Europe and around the world.

Decades before the COVID-19 crisis, the 1978 International Conference on Primary Health Care held by the WHO in Alma-Ata stressed the “need for urgent action by all governments, all those working in the fields of health and development, and the world community to promote the health of all people of the world” (WHO, 1978). 40 years ago, this conference already highlighted that achieving primary healthcare for all means changing the paradigms underlying primary healthcare, for example, to base healthcare approaches on different medical traditions instead of exclusively relying on biomedical practices. Today, politicians and scholars are still struggling in search of new visions for primary healthcare in the 21st century. In this context one group of researchers is inviting discussion about transforming the current healthcare system by overcoming the growth-based economic orientation and to develop sustainable socio-economic bases and systems for healthcare (Aillon D'Alisa, 2020; Borowy Aillon, 2017; Missoni, 2015). During the COVID-19 pandemic, with its immense effects on global economies, arguments to strengthen health systems are getting even more traction, with a view to creating truly universal, publicly funded health services, that reach and include entire populations (Prince, 2020; Yates, 2020; Whittal, 2020). In this sense universal public healthcare and welfare services are key issues of egalitarian policy and crucial alternatives able to overcome market-oriented healthcare (Lucchese Pianta, 2020).

This paper will present formal and informal healthcare structures and everyday routines of health seekers in Indonesia, highlighting their autonomous ways of navigating healing between categorical, structural, and economic barriers. These insights into distinct knowledge and practices of healthcare in Indonesia contribute to ongoing discussions about the social and economic concepts and paradigms underlying Illich's vision of a 'convivial society' (Illich, 1973; Samerski, 2016).

## **1. Medical Pluralism in Indonesia**

In Indonesia the use of 'traditional' medicine is a common phenomenon. In today's Indonesian healthcare system 'traditional' and complementary medicine coexist with globalized biomedicine. Recently, it has been found that even urban, educated households are still more likely to use 'traditional' than biomedical healthcare (Nurhayati Widowati, 2017). The Indonesian market for 'traditional' and complementary medical practices (TCM) has experienced a veritable boom during the past 30 years. The use of a “whole range of over-the-counter (i.e., non-prescription) medications, pharmaceuticals, tonics and new forms of herbal or other mixtures has sprung up, and promise renewed energy and stamina, and to protect one from the onslaughts of hardship and distress” (Lyon 2005, p. 14). In addition to the established market for 'traditional' medicine, a new market of modern alternative remedies is growing, with a wide spectrum of herbal energy products and stamina remedies. The far-reaching economic, political and social changes in past decades are considered to even encourage the use of non-biomedical health-seeking models (Lyon, 2005; Liebich, 2003; Sciortino, 1995). The complexities of transformation processes in Indonesia also implied a transformation of identities. The way of being Indonesian in the time of Suharto has been different, so that through the use of drugs and medications “one in effect tinkers with the relationship of the self to the world, and, through the enactment of that process itself, thereby embodies that world” (Lyon, 2005, p. 14). In this regard, the increasing use of traditional jamu medicine could be understood as a way of establishing a closer relationship with the Javanese part of the self and thereby becoming more Javanese oneself.

This commitment of Indonesian society to traditional Javanese healing practices, particularly the traditional herbal jamu medicine, has also been evident since the beginning of the current pandemic. As the COVID-19 crisis deepened, a new market emerged offering 'Corona jamu' that contains turmeric, ginger and other ingredients, to strengthen the body's immune system against viruses (Weydmann et al., 2020). Various Indonesian politicians have pointed to the benefits of traditional medicine in the current crisis, and in the initial phase some even claimed publicly that COVID-19 infections could heal without intervention, as long as a person's body has a strong resistance to disease, causing some public criticism and questioning of whether politicians are intentionally withholding important information to avoid panic (Lindsey Man, 2020). Despite this criticism the Indonesian President, Joko Widodo, posted a statement on a government website saying that he started drinking a mixture of red ginger, lemongrass and turmeric three times a day

since the outbreak of the virus started (Bloomberg, 2020). He was convinced that a herbal concoction could ward off the coronavirus. This statement of the Indonesian president on his use of jamu medicine contributed to a rapid price increase so that prices of red ginger, turmeric and curcuma multiplied (“Coronavirus: Indonesia's panic buying of herbs, medicinal plants takes toll on 'jamu' vendors”, 2020). The Jakarta Post reported that several jamu producers have seen an increase in revenue of up to 50 per cent and predicted that the habit of drinking jamu will be ‘a new normal’, promoting jamu as ‘the new espresso’ (Prasidya, 2020).

As these insights into current medical policy illustrate, traditional medicine and combinations of multiple healing traditions are a common phenomenon in Indonesia – in rural as well as in urban areas. This coexistence of globalized biomedicine with traditional and alternative medicine in today’s Indonesian healthcare system is, however, not reflected in the Indonesian national Primary Health Care (PHC) program. Only a limited number of TCM practices are officially recognized and only a few hospitals have started to open TCM wards. The public provision of healthcare is almost exclusively based on biomedical treatment approaches and the corresponding way of defining health and disease.

## **2. Structure and Difficulties of Primary Health Care (PHC) in Indonesia**

The government provision of healthcare in Indonesia aims to provide biomedical services for all members of society. In practical terms, considering the physical characteristics of Indonesia with its 13.000 islands spread over 1.9 million square kilometers, it is only to be expected that a healthcare program designed by the central government located in Jakarta will be difficult to uniformly implemented in full, especially in the remote areas of this vast country. Nevertheless, in line with the goal of accessibility, each Indonesian sub-district is expected to facilitate one community health center (Puskesmas). These centers are supposed to have at least one medical doctor on the staff and provide all aspects of primary healthcare services. The centers are furthermore, at least potentially, supported by subordinate facilities, which are regularly headed by nurses and other biomedically trained personnel (Noerdin, 2014; Sciortino, 1995).

After promoting the accessibility of governmental healthcare for the poor and the near-poor in 2014, the reform was criticized for addressing only the need for greater coverage, but ignoring the urgent need for improving the quality of medical supply and treatment. Rural districts of Indonesia in particular face great difficulties in providing biomedical services for curative and preventive purposes, as medical doctors notoriously prefer settling in more comfortable urban areas. Doctors working in remote health centers with difficult supply situations are commonly not willing to stay in those regions (World Bank, 2008). As this is widely known, an increase in wages for medical doctors working in very remote areas compared to wages in central regions is intended to raise the attractiveness of these health centers. Nevertheless, many health centers continue to have difficulties in attracting medical experts. Cristobal Ridao-Cano, a lead economist at the World Bank Indonesia, commented: “Say with the KIS card<sup>20</sup>, if you go to a health center and the doctor is not there, then it's an empty promise – it's a card that gives you access to nothing” (Hewson, 2014, para. 3).

Another structural difficulty in Indonesia's healthcare system is that most medical doctors working in public clinics and health centers (Puskesmas) run private practices in parallel to boost their income. According to the World Bank figures, 70% of doctors working in Puskesmas use this 'dual practice' of working in parallel in the private sector, which has limiting effects on the working hours and quality standards in public health centers (World Bank, 2008).

For some time, there has been rising criticism of Indonesia’s public healthcare, including the closeness of pharmaceutical industries to medical practitioners and related ‘unhealthy practices’ of corruption (Jong, 2017). Now, the existing structural and personnel shortage in the public health system has become glaringly stark due to the pandemic. The latest World Health Organization (WHO) data shows that Indonesia’s ratio of doctors per 10,000 people is 3.8, and it has 24 nurses and midwives per 10,000 people (WHO, 2020b). This is well below Malaysia’s 15 doctors per

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<sup>20</sup> The KIS Card (Kartu Indonesia Sehat) enables and guarantees the supply of public healthcare services to registered poor and near-poor households and individuals. Regulations for the KIS Card are specified through the National Health Insurance (JKN).

10,000 people and Thailand and Vietnam's eight. Besides this, questions about pharmaceutical monopolies and cartel practices in the medical sector, and cases of malpractice and fraud at the expense of patients are mounting. Underlying this mood is a latent mistrust not only of the pharmaceutical industries, the medical profession, and the medical structures of hospitals, but also of the national elites in general and the civil servants of health-related authorities in particular (Weydmann, 2019).

### 3. Contextualizing Healing

To develop new visions for primary healthcare in the 21st century, we urgently need to ask and discuss the fundamental question of what constitutes our health and how people maintain their health. Furthermore, given structural changes, we need to draw conclusions about these discussions and develop new medical and political systems of trust. In this respect, Latouche (2007, p. 32) developed the 'concrete utopia' of a degrowth revolution, to build "convivial societies that are autonomous and economical in both the Northern and the South" and therein confront concepts and paradigms underlying 'Western imaginaries of healthcare'. To promote processes of transformation, he formulated the circle of the eight R's<sup>21</sup>, which has been developed for the transformation of the health field into a model of four steps (Aillon D'Alisa, 2020). These four steps entail the re-evaluation and re-conceptualization of health, illness and healing, the related re-structuring of health services according to this re-conceptualization, health promotion and prevention, as well as the involvement of citizens and patients in health management.

In what follows, I will present insights from my study on Javanese health seekers' way of navigating healing and related boundaries and challenges to the paradigms of medical knowing (Weydmann, 2019). The conceptual discussions form a basis to advance and promote the re-evaluation and re-conceptualization of health, illness, and healing.

#### 3.1. Methodological and Methodical Fundaments

The underlying case study draws on the transdisciplinary field of health psychology and medical anthropology to discuss concepts and approaches that explain the use of TCM in urban Yogyakarta (Indonesia). Discussions of this study are based on the methodological approach of Reflexive Grounded Theory (Breuer, 2009), which allows cross-cultural researchers to distance themselves from their personal constructs and highlight in their building of a constructivist Grounded Theory (GT) the entanglements of conceptual meaning with the given narrative context (Breuer, 1999, 2009; Charmaz, 2000). The specificity of this methodological approach is the way in which researchers trace their own journeys in search of meaning to give a specific sensitivity to the underlying research context. Such a methodological approach is particularly important in sensitive contexts, for example, the postcolonial nature underlying this study, in which a 'Western' researcher is in search of the meaning of healthcare practices in urban Yogyakarta. By engaging in research about healthcare in a postcolonial society, it is only too likely that colonial aspects contribute to the social and cultural production of knowledge in this field. It is therefore crucial for a research methodology to enable reflections about continuations of colonial and neo-colonial relations into the present and emphasize how schools of thought from the past still infuse the present (Bal, 1991; Shohat, 1992).

Another major methodological focus is to enable research participants to communicate their experiences from within their frames of references and at the same time involve the researcher's underlying worldview (Chilisa, 2012). How individuals communicate and interact with their environment must be taken into account during any research activity, so that "indigenous epistemologies and axiologies can inform the undertaking of participatory and collaborative research" (Nicholls, 2009, p. 120). In practical terms, this approach unavoidably entails an emphasis on the way to present research, by making explicit the specific angle from which the phenomenon under study is reflected, and therein traces the author's processes of making meaning in the field of healthcare in Indonesia. This includes the explicit positioning of the author's perspective and voice within descriptions of interviewees, the questioning of assumptions,

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<sup>21</sup> The virtuous circle of eight R's: Re-evaluate, re-conceptualize, restructure, re-distribute, relocalize, reduce, re-use, and recycle (Latouche 2007).

noticing and facing uncertainties, as well as reflexive processes, all as part of making conceptual meaning throughout this study. All of these provide extensive insights into the multiplicity of perspectives and dimensions involved in the field of health-seeking. This means that, even though this paper primarily focuses on casting light on issues of healthcare in urban Yogyakarta in the context of the discussion about processes of medical degrowth, it also finds a textual form to trace the insights of a 'Western' researcher, who tries to make meaning of healthcare in urban Yogyakarta.

The findings are based on a study involving 28 semi-standardized interviews with female health seekers as the main body of data, and an additional 19 semi-structured interviews with medical experts from Yogyakarta. The interview questions for health seekers were designed to elicit narrative elements addressing previous experiences and evaluations of illness and previous treatment as well as possible combinations of medical practices. The expert interviews with different health agents illustrate conflicting interests and controversies between medical traditions. Additional other data, such as observation protocols, were used to supplement the analysis in terms of triangulation, helping to reflect, classify and interrelate codes and categories. The main data corpus for the study was collected between 2010 and 2015, while additional data has been collected during on-site research in Yogyakarta in 2019 and online data collections in 2020.

The sampling strategy for selecting female health seekers was informed by theoretical sampling, aiming to cover the range of women's health-related concepts and approaches underlying the use of TCM in an urban setting, thereby resulting in a heterogeneous sample. A major restriction to the sample was the inclusion of only interviewees who at least partially presented themselves as being Javanese (criterion sampling). Thus, being Javanese was not equated with an ascription of a rigid and enduring attribution of ethnic identity but as a temporary way of localizing themselves in relation to time, place, and context. In this way, my interviewees' being Javanese was not the only narrative location of belonging throughout the interviews. Rather, being Javanese was just one identitarian location of belonging among 'others'. In practical terms, this meant that my interviewees regularly shifted their frame of reference from one moment to another. For example, one woman at the beginning of our interview used 'we' and 'women' to locate her identity, compared to 'them', the 'men'. Shortly after, she introduced her Madurese influences, referring to herself as 'we' and 'Madurese' in distinction to 'them' and 'Javanese'. Finally, when describing approaches to healthcare, she shifted to 'being Javanese' in contrast to 'Western you' and 'Western them' and associated ideas about differences in healthcare. Therefore, my interviewees location of 'being Javanese' was only one location within the multiplicity of 'selves' and particularly highlights how the 'self' is significantly shaped by the 'others' (Butler, 1993; Yuval Davis, 2010). Accordingly, this study is based on a sample population that affiliates itself with a 'Javanese way of healthcare', which is particularly constituted by difference from a 'Western way of healthcare' (Weydmann, 2019).

### *3.2. Insights of Javanese health seekers into their navigation of healing*

Healing categorically presumes the existence of illness and, therefore, aims to restore health, no matter how this is defined. When discussing concepts and approaches to illness and healing, it is inevitable to face issues regarding the beliefs underlying the conceptualization of health. The exploration of health beliefs, at its core, is interested in what people consider to be the nature and essence of health and illness and which aspects enable them to avoid disease themselves, as well as which aspects cause illness (Frankenberg, 1980; Good, 1994; Kleinman, 1980, 1988; Pfleiderer Bibeau, 1991). Concepts of feeling well and the experience of the embodied self invariably underlie healing navigations. Accordingly, issues of being and having a body are of major interest if one is concerned with making meaning of health approaches. When questioning approaches to healing, the dimension of 'doing' cannot be differentiated from the dimension of 'being' healthy (Eriksson, 1994, 1997; Eriksson et al., 1995). This means that a health-seeking person is necessarily part of a diversified 'drama' which begins with the confirmation of the health seeker's suffering, continues with the health seeker's performance of illness and suffering in a given place and time and finally leads to a possibility of reconciliation. Mol (2014) extends this idea of 'doing' to physical bodies themselves, as in her perspective that there is no disease as such, which would presume a fundamentally underlying 'object', the physical body, and imply that there is "a timeline with a

before and an after; and materials out of which x or y might be made". Instead, she identifies the body as an object multiple which is performed, done, and enacted. Bodies are no longer understood as biologically determined objects, but as collective expressions and presentations which are closely interconnected with their historical and anthropological contexts, as the body itself and related perceptions therein become multiple, and related embodiments convert into collective processes with a direct linkage to histories and ethnologies. From this perspective, even though diseases are negotiated within the same 'society', they are still enacted differently in connection with different actors, materials, techniques and sites (Mol, 2002). Against this background, illnesses and diseases are embedded in a particular context, relating to specific individuals and their related collective experiences, ideas and beliefs.

To contextualize these conceptual considerations, I will introduce one of my interviewees, to illustrate paradigmatic characterizations and differentiations against the background of her common ways of navigating healing and related tensions between medical paradigms.

### **Introduction of Ibu Dewi**

Ibu Dewi is a 43-year-old woman, who was born on the outskirts of Yogyakarta and identifies as Javanese. She grew up as the daughter of a small-scale farming family, who worked in their rice paddies and vegetable garden. Today Ibu Dewi is the mother of three children, who are between 7 and 13 years old. Her household consists of her children, her mother, and her disabled adult sister. Her husband is working abroad as a laborer in the construction industry; however, for about 6 years, she has not been in contact with him. She assumes that he has probably started a new family somewhere else.

Ibu Dewi herself attended primary school for about 4 years and left school without any degree. She earns the living for the entire family on her own, by working six days a week as domestic worker for a Javanese industrial family. Her mother takes care of the house, the garden, and the children. The family is not registered in the national health insurance system – too much administration says Ibu Dewi - and in this sense, healthcare is always a consideration of cost and benefit. On the one hand, healthcare services, as well as medications, incur substantial costs, in the governmental community health center as well as any other kind of healthcare services or medications. At the same time, whenever Ibu Dewi is ill and unable to work, she loses the essential daily income of her family.

In terms of self-care, Ibu Dewi has a broad range of knowledge in order to deal with various common illnesses. Usually, her first idea for treatment is simply to sleep and rest and afterwards see whether things are already better. If not, she typically prepares a herbal remedy, whose recipe was passed on by her parents. She prepares these remedies by herself and mostly uses herbs that grow around her house in that particular season. She uses those herbs to prepare teas and pastes to reduce heat inside the body, infections, pain, or to support wound healing. The most common disease in her family is masuk angin<sup>22</sup>, which she treats by giving warm water to drink, sleep, and kerokan<sup>23</sup> massage. Concerning techniques and methods of self-healing, Ibu Dewi reported meeting a gendong<sup>24</sup>, at least two times a week who walks along the street to provide her freshly made herbal remedies. This jamu gendong woman is the daughter of another jamu gendong, and in this sense learned the techniques of producing and prescribing herbal remedies already as a child. Therefore, she is characterized as 'having seen every wave in the wide ocean of illness and healing'. Ibu Dewi's family has been consulting the jamu gendong for decades, meaning that their relationship is characterized by a shared medical history. Ibu Dewi fully trusts her medical advice and remedies and, in this sense, the relationship with this jamu gendong is her major source of support for all health-related questions.

In cases of severe illness, which, 'thankfully' rarely occur, Ibu Dewi additionally consults a nearby community health center (Puskesmas). There, she can get blood checks and further tests.

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<sup>22</sup> Javanese health concept, in which a draft or wind is expected of having entered the body.

<sup>23</sup> Massage technique, to stimulate blood circulation and/or open a path for trapped wind to escape the body. For this kind of massage an oiled coin repeatedly is scraped over the skin, until the skin turns bright red or black (for details see Weydmann, 2019:143ff.).

<sup>24</sup> Traditional Javanese salutation for a woman selling traditional herbal medicine, which is typically carrying glass bottles with different jamu remedies in a basket on the back.

Ibu Dewi described that before she goes to the Puskesmas, there have been situations of great uncertainty, in which severe, unknown symptoms rapidly appeared, accompanied by unsettling and worrying feelings. In most cases, she then used these diagnoses of the Puskesmas and passed it on to her jamu gendong or to a trusted Javanese ritual healer (dukun), who is well known to handle different kind of obsessions. In most cases, family members simply went home and continued with their habitual herbal treatment. Only in one case, Ibu Dewi's sister was directly admitted to hospital, as she had been diagnosed with severe dengue infection and instantly required intense medical care, otherwise she might have died. During her time in the hospital, her sister had been examined by two doctors, treated by nurses, with Ibu Dewi's brother selling a cow to pay for her treatment. Furthermore, the trusted jamu gendong visited Ibu Dewi's sister in the hospital to administer important herbal remedies and provide a particular kind of massage to reduce her fever.

### *3.3. Knowing about healing and the business of healthcare*

In her stories, Ibu Dewi always emphasized that her knowledge about herbal remedies has been passed on from generation to generation. Thereby, she directly felt connected to her Javanese ancestors. For her, this direct relationship with her ancestors and the related validation by experience from her familial ancestors made her feel safe. She therefore traced a direct relation between the Javanese conceptions of illness and her own experiences. Van den Daele (2004) has conceptualized this kind of traditional knowledge as 'embedded knowledge' and also as 'embodied knowledge', as it does not just convey information, but also has social and cultural meaning and gives the bearer of such knowledge a sense of belonging and certitude. He specifies that this kind of knowledge cannot be adequately conveyed in rules or textbooks, as it is ingrained in people through socialization and in their skills and habits (Van den Daele, 2004, p. 27ff).

By contrast, Ibu Dewi characterized the biomedical body of knowledge as a non-personal way of obtaining knowledge about health, illness and healing. It is taught in specific institutions, and for this reason the source of medical knowledge for the physician at the Puskesmas has not been his or her ancestors' experience, but rather professional studies in a medical degree program or institution. In this sense, biomedical knowledge is described as separate from empirical knowledge, and effects are seen as being tested in scientific clinical trials instead of empirical validation. Accordingly, biomedicine is seen as being distant from 'true, real life'.

This idea of distance and closeness to real life was also stressed by contrasting medical relationships underlying different medical traditions. Whereas Ibu Dewi and many other interviewees described their close and established relationships with their traditional and alternative medical professionals, by contrast, they highlighted that there is no such relationship with the medical professionals in the Puskesmas or hospitals. Through the services provided by the national healthcare program, patients make use of a formally guaranteed program and related institutions, since the staff on duty are constantly changing, due to high staff turnover, and the medical services as such not being based on the idea of personal relationships.

The consumption of herbal plants as medicine has been part of Indonesian culture for thousands of years (Beers, 2001), mainly based on oral traditions and without systematic canonization. However, at the same time, it needs to be mentioned that jamu today is no longer the medicine of the poor, but also a vibrant economic sector partially dominated by large international companies such as Air Mancur, Djamu Djago or Nyonya Meneer, which produce a variety of jamu remedies sold as instant powders, tablets or capsules. Therefore, street vendors, such as Ibu Dewi's jamu gendong, compete with big drugstores over jamu sales. This could also be observed when the COVID-19 crisis deepened in 2020, and a new market emerged offering "Corona Jamu" that is based on existing traditional remedies, for example Wedang Uwuh – a herbal specialty in the region of Yogyakarta. In this sector, remedies have been promoted which are traditionally used to prevent colds, warm the body, and boost immunity. The Jakarta Post summarized several reports from marketing and consumer research agencies, e.g., McKinsey, and emphasized that several jamu producers have seen an increase in revenue of up to 50 per cent and predicted that the habit of drinking jamu will be "a new normal", portraying jamu as "the new espresso" (Susanty, 2020). Already within the last decades, traditional jamu remedies have become an important "economic pillar for the nation" (Prabawani, 2017, p. 81) that generated

21.5 trillion Indonesian rupiah (US\$1.38 billion) in 2019; up 13.1 percent from 19 trillion Indonesian rupiah in 2018.

Ibu Dewi's emphasis on jamu medicine does not simply point towards the conceptual ideal of traditional herbal medicine, but also to the different aspects of her relationship with jamu medicine: her particular relationship to her jamu gendong, her specific way of obtaining healing knowledge from her ancestors, her involvement in healing by cultivating and collecting medicinal plants and preparation of herbal remedies and pastes.

In contrasting his work with the paradigmatic approach of a professionalized biomedical doctor, the traditional healer Pak Agusti characterized his relationship with health seekers as follows:

It is very easy to say I help people (.) people say they help me (.) but in the real sense of the word helping (.) this is not easy (.) helping people only with remarks (.) this kind of help requires the helping people (.) if it does not require me it is a lie (.) for sure we choose the requirement if I help Nicole (.) help which is really to help you definitely requires me (.) requires power (.) requires my feeling (.) it requires my heart (.) requires my thoughts (.) I am for you (.) I am helping you (.) maybe requiring material (.) my money (..) if I am not required this is not helping.<sup>25</sup>

In the above statement, Pak Agusti stresses his personal involvement with the people he is taking care of in his role as a traditional healer. In the course of the interview, he highlighted that in biomedicine doctors are required to maintain a professional distance to not get personally involved in their healthcare practices. For this reason, he identified the medical employees working in the local Puskesmas as simply fulfilling an institutional function, which is remunerated and ends after official hours. Instead, he identifies his approach to healing as devoting his full attention and care to the person in need of help, for whatever reason. This devotion means to involve himself to the point that he is not able to knock off work because he is so fully devoted. Therefore, from his perspective, healing never can be a professionalized activity, as it requires personal feelings and involvement of the person, without professional boundaries.

In this respect, both Ibu Dewi and Pak Agusti described in detail the entanglement of medical knowledge and economic interests as one of the major problems of biomedical healing practices, as it has the potential to overshadow the social obligation of helping health-seeking persons for the sake of profit. In particular, drug prescriptions have been characterized as problematic. In another interview, Ibu Rini emphasized how in her experience doctors are particularly focused on 'open[ing] up business'<sup>26</sup> by selling pharmaceutical products and in this sense, she suspects healthcare services to be driven by economic interests and is wary of the related orientation towards personal economic gains. Some interviewees also suspected that biomedical practitioners commonly reject non-biomedical treatment methods in order to protect their medical businesses.

What emerges from these perspectives is that medical care generally should focus on the needs and sufferings of health seekers and not on their social class or financial circumstances. Another interviewee, Ibu Budiwati, stressed that the differentiation of medical treatment based on economic situation causes major harm, especially to poorer segments of Indonesian society. They are caught in the dilemma of, on the one hand, their inability to pay the immense costs of the highly professionalized biomedical practices, and, on the other hand, being at the mercy of confusing and time-consuming administrative procedures involved in registering as a poor or near-poor person in the national healthcare program. These aspects have been described as critical flaws in the formal healthcare services, which thereby fail to provide reliable access to medical care for large parts of Indonesian society. Therefore, interviewees regularly reported that entire families suffered as they need to borrow money to pay for expensive biomedical treatment, and subsequently resorted to selling their land, cows, or other essential goods to save the lives of their loved ones. However, at the same time, the loss of a cow erodes one's economic basis for living.

<sup>25</sup> Excerpt from interview with Pak Agusti 00:33:25-7, original in Bahasa Indonesia. Translation by the author.

<sup>26</sup> The original term "mau buka pasaran" (Bahasa Indonesia) has been used by an interviewee (interview with Ibu Rini 00:10:45-0).

## 4. Medical realities and the context of healing

Even though a condition may be considered an illness in one social group, the same condition may be classified differently in another group (Kleinman, 1973). How people cope with major life events like birth, illness, and death, as well as all aspects having to do with a comprehensive understanding of well-being, are embedded in a particular context and related to specific individuals and their collective experiences, ideas, and beliefs (see section 3.2.). Therefore, on the one hand, there are biophysical realities and/or psychological processes, and on the other hand the experience of illness involves feelings, ideas, values, language and non-verbal communication, symbolic behaviour, and the like. In this context, Kleinman has differentiated between the experience of illness by health seekers and the diagnostic perspective on illnesses by doctors (Kleinman, 1988). This perspective enables the distinction between two worlds: the outside disease perspective of doctors and the patient's personal perspective in which the realities of health and illness are moulded. Accordingly, the related act of healing needs a "plausible practitioner who can deploy a credible system in a successful negotiation that brings order to the patient's experience" (Harley, 1999, p. 434).

### 4.1. Conceptualizing Illness

Understanding someone's health world means making implicit or explicit assumptions about what characteristics and associations constitute the idea of health and, since directly related, the idea of illness. Understanding conceptions of health and illness, therefore, goes beyond a simple meaning-making of biological conditions, but involve orientations of health desires and illness undesirabilities, culture-specific conditions of illness and abnormalities (Fedoryka, 1997; Nordenfelt, 2007; DeVito, 2000).

Before characterizing specific aspects of a Javanese conception of health, I will first introduce a short excerpt from a personal illness experience in Yogyakarta which I recorded in my research diary. The short anecdote highlights the conceptual basis of illnesses and related negotiations of approaching healing:

[...] Since two days ago I feel really, really sick. It began on Saturday morning with a headache, a sick feeling in my stomach, and a bloated belly. I was thinking about whether I had eaten something wrong, whereas my daughter and my flatmate who shared plates with me seemed to be pretty fine. I decided to go to bed again and sleep for a few more hours. During the day my condition worsened, my headache became stronger (terribly strong!), and my sickness increased until I started to vomit. I could not eat or drink anything. Since Sunday my body temperature has also risen considerably. As I nearly never get a fever, or better yet, do not easily get a fever, the temperature rise started to seriously concern me. I was worried whether my symptoms were indicators of a serious tropical disease, as the combination of high fever and strong sickness with headache seemed to me very serious and completely foreign in its characteristics. Finally, this morning when Ibu Yuli came to do the washing, she found me staying in my bed. When I reported my symptoms and concerns, she said smiling: Oh, no worry, Nicole, this is only masuk angin. I give you [...]<sup>27</sup>.

As this diary excerpt illustrates, the emergence of masuk angin has been entirely foreign to me since I had regularly experienced symptoms of the common cold and also stomach flu, but this bundle of incoherent symptoms had been foreign to me. As I could not recall any personal experience, nor personally accompanied anyone who had suffered from this combination of symptoms, this illness left me feeling uncertain, unsettled and worried, particularly as I have been worried about suffering from a severe tropical disease. Ibu Yuli, however, knew this set of symptoms ever since her childhood as a common and minor illness, which she experiences regularly, and which was also common in her social environment. Therefore, she had a wealth of

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<sup>27</sup> Excerpt from research diary from 3.1.2011, original in German.

experience and coached me on how to approach healing and coping with these symptoms. Based on her experience, Ibu Yuli identified the descriptions of my symptoms as single markers for the common illness of masuk angin which for her and her social environment is one of the most common illnesses. In contrast to my state of uncertainty, she had a clear idea of how to cope with this illness.

The above example from my diary highlights how there is a close relationship between previous experience, the assessment of illness, and related ways of handling it – which in this context explicitly comprises the respective cultural and local imprint. In intra-cultural contexts, children gain experience of common illnesses in the context of families and communities at a very early age and build on these shared experiences of their social environment. In the context of my research, it was the cross-cultural context that led to this meeting of ordinariness and complete strangeness in the context of a common illness. In this sense, I needed to understand that the experience of illness is inevitably a relational issue – which builds the basis for the Javanese conception of illness.

In line with my own experience and the reports of Ibu Dewi and many other interviewees, the phenomenon of masuk angin has been widely characterized as one of the most common diseases in Java (Ferzacca, 1996; Triratnawati, 2011; Weydmann, 2019). Nevertheless, in professional biomedical diagnoses, there is no conceptual framework corresponding to the Javanese illness conception of masuk angin<sup>28</sup>. This means, when Ibu Dewi consults a Puskesmas or general physician to receive treatment or medications for her experience of masuk angin, this doctor needs to cope with the fact of not having a direct reference in the biomedical canon. This leads to the fact that physicians in Indonesia either need to refer back to their own empirical knowledge about Javanese humoral medical diagnostic and related healing practices like jamu remedies or kerokan treatment (Triratnawati, 2005, 2011; Weydmann, 2019). The other option – which has regularly been reported by doctors at the university hospital in Yogyakarta (Weydmann, 2019, p. 337) – is to overcome the lack of recognition of masuk angin by simply subsuming the phenomenon of masuk angin under the diagnostic framework of the common cold, which, however, is determined by different causes and symptoms. In this sense, Javanese doctors are caught between a rock and a hard place. On the one hand, there is the cultural background and its accompanying awareness of their own and familial experiences with masuk angin and related treatment methods. On the other hand, there are their fixed professional frameworks from biomedical science, where the phenomenon of masuk angin is ignored so that their professional reality implies that they need to transform their habitual treatment into a biomedical understanding.

This obvious disregard of local experience in terms of illness has already been described in early colonial reports about medical practices, when Western medicine was not yet familiar with tropical diseases, and, therefore, medical practice struggled with poor treatment results as a logical consequence (Sciortino, 1996). Even today, after 500 years of biomedical experience on Java, the biomedical framework still struggles with the recognition of local phenomena. For this reason, as long as patients perceive their physical realities especially through sensory experiences, there is a fundamental paradigmatic difference between subjective experiences of illness and the professional diagnoses of diseases within the framework of biomedical systems and related hospitals and community health centres. Besides Kleinman's differentiation between the internal experience of illnesses by patients and the external assessment of diseases by doctors (Kleinman, 1988), Ibu Dewi and Pak Agusti highlight another dimension which is beyond the conceptual framework of illness and disease, but which points towards structural questions of the human body and the nature of things by relating to the wider social dimension involved in the navigation of healing. The following section will introduce the Javanese relational approach to illness and healing as a basis for further discussions.

#### *4.2. The Javanese Relational Conception of Health, Illness, and Healing*

The traditional Javanese conception of health and illness is based on the principles of humoral medicine, which has a long and sophisticated tradition. It identifies bodies as having four important fluids that are characterized as hot/cold and wet/dry and are based on the belief that a

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<sup>28</sup> Interview with Ibu Maya 00:46:51-4.

balance of these bodily fluids is fundamental to good health. According to this understanding, a balanced unity of body, mind, and spirit is also necessary to withstand outside influences such as viruses, evil spirits, or social discrepancies and in this sense, there is no clear distinction between inside and outside, between mind and body, the personal and the collective (Ferzacca, 2001). Throughout their daily lives, Javanese people experience various embodiments, just as they have different social identities and constellations. Therefore, any Javanese approach to healing is understood as being related to the health-seeking person and the relative context, so that the people involved, spatial aspects, economic aspects, techniques, applications, and the like, need to be considered with respect to the health-seeking person. Accordingly, treatment approaches are necessarily bound to the specific situation in time, as at any moment new aspects can potentially contribute to different considerations, feelings, and meanings. This means that the rationale for choosing a particular treatment method is that both the treatment and the person are *cocok*, meaning that all relevant factors and agents fit together harmoniously or are congruent. However, being *cocok* is not to be understood as a perspective in which treatment options are compared and weighed based on an individualistic worldview in which navigations are centered around what is best for a specific individual. Rather, *cocok* needs to be understood as a relational perspective in all its aspects, which involves the resonance with the surrounding whole. The personal positioning in relation to others, therefore, builds the basis for one's own personal experience. In this sense, the biomedical approach to generalize diseases across cases and persons in a Javanese perspective would mean simplifying the relevant complexities of human nature.

One example which Geertz (1973) used to highlight the relational notion underlying Javanese healing conceptions concerns tasty food: the idea of food that is *cocok* does not focus on rational considerations but is rather based on sensed experiences. The ascription of taste is directly linked with sensory perceptions. Rational considerations fade into the background when discussing taste and considerations of whether a food is healthy, affordable, and so on. Fit, in the case of tasty food, directly takes place between the tongue and the food and no external measurements or categories are to be identified. Hence, without someone to taste the food, tasty food as such does not exist. The same applies to Ibu Dewi's approach to healing when she describes her specific way of preparing a herbal remedy for her son: she simultaneously highlights that this remedy is bound to the person of her son and that, accordingly, it is not necessarily applicable to another person. As Ibu Dewi describes, even though she possesses knowledge about the intricacies of the ingredients and manufacturing process of this specific medication, and she knows that this medication has the potential to heal her son, she has nevertheless had the experience that this medication does not provide any relief for her when she has a similar kind of injury. Instead, she argues that any kind of healing navigation is not to be related to a specific illness or injury but rather needs to fit or resonate with the health-seeking person. A curative approach which is not *cocok* with a person in question is therefore not expected to improve the condition of this person.

## **5. Overcoming conceptual boundaries - the Javanese medical syncretism**

When looking at Ibu Dewi's way of navigating healing, it becomes obvious that her negotiations of approaches are bound to the very moment of consideration and related relevant aspects. This means any other situation potentially contributes to valuing other aspects and therefore potentially leads to different conclusions. In this context, Ibu Dewi described a situation in which she cut herself in the foot with a machete and the wound got infected, even though she thoroughly cleaned the wound and used specific herbs to support healing. She described different considerations and approaches to healing, which involved monetary aspects as well as considerations about practicability, which at the end lead to the fact that she used herbs which had been readily accessible. She adapted and tested different combinations of herbs, leaves, barks and roots to prepare a tea, which she also used to bathe her foot in and clean her wound. Before drinking the tea, she also added a painkiller to the herbs, thinking that this could also help.

This story of Ibu Dewi's foot injury highlights that her general approach to healing is bound to her own sensually experienced, embodied, reality. She is the expert of her own suffering and she herself knows and decides which approaches to healing are necessary. Therefore, as her stories highlighted, she herself is the person who decides which approaches and persons to involve and which approaches and persons to avoid. These insights make it glaringly obvious that in this

perspective, navigations of healing are not exclusively bound to a specific theoretical conception of Javanese herbal treatment, but rather involve a mix and combination of 'whatever is at hand' (Lévi-Strauss, 1966). This also means Ibu Dewi mixes biomedical medications with traditional herbal remedies. She also draws on Traditional Chinese Medicine, for example when an aid organization was providing acupuncture treatment for free and she happened to be suffering from recurring headaches. She described using painkillers, whenever she needed to go to work and there wasn't any time to rest or to prepare other remedies and her headache, thus, simply needed to stop. Another situation led her to identify the bad condition of her son as being caused by a spirit that entered his body and which a traditional Javanese healer needed to drive out. And, last but not least, she only rarely used the biomedical services of the Puskesmas, especially because consultation times are in the morning hours and therefore clash with her working hours. Furthermore, she needs to borrow a motorbike to go there, as the bus does not stop near the community health center.

These insights into Ibu Dewi's approaches to healing show, overall, that her ways of dealing with a particular illness are not to be understood as the most suitable ways, but only 'one' way which in this specific moment is most suitable. At another time, she might deal with the situation differently, as the immediate outside or inside conditions change the way things fit together or another previous experience enables different ways of dealing with this illness which are best in this new situation. This means that the emphasis of my Javanese interviewees on being *cocok* illuminates the provisional and relational nature of 'fitting' between health seekers and healing approaches. In the context of healthcare, this means that the Javanese conceptual orientation on healing in terms of being *cocok* is not understood as descriptions of illness realities that are 'out there' but emphasize the significance of relational considerations in the context of healthcare. My interviews with Javanese medical professionals from different medical traditions<sup>29</sup> confirm the descriptions of Ibu Dewi and other interviewees, highlighting common routines in tinkering and combining healthcare practices between medical conceptual differences – not only for health seekers but also for medical practitioners (Weydmann, 2019). In interviews and focus group discussions Javanese medical professionals from all sectors located their own medical traditions within a pluralistic medical system and recognized that each school of thought presents both limitations and benefits.

Unfortunately, even though the interviews of my study are testaments for a medical syncretism of everyday healthcare practices, allowing for personal ways of tinkering healthcare in between different medical traditions, at the same time, medical professionals stressed the informal character of these co-operations. As one might expect, hospital regulations in Indonesia, as in most hospitals of the world, restrict formal cooperation with non-biomedical outside healing experts. And, accordingly, the hospital visits of the *jamu gendong* to treat Ibu Dewi's sister by no means constitute formal cooperation but are rather testaments to a silent acceptance by the hospital medical staff. My interviewees also emphasized the paradigmatic differences between different medical approaches, even though they traced common routines of combinations and conjunction of medical practices. Besides different fundamental conceptual understanding of the nature of health and illness, the alignment of interests underlying medical practices has been at the heart of this differentiation.

These discussions about paradigmatic differences between medical approaches are not intended to provide a new version of the simple and sometimes sterile dichotomies of local healing knowledge versus scientific biomedical knowledge, to claim justice from a local 'indigenous point of view' in order to obtain recognition from the 'superior scientific Western regime of knowledge' (Nygren, 1999; Silitoe, 2007). The insights into Ibu Dewi's and Pak Agusti's way of approaching healing stress the strong and common normative notion of knowing in the global natural sciences (which at the same time entails that not all scientists agree with each other) and at the same time highlight that, however, there are numerous different ways of knowing within, as well as across,

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<sup>29</sup> An overview of the experts involved in the study is given in Weydmann (2019, p. 402). These experts provide insights into following medical traditions: practitioners and researchers from the field of biomedicine and psychology, the field of traditional herbal medicine (explicitly from the traditions of *jamu* and *Unani* medicine), the field of traditional Javanese *Kejawèn* practices, the wide field of black and white magic approaches, as well as the field of traditional Chinese medicine (TCM).

local sciences (Silitoe, 2007). Instead of emphasizing the integrity and homogeneity of my interviewees as part of a closed Javanese community, in terms of a victimized society left without reason and agency, collectively struggling with the lack of recognition by ('Western') science communities, the discussions point towards my interviewees' autonomy in their ways of navigating healing. Tracing their approach to healing in accordance with their own sense of *cocok*, stresses their routines in intertwining different spheres of healing and knowing, joined together by their situatedness in time and place. These insights into their ways of navigating healing in direct relation to the sensual experiences and embodied realities of the ill person highlight that life is much more complex than is captured in or acknowledged by biomedical perspectives. Reflecting the ordering of formal healthcare systems specifically in the light of persons and contexts, as is shown in above narrative insights into Ibu Dewi's and Pak Agusti's healing reality, leads to focus on the contested ecology of healing in urban Indonesia<sup>30</sup>. The pluralistic medical system in Indonesia is characterized by differences between the epistemological fundamentals of scientific biomedical approaches and other (local) medical approaches. Biomedical healing approaches are identified as competing with any other (local) form of healing and related ways of knowing, testing validity and transfer of knowledge. In the context of Malaysia, the researchers Connolly (2017) and Connolly, Kotsila D'Alisa (2017) similarly outline conflicts between local medical knowledge and official understandings of health and disease. Within the last two decades academic discussions increasingly move away from fixed dichotomous epistemologies to allow for more complex and hybrid spheres<sup>31</sup>. From this perspective human understanding is characterized as diverse and dynamic, so that all knowledge traditions are considered to be based on a complex basis of knowledge relations (Silitoe, 2002, 2007), as the insights into Ibu Dewi's rich and diverse perspectives and approaches on healing demonstrate. However, unfortunately these discussions up until now only rarely extend beyond the social sciences, so that for instance the structures of healthcare still primarily rely on one-dimensional, normative understandings of healing. Voices of health seekers and scholars arguing for the re-evaluation and re-conceptualization of health, illness, and healing and related re-arrangements of healthcare in accordance with hybrid spheres of knowing are not widely heard. As Lyon (2009) has shown in detail, educational training of medical doctors at universities still ignores engagement with the epistemological and ontological situatedness of the medical sciences and corresponding relations to preconceptions, limitations and specific performances. Even today, biomedical students are trained in tenets and procedures of scientific medicine, omitting any kind of local medical beliefs, philosophies and practices. Thus, as long as medical practitioners are not socialized into a given local medical context or adapt themselves to their working environment, the respective local medical concepts and approaches are unknown to formally – scientifically – trained practitioners.

## 6. Conclusions: The Recovery of Healthcare<sup>32</sup>

Medical anthropology and research into the history of the body have shown how representations of the body differ through time and space (Duden, 1994; Lock, 2001a, 2001b). Healing processes are therefore likewise related to a particular local space and time. Accordingly, experiences of healing involve local characteristics, discourses, and tensions underlying these healthcare practices. In this sense, this paper highlights the tensions of recurring epistemological discussions between a one-dimensional biomedical approach to healing and local, hybrid and diverse approaches, which contribute to the renovation of healthcare services.

The insights into health seekers' navigation of healing in accordance with their personal sense of *cocok* particularly questions epistemological principles underlying the national Indonesian healthcare program and scientific biomedical approaches in general. The narratives of my interviewees trace their wish to reduce polarization between medical approaches and to enable

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<sup>30</sup> Fundamental insights into the discussions of 'contested political ecologies' are given by Green (2012; 2013). Further insights into the discussions of a 'political ecology of the body': see Carney, 2014; Connolly, 2017; D'Alisa, Germani, Falcone & Morone, 2017.

<sup>31</sup> Examples of these discussions are the *Decolonial Turn* (Maldonado-Torres, 2011; Mignolo, 2012), the *Mobility Turn* (Landri & Neuman, 2014) and the *Boundary-Turn* (Bagga-Gupta, 2013; Bagga-Gupta & Surian, 2014).

<sup>32</sup> Ivan Illich in *Medical Nemesis* (1976) entitled the last chapter of his book "The Recovery of Health".

healing in their own way, arguing for cooperation as well as negotiation of different understandings of health, disease and healing. Fundamental for their arguments is the wish of Javanese health seekers to follow their own autonomous approach of healing, tinkering, and combining all tools, techniques, and approaches available. Thereby health seekers become a kind of “professional do-it-yourself person” (Lévi-Strauss, 1966, p. 17), who, as craftswomen and craftsmen, combine available and accessible elements in an attempt to solve problems. My discussion highlights the use of a heterogeneous and limited repertoire of healthcare approaches and related ways of combining available and accessible elements in an attempt to solve health issues. Within the conception of Lévi-Strauss (1966) this would identify my interviewees as “bricoleurs” who with ‘whatever is at hand’ navigate their healing, even if this involves using kerosene as a massage oil, as Simbah Mita highlighted in her interview, since she could not afford other massage oils for economic reasons. In this context, Lévi-Strauss described the bricoleur as a ‘primitive scientist’ who makes use of familiar and available materials and resources, trying to reach the best possible outcome. My interviewees unanimously highlighted this common routine of healing as a way of tinkering and combining in between conceptual differences of biomedical and non-biomedical healing approaches. Fundamental to these discussions is therefore the direct basing of healing approaches on the sensory embodied experiences of the health seekers. In the sense of Illich’s vision of a ‘convivial society’ (Illich, 1973; Samerski, 2016) healthcare necessarily implies heterogeneous spheres of healing, enabling health seekers to balance their suffering between autonomous self-care and heteronomous advises. In this respect, Ivan Illich (1973) stressed the fact that “people have a native capacity for healing” (p. 68), as long as people are primarily dependent on their own capacities, without major dependencies on external commodities. Underlying this argument is the assumption that any kind of ‘professionally engineered commodity’ inevitably replaces a culturally shaped use-value (Illich, 1995, p. viii). As a result, this would mean that Ibu Dewi’s navigation of healing in the official healthcare services would lead her to separate herself from her sense of self, her desires, and habits, thereby involving a new logic of production and consumption (Illich, 1973, 1995; Samerski, 2016). In this respect, it must be emphasized that it is Ibu Dewi’s own sense of *cocok* which builds the basis to overcome the normative categorical differentiation between sometimes dichotomous medical traditions and enables her to navigate healing in accordance with her own experiences and embodied realities. Healthcare, however structured, needs to be primarily based on these sensed experiences of health seekers, instead of rational considerations. In this respect, Samerski argued: “Today, it is more important than ever to give space to those concepts and practices that relate to a sensually experienced, embodied reality - first in the mind, and then in the world around us” (Samerski, 2016, p. 9). Such a structuring would also enable the combination of all tools, techniques, and approaches available to address the needs and uncertainties of the ill person, which of course also entails legitimating hybrid approaches to health, illness, and healing, even when these approaches differ or sometimes even contradict each other. Central to a recovery of healthcare, and in this sense a fundamental reform and re-orientation, is therefore the ill person as such. Such a reform would not ‘simply’ involve the transformation of the economic orientation of healthcare systems, but the transformation of our understanding of ourselves.

### **Acknowledgements**

Special gratitude is owed, of course, to the participants of my study for generously sharing their wisdom and giving their time and support. Furthermore, I would like to thank the reviewers of this article, Andrea Pendezzini, Alessandra Morini, and Jean Louis Aillon for their careful reading of the manuscript and their constructive remarks. A special thanks also to Christian Fang for his thorough proofreading. And last not least, this article would not have been completed without the generous and constant support of Prof. Dr. Margrit Schreier, Prof. Dr. Kristina Großmann, Prof. Dr. Silja Samerski, Erny Mardhani, and my husband Andreas Bräuninger.

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