Hospital Births and Frontier Obstetrics in Urban West Papua

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Drawing on ethnographic research and interviews with 60 urban Indigenous Papuan parents, we investigate how a frontier context shapes childbirth and maternity care. Building on arguments about how medical care may perpetuate violence and inequalities, we show tensions and contestations between Papuans and the Indonesian medical system over what care Papuans want and what is made available to them. Urban Papuans embraced medical advice and hospital assistance. They valued preserving the mother's strength and fertility through vaginal childbirth or avoiding caesarean sections, which some described as part of a larger agenda of Papuan persistence amid Indonesian colonialism. But they often encountered what we call 'frontier obstetrics': invasive technological interventions in hospital births that display Indonesian power and authoritative knowledge, with little consideration for consent or culture in medical encounters. Challenging authoritative knowledge and contesting c-sections are ways some Papuans may disrupt and exceed the care that they are offered.

Keywords: Birth; Reproductive Abandonment; Caesarean Sections; West Papua; Frontier Obstetrics

Introduction

Worldwide, technological birth interventions are rapidly increasing to reduce maternal mortality. Yet anthropologists and others know and argue that technological and clinical promises are produced and constrained within existing hierarchies, even as it is possible that new relationships and articulations may also arise (Van Hollen 2003; Street 2014). For the most disadvantaged women, technological

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intervention does not improve birth outcomes (Smith 2019; Chattopadhyay, Mishra, & Jacob 2018; Mumtaz et al. 2014). Obstetric racism (Davis 2018), shaming and inappropriate interventions are common among minority, racialised and Indigenous women (Cerón et al. 2016; Freyermuth, Muños, & Ochoa 2017; Finestone & Stirbys 2017).

In this article, we consider the childbirth experiences of urban West Papuans, which reflect reproductive abandonment in a colonial, frontier context. The contours of reproductive abandonment in West Papua include colonisation (Katmo 2018; Katmo et al. 2022), racism (Karma & Soenmi 2014), violence (Hernawan 2015; Haluk 2012), unwanted reproductive interventions (Butt 2001) and the highest rates of maternal mortality and HIV/AIDS in the Asia–Pacific region. Due in part to a high maternal mortality rate that is four times the Indonesian national average, and increasing, at 573 women per 100,000 live births (Nababan et al. 2018; Ministry of Health 2016), Papuan births are a flashpoint for contests over saving lives, and at what cost.[1] In recent years, the Indonesian national health ministry, supported by global agencies like WHO and UNFPA, has ramped up the focus on clinical antenatal care and hospital childbirth (Nababan et al. 2018). Globally, efforts to improve maternal health are dominated by technical and bureaucratic solutions (Wendland 2007). In Indonesia, there is a target of four antenatal visits and a facility-based birth but limited focus on the quality of maternity care (Afrizal et al. 2020). In some cities, sophisticated maternal and neonatal emergency units have been set up (Ahmed & Fullerton 2019), but in West Papua, we show, the investment is much more modest: relatively old technologies like ultrasounds and foetal heart monitors, and obstetricians who perform, or pursue, c-sections.

This article draws on qualitative, ethnographic research on urban Papuans' antenatal and birth experiences, including what birth technologies and interventions they consider appropriate or desirable. The project grew out of our interests in colonialism, reproduction and racism. Between 2015 and 2019 we conducted 60 interviews with people (6 men and 54 women) who identified as Indigenous Papuan, lived in a city, and had attended antenatal care and given birth (or whose wife/partner had given birth) in a hospital or public health centre in the past five years. Almost half ($n = 27$) of the participants were living in Jayapura, the capital of Papua province, while the rest were evenly distributed between Wamena (central highlands of Papua province), Biak (large island off the north coast of Papua province) and Manokwari (capital of West Papua province). About half of the participants were originally from the central or western highlands of Papua province and the rest were of Biak, Marind, Arfak and Jayapura heritage. Most were at least high school educated. They were not the poorest of the poor but were not comfortably middle class either. We also spoke with two female Papuan obstetric nurses and one Papuan health worker from an NGO focused on maternal health. Most of the interviews were conducted by Els Katmo and Meki Wetipo.[2] Interviews were transcribed and thematically analysed in discussion with all the authors.

We found that these urban Papuans embraced diverse technologies, advice and interventions in striving for what participants described as a ‘smart’ healthy ‘activated’ baby. They valued preserving the mother’s strength and fertility through vaginal deliveries, or avoiding c-sections, which some described as part of a larger agenda of Papuan persistence in the face of colonialism. These hopes drew upon different kinds of technology and expertise, especially during pregnancy, but when it came to giving birth, they often had to respond to, manage or resist the priorities of doctors who wanted to perform c-sections. Some people acquiesced, but others responded by avoiding hospitals, trying not to grow a big baby, seeking second and third opinions, refusing to consent, negotiating with doctors and demanding to see the evidence. We begin by situating these findings within debates about care, colonialism and reproduction. We then advance our argument about frontier obstetrics, namely that within frontier obstetrics, care is minimalistic, invasive and often contested. These are contestations over childbirth as well as who defines and shapes Papuan futures.

Care, Colonialism and Reproduction

Anthropologists and others have shown that because care is contextual and socially embedded, medical care, humanitarian aid and health interventions may perpetuate colonialism, violence and inequality (Fassin 2008; Ticktin 2011; Nguyen 2010). Michelle Murphy (2015) refers to this as care’s ‘non-innocent’ histories. What forms of care are made available, or not, and why, reflects colonial and capitalist regimes and logics (Million 2013; Stevenson 2014; Howard 2018). Saiba Varma’s (2020) analysis of psychiatric care in Kashmir demonstrates that militarism and medicine are mutually constituted. She argues that ‘militarised care’ is both biopolitical and necropolitical, humanitarian and carceral. Health crises offer the state an opportunity to legitimise its presence and power. In Indonesian frontier obstetrics, care is dominated by the expanded provision of technological interventions.

Scholars of reproduction have long demonstrated the politics of care—who receives what reproductive rights and opportunities, who gets to define and decide what care looks like. Some focus on how care serves dominant political and racialised ends (Widmer & Lipphardt 2016; Davis 2019; Bridges 2011; Wendland 2007), including the technocratic narrowing of maternal health (Storeng & Béhague 2014). Others, building on Shellee Colen’s (1995) concept of stratified reproduction, critique reproductive processes and logics that unequally distribute reproductive opportunities and experiences (Ross & Solinger 2017; Smith 2019; Morgan & Roberts 2012; Whittaker 2004). Natali Valdez and Daisy Deomampo (2019, 551) define stratified reproduction as the ways ‘certain people’s reproduction is cherished, while the reproduction of others is denied and denigrated’. The idea of reproductive abandonment that we take up in this special issue focuses attention to understanding how and why denial and denigration take place, and the contestations involved.

The case of West Papua directs us to consider how settler colonialism shapes reproductive abandonment. Since Dutch colonialism and missionisation in the early twentieth century actively tried to destroy Indigenous reproduction and sexualities (Katmo 2018; Katmo et al., this issue), but especially in the Indonesian era, beginning in the 1960s, West Papuans have struggled to make families under life-negating structural conditions (Karma & Soenmi 2014; Hernawan 2015). Settler colonialism stratifies reproduction to advance territorial control and manage the Indigenous populations that trouble it (Million 2013; Howard 2018; Cidro, Bach, & Frohlick 2020). Indonesia has reproduced itself in Papuan territory via its own extensive population projects, particularly through fostering the in-migration and dominance of over a million non-Papuan migrants from other parts of Indonesia. In urban areas, non-Papuans are now the majority (Ananta, Utami, & Handayani 2016). State and global agendas mostly only facilitate contraception, and even this is curtailed. Care is 'militarised' (Varma 2020) and racialised, and the military has sometimes been directly involved enacting violent forms of care such as rounding up young female Papuan sex workers for HIV testing (Butt 2012), although more subtle expressions of this dynamic also exist. Thus, childbirth contests also represent and focus wider tensions over who has 'authoritative knowledge' (Davis-Floyd & Sargent 1997), who controls reproduction and what sort of future (and population) is desired.

The current form of settler colonialism in West Papua demonstrates that care is shaped by the frontier context. Anna Tsing (2003, 5001) argues that frontiers are an imaginative project defined in and through violence: 'On the resource frontier, the small and the great collaborate and collide in a climate of chaos and violence'. Frontiers are often 'sites of intense securitization, instability, conflict, and expansion' (Cons & Eilenberg 2019, 3). In what follows, we demonstrate that the frontier shapes care, with doctors and patients in competition alongside 'entrepreneurs and armies' (Tsing 2003, 5001). We chart the contours of 'frontier obstetrics', which includes clashing and converging desires and transformations, in the rise of hospital births and Papuan experiences of hospital births. The 'obstetric imaginary' (Cheney 2015; Smith 2019) in which biomedicine's cultural power engenders hope (Good 2001, 397) is highly uncertain. As we will show, contestations arise over c-sections—contestations that are deeply connected to what they represent for diverging understandings of population and the future. Technologies like ultrasounds and foetal monitors assist doctors to assert authoritative knowledge, if uncertain truths, about a pregnancy and the best way to birth, but the truth that Papuans are seeking often exceeds medical technology.

The Rise of Hospital Birthing and Obstetric Racism in Urban Papua

Hospital birth is situated within a racialised health care setting. Most doctors and health authorities are non-Indigenous migrants and settlers, and racism among doctors is increasingly well documented (Munro & McIntyre 2016). A Javanese

migrant doctor in Papua describes the challenges of 'patients with low education who need everything explained multiple times' ('Program wajib kerja' 2019).[3] Papuan leaders argue that the lack of Papuan doctors influences care (Munro 2020). However, 'medical racism can be enacted by people of any racial or ethnic background; what matters more is who is being acted upon, and who suffers the consequences' (Davis 2019, 6). Dominant Indonesian perspectives construct Papuans as lacking knowledge about childbirth.[4]

In terms of the rise of hospital birthing, most of our participants were born at home, suggesting a rapid intergenerational move to hospital birthing. Those born in large cities were more likely to be born in a hospital, even 20 or 30 years ago, but participants from smaller cities like Manokwari, Biak, or any of the highlands or coastal inland areas were typically born at home. As mentioned, all our female participants had given birth in a hospital at least once. It was more common for women to go to hospital for their first birth, while second or third babies were often born at home with the help of relatives. This pattern was true regardless of whether the mothers were younger or older, lived in a small town or a capital city and whether they were educated or not.

Participants said that both traditional and modern assistance were helpful for ensuring that pregnancy led to a strong infant and a healthy mother, and most participants had engaged antenatal care of different sorts. This included private doctors, ultrasounds, massage, diet and exercise. Besides health services, participants described seeking antenatal care from Indigenous women (usually aged 40–60) who were known for being skilled at helping with pregnancy, birth and postpartum care. This woman would massage the mother's stomach on several occasions before the birth to help get the baby into the head-down position for delivery. She would also provide support during delivery, including by preparing herbal medicines. Manu, father of three from Wamena, a town in the central highlands, described this multifaceted approach to antenatal health:

> So that the mother and baby are healthy they need to take any necessary medications, make regular visits to the health centre, eat lots of vegetables and fish, listen to music, go for walks in the morning and rub their bellies to invite the baby to talk. They should listen to medical advice. All this is so that the delivery is not difficult and there is no c-section. It also helps the baby to be physically and mentally healthy.

Contrary to some reports (e.g. Alwi 2009) regarding diet during pregnancy, no one said that women should avoid high protein foods while pregnant, but some said that food should be restricted to avoid growing a large baby that would require c-section delivery, a finding we return to later.

Many participants described negative experiences with hospital birth. Hilda went to the hospital for her first birth as she had heard that it is really painful. She said that the nurses were rude with her and when the baby crowned, they refused to take it out. When she complained, they said 'Did you think giving birth wouldn't hurt?' 'They waited until the doctor came … the doctor lifted my legs and the baby shot right

out'. So, her second and third babies were born at home with her sisters helping. Ripka, who had her first child at the hospital, said she was concerned that, 'at the hospital, if you take too long to deliver, they will deliver it by an operation [caesarean section], that's why I don't feel like going there'.

When in labour with her first child, Merry recalled being snapped at by nurses when she arrived at the labour ward, which was busy and too full. 'I was just following instructions, and I was yelled at … Then I had to wait outside until I was 7 cm dilated'. Many said that labour wards were stressful and overcrowded and nurses were unsupportive. Carlina, a mother of six children who were all born in hospital in Jayapura, described her own experience and her observations of other labouring women:

> Six times I gave birth in hospital, I didn't really experience the challenges that I saw other women facing. They moved around a lot, screamed, got angry at the nurses and others, and so it seemed like they were not treated well. On the contrary I always chose to stay quiet and calm and followed all of the instructions from the nurse. They felt valued and they took good care of me, they were friendly and the results, I think, were very good.

At one birth that Jenny Munro witnessed, a stranger walked into the curtained cubicle where a half-naked mother was pushing the baby out. Other women said that strangers roaming around hospitals made them fearful for their infants, who are widely believed to be vulnerable to dark spirits and unseen forces right after birth. In addition to these fears, delays and stresses, women reported receiving little to no post-partum care or assistance with newborn care from the hospital. This is significant given the importance of post-partum care for maternal and newborn health (WHO 2019). Negative experiences with health services were likely a deterrent to hospital births for subsequent pregnancies, especially for women who felt they struggled, were in labour a long time or had been vocal about being in pain.

Thus, while participants were not opposed to using health services for pregnancy and birthing, they were more likely to use antenatal care than consistently birth in a hospital. There was general, but not universal, agreement that an urban home birth was better than a village birth because it would take place in a clean household environment where water, supplies and food were more accessible. We note instances of obstetric violence, including leaving women in pain, refusing to deliver the baby, verbal abuse, neglect and fears of being coerced into a c-section, something we explore more fully below. Obstetric violence combined with medical racism leads to 'obstetric racism' (Davis 2018, 2–3): this includes critical lapses in diagnosis; being neglectful, dismissive, or disrespectful; causing pain; and engaging in medical abuse through coercion to perform procedures or performing procedures without consent. We add that women felt they had to be quiet and obedient to receive care, that their privacy was not protected, and that some felt unsafe, in part because cultural beliefs were not considered. Urban Papuans embraced plural forms of care and technology, but hospital staff and health care approaches were largely unaware of Papuan preferences and values.

C-Sections: A Frontier Approach to Reducing Maternal Mortality?

The history of c-sections in West Papua is still being written. We first heard Papuans expressing concern about the growing rate of caesarean sections during HIV research in Manokwari in 2011. The increase was possibly shaped by the HIV epidemic which is concentrated among Indigenous Papuans. From health workers, we learned that (in line with global health recommendations) c-section was considered an essential way of preventing vertical HIV transmission. Without widespread testing, education and treatment, it was often the only option left. NGO workers described organising emergency flights for women from remote areas to undergo c-section in Manokwari. Maternity staff know that HIV is more prevalent in Papuans, and that most women would either not know their status or may not disclose it. C-section was perhaps as much about protecting health workers from accidental exposure during vaginal birth as it was about preventing mother to child transmission, and it was situated in the context of a mismanaged HIV crisis. Given the circumstances, it is not surprising that Papuan NGO workers and health activists questioned whether c-sections were for their benefit at all, and they suggested that c-sections were being used to stop Papuan fertility through forced sterilisation, limiting the number of children a woman could have, and spacing their births by up to 5 or 7 years.

Our study participants were also concerned about c-sections, but they drew attention to a wider range of reasons. They said they felt it was bad for the baby and the mother. They worried the doctor could sterilise the mother, put organs back wrong, or cause injury. Feelings about c-sections were, according to participants, largely ignored by doctors. Concerns about c-sections plagued participants during and perhaps even prior to pregnancy, and desires to avoid a c-section affected decisions they made about antenatal care and where to give birth. Avoiding or giving in to a c-section came to dominate the obstetric encounter, causing further consequences and effects.

In fact, the predominance of caesarean sections among our participants was unexpected and crossed a range of income levels, urban and rural, younger and older mothers. We did not sample for c-sections, but over half ($n = 35$) of our participants had a child born via c-section. It is likely these people were more interested in talking about childbirth, so this should not be taken as evidence of a high prevalence of caesareans. In Indonesia, c-sections have increased rapidly over the last 20 years. The estimated prevalence in West Papua is around 10 per cent but higher in urban areas, and the rate doubled between 2007 and 2017 (Zahroh et al. 2020). Rana Zahroh et al. (2020) show that among middle-income women, c-section rates are higher in West Papua than in most other Indonesian provinces, including Java and Bali.

In terms of reasons for c-sections, only two of our participants stated, or provided a description suggesting, that it was an emergency c-section. Rather, they were told upon arrival in labour or during antenatal care. The most common reasons were: the mother's pelvis was too small; the baby was too large; the baby was overdue;

the baby was breech or transverse; low amniotic fluid; cord around the baby's neck; the mother had a previous c-section. These are all medically legitimate reasons for a c-section, but the medical encounter raised questions among some participants about how the doctor diagnosed most of these problems. Data from Zahroh et al. (2020) show that poor women in Papua/West Papua have the highest likelihood of c-section being advised before the onset of labour, far greater than wealthy women in Java or Bali who are most likely to undergo c-section after the onset of labour. In our study, one woman recounted, 'The doctor said that because Papua's maternal mortality rate was too high, I should have a c-section'. This is an example of frontier obstetrics because it erases the patient and ignores the serious risks associated with caesarean sections in search of a magic bullet.

Often, no reason was given for a c-section. Aleng and his wife had two children born by c-section in Jayapura. In the first instance, they were told the baby was too large for his wife's pelvis and agreed to the c-section. The doctor further advised that his wife be sterilised. Aleng was not sure if there was any medical reason for this but they said no to sterilisation. On the second occasion, according to Aleng they were 'directed straight to the operating theatre with no assessment and no explanation whatsoever'. His wife complained that she did not want a c-section and asked to be taken home or to another hospital. The c-section was scheduled for 7 am, so she stayed and laboured through the night, delivering vaginally at around 6 am. Aleng regarded the doctor's initial order as a mistake, since there did not seem to be any physiological reason his wife could not deliver vaginally. He continued, 'I am quite certain that many Indigenous Papuans face this kind of treatment when giving birth in the hospital'. In Aleng's case, various cues constitute his experience of frontier obstetrics—a questionable diagnosis, advice to sterilise, no assessment or information, and an unnecessary surgical intervention.

Yakoba, who lived in Wamena, was sent for a c-section in 2007 because her pelvis was said to be too small. The operation went fine, but during her second pregnancy Yakoba was sent for another c-section because, as in many places, attempting vaginal birth after caesarean is considered medically risky. Unfortunately, the hospital was unprepared for Yakoba. The water was not working so they were out of sterile equipment, and they could not find the key to the operating theatre, so, after her family threatened to block the road and cause a riot, she was rushed to a private clinic where she underwent a $AUD4500 c-section paid for by the local government official. She subsequently haemorrhaged and spent a week in a coma while receiving blood transfusions. Yakoba's experience offers another example of frontier obstetrics: simultaneously costly, risky, chaotic and life-threatening because notions of safety are not calibrated for a setting that lacks comprehensive obstetric care.

Benedikta (a Marind woman living in Jayapura area) did not want a c-section and was worried about risks that the doctor had not seemingly discussed, like cleanliness and recovery time. Benedikta shared:

> When I was 7 months pregnant the GP at the pharmacy said 'the baby is healthy, but you have high blood pressure'. Later the amniotic fluid started leaking and I was advised to go to the hospital. The doctor there said that there was no rupture, but that 'the baby is transverse so the baby can't be born normally, it must be operated on' … I was shocked because an older sister had a caesarean and was very weak for a long time. The family also didn't accept this, they were afraid [the hospital] would be dirty so that night we went home. The next week we went to a different hospital, but it was the same doctor [on duty]. When he saw me, he said, 'This is a runaway patient!' So we started to follow the doctor's advice. What was really sad and distressing was that we had to wait in the delivery ward from Friday night until Monday morning for the operation.

Rather than ask more questions or refuse the c-section directly, Benedikta initially left the hospital and hoped to get different advice somewhere else, a logical reaction considering the various diagnoses she had during her pregnancy. The doctor's remarks were judgmental about her decision to leave the hospital and go against his advice the first time. He showed little understanding of her fears about undergoing surgery in a potentially dirty or unprepared environment. While initially confident enough to refuse, after being publicly embarrassed she then felt compelled to undergo the c-section. The fact that she had to wait three more days before the c-section suggests it was not an emergency and the delay could be interpreted as punishment for her initial refusal. Doctor–patient hierarchies are common in Indonesia and many people do not feel comfortable asking questions or challenging a doctor's view (Susilo et al. 2019). In the frontier context, where services are uncertain and populations are vying for dominion, medical hierarchies enact shaming and humiliation that is endemic to Indonesian colonialism (Munro 2018; Katmo 2018).

Melanie (from Biak) was 23 when she had her first baby, an experience she described using the Indonesian–English word 'trauma'. Before she went into labour her doctor told her she would need a c-section because the baby was too large, and she was too small, with narrow hips. When she arrived at the hospital in labour, Melanie agreed: 'I just wanted the baby out because I was in too much pain'. But the operation caused her much more pain than she had expected. Once the anaesthetic wore off, it was extremely painful, and she stayed in her hospital bed for five days. She couldn't move at all. Back at home with her newborn, she could not undertake any activities and had no one to help her. Her sister and some other relatives criticised her for not being strong enough to give birth vaginally. The doctor also told her to wait five years before having another child and she was put on Depo-Provera birth control injections. She stayed on birth control for four years, but during that time she never menstruated, which made her worry about the effect it was having on her body and whether she would be able to get pregnant in the future.

Melanie's experience resonates with other women, usually first-time mothers who were in pain and afraid of what might happen if they did not agree to a caesarean. There was not much information from the doctor about the risks or what to expect and seemingly little pain management and no post-partum care. While the care centres on diagnosing Melanie with a narrow pelvis, which can be solved

through a c-section, other crucial aspects of maternal and reproductive care are missing.

Women described strategies to avoid a c-section, such as going home against medical advice. Teresa (Biak woman in Manokwari, 34 years old with two children born at home) said, regarding her third baby:

> The doctor said 'You need an operation because the size of the baby according to the ultrasound is 3.8–4.0 kg with the cord around its neck and the amniotic fluid is murky and low'. But I was sure I could do it normally, so I did it at home with a nurse [*bidan*] and the baby weighed in at 3.5 kg, there was no obstruction.

Some women also spoke of trying to avoid a big baby through restricting their food intake and arriving at the hospital late in labour when the baby was about to be born. Similar activities have been reported in other parts of the world where women wish to avoid a coercive c-section (Pourette et al. 2018; Lowe 2019).

To avoid a caesarean, some fathers described how they refused to give consent by avoiding the area, delaying the process or, like Manu, re-writing consent:

> I refused to sign while I talked with the family first. We were still waiting for a normal process because there had been no evidence of danger given by the nurses … I did sign the form, but I wrote that I give my consent at the doctor's will not my own.

Indonesian law permits family members, including spouses, to consent for their relatives (Wahyuni, Laskarwati, & Al Qulub 2020). While only fathers discussed their navigation of the consent process, this might be because, as some mentioned (such as Manu, and Nateb below), they found it disconcerting that they were asked to give consent on behalf of the mother, especially if she did not want a c-section, and without discussing it with her relatives. This indicates that if there is a consent process it is not culturally appropriate.

The tensions around consent, discussed further below, reveal a 'legalised lawlessness' common to frontiers (Dunn & Cons 2014). Informed consent is legally mandated in Indonesia, but doctors are at very low risk of formal or legal actions if they do not follow the law due to existing complaint structures (Asia Pacific Observatory on Health Systems and Policies 2017). Moreover, the burden to act ethically is arguably minimised in the name of saving lives. Vinh-Kim Nguyen (2010) describes this as the logic of triage. At the same time, consent has clearly emerged as a key feature of hospital births around which fears of c-section and depopulation coalesce as Papuans consider whether they believe the medical advice is in their best interest or is another kind of invasion.

Increasing uptake of hospital birth creates more encounters with medical expertise, and some participants indicated that a c-section was advised with little to no assessment and no justification provided. How a doctor would diagnose a baby's position, age or size without examining the mother is an important question. It is also interesting that doctors diagnosed large babies as a reason for c-section since there is no standard foetal growth chart in Indonesia (Anggraini, Abdollahian, & Marion 2020).

These findings raise questions about whether c-sections are seen as an 'easy' way to reduce maternal mortality (Freyermuth, Muños, & Ochoa 2017). Frontier obstetrics is guided by a logic of triage and saving lives, so it is care stripped bare but also creates and reflects uncertainties and hierarchies. It does not allow for Papuans to be agentive patients with their own priorities, values or capacities, although some try to assert these anyway.

Contestations Over Truth, Care and the Future

Technology contributes to reproductive abandonment because it supports biomedical knowledge claims and clinical decisions—about Papuan bodies, permissible futures and care. Our participants often disputed or rejected these claims. They emphasised getting the truth from doctors as part of the political project of defining their own futures, including what care looks like, and what care they need.

Sometimes a caesarean was advised without any examination, but in other cases it was an ultrasound or foetal heart monitor that doctors or nurses used as evidence, leading to debates over the truth and whether doctors could be trusted. Nateb, a Mee father from the western highlands, born in 1989, living in Jayapura, described his daughter's birth as follows:

> According to the nurse … according to the heartbeat monitor the baby's heart could be in danger and [it] could die. A nurse brought in an oxygen machine, surgical tools and other things … But the mother did not want a caesarean … to avoid the pressure from the doctor to sign the declaration letter I avoided the area, pretending to be busy doing something. At that point the baby's head was already at the exit. The doctor said, if anything happens to the mother or baby the hospital will not be responsible.

The doctor was reportedly pressuring Nateb and creating fear, both of which are considered malpractice in Indonesia. The reference to responsibility is not likely to mean legal responsibility but perhaps the doctor feared retribution. When conducting earlier HIV research, we heard that some health workers have been threatened by patients for delivering a seropositive diagnosis (Munro & McIntyre 2016). Yakoba's family, mentioned earlier, said they threatened to block the road and cause a riot if doctors did not attend to her. This is not the same as seeking retribution for a maternal or infant death, and we did not hear any stories of patients taking revenge on doctors or hospitals for an adverse outcome.

Nateb's wife delivered vaginally but 'that day [when his fourth child was born vaginally] only two babies were born normally [vaginally], and seven were born by c-section'. He continued:

> This experience left me feeling really disappointed in the doctor because in principle I believed him 100 per cent … but in the end he asked for a caesarean … [the doctor] was Christian too and had lived in Papua a long time so I believed him. When we went to a Papuan doctor, the explanations were a lot different from the first two doctors. The doctor explained what the mother should have in

> her diet to help the brain development of the baby so Papuans can give birth to a generation that is smart and strong.

Nateb emphasises the belief he had which was shattered when he was threatened into a c-section that his wife did not want. Engaging with frontier obstetrics means assessing relationships and political agendas—whose side is the doctor on? And as Hatice Erten (2015, 8) found in her study of c-sections in pro-natalist Turkey, 'population discourses emerge and operate through discussions concerning the C-section'. Is medicine aligned with Papuan futures? Regardless of what may seem like firm boundaries between Indigenous and non-Papuan inhabitants, these relationships are highly contextual, diverse and messy in everyday realities. Thus, despite endemic racism, and 'mutual racialisation' (Butt 2013), a medical encounter still conjures the possibility of trust.

Nateb's hope is not particularly directed at biomedicine but rather that relationships and mutual understanding could lead to care—a Christian doctor familiar with the Papuan context would do everything in his power to avoid a c-section. While Papuans' mistrust of Indonesians is often glossed as conspiracy, in many cases there is empirical evidence and rational observation that contributes to mistrust, as Leslie Butt (2005) demonstrated in her analysis of AIDS 'conspiracies' in Papua. In fact, an obstetric nurse-in-training who we spoke to explained that all the doctors she had worked with so far in Jayapura automatically recommended women less than 153 cm in height give birth by c-section. Moreover, if a doctor suspected the patient would not agree to a c-section, he referred them on to a different hospital. Thus, we cannot say whether the observations of Nateb and others reflect the routinisation of c-sections for Papuan mothers, but we cannot rule it out either. We agree with Varma's (2020) assertion that in militarised contexts a broader culture of impunity breeds mistrust and malpractice in medicine.

Klara, a Marind woman living in Jayapura, also described struggling to find out the truth about her pregnancies through a series of fraught encounters with doctors and ultrasounds to avoid a c-section. Participants' emphasis on truth, as well as the language of confession that they sometimes used, reflect Papuan efforts to decolonise. Much Papuan activism has given a central place to the need to correct history (Glazebrook 2008), to reveal the truth of Indonesian occupation (Haluk 2012), to give and share testimonies of suffering (Giay 2001). Caesarean section, for Klara, represents another form of colonial deception. Her first two children, in fact, were born in Jakarta, the national capital. She spoke of the excellent care she received at a Christian birth clinic with her first child. Klara went back there for her second child, after undertaking regular checks throughout the pregnancy, and was told that she would need a c-section because the baby was in a breech position. She said that she felt deceived:

> The doctor at the hospital was never honest about the position of the baby for the 8 months that we had been seeing him. [Suddenly] they said that the baby was

> breech, and I was really angry because the baby was already nine months, I was in pain and suffering in labour, and I had to go here and there in Jakarta traffic jams to find the truth about the position of this baby.

She ultimately acquiesced to a c-section at the birth clinic in Jakarta but suffered an injury when they injected the epidural, had to stay in hospital for two months, and has permanent nerve damage. As a result, she cannot sit up straight and is quickly fatigued.

When Klara was pregnant with her fourth child, in Jayapura, on a routine visit at about 34 weeks the doctor said the amniotic fluid was leaking so she should have a c-section. Not convinced, and worried that she could die or be injured again, Klara and her husband visited another series of doctors, who all had different explanations for what was happening, and ultimately had another c-section. Revealing fears of depopulation and the importance of fertility for Papuan futures, Klara explained:

> We don't have to 100 per cent believe in the medical advice, maybe just halfway believing is best … Us Papuans are only a few, we still need a lot of Papuans to care for Papua's nature so it is best to avoid the path of caesarean unless it is the last option. We can see that the medical professionals don't solve the problems very well and, in the end, they keep asking us to go on the family planning programme or get sterilised so we cannot have more children. This reality is different from the hopes of us Papuan people who want information that is true and accurate. We believe in the medical staff, so we hope they should protect our trust by giving us the correct information.

Other participants similarly struggled to find out whether in fact c-section was their last option, as Klara said, or whether it just suited the doctor and, by extension, the Indonesian state. For example, Manu (Balim man living in Jayapura) said: 'I want the data, if the pelvis is small, the baby is big, I want the results of the ultrasound. They didn't respond which made me more sure this was all a game'. Similarly, Renwa (Kei man living in Jayapura) said: 'So, the conclusion is that when you go to the doctor for examinations the doctor must acknowledge [*mengakui*; lit. confess] the result of the ultrasound properly and we have to see it first then believe it'. These reflections show contestations over whether technologies simply do the will of medical professionals who are not invested in Papuan futures. They also show the complexities of medicalisation in a frontier context where historically situated 'knowledge practices', such as seeing the truth about pregnancy by looking inside a uterus (Erikson 2007), are not just questioned but politicised.

Truth, as Klara's comment shows, is the basis for trust. But the truth of medical diagnosis is often uncertain, or even undesirable. Not telling the truth can be a way to protect relationships (Street 2014). The truth Klara seeks means that doctors act within the understanding that for many Papuans, c-section should be a last resort, not a routine instruction, because it symbolises the wider fate of the population and may be experienced as a devastating invasion of bodily and cultural autonomy.

Conclusion

It is increasingly evident that technology does not usually improve birth outcomes or experiences for Indigenous, minority or racialised women (Finestone & Stirbys 2017; Chattopadhyay, Mishra, & Jacob 2018). We have provided some further insights into how and why that is the case by examining the confluence of reproductive abandonment and settler colonialism in West Papua.

We found many Papuans in cities are engaging with the medical system and prenatal technologies and interventions. We also found new varieties of obstetric racism (including avoiding or referring on patients who are predicted to be less compliant); the language it may be couched in (saving lives); and how shaming, fear and technology are embedded in obstetric violence. As Dána-Ain Davis (2019, 2) points out, 'technologies of saving' do not change racialised disparities. Rather than being presented with a series of options governed by neoliberal notions of self-responsibility and subtle encouragement from health care workers (McCabe 2016), Papuans seeking to give birth in a hospital seem, rather, to be simply told what to do with little subtlety or pretence of choice and freedom. Or, if there is a choice presented, it is only a choice between life and death, and that is understood to be good enough, for frontier obstetrics. Our participants were eager to seek out reproductive assistance that would help them to have smart, strong babies. Some participants connected this to surviving as a people, a clear aspiration for something beyond life or death, reflecting concepts such as 'reproductive justice' (Ross & Solinger 2017) or 'reproductive sovereignty' (Cidro, Bach, & Frohlick 2020).

Within frontier obstetrics, care is minimalistic, invasive and uncertain. Where one doctor publicly embarrasses a reluctant patient, another doctor reportedly sends all short-statured women for a c-section. Sometimes no explanation is provided, and fathers are pressured to consent to c-sections. Moreover, for some Papuans, the hospital experience includes disrespect, verbal abuse, lack of privacy and little consideration for cultural understandings. Further, it is a feature of frontier obstetrics that the ethical, legal and cultural expectations of doctors may be eased, because doctors are few and maternal mortality is high. Saving lives takes precedence over culture, consent and what kind of existence Papuans want. Reproductive abandonment within the frontier shapes care such that it displays and legitimises Indonesian state power, especially through surgery and medical technologies.

While colonialism has produced structural inequalities, the frontier context also makes for dynamic, uncertain relationships, logics and practices. Thus it is possible that some Papuans said they trusted doctors, or they believed in the medical system, or they were confident that if they kept pursuing the truth about their pregnancies they would find it. Also, it is possible for some to encounter doctors who acknowledge their views, at least about having smart, active babies, if not about securing the future. As Catherine Smith (2015, 274) argues for Aceh, another Indonesian site of protracted state violence and reproductive abandonment, 'biomedicine is a [source] of terror and a point of imagination and longing' (see also Pinto 2004,

337). Where reproductive abandonment meets settler colonialism and frontier obstetrics the result is a broad failure to see the importance of birth sovereignty and reproductive autonomy for people subjected to dispossession and erasure. We see in these birth stories that rectifying reproductive care entails rewriting relationships and renewing Papuan control over population and land, not just saving lives.

Notes

[1] Because data are not disaggregated by Indigenous heritage or cultural identity, these dire statistics do not reflect maternal mortality among Indigenous Papuans, a common tactic for disappearing inequities.

[2] The earlier interviews were conducted by Munro in the course of health services evaluations in Wamena and Manokwari sponsored by local NGOs and funded by the Canadian International Development Agency and the Canadian Institutes for Health Research Knowledge Translation initiative. These were conducted in line with ethics approval from the University of Calgary and vetted locally in consultation with scholars from Cenderawasih University, the University of Papua, and community elders. Interviews by Katmo and Wetipo received ethics approval from the Australian National University and the University of Queensland, and were vetted by their respective institutions. They received government approval from district and village authorities. Research funding was provided by the University of Queensland.

[3] Until 2017, the Indonesian government mandated that specialists had to take up appointments in remote areas for two years (Efendi 2012). This has been replaced by an incentive system.

[4] For example, a recent study (Haya et al. 2014), facilitated by World Vision Indonesia, actually investigated whether Papuan highlanders give birth in animal pens or in the forest alone, and while it found that they do not, it argued that 'the subjects did not understand the concept of date and time, and they recognized their pregnancy only after their abdomen looked larger' (64).

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