Genezers op de koloniale markt: inheemse dokters en vroedvrouwen in Nederlandsch Oost-Indië, 1850-1915
Hesselink, E.Q.

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In 1851, the government of the Dutch East Indies established two schools in the capital city of Batavia, a medical school for male students and a midwifery school for female students. The schools’ purpose was to offer two years of medical training to indigenous students who, upon graduation, would provide Western medical and obstetric care to the native population. In this manner, the colonial government hoped to reduce what they perceived to be the nefarious influence of doekoens (traditional healers) who constituted the primary caregivers among the indigenous population. In order to assess the successes and/or failures of the graduates of the two schools in reaching their goals, the conceptual approach used in this dissertation is the application of the so-called medical market model, which offers a range of analytic possibilities. Through the use of the metaphor of supply and demand it becomes possible to chart all caregivers – both regular and irregular, both European and native – who provided healthcare to those who demanded and were in need of medical attention. The graduates of the two schools represented new entrants in the medical marketplace(s), and the central question of this dissertation is to examine which positions they would acquire in the medical infrastructure of the Dutch East Indies during the period 1850-1915. In order to venture an answer to this question, it is first necessary to examine and describe medical conditions in the Dutch East Indies, with a particular focus on the island of Java, around the year 1850 for the purpose of situating the medical and midwifery schools in their social and medical context.

In the first place, medical care was offered by doekoens. They displayed distinct forms of specialization: some treated only internal diseases, while others were either experts in massage or specialized, such as the doekoen baji, in obstetrics. The professional skills of doekoens entailed both magical incantations and the use of appropriate formulas and rituals at the right moment during treatment.
However, they also employed experiential insights into the efficacy of particular medical interventions and techniques as well as basic empirical knowledge about the medicinal effects of herbs and plants. At the same time, as another part of the supply side, sufferers could cultivate their own medicinal herbs and plants or they could buy them at market stalls, where sellers also offered advice. Some entrepreneurial women prepared medical ointments and syrups, which they sold door to door. In many instances, *drogisten* – i.e. the makers and sellers of medicinal powders, ointments, syrups and other preparations – were of Chinese origin and thus members of a social group in Java and elsewhere in the archipelago that constituted a fairly isolated community. Chinese inhabitants relied on a separate political leadership structure, and had their own doctors (*sinse*), and their own apothecaries and hospitals. Although smallest in number, most is known about the European settlers because they left the lion’s share of written records behind. European suppliers of medical treatment consisted of medical officers in the Dutch colonial army, whose task it was to provide health care not only to soldiers in the garrisons where they were assigned but also to civilians in the surrounding community. In Java’s three largest cities – Batavia, Semarang and Soerabaja – a number of physicians and midwives, appointed and employed by the colonial authorities, provided medical services to the urban populations. In addition, around 1850 only a handful of private doctors, midwives, and civilian or military apothecaries were available.

A range of hospitals also supplied medical care. The colonial government maintained not only military hospitals but also civilian ones, which were often dedicated to the treatment of native prisoners or forced laborers. Chinese hospitals were specialized in caring for ethnic Chinese patients and to oversee mental patients belonging to other ethnic groups, until a psychiatric institution was created in Buitenzorg in 1885 and another mental hospital was established in Lawang in 1902. Because of public health concerns related to syphilis and sexually transmitted diseases, prostitutes were required to submit to a medical examination at regular intervals; in case of infection they were committed to infirmaries specifically for sexually transmitted diseases or incarcerated in a special division of a prison. Moreover, in the Preanger region of West Java, a few indigenous hospitals existed that were financed and maintained by Islamic tithes – *zakat* – which were faithfully paid by Muslim communities in the Sundanese area.

In principle, the demand side for medical services issued from all population groups in Java: Javanese, Sundanese, Madurese, Chinese, Arabs and Europeans. Which medical supplier they decided to approach depended on the patients’ conceptions of health and illness. Even if almost all of Java’s native inhabitants were Muslims, their understanding of issues of health and disease was influenced by animist notions, prompting them to view illness as a disruption of their physical equilibrium due to a loss of spiritual potency which, in turn, was caused by either evil spirits or excessive emotions. Personal harmony might be returned via magical incantations and/or medicinal herbs. Given these convictions, it made
It is evident, however, that not one but several medical marketplaces coexisted in which medical services were offered and consumed. Each of these markets was both determined by the particular composition of the local population and shaped by access to available caregivers. Prevailing social and cultural factors had a regulating influence on the dealings between sufferers and caregivers. Throughout Java and other regions of the archipelago, a potent force that forged this interactive process derived from regional notions of adat – customs and traditions – which were relevant, for example, in the case of childbirth. What needs to be noted, however, is that the colonial government of the Dutch East Indies in 1850 did not engage in concerted efforts to regulate the medical marketplace(s). In compliance with the governing ethos of indirect rule, the Dutch colonial regime only took measures with regards to the forms of healthcare provided by and for Europeans. Exerting overt pressure on the indigenous population to rely more on Western medicine and trained doctors and midwives instead of native healers did not conform to the preferred governing style of indirect rule. The colonial government had divided the population of the archipelago into three categories formalized by legislation: Europeans, foreign Orientals and Natives. Daily life transpired mostly within the autonomous circles of the three separate communities; this tripartite division inevitably affected the medical choices and options as well. There were exceptions. (Indo)European women, for example, often requested a doekoen baji to help with the delivery of a child. At the same time, some European physicians counted Chinese and Arabic residents among their patients. A more structural overlap between the different medical marketplaces in the Dutch East Indies was grounded in the knowledge and use of the medicinal properties of herbs, spices, roots and plants.

It was within this context that the school for native doctors (dokter djawa) and the school for indigenous midwives were established. Given the Dutch colonial preference for indirect rule, which implied abstaining as much as possible from direct interference in the social and cultural life of the indigenous population, the foundation of the two schools appeared at first glance to be an anomaly. In fact it was an ambivalent but inexpensive experiment. Inexpensive because the public revenues required to establish and run the schools were small, as the Minister of Colonial Affairs, J.C. Baud, remarked around 1850. The ambivalence of the experiment can be derived from the lack of clarity as to how the dokter djawa could be incorporated into the colonial civil service. Initially, the native doctors did not receive a salary but instead, had to make do with a small stipend, and as such they were not civil servants and thus not entitled to carry a pajong (umbrella), the status symbol par excellence in Javanese culture.
This deprived them of the status and formal respect customarily bestowed upon members of the civil service and hindered their ability to gain trust and deference among the native communities where they worked. What also seems ambivalent is that, although they were trained medical professionals, in fact they were basically only employed as vaccinators.

For young Western-trained midwives it was also difficult to build up a patient base among native women. Because of their youthfulness and their Western tendency to interfere as little as possible in the natural process of childbirth, indigenous pregnant women continued to prefer the much older doekoens who had more experience in helping deliver babies and who engaged in the more interventionist and elaborate ritual practices dictated by adat. Graduates from the midwife school also received a government stipend and, in return, they were required to provide free-of-charge obstetric care to the poor segments of Java’s indigenous population. However, although their aid was free the young midwives did not find many clients among native women. Instead, they ended up dedicating their professional skills to pregnant women among the Chinese and (Indo) European communities, who appreciated their Western training and gladly paid them a handsome fee. Twenty five years later, the colonial government decided that the experiment of the midwife school had failed to achieve its purpose of reducing the nefarious influence of doekoen baji on prevailing childbirth practices and maternal and/or infant mortality within the native communities of Java. Hence, the school was temporarily closed in 1875. What needs to be added here, is that the dokter djawa school had not fulfilled its expectations either. However, because the native doctors had proven to be a valuable addition to the colonial government’s medical service, as they could be put to work on a wide variety of tasks, it was decided to continue the funding of the school for native doctors.

In fact, the government decided in 1875 to make the curriculum of the dokter djawa school more elaborate and to extend the training from three to seven years. In the same year, the annual number of enrolments was doubled from fifty to one hundred, while Dutch was introduced as the official language of instruction. In 1889, the ability to speak, read and write Dutch became a prerequisite for admission. But the uncertainties about the social status and financial remuneration of the dokter djawa within the European and indigenous medical markets continued to linger. In comparison to other indigenous members of the colonial civil service, their salaries fell behind. Although they received the right to display the pajong as a status symbol in 1882, the indignity of their low financial remuneration was compounded by the fact they were forced to relocate frequently. Having to move so often not only made the lives of dokter djawa more expensive but also disrupted the ties of trust with their patients. As a consequence of these lingering economic issues and their lack of formal status within the Dutch colonial civil service, many students of the dokter djawa school stopped their education before receiving their degree. Moreover, a growing number of graduates chose to accept employment on a private-sector plantation or a factory
where they could receive financial remunerations that were far greater than the salary prospects offered by the colonial government.

Around 1900, however, the Dutch colonial administration experienced a major shift in orientation due to the enunciation of so-called Ethical Policy. The colonial state began to accept a formal responsibility for the physical health and wellbeing of the native population. This implied a much greater demand for physicians and other healthcare workers. As a result, the educational requirements and student conditions at the dokter djawa school improved once more. The curriculum was expanded and the training programme was again extended, in 1902 to nine years and in 1913 to ten years. The number of students grew from one hundred to two hundred, while a new building with better facilities was erected. A new name was expected to be a telling sign of the new status of the school: School for the Education of Indigenous Doctors (STOVIA). The salary prospects for graduates were raised to a more reasonable level and a new contractual arrangement was introduced – the so-called Acte van verband – compelling STOVIA-trained doctors to work for the government medical service for ten years following their graduation.

Now that the scientific training of STOVIA doctors had become increasingly sophisticated, they were endowed upon graduation with a growing independence and authority as physicians and actors in the medical marketplace. While their medical responsibilities in a growing number of instances acquired parity with European colleagues, their financial rewards remained inferior. At the same time, the native doctors increasingly served as intermediaries: because of their cultural origins in the native communities, combined with their Western medical knowledge, they were treated as bridge builders between the European medical establishment and native patients. During the first decades of the twentieth century, despite the contractual arrangement that forced STOVIA graduates to perform government service for ten years after graduation, a growing number continued to accept private-sector employment. Although policymakers considered a plan to lower the educational requirements of STOVIA in order to increase the supply of native doctors, in the end a political choice was made in favor of a smaller group of highly educated indigenous doctors; in 1904, STOVIA doctors also received the opportunity to complete further medical education at academic institutions in the Netherlands, which a few of them did with success.

STOVIA doctors’ burgeoning intellectual stature, in some cases culminating in successful academic medical training the Netherlands, produced tensions. Some Dutch physicians were deliberate in their attempts to humiliate their indigenous fellow doctors because they remained convinced that native medical practitioners were incapable of working autonomously and responsibly without Dutch supervision. The Vereeniging tot Bewordering der Geneeskundige Wetenschappen in Nederlandsch-Indië (Society for the Encouragement of Medical Sciences in the Netherlands Indies) decided in 1902 to exclude native doctors from full membership. After this, STOVIA graduates and older graduates from the
erstwhile dokter djawa school decided to establish their own professional organization. They also rebelled against the discourteous treatment received from high-ranking priyayi (indigenous elite) members of the colonial civil service, who often did not wish to acknowledge the superior training of STOVIA doctors and simply dismissed them on a par with lower-ranking native civil servants with much less education. Some priyayi and Europeans even refused to pay them for treatment, referring to an adat-rule which was supposed to forbid to ask remuneration for services from somebody with a higher status. Some of the STOVIA-trained practitioners tried to escape from these embarrassing situations by wearing Western clothing, making visible that they felt themselves as being part of Western society. But in this Western world they were certainly not accepted by everyone. Dutch civil servants, for example would often answer them either in Malay or in incompetent Javanese, which STOVIA doctors experienced as an insult, since they had thoroughly and proudly mastered Dutch as it had been the lingua franca of their ten-year medical training. All in all, the position of native doctors in the Netherlands Indies in 1915 was controversial and personally frustrating, for a degree because of the reluctance of Dutch medical practitioners to approach their native colleagues as professional equals and to treat them as genuine partners in the medical marketplace.

The temporary closing of the midwives’ school in 1875 turned out to be permanent. Instead, in 1891 a one-to-one apprenticeship program was started in which a small group of young women could learn obstetric skills from European doctors. This produced few trained midwives because European physicians were reluctant to take on young women as apprentices and few young native women volunteered for the training. As a result, the doekoen baji maintained their virtual hegemony as birth attendants who assisted almost all native women with the delivery of their babies, even though some Western-trained midwives were able to negotiate a relationship with a local doekoen baji, who might call for assistance in the case of complications during a delivery.

In late 1898, the renowned editor in chief of the important Dutch national newspaper Het Algemeen Handelsblad, Charles Boissevain, initiated a public debate about childbirth practices in the Dutch East Indies with a controversial article entitled ‘Blanke en bruine Indische moeders’ (White and Brown Mothers in the Indies). Boissevain’s article provoked reactions in both the Netherlands and the Dutch East Indies: it resulted in an endless series of back-and-forth responses in medical journals as well as mainstream newspapers and magazines. In this heated discussion, H.B. van Buuren played a prominent role; as the physician of the town of Kediri in East Java, he was one of the few European doctors who guided and supervised midwife apprentices. He embarked on a veritable crusade against the doekoen baji. Thanks to Van Buuren’s relentless campaign against the dangers of native midwifery practices, the issue continued to figure on the political agenda of the colonial government. However, around 1910, the decision was taken to give priority to improving general medical help in the Dutch East Indies over better obstetric care.
When reviewing the situation of the medical marketplace(s) of the Dutch East Indies in 1915, a few notable changes with 1850 can be discerned. On the demand side, the number of potential patients increased exponentially due to the demographic expansion of the native population and the growing presence of European men and more particularly women in the archipelago. The implementation of the Ethical Policy in 1901 was another important change, resulting in an expansion in the range of medical facilities. New hospitals and clinics were constructed, often led by native personnel. These developments also produced a new generation of STOVIA-trained native doctors.

Due to the increase in civil medical services, the colonial government initiated the *Burgerlijke Geneeskundige Dienst* (civil medical service, BGD) in 1911, which took over the medical care of the civilian population which had previously been the often disregarded responsibility of the *Militaire Geneeskundige Dienst* (military medical service). In principle, the BGD considered providing health care to the indigenous communities to be the task of native physicians. More and more hospitals were not run by the government but by private charities such as the Salvation Army or managed by religious organizations. In these hospitals, a native nursing staff was trained and only the most educated nurses received further schooling to become specialized as practicing midwives. What also shaped the medical marketplace in 1915 was the dramatic growth of private-sector enterprise since 1870, which absorbed responsibility for the medical care of its work force on plantations and in factories. As higher salaries were offered here than the public sector, many dokter djawa and later, STOVIA graduates, preferred private-sector employment over government service.

The 1850-1915 period, which is covered in this dissertation, reveals that the central position of the native healers in general, and the pivotal role of the obstetric doekoen baji in particular, was not substantially affected. Still, during the first two decades of the twentieth century, the indigenous population of the Dutch East Indies was increasingly confronted with Western medical practices. This occurred not only in clinics of private-sector employers but also through the new services offered by the BGD as well as charitable and missionary hospitals. At the same time, a growing number of native children went to school, which in due course fostered different attitudes towards the medical services offered by native healers on the one hand, and on the other those provided by Western-trained medical professionals. All these developments were part of the process of modernization of society as a whole, with the exclusion of the indigenous obstetric market. Indigenous pregnant women continued to be loyal to native healers. Their unaltered faith in the medical services and ritual ministrations of doekoen baji appears to have been as strong in 1915 as it had been in 1850. The European elite seems to have accepted this situation. The government offered free medical and obstetric services to European civil servants who earned less than 150 guilders per month; native civil servants only received free general medical help. Plantation owners offered medical care to their coolies while they provided no obstetric care for female workers.
Research on the medical history of the Netherlands Indies is still in its infancy; moreover, the model of the medical marketplace has rarely been applied to colonial medical history. In this dissertation, however, this model has proven to be both instructive and fruitful in trying to answer its central question: did the mid-nineteenth century founding of the two medical schools for indigenous doctors and midwives contribute to fulfilling the colonial government’s formally stated goal, i.e. to reduce the insidious influence of Javanese doekoen and other native healers? By charting the evolution of the various medical marketplaces in Java, it is possible to gain insight into the successes and failures of the schools’ Western-trained dokter djawa and midwives within the constellation of medical services that were offered and ‘consumed’ during the period 1850-1915. To this model the figure of the intermediary has been added, because in the medical history of colonial societies it becomes obvious that an important role was played by bridge-builders and translators between Western medical science and the cultural sensibilities of the indigenous patient population.

While the medical market model is primarily a heuristic device used in understanding specific medical developments, this dissertation also shows how non-medical transformations were equally significant. In a certain sense, it has become apparent that the establishment of the two medical schools constituted an anomaly in the political culture and policy orientation of the mid-nineteenth century. Similarly, this research project also indicates that vociferous debates in the printed media as early as during the period 1850-1915 – such as Boissevain’s and Van Buren’s tirades against the obstetric interventions of native healers – were already able to affect the decision-making processes of government officials and medical administrators. Finally, this dissertation also makes clear that a sophisticated Western medical education can yield unintended consequences. Apart from providing a thorough medical training, the dokter djawa school and subsequently STOVIA constituted a solitary institution of higher learning in the Dutch East Indies in this period. As such STOVIA was the one and only venue of Western academic instruction in the Dutch East Indies. Perhaps it is no surprise that the first nationalist organization, Boedi Oetomo (beautiful endeavor), was founded at STOVIA in 1908 and that many of the prominent members of the nationalist movement had a STOVIA affiliation.