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Governing the ‘Ungovernable’: Stunting Interventions, Social Capital, and the Limits of State Power in the Baduy Indigenous Territory, Indonesia

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Abstract

This research investigates the constraints of state public health governance by analysing the tension between state-initiated stunting interventions and the robust internal governance of the Baduy indigenous community in Indonesia, employing a dual framework of Foucault’s governmentality and social capital theory. A qualitative research of state and community perceptions revealed that state monitoring and standardised programs are predominantly ineffectual due to community mobility and cultural privacy. Conversely, the community’s strong bonding social capital, anchored in the authority of traditional healers (paraji), operates as an effective system of counter-governance. The principal discovery is that the interaction between these systems has resulted in the development of hybrid health practices. Effective health governance in 'ungovernable' regions cannot be realised through authoritarian oversight. Success depends on establishing social capital connections—a "trust bridge"—that promotes hybrid approaches honouring local knowledge systems. Public health must transition from a framework of discipline to a practice of culturally responsive communication.

Keywords: Public Health Governance, Social Capital, Baduy Community.

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Introduction

In today's global public health context, the modern state has progressively expanded its influence into the most isolated areas of society, motivated by a biopolitical necessity to regulate, enhance, and safeguard the health of its inhabitants. This aspiration, contextualised by Foucault's concept of "governmentality," depends on a range of rationalities and technologies such as statistics surveys and public health initiatives intended to make populations comprehensible and, consequently, manageable. What occurs when this political infrastructure confronts a community that functions on a fundamentally divergent logic, one that deliberately opposes the foundational principles of modern statecraft? This essay examines a pivotal subject with a comprehensive case study of the Baduy indigenous community in Lebak, Indonesia, a group distinguished by its voluntary seclusion and unwavering commitment to ancestral laws (pikukuh) that prohibit various types of modern technology and governance.

The current literature identifies the Baduy territory as a significant focal point for public health issues, especially in relation to childhood stunting. Research consistently indicates a prevalence rate that is notably elevated, with estimates between 27.3% to an astonishing 54%, much above the Indonesian national average of 19.8% and the Banten province rate of 21.1% (Putri et al., 2024, 2025). This dilemma is not merely a dietary deficiency but a multifaceted issue intricately embedded in the socio-

cultural framework of the society (Harahap, 2024; Odii et al., 2024);. Research has progressed from preliminary evaluations of nutritional status and socio-economic determinants (Anwar & Riyadi, 2009; Sukandar & Mudjajanto, 2012); to more sophisticated studies that include biocultural adaptations and obstacles to healthcare access (Putri et al., 2025; Rohmatullayaly et al., 2018; Rohmatullayaly et al., 2024). The primary paradox emphasised in various studies is that the philosophy of *pikukuh*, which promotes environmental sustainability, concurrently establishes structural impediments to health enhancement by restricting access to formal education, contemporary medicine, and varied nutritional resources (Ariningrum et al., 2020; Sukardi et al., 2024).

A significant corpus of research has established the multiple factors of stunting in this specific environment. The cultural adherence to dietary taboos for pregnant women and children significantly limits the consumption of essential proteins and micronutrients (Loihala, 2023; Marsaoly et al., 2021; Nasution et al., 2021). This is exacerbated by a significant dependence on conventional health practices, with the *paraji* (traditional birth attendant) occupying a pivotal position in a system that frequently functions beyond biological standards (a et al., 2022; Routray, 2024). Structural barriers endure despite the prioritisation of stunting reduction, as delineated in Indonesia's National Strategy for the Acceleration of Stunting Prevention Indonesian Ministry of (2021) and several regional health policy frameworks (Banten Provincial Health, 2022).

Moreover, inadequate health literacy, a direct result of the ban on formal education, cultivates a fatalistic perspective in which stunting is regarded not as a preventable medical issue but as a matter of heredity or fate (*beke*) (Putri et al., 2025; Ratnawati & Prameswari, 2022). Monotonous diets reliant on subsistence farming (*ngahuma*), low household income, and elevated rates of early marriage are universally recognised as significant risk factors (Anwar & Riyadi, 2009; Fitriani & Sunarsih, 2024; Mulyanto et al., 2020). Certain scholars advocate for a biocultural adaptation framework, positing that the community's diminutive stature may signify a "small but healthy" phenotype instead of pathological stunting, a discussion that highlights the intricacies of employing universal growth standards for this population (Rohmatullayaly et al. 2018, 2024).

Despite several interventions by governmental and non-governmental entities (Fajar, 2023; Sukardi et al., 2024), the research indicates ongoing issues in healthcare delivery. These encompass substantial geographical obstacles, entrenched scepticism towards external health practitioners, and communication deficiencies frequently intensified by gendered social frameworks (Ariningrum et al., 2020; Putri et al., 2025; Yusriadi & et al., 2024). The essential function of community leadership and culturally specific communication in fostering trust is a persistent theme; however, research also highlights the inconsistent nature of these initiatives and the necessity for sustainable, long-term strategies (Abao et al., 2024; Chapman, 2024; Fransisca & Astuti, 2024). This corpus of work highlights a distinct knowledge deficiency about the governance process specifically, how the state's rationalities and power technologies operate, fail, and are contested in practice. Although factors are extensively documented, the quotidian dynamics of power, surveillance, and community resilience are still inadequately examined. This research seeks to address this deficiency by examining the Baduy area as a domain where the boundaries of state authority are distinctly revealed.

Methods

This research utilised a qualitative, ethnographic case study methodology to investigate the intricate dynamics of public health governance within the Baduy indigenous territory in Desa Kanekes, Lebak Regency, Banten, Indonesia. This site was chosen for its distinctive socio-cultural context as a community that deliberately restricts interaction with modernity and its designation as a high-priority region for stunting interventions. The study sought to document the experiences and viewpoints of individuals positioned at the convergence of state health initiatives and local community dynamics.

Data was predominantly gathered via comprehensive, semi-structured interviews performed from July to August 2025. A purposive sample technique was initially employed to identify key informants,

subsequently augmented by snowball sampling to expand the participant network. This method guaranteed the inclusion of a varied array of perspectives, representing three essential stakeholder groups: (1) State and Health System Actors, including the Head of the regional Public Health Centre (Puskesmas), frontline midwives, and other health personnel responsible for program execution; (2) Community Members, comprising families from the more accessible Baduy Luar (Outer Baduy) and the highly secluded Baduy Dalam (Inner Baduy), offering perspectives on differing levels of adherence to adat law; and (3) Cultural and Intermediary Figures, such as a highly esteemed paraji (traditional birth attendant), local village staff, and a tour guide who regularly traverses both realms. This multi-faceted approach facilitated a comprehensive, triangulated comprehension of the pertinent topics.

This study employed a qualitative design, incorporating extensive fieldwork from May to July 2025, to guarantee methodological rigour. Data were gathered via comprehensive, semi-structured interviews with a varied group of 20 intentionally chosen participants, comprising parents (n=8), prominent community figures (n=5), healthcare professionals (n=2), and more community members (n=5). All interviews were transcribed exactly and underwent a thorough thematic analysis. The method began with open coding conducted by two researchers, subsequently leading to the collaborative creation of a consolidated codebook. A third researcher independently coded 25% of the transcripts to validate the coding procedure, with differences addressed through team discussion. The thematic structure was reinforced by data triangulation, which entailed comparing and contrasting opinions among several participant groups to bolster the legitimacy of the findings.

All interviews were conducted in Indonesian or Sundanese to guarantee clarity and comfort for the participants, and were subsequently transcribed and translated for analysis. The data analysis employed a thematic methodology, informed by our dual theoretical framework. Preliminary open coding was employed to discern recurring patterns and concepts within the raw data. The initial codes were methodically organised and interpreted using the conceptual frameworks of Foucault's ideas on governmentality and biopolitics, as well as the principles of social capital (bonding, bridging, and linking). This paradigm facilitated a detailed examination of topics including power dynamics, the conflict between biomedical and indigenous knowledge, community resilience, and the essential function of trust in navigating state-community relations. Ethical guidelines, such as informed permission and the guarantee of anonymity, were rigorously followed during the research process.

Results

This study's findings indicate a significant disparity between the state's public health objectives and the socio-cultural realities of the Baduy community. The findings are categorised into three principal themes: first, the operational difficulties and intrinsic constraints of the state's governmental framework; second, the strength of the community's internal governance structure, grounded in social capital; and third, the dynamic negotiation space where these two systems intersect, conflict, and occasionally merge.

The State's Governmental Apparatus: Frictions in Surveillance and Intervention

State actors, chiefly represented by the local Public Health Centre (Puskesmas), has a definitive mandate to execute national health programs; nonetheless, they frequently face institutional and cultural impediments that constrain their effectiveness. The principal instrument of contemporary health governance surveillance becomes instantly intricate. The Head of the Puskesmas articulated the procedure for entering data into the national digital system (si Gizi) but expressed concern regarding its inherent incompatibility with the Baduy way of life. He emphasised that the primary difficulty is the population's mobility.

Fifty to sixty percent of the community is absent from the village at any given moment, as they are engaged in agricultural activities (ladang), occasionally for extended periods. This perpetual

mobility complicates systematic data collecting and renders instruments intended for a sedentary population essentially ineffective. Therefore, health workers must "capitalise on the opportunity," performing spontaneous health assessments during infrequent community events such as weddings or funerals, a tactic that is reactive rather than systematic.

Interventions, notably the supplementary feeding program (PMT), encounter same challenges. The program's inflexible, hierarchical structure, including on-site meal preparation by health personnel, is impractical in the Baduy region. The Head of the Puskesmas acknowledged the logistical infeasibility: "The regulation stipulates that the food cannot be provided raw; it must be prepared by the cadres." However, we lack personnel in that location, and the operational budget is limited. What is the appropriate way to request that an individual engage in prolonged daily walking for several hours? This bureaucratic inflexibility, neglecting the local context, effectively marginalises the Baduy from a crucial national stunting initiative.

Table 1. The State's Governmental Apparatus

State Program	Identified Friction	Outcome
Surveillance (si Gizi)	Incompatibility with Mobility	Systematic Collection Impossible
Feeding Program (PMT)	Bureaucratic Rigidity	Effectively Excludes
Frontline Workers (Bidan)	Initial Rejection	Knowledge Transfer Delayed

The frontline health workers, specifically the bidan (state-registered midwife), represent the physical and emotional effort required to bridge this divide. Their accounts are laden with depictions of challenging treks on foot, initial dismissal, and the gradual, laborious endeavour of establishing confidence. A midwife described her initial experiences: "Initially, they were quite reserved." Upon our arrival in their village, they would secure their doors. Her statement emphasises that prior to the transfer of biomedical information, a foundation of human connection a type of social capital must be established, a process she indicated required "nearly a year of just talking and building relationships." This emphasises that the state's authority is not inherently granted; it must be attained via significant personal endeavour within the limits of its administrative capacity.

Community Counter-Governance: The Primacy of Bonding Social Capital

In sharp contrast to the state's exterior and frequently incongruous infrastructure, the Baduy community functions through a robust and highly efficient internal governance system focused on social capital bonding. In all health-related issues, the primary and most reliable source is not the Puskesmas, but rather direct family and traditional authority people. A mother from Baduy Luar remarked, "The initial individual I consult is the kokolot (elder), followed by my own mother, a former health volunteer." We will only consider consulting the midwife if that approach fails. This trust hierarchy positions biological intervention as a final option.

This internal mechanism is considerably more certain in Baduy Dalam. An informant from this inner circle, Ayah Jamaa, depicted a realm wholly autonomous from state health services. Childbirth is an autonomous act: "The woman delivers independently at home." The paraji is summoned only after the birth of the infant. When a kid becomes unwell, the community consults a tabib (traditional healer) rather than a physician, a masculine figure who provides herbal cures and incantations. This dependence on local expertise is absolute, embodying a profound conviction in an epistemology that intertwines health with tradition, nature, and spiritual practice.

Table 2. Community Counter-Governance.

Governance System	Foundation	Function
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Authority Figures	Hierarchy of Trust	First Port of Call
Local Expertise (Paraji)	Community Trust	Indispensable Spiritual Care
Bonding Social Capital	Shared Belief	Formidable Challenge

The paraji becomes a pivotal entity in this counter-governance framework. Ibu Mun's comprehensive evidence illustrates that her responsibilities above those of a mere birth attendant. She serves as a spiritual protector, a source of post-natal care, and a custodian of traditional knowledge of herbal treatments (jamu-jamuan). Her power originates not from a state licence but from lineage and communal confidence. She characterised her responsibility as safeguarding the mother and infant from "invisible disturbances," a duty the bidan "is unable to fulfil." The spiritual aspect of care is an essential service that the biomedical model entirely neglects, elucidating the continued necessity of the paraji's duty despite the increasing accessibility of modern medicine. This resilient internal governance system, founded on centuries of trust and collective conviction, poses a significant obstacle to the state's efforts to enforce a uniform health model.

The Negotiation Arena: Contested Knowledge and Hybrid Practices

The link between the state's health staff and the Baduy community represents a dynamic field of negotiation where various types of knowledge and power converge. This situation involves not merely the replacement of tradition by modern medicine, but a multifaceted process of contestation, adaptation, and hybridisation. The emergence of the biomedical term "stunting" serves as a significant illustration. Despite health workers promoting the concept, numerous community members, as one father observed, continue to regard a child's small height as beke a condition believed to be determined by fate or genetics. This fatalistic perspective clearly contradicts the biological assertion that stunting is a preventable disorder, hence diminishing the imperative for intervention.

Nonetheless, resistance is not invariably absolute. Numerous individuals in Baduy Luar participate in a pragmatic process of selective assimilation. A young man expressed this method succinctly: "We retain the beneficial and eliminate the detrimental." We acknowledge the influence of the external environment gradually, however we refrain from adopting detrimental practices. This sentiment is reflected in health practices, where families may embrace immunisation yet persist in utilising traditional medicines for common ailments.

Table 3. The Negotiation Arena

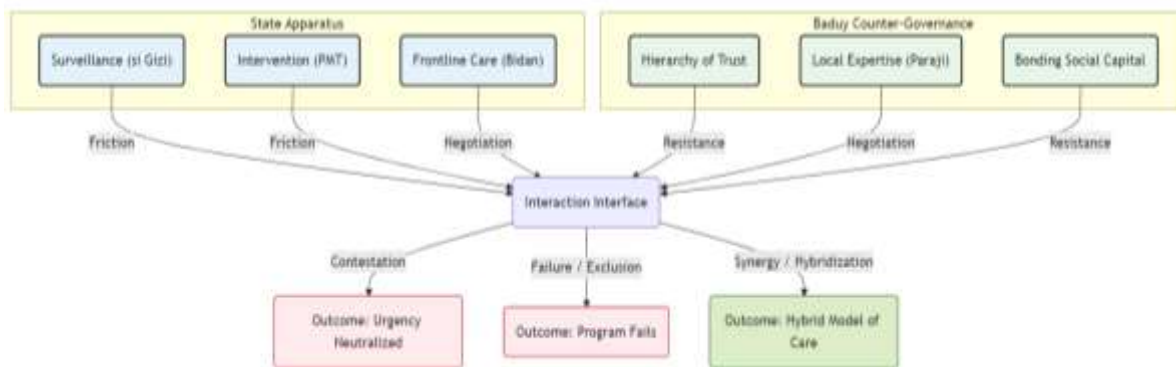
Area of Interaction	Process	Result
Knowledge (Stunting)	Contestation	Urgency Neutralized
Health Practices	Selective Adoption	Pragmatic Blending
Birth Attendants	Complementary Expertise	Hybrid Model of Care

The most persuasive evidence of effective bargaining is the development of a hybrid care model within the collaborative partnership between the paraji and the bidan. Ibu Mun, the paraji, characterised this connection not as competitive, but as one of complementing expertise: "We collaborate." Since the midwife's arrival, my primary role has been to safeguard against the unseen threats. In this collaborative arrangement, the midwife oversees the clinical facets of childbirth, while the traditional healer administers the essential cultural, spiritual, and post-natal care practices. This division of labour exemplifies how governmental power is not merely imposed but is negotiated and adapted to align with local logic.

It exemplifies a successful establishment of social capital, wherein the state's influence is augmented not by undermining local authority, but by harmoniously merging with it. This hybrid approach, emerging from the constraints of state authority, provides insight into a more culturally relevant and

potentially more efficacious style of public health governance. Diagram 1 succinctly encapsulates the interplay between the state apparatus and the Baduy counter-governance system, highlighting the friction spots and their consequent effects.

Diagram 1. State Apparatus and Baduy Governance



Discussion

The findings of this study provide a strong empirical insight into the constraints of contemporary state authority and the robustness of local governance structures. Through an analysis of the Indonesian government's stunting interventions in the Baduy region, we transcend a mere account of implementation difficulties to engage in a more profound theoretical discourse regarding the essence of governmentality, the role of social capital, and the development of hybrid health governance models. The state's biopolitical initiative, designed to enhance population health, faces significant conflict when its universalising principles confront a community led by unique cultural rationalities (Ariningrum et al. 2020; Putri et al. 2025). The mechanisms of governmentality surveillance, datafication, and standardised programs rely on a comprehensible and accessible population, conditions that are fundamentally lacking in the Baduy territory, where geographic isolation and cultural norms of privacy restrict state oversight (Medhyna, 2019; Yusriadi & et al., 2024). The obstacles in executing initiatives such as supplementary feeding (PMT) and the complexities of ongoing health monitoring highlight that state power is not a uniform entity but a negotiated practice, its effectiveness dependent on local circumstances (Rapiudin, 2024; Rivadeneira & et al., 2022; Sukardi et al., 2024). This situation compels state actors to employ flexible, frequently improvised solutions, highlighting the fundamental constraints of top-down public health paradigms when confronted with entrenched socio-cultural autonomy (Fransisca & Astuti, 2024; Selva & Karjoso, 2023)

In the absence of effective official authority, the Baduy community's social capital operates not only as a support network but also as a resilient and autonomous system of counter-governance. The predominance of bonding social capital profound faith placed in family, elders (kokolot), and traditional healers such as paraji and tabib establishes a self-referential framework for health and well-being management (a et al., 2022; Ratnawati & Prameswari, 2022; Routray, 2024). This transcends cultural resistance; it represents an alternative epistemology wherein health is inextricably linked to spiritual harmony and ancestral wisdom, a perspective bolstered by food taboos and traditional feeding practices (Loihala, 2023; Marsaoly et al., 2021; Nasution et al., 2021; Piniliw et al., 2021). The authority of the paraji is not undermined by the bidan's biomedical knowledge, as she provides what the state cannot: spiritual safeguarding and cultural legitimacy (Panda, 2024). The internal coherence, based on common beliefs and strong

social connections, underpins the community's resilience and its ability to remain 'ungovernable' in health matters, frequently resulting in a preference for traditional remedies over modern healthcare, particularly in the early stages of illness (Rostiani et al., 2024; Suminar et al., 2024)

The originality of our findings is particularly evident in the negotiating domain at the intersection of these two systems. This study offers a sophisticated viewpoint that transcends a basic dichotomy between state and community. The paramount result is not the victory of one system over another, but the organic emergence of a hybrid care model, illustrated by the partnership between the paraji and the bidan. This represents a pragmatic synergy rather than co-optation, wherein each participant acknowledges the constraints of their own knowledge and appreciates the worth of the other's expertise (Chapman, 2024; Putri et al., 2024). This hybridity is achievable alone through the intentional and meticulous development of bridging social capital the "trust bridge" that ties the community with external institutions (Fajar, 2023; Hastuti, 2024). Our research indicates that for state actors, establishing trust is the fundamental task, a conclusion that contests traditional public health models that emphasise technical solutions rather than relational approaches (Abao et al., 2024; Nahak & Rua, 2024). The endeavour to manage health in the Baduy region demonstrates that power is not a zero-sum phenomenon; instead, the constraints of the state facilitate negotiation and the development of innovative, syncretic practices that provide a pathway to more culturally relevant and effective public health governance (Fitria et al., 2023; Khoeriyah, 2022; Maulina et al., 2024; Noviana et al., 2022).

The Baduy case provides an essential insight for global health policy, aligning with research from other indigenous contexts where health outcomes are significantly influenced by socio-cultural and economic factors (Ariadi, 2023; Lumbanraja et al., 2024). The difficulties identified ranging from nutritional inequality to healthcare access disparities are not exclusive to the Baduy but are reflected in tribal communities worldwide, underscoring the necessity for coordinated, multisectoral strategies rather than singular medical interventions (Panda, 2024; Sugiyatmi, 2024). Comparative analyses of indigenous and non-indigenous populations repeatedly demonstrate that, whereas universal characteristics such as maternal education and economic position are relevant, their effects are influenced by distinct cultural logics (Nurriszka et al., 2020). Future research should advance beyond merely identifying variables and concentrate on assessing the long-term effectiveness of culturally-integrated, hybrid health models that empower local networks of knowledge and care rather than replace them.

Conclusion

This research's theoretical contribution demonstrates the explanatory efficacy of this dual framework. A Foucauldian perspective (governmentality) elucidates why the state's hierarchical mechanisms of surveillance and biopolitical regulation are ineffective: they represent an external authority that cannot render the community comprehensible or manageable. The idea of social capital elucidates the mechanism underlying this resistance and delineates the pathway ahead. The community's robust bonding social capital, rooted in the paraji and local epistemology, operates as a durable counter-governance mechanism. Consequently, managing the 'ungovernable' is not accomplished by the augmentation of Foucauldian discipline, but rather through the cultivation of connective social capital. The "trust bridge" serves as the essential interface for negotiating and hybridising state authority, facilitating a governance model grounded in dialogue rather than control.

This examination of stunting interventions inside the Baduy indigenous region provides a significant counter-narrative to traditional public health frameworks. We have shown that the Indonesian state's

governmental apparatus, characterised by surveillance, standardised programs, and biomedical rationality, encounters its operational and philosophical limitations when faced with a community governed by deeply rooted social capital and an alternative health epistemology. The Baduy are not simply passive recipients of policy; they are active agents whose social cohesion and commitment to pikukuh (adat law) build a robust system of counter-governance.

Our analysis affirms that the state's authority in this environment is not absolute but requires ongoing negotiation. The tension between the state's biopolitical objectives and the community's sovereign practices generates a domain where knowledge is disputed and power is restructured. The primary discovery is that this negotiation does not inherently result in the supplanting of tradition by modernity. Rather, it can cultivate the development of new, hybrid practices, shown by the synergistic collaboration between the state-sanctioned *bidan* and the community-trusted *paraji*.

This research's theoretical contribution demonstrates the explanatory efficacy of a dual framework. Integrating a Foucauldian perspective with social capital theory enables us to transcend a mere implementation gap and examine the scenario as a dynamic interaction of power, knowledge, and trust. We assert that in environments such as Baduy, linking social capital is not a marginal issue but the fundamental mechanism of efficient governance. The "trust bridge" established by frontline health professionals is the fundamental framework upon which any effective public health initiative must rely.

The endeavour to manage the 'ungovernable' Baduy necessitates a reassessment of the criteria for good public health. It indicates a transition from a universalising paradigm of discipline and control to a more flexible, dialogic, and modest methodology. The future of public health in indigenous and autonomous communities may depend not on refining monitoring methods, but on cultivating trust and collaboratively developing hybrid solutions that respect local contexts while promoting common well-being objectives.

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