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Ubar Kampung: indigenous knowledge and practice of medicinal, aromatic and cosmetic (MAC) plants used for the treatment of diabetes mellitus in the Tatar Sunda Region of West Java, Indonesia

Febriyanti, R.M.

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Chapter IV RESEARCH SETTING: INDONESIA AND THE TATAR SUNDA REGION IN WEST JAVA

This chapter describes the research setting of this study, the Tatar Sunda Region, with a general focus on geographical, cultural, historal, and socio-demographic aspects. It is essential to elaborate on those aspects to further comprehend the transcultural health care utilisation by the community, which forms the main elements of this study.

Section 4.1 is an introduction to the geographical and health care systems in Indonesia, as a broader scope of where West Java Province belongs. Apart from an overview of the demographic and sociographic characteristics of Indonesia, the recent developments in the National Health System are also described.

Furthermore, Section 4.2 describes West Java as a homeland for the Sundanese, the largest ethnic group in the province. Despite sharing the same island with the Javanese, the Sundanese have distinct cultures and consider themselves to live in a separate cultural area known as Pasundan or Tatar Sunda. Bandung, as the capital of West Java, is considered the cultural heartland of the Sundanese. The next paragraph presents the historical background of the Sundanese and the Tatar Sunda region, as well as Kabupaten Bandung as part of it. The description consists of three main subjects which are elaborated further: Section 4.2.1 begins with an introduction to the developments of the Tatar Sunda region since the reign of the Sunda Kingdom, followed by a brief description of significant historical-political events leading to the current cultural diversity in Tatar Sunda. Section 4.2.2 illustrates the cultural diversity, noting the different ethnic groups living there, as well as social organisation and its communities. Section 4.2.3 describes Kabupaten Bandung, more specifically the district where the research area is located, as part of the Tatar Sunda region.

Finally, Section 4.3 focusses specifically on each village which comprises the research setting and background information concerning the lives and livelihood of the inhabitants. The selected research areas are five villages from three subdistricts in Kabupaten Bandung. The description of the research area is complemented by a presentation of the socio-demographic and socio-economic profiles of each village gathered from the household survey and official sources such as data from the regency (*kabupaten*) and statistics agency. These five villages are the focus of this study on indigenous knowledge of traditional medicine and the utilisation of the plural medical system.

4.1 Indonesia: Recent Developments and the National Health Care System

4.1.1 Recent Developments

Indonesia is acknowledged as the largest archipelago in the world, consisting of over 17.500 islands, extending 5,120 kilometres from east to west and 1,760 kilometres from north to south (*cf.* CIA World Fact Book 2018). Geographically, Indonesia is situated in South-eastern Asia, between the Indian Ocean and the Pacific Ocean. Indonesia shares land borders with East Malaysia, Papua New Guinea, and East Timor (*cf.* Figure 4.1). The population in 2019 is estimated at 272.05 million, making Indonesia the fourth most populous country in the world. The population consists of numerous ethnic and cultural groups, of which Javanese is the largest ethnic group, followed by Sundanese, Malay, Batak, and Madurese. According to recent population data, about 56.7% of Indonesia's population resides in Java Island (*cf.* BPS 2019).

Indonesia is a unitary republic divided into the five-tier government hierarchy, consisting of provinces, where five of those have special status. Administratively, the provinces are subdivided into regencies (*kabupaten*), led by regents (*bupati*), and cities (*kota*) led by mayors

(*walikota*). These are further subdivided into districts (*kecamatan* or *distrik* in Papua), and then into administrative villages. The number of those provinces and their divisions have evolved. Currently, Indonesia is divided into 34 provinces, 514 districts (416 regencies and 98 cities), 7,094 subdistricts, and 83,447 villages (8,490 urban villages and 74,957 rural villages) (*cf.* Kementrian Dalam Negeri 2017). The population growth between islands and provinces is unevenly distributed, where most of the population lives on the islands of Java (58%) and Sumatra (22%). Among all of the provinces, West Java is the most densely populated province with a population of 48.1 million (as of 2017) (*cf.* Central Bureau Statistics 2018). Data shows that the number of poor people has decreased from 17.8% to 11.7 within six years, from 2006 to 2012 (*cf.* Kementrian Kesehatan Republik Indonesia 2013).

Map 4.1 Map of Indonesia.
Source:https://www.cia.gov/library/publications/the-world-factbook/geos/id.html

Indonesia is currently in transition, ranging from the demographic and epidemiological, as well as the social, economic and political fields. On the one hand, Indonesia has strong economic growth, while on the other hand, approximately thirty-one million people still live below the poverty line, and the number of urban poor cities is on the rise. Like in most other nations across the world, Indonesia is also experiencing rapid urbanisation. People are moving to urban centres in search of industrial employment and entrepreneurial opportunity, which leads to a gradual change in the economy, culture, and landscape (*cf.* Koenig 2004). Currently, 56% of the Indonesian population live in urban areas (in 2000, the figure was 42%) **(***cf.* CIA World Fact Book 2018). Poverty in the urban areas is projected to be higher than in rural areas by 2020 (*cf.* World Bank 2015). The constant flow of people from Indonesia's rural areas to the urban areas is an indication that the development of the rural areas has not been successful (*cf.* Lewis 2013). With regards to implications for health, several studies documented that urbanisation has negative impacts on ill-health events, particularly for the poor and informal sector in Indonesia (*cf.* Sparrow *et al*. 2014).

The Indonesian government is to find a new paradigm to empower communities in the rural area. It is realised that the 'one-size-fits-all' approach can no longer apply since people are cherishing their norms, cultures, and local wisdom, which varies significantly in the country (*cf.* Antlov 2003). Indonesia is a very ethnically diverse country, consisting of more than 300 ethnic groups, and speaking 742 different languages. Local cultures thagt have passed through generations in the particular area form distinctive characteristics among other communities and ethnic groups in Indonesia. This characteristic means that the design of rural development programs needs to take into account local conditions, social structures, and traditional values.

Indonesia introduced reforms in 1998 to establish a stable democratic government, replacing the New Order's authoritarian and centralised government with local-level institutions based on local knowledge (*cf.* Antlov 2003). In the current period of regional autonomy, regencies and cities have greater involvement in the management of their domestic affairs and are responsible for providing most government services. Good governance becomes the most targeted objective in decentralisation. As Regmi *et al*. (2010) state, decentralisation improves government services in terms of allocation efficiency based on local needs, accountability enhancement of regional administrations, fewer layers of bureaucracy, and fair opportunities for local people.

Following, in 2014, President Joko Widodo created the Village Ministry and issued Law 6/2014 on Villages, which reassesses weaknesses in the decentralisation paradigm, including increasing budget allocations for villages and revitalising village development. The enactment of Law No. 23/2014 and revised Law No. 32/2004 allow authorities in the village governments to execute a wide range of government services in areas such as health, education, public works, environment, communication, transport, agriculture, manufacturing industry and trade, capital investment, land, cooperatives, labour force, and infrastructure services (*cf.* Nasution 2016). The village administration level, as the lowest level of government administration, becomes the most influential in a citizen's daily life.

4.1.2 The Development of the National Health System in Indonesia

Health is one of the developments of the nation to improve the quality of human resources. This effort can be seen from the *Rencana Pembangunan Jangka Menengah Nasional* 2015-2019 which positioned health in number three of eleven national development priorities with goals to strengthen the quality of primary health care. Primary health care or basic health services consist of several types of health services which are considered essential to maintaining the health of a person, family and community to achieve productive life socially and economically. However, referring to the country's Human Development Index figures which were ranked 112 out of 177 countries in the world, development in the health sector has been somewhat left behind.

The national health system in Indonesia today is a result of reformation and transformation over the past sixty years (*cf.* Heywood & Choi 2010). As in most developing countries, modern medicine is the predominant medical system in the national health care system, and the traditional and modern medical systems operate independently without clear hierarchy.

The introduction of modern or conventional medicine was started during the colonial period when the Dutch East India Company established a hospital in Batavia in the 17th century *(cf.* Van Seters 1997). Following Indonesia's independence, the government began to establish public hospitals, mostly by nationalising some of the private hospitals. But the government could only provide limited subsidies for health at that stage, resulting in a severe shortage of resources in public hospitals (*cf.* Trisnantoro *et al*. 2009).

Unemployment, poverty, and inequality during the Asian financial crisis in 1997 triggered the political transformation from the New Order regime to a decentralised system. The health system was reorganised based on the decentralisation system in 1999[1]. In the health sector, it means giving greater opportunity for the region to determine programs and allocation of health

development funds in the region. With a decentralised system, health development programs are expected to be more effective and efficient. As Mills *et al*. (1990) argue, decentralisation in the health sector is the key to achieving primary health care development in various countries. Later, a comprehensive social security framework was initiated by the National Social Insurance System Law in 2004, including a plan for national health coverage (*cf.* Law No. 40 in 2004). This initiation represents the major reform of the health service following decentralisation (*cf.* Republic Indonesia National Health System 2017). Afterwards, Indonesia experienced a significant improvement in its health care in the past decade. The number of hospitals increased to 2,813 in 2019 from 2,454 in 2012.

Health care provision in Indonesia has conventionally been divided into public and private health care providers and public and private financing. The public system is administered in a decentralised system divided into central, provincial, and district responsibilities. The planning process is the combination of top-down direction and bottom-up participation (*cf.* Republic Indonesia National Health System 2017). The health service at the local level is divided between the provincial and municipality level, of which the provincial governments organise the health service through the provincial health officer (PHO), and accordingly the municipality governments through the district health officer (DHO). However, within the decentralised health system, the relationship between PHO and DHO is not a hierarchical one. Each level has its mandates, of which DHO is not responsible to the PHO. Likewise, the PHO is not accountable to the Minister of Health but to the provincial governor (*cf.* Figure 4.1).

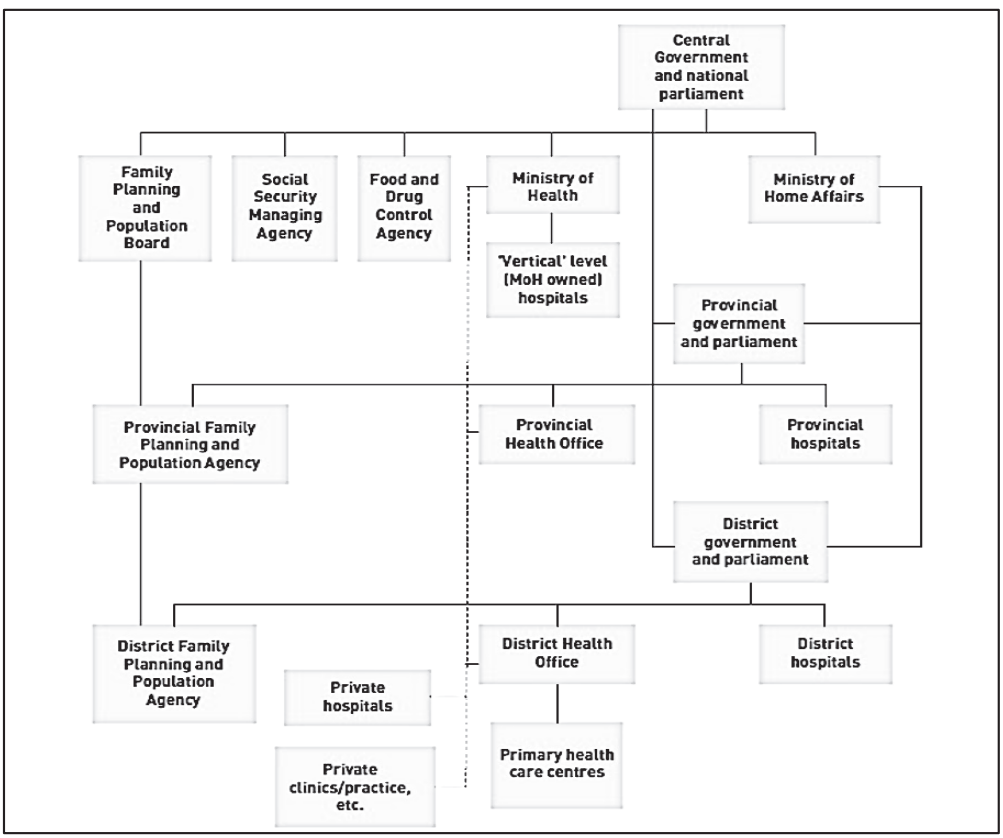

Figure 4.1 Government Organisation, Decentralisation and Health System
Source: Republic of Indonesia National Health System 2017

In general, Indonesia has better health indicators than other countries in South-East Asia. However, there is a wide discrepancy of health outcomes across Indonesia (*cf.* Shidieq 2018). While the eastern part of Indonesia is experiencing a high incidence of communicable diseases such as tuberculosis, lower respiratory tract infections, and diarrhoea, non-communicable diseases (NCDs) such as ischemic heart disease, cerebrovascular disease, diabetes mellitus, and chronic obstructive pulmonary disease have become major public health problems in the western part, particularly in urban areas (*cf.* IHME 2016). In response to the increasing burden of NCDs, the government established the Directorate of Non-Communicable Diseases, a unit in the Ministry of Health, to manage the prevention of NCDs in the country. The service is divided into the provincial and municipality level. At the municipality level, service is provided through the primary health centre (PHC)/*Pusat Kesehatan Masyarakat* (*Puskesmas*).

The public health sector

Puskesmas is a crucial provider of primary health care with a focus on promotive and preventive efforts. *Puskesmas* also serves as a referral for the municipality hospital if patients need further treatment. *Puskesmas* is helped by Pusbindu, a community-based coaching post, for running its service at the village level. At the village level, Pusbindu monitors people with NCD risk factors and enables community participation for early detection (*cf.* WHO 2017). Until 2000, *Puskesmas* were directly under the authorities of the Ministry of Health. Since the decentralisation era in 2000, *Puskesmas* has been handed over to local governments. In 2014, Indonesia initiated the implementation of the National Health Insurance (Jaminan Kesehatan Nasional/JKN)[2], which is mandatory for all Indonesians. JKN guarantees comprehensive health services and is managed by a single management body, *Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS Kesehatan)*. After the implementation of JKN in 2014, *Puskesmas* was determined to be the provider for BPJS.

The numbers of *Puskesmas* have been continuously growing; in 2016, there were 9,767 *Puskesmas* units, of which 2,277 were situated in remote and very remote locations (*cf.* Ministry of Health 2016). However, the increased number of *puskesmas* does not reflect the fulfilment of health care needs among community members (*cf.* Indonesia Health Profile 2017). Most of the Indonesian population have access to primary care, including satellite primary care at the village level such as *polindes, poskesdes*, and village midwives (*cf.* Sparrow & Vothknecht 2012).

The ratio of the community health center to the district in 2017 is 1.36. However, the ratios of *Puskesmas* to the population remain below WHO standards and lower than other Asia-Pacific countries. As in most developing countries, health care facilities in Indonesia tend to be concentrated in the urban area. Data shows that Jakarta, as the capital of Indonesia, presents as the province with the highest ratio, namely 7.73 community health centers per district, while Papua, as the most remote province from the capital, had the lowest ratio (0.7 per district) (*cf.* Indonesia Health Profile 2017). Furthermore, data show that disparity of health care delivery in Indonesia is not only a matter of distribution of facilities among provinces, but also an unequal distribution of health care resources (*cf.* Ministry of Health 2015).

Further analysis by Sparrow & Vothknecht found that 430 sub-districts (6.3%) did not have a *Puskesmas*, most of which were located in Papua, West Papua, and in rural areas outside Java. Most of the *puskesmas* located outside Java, such as in North Sumatra, South East Sulawesi, East Nusa Tenggara and Papua, are not provided with electricity support (*cf.* Sparrow & Vothknecht 2012). Available statistics show that almost all of the provinces in Indonesia have less than one physician per 1000 population, with an average density of physicians at 0.201 (*cf.* WHO 2018).

The private health sector

As a response to the increasing demand for health services, the health sector has been opened up to private investment. Various types of private sector providers include hospitals, clinics and clinical laboratories. According to the Ministry of Health regulations which allow the opening of hospitals, the number of private/corporate hospitals has increased significantly (*cf.* Trisnantoro 2012). Furthermore, since the government also gave the right to doctors, nurses, and midwives to have a private practice in addition to working in public health services and hospitals, more than half of the health services have now become private (*cf.* Heywood & Choi 2010). Private nurses and midwives offered lower fees and became the choice for the poor (*cf.* Heywood & Harahap 2009). For some communities, the private sector is preferable for outpatient care because it is more consumer-oriented and more convenient than the public sector (*cf.* Heywood & Choi 2010).

Traditional Health Care Service

In addition to the formal health care service, the Indonesian government also regulates the traditional health care service as a response to the community needs for traditional healing practices. Since 1982, the Indonesian government has regulated the use of traditional medicines by issuing a decree from the Ministry of Public Health Number 99a/ MenKes/SK/III/1982, recognizing traditional medications as one of the alternatives to improve the health condition of communities. This decree was strengthened by the release of Indonesian government regulation UU RI No.23/1992 which established traditional medication as a formal structure of the health care system in Indonesia. The implementation of traditional medication practices and marketing of traditional medicines was specifically regulated in the Ministry of Health's Decree Number: 1076/Menkes/SK/VII/2003. This decree promotes the formalization of the traditional healer under the surveillance of official health institutions at the district and village level.

In 2012, there were more than 280,000 traditional healers registered at the Ministry of Health (*cf.* WHO 2017). Under Government Regulation Number 103, year 2014, the official traditional health care services in Indonesia are divided into empirical, complementary, and integrative health services. The Ministry of Health has set a target to implement the traditional health service at community health centers and public hospitals. In West Java, there are 147 community health centers providing traditional health services (*cf.* Indonesia Health Profile 2017).

4.2 Kabupaten Bandung as part of the Tatar Sunda Region

4.2.1 Historical Background of Tatar Sunda and the Sunda Kingdom

The island of Java sits in the centre of Indonesia, not only geographically and administratively but also by virtue of the sheer size of its population: 141 million people, resulting in nearly 56.7% of Indonesia's population living on Java (*cf.* United Nations 2019). Geographically and ethnically, Java can be divided into three areas roughly equal in size and population: the Western part of Java, including the national capital of Jakarta and Banten Province; Central Java, including the special territory of Yogyakarta; and East Java, which incorporates the island of Madura. The majority of the inhabitants of West Java is Sundanese. The Madurese occupy their home island and parts of East Java, particularly along its north coast. Central Java and the southern parts of East Java are the homelands of the Javanese ethnic group.

Tatar Sunda is a region located in the western part of Java refering to the area of West Java province and Banten. Characterised by mountainous areas, the Sunda region is also known as *Parahyangan*, derived from the Sanskrit word 'Hyang' which means 'god'. Its name also has several derivatives which are *parahiangan*, *priangan*, or the Dutch adapted name '*preanger*'.

According to history, the Sunda region has existed for many centuries. One of the earliest historical records that mention the name 'Sunda' appear in a Shanghyang Tapak inscription dated 952 *saka* (1030 CE) discovered in Cibadak, near Sukabumi. The name 'Sunda' refers to the people, language, and kingdom in the western part of Java. The largest Sundanese kingdom was Padjadjaran,

Based on inscriptions from the 4th Century, it is revealed that the first ruling kingdom in the Tatar Sunda region was Tarumanegara (*cf.* Ekadjati 2014). In terms of civilisation, during the reign of Tarumanegara, several developments have been achieved, including:

- Utilisation of the *Pallava* letter from India,
- Knowledge about the kingdom institution in the Western part of Java from the first civilisation, and
- Acculturation with other cultures.

The Kingdom of Tarumanegara was lost from history without sufficient written explanation. The kingdom was assumed to be decimated by Sriwijaya, then divided into two kingdoms: the Sunda Kingdom and the Galuh Kingdom. The Sunda kingdom ruled the Western part of Java, while Galuh expanded their authority to Central Java . The Sunda Kingdom was located near the Salak Mountain and Gede Mountain in Bogor. Salak Mountain is considered as the mystical mountain by the ancient Sunda community.

Historically, Sundanese people were influenced by Hinduism, and later Islam. Relics of Hinduism can still be found in the Sunda Region, namely *Candi Cangkuang* (*cf.* Illustration 4.1). *Candi Cangkuang* is a Hindu temple located in Kampung Pulo, Garut, West Java. This temple was also the first to be found in the Tatar Sunda region and is the only Hindu temple in Tatar Sunda.

During the reign of Sang Ratu Jayadewata, some of the Sunda inhabitants converted to the new faith, Islam. Most of the Muslims resided in the port of Cimanuk, the eastern part of Sunda Kingdom. As a result of the expansive Islamic Sultanate Demak in 1517, most of Sunda's inhabitants converted to Islam.

4.2.2 The Sundanese People: Cultures and Communities

There have been some challenges in defining an ethnocultural group in Indonesia because of dynamic changes in the environment. Academically, an ethnic group refers to the cultural identity, which involves language, traditions, and patterns of behaviours. However, there have been many levels of identification of ethnic, including self-defined identity, other perceived identity, and state-defined identity. The level of identification is essential for understanding one's behaviour.

The same questions also arise in defining the Sundanese as an ethnic group. The Sundanese identify themselves as *urang Sunda*, and are generally distinguished through their geographical locations of which 90% reside in West Java and Banten. However, there are some parts from West Java and Banten province which are not considered as the homeland of the Sundanese, e.g. Bekasi and Tangerang. Geographically Bekasi is part of West Java, while Tangerang belongs to Banten. However, most of the inhabitants in Bekasi and Tangerang disagree to be identified as Sundanese. Most of them identify themselves as Betawi, an ethnocultural group who mostly reside in Jakarta. In addition, some Sundanese also reside in the province where most of the inhabitants are Javanese, and they are still speaking the Sunda language and consider themselves Sundanese.

Consequently, the Sundanese are not only defined by geographical location, but also language, blood, and socio-cultural perspective (*cf.* Warnaen *et al*. 1987). As an ethnic group, the Sundanese are not only the second-largest ethnic group on Java but also in all of Indonesia. Sundanese is the dominant culture in the West Java province, and its cultural enclaves also exist in other provinces including the transmigration area of the Lampung province in Sumatra just to the north of Java.

Illustration 4.1. Candi Cangkuang
Source: Photograph by M.Febriyanti (2017)

The description of the Sundanese in the present study is mostly constructed based on the information collected during the fieldwork. Living on the same island with the Javanese, the Sundanese share many similarities with them, although there is some contrast between these ethnic groups which is applicable in the context of the present study. In general, cultural variations between the Sundanese and Javanese are associated with the influence of the earlier Hindu-Buddhist kingdom that ruled the western part of Java. The Sundanese are considered to be less status-conscious than the Javanese, and the royal court (*keraton*) culture which was highly favoured by the Javanese was generally disregarded among the Sundanese.

In the context of ancient beliefs, the Sundanese belief system views that a balanced life can be achieved by a harmonious relationship with nature, gods/spirits, and human beings. The harmonious relationship of people, society and nature form the Sundanese cosmology known as *Tritangtu*. In his study about *Tritangtu* and *gintingan* as Sundanese cosmology, Saefullah (2019) concludes that: '…. *Tritangtu has inspired the Sundanese in their livelihoods, arts, culture and institutions. It transpires from their socio-cultural activities to their economic transactions, i.e. landscape settings, buildings, as well as their social interactions and institutional role ...*'. The Sundanese community who resides in a rural area is still living in such a spiritual way. They have adopted some taboos to conserve nature and maintain the ecosystem. The conservative tendency is demonstrated in several indigenous communities in

the Sunda Region. The Sundanese who are still living in the indigenous communities have rules against interacting with outsiders and adopting foreign technology, ideas, and ways of life. They also have set some taboos, such as not cutting trees or harmng forest creatures, to preserve their natural ecosystem.

To date, there are only limited indigenous Sundanese communities in West Java. According to the data from the Department of Culture and Tourism, there are eight indigenous communities in the Sunda region, namely *Kampung Urug*, *Kampung Pulo*, *Kampung Naga*, *Kampung Dukuh*, *Kampung Gede Kasepuhan Ciptagelar, Kampung Mahmud, Kampung Kuta*, and *Kampung Cikondang*.

During the fieldwork, the researcher visited six traditional villages in West Java to document the Sundanese livelihood. A brief description of each village will be presented in the following paragraph.

Kampung Naga

Kampung Naga is one of the traditional villages in the Tasik area, West Java. It has an area of 1.5 hectares, 101 houses and 297 households. Kampung Naga has a tradition and local wisdom among the people who are still very aware of the authenticity of their local wisdom. In the health sector, the people of Naga Village are accustomed to using plants that grow in the surrounding forest or are planted/cultivated by each family. The people of Kampung Naga know information about plants used as medicine from hereditary information conveyed by elders or exchanging information between families.

Kasepuhan Cipta Mulya

Kasepuhan Cipta Mulya is administratively located in Kampung Cipta Mulya, Sinar Resmi Village, Cisolok District, Sukabumi Regency, West Java Province. Kasepuhan Cipta Mulya refers to a social unit whose citizens are bound by certain specific customs, crystallized in a traditional institution called *kasepuhan*. Therefore, residents of Kasepuhan Cipta Mulya can be categorized as one of the indigenous communities in the Sukabumi Regency, West Java Province. In addition, Kasepuhan Cipta Mulya is part of the Banten Kidul adat unit, along with a number of other Kasepuhan scattered in the regions of West Java and Banten Provinces. Cipta Mulya village is inhabited by approximately 40 families. They live in typical traditional houses. Meanwhile, other Kasepuhan Cipta Mulya residents live in other villages, although they settled outside Kampung Cipta Mulya and they still practice customs refering to Kasepuhan Cipta Mulya.

Kampung Dukuh

Dukuh Traditional Village is a collection of communities with traditional patterns of life, upholding the traditions of ancestors and always living a simple life. Therefore, the indigenous village of Hamlet never depends on outside life. Existing natural resources, especially plants, are utilized as well as possible, and forests and gardens are carefully maintained and managed to avoid damage to nature so that it will always benefit the lives of the people.

Kampung Cireundeu

Cireundeu village is derived from the name of the '*reundeu' tree*, because previously in this village there were a lot of *reundeu* trees. The *reundeu* tree itself is used for herbal medicinal ingredients. Therefore, this village is called Cireundeu Village, a traditional village located in Leuwigajah Village, South Cimahi District. Most of the population embraced and held fast to the Sunda Wiwitan belief until now, always consistent in carrying out the teachings of their beliefs and continuing to preserve the culture and customs that have been passed down from their ancestors.

Kampung Pulo

Pulo is one of the indigenous communities which still conserves their traditions. The community lives in a small village consisting of six houses and a mosque. According to legend, the existence of Kampung Adat Pulo is related to Embah Dalem Arif Muhammad, a messenger from the Mataram Islamic kingdom who was assigned to attack the *Vereenigde Oostindische Compagnie* (VOC) in Batavia. According to legend, Embah Dalem Arif Muhammad had six daughters. The number of these children marks the number of houses in the village. The inhabitants in Kampung Pulo have to follow five rules from their ancestors, namely the provisions of the pilgrimage, the shape of the house, the number of houses and family heads, ownership, and performance of *wayang* (puppet) art (*cf.* Fieldnote 2017).

Illustration 4.2. Traditional Sundanese House in *Kampung Adat Pulo* (Traditional Village)
Source: Photograph by M. Febriyanti (2017)

Since the majority of Sundanese people are Muslim, religion plays an important role in their lives. Religion provides the foundation and framework of normative values for the life of the community. Basically, religion contains, among other things, universal moral messages that apply to daily life. Religion has become the guidance for moral and human relations to achieve value in life. It is the foundation for all human conduct. Having said this, it does not mean that religion is about rigid restrictions. Instead, it serves as a guidance for human life to be organised as orderly and harmonious.

Sundanese people value the beauty and power of their natural landscape. The belief in natural power is manifested in the Sundanese conviction that there are spirits (*guriang*) that control the mountains and who possess supernatural skills which bring and guarantee prosperity and safeguard the lives of all the Sundanese. The three important mountains in the land of Sunda, Mount Gede, Mount Putri and Mount Padang, are believed to be sacred and powerful. Furthermore, a Sundanese legend *Sangkuriang* narrates the origin of Mount Tangkuban Parahu, Mount Burangrang and Mount Bukit Tunggul in Bandung, which is under the strong influence of spirits, deity, and supernatural powers.

In the research area, the traditional community in Lamajang village has rituals which are performed without any interference from outsiders. One of the events is *muludan*, an annual event to celebrate the birth of Prophet Muhammad. During the *muludan*, the women usually gather in the elders' house to prepare some dishes such as *wajit*, *kolontong*, and *opak* (*cf.* Illustration 4.3). The particular meal served during *muludan* is three types of tumpeng made of rice from *ladang*, *huma*, and *ketan* representing their ancestor from *Gunung Tilu* [3].

Illustration 4.3. The Women in Traditional Village are *Gotong Royong* Preparing Dishes for Celebration of the Birth Prophet Muhammad (*Maulid Nabi*)
Source: Photograph by M. Febriyanti (2017)

According to Wessing (1978), Sundanese villagers adopt a '…..*strategy of cautious and flexible integration*….' in the selection of particular symbols suitable in a given situation or to achieve a specific goal. Though 95% of participants in the present study identified themselves as practising Muslims and followed Islamic dietary rules, other rules and beliefs concerning food and health are derived from local traditions. In the research area, some households are still cooking in the traditional kitchen, using furnace and clay kitchenware (*cf.* Illustration 4.4).

In view of dietary habits, meals are generally consumed two or three times a day and always served with rice. Steamed or stir-fried vegetables, fried freshwater fish and *sambal* are also likely to be served in a standard dish. To supplement the meals, the Sundanese also have various kinds of traditional beverages such as *bajigur* and *bandrek*, which are usually served with steamed peanuts or sweet potatoes. The Sundanese people who live in the cool, highland areas consume *bandrek* to warm themselves at night and during cold weather. *Bandrek* and *bajigur* are usually sold by a peddler in a cart (*cf.* Figure 4.5).

Illustration 4.4. Sundanese Traditional Kitchen
Source: Photograph by M. Febriyanti (2017)

Bajigur and *bandrek* are prepared from several spices (MAC plants) such as ginger, cloves, and pandan leaves. Other ingredients such as star anise, coriander seeds, cardamom pods, and lemongrass which have a beneficial effect for health are also added. *Bandrek* is believed to have a healing effect on minor health problems, such as sore throat and cough.

Illustration 4.5. *Bandrek* and *Bajigur*, Sundanese Traditional Drinks, Prepared from Medicinal, Aromatic, and Cosmetic Plants
Source: Photograph by M. Febriyanti (2017) .

4.2.3 Kabupaten Bandung as Part of the Tatar Sunda Region

Kabupaten Bandung is a pilot area for Regional Autonomy in West Java Province, Indonesia. Geographically, it lies between 60.41' - 7 0.19' South Latitude and 1070.22' – 1080.5' East Longitude, with a total area of 1,762.39 Km2, and administrative boundaries as follows: on the North by West Bandung Regency, Bandung City and Subang Regency; on the East by Sumedang Regency and Garut Regency; on the South by Garut Regency and Cianjur Regency; on the West by Cianjur Regency and West Bandung Regency; and in the middle by Bandung City and Cimahi City (*cf.* Map 4.3). Most of the area of Bandung Regency is mountainous, with a tropical climate and average rainfall in 2016 of 6.55 mm/days. Active volcanoes are Mount Ceremai, the highest Mountain in the West; Mount Gede; Mount Tangkuban Perahu; and Mount Galunggung.

Map 4.2 Map of Kabupaten Bandung with the Indication of the Location of the Three Sample Districts
Source: Official Website of Bandung Regency (www.bandungkab.go.id)

Kabupaten Bandung is divided into 31 subdistricts, with its capital of Soreang. Kabupaten Bandung has several tourism attractions, including: *Kampung Adat Cikondang*, *Situs Rumah Hitam, Situs Bumi Alit Kabuyutan, Situs Makam Bosscha, Situs Gunung Padang, Situ Patengan, Situ Cileunca, Situ Cipanunjang, Situ Cisanti, Situ Ciharus, Kawah Putih, Curug Malabar, Curug Sanghiang, Curug Siliwangi, Pemandian Air Panas Cibolang*, and *Pemandian Air Panas Walini*.

4.3 Research Communities

Based on the village statistics available at the *Badan Pusat Statistik* (BPS) office, which gave an overview of the number of inhabitants in each sub-district, three similar-sized sub-districts (*kecamatan*) were selected. From three sub-districts, five villages were chosen. The five sample villages overview based on data available at the village offices is presented in Table 4.1.

Table 4.1 Overview of the Five Sample Villages in Kabupaten Bandung

Sub-district	Total area (km)	Distance to regency capital (km)	Number of village	Number of population	Selected research village	Number of inhabitants	
						Male	Female
Pangalengan	195.41	31	13	150.549	Lamajang	5.361	5.562
					Sukaluyu	4.524	4.536
Cilengkrang	30.12	29	6	127.660	Cipanjalu	3.910	3.593
					Ciporeat	2.695	3.027
Katapang	15.72	6	7	53.223	Katapang	8.188	7.936

Source : BPS office (2017)

4.3.1 Physical Environment

Kecamatan Pangalengan

Pangalengan sub-district is located in the northern part of Kabupaten Bandung. The distance to the regency capital is 31.7 km. It covers 27,294.77 hectares in total, of which 4,805.69 hectares is used for tea fields. There are three types of tea plantation in Pangalengan subdistrict, with three types of plantations: Public, Private and Nation Plantation. Pangalengan District is divided into 13 villages. Pangalengan District also has the Cisangkuy River and Situ Cileunca; the river and Situ are beneficial for agriculture and tourism and as material for hydroelectric power plants (*cf.* Official Website of Pangalengan 2017). Pangalengan is well-known for its cow farms, tea plantations, and Cikondang Traditional Village.

Cikondang Traditional Village

Cikondang traditional village is a Sundanese ethnic settlement which has come under the protected cultural heritage. It is believed that Cikondang Traditional Village already existed since the beginning of the XIX century or around 1800. However, a massive destructive fire struck Cikondang Traditional Village in 1942. Hundreds of traditional houses were burnt down in flames. The fire incident destroyed the Sundanese ancestral heritage village. Only one traditional house survives from the fire, which continues to be used as a traditional house by the local residents until nowadays.

Illustration 4.6. Traditional House in Cikondang Traditional Village
Source: Photograph by M. Febriyanti (2017)

Kecamatan Katapang

Katapang is the most important buffer zone for Soreang as the capital of Bandung Regency and is at the frontline in terms of industrial development in the Bandung Regency and surrounding areas. Geographically Katapang is located 107º32'00'-107º35'30' East longitude and 6º58'30'LS-7º02'30' South latitude. During the rainy season (September-March), several villages in Katapang are regularly flooded, caused by clogged drainage (*cf.* Fieldnote 2017). When a flood occurs, transportation access is often hampered. Several public transportations are cut off. Since this fieldwork was conducted in the months of September–December, on several occasions, household surveys had to be postponed because the roads were blocked by flood (*cf.* Illustration 4.9).

Kecamatan Katapang has seven villages and covers a 1,519.6 Ha area, where 283.29 Ha is dedicated for industrial areas. Among other research villages, Katapang is the closest village to the capital of Bandung Regency as well as Bandung City. This area is also passed by one of the longest rivers in West Java, the Citarum River. The existence of this river benefits the industrial sector. The presence of industrial estates is affecting the livelihoods of the population; inhabitants in Katapang are experiencing rapid industrialisation and urbanisation which changes lifestyles in an individual. Most inhabitants in Katapang have occupations as factory workers. Factory labourers are either native to Katapang or from surrounding districts.

Illustration 4.7. Roads in *Kecamatan* Katapang were Blocked by Flood
Source: Photograph by M. Febriyanti (2017)

Kecamatan Cilengkrang

Cilengkrang sub-district is located in the Bandung Regency region which is the result of the expansion due to the stipulation of PP No. 16 year 1987 concerning Changes in the Boundary of the Bandung Regency with the Bandung City Region, formed in 1989 as a division of the Ujung Berung District. The position of the capital of Cilengkrang District is in Jatiendah Village with the distance from the Capital City of Soreang District being 31 km, and the distance from the Capital City of West Java Province 12 km. Cilengkrang has six villages, which cover 3,176.15 Ha. Cilengkrang has a direct border with Bandung City.

Illustration 4.8. Sub-district Office in *Kecamatan* Cilengkrang
Source: Photograph by M. Febriyanti (2017)

Illustration 4.9. Village of Cipanjalu, one of the research villages in *Kecamatan* Cilengkrang
Source: Photograph by M. Febriyanti (2017)

4.3.2 Characterisations of Local Populations

The socio-demographic characteristics of the samples in the research area constitute predisposing factors in the analytical model (*cf.* Table 3.1). The sample in this research consists of 833 inhabitants living among 209 households. Descriptions of the demographic characteristics of the sample are provided in Tables 4.2-4.4. Table 4.2 presents the gender distribution of the sample, which has been taken from the population of *Kecamatan* Pangalengan, Cilengkrang, and Katapang.

Table 4.2. Distribution of Gender in the Household Members of the Sample in the Research Villages (N=833)

Gender	Lamajang		Sukaluyu		Cipanjalu		Ciporeat		Katapang	
	N	%	N	%	N	%	N	%	N	%
Male	100	47.6	77	52.4	76	50.7	43	47.3	118	50.2
Female	110	52.4	70	47.6	74	49.3	48	52.7	117	49.8
Total	**210**	**100.0**	**147**	**100.0**	**150**	**100.0**	**91**	**100.0**	**235**	**100.0**

Source: Household survey 2017

Table 4.2 indicates that the distribution of males (50.2%, n = 118) and females (49.8%, n = 117) in the five villages is almost equal. This phenomenon also represents the situation in Kabupaten Bandung where males accounted for 51.1% (N= 1,802,064) and females 48.9% (N = 1,720,660) of the total population in 2017 (*cf.* BPS 2017). In conclusion, the household members show an equal distribution of genders among the samples with a representative image for the population in Kabupaten Bandung.

Following the distribution of gender among the respondents, Table 4.3 presents the distribution of age among the household members.

Table 4.3. Distribution of the Age of the Household Members of the Sample over the Research Villages (N=833)

Age	Lamajang		Sukaluyu		Cipanjalu		Ciporeat		Katapang	
	N	%	N	%	N	%	N	%	N	%
0-5	12	5.7	10	6.8	6	4.0	4	4.4	7	3.0
6-10	16	7.6	10	6.8	11	7.3	3	3.3	14	6.0
11-15	21	10.0	12	8.2	19	12.7	8	8.8	17	7.2
16-20	21	10.0	17	11.6	14	9.3	11	12.1	18	7.7
21-25	14	6.7	12	8.2	8	5.3	5	5.5	20	8.5
26-30	13	6.2	6	4.1	3	2.0	3	3.3	11	4.7
31-35	13	6.2	12	8.2	12	8.0	2	2.2	15	6.4
36-40	20	9.5	8	5.4	7	4.7	4	4.4	16	6.8
41-45	16	7.6	9	6.1	14	9.3	5	5.5	9	3.8
46-50	14	6.7	13	8.8	14	9.3	10	10.9	23	9.8
51-55	10	4.8	11	7.5	15	10.0	14	15.3	22	9.4
56-60	4	1.9	10	6.8	10	6.7	6	6.6	25	10.6
61-65	11	5.2	11	7.5	4	2.7	9	9.9	18	7.7
66-70	11	5.2	2	1.4	6	4.0	3	3.3	10	4.3
71-75	6	2.9	2	1.4	3	2.0	4	4.4	6	2.6
76-80	4	1.9	2	1.4	2	1.3	0	0.0	1	0.4
81-85	3	1.4	0	0.0	1	0.7	0	0.0	3	1.3
> 86	1	0.5	0	0.0	1	0.7	0	0.0	0	0.0
Total	**210**	**100.0**	**147**	**100.0**	**150**	**100.0**	**91**	**100.0**	**235**	**100.0**

Source: Household survey 2017

On the whole, the majority of the members are between the ages of 10 and 15 years old. In general, Indonesia's population is relatively young; the median age is 27 years (*cf.* Central Bureau of Statistics 2010). In relation with the dependency ratio, the distribution of age based on productivity in the research area shows that 71.53% of the household members are still in the productive age, with the majority of members between the age ranges of 16–20 and 51-55. This finding is in line with data from the Ministry of National Development Planning, which also stated that Indonesia is currently benefitting from a demographic bonus period where the population in the productive age is more than the unproductive age, which is more than 68% of the total population (*cf.* BAPPENAS 2018).

Figure 4.2 shows the frequency of the household members' age in the sample divided by gender (N=833). Figure 4.2 demonstrates that the distribution of age does not show the classic age pyramid with a broad base of children. There is a gap around the 20-30 year old age group which is implies that community members are generally leaving the village for the cities to pursue better living standards (*cf.* Fieldnote 2017).

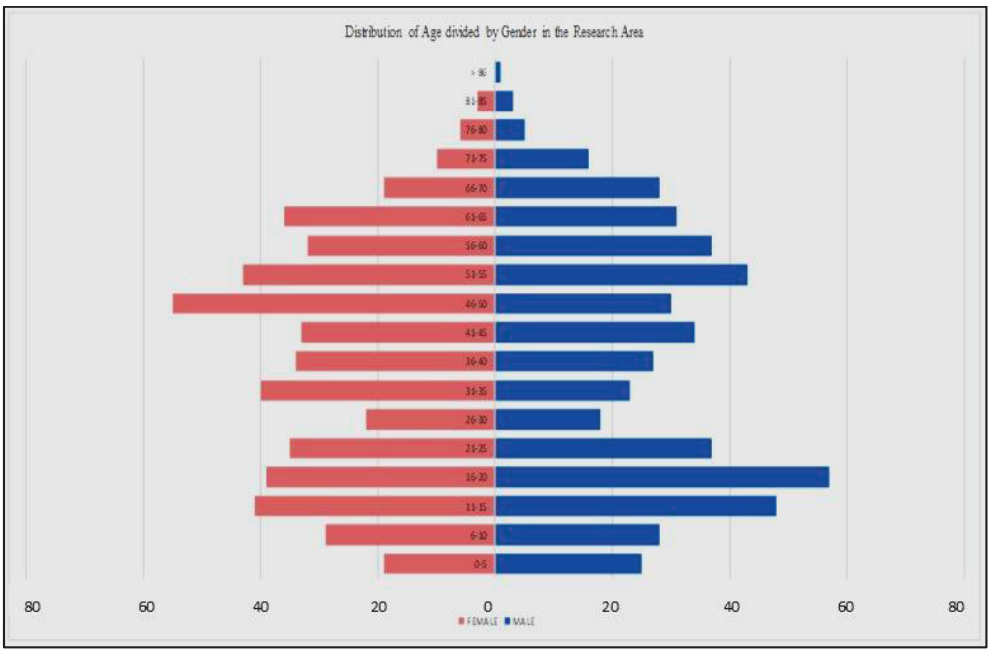

Figure 4.2 Frequency of the Age of the Household Members Divided by the Gender (N=833)
Source: Household Survey (2017)

Furthermore, another important component in the demographic composition with relation to social significance is the household size. The characteristics of the households, including composition and size, are closely associated with well-being in general (*cf.* UN 2017). Table 4.4 highlights the distribution of the number of household members per household in the five selected villages.

Table 4.4. Distribution of the Number of Household Members of the Sample in the Research Villages (N=209)

Number of member	Lamajang		Sukaluyu		Cipanjalu		Ciporeat		Katapang	
	N	%	N	%	N	%	N	%	N	%
1 member	2	4.3	1	2.9	1	2.4	0	0	0	0
2 members	4	8.7	2	5.7	9	22.0	4	14.8	11	18.3
3 members	5	10.9	8	22.9	6	14.6	11	40.7	13.	21.7
4 members	8	17.4	10	28.6	13	31.7	11	40.7	17.	28.3
5 members	13	28.3	10	28.6	11	26.8	0	0	8.	13.3
6 members	13	28.3	2	5.7	1	2.4	1	3.7	11	18.3
7 members	0	0.0	1	2.9	0	0.0	0	0.0	0	0.0
8 members	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
9 members	0	0.0	1	2.9	0	0.0	0	0.0	0	0.0
10 members	1	2.1	0	0.0	0	0.0	0	0.0	0	0.0
Total	**46**	**100.0**	**35**	**100.0**	**41**	**100.0**	**27**	**100.0**	**60**	**100.0**

Source: Household survey 2017

According to a United Nations report, the average household size has declined in almost every country around the globe, reflecting the fall in fertility rates. In addition, the decline in household size is also influenced by migration trends, co-residence, socie-economic, and cultural patterns (*cf.* United Nations 2017). The composition of the households in the sample shows that in Lamajang and Sukaluyu which are in the rural villages category, a majority of households is composed of between five and six members (28.3% and 28.6% respectively), while in Cipanjalu, which is in the semi-urban village category, the majority of household members in one house is between four (31.7%, n=13) and five members (26.8%, n=11), and in Ciporeat and Katapang, which are categorized as urban villages, most households have a smaller composition consisting of three to four members, with a percentage of 40.7% and 28.3%, respectively. Larger households of more than seven members living together are an exception. Those results may indicate a successful family planning programme in an urban village. However, the family planning program is still not well socialised in rural communities. Harun (2014) states that people in rural villages are still unfamiliar with the family planning program, resulting in low participation in the program. Furthermore, the highest percentage is three- or four-member families, which indicates that most of the family consists of the married couple and their children.

The distribution of the marital status and relationship with the household head within the household are presented in Tables 4.5 and 4.6.

Table 4.5. Distribution of the Marital Status of the Household Members of the Sample in the Research Villages (N=833)

Marital	Lamajang		Sukaluyu		Cipanjalu		Ciporeat		Katapang	
status	N	%	N	%	N	%	N	%	N	%
Single	75	35.7	52	35.4	54	36.0	29	31.9	90	38.3
Married	122	58.1	87	59.2	84	56.0	61	67.0	127	54.0
Divorced	0	0.0	2	1.4	0	0.0	0	0.0	3	1.3
Widow/er	13	6.2	6	3.4	12	8.0	1	1.1.	15	6.4
Total	**210**	**100.0**	**147**	**100.0**	**150**	**100.0**	**91**	**100.0**	**235**	**100.0**

Source: Household survey 2017

The majority of the respondents in the five villages is married (57.74%, n=481). Despite the increase of divorce rates in Kabupaten Bandung (*cf.* Pikiran Rakyat 2019), only a minor percentage of the respondents are divorced (0.6%, n=5). The relatively low occurrence of divorce in the research villages is seemingly related to the social esteem and pride associated with marriage in rural communities.

Table 4.6. Distribution of the Relationship with the Household Head of the Sample in the Research Villages (N=833)

Relationship	Lamajang		Sukaluyu		Cipanjalu		Ciporeat		Katapang	
	N	%	N	%	N	%	N	%	N	%
HH head	46	21.9	35	23.8	41	27.3	27	29.7	60	25.5
Spouse	39	18.6	32	21.8	33	22.0	21	23.1	43	18.3
Father	3	1.4	2	1.4	1	0.7	1	1.1	1	0.4
Mother	5	2.4	6	4.1	3	2.0	3	3.3	2	0.9
Son	41	19.5	29	19.7	29	19.3	16	17.6	44	18.7
Daughter	37	17.6	20	13.6	27	18.0	14	15.4	39	16.6
Brother	0	0.0	0	0.0	1	0.7	0	0.0	0	0.0
Sister	0	0.0	0	0.0	0	0.0	0	0.0	1	0.4

Table 4.6. (*continued*).

Relationship	Lamajang		Sukaluyu		Cipanjalu		Ciporeat		Katapang	
	N	%	N	%	N	%	N	%	N	%
Younger brother	0	0.0	1	0.7	0	0.0	0	0.0	1	0.4
Younger sister	1	0.5	3	2.0	0	0.0	0	0.0	0	0.0
Sister in law	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Brother in law	0	0.0	0	0.0	0	0.0	0	0.0	1	0.4
Father in law	2	1.0	1	0.7	0	0.0	0	0.0	0	0.0
Mother in law	4	1.9	1	0.7	0	0.0	0	0.0	12	5.1
Son in law	4	1.9	1	0.7	3	2.0	1	1.1	5	2.1
Daughter in law	7	3.3	0	0.0	1	0.7	1	1.1	4	1.7
Grand father	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Grand monther	0	0.0	1	0.7	0	0.0	0	0.0	0	0.0
Grand son	6	2.9	7	4.8	8	5.3	2	2.2	11	4.7
Grand daughter	13	6.2	3	2.0	2	1.3	4	4.4	8	3.4
Niece	2	1.4	2	1.4	0	0.0	1	1.1	3	1.3
Cousin	0	2.0	3	2.0	0	0.0	0	0.0	0	0.0
Other kin	0	0.0	0	0.0	1	0.7	0	0.0	0	0.0
Total	**210**	**100.0**	**147**	**100.0**	**150**	**100.0**	**91**	**100.0**	**235**	**100.0**

Source: Household survey 2017

Table 4.6 indicates that among the household heads and their spouse, most of the household members are in-living sons (average 19%), and almost even numbers are unmarried daughters (average 16.4%). The household composition is then followed by a small number of mothers-in-law, mostly in urban villages (Katapang, 5.1%) and a lower number of sons-in-law and daughters-in-law in Lamajang Village (3.3% and 1.9%). A relatively high percentage of in-living grandchildren reflect the fact that most of the married children prefer to entrust their children to their parents. In general, the type of family in Indonesia presents as the nuclear family type. This pattern is typical for most households in Asia, where the prevalence of two parents with children under 15 years of age is higher than in other continents. The presence of one or more children in the household provides important implications for household priorities, particularly in decisions of education and health care (*cf.* UN 2017).

Kinship among the Sundanese is bilateral. However, gender and birth order often become important factors in determining obligations and responsibilities in the family. For example, the husband is the leader and decision-maker in the family and responsible for family income while the wife is responsible for domestic tasks. In the same fashion, the elder brother has more responsibilities than his sister, or younger brother in the event that their parents pass away. In the same fashion, when one member is sick, older family members takeon the duties to take care of sick family members. In the research area, it was found that the younger brother is living with his brother and family because it is closer to the clinics. This pattern of kinship is not only observed among the Sundanese, but also the Javanese (*cf.* Fatwa *et al*. 2010).

Education

Education is one of the significant factors to improve the country's human development index, in addition to health and income per capita (*cf.* Ranis & Stewart 2000). The education system in Indonesia implements the 12-year compulsory education program. This program was launched by The Ministry of Education and Culture in 2009 as a response to changing demographic patterns. However, data shows that the educational attainment of residents in West

Java in 2017 is 8.3 years (*cf.* IHME 2017). The report indicates that despite the implementation of the 12-year compulsory education program, the average population of West Java did not complete junior high school.

In 2016, there were about 1,414 primary schools, 304 junior high schools, and 107 senior high schools, both private and public schools in Kabupaten Bandung. In general, education facilities are geographically accessible by the community members. However, education is perceived as too expensive by many community members, especially the higher levels.

In the research area, the trend is to complete basic education (until Senior High School), which in general is finished at the age of eighteen, and then look for a job. Table 4.7 presents the current level of completed formal education of the household members in the five villages (N=833). Children under the age of twelve belong to the 'other' category as, in general, children start basic school at the age of six, then complete six years of basic school by twelve years of age. The level of 'primary education' is represented by SD (basic school) and SMP (junior high school), secondary education by SMA (senior high school) and SMK (vocational high school), and higher education by all education after senior high school, including university.

Table 4.7. Distribution of the Completed Education of the Household Members of the Sample in the Research Villages (N=833).

Education	Lamajang		Sukaluyu		Cipanjalu		Ciporeat		Katapang	
	N	%	N	%	N	%	N	%	N	%
Primary education	83	39.5	92	62.6	75	50.0	30	33.0	48	20.4
Secondary education	84	40.0	33	22.4	51	34.0	24	26.4	123	52.3
Higher education	27	12.9	10	6.8	16	10.7	30	33.0	50	21.3
Others	16	7.6	12	8.2	8	5.3	7	7.7	14	6.0
Total	**210**	**100.0**	**147**	**100.0**	**150**	**100.0**	**91**	**100.0**	**235**	**100.0**

Source: Household survey 2017

Table 4.6 indicates that the majority of household members finished at least primary education. Focusing on the difference between urban and rural villages, it is clear that the majority of the community in the rural villages only finished primary school, with the highest percentage reported by Sukaluyu (62.6%, n=92), followed by Cipanjalu (50%, n=75). Conversely, Katapang as an urban village has the highest percentage of members who finished secondary level education (52.3%, n=123) as well as higher-level education (21.3%, n=50). These findings are in line with the report from BPS, where Katapang district has a higher percentage of population finishing secondary education (34.55%) compared to Cilengkrang district (30.3) and Pangalengan (19.88%) (*cf.* BPS 2016). Although it is not presented in the table, the present study in the five research villages found that women generally do not complete higher education because they got married at a young age. Furthermore, only a minority of the older population have completed nine years of primary education, while most of them did not even receive any formal education at all. In past decades, formal education was not accessible by all the population.

4.3.3 Patterns of Migration and Settlement

For several decades now, the population distribution in Indonesia has been uneven. Almost half the total population of the country lives on Java island, which covers just 6.8% of Indonesia's

territory. The concentration of economic activities has become one of the important factors for interprovincial population movements, where all of the provinces in Java are the most attractive for in-migrants (*cf.* Sukamdi & Mujahid 2015). Table 4.8 presents the distribution of place of birth of household members in the research villages, reflecting the patterns of migration and settlement in the community.

Table 4.8. Distribution of the Place of Birth of the Household Members of the Sample in the Research Villages (N=833)

Place of birth	Lamajang		Sukaluyu		Cipanjalu		Ciporeat		Katapang	
	N	%	N	%	N	%	N	%	N	%
In this village	158	75.2	119	81.0	100	66.7	41	45.1	101	43.0
In other villages	34	16.2	15	10.2	19	12.7	12	13.2	69	29.4
In other municipality	14	6.7	13	8.8	26	17.3	33	36.3	47	20.0
In other province	4	1.9	0	0.0	5	3.3	5	5.5	18	7.7
Total	**210**	**100.0**	**147**	**100.0**	**150**	**100.0**	**91**	**100.0**	**235**	**100.0**

Source: Household survey 2017

Table 4.8 indicates that the majority of inhabitants in the rural villages such as Lamajang (86.7%) and Sukaluyu (98.0%) are native inhabitants. In general, most of the household members were born in the village where they are currently living. However, Katapang village presents the lowest percentage with native inhabitants (43%, n= 101). More than half of the household members in Katapang were born in other villages (29.4%, n=49) and other municipalities (20.0%, n=47). Katapang, as an example of an urban village in the present study, is experiencing urbanisation as are most other urban villages in Kabupaten Bandung. This finding is also supported by the residential status reported by the community members (*cf.* Table 4.9).

Table 4.9. Distribution of the Residential Status of the Household Members of the Sample in the Research Villages (N=833)

Residential status	Lamajang		Sukaluyu		Cipanjalu		Ciporeat		Katapang	
	N	%	N	%	N	%	N	%	N	%
Native inhabitant	182	86.7	144	98.0	106	70.7	54	59.3	130	55.3
Migrant	22	10.5	3	2.0	44	29.3	37	40.7	56	43.0
Temporary inhabitant	6	2.9	0	0.0	0	0.0	0	0.0	4	1.7
Total	**210**	**100.0**	**147**	**100.0**	**150**	**100.0**	**91**	**100.0**	**235**	**100.0**

Source: Household survey 2017

Table 4.9 presents the distribution of the residential status of household members in the research area. Conversely, almost half the members of Katapang are migrants (43.0%). Since migration patterns are generally those of in-land migration, the majority of the ethnic groups in the five villages is Sundanese (*cf.* Table 4.10).

Table 4.10. Distribution of the Ethnicity of the Household Members of the Sample in the Research Villages (N=833)

Ethnicity	Lamajang		Sukaluyu		Cipanjalu		Ciporeat		Katapang	
	N	%	N	%	N	%	N	%	N	%
Sundanese	208	99.0	147	100.0	145	96.7	79	86.8	214	91.1
Javanese	2	1.0	0	0.0	5	3.3	4	4.4	17	7.2
Minangkabau	0	0.0	0	0.0	0	0.0	4	4.4	0	0.0
Others	0	0.0	0	0.0	0	0.0	4	4.4	4	1.7
Total	**210**	**100.0**	**147**	**100.0**	**150**	**100.0**	**91**	**100.0**	**235**	**100.0**

Source: Household survey 2017

Table 4.10 presents the distribution of ethnicity in the research area. The respondents report their ethnicity based on their self-identification (self-defined ethnicity). The predominant ethnicity in all five study villages, as in the rest of West Java, is Sundanese. However, in some urban areas, there are also some immigrants from other parts of West Java and some of the outer islands.

Socio-economic profile

In view of the socio-economic profile of the research villages, the economic standard is generally based on the income of the household head or combined with his spouse. Family members also share the responsibility of their family income. In this way, the distribution of the socio-economic status of the community members is presented on the basis of households (*cf.* Table 4.11).

Table 4.11. Distribution of the Socioeconomic Status of the Households in the Research Villages (N=209)

Socioeconomic status	Lamajang		Sukaluyu		Cipanjalu		Ciporeat		Katapang	
	N	%	N	%	N	%	N	%	N	%
Very poor	2	4.3	0	0.0	2	4.9	0	0.0	0	0.0
Poor	13	28.3	15	42.9	14	34.1	12	44.4	5	8.3
Average	30	65.2	20	57.1	24	58.5	15	55.6	51	85.0
Rich	1	2.2	0	0.0	1	2.4	0	0.0	4	6.7
Total	**46**	**100.0**	**35**	**100.0**	**41**	**100.0**	**27**	**100.0**	**60**	**100.0**

Source: Household survey 2017

Table 4.11 indicates that, in general, households in five research villages belong to the 'average' category. However, Sukaluyu (42.9%), Cipanjalu (34.1%), and Ciporeat (44.4%) show a higher percentage of households with poor economic status. As previously discussed in Chapter III, economic status in the present study is measured on the basis of the presence or absence of a variety of household consumption items, in addition to monthly income. In relation to monthly income, the respondents also reported the occupation of each household member.

Table 4.12 presents the distribution of the occupation of household members in the selected research area.

Table 4.12. Distribution of the Occupation of the Household Members of the Sample in the Research Villages (N=833)

Socioeconomic status	Lamajang		Sukaluyu		Cipanjalu		Ciporeat		Katapang	
	N	%	N	%	N	%	N	%	N	%
Housewife	46	21.9	16	10.9	32	21.3	22	24.2	45	19.1
Farmer	44	21.0	29	19.7	6	4.0	8	8.8	2	0.9
Labour worker	31	14.8	25	17.0	46	30.7	13	14.3	52	22.1
Self-employed	13	6.2	14	9.5	19	12.7	15	16.5	50	21.3
Civil servant	8	3.8	3	2.0	2	1.3	4	4.4	13	5.5
Un-employed	18	8.6	27	2.0	3	2.0	12	13.2	18	7.7
Others	50	23.8	33	18.4	42	28.0	17	18.7	55	23.4
Total	**46**	**100.0**	**35**	**100.0**	**41**	**100.0**	**27**	**100.0**	**60**	**100.0**

Source: Household survey 2017

The distribution of occupation in Table 4.12 shows that the majority of the household heads in Lamajang and Sukaluyu are working as farmers. The villagers are involved in rice-growing, either on their own or rented land, or as labourers for local land-owners, and for which they are partially paid in kind, with a portion of the rice harvest. Some villagers grow vegetables for sale as well, and a smaller proportion grows gardens for family food consumption. Other major occupations include labourers working on construction sites. As a rural village, the majority of the men in the Katapang village earn money as labourers (22.15, n=52) or are self-employed (21.3%, n=50) i.e. as *tukang ojek* (a person who offers his motorcycle to be used as a taxi). Another occupation under the 'Self-employed' category in the research area is *tukang jahit* (tailor).

Furthermore, since most of the inhabitants work in informal sectors, they are not subject to formal retirement. Members in the villages commonly work until an advanced age or even during episodes of illness to keep earning money. The majority of women are classified as housewives, where the family income only comes from their husbands. Some women, particularly in Pangalengan, were employed in one of the tea farms for picking tea leaves. Women, sometimes in partnership with their husbands, may own *warung*[4]. The 'others' category refers to employment in areas involving door-to-door sellers/peddlers. Children who are not economically active were also recorded in the 'others' category.

Illustration 4.10. *Warung* in the Respondent's House
Source: Photograph by M. Febriyanti (2017)

Overall, the characteristics of the inhabitants in the research area have a multifaceted character with several community settlements. In terms of occupation, there is decreased activity in the agricultural sector due to less available land for farming. The socio-economic status of the inhabitants is dependent on the jobs available.

Note:

1. According to Law Number 22 of 1999 concerning Regional Government, decentralisation is the transfer of authority by the Central Government to the Autonomous Region within the framework of the Republic of Indonesia.
2. Jaminan Kesehatan Nasional (JKN) and Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS-K) are sometimes used interchangeably when referring to the participations of the people in public health insurance.
3. Tumpeng are traditional dishes served during a special occasion. In Lamajang village, during the celebration of Islamic New Year and the Birth of the Prophet Muhammad, three kinds of tumpeng are served: the first tumpeng is made from the rice harvested from *sawah*, the second from the rice harvested from *huma*, and the third from sticky rice or *beras ketan*..
4. *Warung* is small stalls in front of the house, which sell vegetables, household items, and snack foods.