Coronavirus Contingencies:

An Ethnographic Case Study of Local Knowledge and Community Responses to COVID-19 in Kupang Kota and Kupang Regency, East Nusa Tenggara, Indonesia

By

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Thesis
Submitted to Flinders University for the degree of

Doctor of Public Health

College of Medicine and Public Health

20 April 2022

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SUMMARY

BACKGROUND & RESEARCH PROBLEM

The COVID-19 pandemic has triggered unprecedented social, economic, and political disruptions in Indonesia. Nusa Tenggara Timur (NTT), among the poorest provinces in East Indonesia, has been drastically affected by COVID-19. Weak leadership, unprepared health systems, misinformation, stigma, and pervasive uncertainty accompanied the virus as it swept through NTT. A systematic review of the qualitative literature was initially conducted, focusing on community-based research into COVID-19 experiences, perceptions, and responses in low- and middle-income countries (LMICs). Gaps in the literature underscored the need for in-depth social ethnographic research to contextualise lived experience, challenges, and perceptions towards improving public health approaches.

METHODOLOGY AND ANALYSIS

An ethnographic case study was conducted in NTT in early 2020 during an acute phase of the pandemic in Indonesia. Observations of daily community and social life, stakeholder interviews, and focus group discussions were undertaken. A critical ethnography of health lens was used, which considered the distribution of power, (de)legitimation and use of various pandemic knowledges, and the intertwining of religious and empirical biomedical epistemologies in pandemic practices. Data from field notes, interviews, and focus group discussions were subjected to qualitative thematic analysis.

RESULTS

Nine themes clustered around three domains (systemic, sociocultural, individual), identifying deficient leadership, power asymmetries, and ill-prepared health systems as exacerbating the negative consequences of the pandemic, with religious institutions and traditional adat culture playing a crucial role. Misinformation, rumours and hoaxes, social restrictions, surveillance, and sanctions affected community responses. A range of narratives revealed the complex nature of how power, politics, religion, and knowledge systems circulated among the villages and influenced behaviour, driving transmission, and exerting significant social pressure amid uncertainty, fear, stigma, and a little hope.

DISCUSSION

The discussion is focussed one two key themes to come from the systematic review, namely reactions and adaptations. Reactions were responses to the exogenous perturbations of the onset of the pandemic; adaptations were examples of resilience, cohesion, and trust-building as the community and health system struggled to establish resilience. Most respondents focused on the disruptive nature of what was occurring in which blame, uncertainty, insecurity, and frustration prevailed. Adaptive responses consisted predominantly of the stabilising structure of religion, both materially and spiritually.

CONCLUSION

Research into the COVID-19 phenomenon in a remote, east Indonesian context demonstrated that the sociocultural rupture of the pandemic revealed more about community structure and vulnerabilities, and less about the biology of a virus and the illness it caused. This crisis was one of temporality, space, and the construction of new cultural forms to address a dramatic disruption and shift in social norms and stability.

KEY CONTRIBUTIONS TO KNOWLEDGE

This research contributes new knowledge into how resource-constrained communities in LMICs face the challenge of this global crisis, adding to our understanding of how these disruptive unique events are confronted by religion, technology, history, and social structure. This research also contributes to the development of qualitative methodology by demonstrating real-world implementation of field data collection at the height of the global pandemic. The results demonstrated that local context embedded in tradition, religion, political economics, and intersubjective experience is vital to consider when designing and implementing public health interventions in constrained locales in LMICs such as Indonesia.

DECLARATION

I certify that this thesis:

1. does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university
2. and the research within will not be submitted for any other future degree or diploma without the permission of Flinders University; and
3. to the best of my knowledge and belief, does not contain any material previously published or written by another person except where due reference is made in the text.

Christopher B. Raymond
Date: 20 April 2022

ACKNOWLEDGEMENTS

Apropos to a social science endeavour, the culmination of the research presented in this thesis was made possible through collective efforts and support provided by extraordinary colleagues, friends, and family. I am indebted to them for their steadfast and unwavering support through the years of my doctoral journey, without which I would have been ill-equipped to complete this study.

Foremost deserving of thanks is my academic supervisor, Professor Paul Ward, whose endless enthusiasm, razor-sharp intelligence, and dedication have inspired me to persevere in this work through to fruition. It is not immodest to claim that he is owed the lion's share of appreciation for his thoughtfulness, kindness, and camaraderie over the years.

A debt of gratitude is owed to my father, David Raymond, and to my friend and confidant Russ Vogel for supporting me materially and emotionally, providing advice and finance towards completion of this monumental task. Also, my mother, Linda Raymond, my sisters and their families, and my children have been evergreen in their encouragement.

Special thanks goes to my partner, Dewi Pramita, who has made my educational trials and tribulations the more tolerable, supporting me with loving kindness and unconditional joy.

I am also deeply grateful for the ongoing encouragement from friends and colleagues, especially my Indonesian classmates at Flinders, Dr. Pande Januraga and Dr. Emi Patmisari, my wonderful colleagues at FHI 360 Ibu Caroline Francis, Dr. Zen Hafy, Dr. Hans Antlov, and my USP Indonesia family who continually showered me with words of support to finish this degree: Ibu Nani, Ibu Kus, Ibu Retno, Pak Eddy, Ibu Oce, Ibu Butet, Mbak Yenny, Mbak Sari (the Jeksons), Mas Oji, and Mbak Diah. Dr. Ans Timmermans, Dr. David Nichol, Mr. Gerard DeKort, Mr. Mark Hammond, Dr. Sally Irwin, Dr. Sandeep Merhawal, and Dr. Seiji Yamada have exerted longstanding (and long-suffering) efforts to steer my fate towards this positive outcome; their kindness and friendship is treasured.

Thanks to my academic editor, Dr. Robert Muller, who helped to shape this thesis and ensure my verbs were properly freighted and buttressed against the weight of this important topic.

I am highly appreciative of Dr. Dommingus Elcid Li, Director of the Institute for Resource Governance and Social Change, and to Dr. Ir. I Wayan Mudita and Dr. Andreas Umbu Roga of the Universitas Nusa Cendana for supporting the logistics and formal arrangements for my research project in Kupang, as well as to Dr. Ermi Ndoen of UNICEF in Kupang for his insight and assistance. Dr. Ida Widianinsih and her team at the Faculty of Social and Political Sciences Universitas Padjadjaran were instrumental in ensuring accurate and timely translation assistance. I also acknowledge and thank the staff and directors of the provincial and district health

offices, the many puskesmas (community health centres), churches, and villages where this research was conducted. This thesis is about the travails of the people of Kupang during a particularly acute and painful moment in history, and my hope is that I was able to do justice by those involved in this research.

Finally, my heartfelt, warmest thanks and deepest gratitude goes to Ibu Oce Boymau, without whom none of this work would have been possible. She has been my beacon and inspiration for this research, and I treasure our time spent conducting field work and exploring the unique mysteries of Nusa Tenggara Timur. To her is owed the spoils of this battle.

PUBLICATION

Raymond, C. B., & Ward, P. R. (2021). Community-Level Experiences, Understandings, and Responses to COVID-19 in Low- and Middle-Income Countries: A Systematic Review of Qualitative and Ethnographic Studies. *International Journal of Environmental Research and Public Health*, *18*(22), 12063. https://doi.org/10.3390/ijerph182212063
IJERPH 5-year Impact Factor: 3.789

DEDICATION

This thesis is dedicated to those who have lost their lives to this scourge,
may their memory be eternal

Coronavirus Contingencies:

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Section One

Section 1: Introduction, Literature Review, and Methodology

1

Chapter 1. Introduction and Setting

Introduction

The COVID-19 global pandemic has revealed significant vulnerabilities and deficiencies in local and global public health systems, evidenced by variability in the effectiveness of responses, unprecedented worldwide morbidity and mortality, and stark inequities in the distribution and access of information and health commodities in countries around the world (Collins et al., 2020; Team & Manderson, 2020). Missing in much of the rhetoric around mitigating the global crisis is the crucial importance of local engagement with communities through empowering and participatory planning and execution of health programs. The predominance of top-down approaches espousing a biomedical paradigm in pandemic management translates into potentially ineffective policy that is not tailored to the local context (Hassan et al., 2021; Murphy, 2020; Nederveen Pieterse et al., 2021; Rajan et al., 2020; Singh, 2020; Wenham, 2021).

Specifically, as the SARS-CoV-2 virus has encountered countries with variable and fractured health systems, a one-size-fits-all discourse of public health responses has been driven by global health institutions, such as the WHO and other UN bodies, and promulgated by the industrial economy countries of the Global North (Fofana, 2021; Ndlovu-Gatsheni, 2020; Richardson, 2020). In the low- and middle-income countries (LMICs) of the Global South, failures in pandemic preparedness, fragile health systems, and ineffective information and communication systems have seen massive burdens from COVID-19, resulting in a global economic and social catastrophe (Holst, 2020; Palma-Oliveira et al., 2021; Sciortino, 2021). Often, these countries unreflexively adopted global health policies, with little tailoring to local complex environments and resource constraints.

This dissertation research aims to explore and identify the experiences and perceptions of remote island communities in Indonesia to better understand the sociocultural and structural contexts of COVID-19 as it was happening in an LMIC of the Global South. This chapter will introduce the study and its setting, identify key areas of inquiry, establish the public health problem context, and discuss the significance of this

research. The overall structure of the dissertation will be outlined in the final sub-section of the chapter.

1.1 Background

Global disruptions caused by COVID-19 offer researchers insight into how pandemics are at once biological and social threats, as communities struggle to construct meaning from novel challenges to their ontological status quo (Trout & Kleinman, 2020; Wade & Halligan, 2017). The threat of contagion, and human efforts to contain, avoid, and eliminate it, has dominated biomedical discourse since early 2020, resulting in governments and international actors adopting technocratic, materialist COVID-19 mitigation policies focused on isolation, physical distancing, quarantine, testing, tracing, and dissemination of risk communications (Hopman et al., 2020; WHO, 2020a, 2020b). The entanglement of the SARS-CoV-2 virus with the kaleidoscope of local sociocultural contexts and individual behaviours, confronts and confounds as the unprecedented pandemic challenges public health systems without exception (Lupton & Willis, 2021). The evolving COVID-19 crisis has exposed vulnerabilities across political, economic, health and other domains, revealing contours of inequity and differential access to information, services, power imbalances and constraints on human agency, and according to official estimates as of 30 September 2021, has infected over 230 million people and left almost five million dead since the pandemic erupted (JHU, 2021; Team & Manderson, 2020; WHO, 2021b). Unprecedented in scope and scale, COVID-19 has destabilised and reorganised how we enact relationships and use our bodies, dramatically influencing how we move, interact, and understand our place in the world (Chao, 2020).

Vulnerabilities affecting nations' pandemic responses centre on the confluence of limited human, commodity, and financial resources, and historical contexts influencing the management and dissemination of reliable competent data and information, and engagement with citizens (Friedler, 2021; Zakar et al., 2021). As SARS-CoV-2 has spread through the LMICs of the Global South, the virus has held fast amidst fractured health systems and ill-prepared governments, resulting in the world's largest share of excess COVID-19 deaths, compared with other income group countries (Gill & Schellekens, 2021; Shadmi et al., 2020). Lack of access to reliable data in many countries, due to challenges in health information systems, testing, and outreach constraints, and other infrastructural and behavioural issues, forces health authorities to estimate without proper evidence, which has had the twin effect of wasting limited resources and engendering mistrust in an already suspicious public. Revisions in modelling estimates demonstrate that COVID-19 deaths are

likely three times higher than what is officially reported to the WHO and national surveillance systems, inevitably causing protracted pandemic suffering by the underestimation of needed resources to quell the crisis (Economist, 2021a, 2021b; Gill & Schellekens, 2021; WHO, 2021a). Chronically over-extended health systems in LMICs have buckled under the weight of COVID-19, and pervasive rifts and ruptures in social life will likely have consequences that will outlast the acute, liminal phase of this pandemic (Bell, 2021).

Social responses to COVID-19 are both expected and novel, as many LMICs confront structural inequality, histories of colonialism, racism, and poverty, and the legacies of recent past outbreaks and high endemic disease burdens. Almost without exception, communities have faced episodes of stigma and social rejection, panic, uncertainty, and novel negotiation of risk perception and evolving explanatory models to understand and respond to COVID-19 (Lupton, 2020a; Manderson & Levine, 2020; van Bavel et al., 2020). However, each community, embedded in its own history, sociocultural milieu of language, ethnicity, religion, power dynamics, and modernity, is unique in its phenomenological experience of the pandemic, and to what degree these experiences have destabilised social life. Prior histories of outbreaks of SARS, Ebola, and global pandemics of HIV and TB for example, while instrumental in understanding best practices and approaches, have not sufficiently prepared communities with robust systems of response and containment, both materially and socially (Abramowitz, 2017; Crawford et al., 2016; Eaton & Kalichman, 2020; Fidler, 2004; Guarner, 2020; Richardson et al., 2016; Sciortino, 2021; Venables, 2017).

It is vital therefore that social analyses be prioritised as policymakers and community members navigate the ever-shifting landscape of the crisis, as there are no easy one-size-fits-all approaches or policies which are effective for the vastly unique communities encumbered by COVID-19 (Adams & Nading, 2020; Campbell, 2011; Daniels et al., 2017; Higgins et al., 2020). As illustrated in the literature review of studies conducted around the world in LMICs in this dissertation, sociocultural contexts and the minutiae of lived experience are paramount for any effective engagement or development of appropriate and participatory public health policy and intervention. As researchers, it is important to strengthen the links between community engagement and policy development, bringing to light the details of daily life and the real contours of social suffering towards amelioration of this massive global crisis. Real change happens in the community, and globally derived discourses and policies are ineffective if they are not grounded in local contexts and understandings.

The fallout from the COVID-19 pandemic response brings into stark relief the deficiencies of the global disease surveillance and control system (Collins et al., 2020; Shadmi et al., 2020). The values embedded in the dominant discourse, such as surveillance and control of populations, moralising an individualist responsibility for hygienic citizenship, control of the production, legitimation, and flow of knowledge and communication, arise predominantly from a Western, empiricist, and technocratic biomedical paradigm (Briggs & Nichter, 2009; Brown, 2019; Davis, Flowers, et al., 2015; Davis, Stephenson, et al., 2015; Wald, 2008). While it is crucial to employ the traditional tools of epidemiology, including vaccination, quarantine, and surveillance, these approaches generally do not take into account the spectrum of embedded social, structural, and historic processes that give rise to inequitable health outcomes during pandemics (Krieger, 2004; Wemrell et al., 2016). These processes involve the control and distribution of power, and how power gradients have generated and perpetuated inequities in health (Farmer et al., 2013).

Social inequality is an important determinant of health, and research has demonstrated that inequitable societies have poor health compared to more equitable societies, regardless of the influence of absolute or relative poverty (Kawachi & Kennedy, 2002; Link & Phelan, 1995; Wilkinson, 1996). Anthropology views disease arising from social inequity as a form of violence, enacted through broad cultural and social structures (Farmer et al., 2006; Kabel & Phillipson, 2021; Parsons, 2007). An approach to health inequities must link local context to "broader geopolitical context", and that analyses of "biological or social determinants should include the full complexity of biosocial interactions" (Nguyen & Peschard, 2003).

A robust analysis of the global COVID-19 pandemic response must link local context to the dominant global discourse (Gray et al., 2020; Lupton, 2020a; Osborne et al., 2021; Padmawati & Nichter, 2008). The monolithic, monological global outbreak narrative reflecting dominant intellectual power structures and biomedical epistemes does not account for the totality and complexity of local understanding of this biosocial phenomenon, and indeed reifies the inequitable production and distribution of COVID-19 knowledge and response (James, 2021; Kleinman et al., 2008; Wald, 2008; Wong & Claypool, 2021).

The COVID-19 'problem' is a socially constructed nosology within the biomedical paradigm (Ali, 2021b; Duman, 2020; Trout & Kleinman, 2020). While not detracting from the reality of the problem, the discourses and global narratives, and the resulting strategies of surveillance and social control, lack a critical recognition of the interplay between

biology, social structures, and disease. Global and local control of this biosocial phenomenon runs along political-economic topographic lines, legitimising how power is used in the production of knowledge around the problem, how it communicates and 'problematises', and how local responses embody inequities in this distribution of power (Feierman et al., 2010; Gaddy, 2020; Keränen, 2015; Lock, 1993; Ndlovu-Gatsheni, 2020).

The question of power is a compelling framework through which to understand how dominant global discourses around COVID-19 and other pandemics arise (Alaran et al., 2021; Farmer, 1996; Lupton, 2013; Ndlovu-Gatsheni, 2020; Osborne et al., 2021; Shiffman, 2014). In reference to suffering, the question of power, through the power to heal, cause disease, and prevent injury, allows for the inclusion of historic and cultural processes to be considered in a more robust manner, rather than simply "reifying [power] in terms of social structure or cultural essence, or individualizing it in terms of human agency" (Nguyen & Peschard, 2003).

Community engagement, as taken from the public health literature, is an essential component of primary health care and people-centered services (Rifkin, 2009, 2014), and 'supports buy-in and sustainability of health interventions, health advocacy, improved quality and satisfaction of services, and contribute to health systems responsiveness and strengthening' (Bath & Wakerman, 2015; Gilmore et al., 2020). Concerns have been raised about the lack of planning and focus on community engagement by global health stakeholders, effectively distancing policymaking from impacted communities (Rajan et al., 2020). The pandemic is ultimately an opportunity to examine different types of community engagement paradigms, ranging from top-down externally driven, to laissez faire approaches. These approaches 'reflect long-standing contradictions around how people and populations are imagined in public health—as a 'problem' to be managed, as 'free agents' who make their own choices, or as a potential 'solution' to be engaged and empowered for comprehensive public health' (Loewenson et al., 2021, p. 1439).

Ultimately, the relationship between the state and the community predicts the degree of social protection against pandemics, as 'more distrusting and conflictual relations with the state have been stimulated by centralized, disorganized, top-down government management of COVID-19, especially when measures neglect local realities and do not provide adequate social protection' (Loewenson et al., 2021, p. 1448). By contrast, historically collaborative relations between the community and the state around multisectoral approaches have positively contributed to cooperation and community engagement. Collaboration offers 'decentralised, self-determined and collective actions in

public health, addressing the real challenges communities face from pandemics, rather than a top-down, bureaucratic and one-size-fits-all approach' (Loewenson et al., 2021, p. 1449).

Structural violence, inequality, structural risk, and social capital are key theoretical considerations when pondering community vulnerability during infectious disease pandemics (Osborne et al., 2021; Quesada et al., 2011; Singer & Rylko-Bauer, 2021; C. Smith, 2020). Osborne defines vulnerability as the 'confluence of biological, social, political, economic, and other emerging factors, which put individuals and communities at greater risk of disease' (Osborne et al., 2021, p. 9). Within this definition, we see the interplay of the micro and macro levels of analyses, including the impact of both political economy and individual risk.

Figure 1: The cycle of vulnerability informing and being mitigated by community engagement (Osborne et al., 2021, p. 9)[1]

A cycle of vulnerability model for mitigation at the community level is illustrated above, focusing mainly on the level of 'community', and accounting for vulnerability arising from historical, social, systemic, and structural contexts, enablers, and constraints. Community engagement, in this case towards the goal of improving COVID-19 pandemic responses, entails adaptation to community identified needs (emic), participation and empowerment, and intersectoral collaboration in both public and private sector stakeholders. As previously mentioned, if the individual body is the site at which biological disease occurs, and community is the site where sociocultural effects are inscribed and interventions are implemented, then what results is a need for dexterity in navigating both systemic and individual agency dynamics to reduce vulnerability at individual patient and social levels.

Risk and vulnerability are rooted in structural and social causes, such as histories of exploitation, mistrust, and inequality. Power distributions influence vulnerability to

[1] Reproduced under the terms of the Creative Commons CC-BY license, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

infectious disease outbreaks, including the wielding and legitimation of knowledge, and histories of mistrust in public institutions, as was evident in the social rifts that worsened the West African Ebola epidemic (Osborne et al., 2021, p. 9). The COVID-19 pandemic aligns with previous pandemic experiences in which shock and confusion at the point of onset is often accompanied by fear, uncertainty, feelings of vulnerability, inadequate information from which to assess risk, and the usual characteristics of stigma, rejection, and a temporary breakdown of social norms and structures in response to containment and mitigation efforts, such as large-scale social restrictions (Hewlett & Hewlett, 2008; Kleinman & Lee, 2006; Lupton, 2020a; Richardson et al., 2019; Wilkinson & Leach, 2015).

Lessons learnt from the Ebola experience clearly demonstrate that the use of social science as an adjunct to biomedical investigation and intervention is crucial for successful outcomes (Abramowitz, 2017; Sams et al., 2017), including using social science to examine the 'why's behind the 'what's' of limited knowledge, why stigma is differentially enacted, who controls the means and mechanisms of information and how is it distributed, what the historic and sociocultural contexts are within which a pandemic is found. The deeper questions push the limits of what is considered as legitimate knowledge, and how theories of learning and examinations of multiple ontologies or life worlds are incorporated into analyses of 'COVID-19 knowledge.'

Incorporation of local knowledge into community participation efforts can be approached using a critical lens on the influence of power and political economy, and through examples of previous programs which successfully adopted local realities, such as with SARS and Ebola (Lenhardt, 2021). COVID-19 pandemic responses have not arisen out of an implementation vacuum, rather they have inherited a legacy of 'imposed humanitarian objectives' led by external actors, and leading to limited local engagement and consideration of local contexts, reducing both participation and effectiveness of a given intervention (Lenhardt, 2021, p. 2). 'During public health emergencies, such as the current COVID-19 crisis, communities are often poorly involved in the planning and implementation of interventions, yet their commitment is fundamental to control outbreaks' (Anoko et al., 2020). Due to failures in learning lessons from global South knowledge and experience, the discourse is shifting toward renewed calls for 'decolonial, post-colonial, and post-development approaches' (Lenhardt, 2021, p. 2), to promote decentralised decision-making to be more responsive to community needs, to innovate using digital technologies, and to encourage leadership from global South researchers and stakeholders in driving the global discourse. Several factors in the decolonial perspective include the recognition that pre-pandemic inequalities have led to uneven social and economic impacts

which have influenced who has the power to design and implement recovery and response efforts. Existing development paradigms are deeply rooted in colonial legacies of power and resource distribution, and this recognition requires a shift towards utilising knowledge from the 'global South' to be integrated into the current 'North'-dominated public health paradigm (Lenhardt, 2021). Hegemonic knowledge discourses generated from the 'global North' are criticised and seen as a catalyst for shifting the knowledge base to local communities through critical scholarship. Citing examples from the Ebola recovery projects (2014-16 and 2018-20) in Africa, successfully curbing the epidemic correlated with an increase in community co-construction and grassroots responses that incorporated local anthropological knowledge (Anoko et al., 2020).

1.2 Research Setting in Indonesia

Local context and local knowledge critically influence how social relations among and between communities and the government play out and have an impact on responses to institutional public health interventions. A rich scholarly literature underscores the crucial importance of local knowledge in this arena (Gaddy, 2020; Geertz, 1983; Kleinman, 1992; Lenhardt, 2021; Nugroho, 2018; Soplanit et al., 2021; Walters et al., 2021). In effect, the field in which health interventions take place is at the boundary between the spheres of governor and the governed, and can be imagined as the locus of both resistance and/or emancipation, depending on how these bodies interact within a framework of power relations (Kentikelenis & Rochford, 2019; Van Rensburg et al., 2016).

To explore the dynamics of how institutional health interventions are enacted within a traditional community in a decentralised system such as Indonesia, I will conduct an ethnographic case study of COVID-19 as it is experienced by communities in one urban municipality and one rural district in East Nusa Tenggara[2] on the islands of West Timor and Semau in the Lesser Sunda archipelago of Indonesia (see Figure 2). A vast, volcanic archipelago of more than 17,000 islands spanning 2,000,000 km^2 hovering on the equator, Indonesia is the fourth largest country by population in the world.

1.2.1 Nusa Tenggara Timur, Indonesia

The districts of Kupang Municipality (Kota) and Kupang Regency (Kabupaten), located in the province of Nusa Tenggara Timur (NTT) on the island of West Timor, are the field sites

[2] In keeping with local nomenclature, for the remainder of the dissertation, I will refer to East Nusa Tenggara, Kupang Municipality, and Kupang District using the Bahasa Indonesia version of 'Nusa Tenggara Timur' or 'NTT', Kota Kupang, and Kabupaten Kupang (Kab. Kupang) respectively.

for the data collection for the study. These are multi-ethnic locales with under-resourced health infrastructures, high prevalence of endemic and chronic disease burden relative to other parts of Indonesia, dynamic, evolving sociocultural identities, adherence to syncretic religious forms, and persistence of *adat*[3] and cultural traditions. These qualities offer a novel and appealing context from which to investigate the interface of biomedical and traditional paradigmatic approaches to the pandemic.

NTT province is a sub-archipelago spanning 624 islands across 48,000 km^2 in the far eastern extent of Indonesia, situated just north of Australia. Besides West Timor, NTT's principal population centres are on the islands of Flores, Alor, and Sumba. Collectively, these islands are known colloquially as *Flobamorata* (FLOres, SumBA, TiMOR, Alor, LambaTA).

[3] In Indonesia, *adat* is a contested concept which generally encompasses customary laws associated with a given ethnic group. Adat is a dynamic, politicised, and negotiated concept, influenced by Dutch colonial rule, New Order politics, and subsequent *Reformasi*. 'Adat can mean traditional customs handed down through the generations by ancestors, or it may mean the way that things are always done in any particular community. Again, adat may mean the way rice is winnowed according to a special rhythm, or the way traditional dances are performed. Adat may also be translated as the customary law of a suku or clan.' Webb, P. (1986). Adat and Christianity in Nusa Tenggara Timur: Reaction and Counteraction: Traditional custom and modern development in Eastern Indonesia. *Philippine quarterly of culture and society*, *14*(4), 339-365.

Figure 2: Location of study sites in Nusa Tenggara Timur, Indonesia[4]

The province is administratively divided into 21 regencies (districts) and 1 municipality (the provincial capital, Kupang City), and further into 309 sub-districts (*kecamatan*) and 3,353 villages (*kelurahan* and *desa*) (BPS NTT, 2021b), with a total population of 5,541,394 residents. There are 404 Primary Health Care Centres and 50 hospitals providing health services to the communities; however, overall health status among NTT citizens remains poor (Dinkes NTT, 2018). There are five layers of government in Indonesia: the central level (national), provinces, *kabupaten* (districts) and *kota* (municipalities), *kecamatan* (sub-districts), and *kelurahan/desa* (villages) (Evans & Millott, 2020; A. Nasution, 2016). The selected study sites for this research were villages located within the provincial capital of Kupang City, consisting of 51 villages, and Kupang Regency, consisting of 177 villages in a mostly rural district adjacent to the capital and encompassing several nearby islands (see Chapter 3) (BPS NTT, 2021b).

[4] Map reproduced with the permission of CartoGIS Services, Scholarly Information Services, The Australian National University CartoGIS Services. (2021). *Map of Nusa Tenggara Timur*. Australian National University. http://asiapacific.anu.edu.au/mapsonline/

NTT is one of the poorest provinces in Indonesia; the poverty rate of 21.21% (8.76% urban poverty, 25.26% rural poverty) is more than double the national rate of 9.22% for Indonesia in general (BPS NTT, 2021b, p. 319; Mahpudin, 2020). Scoring 0.6528 as of 2021, NTT's Human Development Index (HDI) ranks it at 32 of 34 provinces (Figure 3), with internal variation between 0.5703 to 0.6788 (Badan Pusat Statistik, 2021a; BPS NTT, 2021a). As a composite measure of life expectancy, education, and per capita income indicators, the HDI differences between national average and NTT province underscore the burdens of resource constraint and in-country inequities hampering development in this region (Muhidin et al., 2020).

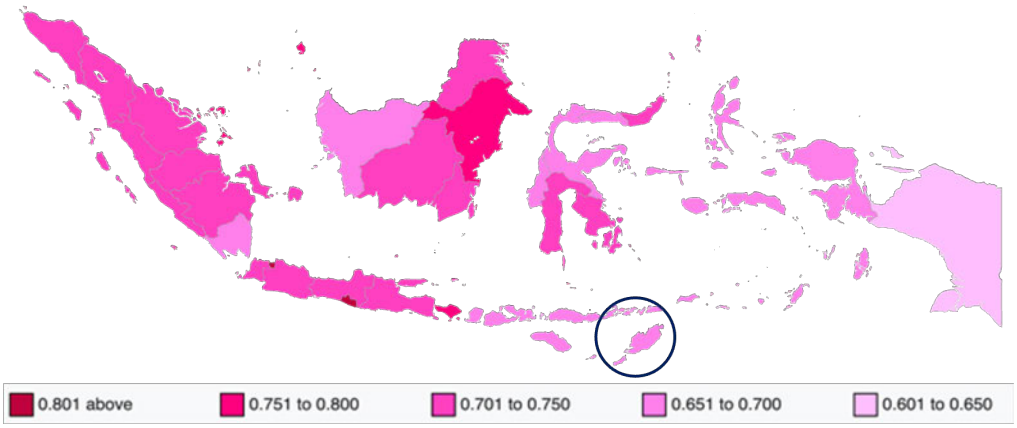

Figure 3 Indonesian Human Development Index rankings by province in 2021; NTT encircled (Adapted from Badan Pusat Statistik, 2021a)

Selected measures of health, income, and education reveal regional inequity between national and provincial attainment (Table 1). Mortality rates for mothers, children, and infants are markedly higher in NTT, and overall indicators for income, poverty severity, childhood stunting, and education demonstrate that NTT is still in the throes of intense development challenges (Badan Pusat Statistik, 2021b; BPS NTT, 2021c). While progress is being made, Sustainable Development Goals milestones are unmet, and on certain indicators such as stunting, NTT ranks 34th among 34 Indonesian provinces (Djara & Jaya, 2021; Laksono et al., 2021; UNICEF, 2019). At 2.9% of GDP, Indonesian health expenditure per capita (measured as a % of GDP) place it in the bottom fifteen of countries globally, and lowest among Southeast Asian nations and LMICs (The World Bank, 2021a). Low prioritization and limited national investments in health, despite embarking on a well-intentioned but as-yet-unproved bid for Universal Health Coverage (BPJS), result in inter- and intra-regional inequities and burdens on social development. NTT, coupled with heavy burdens of endemic infectious and chronic diseases, has yet to overcome its financial and

infrastructural hurdles to make significant progress towards stated development goals (BPS NTT, 2021a; Muhidin et al., 2020; Paju Dale, 2015; Syamruth & Kuntoro, 2018; UNICEF, 2019).

Table 1 National vs NTT Provincial Selected Indicators of Development, Education, Income and Health

Indicator[5]	Indonesia	NTT
Health		
Maternal Mortality Rate (per 100,000 live births)	305	489
Child Mortality Rate (per 1,000 live births)	40	58
Infant Mortality Rate (per 1,000 live births)	32	45
Stunting (chronic malnutrition) Rate	27.7 %	43.8 %
Human Development Index	0.723	0.653
Life Expectancy (years)	71.6	67.2
Income		
Poverty Gap Index[6]	1.23	1.40
Poverty Severity Index[7]	0.42	1.44
Percentage of Poor Population	9.7 %	20.4 %
Education		
Average Household Income (IDR/person/year) 2021	11,156,000	7,554,000
Illiteracy Rate (% of adults unable to read) 2021	3.96 %	6.15 %
Percentage of adults (> age 15) graduating secondary school 2021	66 %	45 %

Sources: (Badan Pusat Statistik, 2021a, 2021b; BKKBN, 2018; BPS NTT, 2018, 2021b, 2021c; Djara & Jaya, 2021; Laksono et al., 2021; LPB, 2018)

The capital city, Kupang, is highly dependent on the state, with almost half the population either employed in the public sector, or operating state-dependent enterprises and state-financed construction or other development projects (Tidey, 2012). A stratified, three-tiered class system has emerged as a result of the public sector-driven economy: the political class (and political elite), the political public, and the *tani* class (Vel, 2008). Political elites general occupy government positions of leadership, including district heads.

[5] Data availability by year for indicators as per the Central Bureau of Statistics (BDS): MMR 2015; CMR, IMR 2012; HDI, LE, PGI, PSI, PP, AHI, IR, ER 2021; SR 2019. Provincial level official mortality rates used by provincial health offices are taken from the most recent Indonesian Health Demographics Survey in 2012 Badan Pusat Statistik. (2021b). *Indonesian National Statistics*. Government of Indonesia. Retrieved 15 April 2022 from https://www.bps.go.id/.

[6] The poverty gap is the ratio by which the mean income of the poor falls below the poverty line. The poverty line is defined as half the median household income of the total population OECD. (2022). *Poverty Gap*. Organisation for Economic Co-operation and Development. Retrieved 17 April from https://data.oecd.org/inequality/poverty-gap.htm

[7] A poverty severity by X percent means that the poorest people are X percent worse off compared to poor people on average SMERU. (2021). *Poverty and Inequality Indicators*. The SMERU Research Institute. https://povertymap.smeru.or.id/indicators-explained

Political publics are generally educated residents, such as those employed by NGOs, or who work in journalism and education, which can collectively exercise political influence but are not public servants. The *tani* class, an emic term, are those who self-report as non-influential, including minibus drivers, farmers, market vendors, etc. (Tidey, 2012; Vel, 2008).

This class system contributes to the social dynamics of how governance is enacted in NTT, including how health programs are instituted, accepted, complied with, and so on. Economic, sociocultural, and political capital influences how power relationally circulates, and is a determinant of health outcomes. However, these are not isolated to questions of class, but also extend to considerations of poverty, religious and ethnic identities, clan relations, the influence of corruption, a post-colonial historic burden, and economic and sociocultural marginalisation by the political centre in Java.

1.2.2 Brief historical and social context

Nusa Tenggara Timur, 'long known as a colonial backwater' (Hägerdal, 2015, p. 94), is colloquially referred to by its inhabitants, using its NTT acronym, as '*Nasib Tidak Tentu, bahkan Nyaris Tak Terdengar, kita hanya berharap Nanti Tuhan Tolong*' ('Its fate is uncertain, it is largely invisible, and we only hope that God will help us') (Nugroho, 2020, p. 90). Viewed at the macro scale, evidence from the narratives in this study demonstrate concordance with the association of NTT as a backwater, as a society in adjustment from political and religious colonisation, and from its ostracising distance from Jakarta. In Giddens' conception of late modernity, place becomes increasingly *phantasmagoric* in the sense that 'locales are thoroughly penetrated by and shaped in terms of social influences quite distant from them' (Giddens, 2013, p. 19). Retention of a colonial ethos persists in NTT, evident by its dependence on the Javanese political centre for COVID-19 policy and guidance. It is yet seen as marginal, as unprioritised, and culturally 'othered' as a non-Muslim periphery. From the standpoint of a moral experience of stigma, NTT was subjected to the discriminatory consequences of structural discrimination arising from the stigmatising effects of political and economic power dynamics in Indonesia. NTT carries forward its status as subaltern into the post-colonial epoch, especially acute during the COVID-19 pandemic as the constraints in technical, economic, and political capital resulted in further marginalisation of its public, a rampant pandemic, and an increase in uncertainty and mistrust.

Present-day NTT is a multi-ethnic, multi-linguistic, multi-religious conglomeration of cultures, geographies, and histories. With 18 distinct ethnic groups,

dozens of ethnic sub-groups, and 69 languages and local dialects of three language families (Dawan, Manggarai, Lamaholot), it is impossible to encapsulate its rich and complicated history through a brief summation without glossing over important influences and dynamics which persist today (Farram, 2004; Windiyarti, 2006). NTT as a provincial entity came into being in 1958, a decade after Indonesia's independence from the Dutch. Although at various times colonised by the Portuguese, the Dutch, and briefly by the Japanese (1942-1954), the islands of NTT were in many ways resistant to unification due to the diversity of the local kingdoms holding court (Farram, 2004; Fox & Sather, 1996). Previously, the archipelago was divided into ethnic kingdoms through complex configurations of traditional and political leaders along clan lineages (Lewis, 2006). The island of Timor first entered the historic record in the thirteenth century with the advent and expansion of the sandalwood trade, attracting merchants from China, Melaka, western Indonesia, and eventually the Dutch East Indies Company (Du Bois et al., 1944; Farram, 2004; Lewis, 2006). Although the Dutch and Portuguese were present through links with the spice trades beginning in the seventeenth century, attempts to control resources resulted in instances of inter-tribal warfare as allegiances were sown and broken, with the political balance in constant shift. In the nineteenth century, the island of Timor was divided into Portuguese and Dutch controlled sections and, through a complex history beyond the scope of this dissertation, eventually became West Timor (Indonesia) and Timor Leste (Strating, 2014).

Ruled by traditional adat leaders, Timor's ethnic groups relied on secular 'lords' to govern sub-districts as European powers vied for colonial control (Campbell-Nelson, 2003; Farram, 2004). In the first half of the twentieth century, Dutch colonists installed a 'raja' system of rulership, in which clan and traditional power structures were replaced by these Dutch proxies. Traditional adat leaders were overlooked as colonial governance evolved through to the end of the Second World War. Meanwhile, Dutch missionaries had infiltrated the traditional animist systems of belief and custom with Protestant Christianity, while the Portuguese had brought Catholicism to the islands. Modern-day religious affiliations reflect the history of competing colonial powers, with Timor Leste (the eastern half of Timor Island) a Portuguese holdout and dominated by Catholicism, and West Timor having a mix of Catholic and Protestant groups, with a minority of Muslims and Buddhists, and others (Farram, 2004; Tule, 2000; Windiyarti, 2006).

The history of religion in this region is as complex and layered as the sociopolitical history of colonisation. As Indonesia embarked on nation building following independence in 1949, Soekarno's "Pancasila" philosophy of "Unity in Diversity" used traditional adat as a political tool to control a highly diverse and multi-ethnic island nation, in which appeals

to nationalism were couched within the diverse frame of adat (Hägerdal, 2015; Mu'ti & Burhani, 2019; Tule, 2000; Webb, 1986). In tandem, the requirement for all Indonesians to profess monotheism meant that the animist beliefs and ritual traditions in areas such as NTT were to be absorbed into a syncretic form of Christianity (currently the population is made up of 55% Roman Catholic and 32% Protestant) (Barlow & Gondowarsito, 2018; Mu'ti & Burhani, 2019). It was not until the 1950s that Christianity took hold in NTT, becoming associated with its identity as a new province in the new nation of Indonesia, but also as a post-colonial unifying form, and in contrast to the majority of Indonesia which is Muslim (Farram, 2004).

Although many of the clan structures and tribal lineages persist into the modern era, the governance imposed by the Dutch installment of 'rajas' and its delineation of administrative governance through the districts, regions, villages, etc. hierarchy have dominated. The present structure of Kupang City and even the rural districts are thus a double hierarchy in which traditional adat clan leaders retain ritual and cultural authority while having no political power, and political leaders assuming roles in the administration of the districts and villages, often through a system of clientelism and ties to the upper echelons of the provincial governments (Berenschot, 2018).

The implications of this arrangement, especially in municipal areas such as Kupang in which internal migration and relocation is abundant, are that many tribal or ethnic ghettos of internal migrants are governed over by individuals who are not associated with a given clan, linguistic, or adat tradition. In Kupang, there are predominantly Helong and Dawan (Atoni) ethnic groups which are indigenous to the area, mixed with enclaves of migrants from Rote, Savu, Sumba, Alor, and Flores, each with distinct ethnic, linguistic, adat, and religious bent. Additionally, ethnic Chinese have a presence, along with Muslim traders who have settled in the area, including the ethnic Bugis from South Sulawesi. Thus, the governance of such a disparate and diverse group is left over from the Dutch colonial structure and does not necessarily promote ethnic representation beyond internal traditional, adat, or intra-ethnic politics.

Although the *Reformasi* movement over the past two decades has shifted this representation by increasing participation in politics by local ethnic groups, there remain many challenges, especially in how government officers are staffed and managed. For example, as many public servants (PNS) are centrally managed, there is circulation of health staff who come from outside NTT, such as new medical graduates doing internships in remote health facilities, or bureaucratic officials who are shifted from post to post throughout the system and who may originate from other areas in Indonesia outside of NTT.

While this may be of benefit to the area by bringing in new ideas and new cultural perspectives, it does little to encourage a deep, emic understanding of the sociocultural, religious, linguistic, traditional, and historical contexts in which these groups have evolved.

1.2.3 Decentralisation's impact on COVID-19

Dutch colonial policies in Indonesia deliberately weakened provincial governments as a strategy to centralise authority in a highly disparate and diverse nation (Holtzappel & Ramstedt, 2009; A. Nasution, 2016). Following independence in 1949, the newly established Indonesian post-colonial government adopted similar policies with the aim of reducing secessionist movements and rebellions (I. Nasution, 2016; Shoesmith et al., 2020). Authoritarian power reached its zenith under Suharto's New Order regime from 1966 to 1998, in which centralised governance was instituted through a military-led political system (A. Nasution, 2016). This centralisation of authority and power entailed strict control of state finance and policy, with little decision-making autonomy granted to provinces or districts in managing health systems (Heywood & Choi, 2010; A. Nasution, 2016; Rakmawati et al., 2019). The fall of Suharto in 1998 coincided with the Asian Financial Crisis and ushered in a massive push for reform (*Reformasi*) in Indonesia, including a move towards democratisation and decentralised authority (Gaus et al., 2017; Shoesmith et al., 2020).

A radical decentralisation, criticised as being ill-conceived and implemented, occurred in 2001 relocating financial and functional autonomy to district governments (Aspinall & Fealy, 2003; Holtzappel & Ramstedt, 2009; A. Nasution, 2016). The largest of its kind in the world at the time, the Indonesian shift of autonomy to the districts was designed to instigate pro-poor policies and democratisation through increased community participation. Initiated through Laws of Local Autonomy No. 22/1999 and No. 25/1999[8], government authority was transferred to the districts to undertake financial, administrative, and implementation of a variety of responsibilities around health, education, public works, environment, communication, transport, agriculture, manufacturing industry and trade, capital investment, land, cooperatives, labour force, and infrastructure services (Aspinall & Fealy, 2003; Holtzappel & Ramstedt, 2009; A. Nasution, 2016; I. Nasution, 2016). Bypassing the provincial level, this refocusing of autonomy to the districts was aligned with concepts of decreasing poverty and inequality, citizen empowerment, and to bring governing closer to the governed citizenry (Duncan, 2007).

[8] Later amended and revised with Law No. 23/2014 and Law No. 32/2004, which itemised sub-national government responsibilities.

The literature on decentralisation distinguishes three stages of the process: de-concentration, delegation, and devolution (Aspinall & Fealy, 2003; Holtzappel & Ramstedt, 2009). De-concentration denotes geographic transfers of administrative responsibilities to field offices of central government ministries; delegation passes policy responsibility to semi-autonomous local governments through central level contractual arrangements; and devolution is the transfer of power and control of autonomy to local regions, involving the surrender of resources by the central state, the degree of which is measured by local deployment of financial authority and policy implementation. Ideally, decentralisation proceeds through these stages sequentially; Indonesia chose to implement a radical approach of direct devolution (Duncan, 2007; I. Nasution, 2016). Criticisms of this decision have centred on the lack of preparation and resources invested at local levels following decades of central autocracy, and the full-scale transfer of power to an unprepared, fragile local context which amplified existing conflicts of interest while decreasing national oversight (Heywood & Choi, 2010; I. Nasution, 2016; Paju Dale, 2015; Sevindik et al., 2021). The shift in the burden of managing all aspects of finance and administration was not accompanied by an increase in local capacity or human resources.

In general, the move to disassemble the autocratic structures of New Order governance did not have the expected and intended effect on levelling the political and equity playing field at the local levels in most of Indonesia. Situating the seat of power at the local level shifted the locus of leadership and management of resources in a highly diversified field of local level bureaucrats[9]. Scholarly analyses of the effects of decentralisation have observed that several factors influence how local politics carry on authoritarian concentrations of power, clientelism, corruption, and nepotism which result in ineffective, inappropriate, and/or inexperienced individuals in positions of leadership (Aspinall & Berenschot, 2019; Berenschot, 2018; Bubandt, 2004, 2006; Duncan, 2007; Kosec & Mogues, 2020; I. Nasution, 2016; Rasyid, 2003; Tidey, 2012).

According to Utomo et al., the decisive factor for electability of local Indonesian candidates is based on access to wealth rather than competence (Utomo et al., 2011). Funds raised for candidature and election creates indenture to party and to patrons, rather than to the electorate or towards improving local governance. A shift in authority to local level bureaucrats was not accompanied by an increase in resources, competence, or effectiveness.

[9] There are 416 regencies (districts) and 98 cities (municipalities) among the 34 provinces of Indonesia, as of 2020.

The conversion from appointed to elected officials[10] simply relocated the possibility for corruption and 'local predatory power', as leaders owe allegiances in a complex clientelist system (Berenschot, 2018; Duncan, 2007). In such a system, local government development contracts are often influenced by nepotism, as central level oversight into local procurement is minimal. By extension, allegiances to ethnic or religious affiliations do little to promote equity in local politics.

Decentralisation of the central Ministry of Health authority and fiscal responsibility occurred in tandem, with transfers of power and budgets to district health offices (P. Heywood & N. P. Harahap, 2009). As a result, provincial health offices were positioned as supervisory, and as a representational conduit between the local and the national levels (P. F. Heywood & N. P. Harahap, 2009; Rakmawati et al., 2019). Although the past two decades of this process has resulted in an increased focus on primary health care and improved public health infrastructure in general, evaluations of the decentralised health system have not demonstrated a marked improvement in health equity and access, or equitable distribution of health, human, and commodity resources, and in fact, have demonstrated a widening rich-poor gap in health care delivery and access (Heywood & Choi, 2010; P. F. Heywood & N. P. Harahap, 2009; Pardosi et al., 2017; Rakmawati et al., 2019). While Indonesia has instituted Universal Health Coverage under the *BPJS Health (Kesehatan)* program[11], aimed at providing financial protection for the poor, this program has been slow to be integrated nationally, and massive gaps persist in access to health care, especially in the eastern Indonesia region (Achadi, 2014; Pardosi et al., 2017; Wiseman et al., 2018). While UHC has reduced out-of-pocket costs to individuals, it has not improved the overall quality of health services (Brooks et al., 2017; Mahendradhata et al., 2017; Wiseman et al., 2018).

Critical literature on the health system impacts of decentralisation have shown decreased responsiveness of local elected leaders to the health sectors, attributed to inexperienced bureaucrats focused on infrastructure and investment, political ties and clientelism, and corruption (Heywood & Choi, 2010; P. Heywood & N. P. Harahap, 2009; P. F. Heywood & N. P. Harahap, 2009; Maharani et al., 2015; Pardosi et al., 2017; Rakmawati et al., 2019). Fragmentation of the health system at the local level, including a burgeoning private sector over which the public sector has little authority or information,

[10] Local elections following reformation are conducted for: Governor (*Gubernur*) and Deputy Governor (*Wakil Gubernur*) at the provincial level; Regent (*Bupati*) and Deputy Regent (*Wakil Bupati*) at the district level; and Mayor (*Wali Kota*) and Deputy Mayor (*Wakil Wali Kota*) at the city level for five year terms in all districts and provinces.

[11] Badan Penyelenggara Jaminan Sosial Kesehatan is Indonesia's national UHC program.

siloing of disease programs, and demonstrated lack of coordination with central Ministry of Health authorities, also creates challenges for local health autonomy at the district level. District health offices are not held to account to report health information to a central MOH clearinghouse, creating tensions, lack of accountability, and limitations in access to data for policy or budget planning (P. F. Heywood & N. P. Harahap, 2009). Additionally, many public sector health employees' contracts are held at the central level, while employees are then seconded to, and paid for, by the districts. This has a drastic impact on local health resource capacity, as well as decreasing local representation in ethnically diverse contexts.

In NTT, limitations in health system capacity constrain overall access to health programs, despite having a robust infrastructure of public health facilities. Partially due to issues compounded by weak local governance, NTT ranks among the highest areas in Indonesia for maternal mortality and childhood stunting, and is plagued by endemic dengue and malaria and a transitional epidemiology of chronic, non-communicable diseases such as diabetes, stroke, and various cancers (BPS NTT, 2020; Dinkes NTT, 2018). It consistently ranks in the lowest quartile for progress towards meeting Sustainable Development Goals indicators, including basic sanitation, water quality, education, stunting and nutrition, and others (UNICEF, 2019).

1.2.4 How has Indonesia managed COVID-19?

Indonesia has been criticised for the slow move to respond to the pandemic during the first few months of 2020. The government downplayed the severity and risk to Indonesia from January to March 2020, losing crucial time to prepare a national strategy. While Singapore and Malaysia were seeing rapid increases in the spread of the virus, Indonesia was claiming no cases. National leaders, from President Joko Widodo (commonly referred to as 'Jokowi') to the Minister of Health Terawan Putranto, speculated that the lack of COVID-19 in the country at that time could be attributed to Indonesia's penchant for prayer, to immunity due to Malay genetics, to tropical humidity and heat, or that the virus itself was nothing more than a regular flu (Dairaini, 2020; Lindsey & Mann, 2020; Mietzner, 2020). President Jokowi was criticised for a lack of data transparency on the pandemic, done to avoid 'stirring public panic'(Staff, 2020a). The fact of 'zero cases' in Indonesia during the early days was more likely due to a lack of testing capacity, and a lack of transparency in disseminating information to the public (Staff, 2020a, 2020b). COVID-19 infections and deaths were dramatically under-reported, and the President was eventually called out for suppression of pandemic information (Lindsey & Mann, 2020; N. Smith, 2020). At the end of March, for instance, 84 deaths were reported in Jakarta, when burial statistics for the

month of March suggested that at least 1,300 people must have died of the virus in the capital during that period (Allard et al., 2020). Combined with the prolific spread of misinformation, disinformation[12] and rumours through both official and unofficial sources, the lack of clear messaging and dampening of reactions by the government created an environment of uncertainty from which citizens could assess potential risks or threats (Dairaini, 2020; Nasir et al., 2020). Much to the frustration of many local leaders calling for stricter measures, Jokowi refused to heed their advice because he prioritised the preservation of the economy (Fealy, 2020; Pinterpolitik, 2020).

When the first case arrived on February 29, 2020, contestations on the handling of the crisis between the economy-focused response of the central government and the public health focus of the provinces and local administrations led to delayed implementation of lockdowns and other measures (Djalante et al., 2020; Van Empel et al., 2020). Tensions in the decentralised system of authority persisted, and while the central government established the National Task Force for Rapid Response to COVID-19 (*Gugus Tugas Percepatan Penanganan COVID-19*) in mid-March, it was the provinces and local governments that were responsible for mobilising to respond to the crisis (Ayuningtyas et al., 2021; Satgas Penanganan COVID-19, 2020). By the end of March, the Indonesian Task Force for COVID-19 had finally issued the Guidelines for Medical Rapid Response and Public Health Aspects of COVID-19 in Indonesia, far behind what other countries in the region had accomplished by that time (UN OCHA, 2020).

The initial months of the pandemic saw a patchwork of interventions, with provincial authorities needing MOH special approvals to implement PSBB (large scale social restrictions) (Mahendradhata et al., 2021). It was not until April 6 that President Jokowi announced, based on Government Regulation 21/2020, the implementation of: (a) school and business closures, (b) limiting of religious activities, and/or (c) limiting of activities in public spaces (Shidiq, 2020). Debates over the economic impact vs the public health benefits were framed around the large contingent of informal workers who were unable to comply with full lockdown, while at the same time, PCR testing rates in the country were the lowest in the world. Thus, the country was operating with little information, a lot of conjecture, and limited political leadership.

The National Task Force for Rapid Response to COVID-19 was headed by the National Disaster Management Office (BNPB), as mandated by Jokowi, coordinating with the Indonesia National Armed Forces, Indonesia National Police, and the Ministry of

[12] Hereafter, 'misinformation' refers to false, inaccurate, or misleading information communicated without intention to deceive, while 'disinformation' as a subset of misinformation refers to deliberately misleading, deceiving information, propaganda, and disseminated with malintent.

Health. This was an interesting choice given that the BNPB was not typically the first responder for epidemics, and the Ministry of Health was criticised for its complacency and lack of proactive leadership in developing policies and guidance (Shidiq, 2020). The MOH had been criticised for its complacency, and for a slow rollout of diagnostic laboratory capacity for PCR testing. The legacy of the National Committee for Avian Influenza (AI) Control and Pandemic Influenza Preparedness was 'nowhere to be seen', and despite Indonesia's previous experience with AI, SARS, and H5N1, these programs had not been sustained in the implementation infrastructure of Indonesia's health system (Djalante et al., 2020, p. 5).

Chronic underinvestment in the health sector in Indonesia (at 3.6% of GDP, Total Health Expenditure is among the lowest in the world, even when benchmarked against other LMICs), combined with corruption by predatory politicians skimming funds from health commodity procurement and infrastructure, have resulted in a highly under-capacitated health system (Aspinall & Berenschot, 2019; Mahendradhata et al., 2021; Olivia et al., 2020). Public health academics raised red flags concerning the limited number of ICU and general hospital beds and ventilators, mostly concentrated in Java, North Sumatra, and South Sulawesi (Mahendradhata et al., 2021; Shidiq, 2020). Health staff were also concentrated similarly, resulting in few resources outside of these highly populated areas. In the poorer regions of eastern Indonesia, chronic poor health outcomes, sub-standard health services, and high inequality within provinces, have generally limited the government's ability to implement testing, tracing, isolation, and treatment effectively (Rakmawati et al., 2019). For example, in NTT where this study takes place, PCR testing capacity for COVID-19 was at zero for most of the first year of the pandemic, with samples being sent to a reference lab at the Eijkman Institute in Jakarta until the provincial laboratory built up its COVID-19 testing capacity towards the end of 2020 (Lab director interview, 2020).

Religious and civic organisations were also heavily involved in the COVID-19 response, having both positive and negative effects. Initial propaganda by government and religious leaders claiming that prayer and God were a viable solution to the COVID-19 crisis led to massive religious gatherings in defiance of social restrictions. The debate around 'fear of God' vs 'fear of COVID-19' surfaced early on, as religious determinism/fatalism confronted biomedical efforts at viral containment. However, large religious groups, such as MUI, Nahdlatul Ulama, and Muhammadiyah, the Indonesian Ulema Council, Indonesian Council of Churches, and others are recognised as crucial non-government partners with highly structured organisations and potential for wide reach into

communities across Indonesia. Religious *fatwas* and guidance from these religious councils and associations has influenced community responses around the management and handling of corpses and burials, as well as providing significant financial and material resources to COVID-19-affected communities.

Provincial governments have been responsible for establishing Emergency Operations Centres and developing contingency plans concerning ICU capacity, PPE, case reporting from districts, and screening for travellers. The provinces also coordinated with district health offices and public primary health centres to scale-up laboratory testing and health care services. Water, sanitation, and hygiene supplies were distributed, and funds from the Ministry of Villages and Disadvantaged Regions were used to offset the economic toll from job loss and an economic contraction of 13% during the pandemic (Olivia et al., 2020; The World Bank, 2021b). Overall, the rollout of the pandemic response in Indonesia was burdened by slow implementation to scale of PCR testing, frequent supply chain issues, and uncoordinated data dissemination and epidemiological tracking.

Grassroots and locally initiated responses to the pandemic were widely reported, as civil society and neighbourhood groups came together in self-initiated screening, quarantining, and redistribution of food to support affected families. In the vacuum of reliable guidance from the national government, local efforts had the largest impact, especially prior to the availability of vaccines and widespread testing. There were many examples of newly developed organisations in response to COVID-19, as well as existing groups that were mobilised during the pandemic. Within the village structure (kelurahan/desa), the *dusuns* (hamlet), RW and RT (neighbourhood associations) received financial assistance to support youth groups, agricultural associations, and others to engage in bottom-up solutions from communities (Lestari & Sularso, 2020; Pradana et al., 2020; Sevindik et al., 2021).

1.3 Problem Statement and Significance of Research

1.3.1 Problem

At the time of developing the proposal for this research (mid-2020), Indonesia had the lowest COVID-19 testing rate in the world. Its patchy record on mitigation through social restrictions and other measures earned much criticism from global health experts. Similarly, during the initial stages of the pandemic, NTT was extremely ill-equipped to manage the crisis: there was no PCR testing capacity, emergency pandemic protocols were not in place, and the provincial leadership mirrored the national government approach of down-playing the severity of risk, hiding data, and even the governor himself refused to wear a mask,

'claiming protection by prayer' (ironically, he was one of the initial tranche of public sector officials who caught COVID-19 in the local government) (Agriesta, 2021). The province had not instituted a blanket lockdown, opting for targeted 'micro restrictions' through moderation of business and traditional market hours, sporadic church closures, and other interventions which were variably adhered to by the community (Walikota Kupang, 2021).

NTT is a highly diverse locale, in which a wide variety of cultures, languages, and religious traditions co-exist on a scattering of islands far removed from the economic and political centres on Java. It is plagued by extreme poverty and intra- and inter-regional inequality, low access to quality health care, and a heavy endemic disease burden of dengue, TB, malaria, high maternal and infant mortality, malnutrition, and a low education achievement status relative to the rest of Indonesia (Adair et al., 2012; BPS NTT, 2018, 2021b; Dinkes NTT, 2018; Nugroho, 2020; Paju Dale, 2015; UNICEF, 2019). Highly dispersed populations living in a transition to modernity with the adoption of a syncretic form of adat and Christianity, a newly instituted *Reformasi* 'democracy', endemic corruption and clientelism, and a multi-layer political and adat form of governance offer a fascinating context from which to study the challenges of implementing a large-scale pandemic response in an LMIC.

The region is also additionally burdened by ongoing disasters erupting across the volcanic island chain, including earthquakes and typhoons, drought, landslides, and a history of political unrest and instability (Hägerdal, 2015; Hooe, 2012; Paju Dale, 2015; Shoesmith et al., 2020; Sunarto, 2005; Vel, 2008; Webb, 1989). These local disasters are experienced in addition to the COVID-19 crisis and present a dual challenge to government and civil society in a resource-constrained context. Given what is at stake for the NTT community, the immense challenges presented by the COVID-19 pandemic offer a unique opportunity for inquiry into the social construction of a disease and its response.

In this research, I will use a critical ethnography of health approach (Baer et al., 1986; Palmer & Caldas, 2015; Shih, 2019; Singer, 2004) to attempt to reconcile culture, inequality, and disease. I will contextualise and analyse local perceptions and responses to COVID-19 as understood by those experiencing the pandemic in villages in Kupang City and Kupang Regency. Asymmetrical power dynamics, as an important determinant of health, will be considered in designing a conceptual framework for studying health inequities in the context of multiple modernities/mixed rationalities during a pandemic. Responses such as blame, fear, stigma, and resistance arising from mistrust or limited reliable information will be analysed considering the production of knowledge favouring

hegemonic biomedical understandings (Alaszewski, 2015; Csordas, 1988; Douglas, 1994, 2002; Lupton, 1993; Manderson & Levine, 2020).

1.3.2 Significance

The COVID-19 pandemic has likely permanently altered the way that societies organise and interact, and this global phenomenon has revealed many of the systemic deficiencies in our public health systems and governance. This research will contribute new knowledge to the context of how a resource-constrained community in an LMIC has met the challenge of this global crisis and will add to our understanding of how these massively disruptive, unique events are confronted by religion, technology, history, and social structure. This research will also contribute to the development of qualitative methodology by demonstrating real world implementation of field data collection at the height of the global pandemic.

1.4 Dissertation Structure

In Chapter 1, I introduced the background, research setting, and significance of the public health problem of a new pandemic threat descending upon a remote, vulnerable archipelago in eastern Indonesia. Chapter 2 follows, in which I provide a review of the relevant literature concerning community experiences of the pandemic in other LMICs through ethnographic and qualitative analytical lenses. The scholarly literature demonstrates commonalities and distinctions of how communities in constrained settings have managed and reacted to the pandemic crisis; the findings from this part of the research subsequently informed the research design, questions, and overall methodology of this dissertation, as presented in Chapter 3. The three following chapters in Section 2 encompass the results and brief thematic analysis of the data collected during field research in the greater Kupang area of NTT, Indonesia: Chapter 4 details system level themes around governance, health system inefficiency, and power; Chapter 5 entails sociocultural themes concerning religion, tradition, and modernity; and Chapter 6 outlines themes in which individuals were impacted and how they responded, including the experience of stigma and emotional effects, the proliferation of misinformation, and the effects of surveillance and control on the community. Chapter 7 brings the data together in the context of the reviewed literature and general themes for discussion. The chapter concludes with a consideration of the research contributions and limitations, recommendations for subsequent policy and research, and the overall conclusion. The summary and conclusion of the thesis in Chapter 8 provide further insights into the overall findings, identifying challenges, and considerations of impact of

the research. An epilogue concludes the thesis, wherein I exposit on my personal experiences and the meaning of this research for me as a student. The appendices that follow include documentation and forms related to permissions, bureaucratic support and approvals, and academic ethics approvals.

2

Chapter 2. Literature Review

This chapter is partially based on the following previously published article:

Raymond, C. B., & Ward, P. R. (2021). Community-Level Experiences, Understandings, and Responses to COVID-19 in Low- and Middle-Income Countries: A Systematic Review of Qualitative and Ethnographic Studies. *International Journal of Environmental Research and Public Health*, *18*(22), 12063. https://doi.org/10.3390/ijerph182212063

Introduction

The empirical research triggered by the global catastrophe that is the SARS-CoV-2 pandemic (COVID-19) over the past year is voluminous in quantity and scope. To inform my dissertation research on COVID-19 field-based studies, I reviewed relevant published literature on studies conducted in communities in Low- and Middle-Income Countries[13] (LMICs). The aims of the review were to: a) evaluate peer-reviewed published data from primary research using community-based and/or participatory field methods designed to provide in-depth analysis of community perceptions and experiences through in-person data collection; b) understand how qualitative research provides insight into the sociocultural effects of the emerging pandemic; and c) identify areas of opportunity for the current research arising from gaps in the published literature.

Social science scholarship on infectious disease interrogates the relationships between the sociocultural aspects of disease transmission and how disease is understood and framed by a given group of people, in addition to providing an analytical lens to critically evaluate local and global policy and the impacts of social and structural forces, such as poverty and racism, on disease outcomes (Stellmach et al., 2018). While recognising the biological implications of infectious disease, the social sciences ponder the underpinnings of vulnerability which reveal themselves in the topography of inequity and

[13] LMICs are defined by the World Bank and OECD as GNI of $1,046 – $4,095 USD, referencing: https://datatopics.worldbank.org/world-development-indicators/the-world-by-income-and-region.html; https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups. Data from World Bank Fiscal Year 2021 used for inclusion of countries.

differential transmission of pandemics (Janes et al., 2012; Lynteris, 2014). The current COVID-19 crises have foregrounded the importance of social considerations, given the alignment of disease burden and impoverished communities worldwide (Alaran et al., 2021; Finch & Hernández Finch, 2020; Niko, 2020; Zakar et al., 2021).

2.1 Rationale for Inclusion and Exclusion Criteria

The focus of this review is to identify what is currently known about how communities in LMICs have responded to the pandemic, the sociocultural context of each selected LMIC, and the theories brought to bear, especially as they pursue critical inquiry into social processes and public health design. Also under consideration are issues of power, identifying how hegemonic knowledge is used, and the use of qualitative methodologies in field data collection. The fundamental question for this review is, what do we know about the meaning of COVID-19 in the communities it has most affected, and how has this been represented in the empirical literature? Unless we understand how impacted communities frame and understand COVID-19, there is a significant risk that policies and interventions will be acontextual and will have limited impact.

Since early 2020, government-mandated restrictions on movement, intended to reduce potential transmission of the SARS-CoV-2 virus which causes COVID-19, have substantially disrupted field-focused empirical data collection and research methodologies. Suspension of in-person data collection at various times during the global pandemic lockdowns has spurred qualitative researchers to consider 'how can qualitative inquiry, founded on human connection, empathetic listening, and "thick description" advance in a world of social distancing?' (Santana et al., 2021, p. 1061). Alternative methods were quickly proposed and adopted by academics, especially those employing qualitative methodologies, including conducting digital ethnographies, shifting to phone and online surveys, interviewing, and focus groups using digital platforms such as Zoom, WhatsApp, and others (Earthlab, 2020; Lupton, 2020b; Rahman et al., 2021; Sah et al., 2020; Teti et al., 2020; Tremblay et al., 2021; Vindrola-Padros et al., 2020). Several scholars have proposed research agendas to collate revisions in research topics, data collection methods, and modes of dissemination stemming from pandemic restrictions and ruptures in the status quo of data collection (Lupton, 2020c; Nichter et al., 2020; Ward, 2020). Epistemological debates have emerged regarding questions of data quality, contextual richness, and study rigour in the context of shifting field methods, in which concern over the health and safety of researchers and participants, in addition to ethical imperatives to ensure compliance with local and international pandemic regulations and the principle of non-maleficence, have

been brought to the fore (Novick, 2008; Santana et al., 2021; Tremblay et al., 2021; Vindrola-Padros et al., 2020).

As qualitative research is, by definition, a 'situated activity that locates the observer in the world … and involves an interpretive, naturalistic approach' (Denzin & Lincoln, 2017b, p. 43), it follows that traditional methods of inquiry, including participant observation, in-depth interviews, and social immersion provide the richest contextual materials with which to develop the 'thick descriptions' necessary for interpretive or critical analyses of social phenomena. For this review, the authors elected to focus on empirical social research conducted at the community level, using in-person, on-site data collection to capture rich, detailed, and contextual information on the pandemic.

Inclusion and exclusion criteria were formulated for the selection of published qualitative research available from six scholarly databases. Studies were confined to literature from LMICs with similar pandemic impacts on poverty, stigma, infrastructure and supply limitations, communications, and/or information access barriers. Regarding the selected study methodologies, data collection methods and research approach paradigms were considered with an understanding of the impact that global social restrictions have had on conducting qualitative field research, specifically those which engage at the community level, and which explore the meanings and experiences of the pandemic.

The review focuses on empirical, primary, qualitative research conducted at field sites, and excludes studies which were not heavily reliant on face-to-face interactions. The following criteria were used for the literature review of empirical qualitative studies on COVID-19 in LMIC communities (Table 1):

Table 2: Inclusion and exclusion criteria

Topic	Inclusion Criteria (met all)	Exclusion Criteria (met any)
Scope	-Focus on COVID-19 impacts using social research methods -Primary qualitative data collection from community or participatory settings -Research conducted in LMICs	-Studies conducted in non-LMICs -Quantitative methodology -Emphasis on virtual, digital, or distance data collection such as phone or teleconferencing interviews or online surveys -Methodologically low rigour
Type	Peer-reviewed journal articles publishing data from empirical studies	Grey literature, systematic reviews, published protocols, or commentaries
Language	English terms used for database search	Non-English articles
Timeline	Published after Dec 2019 through Aug 2021	Data collected prior to Dec 2019

Studies published in peer-reviewed journal articles were selected following screening and in-depth evaluation of articles resulting from database searches using the following Boolean search terms: “COVID*” AND “ethnograph*” OR “anthropology” OR “qualitative”, and variations which included terms such as “case study”, “phenomenology”, “lived experience”, “meaning”, “study”, “research”, and “empirical”. These terms were used to ensure broad capture of the available literature. Databases used for this review were Anthrosource, Google Scholar, Ovid, Pubmed, Proquest Social Science, Scopus, and Web of Science.

A total of 2,152 records from 7 scholarly databases were identified for initial title and abstract screening. In all, 2,067 studies were excluded based on title and abstract appraisal as per the inclusion and exclusion criteria parameters. The remaining 85 studies were downloaded and thoroughly screened by two reviewers working independently using the JBI Critical Appraisal Tools for Qualitative Research (JBI, 2015) to identify studies eligible for inclusion. Following critical appraisal, 59 studies were excluded due to low methodological rigour, geographic ineligibility, or ineligible study focus area. A final set of 26 studies that met the inclusion criteria and passed critical appraisal were included for review. A data extraction table was developed (see Table 2) to highlight the key domains across all the included studies. A PRISMA Flow Diagram of the study selection process is included in Figure 3 (Page et al., 2021).

The selected studies were reviewed by first conducting a full reading of each, followed by data extraction and inductive thematic analysis in which unifying common themes were identified across all papers. Despite the diversity of topic areas in the literature, several cross-cutting themes emerged from the 26 papers, including issues concerning knowledge and information, the psychosocial impacts of the pandemic, effects of social and mobility restrictions, investigations into governance and health system challenges, and community cohesion and innovation. These themes shared traits in common and were grouped into two broad domains of response categories: reactions and adaptations.

The notions of ‘reaction’ and ‘adaptation’ were conceptually useful to classify the literature included in this review, despite definitional associations with positivistic reductionism. In chemistry and physics, reactions are imbued with movement and response, occasionally in violent opposition to a disruptive force ‘exerted in opposition to the impact or pressure of another body; a force equal and opposite to the force giving rise to it’ (Oxford Languages, 2021b). Implicit in the concept of reaction is the framing of novelty and of response to an unanticipated perturbation, being ontologically concordant with complexity,

chaos, and dynamism. Evidence of this is clear from the social and behavioural reactions outlined in the research, in which compensation took the form of stigmatising discrimination, alterations in health-seeking behaviours, rifts and breakages in sociality, and material disruptions to normal everyday life. This review identified several sub-themes to categorise these studies, focusing on knowledge and misinformation and its effects, social and psychological experiences, impacts of mobility and social restrictions, and challenges in public sector governance and health systems.

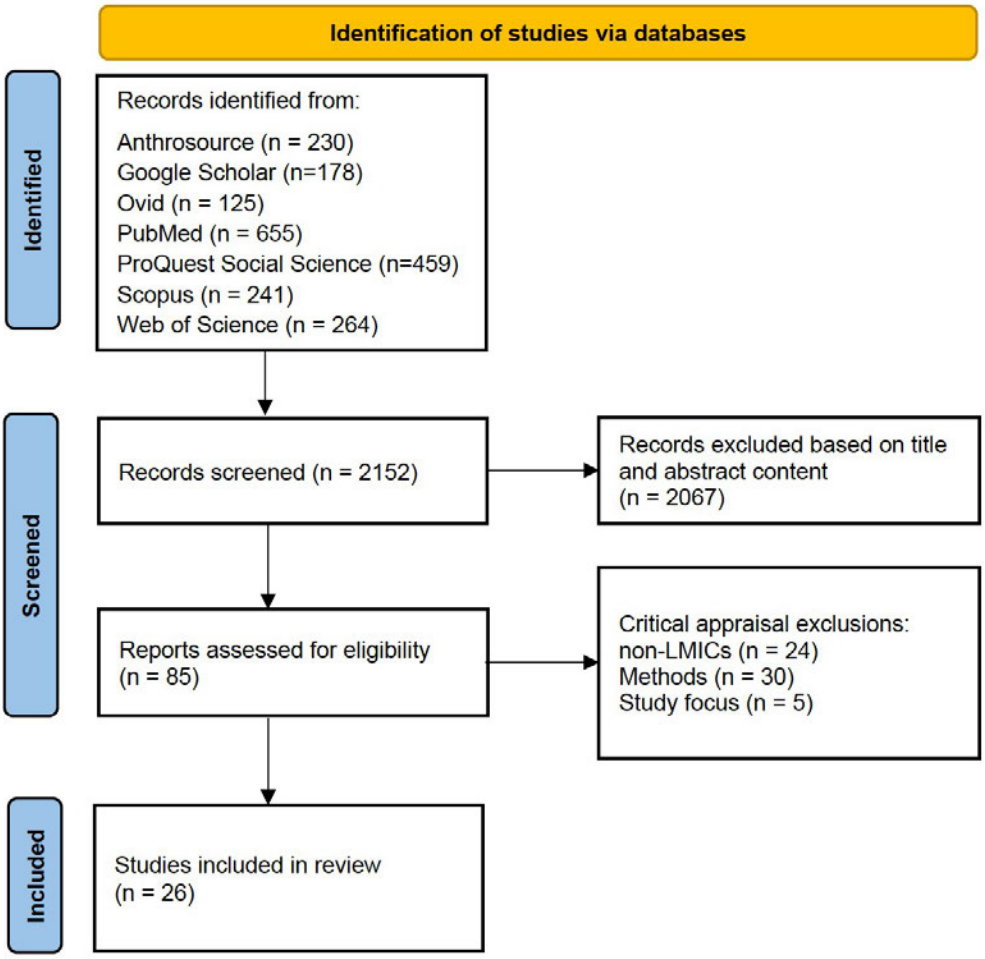

Figure 4: PRISMA flow diagram of study selection process

Adaptation may be thought of as a reaction to reaction, as the cultural system seeks levelling stability and replacement from outbreak disruption and displacement. Biologically, adaptation can be considered as the process by which an organism or species becomes better suited to its environment (Oxford Languages, 2021a). Sociologically, this concept is consonant with resilience, in which the attributes of a complex social system determine

suitability to a new environment, in this case an endemic or post-pandemic world (Keck & Sakdapolrak, 2013; Ungar, 2006). As counterpoint to the sub-section on reactions, two sub-themes are included outlining adaptive responses, including a focus on community cohesion and innovation incorporating local knowledge, and examples of successful public sector governance. Adaptation, as a component of resilience, informs models of best practice which help us to better understand the dynamics of how people are *adapting to jolts* in the system (e.g. a global public health crisis) (Bryce et al., 2020; Meyer, 1982). Meyer suggests that adaptations to jolts fall into three phases: anticipatory, responsive, and readjusting (Meyer, 1982).

Most of the cases in the included literature examine the effects of lacking anticipation, focusing on responses (reactions) and readjustments (adaptations). Weick and Sutcliffe observed that 'unexpected events [*such as a global pandemic*] often audit our resilience' (parenthetical added) (Weick & Sutcliffe, 2007). Resilience, as opposed to time-bound reaction, is a process rather than an outcome. If we consider the web of conceptions around risk and resilience, reactions, and adaptation, we form a picture of how to approach the studies included in this review from both processual and static perspectives.

While the studies investigating pandemic experiences tended towards the descriptive, relating discrete phenomena of reported reactions, both internal and external, a more holistic frame using risk and resilience could potentially capture more of the socially dynamic and temporal aspects of the pandemic. As Evans-Pritchard discovered during his classic ethnographic explorations of witchcraft among the Azande in 1937, the site and timing of misfortune requires two sets of explanations: how and why this happens, and how and why this happens to this person at this time (Evans-Pritchard, 1937). As the respondents in these studies recalled their personal travails with COVID-19, the 'what' of description begged the question of 'why?' As Panter-Brick conceived, Evans-Pritchard's explanations of misfortune can be rephrased when posed by individual subjects in an experiential context as, 'why is this happening to me, at this particular time?' (Panter-Brick, 2014). In my reading of the included literature, an important distinction can be made between the snapshot narratives of discrete experience by respondents, and the need for further, more comprehensive contextualisation, including answering the question of 'why these people, and why now?

Table 3 Twenty-five community-based studies included in the literature review

Citation	Country	COVID Focus	Target Pop.	Article Title and Key Outcomes	Approaches
(Adom et al., 2021)	Ghana	Stigma and mental distress	HCWs and patients	**The psychological distress and mental health disorders from COVID-19 stigmatization in Ghana:** Stigma and psychological distress among HCWs, patients, and others; psychosocial recommendations for policy change	Phenomenology
(Ali, 2021b)	Pakistan	COVID burials	Local community	**Rituals of Containment: Many Pandemics, Body Politics, and Social Dramas During COVID-19 in Pakistan:** Ethnography of funeral rites in the context of COVID government restrictions; changes in burial traditions, social consequences; entanglement of science, religion, and politics	Social Drama, symbolic ownership of 'viral body' by State, liminality and grief, death traditions
(Ali et al., 2021)	Pakistan	Mental health, perceptions	Local community	**When COVID-19 enters in a community setting: an exploratory qualitative study of community perspectives on COVID-19 affecting mental well-being:** Anxiety and fear, social, financial, and religious distress. Coping: closer to God and family, participating in mental health sessions and resetting lives	Qualitative, descriptive
(Amir, 2021)	Uganda	Stigma and mental distress	Recovered COVID-19 patients	**COVID-19 and its related stigma: A qualitative study among survivors in Kampala, Uganda:** narratives of stigma experiences, social rejection, labelling, and distress	Qualitative, descriptive, narrative

(Asiimwe et al., 2021)	Ghana	Perceptions of contact tracing	Contact tracers, contacts, and supervisors	**Stakeholders perspective of, and experience with, contact tracing for COVID-19 in Ghana: A qualitative study among contact tracers, supervisors, and contacts:** perceptions of utility and effectiveness of COVID-19 contact tracing among implementing bureaucrats & recipients; positive experience and expressed concerns of stigma associated with home visits	Phenomenology, narrative, Lipsky's Street Level Bureaucrats Theory
(Bahagia et al., 2020)	Indonesia	Local wisdom, food security, and livelihoods	Community leaders	**Local Wisdom to Overcome COVID-19 Pandemic of Urug and Cipatat Kolot Societies in Bogor, West Java, Indonesia:** Food redistribution, collective action thru *nujuh bulana*n, instigating taboos, indigenous knowledge combats 'life perturbations'	Qualitative, ethnography of local knowledge (ceremonies, taboos, rituals), descriptive
(Bhatt et al., 2020)	Nepal	Perceptions, understanding, and prevention	Local community	**Perceptions and experiences of the public regarding the COVID-19 pandemic in Nepal:** a qualitative study using phenomenological analysis: Knowledge measures, social isolation, inadequate PPE, disorganised public sector	Phenomenology, lived experience
(Ekoh et al., 2021)	Nigeria	Effects of social restrictions	Above 60-aged community	**Digital and Physical Social Exclusion of Older People in Rural Nigeria in the Time of COVID-19:** Elderly are digitally and socially excluded due to pandemic restrictions leading to loneliness and lack of coping	Qualitative, descriptive

(Ghani & Sitohang, 2020)	Indonesia	Knowledge and responses of community	Remote indigenous community	**How People in Remote Areas React to the Covid-19 Pandemic in the Early Phase:** Hoaxes predominate and circulate widely, limited access to reliable information, need to improve access to reliable information, quell hoaxes	Digital vicious cycle, 'illusory truth effect', Bullet Theory of Communication
(Jones, 2021)	Sierra Leone	Experiences of state-led COVID-19 measures	Urban and rural communities	**An Ethnographic Examination of People's Reactions to State-Led COVID-19 Measures in Sierra Leone:** Adaptation, non-compliance, passive, and active resistance; heterogeneous responses by communities	Adaptive capacity, compliance, passive, active resistance theories; social and financial capital
(Kumari et al., 2021)	India	Psychosocial functioning	Peripartum women	**Impact of COVID-19 on psychosocial functioning of peripartum women: A qualitative study comprising focus group discussions and in-depth interviews:** Peripartum women experienced distress, anxiety due to pandemic confinement and social restrictions during and after pregnancy	Qualitative, descriptive
(Kwaghe et al., 2021)	Nigeria	Stigma, trauma	Frontline HCWs	**Stigmatization, psychological and emotional trauma among frontline health care workers treated for COVID-19 in Lagos State, Nigeria: a qualitative study:** Knowledge assessed for biomedical understanding; experienced stigma and social reactions from family and community; insights into improving health care quality based on experiences	Colaizzi's phenomenological method
(Newton et al., 2021)	Ghana	Health-seeking behaviour	Above 60-aged community	**Understanding older adults' functioning and health-seeking**	Qualitative Thematic

				behaviour during the COVID-19 pandemic in Ghana: Reporting physical and emotional health during pandemic; challenges of loneliness and health-seeking restrictions and health provider attitudes	Analysis, descriptive
(Nicoletti et al., 2021)	Bolivia	Patient experiences	Rural patients with epilepsy	**The impact of COVID-19 pandemic on frail health systems of low- and middle-income countries: The case of epilepsy in the rural areas of the Bolivian Chaco:** patients with epilepsy in remote Bolivia experienced drug stockouts, inaccess to health care, and 75% had inconsistent medication use during COVID-19 lockdowns	Qualitative, descriptive
(Okediran et al., 2020)	Nigeria	Experiences and perceptions	Frontline HCWs	**The experiences of healthcare workers during the COVID-19 crisis in Lagos, Nigeria: A qualitative study:** Four themes identified around responsibilities, challenges, and coping strategies, experiences of distress and pleasure, and recommended needs for further material and social support	Qualitative, descriptive
(Østebø et al., 2021)	Ethiopia	Religious and secular perspectives	Local community	**Religion and the 'Secular shadow': responses to COVID-19 in Ethiopia:** Conflations of science and religion, tradition and modernity in the Ethiopian context as local perceptions are considered in the development of public health interventions, explores epistemic tensions	Qualitative, ethnographic, Latour, coexisting epistemologies, modernity
(Prajitha et al., 2021)	India	Government responses	Government bureaucrats	**Strategies and challenges in Kerala's response to the initial**	Qualitative, descriptive, social capital, SDH

				phase of COVID-19 pandemic: a qualitative descriptive study: Five themes emerged in reflecting on government responses, recognising key components of social capital, a robust public health system, participation and volunteerism, health system preparedness, and challenges	
(Prasetyo & Arif, 2021)	Indonesia	Civil society participation	Task Force members	**Civil Society Participation in Efforts to Prevent the Spread of COVID-19:** Four task forces engaged: public education, controlling mobility via gate system, hand washing, and food needs/suspected patient monitoring, etc. Lack of funds and lack of public awareness were main obstacles	Civil society engagement
(Prasetyono et al., 2020)	Indonesia	Leadership and local governance	Village heads	**Patron-Client Relationship between Village Heads and Their Residents during the COVID-19 Pandemic:** Village leaders influence public opinion and awareness, consolidate volunteers and information, and facilitate social assistance. Patron-client relationship between village head and residents, seen as 'father protector'	Qualitative, patron client theories, power relations in bureaucracy
(Samuelsen & Toé, 2021)	Burkina Faso	Ruptures in politics and life	Local community	**COVID-19 Temporalities: Ruptures of everyday life in urban Burkina Faso:** Investigated community responses to government-led restrictions as prevention prior to the advent of COVID-19 in Burkina Faso, placed	Qualitative, anthropology, Giddens 'time-space distanciation', outbreak narratives

				within the socioeconomic, political, and fragile security contexts at the time	
(Sari et al., 2021)	Indonesia	Social protections with village fund	Community and leaders	**The Effectiveness of Tri Hita Karana Based Traditional Village Management in COVID-19 Prevention in Bali:** Experience in managing village fund for social protection during COVID-19 using traditional *Tri Hita Karana* philosophy. Local wisdom provides positive outcomes for village resource distribution and social protection	Tri Hita Karana Hindu philosophy
(Sharma et al., 2020)	India	Information, media, and psychosocial experiences	Local community	**Panic During COVID-19 Pandemic! A Qualitative Investigation into the Psychosocial Experiences of a Sample of Indian People:** Misinformation causes panic, anxiety; quarantines and social restrictions created cognitive dissonance	Qualitative, descriptive, social psychology, grounded theory
(Sukmawan, 2021)	Indonesia	Traditional rituals	Local community	**Tradition-responsive Approach as Non-medical Treatment in Mitigating the COVID-19 Pandemic in Tengger, East Java, Indonesia:** *Nambak lelakon*, an adaptation of traditional *tolak bala* ritual in East Java, used to maintain and protect human life through collective non-medical mitigation of COVID-19. Use of this ritual instils harmony in the community and is a form of prayer and surrender to God	Qualitative, psychosocial, religious
(Sumesh & Gogoi, 2021)	India	Stigma, discrimination	Recovered COVID-19 patients	**Collecting the 'Thick Descriptions': A Pandemic Ethnography of the**	Pandemic ethnography, lived experience, grounded theory,

				Lived Experiences of COVID-19 Induced Stigma and Social Discrimination in India: Embodied experience of stigma; former patients discriminated against and criminalised; social process of stigma analysed	Geertz, Goffman, narrative
(Tan & Lasco, 2021)	Philippines	Local knowledge	Traditional community	**'Hawa' and 'Resistensiya': local health knowledge and the COVID-19 pandemic in the Philippines:** Ethnographic study of 'contagion and immunity' framing in illness understanding and explanatory models for COVID-19; multiple ontologies/traditional knowledge	Ethnography, postcolonialism, risk theory, political economy
(Wibisono et al., 2021)	Indonesia	Religious exclusion and xenophobia	Muslim community	**Turning religion from cause to reducer of panic during the COVID-19 pandemic:** Explored ways to reduce social exclusion and reactions via religious cohesion in a traditional community	Collaborative auto-ethnography, Weber's verstehen, Geertz

2.2. Results: Reactive and Adaptive Responses

The following sub-sections outline the results of ethnographic investigations undertaken since the advent of the COVID-19 global crisis. Anthropological research into local explanations and experiences of COVID-19 foster a deeper insight into the observed social impacts of the pandemic, including social exclusion and stigma, blame, panic, and mistrust (Baer et al., 2003; Lupton, 2020a; van Bavel et al., 2020). Plague and pandemics are characterised by 'cycles of shame and blame, stigmatizing discourses and isolation of the sick' (Herring & Swedlund, 2010, p. 14), and yet offer opportunities for interrogating cultural resilience, as outlined by a few of the included studies.

The reviewed studies are grouped by broad conceptual considerations for coherence and simplicity. As a set, the papers follow the story arc of the outbreak narrative: initial disruptions, displacement, and urgency issued by an uncertain outbreak, followed by regulatory and social (over)compensation designed to ameliorate its effects; a period of interference and instability, infection, and response; and the early appearance of re-stabilisation in which local and exogenous explanations and relationships cohered and synthesised into new cultural forms. Themes are thus grouped into responses arising from reactions to the pandemic, clustering around knowledge and misinformation, social and psychological effects, impacts of social restrictions, and challenges in governance. Adaptations cluster around research illustrating community cohesion and adaptive governance (see Figure 4).

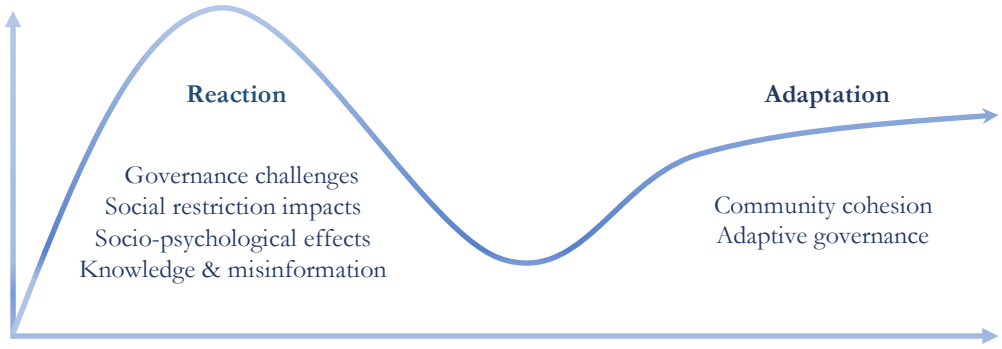

Figure 5: Themes categorising studies from the literature review focused on reaction and adaptation

Reactive Responses

2.2.1 COVID Biomedical Knowledge and Misinformation

Knowledge management during pandemics and natural disasters is a contested site of scholarly engagement, including who decides what knowledge is legitimate, usually following lines of power and authority, freighted by the influence of hegemony. The biomedical paradigm dominates the COVID-19 global discourse, thus linking scientific knowledge with legitimacy (Altiparmakis et al., 2021; WHO, 2020b). However, with the advent of increased access to unreliable sources of information via online or other media, communities are bombarded with competing knowledge paradigms, manifesting as hoaxes, conspiracies, misinformation, and disinformation, in addition to local ontologies which may run counter to biomedical epistemology (Douglas, 2021; Earnshaw et al., 2020; Hakim, 2021; Pummerer et al., 2021; Sturm & Albrecht, 2021).

Investigations into how pandemic information and knowledge arrives at, and is interpreted by, the community was investigated through enquiry into perceptions and understandings of COVID-19 (Ali et al., 2021; Bhatt et al., 2020; Ghani & Sitohang, 2020; Jones, 2021; Kwaghe et al., 2021; Østebø et al., 2021; Samuelsen & Toé, 2021; Sharma et al., 2020; Tan & Lasco, 2021). Information access and its effect on perception and experience was linked to education and geography, with educated, urban, younger populations having better access to technology and social media (Ekoh et al., 2021; Ghani & Sitohang, 2020), yet the perceived or reported reliability of information sources was not described in depth. Rural, low-income populations were associated with lower literacy rates and access to health information sources (Ghani & Sitohang, 2020). Access to knowledge was also seen as a primary driver of risk perceptions, as many hoaxes and sources of non-biomedical conspiracies altered risk behaviours, including the prolonging of the seeking of care at health facilities, potentially worsening health outcomes (Ghani & Sitohang, 2020; Sharma et al., 2020).

The proliferation of rumour was cited in these studies as the principle driver for ‘misunderstanding’ COVID-19, filling gaps in information access with fictions arising from superstition and exaggeration. Researchers in East Java, examining civil society participation in COVID-19 mitigation, noted that many villagers held the belief that ‘the coronavirus did not exist and that it was just a conspiracy deliberately invented in the interests of capitalists’ (Prasetyo & Arif, 2021, p. 30). In remote West Kalimantan on the Indonesian island of Borneo, the Sebaruk Dayak community was reported to have limited understanding of the COVID-19 virus or its transmission. An incident from one village

quickly circulated on social media via WhatsApp, effectively muting and replacing biomedical information:

> *Believe it or not. This afternoon did anyone hear the thunder when it was hot (not raining)? There was a true incident from Popay today. A baby was born this afternoon, and before the attendants could cut the umbilical cord, it spoke and said, 'to avoid the Coronavirus, you must boil an egg.' Immediately after, a strong thunderclap was heard and the baby began crying (Ghani & Sitohang, 2020).*

The researchers reported widespread dissemination of this rumour, which had a negative impact on people's understandings and behaviours. They ascribed the lack of acuity in accessing information in the region to 'a lack of cognitive ability and experience with information technology' (Ghani & Sitohang, 2020).

In Sierra Leone, rumours of police bribes by the wealthy to enable free movement during social lockdowns revealed how suspicion arises from economic inequality. Individual subjugation to the regulations of the state were perceived as uneven, with preference given to the privileged in society (Jones, 2021). Circulation of these rumours, even assuming some basis in truth, had a negative impact on the management of pandemic information, and thereby, on community responses.

Two important components of information access were outlined by these studies, including misinformation and differential access to reliable information. Sharma et al., referencing '*misinfodemics*', noted that the proliferation of misinformation circulating among Indians 'worsened the impact of the pathogen, and caused agitation and frustration' among respondents (Sharma et al., 2020, p. 5). Media-driven misinformation was amplified through collective xenophobia, as perceptions of COVID-19 carried by outsiders was a common theme, both in religious institutions in Indonesia and among the general population in India (Sharma et al., 2020; Wibisono et al., 2021). In Burkina Faso, despite the mass media focus on the Chinese origins of the pandemic, communities located the viral genesis squarely in Europe (France), referencing the 'disease of the whites' associated with European wealth, thus distorting the understanding of the temporality and locality of the pandemic, with assignations distinct and separate from previous infectious disease outbreaks, such as Ebola (Samuelsen & Toé, 2021, p. 10). Similarly, Ethiopians initially viewed the pandemic as a 'white man's disease which struck the Western world due to immorality and sin' before the first COVID-19 case arrived (Østebø et al., 2021, p. 345). It then transformed into a local affliction, God's punishment for people's sins and transgressions triggered by a multiplicity of wrongdoing (Østebø et al., 2021).

Limited access to 'reliable' information was directly linked by the authorities to poor compliance, assuming a lack of understanding and general awareness of COVID-19. In contrast, excess access to disinformation and misinformation was reported to drive stigmatising and ostracising social behaviours among healthcare workers, in which the fear of transmission over-rode protective behaviours established by health facilities (Kwaghe et al., 2021; Okediran et al., 2020).

Observations from the studies included in this review align with the widely reported circulation of misinformation around the world pertaining to COVID-19 (Aghagoli et al., 2020; Cuan-Baltazar et al., 2020; Dairaini, 2020; Larson, 2020; Nasir et al., 2020; Tasnim et al., 2020). As risk and public health communication is fundamental to any containment or mitigation strategy, the empirical data on constraints to information, as well as the proliferation of misinformation, has had a demonstrably negative impact on the overall handling of the pandemic (Briggs, 2020; Lunn et al., 2020; Malecki et al., 2020). However, apart from Tan and Lasco's study on local knowledge in the Philippines (Tan & Lasco, 2021), Samuelsen and Toé's work in Burkina Faso (Samuelsen & Toé, 2021), and Ali's ethnography of death in Pakistan, the reviewed literature shows little consideration of the tensions around how, and which, knowledge came to be legitimised, by whom and for whom, and how to best anticipate and incorporate strategies adapted to local epistemologies and explanatory models. This is an important notion going forward, in the context of the social construction of a pandemic.

2.2.2 Social and Psychological Effects

Most studies in this review observed the psychosocial and economic impacts of the COVID-19 pandemic in LMIC communities around the world (Adom et al., 2021; Ali, 2021b; Ali et al., 2021; Amir, 2021; Bhatt et al., 2020; Ekoh et al., 2021; Jones, 2021; Kumari et al., 2021; Kwaghe et al., 2021; Okediran et al., 2020; Sharma et al., 2020; Sumesh & Gogoi, 2021). The public health literature on pandemics and epidemics of infectious origin is rife with accounts of how these catastrophic disruptions to ordinary life are met by disarray and uncertainty, spawning fear and heightened anxiety (Lupton, 2020a; Manderson & Levine, 2020), and often resulting in marginalisation and stigma as communities grapple with unknowns and avoid risks (Barrett & Peter, 2008; Das, 2005; Kleinman & Lee, 2006; Mahmud & Islam, 2020; Ramaci et al., 2020; Team & Manderson, 2020). Inevitably, these rifts in the social fabric can have profound psychological and sociocultural effects, such as emotional distress, economic exclusion and loss of livelihood, the fostering of mistrust and suspicion, and can also engender stigmas resulting in social

rejection (Barrett & Peter, 2008; Briggs, 2005; Das, 2005; Keusch et al., 2006; Yang et al., 2007).

Psychological and social impacts of disease outbreak can be understood as downstream proximate effects which often have far-reaching upstream causes beyond the merely interpersonal or the immediately apparent (Flowers et al., 2016). Individual experience and perception are embedded in a matrix consisting of sociocultural context and the threads of a number of structures and systems, including inequities arising from the global capitalist economy, political and racial inequality, violence, and other causes (Briggs, 2005; Kentikelenis & Rochford, 2019; Morsy, 1979; Panter-Brick, 2014; Quesada et al., 2011).

Feelings of rejection and isolation resulting from the stigmas attached to COVID-19 uncertainties were reported among healthcare workers, patients, caregivers, and people at high risk of infection. In two separate studies on healthcare workers and stigma in Nigeria, Kwaghe et al. and Okediran et al. described exhaustion and fear arising from concerns about transmitting the virus to family members, overwork from added duties, and from community rejection as suspicious viral entities (Kwaghe et al., 2021; Okediran et al., 2020). They also avoided providing comprehensive services out of fear of catching COVID during the course of their duties, leading to feelings of guilt and frustration. In Nepal, Bhatt et al. provided evidence of extreme social stigmas from COVID-19, including patients being wholly shunned by the community and not allowed to return home despite negative PCR results, and healthcare workers being ejected from housing (Bhatt et al., 2020). Health workers in Nigeria and Ghana were subjected to a spectrum of stigmas, suspicions, and ostracisation, including by colleagues, after being treated for workplace-acquired COVID-19 infections (Adom et al., 2021; Kwaghe et al., 2021; Okediran et al., 2020). Certain religious groups were also blamed for the spread of COVID-19, and local government officials and police responded to suspected cases with violence and destruction of property (Bhatt et al., 2020).

Physical quarantining and isolation of suspected or confirmed patients as a means of reducing transmission, and mitigating the effects of COVID-19 in the community, had the unfortunate side-effect of generating stigma, discrimination, labelling, and social rejection from the community and families, and on occasion, from healthcare providers (Adom et al., 2021; Amir, 2021; Sumesh & Gogoi, 2021). Actual and symbolic labelling of the houses of quarantined patients, regardless of diagnosis, resulted in protracted avoidance and stigma. In one study in India, local health departments affixed large red banners outside quarantined households admonishing passers-by to avoid the area,

effectively delineating the space as unclean and labelling it as a 'containment home' (Sumesh & Gogoi, 2021). Unlike other pandemics of periodic or routine incidence, such as cholera or dengue, the unknown and ontologically insecure place of COVID-19 instils a fear and reflex to reject when confronted with symbolic labels such as 'containment home', which inevitably result in social ostracisation. Ugandans and Ghanaians, still smarting from relatively recent stigmatising outbreaks of SARS and Ebola (Kleinman & Lee, 2006; Wilkinson et al., 2017), experienced taunting, shunning, and social rejection through labelling practices as well (Adom et al., 2021; Amir, 2021). 'Corona families' were unable to shop in their usual markets, being thrown out or physically excluded by vendors (Amir, 2021). In Ghana, vendors reported being rejected from selling products in local markets, resulting in both psychological and economic consequences (Adom et al., 2021). Respondents in these studies reported a profound sense of loss, isolation, sadness, and depression arising from the lived experience of stigma and social rejection.

Sumesh and Gogoi, in their 'pandemic ethnography', drew comparisons between the phenomenological sense of bodily materiality and restriction as the site of pandemic control, and the historic construction of 'untouchability' with the Indian *Dalit* caste (Sumesh & Gogoi, 2021). In this sense, the stigma and rejection associated with quarantine and the labelling of 'unclean' COVID-19 patients was likened to the structural inequality arising from caste members labelled as 'untouchable'. The imperative of the containment of contagion then, whether biological or social, takes advantage of the mechanism of stigma during acute times of instability as a means of reducing uncertainty and panic among uninfected, untainted, or 'morally pure' subjects (Das, 2005; Wald, 2008; Yang et al., 2007).

Mental distress took many forms in these studies, including worry and concern about the future, anxiety about finances, guilt, depression, grief, fear, loneliness, and mistrust. The fear of contagion and death figured prominently in these studies, made more pronounced by social isolation and exaggerated media reports spurring anxieties among the respondents (Adom et al., 2021; Ali, 2021b; Amir, 2021; Bhatt et al., 2020; Kumari et al., 2021; Kwaghe et al., 2021; Sharma et al., 2020; Sumesh & Gogoi, 2021). Fear of the future was illustrated by a spectrum of concerns as reported by researchers in Pakistan, centred on anxieties about the effects on children, the nature of the post-COVID-19 world, and how many deaths would scar the future (Ali et al., 2021). New mothers were particularly anxious and fearful of the risk of infection in themselves or their new-borns, and the concomitant stigma that would likely follow (Kumari et al., 2021).

Fear was also voiced by patients and community members who expressed worry about hospitals as centres of contagion, leading to avoidance of health facilities and the altering of routine health-seeking behaviours (Kumari et al., 2021; Newton et al., 2021). This phenomenon exacerbated health service inequities tied to limited access to information, circulation of rumour, poverty and constraints on personal agency, and increased vulnerability for non-COVID-19, routine, or chronic disease conditions among the impoverished (Ali et al., 2021; Newton et al., 2021). Peripartum women in India were particularly at risk for pregnancy-related complications due to reductions in obstetrics services and anxiety over the fear of infection from health facilities (Kumari et al., 2021). Patients also feared the consequences of a COVID-19 diagnosis, and were reticent to reveal whether they had, or were suspected of having had, the disease (Kwaghe et al., 2021). Older adults, often confined or isolated, experienced disruptions in routine health-seeking, especially given their limitations in access to communication or digital technologies (Newton et al., 2021). The biosocial nature of COVID-19 as a 'syndemic' has profound effects on health system burden, adding to the personal overwhelm and desperation of patients confronting multiple illnesses, economic catastrophe, and intense emotional distress (Singer & Rylko-Bauer, 2021).

Grief and feelings of loss accompanied alterations in tradition, particularly around restrictions in burial practice associated with deceased COVID-19 victims. Inayat Ali described a sense of cultural transience in the way the state has transformed deceased family members into 'viral bodies' to be controlled and regulated, negating the community's need for closure and ritual as the dead depart (Ali, 2021b). Death, paralleling COVID-19 itself, is a complex sociocultural, economic, and political event, beyond simply a biological cessation. Presenting an ethnographic account of death in the Sindh province of Pakistan, Ali contrasted the traditions of *Namaz-e-Janaza* prayers of Islamic death rituals with the disruptive insertion of state control due to COVID-19 mitigation (Ali, 2021a). Stability in the outward ceremonial forms of relationship with Allah via the liminal space of death had been substantially fractured by COVID-19, bringing deep loss and suffering to the community. He refers to the liminal 'betwixt and between' aspect of traditional death rituals, crucial for the mourning process, being commandeered and controlled by the state during the time of COVID-19 (Ali, 2021a, p. 3). State regulations are divisive in that rural, under-resourced communities are unable to fully comply, adding to the stress of mourning.

Emotions of stress, panic, and anxiety associated with the loss of livelihood, especially in resource poor communities, were reported by several authors (Bhatt et al., 2020; Samuelsen & Toé, 2021; Sharma et al., 2020; Tan & Lasco, 2021). The loss of a

sense of personal agency and control, concerns over the ability to provide future stability for family, and a looming feeling of isolation and being 'locked in' resulting from job loss and stay-at-home orders were universally reported by the studies conducted in Burkina Faso, India, Nepal, and the Philippines (Bhatt et al., 2020; Samuelsen & Toé, 2021; Sharma et al., 2020; Tan & Lasco, 2021). The psychological ramifications of job loss were linked with food insecurity, lack of ability to care for parents, having to quit school due to financial restrictions, and the general economic pressures of daily survival. Depletion of savings, insufficient funds for health care, and having to choose between eating and medicine were mentioned by respondents in several studies (Adom et al., 2021; Ghani & Sitohang, 2020; Tan & Lasco, 2021). By contrast, government officials in Nepal were seen as escaping COVID-19-induced economic devastation relatively unscathed due to their stable salaries and the ability to work from home (Bhatt et al., 2020). Generally, there were strong associations between poverty and perceived risk, contributing to the statements of frustration, fear, and anxiety associated with job and income insecurities.

2.2.3 Impacts of Social and Mobility Restrictions

Lockdowns, physical distancing, masking, hand washing requirements, restrictions in business hours of operation, and general regulation of population mobility were universally-employed interventions for containment and mitigation of the pandemic, as reported by all the selected studies. These restrictions, designed to reduce viral transmission and reduce the burden on the health and financial systems, exerted far-reaching social sequelae among the public. Examples from Burkina Faso illustrated how constraints in movement and reductions in business hours had a negative impact on people's access to economic opportunities, translating into loss of income and financial insecurity, as previously mentioned in the above section (Samuelsen & Toé, 2021). Beyond the immediate psychological impacts of job loss, lack of economic security was associated with constraints in the ability to comply with government-regulated social restrictions which increased vulnerability (Samuelsen & Toé, 2021). Several studies observed that marginalised populations in pre-pandemic settings, such as indigenous or poor communities in all settings, were at pronounced risk during the pandemic, compounded by the ever-present risk of natural disasters, such as earthquakes, floods, and the pandemic itself (Ali et al., 2021; Ghani & Sitohang, 2020; Jones, 2021).

Studying state-led pandemic regulation and social restrictions, Jess Jones found that older community members in Sierra Leone were more vulnerable to increased poverty caused in part by limitations in access to digital finance platforms and their lack of mobile

phones (Jones, 2021). She also outlined an analytical framework of community responses around adaptation, non-compliance, and active and passive resistance. Non-compliance arose from constraints in agency resulting from economic hardship rather than from deliberate choice to reject state regulation. She also found that resistance took many forms, from the passive resistance of taxi drivers ignoring curfew restrictions and continuing to work, to active forms of resistance such as youth groups protesting lockdowns and storming public facilities (Jones, 2021).

Poverty and inequality were cited as structural barriers to complying with lockdown orders in the Philippines. Noting that '*hawa*' (an immunity-contagion concept) takes on moral and social dimensions as '*microbiopolitics*', the poor and colonised are pathologised, controlled, and locked in by the elites (Tan & Lasco, 2021). The infrastructural requirements of lockdowns include access to running water, soap, face masks, and proper nutrition, and yet these same life-protecting commodities are the barriers which the poor must surmount when deciding between compliance with social distancing and their livelihood (Tan & Lasco, 2021).

Bhatt et al. in Nepal observed that respondents in their studies were unable to strictly follow stay-at-home orders and restrictions in mobility as low wage earners could not access proper 'work from home' infrastructure (technology) and flexible job types, and thus were forced into the dichotomous 'livelihood versus compliance' considerations (Bhatt et al., 2020). Economic pressures seemed to over-ride risk perceptions for both breaking regulations and the increased possibility of catching COVID-19 in public (Bhatt et al., 2020; Tan & Lasco, 2021). Exacerbating these pressures were reports of the influence of misinformation on lockdowns resulting in job loss, reduced personal income reduction, and mistrust (Sharma et al., 2020).

Among a sample of peripartum women in India, restrictions in movement and confinement to the home resulted in expected feelings of anxiety, isolation, and worry vis-à-vis the reduction in antepartum care, and concerns about their ability to care for new-borns at home without the normal extended family support (Kumari et al., 2021). The usually stressful time of pregnancy and birth was appreciably more emotionally heightened in the context of the pandemic, as many new mothers were expected to relocate to their in-law's homes, yet they feared infection and therefore avoided this normal social behaviour (Kumari et al., 2021). The prohibition of a traditional 'sixth day' ritual for new-borns fractured communal cohesion and connection to heritage, causing rifts in family life and existential anxiety in the new mothers in the absence of spiritual recognition of the newly-born infant (Kumari et al., 2021).

Nicoletti et al. found that lockdowns and mobility restrictions in the Chaco region of Bolivia were detrimental to people with epilepsy (Nicoletti et al., 2021). In these remote areas, shortages of anti-seizure medications decreased health care access at remote health centres, and the inability to transit to access sites by patients were attributed to three quarters of patients with epilepsy not being able to access regular medications. The issue of syndemics during COVID-19, including disability and endemic infectious and non-infectious diseases, has revealed structural weaknesses in health systems worldwide, as diagnosis and management of diseases such as HIV, malaria, and TB have suffered during the pandemic, halting and reversing progress by up to a decade towards international Sustainable Development Goals (Fronteira et al., 2021; GFATM, 2021; Hrynick et al., 2021; Madhi et al., 2020; Shadmi et al., 2020; Singer & Rylko-Bauer, 2021; TB PPM, 2021). The Bolivian study illustrates one of many concomitant health issues dramatically affected by deficiencies in the supply chain, equitable access to health care, and lockdown restrictions on vulnerable communities.

Social restrictions have reduced communal and social cohesion, especially centred around worship, ritual, temple attendance, and related religious activities. Community dependence on religion as a balm against the uncertainty and chaos of the COVID-19 crisis has led to frustration and disappointment, as places of worship have been shuttered during lockdown. Members of the Muslim community in Pakistan have expressed a longing to return to the mosque, and have felt incomplete and dissatisfied by their inability to come together in collective prayer (Ali et al., 2021). Reminiscent of Inayat Ali's ethnography on death, Ali et al. observed that restrictions in the normal, proper burial practices such as *ghusl*, *kafan*, and prayer, created heightened fear and anxiety in the community, as the people were afraid they would die and be denied a Muslim funeral (Ali, 2021b; Ali et al., 2021). Limitations on collective spiritual activities were generally found to have a negative overall impact on community health and wellbeing as reported in this literature. Wibisono et al. observed how disruptions in mosque opening in remote West Java created social insecurities manifesting as xenophobia of outsiders and non-Muslims, attributed to such ideas circulating on social media and the lack of community cohesion arising from the routine practice of Islamic daily prayers (Wibisono et al., 2021).In the wake of bans on religious gatherings (weddings, births, deaths), elderly Nigerians lamented the lack of spiritual buffer afforded by the rituals of collective prayer, 'I can't even go to church to pray to God so that he will protect us from all these things. The whole world is paying for their sins' (Ekoh et al., 2021).

Østebø et al. found that Ethiopian Muslims and Orthodox Christians alike viewed the COVID-19 crisis as having supernatural origins as punishment for sin (Østebø et al., 2021). Remedial actions thus required fasting, prayer, and repentance to ameliorate God's wrath. When the government forced closures of places of worship, communities felt despondent, perceiving abandonment by authorities at a time of desperation in which the only solution was sought through communion with the divine, and only within the consecrated spaces of the church. Ineffective dissemination of restriction and closure policies within the church also played a part in reducing confidence and disrupting social cohesion.

Despite the demonstrable reduction in disease transmission through physical restrictions of movement, lockdowns, and confinement from a biomedical perspective, most studies revealed that the urgency with which lockdowns were instituted resulted in social shockwaves in which communities reeled from the effects of cultural, physical, spiritual, and familial rifts through these injunctions. Cultural transitions and evolution of traditions are normative, yet the rapidity with which the COVID-19 pandemic forced these changes was disruptive and will take time to establish novel adaptation and homeostasis.

2.2.4 Pandemic Governance and Health System Challenges

There was general acknowledgement of the failings of effective governance of the pandemic, including ill-prepared health systems (Altiparmakis et al., 2021). Despite ample opportunities to develop systems and responses to potential infectious outbreaks from prior experience with H5N1, SARS, Ebola, Avian Influenza, and others, many governments and health systems were unable to quickly adapt their infrastructure, policy, and financing to meet the challenges of COVID-19 (Antulov-Fantulin et al., 2021; Nederveen Pieterse et al., 2021; Rajan et al., 2020; Shrestha et al., 2021; Wenham, 2021). Overwhelmed and under-resourced, health systems buckled under the increased strain of patients, lack of PPE, and pandemic panic. Nepali respondents identified poor implementation of tracking and tracing by the government, and a lack of provision of PPE as examples of ineffective public sector responses to the pandemic (Bhatt et al., 2020). Reusing surgical masks in lieu of available PPE and shifting resource allocations from chronic disease management to acute COVID-19 treatment without sufficient capacity were complaints by patients and providers alike, illustrative of larger structural deficiencies and challenges (Bhatt et al., 2020). Lacking PPE, funding shortfalls, and poor public sector coordination were identified as negative stressors on contact tracers working in Ghana, constraining public health efforts to trace potentially exposed members of the public (Asiimwe et al., 2021). Further exacerbating

material constraints were examples of policy discordance at multiple state levels, translating into confusion and difficulties in implementing health programs on the ground (Prajitha et al., 2021).

Other studies reported a lack of promised or committed government assistance to communities and individuals as generative of mistrust and loss of confidence in the public sector (Ali et al., 2021; Prajitha et al., 2021; Prasetyo & Arif, 2021; Samuelsen & Toé, 2021). In remote Borneo, many health facilities were simply closed during the lockdowns, effectively reducing healthcare access among vulnerable rural Dayak communities to zero (Ghani & Sitohang, 2020). Systemic deficiencies in public sector funding commitments for the provision of mental health services was cited in Pakistan as a key area in need of improvement for supporting community resilience (Ali et al., 2021). Researchers in Burkina Faso noted a 'contradictory relationship to the state: mistrust is rife, but more support is relentlessly sought' as communities struggled financially with the closure of markets, loss of income, and lack of government support (Samuelsen & Toé, 2021).

COVID-19 operates at the intersection of the institutional and the personal, where entanglements of tradition and governance create new adaptations via the rituals of the state in managing contagion. Inayat Ali, in his ethnography of the 'rituals of containment' surrounding Pakistan's management of 'viral bodies', tackled questions of governance and who owns the dead during a pandemic (Ali, 2021b). He views the pandemic as having multiple dimensions: social, structural, economic, emotional, psychological, and political. His analysis of deceased COVID-19 patients was seen through the lens of the state as conducting rituals of containment by commandeering bodies, isolating them from family members, and taking ownership to offset the tangential effects of further contamination.

Ali used Turner's social drama (Turner, 1974) as the framing metaphor for conflict arising from tensions between tradition and governance, with the pandemic creating new subjects through the enactment of state-led rituals of containment that run counter to burial and death customs. His use of social drama provides theoretical depth to examining how the state uses soft and hard power to exert containment, which is often at odds with a critical and disagreeing public. Viral bodies, defined and managed by the state, are useful for considering the liminal quality of the pandemic, in which stable social practice is supplanted by crisis management and social upheaval. A government-sponsored national broadcast of a *Namaz Aaft* ritual (meant to reverse a curse or misfortune), was viewed as political coercion to conflate magical thinking with scientific response by placing blame for COVID-19 and its subsequent social dislocations in the realm of the supernatural as punishment from Allah, thereby exonerating the government from responsibility and

accountability (Ali, 2021b). Further dislocations erupted from the government's containment of 'dead viral bodies' through restrictions on family access to burial rituals. It was widely rumoured that the wealthy were able to pay for access to conduct accepted death rituals and prayers, while the poor were not. Denial of last rites for the poor, while privileging the rich, according to the author, illustrated the invisible hand of structural violence perpetrated through the wielding of power in Pakistan (Ali, 2021b).

The negotiated space of tension between the structural imperatives of biosecurity instituted by public sector actors, and social boundaries and responses of governed communities was evident in several studies. Expectations of compliance and rule following was built into many policies, occasionally driven by misinformation, as was reported in the Philippines study. To support the rollout of seemingly harsh social restrictions, Filipino bureaucrats appealed to constituents using familiar, albeit misleading, cultural myths or conspiracies to garner support and compliance (Tan & Lasco, 2021). Political leaders touted unproven remedies and health supplements, and the authors critiqued this practice noting that it was a method for absolving authorities of responsibility in the face of a rapidly-spreading pandemic (Tan & Lasco, 2021).

In what Tan and Lasco refer to as the 'political economy of contagion', COVID-19's impacts among the poor and marginalized was attributed to the State machinery, as oligarchies were largely insulated from the effects of the pandemic, while the poor were 'locked out and locked in', unable to negotiate agency against a government apparatus of control (Tan & Lasco, 2021, p. 11). As impoverished communities bore the brunt of the consequences of lockdowns, the State navigated and straddled imperatives of biosecurity, closing international borders and confining citizens through mobility restrictions, and imperatives of duty of care to its citizens. Histories of terrorism and political instability, as reported from Burkina Faso, previous destabilizing outbreaks as exemplified by Ebola in Sierra Leone, and corrupt use of power severely restricted public sector responses, reduced public trust, and resulted in negative health outcomes for the most vulnerable among the population (Jones, 2021; Samuelsen & Toé, 2021; Tan & Lasco, 2021).

In an Indian study, Sumesh et al. found that local health departments were engaged in the practice of labelling COVID-19 patients' households as contaminated, yet did not provide social support or information to counteract the expected stigma (Sumesh & Gogoi, 2021). Victims felt rejected and unsupported, lacking access to basic needs while being locked in by the government. In Sierra Leone, community resistance to public sector sanctions arose from a sense of powerlessness and voicelessness among the public, using their bodies as protest in the absence of other social capital with which to negotiate (Jones,

2021). In both of these cases, structural inadequacy and inequality led to a form of forced non-compliance, negotiated through imbalanced power relations.

The LMICs profiled in the literature review suffered substantial economic and social losses during the pandemic, faced with ill-equipped health and governance systems resulting from long-standing global inequities. Although many of the countries profiled had confronted numerous natural disasters, and had experienced previous infectious disease outbreaks such as SARS, H1N1, and Ebola, the all-encompassing nature of COVID-19 had devastating effects on local economies, supply chains, social cohesion, and individual resilience. The published articles in this review were in general concord that public sector systems failed to meet the needs of the populace, and were ultimately responsible for the poor performance of government interventions.

Adaptive Responses

2.2.5 Community Cohesion and Adaptive Governance

Examples of resilience and responsiveness to the disruptive pandemic crisis were illustrated by several authors, providing insight into how communities come together in times of distress and need. In Indonesia, two examples of *gotong royong* are provided in Java and Bali, promoting and encouraging local knowledge and traditional practice as a means of social protection and community cohesion (Bahagia et al., 2020; Sari et al., 2021). Gotong royong is an Indonesian concept of mutual assistance, working together, and sharing the burdens among the community, and is an often-referenced term used especially during natural disaster or calamity in which leaders invoke gotong royong to inspire and promote partnership and unity in times of uncertainty. The Balinese traditional philosophy of *Tri Hita Karana* was used as a framework for the redistribution of village funds to offset the economic devastation to the tourism industry, among other pandemic effects. *Tri Hita* Karana is a three-component philosophy guiding the Balinese community (Krama): devotion to God (*Parahyangan*), kindness to fellow humans (*Pawongan*), and compassion for nature (*Palemahan*). The *Tri Hita Karana* philosophy is derived from the values of Balinese local wisdom (*Sad Kertih*) with the aim to purify the soul (*Atma kertih*), preserve forests (*Wana kertih*), lakes (*Danu kertih*), the sea and beaches (Segara kertih), promote social harmony and preserve nature (*Jagat kertih*), and to build the quality of human resources (*Jana kertih*) (Sari et al., 2021). Management and disbursement of funds became a communal affair, promoting trust, transparency, and providing much needed economic relief to families. By couching the redistribution of economic resources within a cultural

wisdom frame, the participating Balinese villages have preserved their traditions while meeting the needs of dealing with an unanticipated disaster (Sari et al., 2021).

Redistribution of food in West Java was conducted using a complex sociocultural methodology among the Ciptagelar, Baduy, Urug, Cipatat Kolot, and Naga indigenous communities (Bahagia et al., 2020). A three-tiered process consisting of annual rice harvest distribution to vulnerable people such as the elderly and orphans, collective food preparation by household matrons for redistribution to pregnant women through a process called *nujuh bulanan*, and instituting strict temporal taboos on shifting land ownership and farming practices, took place during the onset and proliferation of the pandemic. This process prevented food insecurity, especially among the vulnerable in the communities, with the utilisation of local knowledge and wisdom being seen as a key mitigator of the pandemic (Bahagia et al., 2020).

Two studies conducted in East Java detailed the role of local leadership and civil society involvement in successful pandemic strategies (Prasetyo & Arif, 2021; Prasetyono et al., 2020), also utilising the traditional concept of *gotong royong*. A patron-client theory was used to approach how local leaders were viewed and regarded during the pandemic. The researchers found that village heads shaped public opinion and perceptions of COVID-19, served as a consolidating centre for volunteers and a conduit for information and facilitating social assistance. They were also seen as 'father protectors' of the village during the pandemic, serving in the patron-client role, as identified in the study (Prasetyono et al., 2020). Elsewhere in East Java, a village level study looked at community cooperation via the involvement of civil society in the formation of four local COVID-19 task forces responsible for educating the public on health protocols, limiting population mobility, ensuring adequate infrastructure for hand washing, identifying social protection needs and food insecurity, and assisting with identifying potential COVID-19 infections in the community. The *gotong royong* concept served as an instigator of community cohesion, leadership, and effective response.

The deepening of faith and enhancement of spiritual life was seen as adaptive and provided a source of hope among communities, as explicitly reported in studies from Ghana, Indonesia, and Pakistan (Adom et al., 2021; Ali, 2021b; Ali et al., 2021; Sukmawan, 2021; Wibisono et al., 2021). Prayer, meditation, and ritual, when allowed, were important activities that respondents perceived as useful in reducing anxieties and 'nurturing the soul' (Ali et al., 2021, p. 9). Faith in God provided external validation and psychological support, both spiritually and as a community building experience. A deeper analytic may conclude that the use of religion as a technology of explanation and adaptation is socially constructed

in parallel with biomedical technologies, circulating together, yet with differing levels of access; in essence, complimentary ontologies operating in tandem in the community and with varying influence on behaviour and the generation of risk perception.

The Tengger tribe in East Java employed ritual technology steeped in Indonesian tradition to combat the effects of the pandemic and promote harmony in the community (Sukmawan, 2021). The *nambak lelakon* is the Tengger's version of the well-known and widely used *tolak bala* ritual, used to ward off a variety of misfortunes. The Tengger recognise COVID-19 as a virus; it is classified as *pageblug* within their ethnomedical system, grouped together with misfortunes such as earthquakes, tsunamis, and other natural disasters yet to come. Personified as *butha kala*, according to their cosmology, COVID-19 represents unseen negativity, and must be 'sent back in the direction from which it arrived' (Sukmawan, 2021, p. 7). *Butha kalas*, such as COVID-19, are appeased through ritual offerings during the *nambak lelakon*, with the aims of reducing human suffering, warding off the misfortune of the pandemic, and restoring order and harmony. The ethnographic investigation into this process demonstrated that the ritual helped the community, as the pandemic was positioned within long-standing tradition and cosmology, with the remedy spanning both the spiritual and physical realms (Sukmawan, 2021).

The supernatural coincided with the secular in pandemic practices in Ethiopia, in which a 'blurring of boundaries' was seen: COVID-19 was at once a virus and yet had divine origins as sent by God as a curse (Østebø et al., 2021). The epistemes of religion and technocratic biomedicine ran in parallel, with the identity of the disease consisting of natural and perceptual elements. This blurring of boundaries served to legitimise multiple epistemes in Ethiopia, resulting in the adoption of biomedical, traditional, and spiritual remedies to treat the illness. Østebø et al. made analytical use of etiological duality in non-Western pluralistic medical systems, initially described by Foster (1976), in which personalistic and naturalistic paradigms can co-exist. The oscillations and entanglements of prescriptive spiritual 'dos' (such as prayer and fasting), and prohibitive 'don'ts' of public health regulation (such as altering social behaviours and avoiding certain practices), allowed communities to employ multiple, non-contradictory epistemologies to meet the challenges of the pandemic.

Tan and Lasco offer insights into the process of incorporation of novel disease entities such as COVID-19 into local lexicons of illness and politics (Tan & Lasco, 2021). The Filipino concepts of *hawa* (contagion) and *resistensiya* (immunity) provide insight into a biological and moral-political landscape of ideas in which COVID-19 has been inserted. *Hawa* takes on the form of both biological and social contagion, and structures local

understanding and behaviour, including the delineation of infectious physical bodies, as well as ascribing moral responsibility, guilt, and accountability for contagion. *Resistensiya* establishes opposition and immunity, influences risk perceptions based on biological and cultural traits, and is used as a substrate for political or moral non-adherence. The authors demonstrated how these contested concepts are negotiated in the Philippines, at once legitimising traditional medical lexicons, and setting up tensions between the community and governing structures in question (Tan & Lasco, 2021).

Several examples of adaptive and resilient governance were identified by researchers in Ghana and India (Asiimwe et al., 2021; Prajitha et al., 2021). Thematically, successful public health interventions relied on intersectoral collaboration, building upon previous epidemic and outbreak experience and established health policy infrastructure, and a focus on community level engagement, including contact tracing, 'social surveillance', and volunteerism. Despite obvious challenges, the predictors of success relied heavily on a communal sense of responsibility, playing field equality, and building social capital through cooperation. Self-governance and first-hand experience with witnessing positive outcomes, such as patient recovery or community successes in reducing incidence, were important in building social capital and contributing to widespread social cohesion (Asiimwe et al., 2021; Prajitha et al., 2021).

These sources show that as initial shock and disruption is supplanted by a normalising of pandemic life, community innovation and resilient governance may start to take hold. Despite an overwhelming trend towards the negative, the examples of resilience and adaptation provide a bedrock from which to develop future potential solutions, utilising local contexts, social solutions, and effective community engagement and communication.

2.3 Discussion

The reviewed ethnographic and descriptive qualitative studies have demonstrated that responses to the pandemic are at once universal and specific; human emotion unites, while sociocultural context distinguishes. Social suffering in the face of an overwhelming disruptive health crisis is expected and unsurprising, as illustrated in research from the profiled LMICs in which fear, uncertainty, stigma, and anxiety pervaded. Structural insufficiencies, a lack of local understanding, the proliferation of misinformation, and under-resourced health systems all contributed to the destabilisation of emotional responses. Resilience was also profiled, underscoring the importance of drilling down to the local context to find solutions, rather than relying on facile 'copy-paste' interventions and rigid hierarchical power relations. Nimble, flexible, and local solutions which

incorporated traditional explanatory models, and even spiritual technologies, appeared to contribute to resilience, as exemplified in several studies included in this review.

The papers included in this review represent significant variation in geographic and topical areas of enquiry, yet analytically tend towards biomedical reductionism in scope. While explicitly making claims to employing qualitative, phenomenological, and ethnographic methods, many papers made few explicit references to specific scholars or theoretical frameworks for comprehensive analyses and contextualisation of findings within the broad sociological or anthropological literature of epidemics. The use of theory for in-depth analysis in the selected studies was variable, yet some notable exceptions provided rich context and interpretation.

Inayat Ali provided insight into the Pakistani government's containment of contagion by using Turner's 'social drama' as a way of exploring the multiple crises brought on by COVID-19, in which publics and the state managed tensions in the context of new subjects and ways of being (Ali, 2021b). Researchers in Indonesian Borneo made note of the 'illusory truth effect' (Hasher et al., 1977) in their reporting on how misinformation and rumour quickly evolved into accepted truths about COVID-19 through reinforcement and repetition, having widespread consequences for communities with scant access to reliable information sources (Ghani & Sitohang, 2020). Bhatt, et al. outlined their use of Colaizzi's phenomenological analysis of interview transcripts for their research in Nepal. The findings were reported descriptively by theme and compared with other empirical research, but were not subjected to theoretical conjecture or analyses (Bhatt et al., 2020). Jones' comprehensive ethnography in Sierra Leone explored individual meanings and experience of the COVID-19 crisis, while being contextualised in larger issues of culture, governance, and being explored through an adaptation and resilience lens (Jones, 2021). Similarly, Sumesh et al. incorporated Link and Phelan's framework for stigma (Link & Phelan, 2001), and referenced Merleau-Ponty and other phenomenological theorists in their 'pandemic ethnography' in India, and yet a robust interpretation that engaged with phenomenology was limited (Sumesh & Gogoi, 2021). Tan and Lasco, making use of ethnographic investigations into the use of local knowledge around illness concepts, were comprehensive in their interpretations of the political and moral implications of long-held cultural idioms around infection and immunity in the Philippines (Tan & Lasco, 2021). Ali's study of rituals of containment in Pakistan, and Tan and Lasco's study in the Philippines, both provided the most comprehensive linkages between methodology and interpretation and offered models for ethnographic investigations and theory during this pandemic (Ali et al., 2021; Tan & Lasco, 2021). Østebø et al. provided a

comprehensive analysis of the secular-religious debate and embedded their discussion in the deep historical context of Ethiopia, including experiences with previous outbreaks and the cultural forms of 'coexisting epistemologies', as practiced in the Tigray and Amhara communities' systems of traditional knowledge (Østebø et al., 2021). Giddens' concept of 'space-time distanciation' was used to analyse the temporal ruptures in everyday life in Burkina Faso, linking sociocultural context to the passage of time, to distance, and to the influence of the 'absent other' (Samuelsen & Toé, 2021).

While most studies provided insight into community perceptions and the impacts of the COVID-19 pandemic, the framing of analysis and reporting from a dominant biomedical epistemology lacked a robustness in considering multiple ontological stances. Field sites in LMICs were predominantly 'non-Western', and yet were approached using knowledge generated from Cartesian biomedicine and epidemiology, often assessing the 'correctness' of responses to test knowledge and attitudes. Additionally, studies were mostly 'agency-focused' in terms of recommendations going forward, as interventions were mainly at the individual/perceptual level, such as providing communications and education around stigma, but lacking structural or political-economic recommendations. There remain ample opportunities to explore how a rapidly evolving local cultural nosology incorporates COVID-19 into local knowledge structures and the biosocial nature of the pandemic, which was not fully explored in these studies to a satisfactory degree.

Considering the pervasively disruptive nature of the COVID-19 pandemic on the execution of field research in general, few studies explicitly detailed how alterations in data collection were accommodated to comply with pandemic regulations. Bhatt et al., Jones, and Sumesh et al. noted how their data collection methods were adjusted to meet government requirements and to avoid contamination during interviews, including provision of masks, sanitizers, and maintaining physical distancing and barriers (Bhatt et al., 2020; Jones, 2021; Sumesh & Gogoi, 2021). Kwaghe et al. described the accommodations for interviewing put in place for one participant who was in quarantine isolation during the time of the interview, shifting to a telephone interview rather than face-to-face like the other respondents (Kwaghe et al., 2021). Amir and Ekoh et al. also referred to abiding by standard COVID-19 regulations in their methods sections (Amir, 2021; Ekoh et al., 2021), while Samuelsen and Toé denoted adjustments in travel and the use of local field assistants during strict lockdowns (Samuelsen & Toé, 2021). Sumesh et al. also included a sub-section on future considerations for changes to methods to accommodate qualitative data collection during pandemic conditions (Sumesh & Gogoi, 2021). Most

studies, however, described their data collection methods as per usual, with little direct mention of COVID-19-induced adjustments to the status quo in research methodologies.

Regarding geographic coverage, there have been limited published ethnographic studies undertaken in Indonesia during COVID-19. Five studies met the inclusion criteria for this review, while thirty-one community-based studies published in peer-reviewed journals or conference proceedings were excluded for reasons including: low methodological rigour, quantitative/mixed methods surveys, online data collection, secondary analysis as the main method, and lack of field-based primary data collection. Themes from Indonesian literature, published in English and Bahasa Indonesia languages, clustered around communications, conspiracies/myths, and misinformation (Lerik & Damayanti, 2020; Lestari & Sularso, 2020; Nadzir, 2020; Nasir et al., 2020; Sugiarto et al., 2021; Tasnim et al., 2020; Yanto, 2020); village level innovations and perceptions of effective governance (Giartiningsih, 2021; Lamopia et al., 2021; Meckelburg & Bal, 2021; Olivia et al., 2020; Saifuloh & Fitrotin, 2021; Susilo et al., 2021; Yunus & Alias, 2020); indigenous community responses and vulnerabilities (Niko, 2020; Soplanit et al., 2021); experiences and vulnerabilities of health care providers (C. Smith, 2020; Weta, 2020); community perceptions, practices, religion, and social capital (Chavarría et al., 2021; Khotimah et al., 2020; Lazuardi, 2020; Megatsari et al., 2020; Saefi et al., 2020; Sahlan et al., 2021; Sukamto & Panca Parulian, 2020; Sulistyawati et al., 2021; Yanti et al., 2020); blame, stigma, mental health and poverty (Idris & Jali, 2020; Ifdil et al., 2020; Sulistiadi et al., 2020; Wisadirana, 2021), and the economic impact on local coffee farmers (Nazaruddin et al., 2020).

Two studies were conducted in Kupang, NTT, focusing on public perceptions of nursing services provided at community health centres (Weta, 2020), and COVID-19 myths among the public in Kupang City (Lerik & Damayanti, 2020). The geographic focus of most of the selected studies centred on the three largest population and economic centres in Indonesia: Java, Kalimantan (Borneo), and the Sumatra Islands. Structurally vulnerable locales, such as the islands of East Indonesia which are historically impoverished and burdened by heavy infectious and non-infectious disease prevalence, are under-represented in the literature despite demanding analytical focus. The complexity of the management strategies of containment and mitigation of COVID-19, coupled with resource limitations in geographies such as NTT, provide fertile ground for exploration and investigation towards improving public health outcomes in these locales.

Despite rich opportunities for theoretical exploration using qualitative data from empirical studies during COVID-19, the dearth of analytical depth and the opting for

thematic description and comparison demonstrates an unmet need for further research. Although most of the researchers were academics from the same country or culture areas being studied, the majority hailed from positivist clinical sciences, and Enlightenment intellectual traditions. Qualitative analysis tended towards reductive description rather than nuanced and significant contribution to social or anthropological theory of epidemics. This was especially apparent in the general lack of robust analytics incorporating both macro (historical, political-economic) and micro (individual, psychological, economic) influences and impacts within the sociocultural milieu under investigation.

Additionally, there was scant evidence of critical analysis framing the studies in broader questions of power and legitimation of pandemic knowledge in the unfolding novel crisis. Emphasis was heavily placed on the hegemonic biomedical paradigm of knowledge production used as the template from which to grade responses and the performance of interventions. Little has been reported from an anthropological perspective of multiple ontologies, or disease framing via local explanatory models and illness narratives, which underscores the predominance of the top-down colonial model of Western scientific knowledge paradigms in pandemic responses, with the notable exceptions of Østebø et al. in Ethiopia, Tan and Lasco in the Philippines, Ali in Pakistan, Jones in Sierra Leone, and Sumesh et al. in India (Ali, 2021b; Jones, 2021; Østebø et al., 2021; Sumesh & Gogoi, 2021; Tan & Lasco, 2021).

Given the historically unprecedented nature of the global COVID-19 pandemic, examination of modern theories of decolonisation, socio-materiality, power dynamics and risk communication, social vulnerability, and inequity in addition to other 'social determinants of health', the gap in the research remains wide. Gaps in the current literature provide impetus for developing research aims for ethnographic investigations into community experiences of COVID-19 in eastern Indonesia. I thus proposed the following research aims, which will be explored further in Chapter 3 Methodology:

1. To explore the local context of community perceptions and responses to the COVID-19 pandemic in one urban and one rural district in Nusa Tenggara Timor, Indonesia
2. To investigate the extent to which local knowledge and practices are recognised in overall COVID-19 response strategies, and to explore the relationships between the community and health providers
3. To contribute to the development of contextually appropriate recommendations arising from an in-depth investigation of perceptions, understandings, and

knowledge that can improve public health outcomes by utilising contextual information in decision-making

Relevant theoretical considerations and positioning will also be further outlined in Section 3.1 of Chapter 3 Methodology.

2.4 Conclusion

As illustrated by the reviewed studies, local context and community engagement were indispensable for designing public health interventions to meet the challenges of the pandemic. The complex dynamic of perception, experience, and behaviour arising from the entanglement of individuals, communities, and the intangibles of structure and differing notions and understandings of pandemic meanings was brought into sharper relief through ethnographic and qualitative inquiry. The synthesis and analysis of social research outlining local context and pandemic responses is crucial for developing appropriate policy and engagement towards ending the crisis.

Inter- and intrastate politics, influenced by economics, contemporary history and political instability, religion, and structural influences creating inequity and marginalisation are major factors determining pandemic responses in LMICs. Individual experiences in the communities reflected structural inequity, where sense making at the local level was a culmination of these proximate and distal forces which usually resulted in negative health outcomes, stigma, social rejection, and so on. While several exemplars of community resilience were identified, social ruptures caused by the COVID-19 pandemic necessitate large scale rectification, requiring improved commitments by the State and civil society towards future prevention and response. This review also underscores the importance of facilitating and improving public-private cooperation and policy, as most of these studies reveal disjunctures between civil society, the public at large, and the governing bodies responsible for wielding legislative, implementation, and enforcement powers to contain the pandemic.

3

Chapter 3. Methodology: Explorations in the *Covidscape*

Introduction

This study explores the subjective experiences and constructed meanings of the social disruption caused by the COVID-19 pandemic through the eyes of the community in Kupang, the provincial capital of Nusa Tenggara Timur in eastern Indonesia. It asks questions of how this disruption has played out in individual lives and in collective society, and explores the subjective experiences of individuals in the community (Lupton, 2020c). The research also identifies challenges to the governance of social life in addressing pandemic control within the context of the dynamic interplay between public health objectives and cultural expression during a time of contagion (Gray et al., 2020; Kelly et al., 2019).

In the following sections, I clarify the research questions under investigation, provide an overview of the qualitative methodology used for data collection, outline the details of the methods used during field data collection itself, and discuss the approach to the qualitative data analysis.

3.1 Methodology in the Time of Contagion: Research Design

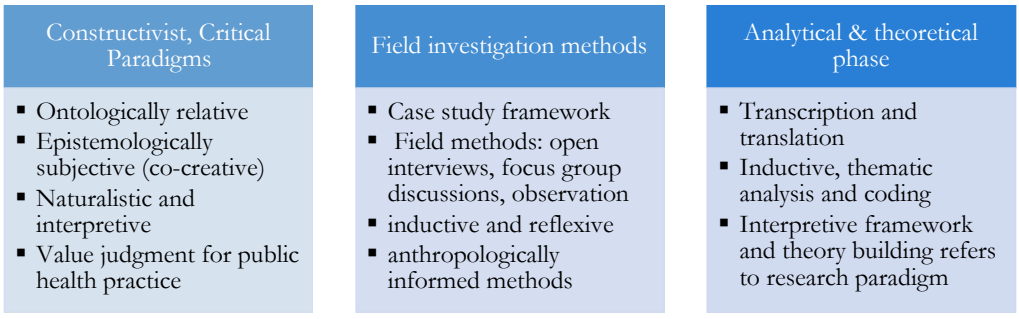

Figure 6: Bricolage approach to research development and framework

The COVID-19 pandemic is a biosocial, or biocultural, phenomenon which impacts bodies at the individual, social, and political levels, the mitigation of which requires large-scale behaviour change and social constraint, in addition to medical intervention at the biological level (Gray et al., 2020; Hengstermann, 2020; Stellmach et al., 2018; van Bavel et al., 2020). Infectious disease outbreaks can throw everyday routine into disarray, leading to a heightened sense of fear, anxiety, distress, and uncertainty (Lupton, 2020a), and while the traditional tools of epidemiology and biomedical science are essential parts of the armory, historically it has been necessary to understand how outbreaks are understood locally and managed through cultural interpretation and construction of disease meanings (Lupton, 2020a, 2020c; Nichter et al., 2020). For example, during the recent West African *Ebola* epidemic, social science played a pivotal role in shaping the approach to the disease, including contextualising messages and activities, deepening understanding of perceptions and local knowledge, and importantly, to critically condemn the use of 'sociocultural factors' to assess blame (Sams et al., 2017).

Examining the impact of disease outbreaks on social restrictions and their effects on cultural activities such as funeral practices, and exploring factors related to 'trust' and 'adherence to public health measures' are reliant on insights provided by social scientists working closely with communities (Davis, Stephenson, et al., 2015; Holton et al., 2017; Sams et al., 2017). Several social and behavioural topics have been identified as areas of focus for research and intervention, including threat perception, panic, trust and compliance, zero-sum thinking, fake news and persuasion, social context, and stress and coping (van Bavel et al., 2020). Investigating these and related issues in specific cultural contexts requires the application of social science data gathering and analysis, including the identification of potential areas for policy design and improving community resilience and pandemic outcomes (Lunn et al., 2020).

A comprehensive COVID-19 social science agenda has been proposed by several authors, (see Lupton, 2020c; Nichter et al., 2020; Ward, 2020), underscoring both the complexity of the phenomenon at hand, as well as outlining the fundamental contributions that social science has to offer. In 2015, researchers noted that despite advances in epidemiological methods, medical science, and improvements in public health infrastructure, the 'world remains ill prepared to handle sustained responses and global pandemics' (Crawford et al., 2016, p. 186). Despite years of funding from global agencies such as USAID, DFAT, and others to prepare for Emerging Pandemic Threats, SARS, AI, and others, there remain major vulnerabilities locally and globally in terms of health system deficiencies (Sciortino, 2021). In *Methods in the Time of COVID-19: the Vital Role of*

Qualitative Inquiries, Teti, Schatz, and Liebenberg reviewed the importance of qualitative research conducted during times of infectious disease outbreak as being especially applicable to the COVID-19 pandemic, recognising that health behaviours, especially during times of disaster or emergency, do not fit nicely within epidemiological models or predictions, and that vulnerable or marginal populations have the double impact of both biological disease and arguably greater social disruption (Teti et al., 2020).

Leach and colleagues noted that 'COVID-19 is revealing, reinforcing, and catalysing new social and cultural relations; laying bare inequalities and anxieties, discrimination and division; but also galvanizing solidarities and collective action' (Leach et al., 2020). Clearly, the biosocial nature of this pandemic underscores the need for both a biomedical and social approach (Farmer, 2000; Farmer et al., 2013; Kleinman et al., 2008; Richardson et al., 2016). While materialist, realist sciences provide second-order understandings of the world, qualitative research provides a first order understanding through concrete descriptions of subjective, lived experiences of how these social and cultural relations impact individual lives (Brinkmann, 2014; Liamputtong, 2019b). It is within this context that I designed the current research around a qualitative social science paradigm with a focus on understanding local knowledge and experiences to contribute to the overall strategy of pandemic mitigation.

I approach this research from a constructivist paradigm, with elements of critical theory to drive interpretive outcomes, which posits that knowledge generation is both interpretive and political in essence (Crotty, 1998; Guba & Lincoln, 2005; Metzner-Szigeth, 2009; Schwandt, 1998). Denzin and Lincoln define the parameters of a constructivist paradigm as 'assuming a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and respondent co-create understandings), and a naturalistic (in the natural world) set of methodological procedures' (Denzin & Lincoln, 2017a, p. 13). Knowledge production, control, and reproduction is viewed as socially constructed, arising from a socially contingent world in which truth is culturally bound and not extrinsically discrete (Berger, 1971; Schwandt, 1998). Data from this research is thus collected via exploration of subjective experiences of participants through conversational interviews and group discussions, with an epistemological stance that knowledge (and thereby meaning) is socially constructed through the interplay and enactments of social life, material, and human and non-human interactions (Chao, 2020; Jensen, 2014; Kohn, 2015; Sayes, 2014).

3.1.1 Case Study Framework

This qualitative research is designed using an exploratory instrumental case study framework to address the sociocultural nature of the phenomenon under investigation (Stake, 2003, 2009), employing ethnographic field data collection methods and a multi-layered, multi-sourced analytical and theoretical approach reminiscent of Denzin and Lincoln's description of '*bricolage*' (Denzin & Lincoln, 2017a) arising from the open exploration and complexity of experiences of community members during the COVID-19 pandemic.

Stake's constructivist approach to the instrumental case study is appropriate for in-depth exploration and understanding of a phenomenon or specific issue in its natural, real-life context (Stake 2009; Crowe, Creswell et al. 2011). Stake holds that most contemporary qualitative researchers 'hold that knowledge is constructed rather than discovered' (Stake, 1995, p. 99), and that qualitative researchers are in fact interpreters reporting on the constructed reality or knowledge gathered through investigation (Stake, 1995; Yazan, 2015). The instrumental case study framework is useful for exploring social phenomena within a bounded context, either temporal, geographical, sociocultural, or otherwise, with the data and insights generated perhaps being applicable beyond the bounded case and useful in developing theory or policy (Stake, 2009). This research framework reflects contextual naturalism and reflexivity and seeks meaningful answers to questions around the 'how' and 'why' of phenomena implicit in qualitative research (Creswell, 2013).

Stake defined the instrumental case as a 'bounded system' which can be simple or complex, and which is examined as a means to providing insight or inducing generalisation of a given phenomenon (Stake, 2003). He further denoted that the case is the choice or object of inquiry, regardless of the research methods used (Hyett et al., 2014; Stake, 2005). The case study approach is particularly useful for investigating a phenomenon within its real-life context, especially when the investigator has little control over the events being studied, such as in a positivist experimental study design (Yin, 2003). Stake mentioned four defining characteristics of the qualitative case study: that it should be 'holistic' in considering the relationship between the phenomenon and context under study; that it must be 'empirically' based on observations in the field; that it is 'interpretive' vis-à-vis the researcher-subject interaction aligning within a constructivist epistemology; and that it be 'empathetic' reflecting the emic, subjective experiences of the research participants (Stake, 1995; Yazan, 2015).

Defining the Case

The 'Case' in this study is 'the context of the COVID-19 pandemic in Kupang Capital Municipality and Regency, Nusa Tenggara Timur, Indonesia in 2021.' The context includes the sociocultural, structural, material, health system, and political-economic dynamics operating within the culturally and economically heterogeneous area of the greater Kupang provincial capital during a time of heightened urgency arising from the COVID-19 public health emergency. Kupang as a site, and COVID-19 as a public health subject of investigation, were selected for several reasons. Over the years, I have developed professional relationships with several government officers and colleagues in NTT, who have been instrumental in facilitating my ability as a foreign researcher to conduct research in Indonesia, thus reducing an already cumbersome process. This has provided a much-needed entry into the field during a time of difficulty with the social restrictions in place during the COVID-19 pandemic.

As a site of academic inquiry, Kupang is an interesting confluence of mobility and migration, making it culturally heterogeneous and dynamic, yet beleaguered by major health issues such as endemic infectious diseases, prone to natural disaster and drought, and facing innumerable developmental challenges around poverty, education, childhood malnutrition, and others (Dinkes NTT, 2018). The way COVID-19 has inserted itself into the morass of challenges NTT is facing provides both opportunity for social change as well as a useful case for studying social and behavioural responses to a global pandemic. The ethnographic instrumental case study of the phenomenon of COVID-19 in Kupang, NTT, is explored through qualitative inquiry using focused, ethnographic methods including in-depth interviews and focus group discussions, supplemented by observations in a naturalistic setting (Briggs, 2007; Creswell, 2013; Denzin & Lincoln, 2003; Liamputtong, 2019a; Vindrola-Padros et al., 2020).

A critical medical anthropology approach (Gray et al., 2020; Madison, 2005; M. Singer & H. A. Baer, 2018) guided the design of the ethnographic methods and theoretical framing of the data collection (Hammersley & Atkinson, 2019) and thematic analysis (Braun & Clarke, 2006; Braun et al., 2019) used during both the data collection in the field and the data analysis and theory building. The critical ethnography of health asks questions of who wields power over the control and distribution of agencies of biomedicine, how power is expressed in social relations through the delivery of health care, and what the political, economic, and ideological causes and consequences of power relations are (Nguyen & Peschard, 2003; M. Singer & H. A. Baer, 2018). A critical ethnographic methodology is 'explicitly political in its epistemic and empirical focus on challenging

power relations and political inequality' and posits 'what should be' instead of 'what is' from an overarching position of aiming at health equity (Madison, 2005; Shih, 2019).

In a diverse cultural context such as Kupang in Eastern Indonesia, a critical approach is especially useful, as interrogations into the acceptability and appropriateness of given epistemological systems concerning health, whether from a biomedical, religious, or traditional standpoint, are essential for analysing the COVID-19 phenomenon. Rather than tacit or explicit acceptance of hegemonic biomedical frameworks, such as through official health policy, critically investigating how patients, providers, and the community understand, describe, and enact the pandemic from multiple ontological stances serves to improve how public health interventions are designed and carried out. At the crossroads of 'multiple modernities,' Kupang presents a unique and diverse case for analytical consideration of the complex dynamics of pandemic response (Eisenstadt, 2000; Parker, 2018).

3.1.2 Analytical Framework

In developing a conceptual approach to the aims and questions of this dissertation research, I make use of critical medical anthropology approaches which examine the role of power relations within health systems spanning structural, social, and individual levels of analysis. Adapted from Baer et al.'s seminal work on critical medical anthropology, along with Scheper-Hughes and Lock's 'three bodies' heuristic, the analytical framework for this dissertation takes into account flows of local knowledge and the influence of hegemonic institutional power structures and influences wielded by governmental, religious, or other cultural/traditional organisations which concentrate economic, political, cultural, or other forms of capital (Baer et al., 1986; Scheper-Hughes & Lock, 1987).

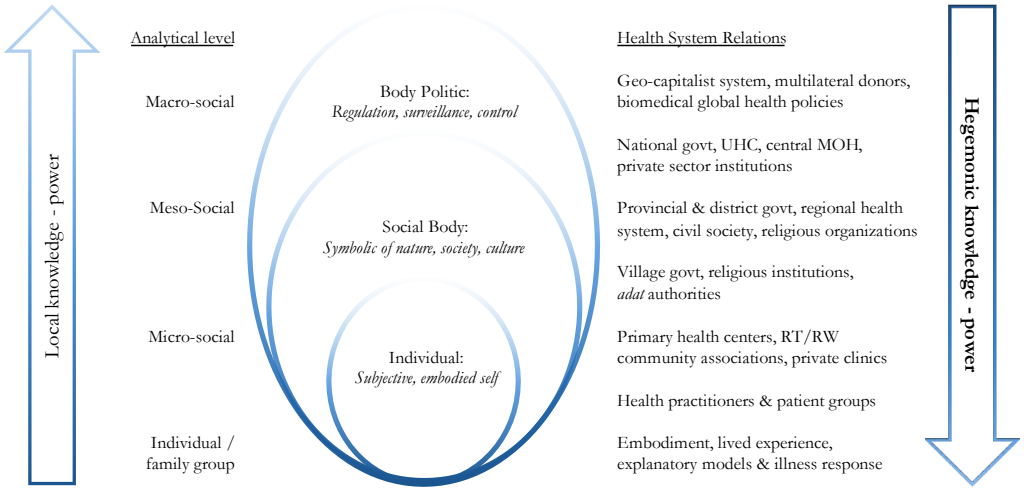

Figure 7: Analytical framework for organising research aims (Baer et al., 1986; Scheper-Hughes & Lock, 1987)

This heuristic model (Figure 6) posits four levels of analysis: individual, micro-social, intermediate or meso-social, and macro-social. These reflect a comprehensive recognition of the global, national, regional, and socio-cultural influences and relationships that affect individual health. I have framed these levels in relation to the 'three bodies' of the individual, the social body, and the body politic. Scheper-Hughes and Lock's foundational work on the 'mindful body' takes an anthropological perspective on how the individual body-self embodies structural inequalities through its expression of suffering and illness (Scheper-Hughes & Lock, 1987). It should be acknowledged that the 'individual' needs to be understood through contextual meaning as being locally defined or conceived. In the communal social structure of NTT, the individual may be the intersubjective permeable self that is defined by 'kinship' and mutuality of being (Carsten, 2013; Grøn & Meinert, 2017). As Geertz argued, the Western conception of the person "as a bounded, unique … integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgement, and action … is a rather peculiar idea within the context of the world's cultures" (Geertz, 1974, p. 31). I refer to the embodied selves and their social relations paraphrasing Farmer's notion of 'the ethnographically visible' (Farmer, 2004, p. 305).

The social body in this model encompasses meaning-making, interpretation and construction of illness as collectives of individuals negotiate and make sense of confluences of nature and culture. In the context of NTT, this implies how social or ethnic groups incorporate tradition (adat), religion, ethnic identity and language in framing understanding of disease processes, etiologies, nosologies, and explanatory models of how and why illness occurs (Good & Good, 1981; Kleinman, 1988). Specifically, the animist traditions which are syncretic with colonial Christian movements, infused with local politics, form the basis

from which many NTT 'social bodies' experience and explain the universe (Dang et al., 2016; Hägerdal, 2015; Katubi, 2019; Webb, 1986).

The third nest of the holarchy is the body politic in which its stability rests on its ability to regulate populations and discipline social and individual bodies. In this research, a tension is recognised between the modes of bodies politic in modernity and a 'mixed modernity' or mixed rationality that may present itself in the indigenous, traditional contexts of NTT (Fassin, 1996; Giddens, 2013; Nguyen & Peschard, 2003; Reed & Weinman, 2018).

Within this model, I incorporate assumptions about the flow of knowledge and power, which are important in the context of epidemics in relation to the production and control of information and communication, surveillance of groups and individuals, and how information is legitimised through hegemonic processes, which are represented by arrows which reflect power gradients and the dominant directionality of knowledge (top-down, bottom-up) as it is understood in this context. Thus, local authoritative knowledge around COVID-19 for example has a weak influence and ability to legitimise itself compared to the dominant discourses generated from global sources which are reproduced locally from national to community levels, and which influence the social restrictions that we see associated with COVID-19 pandemic control.

As a heuristic device, this framework uses ethnography as its methodological tool to fill in the contextual details with thick description arising from field work in the community. Kleinman and Kleinman note that a primary purpose of ethnography is to ask the question 'what's at stake' for the community being studied, thus situating the 'intent' of the research (Kleinman & Kleinman, 1991). The textures of community life in the context of the emerging pandemic can be framed against the notion of 'social suffering'; a useful trope from which to approach the investigation of a pandemic (Bourdieu, 1999; Kleinman, 1997; Kleinman et al., 1997; Wilkinson, 2004).

3.1.3 Considering Positionality, Culture, and Language

The notion of reflexivity is tied to validity and trustworthiness within a qualitative research paradigm, and is used as one component in the evaluation of the rigour of qualitative research (Creswell, 2013; Lincoln, 1985). Reflexivity is the 'process of reflecting critically on the self as researcher, the "human as instrument"' (Guba & Lincoln, 2005, p. 183) and influences our choice of research problem to investigate, and how we engage the research endeavour within the context of our 'multiple identities that represent the fluid self in the research setting' (Guba & Lincoln, 2005, p. 183). Crucial for the effective implementation

of qualitative research is that reflexivity is utilised in the conduct of data collection, such as evaluating methods of enquiry, revising data collection instruments, and encouraging open participation and discussion with the research team, for example. Additionally, reflexivity is important in ensuring that the researcher themselves are aware of their positionality within the overall frame of the project.

In contrast to research conducted under a positivist paradigm in which the researcher is largely 'written out' of the research process in a way to provide value-free objective data, the qualitative constructivist/interpretive paradigm of this research relies on language and communication as being central to the data collection and analytical process (Hennink, 2008). Thus, while a positivist approach sees language as a medium through which to access information from an external or 'etic' vantage point, the constructivist paradigm engages with language with the aim of achieving an insider or 'emic' understanding of the culture or phenomenon (Hennink, 2008).

Positionality

Researcher positionality arises from a combination of 'facets of the self' such as professional identity and privilege, as well as facets of 'social identity' such as nationality, class/caste, age, socioeconomic position, religion and sexuality (Rose, 1997). This positionality can give rise to power dynamics which influence the outcomes of social events such as interviews or other data collection methods in the field, as the relationships between participants and researcher is negotiated (Loftsdóttir, 2002). Thus, it is crucial that the researcher is aware, via their own reflexivity, of the influence of positionality and how it impacts upon research outcomes, especially in cross-cultural and cross-language ethnographic contexts, such as in the present research project (Guba & Lincoln, 2005; Liamputtong, 2008a).

The implications for this study on COVID-19 stem from my positionality: ontologically, I embed myself professionally within a realist stance which sees the physical or noumenological worlds as existing independently of the sociocultural meanings generated from and about an independent world. Thus, for me there are viral entities, biomedical cultural systems, and a world beyond the sphere of a socially constructed overlay of meaning ascribed to these entities. However, my approach as a researcher within the constructivist paradigm recognises the ontological multiplicity of social worlds that extend beyond a positivist or realist definition, and which can only be navigated through the vocabulary of complexity.

The epistemological implications of this stance are such that the complexity of the sociocultural phenomenon of the COVID-19 pandemic are best studied through shared

meaning-making with the subjects of the research. In this case, this means to explore representations of experience through in-depth conversations with members of the bounded case, allowing their emotional, psychological, and non-time bound reflections, memories, and projections to come through in a naturalistic setting. Ontological multiplicity, or ontological relativity as Denzin and Lincoln (2017a) called it, in which multiple realities are acknowledged, allows for the position of researcher-as-outsider to approach a phenomenon which fully accepts the positions, perspectives, and realities of the culture under study. It is in the epistemological sharing and generating of knowledge through interactive methods of data collection that these disparate or overlapping ontologies come together without resorting to essentialising or oversimplification of the complexity of the phenomenon.

As a specific example, I discovered that respondents in this cultural setting expressed disbelief in COVID-19, stating that it was a conspiratorial design by 'big pharma' or other nefarious entities meant to generate income (via material products of PPE, tests, medicines, hospital stays, etc.), or as a method of social control (see further discussion in Section 2: Research Findings). As a researcher, I am presented with a choice to interpret this via my own ontological framing of the world from a Western biomedical perspective which recognises an externally and independently extant viral entity and a concomitant, albeit culturally derived disease category, or as a social science researcher allowing for ontological multiplicity firmly grounded in the facts of how social meaning about the objects in "a" world is generated. My analysis must be grounded in an ungrounded contingent world, otherwise I am left with moral or value judgements that are partial towards one 'system' (i.e., biomedical, realist, positivist) rather than from an authentic, emic, relativist stance. Thus, the analytical perspective taken in this research is not seeking 'conversion' of life worlds, but rather a translation and back translation of understanding and perspective.

This has important implications for the practice of health policy development and implementation, which is the aim of public health discourse in this case; ultimately, this topic is investigated not only as an academic enterprise to take a snapshot of the pandemic in a given social context but is ultimately intended as a model for improving engagement between health authorities and the community aimed at improving health outcomes. This is a complex challenging endeavour when considering that the job at hand is to delineate, demarcate, and describe the relationships between the inner worlds of people with disparate and possibly irreconcilable ontological understandings of the world, and the aim of designing interventions from a standpoint of difference.

Cross-cultural Research

Liamputtong recognised four salient issues when discussing cross-cultural research: cultural sensitivity, language and the use of bi-cultural researchers, gaining access to the 'field', and ethical issues in cross-cultural research (Liamputtong, 2008b). The following summarises the key areas which should be considered when embarking upon cross-cultural research:

1. Cultural sensitivity: high degree of knowledge of the cultural context, tolerance for ambiguity, patience, adaptiveness, capacity for tacit learning and courtesy, and ability to ask culturally relevant and appropriate questions
2. Language issues: preferable to be a cultural 'insider' sharing cultural and linguistic characteristics, employing a 'bicultural' assistant for conducting field research who can understand and translate subtle cultural cues, meanings, and interpretations
3. Gaining access: engaging gatekeepers or key stakeholders who may be leaders of informal community groups or have extensive networks within the target community, or using a 'cultural broker' who serves as a link between the researcher and the community, but who is culturally different
4. Ethical issues: sensitivity and focus must be on the impacts of cross-cultural research, especially in marginalised communities, must use culturally appropriate ways to collect and disseminate information, feedback and making results available to communities is important to avoid ethnocentric interpretations, or may be of no benefit if results and information is not shared appropriately (Liamputtong, 2008b).

As a foreign (Western) researcher conducting short-term field work in a cross-cultural, cross-language setting in eastern Indonesia, I incorporated Liamputtong's recommendations into the research design and implementation to reduce potential negative influences of researcher positionality. I recognised that my identity as a Westerner could potentially invoke neocolonial sentiments in some respondents, especially in older community members. I was also aware of the sensitive nature of the topic under discussion, often relating to death, illness, and suffering. In addition, my limitations in the local dialect of the Bahasa Indonesia (national) language necessitated intervention as well. I have lived in Indonesia since 2012, and my knowledge and use of Bahasa Indonesia is proficient, but not yet fluent.

Tied to positionality is trust and trustworthiness which frames the ethical conduct of the research and has implications for the researcher and the research team (e.g., trustworthiness of the people collecting data in relation to participants involved in the research) (Liamputtong, 2008a; Ryen, 2008), as well as the trustworthiness of the research project itself, aligned with the assessment of authenticity in Guba and Lincoln's framework for paradigm positions in qualitative research (Guba & Lincoln, 2005). While the latter is a methodological concern, remedied through careful design and reporting, the development of trust between researcher and participant often relies on extensive relationship building in the field through prolonged exposure and contact (Hammersley & Atkinson, 2019). To ameliorate the development of trust in the absence of an extended time period, I relied on cultural insiders who could facilitate acceptance and some degree of trustworthiness in the communities engaged in this research (Atkinson et al., 2001).

To address these issues and potential threats to the validity of the data being collected, I engaged a small team consisting of two bicultural field research assistants rather than a professional interpreter, in line with Liamputtong's and other scholars' recommendations from the academic literature (Hennink, 2008; Liamputtong, 2008b; Temple & Young, 2004). I was able to navigate the subtle complexities of issues associated with conducting cross-cultural research, primarily linguistic and sociocultural, by using bicultural assistants who had insider access and understanding of the local context. My team consisted of two women who were employed as mid-level government officers, one with the Ministry of Health and one with the Ministry of Women Empowerment and Child Protection. They both hold master's degrees in public health, one from a local university and one from an Australian university, and both are native to NTT and speak the local dialect fluently as well as Bahasa Indonesia and English.

The research assistants had previous experience conducting qualitative field research, including conducting in-depth, qualitative interviews, data recording, and facilitating focus group discussions. I trained the team in the details of how to approach open-ended unstructured interviews to address the research questions, as well as other techniques to avoid typical pitfalls in qualitative interviewing, such as leading the respondents or introducing other biases. We also held practice interviews with volunteers to test the interview guide, as well as going over the details of the technical and logistical aspects of the research endeavour. Their involvement in the public sector in addition to their relevant academic history ensured familiarity with the topics under consideration, the research aims and objectives, cultural sensitivities, and approaches to in-depth interviewing.

The team worked together on all aspects of the field research, including adapting the interview questionnaire guides, conducting and transcribing the interviews, and most importantly, serving as a reflexive 'think tank' on the knowledge being generated during data collection. Specifically, the research assistants served as primary translators during the interviews and focus group discussions as well as helping to collate field data, organise field visits and logistics, and scheduling interviews with respondents. This enabled me to refine my approaches and improve the quality and breadth of data being collected during the interviews. By using an unstructured conversational interview technique that was based on our questionnaire 'guide', we were able to explore topics that were unique to each respondent, securing a richer tapestry of responses and details. In the next section, I outline the research questions under investigation.

3.1.4 Research Questions

The aims of the research were:

1. To explore the local context of community perceptions and responses to the COVID-19 pandemic in one urban and one rural district in Nusa Tenggara Timor, Indonesia
2. To investigate the extent to which local knowledge and practices are recognised in the overall COVID-19 response strategies, and to explore the relationships between the community and health providers
3. To contribute to the development of contextually appropriate recommendations arising from an in-depth investigation of perceptions, understandings, and knowledge that can improve public health outcomes by utilising contextual information in decision-making

Three broad research questions were posed as a way of accommodating reflexivity and flexibility in research design and data collection to address the research aims, recognising that the COVID-19 pandemic was a novel, constantly changing, dynamic, and unfolding biosocial phenomenon in eastern Indonesia (Abramowitz et al., 2015; Liamputtong, 2013, 2019a). The unique and unprecedented nature of the pandemic and how it manifested itself socially in NTT necessitated an open, exploratory, and inductive approach (Agee, 2009; Creswell, 2018; Denzin & Lincoln, 2017b; Liamputtong, 2013), reflected in the final research questions developed as follows:

How are communities in Kupang City and Kupang District [the catchment area of the provincial capital] in NTT, Indonesia experiencing the unfolding COVID-19 pandemic and associated social restrictions and uncertainty?

The aims of this question were to explore personal and community understandings, experiences, and behaviour, primarily achieved through personal representation via in-depth interviews supplemented by field observation. This allowed for unfettered open discovery of multiple themes arising from personal experience, reflection, and interpretation by respondents. For example, responses encompassed an ontologically distinct spectrum of representations such as expressing doubts about the existence of the SARS-CoV2 virus on the one hand, to the recognition of a Western biomedical explanation of the causative agent of the pandemic on the other. This research question encouraged exploration of how knowledge is legitimised, transmitted, and embodied in practices related to pandemic response and control. Further broad themes that emerged included trust and mistrust, risk perception, uncertainty, stigma, spirituality and religious beliefs, social suffering, access to information, and personal reflections on the enactment of the pandemic through engagement with human and non-human agents or materialities, such as the tools of containment: masks, viruses (real or not), molecular tests, PPE, and the invisible social barriers set up by policy. These themes are further explored in Section 2: Research Findings.

How are public health responses to COVID-19 enacted within the fields of community social dynamics, local knowledge, geographies, and multiple life worlds regarding the pandemic?

This research question aimed to explore the 'results' of what is seen in terms of the translation of the global 'assemblage of discourses' as it appears in the local context, as well as investigating how the pandemic is enacted in Kupang. I explored questions about the prioritisation of health issues, perceptions, and behaviours on social restrictions, access to information technology, health beliefs, and the experience of stigma. This also included exploration of how the community positioned itself in relation, or in opposition, to hegemonic biomedical policies, regulations, and practices in response to the new pandemic. There was also investigation into the interruption of traditional practices around sickness, death, and funerals. While the term 'life world' is associated with Husserl's phenomenology, I use it here in place of 'world view', as the terms have distinct philosophical implications.

What are possible opportunities for improving public health responses and community well-being during the pandemic?

This question was designed to explore the implications of research from an ethical and knowledge transfer perspective, specifically exploring areas of deficiency around communication, understanding, compliance/adherence, as well as focusing in on specific challenges faced by the community and the health authorities. I envisioned that the data generated in this topic would lend itself to recommendations or insights into manners of ontological translation, or at least create sparks of opportunity to improve knowledge and practice around the COVID-19 situation.

The aims of the research were to investigate the extent to which local knowledges were taken into consideration when designing public health interventions implemented by government health officials, and to contribute to the development of contextually appropriate recommendations arising from an in-depth investigation of perceptions, understandings, and knowledge that can improve public health outcomes by utilising contextual information in decision-making. Follow-up dissemination of the research results were to be conducted with stakeholders and community members in Kupang subsequent to thesis finalisation, planned for early 2022. Observations and recommendations following discussions will be compiled and submitted to central and provincial authorities, as per the requirements of the foreign research permit and with the aim of ensuring collaboration and use of data arising from this fieldwork.

3.2 Speaking of Contagion: data collection methods and analysis in the *Covidscape*

3.2.1 Securing foreign research permits

The process for securing multiple, official Foreign Research Permits at national, provincial, and local levels began in May 2020, with all Indonesian government approvals being formally granted by March 2021. Details of the process, as well as formal approval documents are found in Appendix 2. In the next section, I will discuss the data collection methods.

3.2.2 Exploring COVID-19 in the field

Completion of all permits and approvals paved the way for actual field data collection in Kupang, NTT, in eastern Indonesia, conducted during the period of 7 March to 15 April 2021. Data collection was conducted around various locations spread over 14 villages

within the greater Kupang area, spanning both the municipal and regency catchment areas of the capital.

Primary field data collection for this case study consisted of two methods: 1. ethnographic qualitative interviews with individuals from the community, and 2. focus group discussions (FGD) with government health workers. These two data collection methods were supplemented by informal observations I made during my time spent at the field sites, which included observations of interviews and group discussions as both data gathering and social events, as well as observations of events and occurrences while in Kupang, such as attending a non-COVID-19 funeral ceremony, church liturgies, spending time in the traditional markets, etc. Field notes were taken daily and referred to as I developed analytical and interpretive frames of the data as it was generated. To ensure interpretive accuracy, and to amend and refocus my data gathering strategy, I discussed reflections and summaries of each interview and FGD with my bicultural research team. This supported decisions on amending the data collection instrument, such as the open-ended question guide and the respondent sampling strategy.

3.2.3 Interviews

One-on-one, in-depth interviewing as a method for data collection is foundational in qualitative research (Liamputtong, 2013), as it is an important tool for exploring 'socially situated life worlds and of individuals and groups and recording a rich source of knowledge on the distinctive views and perspectives of our informants' (Braun & Clarke, 2013). Semi-structured interviews were chosen as the primary method to address the research questions, using an interview guide developed to focus interview conversations within the bounds of the case of interest. The interview guide was a dynamic and 'living' document which was amended to better target questions depending on the type of respondent. Due to the nature of the interviews and the ethnographic nature of the investigation, a spectrum of interview styles was employed, ranging from formal, sit-down affairs to informal conversations with small groups of respondents. I conducted all interviews with the assistance of bicultural assistant translators during data collection.

Developing Interview Questions

Question guides were developed at the proposal stage of the research to structure the field interviews to gather as much detailed information as possible about the experiences of community members in Kupang during the pandemic. In designing the question guide, I

focused on encouraging deep discussion about beliefs, trust, economics and livelihood, stigma, understanding and explanations of biomedical approaches, power dynamics, and behaviours. The guiding questions can be found in Appendix 5; however in practice, each respondent had a unique set of discussion points and topics depending on their individual experiences, stories, and representations. Thus, the research team would engage conversationally and follow the stories while remaining within the bounds of the case under study. This was a challenging component of the field work, as I was course-correcting on the fly and adapting interview questions while remaining mindful of the research questions to be answered, while also adhering to proper cultural mores and social rules.

Recruitment of Participants

As this was an exploratory instrumental case study using ethnographic methods, the sampling frame was intended as a cross-section of society impacted by COVID-19, designed to identify respondents with a range of views and perspectives. Together with my bicultural research team, I thus approached each village distinctly with the aim of selecting three to four respondents from each village, tailoring as much as we could to identify appropriate participants. For example, in Oesapa, we engaged a small group of fishermen as the village was located by the seaside, whereas in the inland village of Nunleu, there was a large public sector hospital, so we chose to interview one of the ICU nurses.

I used a purposive sampling strategy, which is a non-probability strategy which outlines the parameters or characteristics of respondents who are best positioned to provide insights and data towards answering the research questions and which is designed to achieve maximum respondent variety (Guest et al., 2006; Liamputtong, 2013). Purposive sampling was used to achieve both breadth and depth of knowledge from a non-statistical sampling frame in line with accepted ethnographic methods. However, as I used semi-structured conversational interviews, I did not want to limit the data collection to the saturation of *a priori* themes, and thus took an ethnographic approach in which I investigated as many different 'cases' within the 'Case' to gain a better understanding from this heterogeneous group.

Access to participants at the community level was facilitated by village level bureaucrats, called the 'Kepala Lurahan' ('Sub-district Head') in urban districts, and the 'Kepala Desa' ('Village Head') in rural districts[14] (hereafter referred to as 'Lurah' and

[14] Indonesia's simplified governance structure: 34 provinces are divided into Regencies (Kabupaten) and Cities (Kota), further divided into Districts (Kecamatan) and then into Villages or Sub-districts (Desa or Kelurahan), with the most 'community based' division at the RT/RW level.

'KepDes' respectively). These were the *gatekeepers* who were responsible for assessing our piles of documentary credentials and approvals prior to granting access to their community, as well as identifying and facilitating contact with respondents living within their catchment area. In ethnographic research, gatekeepers are members of the social group under investigation who can facilitate entrance into the 'field', introduce the research team to appropriate participants, and help provide important sociocultural insights (Atkinson et al., 2001; Hammersley, 2006; Hammersley & Atkinson, 2019).

After prior arrangement and sharing of relevant project details, the team would meet face-to-face with the *Lurah* or *Kepdes* to gain approval to sample from their district and interview them directly or subsequently. The positive relationships developed with the Lurahs were crucial to the progress of data collection, as they were gatekeepers not only in the bureaucratic sense, but also had their hand on the pulse of the communities they served. They were instrumental in recommending participants and providing insight into their communities as leaders and as members. Through the Lurahs, we were able to make direct contact with COVID-19 patients, caregivers, and others which would have taken considerably more time for the research to engage without their support.

Decisions about detailed participant selection and sample size per village were made as a team following discussion and reflection after each interview, which included myself and two bicultural research assistants, as well as inputs provided by our hired driver based on his extensive knowledge of the community and geography. These discussions often involved the Lurahs as important sources of community knowledge. In this manner, we constructed a reflexive and responsive data collection strategy which began with a semi-structured question guide that would be revised and tailored to each participant within the framework of answering the research questions and which proceeded with identifying participants that sequentially added new information, confirmed previously discovered information, and enabled us to cast a wide gaze over the community within the confines of our research topic. Total sample size calculation for this type of qualitative research is a topic of contention, and many authors argue for assessing data saturation as an indicator of adequate sample size for interviews (Braun & Clarke, 2021b; Francis et al., 2010; Guest et al., 2006; Hagaman & Wutich, 2017; Hennink et al., 2019). However, given the broad and diverse population from which this study sampled, I avoided sample size calculation based on ill-defined notions of saturation and instead elected to focus on bringing as many perspectives and experiences from multiple stakeholders as possible into this population sample. The qualitative focus of this research necessitates depth of investigation rather than

adhering to strict calculus of 'representative bodies.' Characteristics of the sampling criteria follows:

Standard inclusion criteria for all interview participants were:

1. Adult, aged over 18
2. Must identify themselves as an indigenous local member of the community (non-immigrant) having resided in the community for a minimum of 10 years (in Kupang Kota and Kupang Kab.)
3. Participants should not be related to the village authority, unless specifically identified for potential supplemental interviews (religious leaders, health volunteers, village heads, etc.)
4. Within the small number of participants to be selected, the research team would attempt to identify a broad range of respondents to ensure representation from working aged men and women, the elderly, householders, and employed individuals.

Conducting Interviews

In total, 40 in-depth interview events were conducted by the author with the assistance of bicultural translator research assistants in and around the greater Kupang area among a cross-section of participants from the community, predominantly as one-on-one interviews, but occasionally conducted as small group interviews. Salient participant characteristics are outlined below in Table 3, representing a broad collection of professions, ages, and life worlds.

Table 4: Respondent occupation and gender by sector of work

Job Types	**# / Gender**
Government Sector: Village Head; Midwife; MOH Department Head; Army; RT Representative; Pulmonologist (w/private practice); primary health care staff; Head of District	Male: 12 Female: 10
Private Sector: Tour Guide; Homestay Owner; Kiosk/Shop Owner; Teacher; Catholic Priest; Protestant Pastor; Retired; Security Guard; Bemo Driver; Ambulance/Morgue Staff; Fisherman; Academic; Pharmacist; Housewife; Lab staff; journalist; vendor at traditional market; student	Male: 28 Female: 8

Participants were initially contacted by their respective Lurah/KepDes prior to the research team contacting them directly. This normally took place through WhatsApp (WA) communication, as all the Lurahs had the residents' contacts on a community WA group.

Prior to meeting with the team face-to-face, respondents were provided with a digital version of the research information sheet via WA or email, allowing them time to familiarise themselves with the research objectives.

Once a schedule was agreed upon, the participants were met at a location of their convenience, either at work, at home, or in some other preferred private location. All individual participants were then briefed on the research topic and objectives, provided with a physical copy of the research information sheet (found in Appendix 4) to read (or to be read aloud by the research team, if needed), and were then walked through the Informed Consent Form which was signed by each participant prior to starting the interview.

In the event of unplanned, spontaneous, and informal small group discussions, the team found it challenging to interrupt and formalise the discussions with the introduction of the ICF paperwork. While respondents were aware of the purpose of the research and granted permission to record the discussions, I approached these events as ethnographic instances in which informal chats were occurring in a shared space. I trusted the advice of the research team as they avoided complicating a spontaneous social event happening in a public space, especially during a time of enhanced COVID-19 surveillance by the government. Thus, for three informal small group discussions, I was unable to get signed ICFs, but still included the data in my analysis.

Interviews were conducted in naturalistic settings, with the research team travelling to places of work, homes, markets, seashores, churches, hospitals, and anywhere that the respondents preferred to have the discussions. As social events, the interviews at times took on a ritualised, semi-formal appearance, characterised by formal introductions and particular seating arrangements across a desk, which were reflective of the positionality of respondents' relationship to the interviewer. This was notably the case with government officials who were interviewed at their place of work. For others, interviews were informal conversations, taking place on the beach, or in a church, or casually discussing COVID-19 in an open-air market next to the fish-sellers. I wanted the respondents to feel comfortable and for the conversations to flow as naturally as possible. My intention was to encourage normal, natural exchange so that we were able to achieve some level of trust, given the constrained timeframe.

A slight challenge to this informal approach was the use of a Sony ICD-UX570 digital recorder for all interviews which may have influenced the sense of formality of the discussions at the beginning, but I found that almost everyone forgot they were being recorded almost immediately. The business of embarking on the interviews included the reading and discussion of the research information sheet and research objectives, the

signing of the Informed Consent Form, and the sorting out of the placement of the microphone for the recorder. Once these formalities were out of the way, I found that the interviews flowed naturally and the participants were often remarkably engaged with the research team. Each participant received the standard participation payment allowance as per the local standard.

Avoiding the awkwardness of real time interpretation, all the interviews were conducted directly by one of my bicultural research assistants in the local dialect or in Bahasa Indonesia as appropriate. Given my level of proficiency in Bahasa Indonesia, I participated and guided the interviews as they occurred without resorting to English-to-Bahasa interpreting.

Focus Group Discussions and Triangulation

To better contextualise the data generated from the interviews, I conducted two focus group discussions (FGDs) with government (public) health officers in two locales. The aim of the FGDs were to explore the perspectives of health staff regarding the practices of the community during the COVID-19 pandemic, thereby triangulating representations from the interviews with perceptions by government health officers. This served to confirm what was arising during the interviews, as well as providing insight into relationships between the health system and the community and identifying areas for potential intervention and improvement of public health programs. Triangulation aims to improve the credibility and quality of data generated in qualitative research, and includes methods triangulation, triangulation of data sources, triangulation of multiple investigators, and theory triangulation (Patton, 1999). For the purposes of this project, I used *methods triangulation* to vary the type of data collected to address the research topics, combining in-depth interviews with FGDs (Carter et al., 2014; Patton, 1999). Methods triangulation, defined by Patton and expanded upon by Flick, combines multiple data collection methods towards creating a ‘surplus of knowledge’ around a phenomenon and thus illustrating different forms of an issue which may contradict or complement one another (Flick, 2018; Patton, 1999, p. 23). Extra knowledge generated about the issue at hand, e.g. community perceptions and local knowledge, includes both a ‘convergence of findings as well as irreconcilable contradictions’ (Flick, 2018, p. 19), enriching the analytical and theoretical landscape. In this case, the FGDs with health staff were used to triangulate data generated from the in-depth interviews as a way of approaching the issue from multiple perspectives.

The FGDs were conducted by the author (myself), supported with translation assistance from my bicultural research assistants, with 15 participants at the Kupang City

Health Office and 14 participants at the Kupang District Health Office representing doctors, nurses, surveillance and lab staff, and management. Refer to Table 4 for details.

Table 5: Health care officers from focus group discussions

Public Sector Job Types	# / Gender
Municipal (City) Kupang FGD Surveillance, Health Staff, COVID Data Management, Patient Tracing, Section Head (Mgmt.), Public Health Facility Director, Midwife, Analyst, Logistics, Hospital Physician	Female: 14 Male: 1
Kupang Regency (District) FGD Nurse, Midwife, Physician, District Health Office Data Staff, Public Health Facility Director, Diagnostic Laboratory	Female: 11 Male: 3

FGD Topics

The questions developed for the FGDs were designed to elicit health worker perceptions of community practices and behaviours. As the roles of the government health workers spanned membership in 'biomedical health worker' and 'community' identities, their insights were useful in clarifying, supporting, and contradicting community responses made during the interviews. Small breakout groups of 4 to 5 participants each were formed to discuss topics such as sources of COVID-19 information in the community, beliefs or explanatory models for behaviours, especially around non-adherence to mask wearing or other individual non-pharmaceutical interventions (social restrictions), and exploration of relationships with the health system. All FGDs were digitally recorded and transcribed for thematic analysis.

FGD Participant Recruitment

All participants were from the district or community level health centres/hospitals, from the Municipality (city) Kupang, or from the Kupang Regency. As per government standards, a formal invitation was sent from the heads of the Kupang City Health Office and from the Kupang Regency Health Office to the respective hospitals and public health facilities with the named participants on the list. The selection criteria were purposive with the aim of having representatives from management, lab services, surveillance, and clinical care to provide a broad range of perspectives. Participants were then given leave from their official duties to attend the FGD and were provided with the government standard per diem and research participation stipend.

Interview and FGD Data Analysis

Empirical data collected via interviews, group discussions, and informal observations in the field were compiled for subsequent analysis to address the research questions for this study. Analysis of the qualitative data began concurrently with the initiation of field work through a process of reflection and review of field notes and interview content.

The total duration of all digitally recorded interviews and group discussions (focus groups and informal) amounted to 31 hours and 13 minutes. All interviews and discussions were initially transcribed verbatim into Microsoft Word from the digital recordings by the research team. To ensure the quality of the data, transcriptions were provided to the research participants for review. This was important due to the challenges in transcribing informal conversations in the local dialect, often with the participants wearing a mask during the interviews to adhere to COVID-19 health protocols. In some cases, participants did not use masks particularly when outside in open markets or when being interviewed at home. Regardless, the research team always adhered to strict social distancing, mask wearing, and frequent hand washing/sanitation practices.

Transcripts were then translated into English by an academic team from the Center for Decentralization and Participatory Development Research at Padjadjaran University in Bandung, West Java, with whom I had previously developed a collegial relationship with through my work in Indonesia. I chose to engage this team to ensure adherence to academic research principles and for budgetary reasons, as the cost of commercial translation services was out of reach.

Translation issues are of major methodological concern as failure to adequately and systematically address cross-language issues will reduce the trustworthiness of the data and the quality of the research (Squires, 2009). Efforts were made to ensure the trustworthiness of the data in reference to the quality of translation with a focus on ‘conceptual equivalence’ across transcriptions and that intended meaning was retained (Squires, 2009). As ‘methodological and epistemological challenges arise from the recognition that people using different languages may construct different ways of seeing social life,’ the task involved in translating becomes one of ensuring fidelity to the source and honest interpretations of meaning in the analysis (Temple & Young, 2004, p. 164).

A sample of 25% of the English language transcripts were then back translated into Bahasa Indonesia and reviewed by the research team in Kupang for accuracy, conceptual equivalence, and retention of meaning as compared to the original transcripts and audio recordings (Mohamad Nasri et al., 2020; Squires, 2009). Back translation entails the translation of documents from the target language (English) back to the original source

language (Bahasa Indonesia), with evaluation by bilingual or bicultural individuals familiar with the subject matter to ensure retention of meaning (Chen & Boore, 2010; Ozolins et al., 2020). Once the translations were signed-off by the research team, all transcripts were uploaded case by case into QSR International's NVivo qualitative data software, Release 1.4.1 in 2021 (QSR International Pty Ltd., 2021) for the purpose of aiding in data organisation, assigning codes, and facilitating thematic analysis. The case transcriptions were then analysed using an inductive, reflective Thematic Analysis (TA) method, as detailed in the next section (Braun et al., 2019; Clarke & Braun, 2018).

3.3 Thematic Analysis

The analysis itself was guided by the *Thematic Analysis* (TA) method meant to capture discrete patterns among qualitative data sets by identifying and codifying themes arising from transcriptions and other text being investigated (Braun et al., 2019). For the purpose of this research, I followed Braun, et al.'s definition of a 'theme' as 'reflecting a pattern of shared meaning, organized around a core concept or idea, a central organizing concept' (Braun et al., 2019, p. 845), which aligned with my interpretive epistemological position taken throughout the research. By focusing on patterns of shared meanings among the sample set of interviews, the data was analysed beyond a semantic or reframing categorisation of 'domain summaries' exploring subjective meaning, sense-making, and reflections arising from the social field (Braun & Clarke, 2021a).

Approaches to TA span a spectrum from positivist 'coding reliability' to interpretive 'reflexiv[ity]' for qualitative analysis (Braun et al., 2019). I opted for the latter, in which the coding process of TA is iterative, in which codes evolve in a dynamic manner, combining and separating and reorganising themselves in a coherent but interpretive manner throughout the analytical phase of the research.

Underpinning this type of analysis are assumptions regarding data collection prior to analytical work specifically around sample size determination using the concept of 'data saturation' or 'information redundancy' commonly cited in qualitative research methodologies. I took a critical position on this aligned more with ethnographic approaches as well as with TA:

> *One problem with an information redundancy conceptualization is that it relies on an understanding of meaning as transparent and obvious prior to analysis. As TA (often) involves identifying new patterns of meaning, and this usually happens after data collection, analysis is necessary to judge whether the information generated by participants offers something new or not. Researchers who claim saturation, then,*

> *seem to rely on potentially superficial impressions made of data during data collection (Braun et al., 2019, p. 851).*

If we posit our epistemological stance as a constructivist/interpretivist, then we must therefore reject demarcations of 'knowledge generation' or the active creation of knowledge during interviews as being subject to a simple notion of redundancy or 'saturation'. As each exploration provides unique and varied information, perceptions, and understandings, we must decide at what point the overlaps in related meanings, or 'themes', become significant in our analysis and interpretation. From an ethnographic position, the use of nomenclature such as 'coding' and 'saturation' is problematic for some authors (Atkinson, 2015), yet for the purpose of this research study, I used a bricolage approach to the data collection and analysis, layering methods and analytical methods in a reflective and logical manner, while remaining open to the spirit of open interrogation of data as constructive and subjective (Denzin & Lincoln, 2017a).

3.3.1 Six Phases of Reflexive Thematic Analysis

Braun and Clarke proposed six phases for a reflective TA of qualitative data which guided the analysis of this research:

Table 6: Reflective Thematic Analysis (Braun et al., 2019, pp. 852-857)

Phase	Description
Familiarisation with the data	Shifting from data generation to analysis, reading, re-reading, and thinking about the collected data and how it fits with the research questions
Generating codes	Focused attention on systematic engagement with the data; codes can be inductive (bottom-up from the data) or deductive (using ideas, theories, and concepts to guide coding)
Constructing themes	Themes are built, moulded, and given meaning at the intersection of data, researcher experience and subjectivity, and research question(s)
Revising and defining themes	Compiling coded data for candidate themes, and reviewing them to ensure fit with central concepts; how do themes fit within the overall research
Producing a scholarly report	Writing to make connections to existing research and literature on the topic of interest, and weaving this into the written results and discussion and final analysis

Following this suggested analytical structure from the literature, my analysis began by re-familiarising myself with the data including the translated interview transcripts, field notes, and materials from the FGDs. This included reading each finalised transcript and recalling the context in which the interview took place, as well as reflecting upon each bit of data within the greater whole of the final data set. The data familiarisation phase enabled the start of the crystallisation of ideas around common responses, viewpoints, and perspectives in the community, as well as underscoring the diversity and complexity of ideas held by each of the respondents.

All translated transcripts were then uploaded into NVivo, version 1.4.1 2021 (QSR International Pty Ltd., 2021) as individual cases, or in the event of multiple respondents such as in the FGDs and small group discussions, each respondent's text narrative was encoded as an individual case. Thus, in some cases, a single transcript file could be 'coded' to multiple 'cases' within each document. Once complete, a total of 90 separate cases were generated from 47 transcripts including for individual interviews, small group discussions, and FGDs. Cases were classified by geographic association as being either in Kupang City or Kupang District, and attribute descriptions of each case were further delineated according to age group, gender, profession, village location, and work sector (public/government or private sector).

Next, code generation began by systematically going through each transcript and encoding sections of text, using an inductive method of coding. As opposed to testing theory and assigning pre-selected codes to the data set, I generated codes strictly from the data in an ad hoc manner. A distinction is made by Braun and Clarke in their coding typology between semantic and latent codes (Braun et al., 2019). Semantic codes tend to be close reiterations of a selected text fragment, or a general description (or domain summary) of the data, or even a rewording of the research question. Latent codes, by contrast, are meant to describe the meaning behind a given statement or set of statements that align with the research questions or aims, thus providing a deeper insight into the underlying social processes and context, rather than a list of categories or events. While most reflective thematic analyses use both semantic and latent coding, my aim was to focus on the latter to identify the underlying patterns among the reflections provided by the respondents. Once coding of all cases was complete, which included over 400 pages of transcribed text, a codebook was generated with 415 initial codes.

The next stage involved a revision of the coding in which similar codes were combined or edited, resulting in 309 codes. These final codes were then used to generate themes for an initial thematic framework. A process of re-reading the data and the coded

set of transcripts led to the development of an initial thematic framework that captured the essence of the data identified in the codes. Further refining resulted in the following thematic framework, which will be detailed in the Section 2 Research Findings, numbered according to sub-section within each chapter.

3.3.2 Thematic Framework[15]

Systematic, structural themes

4.1 Deficient leadership has exacerbated structural challenges in pandemic control

4.2 Power asymmetries from bureaucratic hierarchy has negatively impacted pandemic response

4.3 Ill-prepared health system overburdened by pandemic (mis)management

Sociocultural themes

5.1 Religious institutions fill a crucial gap in pandemic community support

5.2 Theology influences local cultural forms of pandemic explanatory discourses and practices in the community

5.3 Traditional knowledge (adat) has limited impact on community pandemic practice and experience

Individual/perceptual themes

6.1 Misinformation, hoaxes, and confusion leads to mistrust in hegemonic biomedical authority, and non-compliance

6.2 Pandemic restrictions have psychological and livelihood impacts on the community

6.3 Surveillance, sanctions, and mobility control as measures of containment

3.4 Brief Reflection on Post-colonial Bureaucracy

The preparation for field work conducted during this research was extensive and unexpectedly challenging, made noticeably more difficult due to the restrictions and social upheaval caused by the COVID-19 pandemic. I included details of the process in this chapter to elucidate an important component of setting the stage for subsequent methods of data collection which reflect how bodies are governed in Indonesia, both local and foreign. The convoluted bureaucratic process in Indonesia ensures that tight control is exercised over foreign researchers, in a manner that may have the effect of discouraging applications, thereby insulating the country from potential foreign influence vis-à-vis researchers in the field, influenced by the public sector's need to maintain authority over intellectual property, and to exert autonomy in a post-colonial governing structure based on protectionism.

Questions of power dynamics and governance, which I explored regarding pandemic COVID-19 control in eastern Indonesia, were relevant during the research

[15] Theme numbers refer to subsequent chapter sections per theme, e.g., Theme 4.1 is Chapter 4, Section 1, etc.

approval stages as I navigated and negotiated the networks of bureaucracy. The effects this experience had on the development of my methodological approach were twofold: first, engagement with the socially constructed bureaucracies of post-colonial Indonesia were a demonstration of the dynamics, control, and wielding of power that would be reflected at the local level in NTT, and second, that my approach to the research must allow for heightened flexibility, delays, and unanticipated roadblocks while conducting research in the field.

3.5 Research Ethics

Ethical considerations for this research extend to standards of basic ethical principles which include a respect for the autonomy and protection of people, fairness and justice, the reduction of harms, and ensuring maximum benefit for the research subjects (Doherty & Chopra, 2008). Ethical conduct of field research is an all-pervasive component of the methodology, which is implemented via several methods in this study. Informed consent is a principle of respect for persons, for privacy, and the right to confidentiality and anonymity in the conduct and reporting of research. Data protection and confidentiality were ensured to individual participants through the guarantees outlined in the Informed Consent Form (see Appendix 4), as well as maintaining password encrypted digital storage for all the gathered data. All names and identifiable features of the participants have been altered in this dissertation to protect identities and ensure confidentiality.

Deliberation and consideration were made regarding the ethics of conducting fieldwork during a global pandemic. The methodology of this research prescribed interviews and FGDs as the primary data collection methods, yet the benefits versus the risk had to be carefully weighed, discussed with the research team, and mitigated to reduce harms to participants and researchers alike. The team was monitored for COVID-19 through routine rapid antigen testing and masking requirements, whether in the car in transit to a field site, on a ferry crossing to an island, or in open public markets or other locations. Although our driver contracted COVID-19 during the time of our data collection, it happened during a lull in field work while I was convalescing with dengue. The driver had apparently been exposed at the local open air fish markets while not wearing a mask. Unfortunately, he was unable to continue working with us thereafter for health reasons, and to ensure the protection of the research team.

Ethics also pertained to the professional imperative of sharing and disseminating the research results to the participants, as according to Hammersley, the ‘only operational goal of [qualitative research] should be the production of value-relevant knowledge’

(Hammersley & Atkinson, 2019). The knowledge transfer component of this research was viewed as an essential part of the methodology, and the participants were informed at the outset of each interview that the results would be shared with them once complete. Ensuring that a summary of the results of the study would be disseminated to the appropriate stakeholders, including the government, was another ethical imperative in the design of the research.

As previously mentioned, the ethics of doing cross-cultural research require that investigators must be culturally sensitive to potential exploitation, asymmetrical power dynamics, and inadvertent sharing of information gained in the field with inappropriate stakeholders (Liamputtong, 2008b). In this research, by using bicultural research assistants, combined with my decade of experience living in Indonesia, served to ameliorate any potential cultural insensitivities or mishaps along the way.

3.5.1 Ethics Approvals

In addition to the government research approvals, the following ethics approvals were granted by institutions in Indonesia and Australia as requisite for conducting field data collection (see Appendix 1 for ethics approval documents):

1. Flinders University Human Research Ethics Committee for Social and Behavioural Research, Adelaide (Project Approval #2219, granted on 11/11/2020)
2. Indonesia Ministry of Health's National Institute of Health Research and Development Health Research Ethics Committee, Jakarta (Approval No. LB.02.01/2/KE.047/2021, granted on 25/02/2021)
3. University of Nusa Cendana Faculty of Medicine Ethics Committee for Health Research (under the Ministry of Education and Culture), Kupang (Approval No. UN02010209, granted on 16/03/2021)

As per the requirements of these ethics approvals, all digital data was stored on a password encrypted OneDrive account at Flinders University. All research assistants and transcribers signed a standard Flinders templated Non-disclosure and Confidentiality Agreement prior to having access to any data.

3.5.2 Presentation of Qualitative Analysis Results

Results of the qualitative data analysis, coding, and synthesis of themes using thematic analysis are subsequently presented in Section 2: Research Findings.

Section Two

Section 2: Research Findings

Introduction

In the three chapters of this section, I explore the research findings generated from time spent in observation and interviewing community members, health workers, and government officials as the COVID-19 pandemic was unfolding on the ground in Nusa Tenggara Timur. As outlined in Chapter 3, a thematic framework was generated from transcript and field note data which captured the major themes and the arc of the story of COVID-19 in NTT as I observed and experienced it, with the aim of addressing the research questions and providing insight into this phenomenon as it happened, as well as identifying areas to improve public health responses[16].

It came as no surprise to me that the political, sociocultural, and individual contexts were complex and peppered with inconsistencies and contradictions, and that simplistic reductions or framing of problems and solutions were elusive at best. As I delved into people's experiences during the past year of the COVID-19 pandemic, structural inequities affecting all aspects of pandemic control were brought into clearer relief, signalling the urgent need for systemic reform, innovation, and a focus on equity in the community. In this and the subsequent chapter, I assume a critical stance in my interpretation and framing of the data with the aim of outlining deficiencies in the public health response, while searching for best practices along the way.

Arriving in 'the field,' I had already resolved my position on the ontological stability of SARS-CoV2; it was my unchecked baggage that I carried along with me into my fieldwork, and which inevitably influenced my approach to understanding the local experiences of this novel disease in an area of the world which had not yet made up its mind. This tension between the known and the unknown, seeking to define and delineate the invisible unseen forces at play in this community, would become a recurring theme

[16] At the time of field work, the provincial vaccination program using Synovac (China) was just getting underway. While the interviews touched on vaccine hesitation or acceptance, this issue was not fully explored during data collection due to limited first-hand experience among respondents.

throughout the work. Reminiscent of Lowe's Viral Clouds[17], the SARS-CoV2 evaded capture, ever beyond my reach, like grasping at so much smoke from the fire.

As I embarked on the field work, the NTT government had just begun its vaccination program, focused on frontline health workers, and employing individual and collective non-pharmaceutical interventions including closure of businesses and restriction of operating hours, monitoring and restricting intervillage movement, and launching a '3M' and '3T' campaign (simplified from the initial 5M strategy) that outlined individual and health system practices to reduce the impact of the pandemic, adopted from the national MOH guidelines (Satgas Penanganan COVID-19, 2020). The 3M strategy outlines the following recommendations: 1. *memakai masker*, 2. *menjaga jarak*, and 3. *mencuci tangan pakai sabun* (wear a mask, keep distant, and wash your hands with soap), while 3T stood for Tracing, Testing, Treatment (curiously using the English and not translating into Bahasa Indonesia), ostensibly under the purview of the local health departments. Subsequently, 3K or -3K ('minus 3K') were also added, which had multiple (and thus mildly confusing) definitions: one version was 1. *kaji informasi* (review information), 2. *kelola emosi* (manage emotions), and 3. *kembangkan sumber daya* (develop resources or hobbies to fortify yourself during COVID-19), while yet another was 1. *kontak erat* (limit close contact), 2. *kerumunan* (avoid crowds), and 3. *kamar/ruang tertutup* (avoid enclosed rooms). Each campaign was accompanied by voluminous infographics published on health department websites, and occasionally posted around various communities[18]. A final component was eventually added: *'vaksinasi'* (vaccination). Thus, iterations of a combination of 3M, 3T, 3K, and *vaksinasi* were rolled out which squarely placed the onus of pandemic control on the individual, with limited consideration of the structural or other impediments which influenced the agency of individuals to adhere. As such, the 3M, 3T, and 3K strategies met with varying success, as will be discussed further in this section.

My initial foray into field data collection included an informal visit to a traditional wet market, the location of the first known fatality from COVID-19 in Kupang. The open-air market, packed with vendors selling local produce, fish, meat, and other sundries presented itself as a microcosm of the cultural mixing common in Kupang. Folks gathered from the surrounding districts to sell in the labyrinthine, winding market street. My first few informal encounters with vendors foreshadowed what was to become a common theme throughout my interviews with the community, in which a wide array of beliefs and practices around COVID-19 were apparent. Immediately clear was the fact that most

[17] See Viral Clouds: Becoming H5N1 in Indonesia Lowe, C. (2010). Viral Clouds: Becoming H5N1 in Indonesia. *Cultural Anthropology*, *25*(4), 625-649. https://doi.org/10.1111/j.1548-1360.2010.01072.x
[18] Some examples can be found at https://covid19.go.id/edukasi/materi-edukasi

vendors wore no face masks, despite government mandates requiring them to do so. There was no appreciable physical distancing between vendors, as every square metre of real estate was readily snatched up and occupied by products and people. Also apparent was the presence of face masks worn by customers visiting the market to purchase goods. The contrast between seller and buyer, between the covered and the mask-less, underscored the variety of pandemic practices that I would encounter throughout the data collection process.

When queried as to why the vendors tended not to wear masks, the answers were telling: they were hot, inconvenient, and were only donned when they knew that the COVID-19 Task Force or other health authorities were coming through to conduct random compliance inspections. Word would pass quickly through the network of vendors aligned along the road, masks would suddenly appear, and compliance achieved. Further queries with an avocado vendor revealed some of the motives behind the non-adherence to required social restrictions which were echoed throughout the community,

> *We only wear masks when the task force is coming, otherwise, what's the point? Is Covid[19] real or not? Let me say, it doesn't matter, the one who is in control is God, so it's the same as any other risk in life. You must accept all what life gives you, positive or negative. When I buy an avocado tree [for the purpose of harvesting fruits to sell in the market], I must buy the whole tree. I can't buy only the good avocados and not the bad ones, I must buy the entire tree. I already know that some will be good, and some will be bad, and that's just the way it is. It's the same with Covid, I may catch it, or I may not, but I must accept all of it and know that God is the one who decides (Mas Josep, avocado vendor at Pasar Sentral, Kupang city, male).*

This pithy example was my entry point to the tangled web of COVID-19 complexity and risk assessment, immediately revealing a spectrum of social entanglements influencing individual behaviour and collective responses which I would encounter throughout the duration of my study, namely that government authority was not to be trusted, and in fact, should be subverted if one's personal beliefs or desire for convenience conflicted with the regulations or pandemic norms; that the fact of COVID-19 was open to debate, as it was still in the process of being crystallised into a socially-sanctioned disease entity; that personal agency, while being the fulcrum point upon which the government based most of its disease control strategy, was supplanted by God [i.e., a divine force] who was actually controlling outcomes; that pursuing a livelihood trumped social restrictions; and that

[19] Respondents in this study referred to COVID-19 variably as 'COVID-19', 'Covid', 'corona', 'coronavirus'. While I used standard nomenclature for COVID-19 in this dissertation, respondent quotes retain original phrasing and references as spoken.

systematic, government-driven risk communication and education regarding the mechanisms of COVID-19 transmission had not yet reached the community in an effective manner.

Over the course of the next few days, I would observe variations in pandemic practice, in the context of a physically distanced Catholic mass I attended, as well as at the funeral of a deceased non-COVID-19 individual, with the attending priest being an eventual respondent for my study. The array of pandemic perspectives and practices reflected both individual interpretations and social pressures to adhere or not to adhere. The common sentiment was that life was different now, it had changed because of something that was still evolving in the collective understanding yet having an impact on each individual despite its amorphous definition. The thread which wove itself through every encounter and social action was the immediacy and pervasiveness of the pandemic: it hovered over every space and filled every vacuum with its invisible presence.

Thematic clusters

The themes generated from the qualitative data set in this study focused on structural and individual concepts, and most respondents voiced concerns and criticisms regarding the government handling of the pandemic in general. Topically, themes clustered around public governance including policy, financing, and communications; sociocultural and religious themes; and individual or collective experiences and representations of how COVID-19 was understood and enacted in the community, and how a wide array of these understandings reflected confusion and uncertainty arising from a lack of systematic engagement with communities on the part of the government. A significant challenge in identifying and generating unique themes was the overlapping nature of each. The thematic framework and individual themes should thus be contemplated as a series of porously bounded ideas, interconnected and overlapping, containing topics and issues that are common to multiple themes at a time. Issues such as ‘budget constraints’ or ‘inequitable access to information’ or ‘governance of the health system’ have far-reaching effects and influence all aspects of pandemic response from government to community. Individual themes are therefore outlined within the context of the whole data set.

Following is the thematic framework along with data excerpts that characterise and represent the findings of this qualitative study. The schematic below illustrates the structure of the chapter as it examines themes as clusters at the levels of structural or systemic issues, the sociocultural, and the individual-perceptual in what could be considered as a *nested*

holarchy[20] in which each increasing level assumes an umbrella-like influence on all levels beneath it. Thus, systemic level themes broadly influence sociocultural and individual ones, and so on. This is not to imply that the boundaries and territory between and among the themes and levels of analysis are fixed and static; rather, the data can be thought of as being more akin to electron probability clouds or wave functions, difficult to locate in space, unbounded yet implicative, and constitutive of all that we perceive and experience.

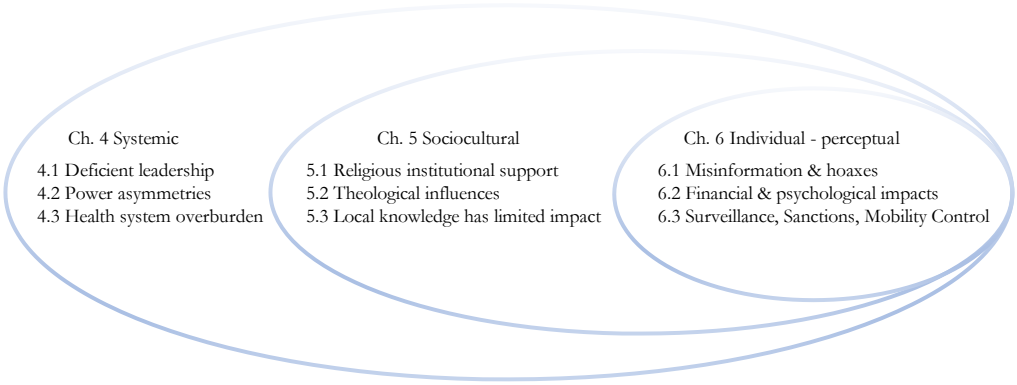

Figure 8: Thematic nested clusters at systemic, sociocultural, and individual levels of analysis

The subsequent section exposits further on the themes generated from structural and systemic issues in NTT, primarily centred on perceptions of government response, allocation of budgets, implementation of policy, and issues of control of information, power, and mitigation of the pandemic. Further sections detail themes generated from the sociocultural and individual levels of analysis that have an impact on pandemic management, and the social construction of the COVID-19 experience.

[20] Arthur Koestler coined the concept of 'holarchy' in which he suggested that we are organised in embedded or nested degrees of increasing complexity. Each whole becoming part of a greater more complex whole. As letters make up words, and words make up paragraphs, and paragraphs make up pages, and pages make up books, so too are we organised psychologically, physically, and socially in ever-increasing complexity. Koestler, A. (1967). *The Ghost in the Machine*. Hutchinson.

4

Chapter 4. Systematic, Structural Themes

Introduction

Themes couched under the 'systemic' heading were generated by the reflections of public officials and community members which coalesced around perceptions of how the government responded to the pandemic. As the principal driver of success or failure, the public sector structural apparatus had a major impact on community resilience, confidence, and compliance.

4.1 Deficient leadership has exacerbated structural challenges in pandemic control

There was consensus from the community and key stakeholders that public institutional responses were plagued by challenges to efficient policy implementation, local government monitoring, budget constraints, and limited stakeholder consultation and communication in pandemic responses at the provincial (regional) and local levels. Indonesia is notoriously overburdened by a top-heavy bureaucracy, and the case of developing the COVID-19 policy response was no exception (Gaus et al., 2017). Despite having developed a robust and comprehensive regulatory and legal framework, consisting of central level multisectoral policies, the translation, adoption, and implementation of these policies at the local level was a major impediment to community pandemic control.

While the research questions for this study focus on community responses, the context of and relationship with the government's handling of the emergency was another important component of the inquiry. In general, the individual community responses were symptomatic of larger structural deficiencies in the overall governance of COVID-19 in NTT. Further in this chapter, I will explore how deficiencies in government preparedness, responsiveness, and community engagement resulted in the confusion and erratic responses that I observed. Themes generated from this research overlapped with one another, and the boundaries between them blurred, since what I was seeing and hearing at the community level were the downstream effects of a fractured and beleaguered system of governance.

One village leader on rural Semau Island spoke about how the initial onset of COVID-19 was met by panic, rather than by a measured sense of reliance on previous government pandemic planning and mitigation,

> *At the beginning it made all of us panic, especially when we heard that the virus was spreading across the world and when it was first identified in Indonesia. The people living in the outer islands of Indonesia, including the people in this village, were worried and caught unprepared (Pak Yonias, Village Head, Semau Island, Kupang district, male).*

The sentiment of initial panic was commonly expressed among many respondents, and in the case of panic in the government, it underscored a lack of contingency planning or systems in place to respond to urgent public health threats. Despite years of experience with previous outbreaks and threats, from Cholera and Dengue to SARS and Avian Influenza, the response was generally one of chaos and a lack of preparation. The additional strain that COVID-19 placed on the government necessitated a high degree of resource prioritisation and efficient use of public resources, whether for diagnostics, data management, or human resource allocation. Consensus from many stakeholders was that this had not been achieved,

> *In managing this pandemic, they simply don't have leadership here in NTT, and people work without clear direction on how to prioritize activities. Covid is about testing and tracking before you treat people, but until now NTT's testing capacity is still one of the lowest in Indonesia. The priority is just not there (Dr. Ratu, director of diagnostic laboratory, Kupang city, female).*

In addition to discussions with community members and public sector stakeholders, I interviewed several outspoken critics of the situation in NTT, including a journalist, a health sector member of the NTT COVID-19 Task Force, and several government officers at the provincial, district, and local community levels. There was general agreement that the government response to the pandemic, via the local COVID-19 Task Forces at all levels, was inefficient in the execution of expected duties, plagued by a lack of clarity in roles and responsibilities, and characterised by a dearth of public funding for activities.

The Government of Indonesia set up the Task Force for the Acceleration of COVID-19 Response through Presidential Decree (Keppres) Number 9/Year 2020, and rolled out at national, provincial, district, and sub-district levels, intended as a means of data collection, information dissemination, and other duties in concert with local government officials. However, the roles and responsibilities as enacted locally were often unclear, with task forces being frequently unfunded as a non-budgeted activity and thus

becoming an additional duty on top of normal public or private sector duties. Although the task forces were quickly organised, due to the fragmented nature of local governance, each task force performed at varying degrees of competence amidst a lack of unifying vision at district or province levels. One journalist expressed his frustration about the rollout of these task forces in the villages,

> *The explanation about these duties and responsibilities has not been conducted properly, why? In certain villages, a task force was formed in the village. But the team was formed without proper explanation about their duties and responsibilities and also adequate protection for the job. There is no available budget. So, they were formed and just left to fend for themselves (Pak Petrus, Journalist, Kupang city, male).*

Systemic chaos in the aforementioned example is symptomatic of issues in planning, financing, and executing novel responses to the pandemic crisis. What is evident is that, despite having a slew of official policies, edicts, letters, and documents outlining scopes of practice, the implementation and local organisation of response teams such as the COVID-19 Task Forces were in disarray. The lack of budget support and unclear roles and responsibilities were a common refrain, as reflected by many local level officials.

In addition, intersectoral or inter-ministerial cooperation within the provincial level task forces, charged with umbrella oversight for all COVID-19 activities in the provinces, suffered from a diffusion of prioritisation and lack of leadership. One member noted when asked about multisectoral cooperation between various ministries such as health, planning, education, and others,

> *From the beginning of the creation of the COVID-19 Task Force the members are expected to conduct routine meetings to evaluate and monitor all pandemic related activities, but most of the time meetings are only attended by the health sector, with few from other sectors like education or economy. After the meetings, there are no follow-up actions; we hear nothing from them … maybe because they don't have any idea what to do. They think Covid is only a health problem and they think the technical activities must be done by the health sector. Or maybe it could be that this is one of our weaknesses too, not to have a better way to communicate with non-health sectors on what should be done (Pak Yohanis, COVID-19 task force member, Kupang city, male).*

Without strong, unifying leadership around the central issue of pandemic mitigation, there appeared to be considerable 'buck passing' from non-health sectors onto the health ministry. Adjacent yet crucial areas of education, economy, infrastructure, and law enforcement were only tangentially involved, despite the overwhelming urgency of the public health threat to destabilise all sectors.

Further observation was made by a provincial level health officer, reflecting on the rollout of the COVID-19 vaccine program, noting that while general COVID-19 'policies' were adequate, at the community level, there were insufficient resources:

> *Overall, the federal and regional policies have been sufficient. The main problem has been the limited resources at the community health centres[21] level, including a limited amount of healthcare workers. That has been a major problem until now. A single healthcare worker can have many jobs (Dr. Joko, Provincial Health Official, Kupang city, male).*

This sentiment was also expressed by one of the directors of a local community health centre in the district. Failures of national, provincial, and district level management of health human resource allocations, and combined additional burdens placed on routine health programs, had consequences at the implementation level, in this instance, in relation to routine childhood vaccinations,

> *The community health centre staff that handle the COVID-19 vaccination program are the same that deal with the routine immunization program. There is a lack of human resources allocated for these programs, and the system has become overly complicated in all provincial programs. The national officers setting targets just think that the vaccination has to be done regardless of any additional burdens and duties (Dr. Yuliana, community health centre director, Kupang district, female).*

A local journalist tempered his enthusiasm with a criticism of how the government was overseeing the implementation of pandemic control,

> *The regional government's supervisory function has not been optimal. It's monitoring function towards the lower levels of government hasn't been effective (Pak Petrus, journalist, Kupang city, male).*

'Appeals' were a commonly referenced mode of engagement with the community to comply with social restrictions during the pandemic, a moralising solution to encourage compliance. However, without concomitant support for education and communication, in addition to funding, the appeals carried little weight in the community.

The framework for the national pandemic response was a result of Indonesia's accession to the revised WHO International Health Regulations in 2007, together with the adoption of the WHO's interim technical guidance on COVID-19[22] from the WHO's IHR

[21] Pusat Kesehatan Masyarakat, known as 'puskesmas,' are the government's frontline public sector community health facilities in Indonesia, of which there are roughly 10,000 throughout the nation providing primary health care to communities.
[22] https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance

Emergency Committee Regarding the Coronavirus Disease (COVID-19) Pandemic's ongoing recommendations. Since 2017, Indonesia has had a fully developed National Action Plan for Health Security which outlines a detailed strategy for zoonotic preparedness and response.

External evaluations of Indonesia's preparedness plans concluded that the nation was fully compliant with WHO recommendations, based on several indicators including financing, policy environment, practical implementation of preparedness exercises, and others. Global WHO policy thus became the adopted standard at the provincial and district levels in NTT, with tailoring occurring at the *walikota* (mayoral) level outlining policy on large- and medium-scale social restrictions such as business operating hours which were not under the direct responsibility of the district health office. District health staff clarified that local (provincial and district) COVID-19 health policy was directly adopted from national policy through local edicts.

Dr. Ibrahim, a pulmonologist on the front lines of the COVID-19 response in government and private sector health facilities, noted that "because we are followers of the WHO, we do whatever the WHO says, we believe them. The research and therapy that we conduct follows the Western world, which is later adapted by the Ministry of Health." Further to this point,

> *Bottom-up innovation doesn't really work in the case of this new COVID-19 pandemic, so we see a lot of the local government officials saying, 'oh we don't have enough knowledge about this situation, we need additional guidance from the province or center.' In the health sector at the local level, they're always waiting for top-down guidelines from WHO and national level. Then the other sectors will say 'ok we will wait until the regional health department or central ministry of health gives us guidelines, and then we will follow them.' It's the traditional practice of how we do things here (Pak Yohanis, COVID-19 task force member, Kupang city, male).*

Biomedicine and global health are the drivers of understanding of the COVID-19 pandemic, yet 'from its transnational positionality global health homogenises the COVID-19 pandemic as a predominantly biomedical and public health problem, onto which the social sciences are frequently outside looking in' (Gamlin et al., 2021, p. 1). Homogenised policy adopted from global discourse which is not tailored to context-specific outcomes seems to have far-reaching effects at the community level, as bureaucrats and authorities struggle to meet the demands of the pandemic with few financial and human resources, and a dearth of contextually-tailored policies. This takes the form of deficient intellectual or thought leadership, effecting how health policy is tailored to the local context.

Limited partnering with non-government entities, and a lack of transparency in community interventions and provision of support were also viewed as failings of local leadership,

> *The village level rollout of the PPKM[23] didn't go well. In my opinion, our government was the reason. For example, we know that funds were available from the public health office to purchase masks, but we don't know where the money went. The heads of villages or religious figureheads who have the responsibility should be enlisted to help, and to manage these activities for transparency and to share the burden. The higher level of government should have intervened with all their power and helped. But this wasn't the case (Eddy, local youth NGO leader, Kupang city, male).*

These perspectives from the community critiquing the lack of transparency and ineffective partnering were echoed by other respondents, engendering a sense of mistrust or lack of confidence in government's ability to effectively mitigate the situation. Over time, the initial momentum of government response and organisation gave way to inertia and pandemic fatigue, observed by many in the community. A physician from the district public health facility spoke on the waning effectiveness of the task force as time wore on,

> *When this pandemic initially broke out, I saw that the COVID-19 Task Force was working extraordinarily hard. If the COVID-19 Task Force in Kupang District had continued to work like that until now, the current situation would have been better. However, after the initial push, they stopped doing these activities and the impact of the task force was reduced (Dr. Paulina, public health facility doctor, Kupang district, female).*

The waning momentum of leadership exerted its effects in community behaviours as well. The lack of strong leadership at the provincial and district levels was reflected down through the ranks, including in the local task forces. Upstream relaxing of policy and programs was evidenced through 'downstream' changes in local pandemic practice. One community member attributed the cessation of hand washing to the disbanding of the local task force, symptomatic of wavering leadership in the districts.

> *At the beginning, people who come to Semau from Kupang City via the medical posts were required to wash their hands, get a temperature check, and there were long lines of people waiting their turn. But ever since the local COVID-19 task force was disbanded, everyone stopped doing it. Even the people who were paid to deal with Covid felt it was*

[23] PPKM = Pemberlakuan Pembatasan Kegiatan Masyarakat or Enforcement of Restrictions on Community Activities which are the regulatory frameworks for containment and mitigation through social restrictions

> *useless. So, everyone became lazy (Lambertus, local farmer and community member, Semau Island, Kupang district, male).*

The lack of effective leadership was also evidenced through limitations in outreach and pandemic risk communications, especially in providing a conduit for the community to access reliable pandemic information and local sources for testing and advice on what to do in the event of a suspected COVID-19 case,

> *I asked the Provincial Task Force to set up a call centre so people can get reliable information about where to go to hospital or where to go get Covid testing or where to find information about oxygen or what to do if there is suspected Covid case. And the government issued an formal edict about starting an information call centre, but then after that we saw that it never even started (Pak Edi, international NGO representative, male).*

The vacuum left by the lack of reliable, easy to access sources of pandemic information on the part of the government was filled by misinformation, which is further discussed in Chapter 6, Section 6.1 below. One local government leader identified the lack of community awareness as an important obstacle in pandemic control pointing to pandemic fatigue,

> *The biggest obstacle is connected to the citizens' lack of awareness, especially among the youth. Every Saturday and Sunday I go through our neighbourhoods with a megaphone, telling them to wear face masks because keeping a safe distance in the markets is so difficult … so at least they can try to wear face masks. I usually do this with the village taskforce, we also ask the community for donations to buy gloves and face-shields that can be given out to the sellers in the markets. I think people here are bored of the situation that has gone on for too long. Last year, due to active socialization efforts on the part of the army and police, the community complied. But now, they don't seem to be (Pak Tomas, Village Head, Kupang city, male).*

Understanding the monumental task required of the local village heads, with practically no support financial or otherwise, we can sympathise with Mr. Tomas's conundrum. Faced with a situation in which the upper level of government was not providing sufficient resources to track and tame the pandemic on the ground, he had to go through the villages like a latter-day Pied Piper of COVID-19 with his megaphone, exonerating the public to 'please wear masks if you will', while begging door-to-door for funds to purchase said masks for vendors in the market. Commendable efforts indeed, yet ones that were symptomatic of systemic inequity, and which resulted in structural vulnerability from asymmetric concentrations of power within the government apparatus.

The government itself was not immune to self-critique, as during the focus group discussions with public sector health officials, there was recognition of some of the failings in government to reach the people adequately,

> *From the start of this crisis, I don't think we have communicated very well. We in the government are not utilizing existing social media for communications related to the current situation and progress of COVID-19 here in Kupang City, and we must improve risk communications with the public (Dr. Yanti, staff physician at primary care facility, Kupang city, female).*

One local leader at the RT level, whose entire family were COVID-19 patients in isolation, reflected on the difficulties in communications, further attesting to a need for improved commitment by the government,

> *The communications must be clear, from top levels to the bottom levels of government and vice versa. The people that know the most about the situation in the field are the heads of the RT, RW, and village, who sacrifice everything for the safety of their citizens and their environment. We don't ask to be paid, but at least there should be food for us to eat (Pak Markus, RT Head and COVID-19 patient, Kupang city, male).*

Tacit reference to pandemic fatigue, or what could be thought of as 'pandemic attenuation', illustrated the downward trend of commitment and intensity of pandemic response following the initial shock from COVID-19 onset. The usual spectrum of responses such as fear, panic, confusion, blame, and stigma were eventually supplanted by tentative familiarity, exhaustion, and a loss of interest by all parties.

As time marched on, respondents reflected on the decrease in the intensity of these responses, including a lackadaisical attitude, reduction in adherence to social restrictions and use of personal protection such as face masks, and a general fatigue surrounding the pandemic discourse. Understandably, COVID-19 has dominated daily news cycles, daily movement, and has taken over everyone's lives in one way or another. The heightened level of vigilance and emotion associated with the onset of the pandemic is unsustainable for long.

Thus, as the community settled into relaxed adherence and general exhaustion, there was a missed opportunity for political and community leaders to reinvigorate the outbreak response. The false sense of security accompanying an attenuated, exhausted mindset around the pandemic masked the ever-present danger of community transmission that raged on. The prolonged community infection and inability to control transmission, as of today, is evidence of weak leadership and guidance on all aspects of pandemic control.

Recently, the NTT government closed the airport and effectively cut off the island of Timor to quell the catastrophic increase in cases due to limited vaccination coverage, relaxed social restrictions, ineffective risk communication strategies, and pandemic fatigue. Months after my interviews were conducted, they were faced with cases spiralling out of control, and reeling from the missed opportunities to strengthen leadership from the outset.

A prescient comment made by one of the Village Heads drove home many of the frustrations of managing the public health emergency without effective leadership,

> *Who even wants to work? Even I don't want to. The people who don't go around visiting the citizens still contract Covid, let alone the people who have to work in the taskforce (Pak Lukas, Village Head, Kupang city, male).*

The pervasive effects of weak leadership were evident through low commitment to community testing and screening, a general decrease in the intensity of mitigation over time, lack of prioritisation for local funding, and inefficient risk communications carried out by the government to the community. These deficiencies manifested within the community as expressions of uncertainty, lack of confidence in public sector competence, and pandemic practices which were enacted piecemeal without sufficient community knowledge or support to stave off the looming COVID-19 threat. Critical analysis reveals that while the onus of addressing these issues was part of the government's duty of care, the locus of control shifted tacit blame or overt responsibility onto those in the community who were structurally vulnerable. Systemically, diffuse leadership had a negative effect on crucial responses such as the vaccination rollout, intersectoral partnerships, and the ability to effect change across the spectrum of government institutions.

4.2 Power asymmetries from bureaucratic hierarchy has negatively impacted pandemic response

Management of information during the COVID-19 pandemic was the foundation upon which public health measures were designed and rolled out. In NTT, the flow and use of information was tied to power structures within the government and between the government and the community which existed prior to the advent of the pandemic yet were exacerbated and brought into high relief during this public health emergency. The top-down approach to the delivery of health policy was meant to drive efficiency, and yet was viewed from the so-called 'lower' levels of government as unresponsive.

The sheer volume of bureaucratic documents that were designed to respond to the COVID-19 pandemic in Indonesia was striking, unwieldly, and impossible for a single

bureaucrat to have complete knowledge of. Thus, knowledge distribution across agencies was required to track new and revised versions of relevant policies, laws, and regulations in a constantly transforming policy environment. At the time of writing, due to the appearance of the delta variant of concern in Indonesia, the government instituted new restrictions which included amending policies from the Ministry of Religious Affairs (Circular No. 13/2021), the Ministry of Domestic Affairs Instruction No. 13/2021 on PPKM *Mikro* (restriction of public activities on the micro-scale), and Ministry of Health regulation No. 18/2021 which amends No. 10.2021 on handling vaccinations during the COVID-19 pandemic. In addition, the Ministry of Education, Culture, Research, and Technology revised regulations around schooling, and the MOH issued a new decree no HK.01.07/4641/2021 which was a revision of two previous decrees on Examination, Tracing, Quarantine, and Isolation in Preventing and Mitigating COVID-19. There were dozens more decrees, regulations, and *surats* that were in circulation and in varying degrees of revision, replacement, and conclusion from numerous ministries in charge of various aspects of pandemic control at the central level.

Regional/provincial governments then had to adopt these policies and oversee their implementation at the district and sub-district levels where money was spent, and activities carried out. This overwhelming bureaucratic situation was simply one aspect of the responsibility of a given local level government officer in charge of 'health' or 'economics' in a district, in addition to all other communicable and non-communicable diseases, operations of health facilities, and ongoing primary care efforts, such as routine vaccinations.

While large amounts of paperwork and policy accompanied government work, with the advent of the pandemic, the system of distribution of information via policy socialisation and then adding enforcement, contact tracing, and mitigation of a single disease, completely overwhelmed the system. Health officers who were responsible at the local level for implementing policy were inundated and overworked, thus leaving little time for district or sub-district tailoring and adaptation of central policies to fit the context in NTT. The result was that, in a country with hundreds of languages, religions, cultural identities, and practices, the government adopted a hegemonic model of global biomedical solutions to overlay onto the constellation of diversity that is Indonesia.

Several interviews with community government officers and health officers alike exposed the fact that the pandemic efforts were homogenising, both from the 'one size fits all' approach to health policy, but also in the delivery of health information using the common Bahasa Indonesia rather than local dialects for health communication campaigns.

The utilisation of globally defined, hegemonic biomedical discourse in the application of local health interventions for the pandemic was an important consideration of analysis concerning the lack of adherence to pandemic practices, low levels of testing, limited contact tracing, and overall deficiencies in NTT's response program.

Power hierarchies operating within government are the norm, as governing without structure is impossible. However, the wielding of power to subordinate levels lacking a mechanism for feedback, consultation, or collaboration can result in frustration or even rejection of policies and practice. Specifically, the power dynamics that revealed themselves during this study demonstrated that the overall system lacked an efficient means of feedback and community level responsiveness, as reported by both public servants and community members. Discussions with one Village Head that we interviewed illustrated these fundamental frustrations with how policies were carried out within the government itself,

> *We want to voice our opinion, but they don't listen. We try and talk to the higher levels of government, but they simply don't listen. We relayed info that more and more of our citizens have contracted Covid: 'should the village office workers get tested?' There was no response from the district health office, even when we send letters, we get no response (Pak Lukas, Village Head, Kupang city, male).*

Evident from this was a sense of vertical isolation of the government from itself, as well as a clearly stated frustration and sense of powerlessness. Vertical hierarchies and concentrations of power at the higher levels of government, in terms of the control of both material and non-material resources, affected the ability of the lower levels of government to operate. The one-way flows of the wielding of power and information restricted inputs from 'on the ground' sources, as well as restricting autonomy, and thereby resilience, in the community. One example was provided by a neighbouring village, in the context of the lack of assistance being provided by the district or municipality. Limited flows of information internally led to frustration at the lower levels, and inefficiency or even inappropriate responses at the higher levels,

> *There has been little coordination between the city and the villages. All of us as heads of the villages in Kupang City have the same experience. When making any type of policy, even if the city officials view us here in the village as 'something small and unimportant', they should still have to listen to us. The mayor's team and the house of representatives work in isolation, but they should at least try and listen to us first before they go about their business (Pak Tomas, Village Head, Kupang city male).*

As the city and districts struggled to design programs and allocate budgets based on guidance from provincial and national level edicts, they in turn neglected those further down the food chain. Impacts were felt in many instances of pandemic interventions,

> *It feels like we are social or voluntary workers. When we recently had a meeting with the vice-mayor to ask about funding for Covid activities in our villages, there was no follow up or commitment (Pak Jefry, Village Head, Kupang city, male).*

What was clear was that 'business as usual' was no longer accepted by the street level bureaucrats, as they were faced with the burden of reducing COVID-19 transmission without context-tailored interventions, guidance, and adequate funding support from the district or provincial health offices or other government agencies. The lack of assistance included budget matters as well as guidance on logistics or social mitigation strategies. The tacit implication in these power hierarchies was that the central or regional policies were adequate and appropriate, while community level consultation or engagement was unnecessary. Policies were handed down with the expectation that they would be followed at the village level and questioning authority was not encouraged,

> *As a head of the village, as a part of the government, there is nothing to do but go along with the decisions that are made by higher levels of government (Pak Markus, Village Head, Kupang city, male).*

This type of fatalistic resolve was reminiscent of the theological underpinnings of understanding COVID-19: "God is in control, so there's nothing for us to do …". Similarly, the powerlessness felt by local bureaucrats which led to structural vulnerability from lack of funding, guidance, and two-way communication informing policy and procedure, was amplified further down the chain within the community itself. Perceptions of powerlessness and frustration echoed through many of the discussions had in these communities.

The dividing up of territory to manage the pandemic was also an important observation made during fieldwork, whether the territory referred to the governance and distribution of health policies, or the boundaries of authority between one village and another, or between a village, the district, and the province. Artificial boundaries separating villages and sub-districts were colonial artifacts left over from the days of the Dutch governing a subjugated subaltern population (Holtzappel & Ramstedt, 2009); these territorial demarcations persist today and influenced how pandemic information and control were executed.

Decentralisation in the Indonesian government placed more power at the regional (provincial) and district (or regency) levels, yet the formulation of policies around large- or

small-scale social distancing, testing protocols, and others were handed down from the central level (Holtzappel et al., 2009). Thus, local officials were expected to implement policy handed down to them, while also managing the flow of people, information, and power within the territory under their responsibility. However, confusion over how to enact policy within a particular village context persisted, echoed by one staff member during a focus group discussion with public sector health workers,

> *Policies from the national government change often and quickly so they can adapt to handling Covid. Initially when going to the field we had to use PPE level 3, now we only using masks and medical gloves only (Ibu Oktavia, District Public Health Facility nurse, Kupang district, female).*

And from another health officer, working in the rural district, who was not spared the confusion surrounding the ever-changing documentary landscape,

> *The policy from the national government is confusing. Not all policies can be followed because it all depends on individual conditions. For example, PPE is not evenly distributed, so those who do not have PPE have to ask another community health centre that is far away or even to use a raincoat to go down to the field. The policy that reaches our community health centre is that some are using PPE level 1 but some are using PPE level 2, so it is confusing (Dr. Rima, district community health centre physician, Kupang district, female).*

An elderly member of the community, when queried about how the village government transmits information using loudspeakers or megaphones, quipped

> *Each house should be visited and given education; don't just scream and yell about it outside. People my age have trouble hearing.*
> *Q: Don't you use a cell phone?*
> *A: No, I don't have a cell phone, only the kids do (Pak Josep, community elder, Kupang city, male).*

This was a point of contention for Pak Josep, as he preferred to have more direct contact with the custodians of government, especially in such a time of distress for many, including the elderly population. He expressed much frustration in the lack of information and action by the government, regarding everything from prevention, vaccines, medicines, financial support, and religious issues. The seat of power was seen as being located with the health or local authorities, rather than with the community stakeholders or the recipients of communications and health interventions. This is illustrative of the view that pandemic control ultimately rests with the decisions and actions of individuals, while at the same time, restricting their access to useable information and agency from which to act. Reliance

on the perceived 'level of importance' of the pandemic by everyone within the community that would lead to compliance with social restrictions was an ineffective communications strategy.

Bureaucratic requirements restricted the flow of information and activity, which frustrated efforts at rolling out responses, such as vaccination campaigns,

> *At first, we received a letter announcing the use of the single-dose Chinese vaccine. Then, the vaccines that arrived were the double-dose vaccines from Astra Zeneca, a totally different brand and type of vaccine than what had been planned. This makes it difficult for the healthcare workers at the community health centre level in terms of scheduling and logistics. They think that the provincial governments' planning is inadequate, but we just follow through with directives from the national government, including the target allocation of the vaccines (Dr. Fransiskus, Provincial level health officer, Kupang city, male).*

Staff from the university-managed biomolecular lab where PCR testing occurred, also noted frustrations with pandemic bureaucracy, which added further insult to injury considering that lab staff had been functioning as extremely low-paid technicians, despite providing a crucial service to NTT in the form of PCR testing as a Biosafety Two-level laboratory. Streamlining or digitising testing data would go a long way towards improving efficiencies and decreasing response time for patients awaiting results and follow up.

> *We are hampered by the bureaucracy. We admit that bureaucracy must exist, but it can be streamlined, especially in the context of handling the pandemic. When we have a positive test result from the lab, we must send a hard copy letter to the health office to report, and this takes a few days. In those few days, the people who tested positive have gone around to other places, spreading the virus. In the digital era, we should be able to instantly send it immediately to get processed, instead of through a hard copy letter. Systems are important but we must make the bureaucracy simpler … Within the government everything is still manual, paper-based … the government officials say that they don't know how to use digital technology, so sometimes we back down and don't push too hard (Mas Viktor, PCR lab manager, Kupang city, male).*

Inconsistencies in policies around how and when to use digital technology impacted the government's ability to plan and execute, especially regarding the management of commodities, forecasting, providing updates to the community, and following up with patients who had tested positive. Tensions existed between the perceptions of a slow out-of-date bureaucracy based on reams of paper being posted from one site to another, and a

high-speed digital architecture in which sample data could be instantly transmitted for immediate management and response. As illustrated in the previous quote, this was attributed primarily to the mindset of public workers who were slow to adopt new technologies, but who were often bounded by regulations and policies precluding them from doing so.

The concentration of power and authority within a rigid bureaucratic hierarchy was seen as an impediment to pandemic mitigation and activity in the community. The lack of responsiveness to requests, confusing policies being handed down for wholesale consumption, and inequitable distribution of control and dissemination of information had a negative impact on pandemic practice in the villages. Despite recognising these issues, the respondents felt like cogs in a wheel, unable to effect substantial change despite the magnitude of the ramifications of the COVID-19 crisis being felt around them.

4.3 Ill-prepared health system overburdened by pandemic (mis)management

There was general recognition among stakeholders that the health systems that were previously in place to prepare for emergent zoonotic or other infectious disease outbreaks had broken down under the COVID-19 crisis. Referencing the response of the central and local governments during the pandemic, a member of the NTT COVID-19 Task Force noted that despite previous efforts on pandemic preparedness and response afforded by the SARS and H5N1 epidemics, the COVID-19 situation fractured an already fragile, unprepared health system,

> *It's about governance, and it all collapsed during the Covid pandemic; nothing works. Our health system and our health facilities didn't really have the capacity. In the past we had experiences during the Avian Influenza and SARS epidemics, but then after those problems were over no one really cared about what was going to happen in the future. Everything was neglected by our local leadership. So, everyone was surprised when Covid happened because none of the systems that were set up during the avian influenza response were still in operation (Pak Yohanis, COVID-19 task force member, Kupang city, male).*

In contrast, perspectives from the provincial level government on NTT's pandemic preparedness using previous experience differed from those in the community and even the task forces. A high-ranking government official commented on the effectiveness of preparations,

> *Before the pandemic, we carried out outbreak preparedness war games such as simulations and practice sessions. During a pandemic, we only need to implement the simulations in real life … We had a few chances to learn about pandemics, specifically during the Avian Influenza Pandemic in 2002 and the Mexican Flu Pandemic in 2009. So, if you ask what the difference was between before and after the pandemic with regards to our jobs, the answer is there is no difference, because we have prepared (Dr. Agus, Provincial health quarantine officer, Kupang city, male).*

These contrasting perspectives foregrounded the complexity of how the bureaucracy was managed, specifically that divisions within the hierarchy of regional government were charged with differing roles and responsibilities. Following Indonesian decentralisation in 2001 granting regional and district autonomy from the central government, provincial governments were largely responsible for supervision, overseeing inter-jurisdictional coordination, and representing the national government in order to ensure effective management of a decentralised system (Holtzappel et al., 2009; A. Nasution, 2016). In contrast, districts were responsible for managing budgets, and prioritising, developing, and implementing policy in areas such as education, health, infrastructure, and other areas of governance (Rakmawati et al., 2019). Thus, experiences at the community level may have conflated the regional, district, sub-district, or municipality levels in terms of expected outcomes.

Referencing the previous two quotes, one respondent represented both the Task Force as well as a multinational donor agency (non-Indonesian government), with a bird's eye view of the breakdown of the health system and the actual challenges in COVID-19 pandemic response and management. Meanwhile, the government representative from the provincial level attested the preparedness and response as adequate. This was a recurring theme in discussions with health staff and others, who viewed the custodial supervisory response (largely around policy adoption and supervision of districts) as sufficient, yet the 'on the ground' implementation as messy and deficient. In general, the respondents were more apt to view their own 'field' through a veil of bias insofar as they were representing constructed facts influenced by power, position, and expectations to be met.

The shock to the ill-prepared health system by a disruptive pandemic event of historic proportions sent routine methods of data collection and use, and health management and delivery spiralling into disarray. The exercise of authority by restricting social behaviours, movement of people, and operation of day-to-day life rested upon an assumption of the appropriate use of epidemiological data. Reflections from the field demonstrated more of a 'knee-jerk' reactivity in which sanctions and restrictions were

employed using little rationale, especially in terms of setting indicators or thresholds which would trigger social restrictions and other measures.

From the initial onset of the pandemic, the health system in general found itself unable to manage the influx of patients and the rapidly changing diagnostic and treatment algorithms being rolled out according to global and national guidelines. Dr. Ibrahim, the pulmonologist who spread his workload between a private clinic and the public referral hospital, astutely observed the new difficulties ushered in by the pandemic era,

> *When the first case appeared in the NTT, we were really shocked, as healthcare workers and doctors. The readiness of the hospital to receive Covid patients and the diagnostic processes were still unclear. Many people were panicked, they didn't want to look after Covid patients. There was also an issue regarding PPE, at the time we weren't prepared, at the national or regional levels of government (Dr. Ibrahim, pulmonologist, Kupang city, male).*

Many of the health workers who were interviewed reflected similar perceptions, in that everything seemed to be in disarray, chaotic, and uncertain. When compounded by the sense of urgent uncertainty and fear experienced in the community, it is not surprising that there was an initial social breakdown in day-to-day life. One nurse, who was also a recovered COVID-19 patient, spoke of the psychological stresses impacting the ability of the health system to manage physical illness,

> *I am part of the surveillance team, and our work is constant from morning when we wake up until night when we want to go to sleep and we are still holding our mobile phones. In addition to surveillance, we often must deal with patient psychological complaints in addition to the physical illness. I'm required to be a mental health nurse, religious advisor, in addition to my other duties and relating to them as a former patient myself (Ibu Ester, ICU referral hospital nurse, Kupang city, female).*

The exceptional burden on the health system was outlined by a manager at the provincial health office,

> *The availability of resources at the community health centre and hospitals are still lacking, so the workload is getting bigger and heavier. Logistics at the community health centre are limited, making it difficult to handle COVID-19. Health workers have to work in 24 hour shifts and even outside office hours, the health facilities no longer recognize holidays. Healthcare workers are at high risk of exposure, and 25% of our health staff has tested positive for Covid. Since human resources are also lacking, so we must train midwives or nurses to become analysts.*

> *For antigen and PCR tests at the community health centre, the obstacle is the test results can come out more than two days later, and patients cannot bear to be isolated for long, so they leave the house and do their normal activities. Pharmaceutical treatment is not evenly distributed or available (Dr. Joko, Provincial Health Official, Kupang city, male).*

A public sector health worker remarked on the issue of a lack of reliability in how health information systems and data were being used by authorities to set trigger points for the closure of businesses and other social restrictions, noting that

> *We don't have an indicator concerning the rise and fall of COVID-19 in NTT. The government suddenly closed all shops, supermarkets, and malls. For two weeks, for example, and then they suddenly opened them back up again. What was the basis for the lockdown? When deciding to close everything, what was it based on?*
> *I also spoke about this with church leaders when they closed the church and people were not allowed to worship together. Were there clusters in the church? What was the basis for deciding to reopen the church?*
> *In NTT, where has the transmission rate come from? Which clusters are most responsible? Have we correctly complied with health protocols? Does it even matter that we wear face-masks? (Dr. Yakomina, surveillance manager at primary health facility, Kupang city, female).*

The ramifications of resource pull to implement COVID-19 interventions spanned the entire complex of the health system, namely financial, human resource allocations, policy, logistics management, and field implementation.

Interviewing an ICU nurse who worked in a large public referral hospital was illustrative of some of the exasperation felt by health workers around stockouts. She was exhausted by the burden of heavy PPE and the risk of contracting disease. On top of this, the system did not provide adequate tools with which to do her job. She recounted one episode,

> *... there was an explosion in Covid cases; we were totally overwhelmed. The rooms that were used for Covid patients were all full. So some patients were forced to self-isolate at home, some were taken to other hospitals which then had to prepare additional beds and rooms for Covid patients. At the time, there was a shortage of oxygen, all the hospitals in Kupang experienced that shortage (Ibu Maria, Nurse at Government Referral Hospital, Kupang city, female).*

Health system supply deficiencies and stockouts clearly affected both COVID-19 and non-COVID-19 patients, leading to potential increased morbidity and protraction of disease in

general. In turn, limited resources strained an already over-burdened health system, potentially leading to collapse. One of seven key mitigation recommendations made by NTT during a government status update on COVID-19 was that "hospital/health care facilities and logistics are advised to overcome the oxygen scarcity in Kupang City" (NTT Provincial Govt, 2021a).

During the focus group discussions with health workers at the primary health facility level, sentiments of frustration and critical reflection added to the ongoing conversation on resource limitations,

> *The reason why the community health centres don't get antigen test kits, PCR tests, and supplements is due to the difficult access to the facility, because not all of these centres in the rural Kupang district can be accessed easily or by road. There are several community health centres which are also flooded with water, so that the distribution is impossible. PPE availability has been fulfilled through support from the district Public Health Office or from local NGOs (Ibu Mince, community health centre officer, Kupang district, female).*

Frequent reference to stockouts and mismanagement of commodities and supply chain at all levels was symptomatic of a systemic failure in both planning and execution. Provinces, especially impoverished ones such as NTT, Papua, and others in eastern Indonesia, bore the brunt of supply chain damage; one more cog in the cycling wheel of structural insufficiencies leading to poor health, poverty, and social suffering.

A fundamental resource for COVID-19 mitigation is proper funding, especially from public sector sources aimed at providing the additional budget support required to meet the needs of additional staffing, commodities, policy-making exercises, communication campaigns, testing, reporting, data systems, and the like. Structurally, budgets were managed and distributed primarily at the district level in response to national and local policy. As annual budgets had already been allocated for 2020 prior to the advent of the COVID-19 emergency, the government scrambled to reallocate and redistribute budgets to pay for needed interventions, consumables, and services (Muliadi et al., 2021).

The complexities of budget management and limitations were expounded upon by a member from the provincial COVID-19 Task Force when queried about whether and how money moves through the government to provide for COVID-19-related services,

> *It seems like the districts are always waiting for the province to support them. In the last task force meeting that I attended, we looked at the budget and not many districts provide enough budget for Covid activities. Most of their budget comes from the NTT province or*

> *national budget … especially to support logistics or rapid tests … drugs, PPE equipment, these mostly come from the NTT provincial or national supply.*
> *NTT only has one lab built by the government in Yohanes Hospital, the other one here in Kupang was developed and financed from the academic support and UNDANA, not from the government. After they launched the lab there was not enough money for staff salary, they pay lower than minimum wage, there's no budget for them to go to the field to do tracing or tracking.*
> *Another example was from last week from a social media post showing that gravesites couldn't be dug because there was no fuel for the excavators. When they called the head of the health office, they said 'oh we don't have enough money for that, we are still under discussions'. COVID-19 is an emergency but the way they deal with the emergency is totally lacking (Pak Yohanis, provincial COVID-19 task force member, Kupang city, male).*

From these stories we can tease out the power that financial restrictions have, not only on the custodial and implementary functions of government, but on all aspects of interventions in the health system down to and including how bodies are treated at burial. Numerous tales were told of anger regarding the breaking of burial traditions, which will be elaborated upon further below, but in this instance, one can only imagine the suffering and frustration that the family went through knowing that their kin was lying wrapped up and exposed in the cemetery with nowhere for a final resting place prepared. The usual excuses offered by bureaucrats imply that the government could simply blame the bureaucratic processes to absolve themselves from personal or moral responsibility and accountability.

In another village in Kupang, the Village Head reiterated what I had heard from so many respondents: the money simply was not there for following up with COVID-19 patients. So, what to do? How were the community and local bureaucrats meant to address the most devastating pandemic in recent human history without sufficient financing to do so?

> *Q: Does your village track COVID-19 patients?*
> *A: No, we don't. I'm not sure about other villages in the city, but here tracing or tracking isn't conducted. Who would want to deal with a dangerous disease like Covid, especially without any PPE? We don't even get water or any funding, so what can we possibly do? How can we work like this? Living in the city, who would want to waste time with dangerous work such as this? We aren't even protected with PPE, nothing that was promised by the government has come to pass (Pak Lukas, Village Head, Kupang city, male).*

Lack of funding was the status quo in most of the villages I visited, which primarily affected outreach and risk communications, tracking and tracing of patients, and coordination among local government officials. However, the opaque budget policies directly affected the provision of health care. Unhonoured promises of financial incentives to motivate overworked and stressed health care providers served to further destabilise a broken health system,

> *Economically speaking we have to sacrifice a lot. I don't know if there is something wrong here, but the government had said that there was an incentive for us. But we only received one million rupiah total [less than $100 AUD]. We should protest, but I don't know what the procedure is. I also feel sorry for my other colleagues because every day we have to use the heavy and uncomfortable PPE but we don't receive any adequate compensation for it. What we give isn't proportional to what we get (mbak Hani, Nurse at government hospital, Kupang district, female).*

Health workers expected to put themselves at daily risk and to shoulder the additional burdens arising from the pandemic in a health care environment, and were not being compensated for this additional risk. Individuals on the frontlines were placed there by a system which then seemed to abandon them while expecting more and more from them. Orchestrating a structure in which people had limited alternatives but to comply with the duties of their job without sufficient incentives built-in was a form of structural vulnerability. The lack of knowledge of how to even lodge a complaint further demonstrated the imbalance in the use and wielding of power in these communities.

An interesting conversation with a hardy group of ambulance drivers working for a private hospital provided additional insight into how the lack of a budget affected their work and the burdens of financing self-isolation,

> *Whenever we want to go home and visit our families[24], we weren't allowed to by our head of the RT. They tell us we must isolate first. To do that we need money to eat. We are a 'third party' contractor working for a private hospital, so we don't get extra Covid money from the government. If we want to get Covid funds, we need a special business permit. What business permit could we make? It's difficult and confusing.*
>
> *In government owned hospitals, there are task forces that handle the Covid cases; they say that every time they handle a Covid corpse, they get 500 thousand rupiah extra. Since we work in a private hospital, we*

[24] During normal work weeks, the ambulance team is required to live in dormitories to ensure isolation from the family or others in the community and to reduce risk of transmission

> *don't get anything (Mas David, ambulance driver and morgue staff at private chain hospital, Kupang city, male).*

Imagine the scene in which an emergency medical team in an ambulance, fully clad in white with hot immobilising PPE, are required on a daily basis to put themselves on the frontline of picking up and disposing deceased patients from COVID-19 or other infectious causes. This is a daily, extreme risk environment, transporting the deceased, being at the cemetery and morgue, and witnessing first-hand the devastation to individuals and families caused by this outbreak. And when they request to return home to visit their families for some respite, the local government requires them to endure a fourteen day isolation with no financial, logistic, or medical support.

The structural impacts of weak leadership, imbalances in power within a rigid bureaucratic hierarchy, and an unprepared health system resulted in significant destabilisation of communities in Kupang and associated districts. Little evidence of harmonised planning and implementation was observed or reported, attributable to these systemic weaknesses. What was visible on the ground and reported by the community was a strong sense of mistrust, uncertainty, and insecurity around how the pandemic was being handled.

5

Chapter 5. Sociocultural Themes

Introduction

Nusa Tenggara Timur has been subject of multiple *colonisations* over time, influencing the course of how traditional adat, language, and political organisation have evolved. The archipelagic nature of Indonesia allows for isolation, cultural adaptation and place specificity, and strong identity-framing as islands exhibit unique social characteristics stemming from ethnolinguistic, religious, and historic influences (Farram, 2004; Paju Dale, 2015). The political colonisation of Indonesia by the Dutch was mirrored by theological colonisation and conversion of NTT, predominantly to Protestant and Catholic brands of Christianity, beginning in the 16th century, but not taking hold until the 20th (Fox, 1996; Nugroho, 2020). What has evolved over time in NTT has been a syncretic form of adat and Western Christianity, which has had far-reaching effects on cultural identity and interpretations in relation to health, pathology, and remedy (Boellstorff, 2002; Butterworth, 2008; Hägerdal, 2015; Lewis, 2006; Taek et al., 2019).

Religious affiliation is mandated by the national philosophy of *Pancasila*[25], adopted by Sukarno at the birth of Indonesian independence in 1945 in which citizens are required to declare one of several monotheistic religions as their own (Mu'ti & Burhani, 2019). This declaration is associated with identity, with government issued identification cards, and creates strong cultural bonds within the community. Most of the respondents in this research identified as either Protestant or Catholic, with a minority identifying as Muslim. For this thematic exploration, data has been derived from the responses given from a Christian ethos.

In my analysis, I approached the phenomenon of religion in NTT, and its influence on the COVID-19 pandemic, as a form of neocolonial technology utilised to confront and mitigate unknown threats and 'novelty' to maintain the status quo, homogeneity, and sociocultural harmony in the face of uncertainty and ethnic diversity. Consistent with the

[25] English = 'Five Principles'; The Indonesian state philosophy first articulated on June 1, 1945 by Sukarno who argued that the Indonesian state should be based on the Five Principles: Indonesian nationalism; internationalism, or humanism; consent, or democracy; social prosperity; and belief in one God.

thesis that the adaptations and explanatory models which influence behaviour in NTT arise from a context of multiple ontologies, I view the use of both the institutional and theological framing of the Church by the people of NTT as a sociocultural technology similar to biomedicine, or other cultural systems which provide context for explanatory models, adopting new *nosologies* and disease categories, and prescribing remedial solutions to a given problem, especially of the unseen and unknown.

To further elucidate the manner in which *medico-religio* syncretism manifests in NTT, it is useful to explore Parkin's concept of counterwork and latticed knowledge (Parkin, 2003). To understand the coexistence and overlapping of 'modern' (i.e. biomedicine and Christianity) and 'traditional' (adat) notions of illness, the body, and distress, I will explore the concept of 'counterwork,' defined as "the rebounding effects of knowledge in its diversity" (Parkin, 2003, p. 144), and the intertwining of religious and medical knowledge and practice.

This concept becomes significant in a context where individuals interact simultaneously with various cultural frames of reference in the realm of illness and distress. It assists us in looking at people's active role in the dispersion and *hybridisation* of medical knowledge within these multiple frames. Indeed, through 'counterwork,' people themselves engage in a continuous negotiation about the nature of knowledge, as people 'constantly relocate the origins of beliefs and behaviour' (Parkin, 2003, p. 148).

In the case of NTT, while biomedicine is hegemonic as the frame of reference for instituting biomedical interventions to the COVID-19 pandemic from an 'authoritative' perspective, what I discovered playing out in the community was indeed a hybridisation of both ontological and epistemological tools to develop understanding and response. 'Systems' as such, whether in reference to the 'health system' or the 'religious system', a 'biomedical nomenclature' or a traditional 'system' such as adat, have blurred boundaries and rough topologies which defy simple definitions. Latticed knowledge seems an appropriate heuristic from which to analyse the mechanism by which respondents in NTT incorporated and synthesised what could be considered as the 'technologies of pandemic control', whether theological or biomedical. Lattices of western biomedical cultural 'systems' are intertwined with lattices of local knowledge and lexicons with neocolonial theological technological 'systems' and integrated into explanatory models and modes of behaviour. Fundamental to these dynamics is the influence of power on knowledge. As power's relationship with knowledge in this pandemic is predominantly centred on the biomedical epistemology, alternative frames of reference are viewed as less potent, despite pervading each community and even health care providers.

The parallel epistemologies of religion and biomedicine, as they interact in NTT, are generative of the language of new 'idioms of distress', as the church has as its core function to provide explanations of the ineffable and invisible. COVID-19 thus evolves an object of intangible cause within the revised epistemology of the church, reminiscent of the invisible 'viral' causative agent in biomedical epistemology.

What I observed during my field work, was the dual roles that the Christian church played in the pandemic: institutional and theological. The institutional role was brought to bear as the church positioned itself at the centre of surveillance and outreach, supporting the community through financial and material support, coordinating with local governing bodies, and gathering and disseminating information in multiple directions. Its theological role was more subtle, as the Christian ethos and cosmology played a part in developing COVID-19 explanations, defining moral responses, and generating a sociocultural frame within which people could assume biological and religious citizenship by adopting the philosophical and theological tenets espoused by the churches. To belong, to succeed in overcoming the pandemic crisis, was to be a Good Christian. Moral overtones thus coloured how the community represented their experiences, hopes, fears, and explanations for why they fell ill and why they did not, or why their neighbour was struck down by the plague.

5.1 Religious institutions fill a crucial gap in pandemic community support

In many of the interviews I conducted, the church was viewed unanimously as the most trusted, reliable, and accessible source of pandemic information. This tracked consistently among community members as well as public sector bureaucrats and local leaders. In villages where the local leaders coordinated closely with the church, pandemic-related activities such as diagnostic testing seemed to be more effective. One local village head noted that the Oe Village cooperated with one of the Protestant Churches to conduct testing for citizens who had close recent contact with COVID-19 patients, remarking that they identified 17 new cases from 145 people tested. Despite evidence of impact, the local government seemed to under-utilise the church as a source of outreach, support, surveillance, and social cohesion. Many of the initiatives to manage COVID-19 among parishioners were self-initiated, thus there was high variability from village to village in terms of the types of support provided by a given church.

One community member spoke about the role of COVID-19 information dissemination that the church played,

> *There was a lot of Covid health information relayed to us by the church. Every Sunday the pastor would appeal to the congregation to*

> *comply with the health protocols, saying that it was a part of loving each other. If you loved your "siblings" you would comply with the health protocols. In my opinion, there has been more information provided by the church than from the government (Ibu Yuliana, public sector worker, Kupang city, female).*

A Protestant pastor outlined the engagement that their church had with the community and local government,

> *Of course, this pandemic has made it difficult for us. When seeing the citizens here in distress, the congregation in distress, it saddens us. The church tries to give understanding to the people that the main thing is to follow the health protocols. The church was closed because some members contracted Covid and some even passed away, so people pray from home. Thirty nine people in our parish have contracted Covid, but many are ashamed and don't report. We created a church granary and we have rice and eggs for distribution to families that must self-isolate. The church Covid team coordinates with local government and data is also given to the church council in East Kupang (Pendeta Kristina, protestant pastor, Kupang City, female).*

Evident from this exchange is the significant role of the church in monitoring and supporting local government in the overall pandemic response. One woman, a public servant and COVID-19 patient whose entire family was infected, also spoke of the importance of church support during a time of heightened sensitivities,

> *The church has been very supportive to us. Prior to my family getting it, there were two other families that contracted Covid. There was one in which tragically the entire family passed away, while the other family had self-isolated and were eventually cured. From the church, we decreed that people with Covid had to report to the church council so that the pastors could support them through prayers, phone calls, and video calls. Here in Maranatha, there is a program called Disaster Alert Church Team that goes from house-to-house to give aid in the form of providing groceries and also spraying disinfectant at people's homes. Every week, there is a Church congregation newsletter that contains information about Corona, and advises us to stay home (Ibu Ina, public sector officer and COVID-19 patient, Kupang city, female).*

Furthermore, a Catholic priest detailed how the church managed to conduct services during the pandemic, an important aspect of social cohesion and source of support for the community,

> *Many parishioners here have contracted Covid. Normally, when people are sick they ask the priests to come and pray for them at home, and we now ask them what disease they have…if it's a chronic illness*

> *that they've had for a long time, we can go and visit them at home. If it's Covid, we avoid home visits (Father Yakobus, catholic priest, Kupang city, male).*

An Army captain, who was one of the first in his village to contract COVID-19, which eventually infected his entire family, experienced the 'help from afar' from the church first-hand,

> *In the case of the church, the priest told me they could only help me through prayers. I felt nice to be looked after in that way. Maybe without the prayers, I wouldn't have been helped and cured. Because I was the first army man to have contracted Covid in Kupang City, many people were panicked (Pak Tommy, Army Captain, Kupang city, male).*

Services and the structure of worship changed during the advent of the pandemic, and the church struggled to ensure 'continuity of care', despite the limitations in the ability to congregate in person,

> *During the eucharistic service there is no more singing to avoid spreading droplets in the air, and during communion we social distance and use hand sanitizer. Many celebratory rituals like baptisms or marriages we don't do now because it involves too many people. We also set the chairs at least one meter apart and provide areas for hand washing outside the church, with dozens of spigots and sanitizer. We created a schedule for each village area who could attend mass at the allotted times (Father Yakobus, catholic priest, Kupang city, male).*

This was confirmed by my observational experiences at some churches, in which the pews were tied with string barriers to ensure that churchgoers maintained proper physical distance. The normal celebratory singing of the choir during masses was absent, fostering an atmosphere of solemnity and sadness in a way. While attending masses, I felt that the unseen angels normally presiding over the services, invisible yet felt, were replaced by viral demons, the COVID-19 spectre which filled the sanctuaries with risk and contagion.

As a source of institutional support which provided coherence and social shelter during a time of heightened uncertainty, the Church positioned itself as a key partner in pandemic mitigation and community resilience. The qualitative data from this investigation underscores the fact that the Church was positively regarded as sanctuary for parishioners, buffering the effects of social or structural vulnerability in the context of inadequate public sector responses. Despite this prominent role in pandemic intervention, the role of the Church was not uniformly or consistently integrated into local or regional government interventions, which tended to be ad hoc and variable between communities, and highly

dependent upon the relationships between local village or neighbourhood leaders and church clergy.

5.2 Theology influences local cultural forms of pandemic explanatory discourses and practices in the community

Theologically, COVID-19 was filtered through a complex assemblage of beliefs but could generally be summarised as a type of fatalism or acquiescence to the will of God. Many of the respondents expressed strong faith in their religion and their god, despite the cognitive dissonance associated with many of the beliefs expressed. God was seen as both the cause of, and the solution to, this plague. God healed some and let others die. God would bring them through this, especially if they maintained their moral dispositions. God would cast them down if they did not.

The theological underpinnings of the explanatory processes for understanding COVID-19 penetrated all aspects of life and determined how individuals responded to crisis. Interestingly, the ways in which COVID-19 influenced the church, especially considering the extended closures and restrictions such as not 'shaking hands' during certain times in the service, was not always welcomed,

> *The congregation thought "what has the priest become? Why aren't we shaking hands after worship?" When dealing with some of the religiously fanatical elders, it made my head hurt. The elders would ridicule our faith when we bow down to the fear of Covid. I usually reply with "You talk about faith, but if you see a large car right in front of you about to run you over, but due to your faith you stand still, do you think that you won't die?" Many people protested when we closed the churches and places of worship, when everyone had to worship at home, but everyone had to comply with the health protocols (Pak Yonias, Village Head, Semau Island, Kupang district, male).*

In Kupang city, this experience was mirrored by the local Catholic priest. A common refrain was that 'people were more afraid of COVID-19 than of God', the implication being that there was a strong moral component to the disease. Mitigating the disease was tantamount to rejecting the will of God in some cases, and the displaced fear of the virus from the requisite fear of God was viewed as a moral failing. This reflected a zero-sum type of thinking in a tank half full of fear,

> *Some of our villagers protested the closing of the churches, saying it seemed we were more afraid of Corona than of God. But we try and explain to the people, 'it's not that we aren't afraid of God, but we have a responsibility of keeping our togetherness with people of the faith'. We don't tell them straight away that Covid was sent by God, but we*

> *ask them to look back and see how we have lived our lives. Are we people who are close with God, so that we could accept any situation within our lives, or not? Don't let them think that God is unfair because of the Corona situation. We try and calm them spiritually, ask them to think logically (Father Yakobus, catholic priest, Kupang city, male).*

Conversely, another Protestant pastor who was also a public health staff member in the district health office, had a different experience,

> *Most of the congregation that I serve fears God more than the corona virus. They were sure that if they just prayed to Jesus, Covid would go away. It has become a part of the flesh, I as a pastor speak like that and the reality is like that. This is why we have to find the way for them to understand. They think if they die, they die by God's hand. It's like that (Dr. Yuli, protestant pastor and public health official, Kupang district, female).*

COVID-19 incited mixed emotions and responses that were entangled with feelings of fear, rejection, stigma, moral failure, blame, and embarrassment. Sin was a common thread, as COVID-19 was often seen as a curse among the people for some unknowable infraction of ineffable laws,

> *The infected people are stressed because they think the disease is some sort of curse from God, and the neighbours refuse to come near. If we follow the health protocols, it shows our good intentions, and God will look after us. I go around the neighbourhood to make reports and then I call the health office, so they would come and disinfect the place. Neighbours don't want to be close to the infected families fearing the curse, so the Covid patients feel insecure and lock themselves in the house. So, I said 'no don't be like that, because the people would feel depressed, they feel under pressure' (mama Serlina, RT leader, Kupang city, female).*

"If we follow the health protocols, it shows our good intentions, and God will look after us." Deconstructing this singular statement reveals many of the underlying assumptions and 'biosocial' determinants operating in this context. An unseen deity is in control, effectively relinquishing agency to an all-powerful being who determines who deserves to survive based on 'intention' and the moral implications of 'following authority', whether on Earth or in Heaven. I found this perspective to be fairly universal among the respondents, in which there was a matrixed entangling of personal responsibility for pandemic control coupled with moral certitude, and ultimately, that the creator of the universe was the solution. As we unravel these concepts, we find limited evidence that the true cause and solution lies in restructuring systemic determinants such as governance, power distribution, and the

influence of global discourses and the inequitable distribution of wealth, especially in these communities in NTT. We find tacit exoneration of the public authorities charged with a duty of care, and instead locate resolution among the stars.

An elder on the rural island of Semau, who recalled many of the past traditions and how they had been replaced by modern Church rituals, discussed how modern forms of worship were the new technology of salvation, especially during the outbreak crisis,

> *Josephus: Here in Semau, we believe that the lives of humans are determined by God. If the illness comes, God has willed it, we can't refuse it. Therefore, we aren't afraid, because only God can determine if we live or die.*
> *Q: But in December, there was a prayer that was conducted in the forest, right?*
> *Josephus: Yes, but we refused to attend. It is better to pray in church, rather than the forest. Semau people would probably answer like this, "never mind, it's up to Jesus". What happens, happens. They aren't afraid, but if they come to me, I tell them that Jesus comes first, and that they shouldn't worry (Pak Josephus, church elder, Semau Island, Kupang district, male).*

Attestations of faith were adaptive and led me to consider the way religion filled the gaps in a social construction of knowledge in which restrictions in access to information were endemic. Viewed as being adaptive, religion filling a gap paralleled the experience of many in the community who filled gaps in information with hoaxes and rumours which heightened emotions and served to place blame and responsibility outside the real culprit: structural inequities and limitations in resources to deal with a rapidly spreading virus.

A former sub-district leader from the rural island of Semau summarised his reflections on how COVID-19 should be approached by the community from a theological perspective,

> *They say that praying to idols is a sin according to the Bible's teachings. The village people think that this is a curse sent from God to the world. Long ago God sent the floods, and the bible said that thereafter God would not punish the world with floods but through another way. So, the locals here think that this global disaster is a punishment. I told them to view Covid as a metaphor similar to the floods from the Bible stories. I told them to wash their hands, use face-masks, and keep a safe distance, otherwise they will die like the unbelieving people in the floods. Long ago, Noah was told to make a boat and get on it to survive, so in a sense our 'ark' is washing hands, using masks and distancing (Pak Donni, ex-Camat, Semau Island, Kupang District, male).*

Despite the seeming cultural sensitivity displayed in his approach as a leader, his position stood in contrast to what I found expressed by most of the communities: a better understanding of the phenomenon through the lens of modernity. Perhaps the quaint metaphors were intended to simplify a complex issue, yet I could not help but wonder if this type of patronisation was counterproductive. Regardless, what emerged from this work was that a mixed modernity entangling multiple ontologies was quickly evolving and influencing the explanatory models and even the illness narratives encountered.

> *Covid is a virus, which will pass with time. Just view it as a* tulah[26]*. I believe that this virus exists because of the polluted environment. We say that Covid could not come into existence by itself if humans hadn't done something wrong towards God. So, we only rely on prayers. This disease doesn't only exist here in Oebasah, but also over the entire world, therefore only God can control it. No single person can control it (Pendeta Kristina, protestant pastor, Kupang city, female).*

In line with many of the respondents, there was a mixing of the nomenclatures of the Western Church and biomedicine, infused with concepts from traditional, pre-Christian adat. The mixing of nomenclatures is symbolic of the emergence of new cultural forms to explain invisible threats subject only to divine intervention. The concept of the 'invisible' was frequently encountered in my discussions, coloured as a dialectic: many respondents equated the 'invisibility' of the Coronavirus as 'non-existent', as it had not yet coalesced into a firm nosological fact, while in the same conversation, professing strong beliefs and dependence on another 'invisible' entity, namely God, which was set firm on ontological ground and was indeed the 'man behind the screen' pulling the levers and pressing the buttons,

> *Hermanus: Corona is like an invisible invader. In a typical invasion, we see the invaders. For example, if I were to hit or attack you, you would obviously be able to see me coming at you and be able to respond. But this Corona is some form of an invisible invasion. It is very dangerous.*
> *Jhon: With time we come to fear Corona more than we fear God. But for us, we have our remedy: our 'anti-corona' is the sea.*
> *Q: What do you mean 'the sea is your anti-corona'?*
> *Jhon: The air at sea. We know that the sea air is clean. We were born here. (Pak Hermanus and Pak Jhon, fishermen in seaside village, male)*

[26] 'tulah' is a type of plague caused by a curse, or wrongdoing against elders

The invisible and inscrutable existed in a parallel life world alongside the hegemonic biomedical epistemologies that had also invaded this land. A competition of sorts ensued between latticed ontologies of adat and modernity, religious technology, and reductive biomedical positivism. This constant negotiation was coloured by moral overtones incited by theological ethos, as one gentleman revealed as he questioned the motives of the unseen creator of the universe,

> *My family got tested and were told we all had Covid. We felt hopeless and there was a moment when I cried hysterically and I yelled, 'why would God give this disease to my family?' My entire family was infected, not even leaving one of us healthy enough to take care of the others. Now, even though I'm the head of the RT, all the doors to my house are locked. Where else could we go? That's what made me so afraid, until I even cried out 'What have I done wrong, God?' All five of us were trapped and weren't free to go anywhere. The important thing was that we surrendered ourselves to God. I was most worried and stressed about my wife, because she has asthma in addition to Covid. I asked 'God if you had willed this, then it is for the best. We can accept anything, but please give us the strength to self-isolate and survive this' (Pak Gideon, RT Head and COVID-19 patient, Kupang city, male).*

The genesis of these sentiments was outlined by one of the local pastors, whose church was highly engaged in providing community support throughout the pandemic. She provided an apt summary of COVID-19 cosmology,

> *In the context of religion, we tell them that everything happens according to God's will. Through our sermons we tell the people that Covid was sent by God to teach us something good. We are reminded that we had made three sins: first, sinning towards each other, second, sinning towards nature, and third, sinning towards God. We not only sin towards each other, but it's also about how we have treated the environment. Many strange illnesses like Covid can arise as a result of this sin (Pendeta Kristina, protestant pastor, Kupang city, female).*

The moral overtones of the COVID-19 story can easily be interpreted as a victim-blaming scenario, further detracting from social justice objectives, and promoting the endurance of structural power imbalances. The conflation of abiding by COVID-19 social restrictions with a disbelief in the power and authority of God was often heard in my encounters,

> *There are also those who think that if they have contracted the disease they accept it as their destiny. In my arisan*[27] *there are many elderly*

[27] *Arisans* are social and financial support groups primarily consisting of women, especially in rural areas, akin to a type of 'lottery club' in which financial resources are redistributed on a routine basis as a form of microcredit

> *people who abide by the traditions. They hug and kiss, yet I avoid it and distance myself. They say that it seems like I don't believe in God anymore. Yes, I do believe in God, but they think I fear Covid more than I have faith in God (Ibu Ani, public servant and Covid patient, Kupang city, female).*

The diffuse cultural logics around the morality of COVID-19, and its associated stigmas and social pressures, were interrogated by one respondent who tried to make sense of the dialectic of sin and justice,

> *I see many social media posts written by people who have negative swab tests, and they thank God, saying 'God has protected them.' But does this mean that God doesn't care about or protect the people who test positive or get Covid? They say, 'I'm negative because I pray to You every night, I believe in you, and all is not in vain because my faith has protected me from Covid. I want to tell them, 'don't mention about God!' I am sure they are also sinners, but maybe there sin isn't big enough to matter (Dr. Elen, physician primary health facility, Kupang city, female).*

Moralising and moral fortitude vs failure equates to victim-blaming and laying the onus of pandemic control on the individual, in the context of the theological landscape of COVID-19 in NTT. The wavering and internal negotiations in which respondents navigated religion, the moral ramifications of having COVID-19, new cultural forms, and a pervasive yet incomplete influx of biomedical knowledge was adaptive in meeting the challenges of the COVID-19 crisis.

5.3 Traditional knowledge (adat) has limited impact on community pandemic practice and experience

Rejecting traditions is seen as prerequisite to modernity

Socially constructed illness narratives generated by the community around the experience of the pandemic, both as a risk and an actuality of infection, were embedded within the latticed, multiple technologies such as the adat traditions, missionized Christianity, and biomedicine. The rapid onset and ubiquity of COVID-19 in NTT precluded extensive sociocultural negotiation with hegemonic biomedicine and governance of the health system. In effect, the community scrambled to piece together a cultural buffer from the COVID-19 threat by utilising counterwork and synthesizing tradition and biomedical modernity.

From my observations and experience, this synthesis and rapid onset of locally shared illness construction incited a dialectic tension with the hegemonic biomedical culture. The forces of biomedicine, including the government authority, were repositories of power over the control of bodies, and thereby control and rejection of syncretic responses by the community adapting to a rapidly changing society. The net effect exerted on the community was one of constant negotiation between maintenance of adat and religious 'tradition', and an acquiescence to state power in the form of biomedical epidemic containment.

Examples of this dialectic and struggle included community expressions of anger and frustration over breaking sacred burial traditions for the deceased, many of which predated neocolonial Christianity. This was especially acute in cases of perceived wrongdoing or aberrant COVID-19 diagnosis in which the community reflected acute distress at sacrilege and systematic injustice perpetrated upon them.

Negotiation of the boundaries of tradition and modernity was another example where adat, theology, and the recognition of biomedical science flirted between ontological stability and rejection. The community, faced with a growing sociocultural and biological threat, improvised and synthesized a novel cultural meme from which to approach the pandemic, and in so doing, was required to undertake the boundary work of inclusion and rejection of traditional beliefs, behaviours, and explanations along the way. What follows are accounts of how the community used ritual and custom to address the COVID-19 event within the diversity of cultural and spiritual lineages in the Kupang area, perceptions of modernity, and experiences of taboos around COVID-19-induced changes in traditional burial practices.

Non-Christian (or non-Muslim) customs and rituals (what would be considered as 'adat') conducted in response to COVID-19 were less prevalent than I had expected from the outset of my field research. While there were sporadic ad hoc rituals performed, they were localised to the rural island of Semau, or else referred to as hearsay among respondents. While stories abounded from some of the other islands such as Flores and Alor, and in remote areas in Timor Tenggara Selatan, within the focus geography around Kupang city and district, this was less evident. Some respondents recounted their reflections on the conduct of rituals, especially within the context of previous threats such as cholera outbreaks:

> *The people of Semau Island had a ritual that was performed. A long time ago, when the Christian religion did not play a large role here, there were certain places that were sacred and used for worship. Some*

> *people were chosen as a* tabib[28]*, some of the places where they resided are still here today. For example, we used to pray at the large tamarind banyon tree on the side of the road, back when this ritual was done. The previous head of the village had once asked "why were the elderly of the past smarter than us?" It was because of the tabib, which are no longer here. Only the elderly that still gather and pray like they used to. The tabib were people who were chosen to become the guardians of the village. In cases of an epidemic, like during the cholera pandemic , the tabib would ride around the village on a horse with his hair set free and attract all of the bad spirit infecting the village. With the arrival of Covid, the previous head of the village came here to suggest that we try this tradition again, but we don't care because we now have Christian religion and are more advanced (Pak Josephus, church elder, Semau Island, Kupang district, male).*

The head of the local village on Semau also detailed the revitalisation of past rituals as an attempt to curb the effects of COVID-19, modelled on the successes of allaying past epidemics through the use of customary ritual,

> *Q: Is the condition in Semau similar to the condition in Timor, where the people believe that the pandemic is due to disobedience to certain customs? For example, if there are sick people you must perform Naketi … Does this apply in Semau too?*
> *A: Yes, at the start, there were elders who came here and said that. They explained that if it was possible, we should climb the mountain to conduct a ritual, similar to how in Timor, we call it* naketi *or* poepah[29]*. In our case there were the elders who came here to make the request, and I delivered the message to the church to carry it out as part of our custom. The elders said that long ago they conducted these rituals and illnesses disappeared. In 2004 there was a cholera outbreak here and the elders performed this ritual and the cholera started disappearing. The same thing was done for Covid. We had many attendants, half of the village came. It was conducted in the forest nearby as the water source there is protected by local customs. We were remembering what our ancestors had done before (Pak Yonias, Village Head, Semau Island, Kupang district, male).*

I observed the tension between the relinquishing of tradition supplanted by modernity as represented by Christianity, Western biomedicine, and throwing off habits associated with the 'old-timers'. Predating COVID-19, this transition had already begun as traditional

[28] *Tabib* is a traditional, non (pre)-Christian healer
[29] Naketi is a confessional tradition of the Dawan Tribe in Timor, in which participants admit their mistakes (sins) against *Uis Neno* (the ruler of the afterlife) and *Uis Pah* (the supervisor of human life on Earth). It was viewed that various communal challenges faced were the consequences of offending *Uis Neno* and *Uis Pah*; thus, naketi was carried out by traditional leaders to make peace with these deities.

healers, shamans, and even beliefs in magic and sorcery were slowly replaced. COVID-19 forced the issue, demanding a rapid change in behaviour, especially around traditional greetings, socialising and gathering, and togetherness. Ancient habits are hard to break, and a rift was created between those who put aside traditional greetings to adhere to pandemic practices, and those who persisted in traditions despite increased risk of transmission. People's hold on customs, and the integral part they played in personal and social identity, outstripped the fear of contagion. This was a powerful recognition that was often conflated by the biomedically-trained health providers with 'stubbornness' and deliberate disobedience. One of the residents summarised the changes occurring because of the 'COVID-19 culture,'

> *Maybe there are aspects of our traditions that will disappear, like hugging each other and kissing noses when we greet which represents our closeness to each other. We ask the question 'is that tradition really important at this time or not?' I don't know if the habits that are being instilled within us during the Covid "new normal" transition will affect our society's way of life in the long term. But in my opinion there will definitely be things that change. Spiritual activities and burial process have already been simplified and shortened. The characteristic of the people here are to always have social gatherings, share stories, dance together, and so on. With the appearance of COVID-19, we have started to rethink everything we do (Ibu Fransiska, teacher, Kupang district, female).*

Further to this point was the uncertainty around the permanence of these changes, fostering insecurity over the future as traditions changed,

> *The elderly villagers use the Sabu language and say "that's enough already, we are old and if we are going to die, well we will just die." But I explain to them, "Don't be like that, remember your children and grandchildren, they still want to spend time with you. What would happen if you die?" They mostly listen, but some of them called me "arrogant" because I told them that 'nose-to-nose' kissing was not allowed because of Covid, and that we must wait until the condition returns to normal so we can do it again. But maybe even in the normal situation, our behaviour and habits might have changed ever so slightly (Pak Markus, Village Head, Kupang city, male).*

As he mentioned, changes in tradition were not abrupt; rather a slow transition to a more socially distanced society was set in motion by COVID-19. Health providers outlined how new pandemic practices were awkwardly employed within the context of an enduring ethos to maintain tradition,

> *With greeting customs in society, like shaking hands and kissing nose-to-nose when they meet their families, they open the masks or wear their masks under the nose so in the end it's useless to wear a mask. The habit of shaking hands is still there, but it has started to diminish as many people are performing "Covid greetings" (Pak Antonius, surveillance officer at public health facility, Kupang district, male).*

Some respondents noted how society was undergoing a transition with the loss of traditional leaders and healers. This could be attributed to the disruption in social cohesion through internal migration to the urban area of Kupang, with mixing of various culture groups, along with the transition to modernity influenced by biomedicine,

> *They say that we now live in a modern world. There isn't anyone to continue the old traditions, and that praying to idols is a sin according to the Bible's teachings. No one does the old rituals anymore, so they have been left behind. The elders who did it are now gone, so the teachings about the rituals was cut off. Now we have modern medicine, with doctors at the community health centre. Long ago, those things didn't exist, so the people relied on nature and traditional knowledge for their medicine (Pak Donni, ex-Camat and community member, Semau Island, Kupang district, male).*

Loss of traditional knowledge and practice is linked to the absence of community members who keep this knowledge, along with a concomitant loss of recognition of its social value within the community, ostensibly attributable to hegemonic biomedicine. Villages tended to coalesce around the tribal identities of the founding members or founding migrants, and yet in some places, there were no longer elders who kept traditional knowledge. When asked about the traditional figureheads of the Sabu tribe in village Oebadi, the village head remarked that "there aren't any. Even though we are mostly Sabu people here, there aren't any elderly residents who take on that role, unlike in Penkase and Oelata with their Timor tribes, where they have traditional community and the elderly people are listened to" (Pak Lukas, Village Head, Kupang city, male). A vendor at a rural transit market in the mountains attested to the loss of tradition in her village, referring again to the *naketi* ritual, when queried if any shamans or dukun remain,

> *There aren't any, it's a different era, an era of modern trends now. Maybe some still seek out the dukun to have children. The elderly no longer practice Naketi. Now, if we slaughtered a chicken, it is only for food. It serves no other purpose (Ibu Novelia, market vendor in Desa Camplong, Kupang district, female).*

Another community respondent noted the disappearance of traditional dukun or healers resulting from the transition to modern medicine, pointing out that,

> *... there aren't even any dukun beranak[30] here, they all received certified training as midwives and now work with the local community health centre. When women are about to give birth they are taken to the modern healthcare facilities. We don't really have traditional practices here in the city any longer. If there are, they tend to have a negative effect. For example, there are people who practice suanggi[31] that is a manifestation of an envious heart. There are still some people who may think that way (Ibu Agnes, community resident, Kupang City, female).*

Ilmu hitam, or black magic, is part of the common lexicon among the communities, and is widely recognised in Southeast Asia as a component of traditional ritual practice (Bubandt, 2006; Butterworth, 2008; Imber-Black, 2020; Lorea, 2020). During my initial foray into NTT, I had mistakenly assumed that these types of practices would still be widespread and adaptive as a measure against COVID-19. In most of my encounters, reference to these practices was through hearsay, and never empirically reported as experienced by the respondents in this sample. Some viewed these traditional arts as antithetical to the ethos of modernity,

> *Q: Are there people who still practice ilmu hitam?*
> *A: No, everyone here knows that it is a virus; we live in a modern world now. No one here in the city thinks like that, maybe only uncivilized people in the countryside think like that (Ibu Serlina, RT Head and community member, Kupang City, female).*

Alterations in Death Rituals

The most striking example of the changes in the community arising from the COVID-19 crisis centres on the breaking of burial traditions and rituals, and the handling of bodies according to COVID-19 health protocols. Burial customs in NTT are synthesized from pre-modern adat traditions and missionised Christianity, and the cultural value of maintaining these traditions especially during crisis cannot be overstated. With the advent of COVID-19 health protocols, strict guidance on managing corpses according to COVID-19 status superseded cultural protocols, creating a rift between authorities and the community.

Immediately following death, the deceased COVID-19 patient would be wrapped in plastic, sterilised, and carted away to be unceremoniously buried post-haste in a dedicated cemetery for the victims of the contagion. To the family members and the community at large, this represented an onerous taboo, a defilement of the spirit of the

[30] Traditional birth attendants
[31] Suanggi is a type of malevolent spirit, referred to here as a type of black magic used to influence outcomes in the community

person who had died, running counter to spiritual and social decorum. Frequent reports of 'grave robbing' or entire clans showing up to confiscate the dead from mortuaries prior to interment in protest attested to the deep emotions stirred by the restrictive COVID-19 death protocols. The fear of having a loved one pass away who had been 'diagnosed' with COVID-19 was a prevalent sentiment among most respondents in this research. Anger at, frustration with, and outright rejection of authorities to defile a body, betraying a sacred and universal duty, rippled through the communities.

The genesis for much of the contention stemmed from confusion around how patients were diagnosed with COVID-19, or misdiagnosed, or diagnosed and not believed, or frankly diagnosed with something that did not exist in the minds of the family members. Further up the causal chain, anger and upset were symptoms of deeply embedded feelings of mistrust and not being listened to, similar to being subjected to harsh regulations forced upon them by the colonial overseers of the past. In the eyes of the community, the breaking of burial traditions was both a sacrilege and a potent demonstration of state authority to control the bodies of its subjects.

> *Many people died and their families did not pray and bury their bodies according to our traditions. They were just buried like an animal. We Christians can't do that (Pak Josep, village elder, Kupang City, male).*

Dr. Ibrahim explained in quite some detail about the effect that the change in burial traditions had on the community,

> *The people of NTT have a very close bond with their traditions, which can be observed during marriage ceremonies and the mourning process of death. This has led to friction with the existence of Covid protocols that set new rules regarding the mourning and burial process. People who died of Covid cannot receive the traditional ceremonies. The families can only pray from afar, watch the body get wrapped and put inside a body bag, and then a coffin. Afterwards the coffin would be buried without any tribute ceremonies, speeches, and other traditional ceremonies. This has led to the people refusing to accept the situation (Dr. Ibrahim, pulmonologist, Kupang city, male).*

The wife of the first patient to die from COVID-19 in NTT last year, related her family's experience of how her husband was treated as he passed away,

> *When my husband died, they didn't tell us what had caused it. At that time, everything was unclear. I didn't even know that he had died, I was told an hour after it happened.*
> *At first, he had stomach issues, so we went to the community health centre, and then we went to Dr. Ita's house, then to the army hospital. We spent a week there and then were moved to the general hospital*

> *after he was diagnosed with Covid. First they said it was typhoid, and then it was Covid. It was all very confusing.*
> *We were told that he was being taken to a general hospital that had PPE. When he got there, they took him inside via a back door and through the mortuary. We went to the emergency room and asked about him. They said that my husband was already inside the isolation ward. I never saw my husband again after that. When my husband passed away, none of us were there with him, I didn't get to see his face. Even before they buried him (Ibu Yustina, wife of first COVID-19 patient, Kupang city, female).*

A common thread woven among the many tales of suffering that I heard was the confusion inherent in misinterpreting COVID-19 diagnoses, which inevitably led to cutting off the family and control of the movement and ultimate destination of the patient. At times, confusion led to conflict and refusal to comply with the COVID-19 restrictions around burial, which most authorities who I interviewed attributed to poor communications and explanations from health workers to family members. Perceptions among the community were influenced by limitations in diagnostic turnaround of results, and the disarray of how diagnostic information was relayed to the family,

> *There was a case where the test result arrived after the person had passed away. Even though the test was negative, the hospital buried them according to the Covid protocols, saying they had Covid. But the test results then showed they didn't have it. There were many cases like that (Pak Lukas, Village Head, Kupang city, male).*

In these cases, the families responded with suspicion and upset, and often claimed that the health workers had 'sentenced' their loved ones to COVID-19, and thus to being buried without ceremony. In other instances, the family simply refused to comply with the COVID-19 burial protocols despite the deceased having been positively diagnosed, further complicated by the timing of the test result not coinciding with the release of the body. Backtracking ensued,

> *Pak Asep passed away recently, and the hospital had signed out his body to the family before the Covid test results came back positive. I had to accompany the head of the community health centre to go to the family and inform them that he must be buried according to the Covid protocols, but they refused (Pak Jefry, Village Head, Kupang city, male).*

One family went as far as to sue the hospital where a death occurred. The husband, who eventually passed away following a positive diagnosis of COVID-19, was buried according to COVID-19 protocols. However, within days of the death, the wife and child tested

negative, and thus did not believe that the husband actually had COVID-19. "The conviction of COVID-19 resulted in burial at Fatukoa, the mass grave, which is not a normal burial. The family rejected that, and took the hospital to court over their grievance" (Ibu Ani, COVID-19 patient and PNS, Kupang city, female).

Over the duration of my research, I had the opportunity to spend time in one of the local morgues of a hospital, together with the swarthy ambulance drivers and morgue staff who regaled me with thanatological tales of woe in the time of COVID-19. They spoke of the difficulties and challenges in their daily duties in communicating with family members of the sick and deceased, navigating tensions between their official task of complying with COVID-19 transport and burial protocols, and the suffering family's wishes for a normal burial for their loved ones. Many of the grieving public refused to acknowledge a COVID-19 positive diagnosis, as the cultural impetus for last rites ceremony would be denied. There was confusion even among the morgue staff themselves, who had experience with embalming bodies who later turned out to have died from COVID-19 unbeknownst to them at the time. Despite not donning PPE during the procedure, they did not contract COVID-19, which led them down a path of suspicion and disbelief in the virus. During my interviews, most of them expressed uncertainty and disbelief in COVID-19, yet complied with the use of PPE when handling the dead in the field. The purpose was twofold: to comply with regulations, and to present a unified 'appearance' of contagion control to the families who had to acquiesce to COVID-19 burial protocols.

> *Q: Do you all still wear PPE when handling corpses?*
> *A1: Yes, we all must wear the PPE in order to prevent miscommunications between the hospital and the families. We have to treat the Covid corpses accordingly (Mas Daniel, ambulance driver, Kupang city, male).*

Another ambulance staff member described how these miscommunications came about, resulting in resistance from the families,

> *When the patient died the family told me that the patient had already been sick for a year at home. But when they were taken to the hospital, the patient was suddenly 'sentenced' to Covid by the doctors. But none of the family members who took care of the patient had contracted Covid. This leads to a lot of confusion for people, and suspicion about what's really going on. This was what caused the altercation between the family and the hospital staff. So that the family had refused to have the burial based on Covid protocols. For us that are working, we handle the corpse according to Covid Protocols, whether the family accepts the facts or not (Pak David, ambulance driver, Kupang city, male).*

The team also had experience with the changing of strict Muslim requirements to bury a body before the setting of the sun, including performance of traditional ablutions, prayers, and ceremony. Given the situation in Indonesia, the Indonesian Council of Ulama, charged with handling haram issues and issuing *fatwa* (exceptions) to allow for change in tradition and practice, allowed for new adjustments to be made in the management of the dead,

> *At the time I tried to explain to the family about the handling of the corpses. But because the corpse had to bathed in accordance to the Muslim (Sharia) way, I suggested that they let us handle the corpse. We were afraid that if the family handled it, they wouldn't be wearing full PPE and could get infected. Anyway, there was an MUI (Indonesian Council of Ulama) Fatwa that said it was ok to not fully bathe the corpses of Muslims in accordance to Islamic ways. We could do the Tayammum[32] instead, and it would be acceptable (Mas Ricky, ambulance driver, Kupang city, male).*

A further example demonstrates how the diagnostic confusion and disorganisation had a marked impact on the final journey for the deceased,

> *There was a case, a small child who was a PDP[33]. When they passed away, they were buried according to Covid protocols. However, the family told us that the child had a heart problem and had fallen off his bike and hit his chest, causing a shortness of breath. We think that's why the doctors placed him under Covid supervision.*
> *I think that the child was the first Covid corpse in this hospital. Even though he was a PDP, we still followed the health protocols. If the staff here don't use full PPE according to standards, the people and family would be more disbelieving and would not accept the situation. Even if we don't believe it ourselves, we still do things according to protocol. After the child was buried, the results came back negative. When the child had the swab test, they were still alive. While waiting for the results, they passed away and were buried without ceremony according to the Covid protocol (Pak Ferrmin, morgue staff, Kupang city, male).*

As members of the communities in which they worked, conflicted emotions arose when they were charged with breaking taboo or violating traditional cultural mores in the service of state-sponsored burial protocols. Concerns were expressed,

> *Ethically, considering our customs and traditions, we feel as if the people who died are just being thrown away. Although they're dead, they should still be treated well. If we find an animal carcass on the*

[32] Muslim dry ritual of purification
[33] Patient Under Supervision

> *road, we would treat it well, so we should at least do this for humans. But here at the hospital everything is in a hurry. I have had experienced in handling a corpse that was unknown. A "john doe" with no family. I took care of the body properly and with care as a fellow human. I felt sorry for the way that the task force handled the body. The coffin was wrapped in aluminium. I felt sorry for the families that couldn't pay their last respects towards the deceased. The families should be given a choice, because this was an important part of burial. The bodies that are taken by the Covid task force are more pitiful when compared to an unknown corpse (Pak Teodorus, morgue staff, Kupang city, male).*

Sociocultural traditions and forms are imperatives that drive behaviour, especially in the realm of deep adat traditions and religion. These cultural technologies were adaptive, despite the at times contrasting social restrictions established for COVID-19. The multiplex of ontologies, incorporating epistemologies local and imported, sit astride a complex tension of compliance/acquiescence and the preservation of heritage and cultural autonomy/integrity. Sociocultural analyses should have a prominent position in the unfolding evolution of contagion control.

6

Chapter 6. Individual Themes

Introduction

In the following sub-sections, I examine three themes identified as influential in how the pandemic has been perceived and responded to by individuals, within the framework of the influence of larger political economics, religion, poverty, constraints on access to appropriate information, and the rifts created or widened between the community and the health system. Misinformation, disinformation, the proliferation of hoaxes and rumour, and constraints on access to reliable sources of information influenced behaviours and led to mistrust and non-compliance, as stated by many of the participants. Official restrictions on individuals and communities had demonstrable psychological and livelihood effects, including emotional distress and financial insecurity. Surveillance, restrictions on mobility, and sanctions were identified as key drivers of the containment and mitigation strategy which had both positive and negative consequences for the community.

6.1 Misinformation, hoaxes, and confusion leads to mistrust in hegemonic biomedical authority and non-compliance

Pandemic knowledge construction is a site of contention as competing explanatory models vie for legitimacy. As communities grapple with facing high-risk environments ill-equipped to both explain and mediate pandemic risks effectively, responses and behaviours arising from constricted information access are interpreted by practitioners employing a biomedical knowledge framework as invalid, non-adherent, or incorrect. Blame, exerted by experts, is ascribed to ‘culture’ or ‘tradition’ for failures in adherence to pandemic social restrictions, ignoring the larger structural forces at play which are determinate of a community’s or individual’s ‘compliance’. What seems ignorant or misinformed is actually based on complex explanatory models that tap into the available information. This is not a rejection of the biomedical model, rather it is a structural prohibition against accessing adequate biomedical knowledge by the community.

The participants often remarked on the need for better testing, better medicines, nutritional and vitamin support, and embedded their discussions within a quasi-biomedical framework. Insisting on using terms such as virus, contagion, pandemic, and other

nomenclature, this underscored the fact that COVID-19 had not been absorbed into the collective ethnomedical knowledge as a 'culture-bound syndrome' or framed within an indigenous medical model. Thus, the issue is not that cultural explanations or ethnic understanding somehow prevented knowledge acquisition and therefore influenced behaviour; rather, the structural systemic detention of biomedical knowledge by elites further exacerbated social vulnerability in the community.

When health authorities referred to the distribution of 'misinformation' in the community which led to the observed behaviours, a dichotomy was applied: there was a tacit assumption of 'correct' and 'incorrect' information and legitimate knowledge to be accessed and used. Non-compliance by the community was explained by medical experts as ignorance, or a lack of information, as non-biomedical knowledge was perceived as illegitimate. During the examination of how knowledge is brokered and used, it is pertinent to consider who owns and controls this information and knowledge, and how it is used and judged to be proper or improper.

Not wearing masks and not being vaccinated are indicators of increased physical risk of transmission stemming from the biological aspects of COVID-19. Physical interventions in epidemic control have centuries of data supporting them yet arriving at that point requires the filtering of entire cultural models of biomedicine, which inevitably becomes polluted by hoaxes, rumours, and misinformation circulating in the community. Individuals within the community in which I worked had to constantly navigate the minefield of social media, word-of-mouth innuendo and rumours, as well as conflicting information from health providers and policymakers. Without adequate access to relevant knowledge, decisions, beliefs, and behaviours were highly variable, and the resulting confusion led to widespread suspicion, mistrust, and non-compliance. One village leader spoke of this suspicion in the context of his workplace and community,

> *We don't know who has the disease and who doesn't, so people become suspicious of one another. I mandate that everyone wears a mask in our office, even visitors, because what I see is that everyone suspects everyone else (Pak Lukas, Village Head, Kupang city, male).*

The sheer volume of competing bits of information and knowledge was daunting, and the concept of 'trusted sources' of information was an important consideration when filtering messaging. Variability in reported sources of trusted information was tied to the makeup of the village: in villages with cultural homogeneity such as shared tribal and linguistic identity, the village elders were seen as reliable sources of pandemic knowledge. In others, it was often reported that religious leaders, priests or pastors, and the Church itself provided appropriate messaging. On occasion, a proactive village head, regardless of cultural

affiliation, was seen as providing strong leadership and therefore trusted information and advice. In addition to these 'offline' sources, most respondents remarked that they sought information from the television, or on social media such as *Whatsapp* groups and Facebook, as well as ongoing and evolving discussions with friends and neighbours. The regional or city government was viewed as a potential source of information, yet it was coloured by suspicion and mistrust based on it limited reach into the community.

The individual level of analysis was challenging, as variability in language, culture, age, religious affiliation, education, occupation, and other characteristics influenced perceptions, pandemic practices, and actual health outcomes among individuals. Generally, there was a 'flow of mistrust and resistance' along these lines:

1. Conflicting information, regardless of the source, about the nature of COVID-19 led to high suspicion about its existence and resulted in non-compliance with social and physical restrictions
2. Lack of access to in-depth appropriate messaging and information on, and the implications of, COVID-19 diagnostics tests resulted in widespread confusion and spurred rumours and circulation of false information
3. These rumours led to significant mistrust in hospitals across all communities, which were seen as sites of contagion, forced isolation, and intentional conviction of COVID-19 diagnosis, as well as influencing vaccine hesitation
4. Avoidance of hospitals had negative reverberations through the community, as patients and families refused to seek health care for routine chronic conditions and acute illness, in addition to suspected COVID-19 illness
5. Community resistance to forced isolation and sequestering by the COVID-19 Task Force resulted from this mistrust and confusion about hospitals, and further resulted in families trying to skirt regulations to maintain control of their ill or deceased family members and avoid the required quarantines, isolation, and broken burial traditions.

As one frontline physician commented, the gradient of the educated vs uneducated determined compliance, sparking questions regarding barriers in communication and outreach between experts and the lay community,

> *We can explain COVID-19 in detail and how it spreads, but the people with a low education level cannot understand it. However, we also observe that people with a high level of education who don't have health knowledge also argue or deny it. It means that people find it hard to accept that Covid is dangerous and can kill us and our families (Dr. Ibrahim, pulmonologist, Kupang city, male).*

Another village head also outlined his perspective as a local government member on the dynamics of community non-compliance arising from both education and apathy,

> *People here have different mindsets and education. Normally when government releases health protocols we expect everyone under their jurisdiction to automatically follow. But there are people here who don't want to know about Covid or who just don't care, even though people have died from it (Pak Markus, Village Head, Kupang, male).*

During my discussions with the respondents, the fact of non-adherence to health protocols and social restrictions in the community was often cited. Many of the reasons for non-adherence revolved around the belief in their non-utility, questioning the existence of the virus, the effectiveness of wearing masks, distancing, or reduced operating hours of business. Vendors in the local markets often spoke about the oral networks they had set up to alert everyone when the health authorities or COVID-19 Task Force arrived to check compliance. When asked about the use of face masks which are mandatory in the public markets, one vendor remarked that,

> *Why do we need to use them? They're hot, and we are outside all day, so what's the purpose? We only wear them when we get the signal that the task force is coming, because we don't want to get fined or must do pushups in public. Normally, none of us wear masks while we are selling (Ibu Yovita, Market Vendor at traditional market, Kupang city, female).*

The open avoidance reflected both a limited understanding of why regulations were in place, as well as reflecting the community's perception of weak state authority.

Variability in the perceived weight of discipline from the government was elucidated by some of the fishermen I spoke with, working on the beach together with five others, while building a boat. Their comments are illustrative of a common refrain in which there was a disconnect between the 'what' and the 'why' of COVID-19, especially around the notions of policy, discipline, self-regulation, and surveillance,

> *I still wear a mask when I'm in public. We follow the rules. It is better than being seen as going 'against' the government even though we feel very healthy. For us, we haven't felt the effects of Corona. We are only afraid of the government, so we follow their directives (Pak Hermanus, fisherman, Kupang city, male).*

The group of ambulance drivers working in the morgue department also had similar perspectives on wearing masks,

> *We still use masks even outside the hospital in order to avoid fines. But what I see in society is that the people only comply because of their fear of the government apparatus. For example, when people here use motorbikes, now they just wear a face-mask and no helmet. They are more afraid of the consequences of not wearing a face-mask than of not using a helmet. They should be more afraid of not using a helmet! (Mas Daniel, ambulance drivers at private hospital, Kupang city, male).*

The calculation of risk here is an interesting topic which I found in statements such as the above comparison of a face mask to a safety helmet on a motorbike. Risk assessments in this context were driven by fear of fines for COVID-19 non-compliance, which took priority over risk assessment for personal safety while driving a motorbike. This was a powerful reflection of the impact that sanctions seemed to have, in theory, and was echoed by the widespread acknowledgement that discipline arose from threats of punishment more than from commitments to personal safety, health, or risk. Thus, as we saw with the open market vendors previously, 'risk' was not calculated as risk of disease transmission, rather it was 'risk of getting caught for not wearing a mask.' While the end result downstream was the same (compliance with health protocols), the upstream ontological frameworks were entirely separate. To wit, one of the local *bemo* drivers admitted that he did not even think COVID-19 was real, yet persisted in his compliance out of fear of sanctions,

> *I don't believe in the disease and I'm not afraid of Corona, but I wear it because I don't want to oppose the government or get in trouble. There are police operations and raids concerning face mask usage every day, so I use the face to avoid the fines and sanctions (Mas Tinus, bemo driver, Kupang city, male).*

Thus, we see examples of two distinct sets of behaviours arising from similar perspectives or ontologies: suspicion of the validity of COVID-19 as an entity led to compliance in one group due to 'fear' of government-imposed consequences or social perceptions, and non-compliance in another group which actively skirted authority and used social networks to avoid detection. This behaviour created tensions between health workers and the public, as noted by one nurse working with COVID-19 patients,

> *I see people that don't wear face-masks everywhere. As healthcare workers we have sacrificed so many things, including leaving our families. So I tell them 'I am a Covid nurse treating Covid patients, working half to death. If you people continue being ignorant like this, it adds to our burden' (Ibu Ester, ICU nurse, Kupang city, female).*

There were often references to the stubbornness, or 'hard-headedness' of the people of Kupang, including the following example from a lab officer,

> *The people of Kupang are stubborn like a 'rock.' The most difficult people to educate are the people selling at the markets (Mas Viktor, staff at PCR lab, Kupang city, male).*

This perspective of stubbornness led to boundaries between compliance and non-compliance, relegating the non-compliance to active rejection rather than lacking access to reliable information. Although the ability or impetus to comply was situated within a complex web of tensions between structure and agency, by oversimplifying and generalising the public as 'hard-headed', the authorities elided responsibility and the opportunity for systemic improvement.

A major impediment was that the government had been stymied in its outreach and risk communications and was unable to counter the tsunami of rumour and disinformation being spread on social media sites and through the community. The mere defining of COVID-19 was a difficult prospect, with multiple notions. As I interviewed health providers and community members, I encountered a wide array of responses, reflecting the pollution of information and influence of social media on how the pandemic was being defined. Below is a word cloud reflecting some of the perceptions and definitions of COVID-19, including moral colourings, emotional identity, false information, religious tones, in addition to biological explanations.

Figure 9: What is COVID-19? Responses from the community

The variability of responses that I received to the question 'what is COVID-19?' certainly underscored the challenges facing the government in formulating appropriate responses to mitigate the pandemic. There were an overwhelming number of people who expressed disbelief or suspicion, which was often only remedied when they were exposed to cases or deaths happening nearby. Some respondents even invoked the Biblical reference of 'doubting Thomas', revealing that 'seeing is believing' and until COVID-19 became visible to them, they would continue to doubt. This visibility implied nearby catastrophe that could be witnessed or experienced, thus initiating conversion to belief. A Catholic priest related to me that,

> *After half a year, there were still many in my congregation who didn't believe. When many deaths started happening here, they started to slowly believe and understand the situation (Father Yakobus, catholic priest, Kupang city, male).*

And from a vendor in the local market, roughly twenty metres from the stand where the first patient to die of COVID-19 had worked, "we don't believe something we don't see. If we look and can't see Corona, it means Corona is a lie." The association of seeing and belief was a common refrain, which seemed to propagate itself in the absence of solid

information being disseminated from the authorities. The notion of visibility tied to belief betrayed the frail foundations of COVID-19's nosology in this community.

> *The public knows the rules, but they are still scared. They are confused by the PCR test results, because It could be that the virus in the patient's body is no longer capable of transmission, but it has been detected positive. The public doesn't want to understand, they are just afraid. That's the problem (Ibu Rut, lab tech, Kupang district, female).*

Further confusion was piled on through the labyrinthine gauntlet that was COVID-19 testing and diagnosis. The topic of diagnostic confusion is complex, as it is layered upon many assumptions and bound by material and non-material influences. Almost all the respondents expressed confusion or uncertainty about how diagnostic tests were used and interpreted, and what the implications of a positive or negative result were. Health workers followed the most up-to-date guidelines on rapid screening with antigen or antibodies and PCR testing, using algorithms set up by the government. These algorithms were confusing even for health workers but established how a patient in the community or in a health care setting should be tested for case confirmation. The government was ostensibly responsible for developing appropriate communications and information campaigns with the community to build trust, in addition to providing information about how, where, and why to get tested for COVID-19. Hoaxes prevailed, and government responses were not necessarily designed for their dexterity and appeal,

> *There are large amount of accurate information and hoaxes on social media, so as the government we must strengthen our key functions around the pandemic including supervision, guidance, and coordination with the districts. Of course, everything must follow the correct steps and in accordance with their authority from province on down to the village, using official letters to prevent false information spreading (Dr. Agus, PHO, Kupang city, male).*

Epistemologically, the community was assumed (correctly or not) to ascribe to some notion of biomedical framing of disease causation and cure, and thus, to have had confidence in the biomedical tools being made available. An example of the potential for confusion was the ever-changing landscape of diagnostic algorithms handed down by the government. Summed up by a provincial health officer, it was immediately apparent that these complicated procedures would create dismay and misunderstanding among the public and health providers alike,

> *Many front line staff were confused by the testing algorithms for rapid antigen tests. Based on Ministry of Health regulation no. 3602, there are now three criteria for use as a diagnostic tool. Criterion A is if the*

> *delivery time from the district to the PCR lab is under 12 hours and the waiting time is under 24 hours, criterion B is delivery time under 24 hours and PCR waiting time under 48 hours, while criterion C is delivery time over 24 hours and waiting time above 48 hours. For criterion B areas, when a person takes a rapid antigen and the result is positive, then they are declared positive for COVID-19 without PCR, then on the fifth day according to the SOP a sample must be taken and sent to the provincial lab for PCR examination. For criterion C areas, when someone takes a rapid antigen test and the results are positive, then they are declared positive for COVID-19, while those with negative results must be followed up by a PCR test. NTT Province falls into criteria B and C (Dr. Joko, Provincial Health Official, Kupang city, male).*

The monologue above illustrates the importance of developing information and communication which is clear, concise, and understandable – which was obviously not often the case. In my discussions with many health officers, it was widely agreed that the ever-changing information being shuttled to them was overwhelming to absorb. I include this in the 'misinformation' section as misunderstanding information gives rise to error and suffering, just as much as deliberate misrepresentation or deception does. A former COVID-19 patient and government officer expressed frustration as she observed that the medical staff were confused about the diagnostic algorithms,

> *The healthcare workers at the Public Health Office have little understanding. For example, when I asked them why we didn't have to take another PCR test there was no explanation. I found that according to the WHO standard, a patient with mild Covid symptoms only needs to self-isolate for fourteen and there doesn't need to be a PCR test afterwards. I then concluded that the healthcare workers at the Public Health Office didn't understand the regulations (Ibu Ani, public sector officer and COVID-19 patient, Kupang city, female).*

Staff from the biomolecular laboratory also noted some of the challenges in reaching the community with proper information, and misunderstandings led to refusal to participate in diagnostic testing,

> *There are many people in NTT who don't have a clear understanding about COVID-19 which has hampered our efforts in handling the pandemic. One member of our congregation had Covid, but when they were approached to take the PCR test, they refused because they were afraid and didn't understand. There was another case in Kupang District where two families had Covid but when the community health centre approached them, they were rebuked and they refused to get tested. They didn't have an understanding about Covid tests and they*

> *felt Covid is something they can handle themselves (Pak Viktor, Biokesmas Lab staff, Kupang city, male).*

There were more than a few health officer respondents who recognised the deficiencies in the government's provision of reliable information,

> *We have to admit that the socialization process regarding COVID-19 diagnostics hasn't been that intense. We are still learning how to use social media for socialization. A lot of the information that is spreading through social media is mostly incorrect or hoaxes (Dr. Ibrahim, pulmonologist, Kupang city, male).*

This lack of accurate information resulted in a terrifying incident for one health worker, who described her experience as follows,

> *I was threatened with a machete by a patient. This patient had a fever and was brought to our health facility, and the result of the swab test was positive, so we went to his house to do close contact swabs. Since there were too many samples piled up in Yohanes Hospital's PCR lab, the test results came two weeks later. While waiting, the family did an rapid antigen swab at the Kupang Health Laboratory, and the results came back negative. When the PCR test results from Yohanes Hospital came back as positive, we told the family that they were expected to carry out self-isolation.*
> *They did not accept it, and because the family was 'accused of being exposed to Covid,' the community moved away and motorbikes don't want to pass. When we went to conduct socialization and disinfection, they immediately grabbed their machetes and there was a huge commotion; they threatened to report us to the Regional Police. It was all a big miscommunication, they didn't have a correct understanding of antigen and PCR swabs (Ibu Hani, nurse at community health centre, Kupang district, female).*

During the focus group discussion with health officers in the district, it was clearly identified that community disbelief was an important driver of consequent behaviours,

> *The public does not believe in the existence of Covid and thinks that Covid was only made up for financial gains in the hospital or health system. Some believe that Covid is caused by a virus, but there are also those who believe that Covid was only made up by health workers to get money and profit (Dr. Rima, community health centre physician, Kupang district, female).*

Throughout the data collection process, it was evident that many of the respondents were unsure what exactly COVID-19 was and were wholly unfamiliar with the sometimes-complex interpretation of medical data arising from diagnostic testing. This created a

cascade of consequences, including a widespread fear of being 'wrongly convicted' or 'sentenced' to COVID-19 resulting from being hospitalised for another malady, or from more nefarious malintent on the part of health workers to generate profits. Many respondents reported a high degree of uncertainty about how a patient could enter hospital with one disease and yet subsequently die of COVID-19. The confusion also extended to the treatment of deceased COVID-19 patients, inciting anger in families who were unable to properly bury their relatives according to religious tradition.

The lack of diagnostic understanding on the part of the community was seen by health workers as a type of ignorance or indifference, rather than recognising the limitations in appropriate government mass communications to improve pandemic knowledge. This created mistrust between the public and health providers,

> *The way they view or think of us health care workers and the hospital, they just think that we 'Covidify' the patients. They say that healthcare workers at the hospital convict people to Covid on purpose in order to get more money. I was offended and told them that as a Covid nurse, I don't get any extra money. Why are you accusing me of that? Many of the citizens here are like that. They are often indifferent, when they don't wear face-masks, there is a risk of helping to spread the disease, especially considering the large number of asymptomatic individuals. I try and explain that to them (Ibu Hani, ICU nurse, District Public Hospital, Kupang district, female).*

Another health care worker spoke about patient disbelief, and her frustration,

> *The public doesn't believe in Covid until they have contracted it. When I was in the market, I heard people saying that Covid wasn't real, I tell them, 'if Covid isn't real, come with me to the hospital and you treat those patients without PPE and without a face-mask and I guarantee you would contract Covid.' I feel that it is very hard to deal with. But I just don't know, maybe the problem is with the people. Maybe the way they think, I don't know (Dr. Yanti, Covid team member at community health centre, Kupang city, female).*

The confusion of diagnostics is related to limitations in understanding what is being tested for, and why. This results from insufficient information being provided by the responsible government agencies,

> *I don't want to get tested, even if I have symptoms. Rather being told that I had Corona after getting tested – it is better not to get tested, testing always make things worse. I don't want to go to hospital and get 'sentenced' to Corona. We don't understand what the testing device is, and we don't know what Corona is (Pak Jhon, fisherman on the seaside, Kupang city, male).*

Some patients feared the consequences of a positive test, or of even being suspected of COVID-19 exposure, preferring to hide their comings and goings instead of risking isolation under observation in hospital,

> *We encounter many cases of people lying about their personal histories to avoid isolation under supervision. For example, when we asked if they had a history of travelling or interactions with positive patients, or if they have a fever, and they lie and answer "no". There were cases where these patients were treated in the regular ward, but after a few days their tests came back positive. This is due their dishonesty (Ibu Esther, ICU nurse at hospital, Kupang city, female).*

Resulting from the confusion and lack of access to appropriate information, there was a widespread phenomenon of avoidance of health facilities due to an overwhelming fear of being wrongly diagnosed with COVID-19, leading to imposed quarantine or death as a result. The fear of being wrongly diagnosed and 'sentenced' to, or 'convicted' of, COVID-19 was spoken about in the same manner as being wrongly convicted of a crime. The social topography of this fear was made apparent by almost every single community respondent I interviewed; there was a full spectrum of suspicion, rumour, fearmongering, and the like circulating in the society which marked hospitals as sources of death.

> *The people often come to wrong logical conclusions. There was a case where the husband tested positive but the wife was negative. The people thought 'how could the wife not be positive, because she had spent one week with him?' When the husband was taken to the hospital, he passed away on the way there. When he was going to be buried according to Covid protocols, the family refused to accept the reality. They think that the positive result was a lie, because of the negative result of the wife (Dr. Ibrahim, pulmonologist, Kupang city, male).*

Fear of hospitals and diagnostic testing came from a lack of access to trustworthy information. Thus, communications campaigns may have told the community to get tested, but people were not provided with adequate details or information regarding these tests and the implications of the results. With a lack of usable information, patients and the community 'filled in the blanks' with competing explanatory models based on their own experience.

> *So, now I observe many people that have the flu or cough, but they refuse to go to the community health centre because they are afraid of being sentenced to Covid, only just because of a flu and cough. This had happened recently, a person had some previous disease, but after they had reached the hospital and died, they were said to have contracted Covid. Because going to the hospital means a certain*

> *conviction of Covid (Pak Josephus, church elder, Semau Island, Kupang district, male).*

Stories abounded in which hospitals were seen as both sources of infection, but also viewed as taking part in a nefarious scheme to misdiagnose patients with COVID-19. This fear in the community led to a marked reduction in care-seeking, including for chronic disease or routine concerns, as well as emergent health issues such as stroke, heart attack, and other maladies. The stress of being incorrectly diagnosed engendered the fears of having to be buried according to COVID-19 protocols, alone and without ceremony, as many in the community had witnessed. Health providers from the Kupang municipality hospitals had a clear view of the phenomenon,

> *I saw that the patient was afraid to come to the health facility for fear of being falsely convicted of Covid. This is actually a very big thing as many patients feel that way, that they are afraid to go to health facilities, afraid of being falsely convicted of Covid so they only come when they have a severe illness. For us it has impacted the handling other diseases, many other diseases are not focused on because we are focused on Covid, the people are afraid to come to health facilities, afraid that even if they are only a little sick, they will be falsely convicted of Covid (Ibu Liliana, nurse at city community health centre, Kupang city, female).*

Examples from the community were varied and comprehensive, as the fear of 'being convicted' was fuelled by rumour, as witnessed by Ronaldo, one of the residents on Semau Island,

> *There is a rumour going around that if we visit the primary health facility, we will be sentenced to Covid. We have heard that in Kupang, anyone who has passed away due to accidents are said to have died due to Covid. There are also cases where people who had normal fevers and took a swab test and were accused of contracting Covid.*
> *The owner of OCD Hotel says that his cousin passed away due to a congenital disease, but was said by the doctors to have died from Covid. She was buried at three in the morning in Fatukoa, a burial ground for people convicted of Covid in Otan (Mas Ronaldo, community member in Semau Island, Kupang district, male).*

Another Semau resident waivered on belief based on a lack of first-hand experience of COVID-19,

> *There are people who think that there is a political factor in play amongst other things. For me, I don't really know or understand, I have become more suspicious. To believe or not, I'm still not sure because I haven't personally seen what happens to a person with*

> *Covid. I feel that there is no Covid in Semau, that it is just misinformation and lies. There say there are rapid tests, but I have never taken any because I'm afraid and especially considering that we are all healthy. If we contract it and we die, it's God's will (Mas Andri, tour guide, Semau Island, Kupang district, male).*

Dr. Joko, an official from the provincial health office, noted that the avoidance of hospitals was attributed to concerns about misdiagnosis which led to forced isolation and, in the event of death, burial in the mass grave for COVID-19 victims,

> *People are increasingly afraid to go to the hospital for fear of being falsely diagnosed. If they tested positive for Covid, automatically the burial process must be done as soon as possible and comply with the health protocols. People who do not go to the hospital, a community health centre, or other health facilities avoid this, even though it is very dangerous for other people. In Kupang City, someone died at home with symptoms that indicated Covid, and when samples were taken, it was positive. Then their body was picked up again by the hospital and immediately buried in Fatukoa (Dr. Joko, Provincial Health Official, Kupang city, male).*

Religious leaders also noted this common sentiment among parishioners, such as the case in Oenani, in which one of the pastors remarked,

> *The congregation thinks that if they go to the hospital they would die. That's why the congregation sometimes just choose to self-isolation at home. They only go to the hospitals during emergencies. When the situation worsens, they blame themselves or others (Pendeta Kristina, Protestant Church Pastor, Kupang city, female).*

Further exacerbating this avoidance of health care due to false information was the common rumour that the hospitals were deliberately financially profiting from the invention of COVID-19. Doctors and health providers were aware of these circulating rumours which said that health workers were falsely 'sentencing' patients to COVID-19 to get a monetary bonus or that hospitals would benefit from large amounts of COVID-19 claims. Dr. Ibrahim, a pulmonologist at a local hospital, stated that "the local government should have socialized the correct information, to clear up the misinformation, because no one has really benefited from the existence of COVID-19; everyone has suffered" (Dr. Ibrahim, pulmonologist, Kupang city, male). A local midwife at a public health facility heard these fabricated tales as well,

> *There was a rumour going around that said that for every Covid death we got 50 million rupiah, and either the family or the healthcare*

> *workers would get the money (Ibu Yakomina, government midwife, Semau Island, Kupang district, female).*

Another community member in Kupang reinforced this circulating rumour,

> *What I have heard is that the hospital purposefully convicts people of having Covid, so the hospital can get 100 million rupiah from claiming to have a patient. That's what I have heard, because the ordinary people don't know that Covid treatment needs a large amount of money, and that the BPJS [national health insurance] cannot cover it because the medicine is expensive (Ibu Esther, nurse at referral hospital, Kupang city, female).*

The conspiracies and rumours were not limited to the health system, but extended also to individuals, and social media seemed to fuel the fire. In the following example, rumours of a death due to COVID-19 were being spread about the husband of a nurse, due to his proximity with a health care provider, resulting in stigma,

> *False information was being spread around because I had treated Covid patients, saying that my husband had contracted Covid because he was near to me. The information had spread through my husband's office saying that because his wife is a Covid nurse, so he must have Covid. My husband was shunned by his friends for a while (Ibu Esther, nurse at referral hospital, Kupang city, female).*

Social media rumours even went so far as to report a COVID-19 death when none had occurred. The wife of the first COVID-19 victim, already burdened by the stigma of that event, had to further endure rumours that she too had died,

> *I told my uncle that I was being isolated at Siloam Hospital. He then informed me that many people on Facebook were posting that I was dead, saying that he had seen posts on Facebook saying that I had been isolated and had died in isolation. I had said that I was still alive (Ibu Yustina, wife of first COVID-19 victim, Kupang city, female).*

Misinformation about potential treatments or prevention in the community also persisted, including the potentially harmful notion that the local fermented beverage called '*moke*' could prevent and cure COVID-19. While it was tempting to assign this category of response to 'traditional medicine', from what I observed in many communities, this tended towards self-medication through drunkenness. Although the use of *moke* is commonplace, associated with marriage and funeral rituals as well as everyday life, reliance on rumours of its effectiveness as a COVID-19 remedy enabled maladaptive behaviours, such as avoidance of mask wearing. This was a difficult topic, as some of the traditional remedies were officially sanctioned by the government in the absence of biomedical solutions,

> *In line with the advice given by the Governor, we have to use moringa leaves and eat papaya leaves[34]. People also believe that moke will prevent or treat Covid. Even when we tell them it's incorrect, the information and rumours still spread. People thought since there were few cases at the beginning, that it must be because the people drink moke. This perspective was widespread at the start, that East Nusa Tenggara was safe from Covid because it's hot here and with the consumption of alcohol, we were safe[35]. But with time, we stopped believing that alcohol could reduce the chance of catching the virus (Pak Yonias, Village Head, Semau Island, Kupang district, male).*

Health staff from a municipal public health facility opined on the community use of *moke* as a curative and preventative, revealing sentiments about how some traditional practices were viewed as having a negative impact on community behaviours,

> *Many communities use tuak, moke, or sopi. It hinders us as health workers when they believe that things like drinking alcohol can prevent Covid. They think it's okay not to wear a mask because the important thing is that they are drunk (Dr. Paulina, community health centre physician, Kupang district, female).*

Circulation of misinformation (and pdeceptive disinformation) in the community influenced how negotiations of compliance were performed, and had demonstrated negative effects in restricting access to proper health services, creating rifts between the public and health care providers. In the next section, I will discuss the psychological and financial impacts of the pandemic as related by the community.

6.2 Pandemic restrictions have psychological, and livelihood impacts on the community

6.2.1 Emotional Distress

The social and physical restrictions accompanying the pandemic mitigation strategies in NTT drastically altered how individuals could move within spaces of contagion, support themselves financially, and engage with others in their communities, tribes, and families. The stresses of uncertainty, isolation, and economic insecurity were compounded by the forces of stigma, inequitable distribution of resources and information, and feelings of

[34] Papaya leaves are often used in the treatment of dengue, and moringa is a commonly consumed shrub with high nutrient leaves

[35] This is in reference to the fact that most of Indonesia is Muslim, with little to no alcohol consumption, as compared with NTT

imposition from unseen sources. As expected, the respondents commonly expressed feelings of stress, worry, uncertainty, mistrust, and fear regarding the COVID-19 pandemic as it unfolded in their communities. A swirl of emotion engulfed the villages where I conducted my research, as the psychological impacts of the pandemic were insidious, and influenced every facet of modern life. As I have mentioned previously, the challenge in teasing out and defining the scope and breadth of individual and social responses is that they are inextricably intertwined, from the individual to the social and structural and back down again. Fear, uncertainty, isolation do not occur in a vacuum, but are linked responses to the imposition of the structure of public health interventions controlling the day-to-day lives of the inhabitants at risk.

Feelings of rejection, stigma, and fear arising from misunderstanding or limited access to information led to mistrust in the governing structures intended to protect and serve. An example was found in discussions with the wife of the first COVID-19 patient to die in NTT, who was subjected to enormous stigma and social rejection, including the behaviour of the local COVID-19 Task Force,

> *After the Covid test results came back two days later, the COVID-19 Task Force contacted me to bring my family to isolation. I lied and said that there was an event being held that blocked off the road to my house. When they finally arrived, they brought along the army and the police, because they were afraid of us. I asked them, why didn't they bring the regional police chief as well? (Ibu Yustina, wife of deceased COVID-19 patient, Kupang city, female).*

This was the first case in NTT of a deceased patient from COVID-19, when uncertainty and panic were high. The Task Force was seen as an extension of the oppressive structures being put in place by the government, which had not yet gained trust or confidence in the community. This respondent endured tremendous social rejection, as officials cordoned off her street and treated her home as a site of active contamination. The case was featured widely in the local media, causing her family to be burdened with stigma in addition to the emotional toll of losing a husband and father.

Reflecting also on the first COVID-19 patient to die, one hospital ICU nurse explored her experience with the transference of stigma and avoidance to health professionals, due to misunderstandings in the community,

> *At the beginning of the pandemic when the first Covid patient died, we were the first health providers to handle it. There weren't many workers assigned to the ICU, and the Covid team only consisted of the ICU nurses and the isolation team of nurses from Komodo. During that time, the public and even our friends working at the hospital stayed*

> *away from us. The other healthcare workers were scared of us and they avoided seeing us who worked the ICU with Covid patients. But now there are many cases, and because we use PPE, they have stopped treating us like they did at first (Ibu Esther, ICU nurse at hospital, Kupang city, female).*

This experience was reflected by a number of health care providers during the focus group discussions, ranging from dental nurses, primary care providers, and others involved in the care and treatment of COVID-19 patients. The respondents described how their families asked them to change jobs, and how the communities shunned them making the assumption, as one nurse frequently heard among her peers, *"ah, surely she has the virus".*

Health care providers seemed to bear the bulk of indirect suffering, as many of them reported fear of the high risk of contagion they endured, combined with the need for wearing bulky, uncomfortable PPE which restricted movement and breathing, in addition to the stigma and social rejection experienced at the outset of the crisis when little was understood. The repeated stories of the physical discomfort and exertions from PPE, combined with risk and rejection, was an unfortunately repeated story,

> *We have to use level three PPE hazmat suits. We use the hazmat suit and our face-masks have multiple layers, we also wear multiple layers of gloves. The face-masks have to be "N95" standard, after that we also use surgical masks on top, also goggles, helmets, boots, and gloves. During the morning shift, we split the work so each person works for four hours. When we go in to the ward, it's better that we aren't hungry or thirsty, and we also cannot go to the toilet. Maybe we might experience shortness of breath. The biggest problem is that we feel constricted, it's very hard to breathe (Ibu Liliana, ICU nurse, Kupang city, female).*

Many reported that they themselves or known colleagues had fallen ill with COVID-19 in the course of their duties, exacerbating the sense of desperation. In addition to the social stigma associated with health care vocations, there was a constant fear of being ejected from short-term housing, as some respondents noted. A poignant story came from one nurse who was diagnosed with COVID-19 during her own labour, and the difficulty in getting accepted by a hospital to give birth,

> *When I gave birth to my second child the Corona situation was at its peak. When registering at the Bhayangkara Hospital, the admissions officer said "there are 13 police officers who are currently undergoing corona treatment, so if you want to go to this hospital, if anything happens to you it is beyond our responsibility". I felt scared and looked for another hospital. At Namami Hospital, it was the same, and I finally went to Siloam Hospital. When the rapid test turned out to be positive,*

> *all the health staff who saw me immediately felt disgusted. Then I was left alone, the medicine was only put on the table. I was afraid, I prayed, and many people were disgusted. I am a health worker, but why do my friends treat patients like that? There I was stressed and scared. Finally I gave birth normally (Dr. Yanti, doctor at primary health care facility, Kupang city, female).*

The fear that circulated was not limited to health providers. One of the local village heads also spoke about the fear, especially in the context of the COVID-19 stigma,

> *At this time, especially during the rainy season, many people get the coughs, flu, and other diseases, but going to hospital is very scary. The fear comes from the stigma surrounding Covid and that people would be guaranteed to be diagnosed with Covid. If people were diagnosed with Covid, it would be like 'game over', they won't be able to come home. They would be 'finished' there at the hospital. Furthermore, the people would see ambulances and hear the sirens going to Fatukoa. There is fear there. Now people are afraid of going anywhere (Pak Lukas, Village Head, Kupang city, male).*

Another community leader noted the shift in relationships in the community arising from the fear of contamination. When one resident was diagnosed with COVID-19, his neighbours refused to help, thereby stigmatising the disease even further,

> *There was a citizen here who was diagnosed with Covid. The health office told him to self-isolate, and a few hours later, the head of the RT contacted me: 'The person who was told to isolate has no access to water. Before, he shared water with his neighbour, but now that he has Covid, the neighbour refuses to give him water. What do we do?' … Imagine how he feels? They used to share water; now they refuse. Water is important, what happens when there is no water? The people in the area are scared … That is just water, what about his other primary needs? The disease has now spread and is out of control. During self-isolation there should have been aid, but there is none (Pak Tomas, Village Head, Kupang city, male).*

Other community members noted similar experiences that stress, fear, and isolation were driving behaviours. As previously mentioned, theological epistemology influenced people's responses, and in the case below, the isolation was driven by the belief that COVID-19 was a curse,

> *The neighbours are stressed because they think the disease is some sort of curse, and they don't come near. They make the Covid patients feel insecure, and they lock themselves in the house. I feel sorry for them, because they feel like it's a curse. I try to tell them not to be like that,*

> *because it makes others feel depressed and under pressure (Ibu Serlina, RT Head, Kupang city, female).*

Fear struck many communities: fear of the unknown, fear of the infected, and ultimately, the fear of death. One local neighbourhood leader expressed fear for his family lineage,

> *When I found out we all had COVID-19, this was a huge tragedy for me and my family. Of course this was scary. I thought that if this Coronavirus really caused death, my whole line of descendants would be wiped out. That's what scared me (Pak Gideon, RT Head and COVID-19 patient, Kupang city, male).*

One public worker reported being traumatised by her COVID-19 experience, and despite her recovery, the emotional toll persisted well into convalescence,

> *When I was declared healthy, I was afraid of going to the office or market. I was traumatized, I didn't want others to spread it to me again. I was very suspicious of everything; I didn't want to contract it again. At the office, my friends were also suspicious of me, was I really cured? The same thing happened with my family. They told me not to go anywhere, even after I was declared healthy. Everything had to be soaked and washed in hot water. I had become traumatized because of it all (Ibu Ani, PNS, Kupang city, female).*

During the course of my discussions and in the context of COVID-19-derived stigma, there was frequent comparison to the stigma associated with HIV. Despite being endemic for decades, HIV still attracted a moral distaste among residents in NTT; infection was the consequence of 'negative' behaviours such as infidelity, and the appropriate response to getting HIV would be shame. This perspective was set up against COVID-19, in which the viewpoint seemed to be 'unlike HIV, you can't really control getting COVID-19, so you shouldn't be ashamed if you get it'. One provincial health officer discussed community stigma against COVID-19 and how it resulted in low levels of self-reporting, and thus low levels of contact tracing, remarking

> *At the beginning, the community had a negative stigma against COVID-19, so they were ashamed if they were declared positive, even though there is no need to be ashamed because the transmission is accidental, unlike HIV which is a behavioral disease. We were encouraging them to declare themselves, to achieve higher tracing results. Maybe the stigma of people who were initially more afraid of Covid than HIV was because people knew that HIV could only be transmitted if they had sex. But when talking about Covid, the community actually shunned the person who had it, and sealed their house for fear of contracting the virus (Dr. Nelson, PHO, Kupang city, male).*

An additional comparison with HIV was that COVID-19 was 'more dangerous', since HIV transmission only occurred in the context of infidelity,

> *But as we thought about it more, only the people that are unfaithful to their partners could get HIV. So, if we compare it to Covid, it is less dangerous (Pak Gideon, RT Head, Kupang city, male).*

A local journalist made an interesting comparison between the COVID-19 stigma and other stigmas attached to vector-borne or sexually transmitted diseases,

> *What we are afraid of is the stigma; Covid is scary because we cannot see the virus. Covid is not spread through liquid or blood contact, but it spreads after we get too close to the virus, so that's why people are more afraid of it. In cases of dengue fever and AIDS deaths, the handling of the body when they die is not as bad as with Covid. In the cases of death from dengue fever, relatives can still hug the deceased and bring them home to the family for burial. With Covid, a positive result ends up with shunning and alienation. They are isolated and the family usually can't see them again. That's what made the stigma surrounding Covid seem like a 'big monster', invisible but scary for everyone (Pak Petrus, journalist, Kupang city, male).*

Harkening back to the previous section, the importance of maintaining burial traditions was paramount, and breaking them immediately imbued COVID-19 with stigma, fear, and a sense of doom much greater than those associated with other potentially fatal diseases.

There were a few instances of respondents taking a more moderate view of the situation, especially as time wore on and the community started to acclimate to the radical changes during the past year. I noticed in many of my interviews that over time there was a shift in perspective, as people recalled responses and panic early in the pandemic when it was fresh and uncertain, and later as it morphed into a daily burden, less urgent and yet just as dangerous. A midwife in the rural island district had this perspective,

> *We in Uiasa see Covid as something scary because it has something to do with death. You can say that our understanding can still be considered as lay knowledge. However, lately there were cases in this community health centre and in Otan, where sick people were cured without any lasting damage. That caused our perspective of Covid to shift, into a slightly more positive light. People start to see it as a normal illness, just one that is of a higher degree of severity than other day-to-day illnesses (Ibu Yakomina, midwife, Semau Island, Kupang district, female).*

When queried about how he explained the situation to residents under his charge, one neighbourhood leader explained that,

> *I tell them that Covid exists, but that we shouldn't be overly afraid of it. We need to look after our health, but we shouldn't treat Covid like it was doomsday. I dare to speak like that because I have experienced what having Covid is like (Pak Gideon, RT Head, Kupang city, male).*

The correlation of personal experience of disease with a modified view of its danger was reported by some of the former patients. This was consistent with the notion that personal experience, or 'seeing' COVID-19 made it real and helped solidify and ground it as a new cultural form.

Loss of Livelihood

As experienced elsewhere around the globe, there were massive economic losses resulting from the pandemic's restructuring of daily life and mobility restrictions in NTT. Most respondents reported economic insecurity and loss of income, hitting especially hard in the municipal areas where job losses were the highest. Interestingly, residents of rural island villages which had access to farming and fishing seemed to be less severely impacted compared with citizens living in Kupang city and working in businesses, transportation, or other industries. Fear of financial losses forced a false dichotomy of choosing between livelihood and non-compliance, constraining individual agency, and impacting pandemic restriction compliance.

The significant economic impacts were most pronounced during times of imposed isolation due to COVID-19 diagnosis or suspected transmission, due to a lack of access to income or depleted savings, combined with variable security of village, neighbour, or government material support such as food and water. The social stress of self-isolation during quarantine, combined with the financial pressures from loss of income, made surviving the pandemic an almost untenable goal,

> *None of us could sell anything at the market, because we were all isolated, we didn't have money. After we were released from the hospital, we had to self-isolate for 11 days at home. We ate anything that was available. Our neighbors were afraid of us at the time, since my husband was the first death here, and the alley access was closed, and people couldn't use the road. In the area, there are many boarding houses, and the owners had built fences around their houses. It felt like we were all alone in the world (Ibu Yustina, wife of deceased COVID-19 patient, Kupang city, female).*

Many respondents reported financial struggles associated with self-isolation. Some villages had set up a cooperative for the redistribution of money and food, such as in X village with a farmer's association. Others received nothing.

The situation set up a false dichotomy of 'work vs health' in which people were forced to choose between livelihood and contagion. There was a constant weighing of the need to provide income vs the need to comply with health regulations. The costs of quarantine, borne by the individual, represented a loss of agency and a restriction in autonomy to comply with pandemic control measures,

> *The economic impact was very pronounced. If my husband can't go to work at the bank due to quarantine requirements, funds will be deducted from his pay check even though he is sick. During isolation we cannot be productive. We must only stay inside and do nothing even though we still have expenditures. We need food and water and vitamins, but we cannot work to earn money (Ibu Ina, COVID-19 patient, Kupang city, female).*

The contemplations of work versus health were expressed in response to the pandemic restrictions by a local schoolteacher in the forested village of Camplong,

> *It feels like we have to work half to death thinking about our money problem. Just leaving the house is very difficult, especially for the children who need to go to school, and who need money. We have to buy phone credit because of the online classes so they can have face to face interaction with their teachers. We simply can't afford it for much longer (Ibu Fransiska, schoolteacher, Kupang district, female).*

One of the residents who belonged to the farmer's cooperative in Oebasah village noted that "we can't stop working just because we are afraid of Corona. What if Corona lasted for ten years? We would be dead if we didn't work." The local bemo drivers shared this sentiment, noting that when possible, they redistributed funds amongst the group,

> *We try to be frugal and we use our money for food. In order to stay alive, we have to work to afford food. If there is an abundance of money, then we can share with other drivers and the konjak[36] (Mas Tinus, bemo driver, Kupang city, male).*

Emotional distress in the form of stress, worry, anxiety, fear, and suspicion gave rise to mistrust, amplification of conspiracies and rumour, and affected pandemic practices and behaviours in the community and among healthcare workers. Stigma was a significant driver of behaviours, especially at the outset of the pandemic experience, as well as a pronounced fear of hospitals as sites of contagion stemming from widespread conspiracies of healthcare workers' malintent to diagnose COVID-19 for profit. Loss of livelihood was one component of an individual's ability to comply, as people were often forced to choose

[36] The konjac's job is to help the driver, clean the bemo, shout for passengers, collect fees, arrange passenger seats, and to load and unload passengers' luggage. Every bemo has one.

between abiding by stay-at-home orders or seeking out income through work to support their families during the pandemic.

In the next section, data is presented on perceptions around mitigating and containing the pandemic through surveillance, sanctions, and mobility control.

6.3 Surveillance, Sanctions, and Mobility Control as Measures of Containment

Surveillance is a core function of pandemic control and public health systems in general, and can include contact tracing and quarantine utilising street-level techniques and more commonly digital technologies to accomplish surveillance goals (Couch et al., 2020). While public health officials see the utility and importance of surveillance, without integral involvement and clear communication with the community, the public may fail to see the purpose for which they are being surveilled and perceive it as a threat or invasion of privacy. What has been markedly clear throughout my investigation in the field is that there is a fine line between public health utility and public aversion resulting from limited understanding on the part of the community, and deficiencies in outreach from government bodies. Rules and regulations designed to improve public health and reduce morbidity and mortality are often seen as obstacles to traverse undetected to maintain personal freedoms, as defined through a veil of limited biomedical knowledge and a mixing of ontologies.

6.3.1 Sanctions Without Teeth

When asked about how to address these issues, many respondents reported that sanctions were the best mechanisms. Many respondents expressed the view that the most effective way to ensure compliance with biomedical interventions was the threat of punishment in the form of social embarrassment or shaming, such as having to perform push-ups in public, or monetary fines. These mechanisms have been conducted the world over, and throughout history, with variable success. However, what I found during the interviews was that most respondents, both from government and in the community, felt strongly that sanctions would have the greatest impact on curbing the pandemic.

First, from a local level governance perspective, the formation of the ‘infrastructure’ of compliance was in place, meaning the policies, task forces, and directives. What seemed to be missing was the discipline of enforcement of sanctions, of punishment,

> *Regarding the regional government program, we implement it at the local level, whether through the perda or aturan walikota regulations. However, there must be sanctions. If we make laws, but they're not strengthened by sanctions, people say it's 'like a weapon without ammunition'. What is a law for if it's not followed up by sanctions? That's what has become the problem.*
> *There are taskforces at the village, sub-district, and city levels. There is the kelurahan tangguh (strong villages) group. All the heads of the villages are there, so if there is a problem we can talk about it and relay it to the group. Especially considering the current situation when we can't meet face-to-face, so this has become a way to relay information via Whatsapp. Maybe there are some cases where sanctions were given, but not very often. There isn't really a strictness in the case of sanctions here (Pak Lukas, Village Head, Kupang city, male).*

In another village, similar experiences were expressed. There was a common thread in that the internal communication, whether through formal policy or informal groups via *Whatsapp* or others, seemed to be intact. What was lacking was follow-through, or amendment of sanctions to 'give teeth' to the policies that were on the books. Despite the presence of billboards, signs hanging in the markets, posters, and other media, they remained as mere recommendations rather than strictly enforceable requirements for citizens in the community. In a nearby village, another leader expressed his views on the need for stronger sanctions,

> *Our efforts to appeal to the moral responsibility of the community has gone on for too long with minimal results. I think enforcing fines would be better. The Governor's and the Mayor's legislation already exists. Now, if we only rely on 'appealing' to the people, how long will that last? We grow tired of appealing, repeating the same things every single day. Sometimes when dealing with us, the people of NTT, there has to be a certain strictness, so I want the Governor to try other ways, including imposing fines … just do it! Because the laws like the governor legislation and mayor legislation pergub and perwal are already in place, there are social fines and administrational fines mentioned there. But for now, the social sanctions only involve doing push-ups … but we can't tell the elderly to do that, it's unethical.*
> *So, we just stand guard at the check post gate, but I don't want to have to keep reminding people to wear face-masks. It has been a year already, it's silly that we have to still remind people of that! It's really difficult to control people here.*
> *Q: So, after a year, fines haven't been implemented yet?*
> *A: Not yet, because we are still waiting for news from the higher ups in the regional or district government to direct us and give permission (Pak Tomas, Village Head, Kupang city, male).*

One of the nurses from a public hospital, faced with the daily onslaught of COVID-19 patients, pointed to general lack of awareness by the community despite the risk communications, and the waning implementation of sanctions over time,

> *At the beginning, the government implemented sanctions, which I saw on social media, like making offenders do push-ups and pay fines. But I don't know if that's the correct solution or not. I also see patrol cars driving around conducting socialization with loudspeakers at each village. There are also many posters hanging with information. There have been many strategies used by the government, but the citizens' awareness is still very lacking. I don't know about other countries, but that is how things are in Indonesia, it is hard to make people comply with the law/rules (Ibu Esther, Nurse at hospital, Kupang city, female).*

Occasional raids or checkpoints were implemented, similar to what was reported by the vendors in the open markets, in which health authorities or police would check for health protocol compliance. Members of the community were aware of these activities; however, there was a high degree of variability from village to village.

> *The authorities usually conduct patrols, they check on social gatherings and people who aren't wearing face-masks. There were a few times where the army, police, and Satpol PP came to the places where people gathered like at car washes and taxi bike waiting areas. The people who were not wearing face-masks ran away rather than get caught! (Ibu Peggy, owner of general goods shop, Kupang city, female).*

When queried on potential pandemic solutions, I found that the respondents, from students to professors, business owners to public servants, agreed that sanctions and the enforcement of sanctions were necessary. Citing lack of discipline, stubbornness, lack of obedience, and the hard-headedness of people in NTT, consensus revolved around punishment of individuals to ensure compliance. There was little mention of what the punishments should ideally be, except for push-ups and fines. Reference was made by a few regarding the futility of 'appeals', which was meant in the sense of appealing to people's sense of civic duty, morality, or belonging as a COVID-19 citizen. Appeals, after a year of trials, seemed to be ineffective according to their reports.

There also appeared to be a lack of harmonisation and standardisation of how sanctions were carried out in different locations. In some villages, fines and other punishments had not been implemented, whereas in others, they seemed to be. However, there were no first-hand accounts by anyone reporting having been caught or sanctioned, thus the interviews described third-person knowledge, hearing things through 'the

grapevine', on social media, or through other sources. One public sector nurse noted with frustration that in her area, there were no punishments for people who left their homes during quarantine or self-isolation, thus increasing the chances for additional community transmission. She was unaware of any formal regulations in place to curb this behaviour, thus exemplifying further gaps in knowledge in the community.

There were strong opinions in support of sanctions as expressed by health officials working in public health facilities in both the municipal and rural districts. During the focus group discussions, the topic of how and why the community was generally 'non-compliant' was brought up frequently. One doctor commented,

> *Sometimes the community gathers and crowds around, breaking physical distancing requirements. As health staff trying to control the situation, we may use threats that if they can't control themselves, the health post facility will have to close. This means that in the relationship that we have with the community, sometimes we have to be a little bit tough, using threats to motivate behaviour (Dr. Debora, primary health facility officer, Kupang city, female).*

The tendency for 'pandemic attenuation' pervaded most of the villages, in which communities and authorities exhibited a slackening of strictness over time, symptomatic of pandemic fatigue combined with loose cultural mores, as noted by one of the physicians who participated in the focus group discussions,

> *As a community, we are very 'chilled out' like we have a character that is less istiqomah (strong willed), and we can be inconsistent. When something starts to improve, we slack off and don't follow up very well. So the Government really has to be very strict, now that things are starting to loosen up again in public … the municipal police raids to check mask wearing compliance should continue. Last January, the Kupang City Government carried out raids, but in recent months it has started to become rarer and people have started to gather at night again (Dr. Yanti, doctor at primary health facility, Kupang city, female).*

Consistent with prescriptions offered by other respondents, a strict discipline was possible only through sanctions. Officials in the districts outlined their thoughts on how enforcement was to be conducted in the community,

> *The TNI and the National Police should make a sanction and then go down to the community. Indeed, at this time we are not allowed to gather the community, so it can be done by going from house to house, but it also has to be firm. The police also have to be present and evenly distributed in all areas. What has to be done here is to dispatch the police and TNI into the community every day and disperse the crowds.*

> *What is happening now is that the police and the TNI only go to the community during curfew checks at night. If they really cooperate, doing community socialization of regulations every day, even though this is tiring, just try to it for a month and see the results … (Dr. Paulina, community health center doctor, Kupang city, female).*

Sanctions and strict enforcement of regulations were seen by both the community and public servants as the key to improving community compliance and adherence to health protocols. While there was consensus on this topic, there was a marked variability in the degree and effect of enforcement from village to village, stemming from a lack of coordination at the district and local levels, in addition to unclear mandates from higher level government bodies.

6.3.2 Mobility Control

Control of movement and monitoring through temperature screening and document review of the general public was the primary strategy for local government surveillance of its population in Kupang and the districts. According to government respondents, control of inter-village and inter-area (between districts and municipalities) mobility was accomplished by establishing 'health security posts' at transit locations, effectively granting the ability to quarantine or cut off movement completely as needed. Needless to say, mobility restrictions were not always met with a welcoming smile by the community, and numerous media reported clashes or confrontations between the public and health post staff, usually volunteers from the local government or community leaders.

At the outset of the pandemic, health posts were used to strictly control access and monitor who was coming and going, as well as providing an outlet for community engagement and communications. However, as with other aspects of the pandemic response, over time the effectiveness and efforts to support the health post, including staffing, waned. During my time in the field, I only encountered a couple of these health posts, as most of them had ceased operations by the time I was conducting my data collection in early 2021.

The provincial health quarantine office helped guide the implementation of the roles of the health posts in villages, noting that

> *… village movement is controlled according to Law No. 6 of 2018 concerning Quarantines. So, quarantines are divided into two categories namely, the quarantine conducted at the entrances between villages and quarantine conducted in the transit points between districts and municipalities. At the start of the pandemic, the world was*

> *still ignorant of the details of the pandemic so we didn't know what to do. We initially screened the body temperature, oxygen saturation, and the Health Alert Card (HAC) of all visitors arriving by air or sea. From the HAC we made a report to the Provincial Health Office (Pak Agus, Provincial Health Quarantine Officer, Kupang city, male).*

Mr. Yonias, a village head on the rural island of Semau, detailed how their village established and implemented health posts for monitoring potential cases, as well as educating the populous.

> *Last year, all the villages on the island, including Semau Sub-district, created guard posts at every entry point to the villages. We created a volunteer-based group that staffed the guard posts. When people arrived on the island, they would report at the posts and then their information was given to the community health centre and to the local task force. Many people come and they have to report themselves. During that time, the security was tightened. We installed warning signposts on all roads. There were people who protested, but the police got involved and everything was controllable (Pak Yonias, Village Head, Semau Island, Kupang district, male).*

Health posts served the purpose of monitoring and surveillance, as well as providing needed information. One local resident in Semau island, a young community member who had previously worked as a tour guide, noted their utility in providing this information,

> *During April 2020 many medical posts were built, like next to the school with the Banyan tree, to provide information about Covid. This really helped elderly who don't watch TV and who need the information (Mas Ronaldo, tour guide, Semau Island, Kupang district, male).*

A former sub-district leader in Semau Island, from the village where the first imported case of COVID-19 was discovered, saw the role of the posts as instrumental in ensuring community compliance,

> *The existence of the posts help make people comply with the protocols. Because of the posts, people that want to enter the village are required to wear face-masks. Especially if they come from outside the island, we isolate them. There are also face-masks raids, so the people of Semau always use it when going outside (Pak Donny, ex-Camat, Semau Island, Kupang district, male).*

One example of the integration of public and private cooperation in establishing health posts was illustrated by a local representative of an NGO focusing on youth empowerment in NTT,

> *Last June, though our initiative, the Karang Taruna established five Covid monitoring posts in five urban villages. There are residents' buildings that we use for the post and the ones on standby at the posts are volunteer members of the youth organization as well as the head of the local RT and also anyone else who wants to help. But as time went on, they stopped functioning maximally without government support (Pak Edi, representative of NGO, Kupang city, male).*

While many respondents supported the utility and overall effectiveness of the COVID-19 guard posts, despite the occasional protest, it was generally observed that operations peaked during the outset and first few months of pandemic onset, with a gradual reduction thereafter. Attributed to lack of funding, fatigue, and overwhelm of roles and responsibilities required of volunteers, the guard posts were yet another example of a structural innovation which had not lived up to expectations.

Section 2 Conclusion

Analysis of the individual level of themes in this study reveal the complexity of responses that are linked to greater social and structural components in which a community is embedded. In NTT, the grief and emotional distress expressed by participants was related to how information was disseminated and used, and how constraints in access to reliable information bred suspicion and rumour and resulted in stigmas and social rejection. While occurring at the individual interpersonal level, stigma was the result of structural, political economic, and sociocultural or religious influences, necessitating a broad contextual understanding.

In the next chapter, I will discuss the interpretations and implications of the results of this research study and will provide recommendations for potential areas of focus for improving pandemic health interventions in Kupang.

Section Three

Section 3: Discussion, Summary, and Conclusion

7

Chapter 7. Discussion

Introduction

Referencing the evidence presented from the results of Section Two of this study, the exogenous rupture created by the pandemic was met by an unprepared and ineffective government and health authority resulting in deficient pandemic control and spread of infection, causing panic and widespread uncertainty among the population. To ameliorate this crisis, attempts were made to contain, surveil, and restrict the mobility of people, and rumours, conspiracies, stigma, and social dislocation filled the vacuum of ineffective governance and reliable information. Communities responded by incorporating misinformation along with trusted information into long-established social forms to create new, albeit locally embedded, explanatory models and pandemic practices. They leaned on familiar structures, such as religious institutions, to provide relief in the absence of secular remedies during the early stages of the crisis.

In the following sections, I integrate and discuss the results of this study through two domains: reactions and adaptation. The published research outlined in this dissertation was grouped according to these broad domains (refer to Chapter 2: Literature Review). Reactions were responses to the massive perturbation of the initial onset of the pandemic; adaptations were examples of resilience, cohesion, and the building of trust as the community and health system struggled to make sense of a changing world with the aim of establishing resilience towards a potential future post-COVID-19 world. Notably, this research was conducted at a time of heightened crisis and uncertainty, with the participants struggling to make sense of what was happening, especially as government responses were lacking, misinformation was rife, and communities were grasping at solutions. Despite having several examples of resilience and adaptation from the published literature in response to crisis, the cross-section of time of this study was quite early in the unfolding pandemic drama, and locally resilient approaches had not yet been developed in Kupang. Most respondents focused on the disruptive nature of what was occurring in which blame, uncertainty, insecurity, and frustration prevailed. Adaptive responses in this chapter thus

consist only of what was identified in the data, and which circulated predominantly around the stabilising structure of religion, both materially and spiritually.

7.1 Reactive Responses to COVID-19 crises

Multiple problematisations, multiple ontologies

Pandemic temporality implies a sequence or progression of how an outbreak event moves through a population, causing perturbations and ripples in the social structure, and if severe enough, instigating changes in cultural forms and ways of being (Lynteris, 2014; Roth, 2020). The findings of the research in NTT illustrated a pattern of temporality to the COVID-19 pandemic, as routine social disturbances such as endemic disease, floods, and typhoons, were amplified by the shockwave of a new entity that ruptured society.

The pandemic represents a lapse in 'normal' life, akin to Durkheim's *anomie* in which there is a dissolution or cessation of established norms and moral values, in which 'normative boundaries are thrown away' (Marks, 1974, p. 333). The COVID-19 pandemic, viewed as an anomic crisis, restructured socialisation as it weakened communal bonds and amplified individual stress and frustration (Powell et al., 2021). Unanticipated social disorder brought about through this anomie is seen in retrospect as a period of liminality, of *betwixt and between*, as norms reshuffled and adapted, and as the period of moral dissolution transitioned to a period of adaptation and new cultural forms (Ali, 2021b; Turner, 1964). If characterised as liminal, the pandemic epoch is a time where moral boundaries of common social order are blurred and, as Douglas has argued, that which cannot be clearly classified in terms of traditional criteria of classification, or that falls between classificatory boundaries, is almost everywhere regarded as 'polluting' and 'dangerous' (Douglas, 2002). Turner expands upon this by extending the notion that 'what is unclear is unclean' and applies it to the concept of liminality of personae (transitions between socially delineated states are undefinable); the pandemic, in its anomic liminal character, can be thought of in terms of a transitive state, in the midst of which social norms become unclear, unclean, and polluted (Turner, 1964). It is in this context that I observed that most of the notions, experiences, and reflections by the participants in this research tended towards this representation of the polluted: uncertain, reactive, insecure, and suspicious.

The data from this study suggest that COVID-19 entered NTT first as an idea, then subsequently as a virus which was constructed into a social crisis. Global discourses about the SARS-CoV-2 virus in the early days of the pandemic were modeled on materialist technocratic biomedicine circulating in the knowledge centres of the UN, the WHO, and

the countries of the Global North (Huhn, 2020; Lenhardt, 2021). Eventually, these discourses and their associated recommendations and guidelines for addressing the new coronavirus landed on the shores of the Indonesian archipelago and were adopted and molded into national policy. In parallel, popular discourses circulated widely by the global community, attempting to explain what COVID-19 was and how it should be mitigated, often with moral constructs seeking objects of blame and othering, fomented mistrust (Caduff, 2020).

The evidence from this research illustrates how COVID-19 was constructed in NTT, using biomedical, local (adat), and religious epistemologies. Communities constructed pandemic identities, framed within worldviews arising from religious denomination, ethnicity, language, location, and profession. COVID-19 was alternately perceived as a virus, as a hoax, as a mystery, as a curse from God, and so on. What seemed to influence the ultimate ontological position of COVID-19 was closely tied to the circulation and use of what was perceived as trusted, credible sources of information.

A significant finding from the research demonstrated that there was a lack of a standardised or agreed upon problematisation among various epistemic communities. Discord regarding what was at stake led to a constellation of interpretations, knowledge-seeking, and pandemic practices. The confusion and contention surrounding definitions of the problem reflected the fact that COVID-19 had not congealed as a culturally sanctioned or well-described entity; the process of construction and negotiation of meaning was yet unsettled. The regional and local government mostly defined the problem according to biomedical epistemology, to be mitigated using tools of epidemiology, molecular testing, and exerting the force of law and regulation to control the population and reduce potential transmission of the virus. Clergy and parishioners described the influence of God and sin, that COVID-19 was a punishment, or a theological lesson to be learned, and framed the problem and solution using eschatology and prayerful petition, among others. There were some in the community who adhered strongly to a religious perspective yet held the position that the COVID-19 pandemic was a hoax, a conspiracy for profit or population control, and was of no concern beyond novelty and inconvenience.

The interviews revealed that members of these communities did not necessarily subscribe to binary, either/or explanatory models such as ‘biological virus’ vs ‘curse from God’; rather, what I discovered was a syncretic process of what Parkin described as a ‘creolization of knowledge construction’ leading to a type of latticed knowledge (Parkin, 2003). Many community members employed techniques of latticed knowledge to derive meaning and construct explanatory models for the phenomenon as it happened, using a

combination of epistemologies. Priests would preach about COVID-19 using metaphors of the floods in the Old Testament, and yet the churches were seen as the primary and most reliable sources of government-sanctioned public health messaging and information about the pandemic. Medical doctors, steeped in PCR diagnostics and reductive biomedical processes, also professed the need for prayer and faith. The pandemic was possibly real, possibly sent by God, possibly imaginary. Within the possibilities were found the multiplicity of adaptive behaviours and responses to the phenomenon. In the absence of a homogenised, legitimated knowledge around what defined COVID-19, the community improvised by synthesizing explanations using a latticing of biomedicine, religion, and tradition, as well as less reliable forms of information such as conspiracies and rumour.

7.1.1 Belief, misinformation, and the social construction of a pandemic

The findings of this research show that the legitimation of pandemic knowledge in NTT was highly contested and unstable, as local communities grappled with evaluating trustworthy and credible sources of information. Proliferation of rumours, such as 'COVID-19 is a vast hoax perpetrated by the health industry to profit from testing and hospitalization charges' (Section 6.1), was fuelled in communities by amplified messaging through informal networks of communication by word-of-mouth and social media. Despite claims that government authorities were countering rumour through valid, sanctioned biomedical information dissemination, these efforts seemed insufficient to quell the widespread circulation of false or misleading information from dubious or 'social' sources. These findings reflected the data from the qualitative literature which reported significant challenges in how to legitimate knowledge and disseminate it properly to affected communities.

As reported in the literature, misinformation and rumour are cited as key drivers of non-adherence to health restrictions, and proliferation of mistrust (Ali et al., 2021; Amir, 2021; Asiimwe et al., 2021; Kwaghe et al., 2021). Collective xenophobia and the placement of blame on 'outsiders' seemed widespread and targeted at different religions and foreigners, and initially assigned blame to the Chinese in this study and in the published literature (Ghani & Sitohang, 2020; Samuelsen & Toé, 2021; Sumesh & Gogoi, 2021). As reported from study sites in Africa and Asia, COVID-19 was initially perceived as a disease of affluent Europeans, due in part to residual post-colonial tensions and media reports of how the disease circulated, as well as 'othering' non-members of religious groups (Østebø et al., 2021; Samuelsen & Toé, 2021; Sharma et al., 2020; Wibisono et al., 2021). The communities in NTT also expressed similar viewpoints, especially at the outset of the

pandemic when people were scrambling for explanations of the causes of the fear and uncertainty.

The notion of *ethnolocality* is useful to consider here, in which ties to geographic space are intimately associated with ethnic boundaries and identity in Indonesia (Boellstorff, 2002). When communities in Kupang, consisting of heterogeneous ethnic groups from throughout the sub-archipelago and greater Indonesia, were threatened by an outside, unknown, and invisible force, they reacted by placing blame externally on these unknown sources such as China, or Foreigners. This served to mount a cultural defence and a sense of belonging, in essence, to preserve cultural forms and identity from external threats. This *ethnolocal* insulation helped bolster the distinct framing and interpretation of COVID-19 as it infiltrated the local imagination.

Respondents' viewpoints and understandings were not identified as *conspiracy beliefs* per se, which are characterised by attempts to explain the 'ultimate cause of an event as a secret plot by a covert alliance of powerful organizations or individuals, rather than as a natural occurrence' (Jaiswal et al., 2020, p. 2776). Although these beliefs were expressed, specifically in reference to the conspiracy that COVID-19 was manufactured for medical industry profits, it is important to explore the underlying causes of vulnerability to the influences of these types of beliefs in social context, rather than outright rejecting these beliefs as erroneous. In practice, beliefs and perspectives, and by extension, behavioural responses are constituted and shaped by local cultural forms and influenced by perceived social capital, class position, credibility, trustworthiness, etc. of authoritative sources of information, which are then filtered through religious or other epistemologies, shaped by peer reflections, discussions, and finally, personal first-hand experience. However, characterisation of 'believing in conspiracies' oversimplifies the 'whys' of how a given phenomenon is described, outlined, bounded, and internalised (Jaiswal et al., 2020). This also elides the multifactorial effects of social status, poverty and its impact on education and access to information, the ability to double-check or confirm validity of information using acceptable means and methods, and essentially squares blame on the target of misinformation rather than on the medium and source of false information.

This dissertation research has extended the current literature by demonstrating that understanding of the pandemic is not limited to degrees or grades of empiricist scientific comprehension of virology and biomedicine; rather, there exist basic contentions about the actuality of SARS-CoV-2 which must be viewed in the context of access to reliable information, history, and alliance with epistemic communities. Cosmologies which

incorporate supernatural causes of disorder or misfortune develop explanatory models in concordance with these knowledge traditions.

It is useful to consider how the empiricist paradigm framing the COVID-19 discourse is confronted by local epistemologies. There is opportunity to reflect on how the analytical and linguistic categories of representations of 'belief' and 'fact' seem to conflict in much of the literature, as there is tacit promotion of biomedical knowledge as superior, and local 'belief' characterised as misinformation or as error. Medical anthropology has a long history of negotiating these domains, in which ethnographers attempted to reconcile an Enlightenment-era realist paradigm with locally situated aetiologies, especially when concerning explanatory models of illness in pluralistic medical systems (Evans-Pritchard, 1937; Foster, 1976; Glick, 1967; Holst, 2020; Lock, 2004; M. Singer & H. Baer, 2018; Willen et al., 2010). There is also a demarcation between the 'how' of COVID-19 and the 'why' of COVID-19 which relates to how latticed knowledges are derived using extant cultural forms (pre-pandemic), synthesized into new cultural forms which are adaptive, and which in effect are consistent with a logic of practice and rationality (Bourdieu, 1990; Parkin, 2003).

Foster's seminal research on disease aetiology in non-Western cultures outlines two basic medical belief systems: personalistic and naturalistic; personalistic models emphasise intentional intervention as causative of disease, such as by a supernatural (God) or mystical (magical) agent, while naturalistic models rely on natural (biological) or 'unintentional' causes (Foster, 1976). These models are heuristically useful, as the internal logic of each model illustrates how the latticing of knowledge plays out. In this study, beliefs about personalistic vs naturalistic aetiology of COVID-19 were loosely aligned with reported epistemic community affiliation. Cosmological standpoint became the etiological determinant for many people in NTT.

For the community in NTT, the 'how' of the pandemic was associated with a virus, with conspiring health industrial complexes for profit, or with an undefinable category of 'I don't know', among others. The 'why' often circled around supernatural causes related to Christian ideologies of sin, 'a moral test', and punishment. Implicated in the data are that COVID-19 was predominantly a moral episteme, regardless of the materiality of cause (viral, supernatural, ephemeral). Perceptions and responses thus circled a moral fulcrum point, so that in the context of unverifiable sources of information explaining the ontological basis of COVID-19, the fact of the matter was that the epistemological 'solutions' were to be found through reconciliatory petitions via prayer to appease God, as well as through the cleansing redemptive power of social suffering in response to sin.

7.1.2 Local Worlds of Suffering[37]: Moral Stigma, Social Rejection, and Othering

In the context of the COVID-19 pandemic, the individual and the body constitute the site of infection, illness, or health, and individual bodies suffer in interaction with and in relation to other human and non-human bodies and objects (Csordas, 1990). Thus, suffering and illness are both bodily and social experiences occurring within sociocultural contexts. There is a constant interplay, or dialectic framing, between illness experiences as both expressive of and being shaped and modified by social meanings and cultural forms. As we have seen, for example, the structural influences of governance in NTT and the sociocultural context of the missionized/colonial Christian institutions, imbued the biological phenomenon of illness (or threat of illness) with meaning, expressed at the individual level as 'idioms of distress' which in turn refracted and modified cultural meanings, and so on (Kleinman, 1988). As the community struggled to assign meaning to experience, the nexus of body and society became locations of contest, as 'embodiment is eminently individual, but it is no less a social and cultural process' (Marques, 2018). The entanglement of individual bodies with the social is clearly explicated by Kleinman, and aligns with the ethos of the porous and interdependent conception of the self in Indonesia:

> *... think of the subjectivity of the person as deeply, though not entirely, bound up into this mediating intersubjective flow of social experience ... [Local worlds] are to be understood as moral worlds, for what preceded, constitutes, expresses, and follows from our actions in interpersonal flows of experience are particular local patterns of recreating what is most at stake for us, what we most fear, what we most aspire to, what we are most threatened by ... and what we jointly take to be the purpose, or ultimate meaning, of our living and our dying. Nowhere is this moral cast to the flow of experience more recognizably influential than in that type of experience of contingent misfortune or routinized misery to which we give the perennially resonant name 'suffering' (Kleinman, 1992).*

The moral local worlds characterised by the flavour of 'what is most at stake' contextualises contemporary notions of stigma (as a significant indicator of social suffering) in which status loss and structural discrimination are appended to individual, socio-psychological components of labelling, stereotyping, cognitive separation, and emotional reactions (Link & Phelan, 2001; Yang et al., 2007). Contrasted with the traditional Goffmanian view of

[37] From Kleinman, A. (1992). Local Worlds of Suffering: An Interpersonal Focus for Ethnographies of Illness Experience. *Qualitative Health Research*, *2*(2), 127-134. https://doi.org/10.1177/104973239200200202

stigma as a discrepancy between 'virtual social identities' (how a person is characterised by society) and 'actual social identities' (the attributes really possessed by a person), anthropological definitions of stigma seek to articulate how political and economic power drives discriminatory consequences seen at the interpersonal level of social interaction (Yang et al., 2007). Stigma as a moral experience is derived from the loss of what is at stake in the lived experiences of the stigmatised, such as jobs, loss of social status, relationships, health, and so on. Tied to this on a macro scale are the forms of social control embedded in knowledge systems that 'legitimize structures of social inequality and thus limit the ability of marginalized peoples to resist hegemonic forces', resulting in stigma at the 'convergence of culture, power, and difference' (Bourdieu, 1977; Foucault, 1977; Yang et al., 2007, p. 1527).

The process of meaning-making during the pandemic was tumultuous as bodies became the objects of ostracisation associated with contagion, while rapidly shifting notions of moral responsibility caused turbulence in the community. At the outset, moral panic caused by over-reactions of the local government to contain, blockade, and quarantine affected families resulted in acute social rejection as reported by those who were diagnosed or suspected early on. Physical segregation and labelling in NTT were consonant with reports from elsewhere and has been a common reaction to infectious outbreaks throughout history. Interestingly, 'stigma' as an explicitly named concept, was used heuristically by respondents referencing third person accounts of community responses, usually by health professionals, and never by the stigmatised individuals themselves. Their first-hand experience was thus reported as feeling isolated, as being rejected by neighbours or colleagues who refused to help or avoided the homes of patients, as feeling targeted by authorities, singled-out, and indeed as being marked as unclean. This extended to family members of the affected as well, as the contagion of stigma marked those in proximity to the infected, encompassing both persons and property.

The published literature mostly reports stigma as a singular category of individual experience (e.g., 'labelling' or 'social rejection') and events (being expelled from housing) during acute phases of panic and uncertainty (Bhatt et al., 2020; Kwaghe et al., 2021; Sumesh & Gogoi, 2021). Stigma was operationally defined as a social process affording protection against contracting COVID-19, exclusion, discrimination, and social rejection (Amir, 2021; Bhatt et al., 2020; Kwaghe et al., 2021; Sumesh & Gogoi, 2021), with people who had experienced 'being in the struggle' being the target of stigma (Sumesh & Gogoi, 2021, p. 11), which was applied to patients and health care workers alike. Extending the current literature, this study in NTT revealed that the target of stigma was also conflated

with dissonant interpretations of intention or pandemic practices by 'unaffected' community members. Specifically, as new cultural norms were negotiated, tensions and pockets of contention opened around compliance with regulations that were based on assumptions about the nature of COVID-19. To illustrate, respondents who wore masks in open spaces would be judged as being arrogant by their peers, as being 'inappropriately compliant', and thus, seen as aligned with government authority or biomedicine and as lacking in religious faith. When priests or pastors were required to close their churches, they were judged as 'fearing Covid more than God'. PPE-clad bodies of health workers were associated with contagion and risk, despite having the opposite intention.

Social rejections were moving targets aimed predominantly at the infected, but also at those seen as being out of sync with a rapidly evolving and contested social norm. Interestingly, social norms eventually incorporated aspects of both biomedical (social distancing, masking) and supernatural (prayer) remedy, thus it seemed that causes of stigma were heavily dependent upon institutional and etiological alignments and understandings. Essentially, stigma as a social response to fear of infection was afforded a wide berth and applied to physically diagnosed infections as well as to individuals or institutions whose behaviours were seen as morally non-compliant with dissonant social norms.

This study also demonstrated that the moral stigmas associated with COVID-19 were driven by knowledge systems, as alignment with 'legitimated knowledge systems' such as biomedicine was judged as morally superior by authorities and health practitioners in opposition to 'traditional knowledge systems', which were often perceived as being aligned with superstition, a lack of education, and with non-compliance and associated with delinquency or stubbornness. Tied closely with the locus and control of power (discussed in the subsequent section), social rejection via moral judgement, as reported by health workers against a 'superstitious public', can be viewed as perpetuating a type of stigma in which 'uneducated, superstitious' community members are delegitimised, discriminated against, or viewed as 'other' in the context of an opposing, hegemonic worldview. In the cultural-symbolic approach to risk, othering is a key element in transforming threats to local values or stakes invested in maintaining local identities, and assigning external blame to defend against defilement and impurity (Douglas, 1994). Risk is thus acted upon via moral stigmas to isolate threats, seen and unseen, against the community, and serves as a mechanism for both social cohesion and social rejection.

7.1.3 Uses of Power and Resistance

Discussions of power and resistance as reactions in the context of this study imply a complex interweaving of history, institutional influence, and multivalent ideas about the locus and control of power in NTT, and how it is enacted and resisted. Power in the form of accumulated cultural and political capital was observed through its association with the legitimated knowledge systems of the Christian Church and the State, in which the functions of the public and religious institutions dominated community experiences of the pandemic. Individuals, nested as fulcrum points against a post-colonial political/religious system, negotiated both ideal and manifested power structures vying for control in a disrupted field of relations. State-society relations, as per Abrams' and Migdal's two-tiered approach, were represented by the dialectic of the 'state idea' of a unified coherent controlling apparatus of local, provincial, and central functioning government, and the 'state system' as actually practiced and experienced day-to-day in its fractured and contentious implementation among the villages in Kupang (Abrams, 1988; Migdal, 2001).

Analyses of the flows of power from data provided in this study tend to coalesce around the four forms of limiting power outlined by Popay, et al's Limiting Power Framework (see Table 6) adopted from Barnett and Duvall, and Gaventa (Barnett & Duvall, 2005; Gaventa, 2006; Popay et al., 2020). This framework identifies the forms of power which can 'restrict the collective control that disadvantaged communities of interest/place can exercise over their own or others decisions and actions' (Popay et al., 2020, p. 6).

Table 7: Limiting Power Framework
from (Popay et al., 2020, p. 6) and adapted from (Barnett & Duvall, 2005; Gaventa, 2006).

Forms of Power	**Operating through …**	**Forms of Resistance**
Compulsory power	Direct and visibly exercised by formal instruments of the state and legislation	Changes in the 'who, how, and what' of policy processes to make them more democratic and accountable
Institutional power	Less visible, exercised through organisational rules, procedures, and norms—controlling information put into the public sphere, who is involved in decision-making, etc.	Establishing and supporting new forms of leadership to influence how political agendas are shaped, increase visibility and legitimacy of issues, voices, and demands of disadvantaged communities/people; action for extension and protection of the right to information and voice; protecting participatory spaces for community
Structural power	Invisible, work through systematic biases embedded in social institutions—social	Strengthening organisations and movements of disadvantaged people to build collective power through social movements of resistance, opposition, and movements for positive social

	hierarchies of class, gender, ethnicity, etc.; distribution of resources, social status, etc.	change; in turn, effectively resisting other forms of limiting power
Productive power	Invisible—operates through diffuse social discourses and practices to legitimate some forms of knowledge, while marginalising others. Shapes the meanings of different social identities	Actions targeting social and political culture and individual and collective understandings to transform how people perceive themselves and those around them, their sense of individual and collective self-worth and how they envisage future possibilities and alternatives. Challenging dominant stigmatising discourses and representations through innovative use of media, opportunities to develop positive collective narratives about people's histories and future possibilities to develop 'narrative resilience'

Compulsory power operated through formal legislative acts, such as governor's decrees, provincial and local health department edits, nationally adopted policies on the formation of task forces, delegation of authority for budget renegotiation, and so on in the realm of liberating state enforcement power at the local levels (UN OCHA, 2020; Walikota Kupang, 2021). However, as reported by the respondents, often the entitlements of compulsory power were questioned, either as being unclear, having a limited budget to implement, or lacking in actual enforcement.

Institutional power flows were seen as both inter-institutional and intra-institutional, and operated between the state, the church, civil society, health institutions and organisations, and at the village level. Circulation of misinformation, of sanctioned government information, and interpretation of regulations instituted through compulsory powers were seen in this domain. Evidenced by critiques at all levels, institutional power flows bottlenecked most of the responses, as local village heads were disempowered and unengaged, communities expressed mistrust in public sector responses, and the community relied on religious rather than secular organisations operating in the public sphere. The lack of responsive and trusted leadership identified by most respondents attested to the fractured flow of institutional power in Kupang.

Structural and productive power flows operated through the media of embedded histories of inequality, colonial and post-colonial domination by domestic and foreign governments, constraints in resource distribution such as commodities for pandemic intervention, and the persistence of social inequality and the low social status of NTT in the greater national conversation. These two domains of power had major impacts on the communities, as the forms of legitimate knowledge tied to dominant biomedical and legislative authority elided local contributions and collaborations around how the pandemic

should be mitigated at the village level. Wee (2002) and Nugroho (2020) described this as a 'coexistence of oppositional narratives' particular to fault lines of power and dominance between the Jakarta power centre and NTT on the periphery (Nugroho, 2020, p. 93; Wee, 2002). Structural and productive power is inseparable from the institutional forces behind it, in this case a rigid hierarchy of top-down, centre-to-periphery mode of governing, augmented by the institution of the Church, through which the control of budgets, legislative power, the threat of enforcement, and a history of marginalisation all led to poor outcomes in how NTT managed the pandemic.

Integral to this was the endemic corruption in Kupang, noted as being one of the most corrupt cities in Indonesia, in which clientelism created ruptures in the flow of all four domains of limiting power (Berenschot, 2018; Mietzner, 2020; Tidey, 2012). The overt legitimation of government authority, and thus its associated systems of knowledge and governance, was undermined by this clientelism which directly resulted in weak leadership, ineffective or incompetent individuals in positions of legislative power, and caused pervasive political mistrust (Berenschot, 2018). This was echoed in the data presented in Section 2 of this study, in which community members, village heads, church leaders, and even government officials expressed frustration, mistrust, and lack of confidence in how public sector governing was executed in response to COVID-19.

The dynamics of governing in NTT were reminiscent of Foucault's *Panopticon* (or, rebranded here as the *PanoptiCovid*), which engendered discipline and self-regulation through an ever-present surveilling eye which was always felt, but not always seen (Foucault, 1977). The NTT government's policies tilted heavily towards expectations of unreasonable individual agency and self-regulation, under threat of sanctions or punishment, and thus fostered the sense that discipline was key to surmounting the pandemic. The wielding of discipline could be viewed as a form of biopower exerted by the state to force compliance, in this case through obeying regulations to wear masks, to quarantine, to physically distance, and so on.

I noticed that the way the *PanoptiCovid* evolved and took root was tied to the idea that the biomedical epistemology, and the trailing concepts around biosecurity, surveillance, and control, was legitimised and validated in opposition to many of the expressions of understanding held by the community, which were often fragmentary or based on religious or superstitious epistemology among the lay vernacular community. This hegemony of knowledge was conceptually linked to *institutionalisation*, as understood by Berger and Luckmann, in which habituated action by social actors (in this case, a dominant political elite) coalesce into historic truth and 'legitimated' as socially constructed

knowledge, regardless of its validity or invalidity (Berger, 1971). When transformed into policies backed by organisations with claims of authority, such as the Church or State,

> *... legitimized knowledge comes to exert social control over individuals. People feel pressure to obey rules and conventions that have become dissociated from human agents and are instead imbued with coercive power because they have been legitimated and institutionalized (Hanna & Kleinman, 2013, p. 19).*

Resisting what?

A significant issue that threaded its way into most conversations and observations was in relation to individual behaviours around adherence or non-adherence to regulations, especially mask wearing, social distancing, and the like. The scholarly literature traces how constraints on individual agency are determinate of the ability or volition to 'comply', and include questions of access to masks, the role of poverty, dissemination of appropriate information, and so on (Jones, 2021; Wilkinson & Fairhead, 2017). There are important distinctions between how these issues are conceptually framed, as discourses around 'adherence,' 'resistance', 'compliance', 'non-compliance' are defined by the object being resisted, the object against which a person is not compliant, etc. Framing in the academic literature becomes complicit in legitimising biomedical epistemologies such that non-adherence or non-compliance is essentially 'noncompliance with regulations established by a hegemonic order instituted by biomedical authorities' (Farmer, 2000; Hilfiker & Ganguly, 2020; Panter-Brick, 2014; Walker et al., 2020). Thus, in my consideration of the evidence from this study, I was confronted by the challenges in analysis and discussion which gave tacit acknowledgment to a regulatory framework which normalised, even moralised behaviour based on a biomedical, epidemiological standard of reference.

I consider resistance as an important component of the overall experience of the communities in this study. Aligned with several of the studies in the literature which reported how resistance and non-adherence functioned in the ethnographic settings, the evidence in this study revealed that resistance was illustrative of political mistrust, of uncertainties resulting in decisions being made to not comply with regulations, and in behaviours reflecting internal states of suspicion and mistrust of the health system (i.e., authority). Evident from expressions by vendors in the public markets when remarking why they did not use masks, or by the groups of fishermen working maskless on the shores, underlying mistrust directed their behaviours. Often, respondents would only comply when they felt they were being actively surveilled, when the task force was nearby, or when threatened by immediate censure or threat of enforcement. Thus, non-adherence for many

of the respondents was a passive resistance, that compliance happened to 'follow the rules' but only insofar as they were in a context of being discovered by the authorities.

This resistance could also be seen as religious affirmation, as an expression of moral certitude, when done in the context of acknowledging the power of God over the power of COVID-19. This was a common refrain, as the moral framing of compliance with the regulations of humanity vs the regulations of God was a site of contention for many respondents. This also aligned with observations made in the heavily religious social contexts of the studies undertaken in Ethiopia and Pakistan (Ali, 2021b; Østebø et al., 2021).

Resistance to the power of the state was also observed in the way the deceased were controlled. In Kupang, I observed a phenomenon which could be considered as a 'pollution taboo inversion'; infected, contaminated bodies which would normally be the object of taboo became sites of contention of the bounds of state authority. Families, normally fearful of approaching 'contaminated' health facilities, would steal bodies or actively resist authoritarian claims over the disposal of the deceased. The social imperative to conduct death rituals superseded the perceived risk of contagion and the need for regulatory compliance on the part of the families of the dead. Ali, from Pakistan, observed similar cases of family protest and resistance to state control of bodies, referencing authoritarian control of the dead as performing 'rituals of containment' (Ali, 2021b). However, this dissertation has also found that those who conducted the rituals of containment, namely the morgue workers and ambulance staff charged with disposing of the bodies, did so merely to comply with regulations and not from a sense of concordance. It was evident that mistrust was pervasive; however, resistance was expressed differentially as the agents of government regulation at times conducted their affairs begrudgingly.

In Sierra Leone, resistance took the form of both active protests and passive non-compliance, as well as resisting power through local grassroots organising by housewives setting up financial distribution systems and facilitating access to mobile phone technology. Resistance in much of the published literature is grounded in historic relations of coloniality and economic or social inequities, especially referencing the Ebola outbreaks in particular (Cohn & Kutalek, 2016; Hewlett & Hewlett, 2008; Samuelsen & Toé, 2021; Walker et al., 2020; Wilkinson & Fairhead, 2017). Paralleling the situation in NTT, refusal to consult local communities regarding the social aspects of outbreak perpetuated colonial approaches, continuing the 'othering', and inviting in the usual suspects of debates around compliance, who to blame, and how stigma is distributed during times of crisis.

Grassroots organising in Indonesia was also seen in the literature, through redistribution of finance and food based on wilayah adat traditions in Bali and West Java (Bahagia et al., 2020; Sari et al., 2021). In NTT, passive collective resistance seemed more centred on discourse and how knowledge was being legitimated through word-of-mouth and social media, with less evidence of formal structures or organisation being instituted. Thus, while there was some mention of activities by youth organisations or academic centres, these were through third person references. Thus, I can conclude that while the community seemed to have ample information distribution networks, compared to the literature, there were fewer examples of organised resistance in NTT during the time of this study.

7.2 Adaptive Responses to COVID-19

The published literature details a number of studies from LMICs which illustrate adaptive responses to the pandemic, including exemplars of leadership, community cohesion and support, and institutional resilience. In contrast, this study was conducted during a time of acute crisis, as COVID-19 cases were on the rise, laboratory capacity for PCR testing was being built, and there was still a lot of confusion about who was responsible for doing what. At the time of the field work, the vaccine program had only just begun and was focused on frontline health workers, and was not widely available or disseminated. Businesses were going under, and there was a pervasive sense of uncertainty in the communities.

As such, the Kupang villages under study had not yet coalesced strategies aimed at resilience and recovery, as they were still embattled with increasing chaos, implementing new policies, figuring out budgets, and scrambling to provide basic provisions and protections to citizens. While there are multiple examples of positive adaptive responses from elsewhere in Indonesia, and from other LMICs generally, the respondents in this ethnography in NTT at the time were hyper-focused on the urgency, uncertainty, and disruptive aspects of the pandemic. However, a few salient observations can be made regarding the importance of institutional support, and micro-level village cohesion which indicated the beginnings of sustainable recovery for the long-term. In the following sections, I outline the adaptive responses from the community in NTT, embedded in the context of the published literature.

7.2.1 Religious institutions provide material support and explanatory frameworks

The dominant explanatory framework for COVID-19, expressed by most participants in this study, was heavily influenced by Christian institutions and local religious leaders

invoking supernatural causes and remedies. Supernatural explanations were also reported by several authors in the included scholarly literature and reveal tensions around a secular vs religious approach to the pandemic (Ali, 2021b; Ali et al., 2021; Bhatt et al., 2020; Østebø et al., 2021; Tan & Lasco, 2021; Wibisono et al., 2021). Religion was seen as both a cause and a remedy for the pandemic; in Nepal, mass ritual gatherings were seen as 'super spreader' events of increased viral transmission and condemned (Bhatt et al., 2020), while for others in Nepal, as well as in Pakistan, Ethiopia, Indonesia, and the Philippines, religion was actively sought for comfort, social cohesion, and individual assistance. Improved relationships with God were also noted as essential adaptations to the pandemic crisis (Ali, 2021b; Ali et al., 2021; Bhatt et al., 2020; Østebø et al., 2021; Tan & Lasco, 2021; Wibisono et al., 2021).

In NTT, religion figured prominently in the community's adaptive responses, as church leaders organised material support, especially for quarantined or affected parishioners, as well as psycho-spiritual support by providing a platform for prayer and reassurance as the pandemic was couched as part of a divine plan. Despite the church's representations of COVID-19 being a punishment for sins, the religious structure provided institutional solace, as reported by most of the respondents (refer to Chapter 5, Sections 5.1 and 5.2). This was also reported by researchers in Pakistan and Ethiopia, where the influence of Islam and Orthodox Christianity, respectively, dominated the COVID-19 secular discourse (Ali, 2021b; Østebø et al., 2021). Illness, religion, and magic were inseparable, as rituals to ameliorate the pandemic were framed as magic spells counteracting COVID-19. Religion provided meaning, as the symbols of these Abrahamic traditions offered cultural metaphors of suffering and redemption, including long histories of God's intercession in the world to remedy plagues and to provide eventual hope for salvation.

During this epoch of anomie, symbolic interpretation of the meaning-making of religion provide context for most of the responses by the communities in NTT, Ethiopia, Pakistan, and elsewhere. Geertz, framing culture within a Weberian reference that humanity is caught in 'webs of significance', noted that the concept of culture is not an empirically reductionistic science in search of laws; rather, it is an interpretive search for meaning (Geertz, 1973, p. 5). Within this context, it is useful to consider that religion serves as an interpretive, symbolic structure from which to derive meaning about the events of the pandemic crisis. Based on narratives from the community in this study, the crisis of COVID-19 was not a naturalistic biomedical one, but rather a crisis of meaning amid an epoch of anomie. Divine control and intercession thus superseded biomedical explanations,

as was evidenced by the overwhelming reliance on local religious institutions, on prayer networks and associations, and on divine explanations for COVID-19 as an event embedded in the larger plan for humanity.

Christian institutions, whether Catholic or Protestant, were adaptive resources during the pandemic in NTT, especially given both their dominance as legitimate social entities (and thus imbued with symbolic and institutional power), as well as being located within and among the community, as 'experience near' stakeholders in contrast to distant secular bureaucracies. Social suffering, at once an embodied and shared experience of the fears, stresses, and uncertainties associated with the pandemic, resonates with the theology of the Church as Jesus' suffering is seen as the divine sacrifice on Earth. As Kleinman illustrated, the 'suffering body becomes the meeting place of the human and the divine; healing becomes the material manifestation of Christian power' (Kleinman, 1997). Christianity thereby is involved in a transformation of subjectivity, of an institutional form of suffering which provides metaphysical as well as material comfort. As seen in NTT, and elsewhere in recent history, the 'organized collection of funds, administration of hospitals and poor-houses, and experiences of religious transformations [by the Church], became a vehicle of political power' (Perkins, 1995, p. 202). This transformation was evident through the narratives of how the Church was a location of solace and respite, as well as a centre of institutional power.

7.2.2 Danger, risk, and uncertainty: pandemic imaginaries in a society in transition

The 'pandemic imaginary' in NTT, as elsewhere, evolved as disparate institutions constructed and inhered the values and symbols associated with COVID-19 events (Lynteris, 2019). As I have demonstrated in this thesis, the distinctions in local responses straddle two worlds of tradition and modernity of adherence to adat and religion, and the adoption of technocratic, reflexive, allocative, and predictive tools for risk mitigation and anticipation of the future. The community's approach to the crisis was an engaged discourse between framing the pandemic among familiar dangers and threats, drawing comparisons with cholera or AI, and negotiating adaptive responses using the tools of tradition, religion, and modern technology (diagnostic tests, treatments). Governmental approaches, however deficient, were modelled on technocratic mitigation, public health prevention, and predicting future uncertainty using empirical data, government policy, epidemiology, and so on.

Beck and Giddens' views on modernity revolve around distinctions between risk and danger in modernised, industrial, and globalised society (Beck, 1992; Giddens, 2013).

According to Beck's *Risk Society* thesis, risk is a 'systematic way of dealing with hazards and insecurities induced and introduced by modernisation itself' (Beck, 1992, p. 21), while for Giddens risk is the 'mobilising dynamic of a society bent on change, that wants to determine its own future rather than leaving it to religion, tradition, or the vagaries of nature' (Giddens, 2003, p. 24). Dangers are distinctly tied to notions of how traditional societies conceptualised misfortune or hazards in a framework of religion and faith, while risk is linked to modernisation, the desire to control the future, and is managed reflexively through engagement with policy, planning, and prediction.

> *Traditional cultures didn't have a concept of risk because they didn't need one. Risk isn't the same as hazard or danger. Risk refers to hazards that are actively assessed in relation to future possibilities. It comes into wide usage only in a society that is future oriented – which sees the future precisely as a territory to be conquered or colonised. Risk presumes a society that actively tries to break away from its past – the prime characteristic, indeed, of modern industrial civilisation (Giddens, 2003, p. 22).*

Taken further, Luhmann distinguishes between danger and risk in his notion that danger is external to the system, while risk is conceptually generated by decisions of the system (Luhmann, 2002). Taken as a whole, the concepts of risk and danger as associated with a discontinuous, non-linear process of late modernity in industrialised society are important distinctions in the context of Timorese village life in NTT.

Late modernity emphasizes non-linearity, conceived as 'multiple modernities' in which people who live traditional, modern, or late modern lives co-exist within the same society (Therborn, 2003, p. 294). Within NTT, this is expressed as the diversity of values, from traditional adat held by Atoni Pah Meto, Savu, Rote, or other ethnic domains, immersed in a changing society embracing modernity, technology, and a focus on the future, referencing Beck's risk society (Beck, 1992; Olofsson & Öhman, 2007). McWilliam provides insight into the inherent tensions among these multiple modernities, in the form of the modern, post-colonial village form of '*desa*' and the *wilayah adat* encompassing traditional ethnic domains; the former seen as the administrative powers of modernity from the nation state, the latter adhering to pre-modern traditions and ethnic identity (McWilliam, 1999). These tensions persist as state-led development focuses on the casting off of tradition perceived as backward, feudal, and encumbered with economic inertia to

usher in modern prosperity in the form of neoliberal capitalism (Kambaru Windi & Whittaker, 2012).

As an uncertain danger in the present, COVID-19 was renegotiated by the communities and the government into various risks depending on how modernity expressed itself in the local context. As evidenced in the respondents' narratives, reflexive negotiations about defining, mitigating, and predicting the COVID-19 crisis were heavily influenced and dependent upon seeing it as a danger to be managed through tradition (traditional remedies, Christian prayer, adat rituals, reliance on traditional leaders for guidance), or as a modern risk best managed through biomedicine, PPE, diagnostics, and government policies and procedures tied to bureaucratic modernity. Often, individuals negotiated these degrees of modernity by combining seemingly incompatible epistemic solutions: prayer and mask wearing, social distancing and traditional remedies, and so on. What is evident is that the communities' responses were multivalent and incorporated multiple modernities which were at once distinct and yet intertwined as expressed by the diverse publics in NTT. While older respondents embraced tradition, others rejected it in favour of 'modernity', including modern religious sentiments (i.e., Christianity). Assessments of these risks and dangers, as demonstrated by the narratives, are inextricably linked with how the phenomenon is understood, the information or misinformation in circulation, associations with epistemic communities which influence cosmology and explanatory models, and political trust or mistrust as expressed by the respondents.

7.3 Critical reflections on the study

Popay, et al. identify a primary 'marker' of qualitative research regarding investigations into understanding and relationships between lay and professional knowledge which should 'privilege subjective knowledge' to provide evidence to inform policy or practice (Popay et al., 1998, p. 344). The key question they ask is 'Does the research, as reported, illuminate the subjective meanings, actions, and context of those being researched?' (Popay et al., 1998, p. 345). The emphasis in my study on the meaning and understanding of the COVID-19 pandemic in the community (lay) context provided this illumination, producing evidence around tensions in definitions and behaviours and how the pandemic came to be known and enacted as a site of ongoing contention between the health authorities and the public. The aims and research questions were designed toward the end of a deepening understanding of lay explanations, and thus, this study significantly adds to the knowledge base of subjective experience in this specific setting.

Reflecting on the process of data collection and study design, several opportunities for improvement could be identified. The strict bureaucratic requirements for permissions and approvals which meant that village leaders were the primary informants to connect me with community respondents was both enabling and constraining. In retrospect, rather than spreading across many villages, sampling of a more diverse population within a limited number of villages could have potentially yielded a deeper understanding of a cross-section within a given locale.

This is tied to the fact that villages in Kupang city are structured *ethnolocally*, as internal migrants from the same ethnolinguistic group cluster together, transplanting adat, cultural hierarchy, and lineages to the urban site. Rote, Savu, Alor, or other ethnic communities relocated around previous migrants from the same clans or ethnic groups as they relocated from their home islands and were often governed by local village heads with other ethnic origins as political leadership did not automatically coincide with ethnic affiliation (McWilliam, 2006). Similarly, sampling clusters from specific religious denominations could provide more in-depth understanding on theological implications, which were identified in this study, but nevertheless warrant further investigation. Specifically, only one Muslim respondent was included in this study, and while they are a minority in NTT (roughly 8% of total provincial population), Indonesia is a predominantly Muslim country (BPS NTT, 2021b). The effects and influences from Muslim-majority Java, where the central government sits, could potentially have an impact albeit within the larger context of a Christian ethos in the Lesser Sunda Archipelago.

Focus group discussion (FGD) methods evolved and were adapted as field work progressed in the context of interviews and other data. Selection of FGD participants was partially determined by the number of available sub-district health facilities and the dictates of the district health office leadership, as the process for organising these discussions was heavily bureaucratic, including official appointments of health staff delegated to participate. Methodologically, the FGDs proved essential, yet further in-depth interviews with some of the health staff would have made an interesting contribution to the data set.

The field data collection, conducted during government-imposed limitations in movement during the pandemic, was necessarily constrained in time and scope. As a cross-section of life during a brief window of time during the unfolding pandemic, it was impossible to fully reconstruct events of the crisis in its temporal evolution. While respondents recollected and represented experiences comprehensively, restrictions in the allotted time for field work may have impacted the overall scope of the data collected.

These restrictions also crossed over to the day-to-day functions and logistics of field work. Requirements to wear masks and remain distant during interviews likely impacted the ease with which people shared their stories, as it created a barrier of difficulty to see facial expressions, and potentially to read non-verbal signs or cues. It also added a feel of artificial formality to the interviews, ritualising the space, as all participants needed to comply with regulations and remain masked and distant. The ever-present feeling of pervasive contagion was apparent, which made for interesting dynamics as the conventional hand-shaking greetings or traditional acknowledgements were absent.

7.3.1 Considerations for Future Research

As this study was conducted mid-stream during a historically unprecedented global disruption to humanity, it was a unique and compelling opportunity which investigated real time unfolding and experiences of the public and health care providers in a rural, remote island setting in Indonesia. Considering the temporality of pandemics, the study's location towards the inception of the event meant that data was localised to experiences during heightened urgency in which a chaotic and fragmented system attempted to respond to unknown threats. Future studies in this area should focus on how these responses unfolded and evolved, especially in terms of resilience and adaptations as COVID-19 becomes normalised, and new cultural forms are instituted. It will be of vital importance to investigate how communities adapted, and what systems and structures were put in place to anticipate future crises in the sociocultural context that arises from this series of events.

Furthermore, it will be crucial to explore how theoretical frameworks which include community empowerment, incorporation of local knowledge (adat), and religious beliefs can be used to enhance community participation and co-creation of interventions. This dissertation has demonstrated that ineffective consultation and fragmented governance had far-reaching consequences in the vulnerable communities of Kupang, and thus, future investigations should focus on if and how equity was achieved, with the understanding that overly simplistic interventions adopted from far distant centres of authority may not successfully translate into effective interventions for the people who need them most.

7.4 Key Intellectual Contributions of the Study

This ethnographic case study of community experiences of the COVID-19 pandemic in NTT created new knowledge by revealing how cultural forms are shifting, remodeling, and adapting to the continually emerging *Covidscape*. The data elucidates how power dynamics, multiple epistemologies, and the dialectic of modernity and tradition dictate

pandemic practice, foregrounding the need to improve public health interventions in consideration of equity and local context. I have also demonstrated that COVID-19 is a subjective, constructed phenomenon in NTT, connoting both an experiential as well as a historically situated event. Learnings from this study have outlined the need for concerted and sustained efforts to decolonise health policy and practice if NTT envisions normalising and adapting to the ongoing presence of the SARS-CoV-2 virus and its sociocultural sequelae.

The unique contributions of this study to extending the literature concerning an evolving 'pandemic methodology' consist of lessons learned while navigating bureaucratic and ethical considerations, adapting data collection instruments and field methods in response to local regulations and protection of subjects, ongoing antigen testing, while ensuring validity and trustworthiness of the study. The ethnographic methods, which emphasised on-site involvement with the communities, built trust and enabled me as a researcher to better understand the modification of space, and the shifting landscape of how bodies interact and enact a pandemic in NTT. Being subject to the same restrictions and regulations, and the same fears and concerns, while undertaking this research provided me with a unique perspective from which to approach this study.

This study is the first qualitative research project to be conducted during the COVID-19 pandemic focusing on community experiences in Nusa Tenggara Timur. It developed new knowledge on adapting data collection methods during social restrictions, as well as engaging with multiple stakeholders and community representatives to provide a comprehensive, robust qualitative data set. It brought together three distinct institutions to support my endeavours of data collection, analysis, and dissemination, and was thus an exemplar in both the generation of new knowledge and the promotion of domestic and international cooperation around priority public health issues in an often-neglected area of the Indonesian archipelago.

8

Chapter 8. Summary and Conclusion

8.1 Summary of Research

Communities in Nusa Tenggara Timur continue their struggles against COVID-19, and this dissertation research has contributed to improving understanding of the context in which this struggle played out. Located in the poorest region of Indonesia, NTT is structurally vulnerable to the widespread effects of the pandemic crisis, especially considering the high burdens of endemic disease, a disaster-prone archipelago of volcanic islands, and sociopolitical ostracisation to the margins of Indonesia far from the centre of policy and wealth in Jakarta (Dinkes NTT, 2020; NTT Provincial Govt, 2021b). Religious syncretism is embedded within a context of ethnic heterogeneity and mobility, producing a rich landscape from which to study the pandemic phenomenon. NTT was selected as a site of enquiry due to its position in space, structure, and history. It is far removed from the governing, economic, and population centres of Java, and is vulnerable to disruptions due to a fragile health system, endemic disease, and the fact that it is among the poorest regions in Indonesia, being historically situated as a post-colonial, heavily missionized, post-New Order sub-archipelago. These factors influence how the communities engage with the government and with each other in terms of dynamics around trust, inequality, historical position as subaltern, and ethno-religious relationships. The compounding weight of the COVID-19 pandemic offered a unique opportunity to examine social dynamics, as new cultural forms were emerging from an unprecedented calamity.

This research has demonstrated that the entanglements of individual bodies, communities, and social structures cannot be analytically essentialised, reduced, or oversimplified for the purpose of explanation or public health planning. Owing to the dynamics of power, spirit, and materiality, the pandemic practices in NTT were complex and quickly evolving, creating new social forms which were unanticipated and resistant to reductive description and analysis.

The aims of this research were to explore the local context of community perceptions and responses to the COVID-19 pandemic in one urban and one rural district in Nusa Tenggara Timor, Indonesia and to explore how local knowledge was used in the construction of pandemic responses, in practice and in representation. I examined

relationships between governing authorities, health providers, and the communities they work with, with the aim of understanding the context of the spectrum of local responses, and to potentially discover areas of concord while unpacking the tangled ball of metaphorical twine that I encountered in the field. The narratives and themes presented in Chapters 4, 5, and 6 provided the data of those encounters, revealing insight into how a relatively remote local community meets the unprecedented global crisis of COVID-19.

Referencing Chapter 3 (Section 3.2.3), three research questions guided both the structure of the qualitative inquiry and the focus of the field data collection, which asked: How were communities in Kupang municipality and district experiencing the unfolding pandemic, as they confronted uncertainty and social restrictions? How were public health responses enacted within the fields of community social dynamics, local knowledge, geographies, and multiple life worlds? and What were the potential opportunities for improving public health responses in these communities? To answer these questions, I conducted a focused ethnographic field study combining in-depth interviews, focus group discussions, and observation of members of the public and healthcare providers in Kupang in urban and rural environs. A constructivist paradigm guided my approach and interpretation of the cross-cultural research, which yielded data elucidating how meaning was negotiated, constructed, and legitimised around a novel, socially destabilising event such as COVID-19 (Crotty, 1998; Guba & Lincoln, 2005; Liamputtong, 2008b; Schwandt, 1998). This approach posits that meaning, experiences, and responses to COVID-19 are socially constructed from the pre-existing cultural milieu, traditions, religions, political economy, and other factors which coincide in a given locale and give rise to cultural forms and norms from which people enact pandemic practices (Panter-Brick & Eggerman, 2018; Werron & Ringel, 2020).

Qualitative analysis of field notes and transcripts using an inductive thematic analysis method revealed that pandemic responses and practices were complex and contextually heterogeneous, and operated at individual, sociocultural, and structural intersections (Braun et al., 2019; Denzin & Lincoln, 2017b). Efforts to distil a heuristic model from the large amount of data collected resulted in nine thematic areas representing the spectrum from structural to individual levels of analysis (refer to Chapters 4, 5, and 6). Concurring with the reviewed literature on community responses to the pandemic, this research demonstrated that the COVID-19 event was dynamic and temporally evolving, eliciting profound responses to the initial shock, which eventually gave way to attenuation, adaptation, and resilience (Lynteris, 2014; Roth, 2020). Data from this study suggested a complex structure of community perceptions and experiences, contextualised by influences

of religion, power dynamics, a fragmented system of governance, rampant circulation of misinformation, and stigmas, 'othering', and social rejection. Instances of community cohesion and resilient responses were also demonstrated by the data.

In the context of the community and health system in Kupang municipality and district, weak institutional leadership was identified at all levels, resulting in confusing policies and planning, limitations in regulatory reach and enforcement, and ineffective partnering with community stakeholders (refer to Chapter 4, Section 4.1). Power asymmetries within and between institutions, from central to periphery, and between the government sector and the community caused inefficiencies in mitigating the pandemic and rolling out effective measures to reduce transmission and engender trust among the public (refer to Chapter 4, Section 4.2).

Despite historic experience with infectious disease outbreaks, such as AI, SARS, Cholera, and Dengue, the health system was unprepared to meet the demands of an urgent public health crisis, with task forces hastily assembled and policies hurriedly rolled out in under-resourced communities. Challenges in commodity management and delays in testing contributed to a spiralling increase in cases. These issues created rifts in trust and amplified uncertainty in the communities affected by the pandemic (refer to Chapter 4, Section 4.3).

The Church institutions played a significant role in how the community framed, understood, and responded to the pandemic, providing institutional support for contact tracing, material support, and dissemination of information (refer to Chapter 5, Section 5.1). During lockdowns and closures, the Church was seen as a haven and a site of potential infection, confounding its identity as a refuge. Parallel epistemologies were constructed in the dissemination of theological and biomedical explanations of the pandemic. Multiple ontologies of COVID-19 were identified, underscoring the complex process of constructing meaning using seemingly incompatible reductionist, biomedical vs. theological perspectives of the phenomenon. This influenced the behaviour of the community and the health providers, as people struggled to make sense of an unknown threat (refer to Chapter 5, Section 5.2).

Misinformation and circulating rumours resulted in stigma exerted against infected or suspected COVID-19 patients, as well as driving fears in the community to avoid health facilities which impacted both acute and chronic disease management (refer to Chapter 6, Section 6.1).

Surveillance and control of the population, in the form of lockdowns, social restrictions, and control of sick and deceased patients had significant impacts on the community (refer to Chapter 6, Section 6.3). Job losses caused dramatic financial

insecurity, although rural islanders seemed to have better protections through small-scale farming and fishing, staving off financial ruin compared to city dwellers (refer to Chapter 6, Section 6.2). Community responses included resistance or non-adherence to basic pandemic practices such as masking and physical distancing. Frustration and anger erupted over the handling of dead bodies, as religious traditions were disrupted and debates over the management of the deceased centred around the regulatory power of the state vs the inertia of community tradition.

The respondents tended to equate modernity with a rejection or delegitimisation of local adat (refer to Chapter 5, Section 5.3). While elderly respondents were tied to adat through memory and practice, the supplanting of traditional ritual and illness framing by Christianity was pervasive among younger and middle-aged community members. The construction of legitimate knowledge around the pandemic occurred in a context of rampant misinformation, disinformation, rumour, and officially sanctioned information. Legitimacy was predicated on perceptions of trust and credibility, associated with the source of information. Church and village heads were seen as trustworthy, and yet rumour and misinformation were also legitimised through amplification via social media, informal networks, and peer groups which became contextually legitimised (refer to Chapter 6, Section 6.1). Information, filtered through religious or biomedical epistemologies, dictated conclusions about the nature of COVID-19 and influenced pandemic practices, adherence, and non-adherence to government restrictions, and drove public responses around stigma, social rejection, and disruptions in community cohesion.

8.2 Conclusion

Research into the COVID-19 phenomenon in a remote east Indonesian context has demonstrated that the sociocultural rupture of the pandemic revealed more about the structure and vulnerabilities of the community and less about the biology of a virus and the illness it caused. This crisis was one of temporality, space, and the construction of new cultural forms to address a dramatic disruption and shift in social norms and stability. Pandemic knowledge and subsequent adaptive practices were limited by constraints in access to information and differential legitimation of epistemological methods that groups of people used to explain and ameliorate the effects of this phenomenon. Essentially, what I discovered was that the SARS-CoV-2 virus was a sociocultural irritant, a catalyst which pulled back the curtain to reveal underlying persistent inequities in how society was structured. Uncertainty and fear was driven by inconsistent engagement by authorities with

affected publics as well as by confusing discourses inherited from far-flung intellectual corners of the Global North.

This expedition into the rich matrix of culture and tradition in NTT was coloured by themes of social suffering, concern, frustration, and sparks of hope and resilience. The ongoing negotiation of meaning in the construction of a pandemic was fraught with the perils of inequitable power distribution and use, ancient superstitions and traditions transforming into a new latticed modernity, and marked by the growing pains of how the unfamiliar and alien become normative and absorbed into the daily textures of life. I realised that the nomenclature, nosology, and revised aetiologies of COVID-19 could easily be overlaid onto any socially destabilising event: the dynamics of culture change and adaptation in response to a deeply antagonising disruption are not merely domains of health and illness, and of virology and containment, but rather are about the character of how individuals, communities, and the custodians of government interact given plural, syncretic life worlds, language, and tradition.

Suffering and its transformation, through the experiences of the Timorese community in NTT was intersubjective, and COVID-19 was a socially constructed reality with complex symbolic, political, and cultural implications. I demonstrated how these complex dynamics were inhered and experienced by a variety of stakeholders and publics, illustrative that public health solutions must be embedded in the local context and are historically contingent. It was also noted that oversimplification can elide autonomy, agency, and undermine trust.

At its most basic, the pandemic in NTT was a confrontation of ontologies, where the phenomenological *whats* and *hows* of a dominant biomedical paradigm were locked in a cosmic dance with the 'whys' of a supernatural, theological one. Public health empirical biomedical science imperatives negotiated with interpretive cultural mores, as new logics of practice emerged in the COVID-19 era. Star-crossed lovers, spirit and biology fated to intertwine and entangle, continue to play out this relationship in these communities as new meanings are constructed, new ways of being are negotiated, and new hopes for the future are imagined.

Epilogue

Reflections on the challenges I faced during field work for this dissertation could eventually fill an entire book but will be recollected here in brief. As recounted in Chapter 3, bureaucratic hurdles to gain clearance to embark on data collection took up the better part of a year, protracted due to limitations in government staffing and office closures during the height of the pandemic restrictions. Once I arrived in Kupang, I followed the formalities of local meetings and additional village level approvals, with the conduct of field work being punctuated by expected delays and ongoing schedule changes, as bureaucrats and community respondents alike had experienced significant disruptions in their daily lives. Coupled with the need for masking, physical distancing, and routine antigen tests for COVID-19, organising focus group discussions and interviews required monumental patience and flexibility.

Midway through the data collection process, I was struck down by a severe case of dengue fever, contracted somewhere during my excursions, and was forced to delay field work by an additional two weeks, as I was simply too ill to continue with our planned schedule. Upon my return, our driver and his family caught COVID-19 (rumoured to have been picked up from the local fish market), followed by my research assistant's father falling ill with a stroke. She acquiesced to sibling pressure and was unable to get him proper medical care at the hospital, as the family elders were afraid of COVID-19 transmission at health facilities, and thus, his health deteriorated.

Subsequently, during the first week of April, a tropical cyclone named Seroja hit NTT, a storm unlike any of the past two decades which devastated the area. As I spent two days stranded at the flooded airport trying to evacuate, I had first-hand experience of the destruction caused by this storm, which destroyed buildings, bridges, and entire communities. The Indonesian National Disaster Management Board eventually reported that half a million people were affected, with 11,406 people displaced, 181 deaths, 45 people missing, hundreds of injuries, and over 66,000 homes destroyed. In the weeks following, COVID-19 cases increased by 200% over the normal rate. The cyclone was a disaster upon a disaster, taking weeks to get electricity and freshwater services reestablished, and testing the resilience of the population.

These compounding problems were the norm for NTT, as flooding, volcanic eruptions, cyclones, and a heavy burden of endemic diseases had prevented the progress

and development enjoyed by the larger islands of Java and Sumatra. For the people of NTT, this disaster simply became another chapter in the story of a divine plan, somehow being meted upon an innocent people and challenging their faith and ability to survive.

Upon completion of the fieldwork, and during the write-up phase of the dissertation, my research assistant's parents caught COVID-19, and again the elder siblings would not allow proper medical care or hospitalisation, as beliefs about black magic and sorcery punctuated the reality of the COVID-19 biomedical diagnoses. Her father, untreated, passed away within a week of being diagnosed—yet the family, afraid of causing additional stress and strain, had never divulged to their parents that they were infected with SARS-CoV-2. Following his funeral, despite being masked and vaccinated, I too caught COVID-19 and became severely ill, eventually suffering from long Covid and experiencing a protracted disease course.

These experiences, beyond serving as anecdotes of the travails and challenges of ethnographic field work, deeply affected me. As a Western white male, I was afforded an education which buffered my suffering with knowledge of medicine, diagnostics, disease progression, and easy access to medical doctors and hospitals. I 'knew' the risks and sought care from an informed position. My concerns were of pathology, not sorcery. And yet, I could viscerally understand the pull and pressure that these competing modes of being, epistemologies, beliefs, and social constraints had on the ability to seek care, to make decisions, and to exercise agency. My friend's father was the village head, wielding large amounts of social capital, yet was struck down partially due to competing belief systems and control exercised by his kin, embedded as they were in traditional lines of authority and beliefs which ran counter to effective treatment or palliative support.

This quandary of belief became a moral one for me, as I was acutely aware of the issues of cultural relativism and anthropological debates on the ethics of interference, of maintaining an ethnographer's gaze while being challenged in my own beliefs and standpoint. The adat traditions, and the Christian dicta that pervaded this syncretic ethos among the people were strong forces that I felt I was ill-equipped to counter, despite leading to an outcome that could have possibly been prevented. As I come to the end of this research, the final fact of his death, of my contracting COVID-19 and experiencing this illness that I spent so much time studying, are the resonances that sound through my memory and will leave an indelible impression for the rest of my life.

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Appendices

Appendix 1: Official Ethics Approvals
Appendix 2: Official Indonesian Government Research Approvals
Appendix 3: Letters of Agreement with IRGSC and UNDANA
Appendix 4: Information Sheet, Informed Consent Forms
Appendix 5: Interview and Focus Group Discussion Question Guides

Appendix 1: Official Ethics Approvals: Flinders, LITBANG, UNDANA

11 November 2020

HUMAN RESEARCH ETHICS COMMITTEE

APPROVAL NOTICE

Dear Mr. Christopher Raymond,

The below proposed project has been **approved** on the basis of the information contained in the application and its attachments.

Project No: 2219

Project Title: Coronavirus Contingencies: a case study of local knowledge & community responses to Covid-19 in Kupang City and Kupang District, East Nusa Tenggara, Indonesia

Primary Researcher: Mr. Christopher Raymond

Email: raym0065@flinder.edu.au

Approval Date: 11/11/2020

Expiry Date: 31/12/2023

Please note: *Due to the current COVID-19 situation, researchers are strongly advised to develop a research design that aligns with the University's COVID-19 research protocol involving human studies. Where possible, avoid face-to-face testing and consider rescheduling face-to-face testing or undertaking alternative distance/online data or interview collection means. For further information, please go to https://staff.flinders.edu.au/coronavirus-information/research-updates.*

RESPONSIBILITIES OF RESEARCHERS AND SUPERVISORS

1. **Participant Documentation**

Please note that it is the responsibility of researchers and supervisors, in the case of student projects, to ensure that:

- all participant documents are checked for spelling, grammatical, numbering and formatting errors. The Committee does not accept any responsibility for the above mentioned errors.
- the Flinders University logo is included on all participant documentation (e.g., letters of Introduction, information Sheets, consent forms, debriefing information and questionnaires – with the exception of purchased research tools) and the current Flinders University letterhead is included in the header of all letters of introduction. The Flinders University international logo/letterhead should be used and documentation should contain international dialling codes for all telephone and fax numbers listed for all research to be conducted overseas.
- the HREC contact details, listed below, are included in the footer of all letters of introduction and information sheets.

This research project has been approved by the Flinders University Human Research Ethics Committee (Project Number 2219). For more information regarding ethics approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au.

2. **Annual Progress / Final Reports**

In order to comply with the monitoring requirements of the *National Statement on Ethical Conduct in Human Research 2007 (updated 2018)* an annual progress report must be submitted each year on the anniversary of the approval date for the duration of the ethics approval using the HREC Annual/Final Report Form available online via the ResearchNow Ethics & Biosafety system.

Please note that no data collection can be undertaken after the ethics approval expiry date listed at the top of this notice. If data is collected after expiry, it will not be covered in terms of ethics. It is the responsibility of the researcher to ensure that annual progress reports are submitted on time; and that no data is collected after ethics has expired.

If the project is completed *before* ethics approval has expired please ensure a final report is submitted immediately. If ethics approval for your project expires please either submit (1) a final report; or (2) an extension of time request (using the HREC Modification Form).

For student projects, the Low Risk Panel recommends that current ethics approval is maintained until a student's thesis has been submitted, assessed and finalised. This is to protect the student in the event that reviewers recommend that additional data be collected from participants.

First Report due date: 11 November 2020

3. Modifications to Project

Modifications to the project must not proceed until approval has been obtained from the Ethics Committee. Such proposed changes / modifications include:

- change of project title;
- change to research team (e.g., additions, removals, researchers and supervisors)
- changes to research objectives;
- changes to research protocol;
- changes to participant recruitment methods;
- changes / additions to source(s) of participants;
- changes of procedures used to seek informed consent;
- changes to participant remuneration;
- changes to information / documents to be given to potential participants;
- changes to research instruments (e.g., survey, interview questions etc);
- extensions of time (i.e. to extend the period of ethics approval past current expiry date).

To notify the Committee of any proposed modifications to the project please submit a Modification Request Form available online via the ResearchNow Ethics & Biosafety system. Please open the project, then select the 'Create Sub-Form' tile in the grey Action Menu, and then select the relevant Modification Request Form. Please note that extension of time requests should be submitted prior to the Ethics Approval Expiry Date listed on this notice.

4. Adverse Events and/or Complaints

Researchers should advise the Executive Officer of the Ethics Committee on 08 8201-3116 or human.researchethics@flinders.edu.au immediately if:

- any complaints regarding the research are received;
- a serious or unexpected adverse event occurs that effects participants;
- an unforeseen event occurs that may affect the ethical acceptability of the project.

Yours Sincerely,

Andrea Mather

on behalf of

Human Research Ethics Committee
Research Development and Support
human.researchethics@flinders.edu.au
P: (+61-8) 8201 3116

Flinders University
Sturt Road, Bedford Park, South Australia, 5042
GPO Box 2100, Adelaide, South Australia, 5001

http://www.flinders.edu.au/research/researcher-support/ebi/human-ethics/human-ethics_home.cfm

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Laman : www.litbang.depkes.go.id Surat Elektronik : sesban@litbang.depkes.go.id
GERMAS

PERSETUJUAN ETIK
ETHICAL APPROVAL

No. : LB.02.01/2/KE.047/2021

Komisi Etik Penelitian Kesehatan, Badan Penelitian dan Pengembangan Kesehatan (KEPK-BPPK) dengan berdasarkan Deklarasi Helsinki, telah melakukan telaah, pembahasan dan penilaian melalui proses **EXPEDITED.**

Health Research Ethics Committee, National Institute of Health Research and Development (HREC-NIHRD), in accordance with Helsinki has conducted a thorough review of research protocol entitled :

Kontigensi Corona Virus: Studi Kasus Pengetahuan Lokal dan Respon Masyarakat terhadap COVID-19 di Kota Kupang dan Kabupaten Kupang, NTT, Indonesia
Versi Protokol (*Protocol Version*): Revisi 1, tanggal 24 Februari 2021

yang akan mengikutsertakan manusia sebagai partisipan/subyek penelitian dengan Ketua Pelaksana/Peneliti Utama :
in which will involve human participant(s). As Principal Investigator :

Christopher B. Raymond

dapat diberikan persetujuan etik. Masa berlaku surat persetujuan etik ini adalah :
has hereby declared the protocol is approved for implementation. This letter is valid from/to :

25 Februari 2021 s/d 24 Februari 2022

Jika ada perubahan protokol (amandemen) dan/atau perpanjangan penelitian, Ketua Pelaksana/Peneliti Utama harus mengajukan kembali protokol versi terbaru untuk kaji etik penelitian. Pada akhir penelitian, laporan pelaksanaan penelitian juga harus diserahkan kepada KEPK-BPPK.

Should there be any modification (amendment) and/or extention of the study, the Principal Investigator is required to resubmit the latest version of protocol for approval. The final summary reports should also be submitted to HREC-NIHRD.

Jakarta, 25 Februari 2021

Chair of HREC-NIHRD :

Ketua
Komisi Etik Penelitian Kesehatan
Badan Litbangkes,

Prof. Dr. Rustika, SKM., M.Si.

KEMENTERIAN PENDIDIKAN DAN KEBUDAYAAN
UNIVERSITAS NUSA CENDANA
FAKULTAS KEDOKTERAN
KOMISI ETIK PENELITIAN KESEHATAN
Sekretariat : Lantai 2 Gedung Laboratorium Terpadu
Jl. Adisucipto Penfui Kotak Pos, 104 Kupang 85001, NTT Tlp. 881972; Fax.0380881972
website http://www.undana.ac.id E-mail:mesfkundana@co.id

LEMBAR KEPUTUSAN
Nomor : 12/UN15.16/KEPK/2021

Judul Penelitian : **Kontingensi Coronavirus; Studi Kasus Tanggapan Masyarakat Terhadap Pandemi Covid-19 di Kabupaten dan Kota Kupang, Nusa Tenggara Timur, Indonesia**
Nama Peneliti : **Christopher Bailey Raymond, MPH**
No. Register : U N 0 2 2 1 0 2 0 9

A	Rangkuman penilaian oleh *reviewers* : -
B	Perlu full board : ☐ Ya ☑ Tidak a. Ya (terus ke C) b. Tidak (terus ke D)
C	Catatan Rapat Etik (Full Board): **Pemeriksaan dilakukan secara Expedited**
	Tgl/bulan/tahun: **26 Februari 2021**
	Tindak Lanjut/ Catatan Rapat Etik Dikirimkan kembali ke yang bersangkutan dengan tembusan kepimpinan instansi
D	Hasil Penilaian
	☐ a. Disetujui
	☑ b. Disetujui dengan sedikit perubahan tanpa perubahan subtansi (lihat lembaran pertimbangan / saran / petunjuk)
	☐ c. Disetujui dengan perubahan subtansi (lihat lembaran pertimbangan / saran / petunjuk)
	☐ d. Ditunda untuk beberapa alasan (lihat lembaran pertimbangan / saran / petunjuk)
	☐ e. Tidak dapat disetujui dengan beberapa alasan (lihat lembaran pertimbangan / saran / petunjuk)
E	Penugasan pengawasan jalannya penelitian di lapangan untuk yang berisiko sedang – berat, mengobservasi apakah ada penyimpangan etik (tulis nama anggota komisi etik yang ditunjuk oleh rapat) : -

Kupang, 01 Maret 2021

Komisi Etik Penelitian Kesehatan Fakultas Kedokteran Undana

Ketua

Dr. dr. Idawati Trisno, M.Kes
NIDK. 8800511019

Sekretaris,

dr. Desi Indria Rini, M.Biomed
NIP. 19800130 200801 2 015

Appendix 2: Official Research Approvals

Appendix 2a: Pre-departure: Policies, Paperwork, and the Pandemic

The collection of empirical data for this dissertation began with the navigation of the complex bureaucratic system of the Indonesian foreign researcher approvals process, including visas, stay permits, and a laundry list of formal approvals by numerous ministries and departments. To facilitate government approvals, I secured collaboration agreements with two local institutions based in Kupang, NTT, which served both as sponsors for my stay visa, as well as for academic oversight and facilitation of logistics while conducting fieldwork. In my experience, this preparatory phase of research, including the extensive formal approvals required before any data collection could occur, was my trial by fire to test my mettle and dedication to conduct research in Indonesia during the height of a pandemic[38].

The logistics of processing paperwork both online and in-person during this time was challenging and tested me intellectually, physically, and emotionally. My intentions of exploring the underlying power dynamics and experiences of the local community in NTT during this research began with my own exposure to, and experiences of, the power structures of the Indonesian bureaucracy, foreshadowing the difficulties and challenges residents were facing at the same time in far off Nusa Tenggara Timur during the time of COVID-19.

Although initial plans were to begin fieldwork in July 2020, the global COVID-19 pandemic and shutdown of the country in April 2020 threw my plans into disarray. I had designed my research project to extend over a six-month period of intensive fieldwork and data collection in NTT. However, as Indonesia was on lockdown during several months from April through August, in which I was required to remain in Jakarta where I was living prior to the onset of the pandemic, I was unable to get to the field. Domestic flights were cancelled, government offices were closed with staff required to 'work from home', and as a result, the approval process for this research project was delayed and protracted for the better part of 10 months, from June 2020 until my final local ethics submissions were approved in March 2021.

It was fortunate that following discussions and negotiations starting in April 2020, the Institute for Resource Governance and Social Change (IRGSC) agreed to sponsor my

[38] For a more thorough treatment, see Pollock, I. (2016). *Presentation: Applying for an Indonesian Research Visa*. Australian National University.

'*kitas*[39]' visa, allowing me to legally remain in Indonesia for the duration of my research project as part of a collaborative agreement with Flinders University. In addition, a collaboration agreement was signed with the Nusa Cendana University (UNDANA) in Kupang, NTT, which provided academic oversight as per Indonesian Govt. Regulation no. 41/ 2006 to ensure ethical and intellectual compliance while a foreign researcher conducts data collection in the field. The Letters of Agreement between Flinders University, the IRGSC, and UNDANA can be found in Appendix 3.

These agreements with local institutions were part of a larger package of required documents that were then submitted to the Indonesian Ministry of Research and Technology of Indonesia (RISTEK-BRIN), the central level government entity responsible for approving all foreign research conducted in the country. The required RISTEK-BRIN foreign research permit approval allowed for subsequent application to additional central, provincial, and district government entities for approvals and permits as required prior to conducting any field work. The required documents for initial RISTEK-BRIN approval, which then triggered the initiation of the request for a kitas stay visa and other requests, were:

1. Formal letter of request from the researcher to RISTEK to conduct research
2. Researcher's Curriculum Vitae
3. Red background visa photo
4. Researcher's passport copy
5. Official Statement of Support from IRGSC as Visa Sponsor
6. IRGSC Director's Curriculum Vitae
7. Detailed Research Proposal
8. Official Letters of Recognition from Flinders University of student status and prior approval to conduct field research as proposed
9. Recommendation Letter from Senior Academic Researcher at Flinders University
10. Statements of: equipment used in the field and other foreign researcher team members
11. Statement on Visa Collection at Indonesian Embassy Abroad
12. Researcher's Bank Statement and Letter of Guarantee of Sufficient Funds to conduct research
13. Agreement on Joint Publication Statement between Flinders University and Nusa Cendana University and IRGSC

[39] A Kartu Izin Tinggal Terbatas, abbreviated 'kitas', is a limited stay visa issued by the Indonesian Department of Immigration which enables foreign visitors to gain temporary residency to conduct business, research, etc.

14. Letters of Agreement between Flinders University and IRGSC

The RISTEK-BRIN approval submission process began in June 2020, following an extensive period of discussion, negotiation, and agreement with both the IRGSC and UNDANA, which had begun in April 2020.

The procedure for acquiring a kitas stay visa, following formal RISTEK-BRIN approval, is outlined in the following table, taken from their website[40]. This process, and the subsequent approvals required by other government agencies, resulted in months of back-and-forth visits to the Department of Immigration, RISTEK-BRIN, the Ministry of Home Affairs, and the Indonesian Police to secure these central level government approvals. Exacerbating and protracting this process was the fact that most government offices were sporadically open, with many staff working from home during the pandemic. This served to reduce efficiency and speed of document movement through the system.

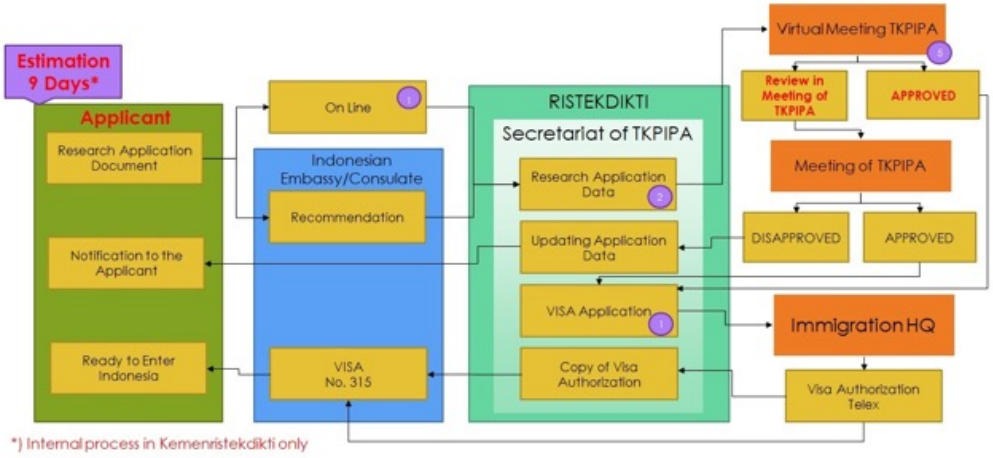


Figure 10 RISTEK-BRIN Foreign Research Permit Procedures

RISTEK-BRIN approval of my foreign research permit was formally granted on 13 October 2020, accompanied by the following official documents required for the next steps in the approvals process and acquisition of the kitas stay visa from the Department of Immigration:

- Research Permit from RISTEK-BRIN
- Telex to Immigration for the C315 Visa
- Letter of Request to the Head of the Immigration Office in Jakarta
- Approval Report addressed to the director of the IRGSC

[40] https://frp.ristekbrin.go.id/index.php

- Researcher Permit Temporary ID
- Request to the Intelligence Department of the Indonesian Police for approval of a "surat jalan" allowing domestic travel to the research site
- Research Notification letter to the Director General of Public Administration of the Ministry of Internal Affairs for subsequent formal approval

These documents can be found in Appendices 1 and 2. Subsequent central level government approvals were granted as follows:

1. Kitas Stay Visa issued by Immigration: end of October 2020
2. Travel Permit issued by Indonesian Police: 1 Dec 2020
3. Research Approval issued by Ministry of Internal Affairs: 28 January 2021
4. Central level Ethics Approval by the Agency of Health Research and Development of the Ministry of Health: 25 Feb 2021

Simultaneously, as central level approvals were sought in Jakarta, my local counterparts in Kupang, NTT, were seeking formal approvals from the provincial and local governments. This consisted of clearance from the Governor of Nusa Tenggara Timur, followed by application and approval through the Politics and National Unity Agency (BKBP) of NTT which acts as a clearinghouse for government affairs, including approval and monitoring of foreign research projects in each province. In addition, clearance was required from the One Door Investment Service (DPM-PTSP) at the city (Kota Kupang) and district (Kabupaten Kupang) levels. Simultaneously, ethics clearance was sought from the Universitas Nusa Cendana Faculty of Medicine, to comply with local requirements for ethics approval in addition to the central level MOH Litbankes approval already received in February (and which was the only requirement for RISTEK compliance). Local NTT ethics approval with UNDANA was granted on 16 March 2021. Specific approvals were then granted for work in specific villages within the research target areas in the greater Kupang catchment area.

Appendix 2b: Official research approval documents

RISTEK-BRIN

KEMENTERIAN RISET DAN TEKNOLOGI/
BADAN RISET DAN INOVASI NASIONAL
DEPUTI BIDANG PENGUATAN RISET DAN PENGEMBANGAN
Gedung B.J. Habibie Lantai 19 – 20, Jalan M.H. Thamrin No. 8, Jakarta 10340
Telepon 021-3162222 Ext. 9702, 9782, 9707; Faksimile 021-3101728

SURAT IZIN PENELITIAN
(LETTER OF RESEARCH PERMIT)
Nomor : 94/E5/E5.4/SIP/2020

Kementerian Riset dan Teknologi/Badan Riset dan Inovasi Nasional dengan ini menerangkan bahwa berdasarkan rapat Tim Koordinasi Pemberian Izin Penelitian Asing (TKPIPA Nomor : 7/TKPIPA/E5/Dit.KI/VII/2020, tanggal 30 Juli 2020), telah diberikan izin untuk mengadakan penelitian di Indonesia kepada peneliti berikut :

(The Ministry of Research and Technology/ National Agency for Research and Innovation hereby state that based on the Foreign Research Permit Coordinating Team (TKPIPA) meeting above, a permit to conduct research activity in Indonesia is granted to the following) :

Nama ***(Name)***	:	**Mr. Christopher Bailey Raymond**
Tempat dan tanggal lahir ***(Place and date of birth)***	:	United States of America, 20 April 1972
Warga Negara ***(Nationality)***	:	[redacted]
Jabatan ***(Position)***	:	
Institusi ***(Institution)***	:	
Email ***(email)***	:	
Alamat ***(Address)***	:	
Nomor Paspor ***(Pasport no.)***	:	
Judul Penelitian ***(Research Title)***	:	*"Coronavirus Contingencies: an ethnographic case study of community responses to the Covid-19 pandemic in East Nusa Tenggara, Indonesia"*
Tujuan Penelitian ***(Research Objective)***	:	mengeksplorasi komunitas lokal dan tanggapan resmi terhadap krisis Covid-19 di NTT dengan tujuan meningkatkan intervensi kesehatan masyarakat
Bidang Penelitian ***(Field of Research)***	:	Kesehatan publik
Lama Penelitian ***(Research Duration)***	:	12 (dua belas) bulan, mulai 13 Oktober 2020 ***(month, starting from)***
Daerah Penelitian ***(Research Location)***	:	Nusa Tenggara Timur (Kab. Alor, Kota Kupang)
Mitra Kerja ***(Counterpart)***	:	Institute of Resource Governance and Social Change (Dr. Dominggus Elcid Li PhD)

dengan ketentuan sebagai berikut ***(with the following norms as stated in the following)*** :

1. Melaporkan kedatangan dan maksud penelitiannya kepada pemerintah daerah, instansi keamanan setempat serta instansi pemerintah terkait lainnya dengan menunjukan Surat Izin Penelitian ini, segera setelah ia tiba ditempat tujuannya. Peneliti asing juga harus melaporkan diri sebelum meninggalkan daerah penelitiannya kepada Pemerintah Daerah, Mitra Kerja di Indonesia, instansi keamanan dan instansi pemerintah terkait lainnya.
   (The foreign researcher should report his/ her arrival and his/ her purpose of activities to the Local Governments and other local authorities, as soon as he/ she arrive by showing this Letter, and reporting back before leaving the area)
2. Berbuat positif terhadap bangsa Indonesia, dan mentaati peraturan-peraturan hukum yang berlaku di Indonesia, khususnya yang berlaku di daerah penelitiannya. Untuk penelitian yang dilakukan pada kawasan konservasi di Indonesia, perlu perhatian khusus, terutama pasal-pasal yang harus dipatuhi pada Surat Ijin Masuk Kawasan Konservasi (SIMAKSI).
   (To conduct positively towards Indonesian people, to obey the rules, especially those in the area of research. Research in conservation areas should obey the rules as stated in the Permit for Entering Conservation Area- SIMAKSI)
3. Menjaga tata tertib, keamanan, kesopanan dan kesusilaan serta menghindari pernyataan-pernyataan baik dengan lisan maupun tulisan/ lukisan yang dapat melukai/ menyinggung perasaan, adat istiadat atau menghina agama, dari sesuatu golongan penduduk di Indonesia.
   (The foreign researcher should perform good/ agreeable manner, tolerant, and obey all custom rules in every area in Indonesia)

4. Memberikan Laporan....
(The foreign researcher has to submit a progress report ....)

4. Menyerahkan laporan kemajuan setiap tiga bulan sekali, dan Laporan Akhir sebelum meninggalkan Indonesia, kepada Kementerian Riset dan Teknologi/Badan Riset dan Inovasi Nasional.
(The foreign researcher has to submit a progress report in every three month and final report once he/ she finishes the research project in Indonesia)
5. Tidak dibenarkan membawa barang-barang atau bahan-bahan yang menurut peraturan yang berlaku dilarang untuk dibawa ke luar negeri, kecuali dengan izin instansi yang berwenang menurut peraturan yang berlaku, dan dilengkapi dengan perjanjian alih material/*Material Transfer Agreement* (MTA).
(It is prohibited to bring any specimen/ samples abroad without the stakeholder permission and should be equipped by Material Transfer Agreement signed by all parties)
6. Apabila penelitian yang akan dilakukan diperkirakan akan menghasilkan hak milik *Intellectual Property Rights* (IPR) seperti paten, hak cipta dan merk harus dibuat perjanjian tertulis dengan Mitra Kerja, dengan memperhatikan peraturan Perundang-undangan yang berlaku di Indonesia.
(The foreign researcher should make an agreement with the counterpart for any patent, intellectual property rights, brand, and registered mark as resulted from the research, referring to the existing Indonesian law)
7. Diwajibkan bagi peneliti asing dan mitra kerja di Indonesia untuk mempublikasikan bersama hasil penelitiannya baik berupa Jurnal nasional maupun internasional.
(To publish jointly with the Indonesian researcher, the result of the research in an International or National Journals)
8. Memberikan salinan dari tulisan-tulisan (Thesis/Disertasi, Makalah, Laporan atau Publikasi lain) mengenai hasil penelitiannya tersebut kepada Kementerian Riset dan Teknologi/Badan Riset dan Inovasi Nasional.
(To submit copies of research result include thesis/ dissertation, paper, report, or another publication to Ministry of Research and Technology/ National Agency for Research and Innovation)
9. Memberikan 1 (satu) copy foto-foto, slide/microfilm dan film/video casette, casette sebagai hasil penelitian kepada Kementerian Riset dan Teknologi/Badan Riset dan Inovasi Nasional (kalau ada).
(To submit one copy of photo, slide/ microfilm, video cassette, and cast as research result to Ministry of Research and Technology/ National Agency for Research and Innovation)
10. Surat Keterangan Izin Penelitian ini hanya berlaku selama visa dari Direktorat Jenderal Imigrasi R.I dan Surat Keterangan Jalan dari Polisi masih berlaku.
(This Letter is only valid as long as the Visa from the Directorate General of Immigration RI and Travelling Permit from the Police Head Quarter are valid)
11. Permohonan perpanjangan dan atau perubahan daerah penelitian harus diajukan kepada Kementerian Riset dan Teknologi/Badan Riset dan Inovasi Nasional selambat-lambatnya satu bulan sebelum Surat Izin Penelitian habis masa berlakunya dengan melampirkan surat rekomendasi dari mitra kerja di Indonesia.
(Extention of this Permit, or amandement of Location, should be requested to the Ministry of Research and Technology/ National Agency for Research and Innovation, at the latest one month before expiry date of the Research Permit Letter, with recommendation letter from the counterpart)
12. Setelah penelitian selesai diharapkan supaya Surat Izin Penelitian ini dikembalikan kepada Deputi Bidang Penguatan Riset dan Pengembangan selaku Ketua Tim Koordinasi Pemberian Izin Penelitian Asing.
(At the end of the research, this Letter of Research Permit should be returned to the Deputi of Strengthening for Research and Development, acting as the Head of Foreign Research Permit Coordinatimg Team)
13. Penelitian yang menggunakan Kapal Riset, pesawat survey udara, atau wahana apapun di wilayah Teritorial RI dan ZEE, serta wilayah udara RI, juga harus memperoleh *Security Clearance* dan didampingi *Security Officer*.
(Research using Vessel Research, Airborne Survey Flight, or any other vehicles in Indonesian territorial and EEZ as well as aerospace territory, should obtain Security Clearance and accompanied by Security Officers)
14. Izin Penelitian dapat dibatalkan/ dicabut apabila Peneliti Asing melakukan pelanggaran terhadap peraturan perundangan yang berlaku.
(Annulment and/ or revocation of the permit shall be applied if the foreign researcher violates the provisions of the prevailing laws and regulations)
15. Pelaksanaan penelitian dalam masa pandemik COVID-19 harus mematuhi protokol kesehatan yang diterbitkan oleh Kementerian Kesehatan dan instansi lain yang berwenang.
(Implementation of fieldwork in the pandemic of COVID-19 time shall follow the Health Protocol issued by Ministry of Heathl and other authorized agencies)

Demikian **Surat Izin Penelitian Nomor : 94/E5/E5.4/SIP/2020, tanggal 13 Oktober 2020,** untuk dapat dipergunakan sebagaimana mestinya. Kami mohon dengan hormat kiranya instansi-instansi Pemerintah/Swasta maupun perorangan yang dihubungi untuk memberikan bantuannya kepada yang bersangkutan sesuai dengan peraturan yang berlaku.
(Herewith the Letter of Research Permit is issued to be used accordingy. We request the Government and private Institution or individual that receive the bearer of this letter to provide assistance in accordance with the rules)

Dikeluarkan di *(Issued in)* : **J A K A R T A**
Tanggal *(date)* : **13 Oktober 2020**

KEMENTERIAN RISET DAN TEKNOLOGI/BADAN RISET
DAN INOVASI NASIONAL

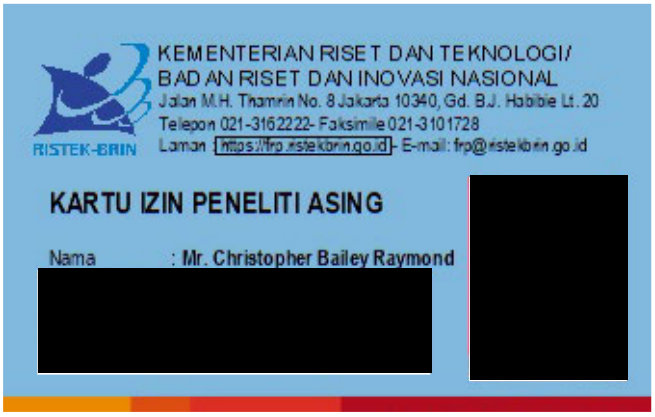
Penerima Surat Izin Penelitian
(Bearer of Permit Letter)

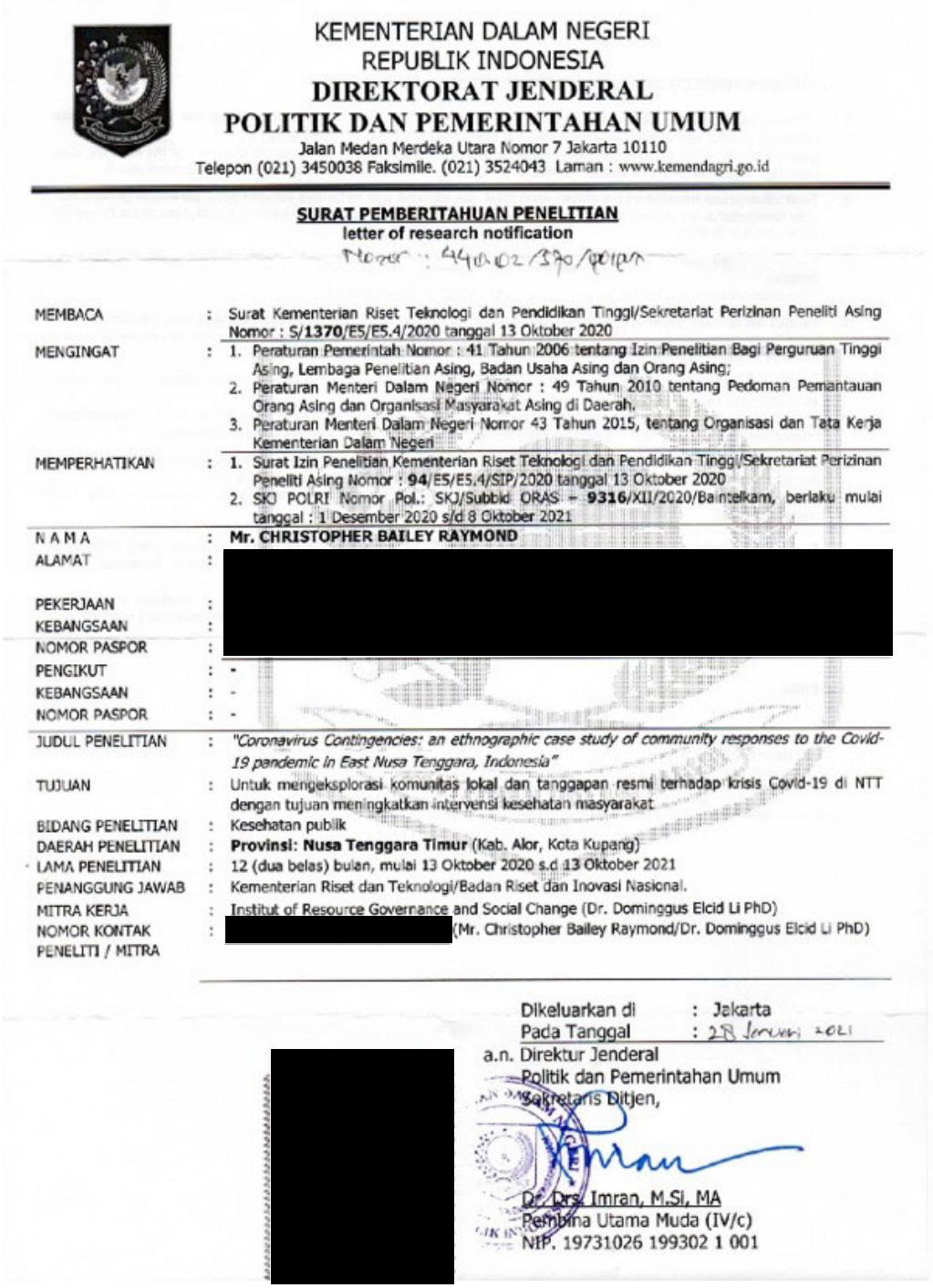
a.n. Ketua Tim Koordinasi Pemberian Izin Penelitian Asing
Direktur Pengelolaan Kekayaan Intelektual/
selaku Sekretaris TKPIPA
(on behalf of The Head of Foreign Research Permit Coordinating Team)

MATERAI
RP. 6.000,-

Mr. Christopher Bailey Raymond

Prof. Dr. Heri Hermansyah, ST., M.Eng. IPU





KEMENTERIAN DALAM NEGERI
REPUBLIK INDONESIA
DIREKTORAT JENDERAL
POLITIK DAN PEMERINTAHAN UMUM
Jalan Medan Merdeka Utara Nomor 7 Jakarta 10110
Telepon (021) 3450038 Faksimile. (021) 3524043 Laman : www.kemendagri.go.id

SURAT PEMBERITAHUAN PENELITIAN
letter of research notification
Nomor : 440/02/370/2021

MEMBACA	:	Surat Kementerian Riset Teknologi dan Pendidikan Tinggi/Sekretariat Perizinan Peneliti Asing Nomor : S/**1370**/E5/E5.4/2020 tanggal 13 Oktober 2020
MENGINGAT	:	1. Peraturan Pemerintah Nomor : 41 Tahun 2006 tentang Izin Penelitian Bagi Perguruan Tinggi Asing, Lembaga Penelitian Asing, Badan Usaha Asing dan Orang Asing; 2. Peraturan Menteri Dalam Negeri Nomor : 49 Tahun 2010 tentang Pedoman Pemantauan Orang Asing dan Organisasi Masyarakat Asing di Daerah. 3. Peraturan Menteri Dalam Negeri Nomor 43 Tahun 2015, tentang Organisasi dan Tata Kerja Kementerian Dalam Negeri
MEMPERHATIKAN	:	1. Surat Izin Penelitian Kementerian Riset Teknologi dan Pendidikan Tinggi/Sekretariat Perizinan Peneliti Asing Nomor : **94**/E5/E5.4/SIP/2020 tanggal 13 Oktober 2020 2. SKD POLRI Nomor Pol.: SKJ/Subbid ORAS – **9316**/XII/2020/Baintelkam, berlaku mulai tanggal : 1 Desember 2020 s/d 8 Oktober 2021
N A M A	:	**Mr. CHRISTOPHER BAILEY RAYMOND**
ALAMAT	:	[redacted]
PEKERJAAN	:	
KEBANGSAAN	:	
NOMOR PASPOR	:	
PENGIKUT	:	-
KEBANGSAAN	:	-
NOMOR PASPOR	:	-
JUDUL PENELITIAN	:	*"Coronavirus Contingencies: an ethnographic case study of community responses to the Covid-19 pandemic in East Nusa Tenggara, Indonesia"*
TUJUAN	:	Untuk mengeksplorasi komunitas lokal dan tanggapan resmi terhadap krisis Covid-19 di NTT dengan tujuan meningkatkan intervensi kesehatan masyarakat
BIDANG PENELITIAN	:	Kesehatan publik
DAERAH PENELITIAN	:	**Provinsi: Nusa Tenggara Timur** (Kab. Alor, Kota Kupang)
LAMA PENELITIAN	:	12 (dua belas) bulan, mulai 13 Oktober 2020 s.d 13 Oktober 2021
PENANGGUNG JAWAB	:	Kementerian Riset dan Teknologi/Badan Riset dan Inovasi Nasional.
MITRA KERJA	:	Institut of Resource Governance and Social Change (Dr. Dominggus Elcid Li PhD)
NOMOR KONTAK PENELITI / MITRA	:	[redacted] (Mr. Christopher Bailey Raymond/Dr. Dominggus Elcid Li PhD)

Dikeluarkan di : Jakarta
Pada Tanggal : 28 Januari 2021

[redacted]

a.n. Direktur Jenderal
Politik dan Pemerintahan Umum
Sekretaris Ditjen,

Dr. Drs. Imran, M.Si, MA
Pembina Utama Muda (IV/c)
NIP. 19731026 199302 1 001

MARKAS BESAR
KEPOLISIAN NEGARA REPUBLIK INDONESIA
BADAN INTELIJEN KEAMANAN

SURAT KETERANGAN JALAN / *TRAVELLING PERMIT*
Nomor : SKJ / Subbid Oras - *9316 / XII / 2020 / Baintelkam

DIBERIKAN KEPADA / *ISSUED TO*

1. Nama / *Name*	:	Mr. CHRISTOPHER BAILEY RAYMOND
2. Tempat dan tgl.Lahir / *Place and date of birth*	:	[redacted]
3. Warga Negara / *Nationality*	:	
4. Pekerjaan / *Occupation*	:	
5. No. Paspor,tgl dan berlaku s/d / *Pasport No. Place and date of issued valid until*	:	
6. Dokumen lain / *Others document*	:	
7. Atas perintah/persetujuan/ *Applied/approved by*	:	KEMENRISTEKDIKTI
8. Tersebut dalam suratnya tgl / *Re-letter of date*	:	13-10-2020 No.: S/1368/E5/E5.4/2020
9. Maksud kunjungan / *Purpose of visit*	:	Research dalam bidang Kesehatan publik.
10. Ke / *To*	:	NTT (Kab. Alor, Kota Kupang).
11. Dalam Rangka / *In accordance with*	:	Penelitian dengan judul "Coronavirus Contingencies: an ethnographic case study of community responses to - @
12. Mulai tanggal / *From*	:	01 Desember 2020 s.d / *till* 08 Oktober 2021

PERHATIAN / *ATTENTION*

@ the Covid-19 pandemic in East Nusa Tenggara, Indonesia"

1. Surat keterangan jalan ini dibuat untuk memenuhi ketentuan Undang-Undang Kepolisian RI No. 2 Tahun 2002 Pasal 15 ayat (1) huruf k , yaitu mengeluarkan surat ijin / surat keterangan yang diperlukan dalam rangka pelayanan masyarakat, serta ayat (2) huruf i yaitu melakukan pengawasan fungsional terhadap orang asing yang berada diwilayah Indonesia dengan koordinasi instansi terkait.

   The Travelling Permit for grant police government regulation No. 02/2002 articles 15 paragraph 1 letter k, that is issued regulation who is to need in scheme to serve community and than paragraph 2 of the letter i ,that is took the auspices of base on function of the foreigners at that time in Indonesia with coordination hooked authority.

2. Surat keterangan jalan ini tidak berlaku sebagai Surat ijin kegiatan yang bersangkutan.

   The Travel Acknowledgement Letter is not as for Activities Permit for the above person.

Dikeluarkan di / *Issued at* : Jakarta
Pada tanggal / *Date* : 01 Desember 2020

a.n. KEPALA BADAN INTELIJEN KEAMANAN
KABID YANMAS
u.b.
KASUBBID ORAS

IBRAHIM AJI, S.I.K.
AJUN KOMISARIS BESAR POLISI NRP 76010872

METERAI TEMPEL 6000 ENAM RIBU RUPIAH

[redacted]

Pas photo dan tanda tangan pemegang
Fotograph and Signature of bearer

PEMERINTAH PROVINSI NUSA TENGGARA TIMUR
BADAN KESATUAN BANGSA DAN POLITIK
Jln. W.J. Lalamentik Nomor : 100 Kupang – NTT Telp/Fax. (0380) 822723
Kode Pos 85111

10 Desember 2020

Nomor : BKBP.045.2/63/KSBAKE/720/2020
Lampiran : 1 (satu) Eksemplar
Perihal : Rekomendasi Izin Penelitian

Kepada
Yth. Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Provinsi Nusa Tenggara Timur
di-
Kupang

Memperhatikan Peraturan Menteri Dalam Negeri Nomor 3 Tahun 2018 tentang Penerbitan Surat Penelitian, bahwa pelaksanaan penerbitan Surat Keterangan Penelitian (SKP) dilakukan oleh Gubernur melalui Dinas Penanaman Modal dan PTSP Provinsi dan berkoordinasi dengan Badan Kesatuan Bangsa dan Politik Provinsi untuk SKP lingkup daerah Provinsi dan Surat Flinders University Adelaide Australia Nomor. 7/TKPIPA/E5/Dit.KI/VII/2020 tanggal 1 Desember 2020 perihal Permohonan Ijin Penelitian, dengan ini kami memberikan rekomendasi/ Izin untuk melaksanakan kegiatan dimaksud kepada :

Nama	:	**Mr. Christopher Bailey Raymond, MPH, BA**
NIM	:	
Alamat	:	[redacted]
Fakultas/Program Studi	:	College Of Medicine and Public Health
Untuk Melakukan	:	Penelitian/ Riset dengan Judul Proposal : **"Kontigensi Corona Virus ;Studi Kasus Pengetahuan Lokal dan Respon Masyarakat Terhadap Corona 19 di Kota Kupang dan Kabupaten Kupang"**
Lokasi Kegiatan	:	Kota Kupang ,Kabupaten Kupang
Waktu	:	Desember 2020 – Januari 2022
Email	:	raym006@flinders.edu.au

Sehubungan dengan hal tersebut dimohon agar kepada yang bersangkutan dapat diberikan surat Izin untuk melakukan kegiatan dimaksud. Setelah melaksanakan kegiatan diharapkan dapat melaporkan hasil penelitian pada Badan Kesatuan Bangsa dan Politik Provinsi Nusa Tenggara Timur.

Demikian penyampaian kami, atas kerjasama yang baik diucapkan terima kasih.

Kupang, 10 Desember 2020
KEPALA BADAN KESATUAN BANGSA DAN POLITIK
PROVINSI NUSA TENGGARA TIMUR

Ir. YOHANES OKTOVIANUS, MM
PEMBINA UTAMA MADYA
NIP. 19661029 199403 1 007

Tembusan :
1. Gubernur Nusa Tenggara Timur di Kupang (sebagai Laporan);
2. Wakil Gubernur Nusa Tenggara Timur (sebagai Laporan);
3. Flinders university, Adelaide -Australia.

PEMERINTAH KABUPATEN KUPANG
DINAS PENANAMAN MODAL DAN PELAYANAN TERPADU SATU PINTU
(DPM-PTSP) E-Mail dpmptsp2@gmail.com
Jln.Timor Raya Km. 36 Oelamasi

Oelamasi, 18 Februari 2021

Nomor : 074/26/DPM-PTSP/II/2021
Perihal : **Izin Penelitian**

Kepada
Yth. .....
.....
Kabupaten Kupang.
di-
Tempat

Menunjuk surat Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu (DPM-PTSP) Provinsi Nusa Tenggara Timur Nomor : DPMPTSP/070/3179/PTSP/XII/2021, tanggal 16 Desember 2020, Perihal Izin Penelitian dan setelah mempelajari rencana kegiatan / proposal yang diajukan, maka dapat diberikan izin penelitian kepada:

Nama : Christopher Bailey Raymond
Nomor Paspor : [redacted]
Kebangsaan :
Instansi/Lembaga :

untuk melakukan penelitian dengan judul :

"CORONA VIRUS CONTINGENCIES: A CASE STUDY OF LOCAL KNOWLEDGE AND COMMUNITY RESPONSES TO COVID-19 IN KUPANG CITY AND KUPANG DISTRICT, EAST NUSA TENGGARA, INDONESIA"

Lokasi : Desa Uitiantuan, Desa Otan, Desa Camplong II Kabupaten Kupang
Lama Penelitian : 17 Desember 2020 s/d 16 Desember 2021

Peneliti berkewajiban untuk menghormati/mentaati peraturan dan tata tertib yang berlaku di daerah setempat dan wajib melapor hasil Penelitian kepada Bupati Kupang Cq. Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Kabupaten Kupang.

Demikian izin penelitian ini dikeluarkan untuk dipergunakan sebagaimana mestinya atas kerjasama yang baik disampaikan terima kasih.

An. Kepala DPM-PTSP Kab.Kupang
Kabid Penyelenggaraan Pelayanan
Perizinan dan Non Perizinan
Ub. Kasubid Pelayanan Perizinan ,

DRIYANTI A.N. MONE, SE
NIP. 19871011 201101 2 019

Tembusan :
1 Bupati Kupang di Oelamasi (Sebagai Laporan);
2 Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Provinsi NTT di Kupang;
3 Kepala Kantor Kesbanggpol Kabupaten Kupang di Oelamasi;
4 Pimpinan Instansi/Lembaga yang bersangkutan;

PEMERINTAH KABUPATEN KUPANG
DINAS PENANAMAN MODAL DAN PELAYANAN TERPADU SATU PINTU
(DPM-PTSP) E-Mail dpmptsp2@gmail.com
Jln.Timor Raya Km. 36 Oelamasi

Oelamasi, 18 Februari 2021

Nomor : 074/26/DPM-PTSP/II/2021
Perihal : **Izin Penelitian**

Yth. Kepada
.....
.....
Kabupaten Kupang.
di-
Tempat

Menunjuk surat Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu (DPM-PTSP) Provinsi Nusa Tenggara Timur Nomor : DPMPTSP.070/3170/PTSP/XII/2021, tanggal 16 Desember 2020, Perihal Izin Penelitian dan setelah mempelajari rencana kegiatan / proposal yang diajukan, maka dapat diberikan izin penelitian kepada:

Nama : Christopher Bailey Raymond
Nomor Paspor : [redacted]
Kebangsaan :
Instansi/Lembaga :

untuk melakukan penelitian dengan judul :

"CORONA VIRUS CONTINGENCIES: A CASE STUDY OF LOCAL KNOWLEDGE AND COMMUNITY RESPONSES TO COVID-19 IN KUPANG CITY AND KUPANG DISTRICT, EAST NUSA TENGGARA, INDONESIA"

Lokasi : Desa Uitiuntuan, Desa Otan, Desa Camplong II Kabupaten Kupang
Lama Penelitian : 17 Desember 2020 s/d 16 Desember 2021

Peneliti berkewajiban untuk menghormati/mentaati peraturan dan tata tertib yang berlaku di daerah setempat dan wajib melapor hasil Penelitian kepada Bupati Kupang Cq. Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Kabupaten Kupang.

Demikian izin penelitian ini dikeluarkan untuk dipergunakan sebagaimana mestinya atas kerjasama yang baik disampaikan terima kasih.

An Kepala DPM-PTSP Kab.Kupang
Kabid Penyelenggaraan Pelayanan
Perizinan dan Non Perizinan
Uk Kasie Non Perizinan ,

ORIYANTI A.N. MONE, SE
NIP. 19821011 201101 2 019

Tembusan :
1 Bupati Kupang di Oelamasi (Sebagai Laporan);
2 Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Provinsi NTT di Kupang;
3 Kepala Kantor Kesbanggpol Kabupaten Kupang di Oelamasi;
4 Pimpinan Instansi/Lembaga yang bersangkutan;

PEMERINTAH PROVINSI NUSA TENGGARA TIMUR
DINAS PENANAMAN MODAL
DAN PELAYANAN TERPADU SATU PINTU (DPMPTSP)
Jalan Basuki Rahmat No. 1 Kota Kupang – Telp / Fax. (0380) 833213, 821827
Email :dpmptsp.nttprov@gmail.com; Website:www.dpmptsp.nttprov.go.id

SURAT IZIN PENELITIAN

NOMOR : DPMPTSP.070/3181/PTSP/XII/2020

Yang bertanda tangan di bawah ini :
Nama : Drs. Marsianus Jawa, M.Si
Jabatan : Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Provinsi Nusa Tenggara Timur

Dengan ini memberikan Izin Penelitian kepada :

Nama : *Christopher Bailey Raymond*
Nomor Paspor : [redacted]
Kebangsaan :
Instansi/Lembaga :

Untuk melaksanakan penelitian, dengan rincian sebagai berikut :
Judul Penelitian : CORONA VIRUS CONTINGENCIES: A CASE STUDY OF LOCAL KNOWLEDGE AND COMMUNITY RESPONSES TO COVID-19 IN KUPANG CITY AND KUPANG DISTRICT, EAST NUSA TENGGARA, INDONESIA
Lokasi Penelitian : Kelurahan Oebufu Kecamatan Oebobo Kota Kupang
Pengikut : Oce Boymau
Waktu Pelaksanaan
a. Mulai : 17 Desember 2020
b. Berakhir : 16 Desember 2021

Dengan ketentuan yang harus ditaati, sebagai berikut :
1. Sebelum melakukan kegiatan penelitian, terlebih dahulu melaporkan kedatangannya kepada Bupati/Walikota Cq. Kepala Kesbangpol/DPMPTSP setempat yang akan dijadikan obyek penelitian;
2. Mematuhi ketentuan peraturan yang berlaku di daerah/wilayah/lokus penelitian;
3. Tidak dibenarkan melakukan penelitian yang materinya bertentangan dengan topik/judul penelitian sebagaimana dimaksud diatas;
4. Peneliti wajib melaporkan hasil penelitian kepada Gubernur Nusa Tenggara Timur Cq. Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Provinsi NTT;
5. Surat Izin Penelitian dapat dibatalkan sewaktu-waktu apabila tidak sesuai dengan ketentuan yang berlaku.

Demikian Izin Penelitian ini dibuat untuk dipergunakan sebagaimana mestinya.

[redacted]

Kupang, 16 Desember 2020

a.n GUBERNUR NUSA TENGGARA TIMUR
KEPALA DINAS PENANAMAN MODAL
DAN PTSP PROV. NTT,

Drs. Marsianus Jawa, M.Si
Pembina Utama Muda
NIP. 19650808 199503 1 003

Tembusan :
1. Gubernur Nusa Tenggara Timur di Kupang (sebagai laporan);
2. Wakil Gubernur Nusa Tenggara Timur di Kupang (sebagai laporan);
3. Sekretaris Daerah Provinsi Nusa Tenggara Timur di Kupang (sebagai laporan);
4. Kepala Badan Kesbanggpol Provinsi NTT di Kupang;
5. Pimpinan Instansi/Lembaga yang bersangkutan.

PEMERINTAH PROVINSI NUSA TENGGARA TIMUR
DINAS PENANAMAN MODAL
DAN PELAYANAN TERPADU SATU PINTU (DPMPTSP)
Jalan Basuki Rahmat No. 1 Kota Kupang – Telp / Fax. (0380) 833213, 821827
Email :dpmptsp.nttprov@gmail.com; Website:www.dpmptsp.nttprov.go.id

SURAT IZIN PENELITIAN

NOMOR : DPMPTSP.070/3182/PTSP/XII/2020

Yang bertanda tangan di bawah ini :

Nama	:	Drs. Marsianus Jawa, M.Si
Jabatan	:	Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Provinsi Nusa Tenggara Timur

Dengan ini memberikan Izin Penelitian kepada :

Nama	:	Christopher Bailey Raymond
Nomor Paspor	:	[redacted]
Kebangsaan	:	
Instansi/Lembaga	:	

Untuk melaksanakan penelitian, dengan rincian sebagai berikut :

Judul Penelitian	:	CORONA VIRUS CONTINGENCIES: A CASE STUDY OF LOCAL KNOWLEDGE AND COMMUNITY RESPONSES TO COVID-19 IN KUPANG CITY AND KUPANG DISTRICT, EAST NUSA TENGGARA, INDONESIA
Lokasi Penelitian	:	Kelurahan Oesapa Kecamatan Kelapa Lima Kota Kupang
Pengikut	:	Oce Boymau
Waktu Pelaksanaan		
a. Mulai	:	17 Desember 2020
b. Berakhir	:	16 Desember 2021

Dengan ketentuan yang harus ditaati, sebagai berikut :

1. Sebelum melakukan kegiatan penelitian, terlebih dahulu melaporkan kedatangannya kepada Bupati/Walikota Cq. Kepala Kesbangpol/DPMPTSP setempat yang akan dijadikan obyek penelitian;
2. Mematuhi ketentuan peraturan yang berlaku di daerah/wilayah/lokus penelitian;
3. Tidak dibenarkan melakukan penelitian yang materinya bertentangan dengan topik/judul penelitian sebagaimana dimaksud diatas;
4. Peneliti wajib melaporkan hasil penelitian kepada Gubernur Nusa Tenggara Timur Cq. Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Provinsi NTT;
5. Surat Izin Penelitian dapat dibatalkan sewaktu-waktu apabila tidak sesuai dengan ketentuan yang berlaku.

Demikian Izin Penelitian ini dibuat untuk dipergunakan sebagaimana mestinya.

[redacted]

Kupang, 16 Desember 2020

GUBERNUR NUSA TENGGARA TIMUR
KEPALA DINAS PENANAMAN MODAL
DAN PTSP PROV. NTT,

Drs. Marsianus Jawa, M.Si
Pembina Utama Muda
NIP. 19650808 199503 1 003

Tembusan :
1. Gubernur Nusa Tenggara Timur di Kupang (sebagai laporan);
2. Wakil Gubernur Nusa Tenggara Timur di Kupang (sebagai laporan);
3. Sekretaris Daerah Provinsi Nusa Tenggara Timur di Kupang (sebagai laporan);
4. Kepala Badan Kesbanggpol Provinsi NTT di Kupang;
5. Pimpinan Instansi/Lembaga yang bersangkutan.

PEMERINTAH PROVINSI NUSA TENGGARA TIMUR
DINAS PENANAMAN MODAL
DAN PELAYANAN TERPADU SATU PINTU (DPMPTSP)
Jalan Basuki Rahmat No. 1 Kota Kupang – Telp / Fax. (0380) 833213, 821827
Email :dpmptsp.nttprov@gmail.com; Website:www.dpmptsp.nttprov.go.id

SURAT IZIN PENELITIAN

NOMOR : DPMPTSP.070/3180/PTSP/XII/2020

Yang bertanda tangan di bawah ini :

Nama	:	Drs. Marsianus Jawa, M.Si
Jabatan	:	Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Provinsi Nusa Tenggara Timur

Dengan ini memberikan Izin Penelitian kepada :

Nama	:	Christopher Bailey Raymond
Nomor Paspor	:	[redacted]
Kebangsaan	:	
Instansi/Lembaga	:	

Untuk melaksanakan penelitian, dengan rincian sebagai berikut :

Judul Penelitian	:	CORONA VIRUS CONTINGENCIES: A CASE STUDY OF LOCAL KNOWLEDGE AND COMMUNITY RESPONSES TO COVID-19 IN KUPANG CITY AND KUPANG DISTRICT, EAST NUSA TENGGARA, INDONESIA
Lokasi Penelitian	:	Kelurahan Nunleu Kecamatan Kota Raja Kota Kupang
Pengikut	:	Oce Boymau
Waktu Pelaksanaan		
a. Mulai	:	17 Desember 2020
b. Berakhir	:	16 Desember 2021

Dengan ketentuan yang harus ditaati, sebagai berikut :

1. Sebelum melakukan kegiatan penelitian, terlebih dahulu melaporkan kedatangannya kepada Bupati/Walikota Cq. Kepala Kesbangpol/DPMPTSP setempat yang akan dijadikan obyek penelitian;
2. Mematuhi ketentuan peraturan yang berlaku di daerah/wilayah/lokus penelitian;
3. Tidak dibenarkan melakukan penelitian yang materinya bertentangan dengan topik/judul penelitian sebagaimana dimaksud diatas;
4. Peneliti wajib melaporkan hasil penelitian kepada Gubernur Nusa Tenggara Timur Cq. Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Provinsi NTT;
5. Surat Izin Penelitian dapat dibatalkan sewaktu-waktu apabila tidak sesuai dengan ketentuan yang berlaku.

Demikian Izin Penelitian ini dibuat untuk dipergunakan sebagaimana mestinya.

[redacted]

Kupang, 16 Desember 2020

GUBERNUR NUSA TENGGARA TIMUR
KEPALA DINAS PENANAMAN MODAL
DAN PTSP PROV. NTT,

Drs. Marsianus Jawa, M.Si
Pembina Utama Muda
NIP. 19650808 199503 1 003

Tembusan :
1. Gubernur Nusa Tenggara Timur di Kupang (sebagai laporan);
2. Wakil Gubernur Nusa Tenggara Timur di Kupang (sebagai laporan);
3. Sekretaris Daerah Provinsi Nusa Tenggara Timur di Kupang (sebagai laporan);
4. Kepala Badan Kesbangpol Provinsi NTT di Kupang;
5. Pimpinan Instansi/Lembaga yang bersangkutan.

PEMERINTAH PROVINSI NUSA TENGGARA TIMUR
DINAS PENANAMAN MODAL
DAN PELAYANAN TERPADU SATU PINTU (DPMPTSP)
Jalan Basuki Rahmat No. 1 Kota Kupang – Telp / Fax. (0380) 833213, 821827
Email :dpmptsp.nttprov@gmail.com; Website:www.dpmptsp.nttprov.go.id

SURAT IZIN PENELITIAN

NOMOR : DPMPTSP.070/3183/PTSP/XII/2020

Yang bertanda tangan di bawah ini :
Nama : Drs. Marsianus Jawa, M.Si
Jabatan : Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Provinsi Nusa Tenggara Timur

Dengan ini memberikan Izin Penelitian kepada :

Nama : Christopher Bailey Raymond
Nomor Paspor : [redacted]
Kebangsaan :
Instansi/Lembaga :

Untuk melaksanakan penelitian, dengan rincian sebagai berikut :
Judul Penelitian : CORONA VIRUS CONTINGENCIES: A CASE STUDY OF LOCAL KNOWLEDGE AND COMMUNITY RESPONSES TO COVID-19 IN KUPANG CITY AND KUPANG DISTRICT, EAST NUSA TENGGARA, INDONESIA
Lokasi Penelitian : Kelurahan Airnona Kecamatan Kota Raja Kota Kupang
Pengikut : Oce Boymau
Waktu Pelaksanaan
a. Mulai : 17 Desember 2020
b. Berakhir : 16 Desember 2021

Dengan ketentuan yang harus ditaati, sebagai berikut :
1. Sebelum melakukan kegiatan penelitian, terlebih dahulu melaporkan kedatangannya kepada Bupati/Walikota Cq. Kepala Kesbangpol/DPMPTSP setempat yang akan dijadikan obyek penelitian;
2. Mematuhi ketentuan peraturan yang berlaku di daerah/wilayah/lokus penelitian;
3. Tidak dibenarkan melakukan penelitian yang materinya bertentangan dengan topik/judul penelitian sebagaimana dimaksud diatas;
4. Peneliti wajib melaporkan hasil penelitian kepada Gubernur Nusa Tenggara Timur Cq. Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Provinsi NTT;
5. Surat Izin Penelitian dapat dibatalkan sewaktu-waktu apabila tidak sesuai dengan ketentuan yang berlaku.

Demikian Izin Penelitian ini dibuat untuk dipergunakan sebagaimana mestinya.

[redacted]

Kupang, 16 Desember 2020

a.n. GUBERNUR NUSA TENGGARA TIMUR
KEPALA DINAS PENANAMAN MODAL
DAN PTSP PROV. NTT,

DPM & PTSP

Drs. Marsianus Jawa, M.Si
Pembina Utama Muda
NIP. 19650808 199503 1 003

Tembusan :
1. Gubernur Nusa Tenggara Timur di Kupang (sebagai laporan);
2. Wakil Gubernur Nusa Tenggara Timur di Kupang (sebagai laporan);
3. Sekretaris Daerah Provinsi Nusa Tenggara Timur di Kupang (sebagai laporan);
4. Kepala Badan Kesbanggpol Provinsi NTT di Kupang;
5. Pimpinan instansi/Lembaga yang bersangkutan.

PEMERINTAH PROVINSI NUSA TENGGARA TIMUR
DINAS PENANAMAN MODAL
DAN PELAYANAN TERPADU SATU PINTU (DPMPTSP)
Jalan Basuki Rahmat No. 1 Kota Kupang – Telp / Fax. (0380) 833213, 821827
Email :dpmptsp.nttprov@gmail.com; Website:www.dpmptsp.nttprov.go.id

SURAT IZIN PENELITIAN

NOMOR : DPMPTSP.070/3179/PTSP/XII/2020

Yang bertanda tangan di bawah ini :

Nama	:	Drs. Marsianus Jawa, M.Si
Jabatan	:	Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Provinsi Nusa Tenggara Timur

Dengan ini memberikan Izin Penelitian kepada :

Nama	:	Christopher Bailey Raymond
Nomor Paspor	:	[redacted]
Kebangsaan	:	
Instansi/Lembaga	:	

Untuk melaksanakan penelitian, dengan rincian sebagai berikut :

Judul Penelitian	:	CORONA VIRUS CONTINGENCIES: A CASE STUDY OF LOCAL KNOWLEDGE AND COMMUNITY RESPONSES TO COVID-19 IN KUPANG CITY AND KUPANG DISTRICT, EAST NUSA TENGGARA, INDONESIA
Lokasi Penelitian	:	Kabupaten Kupang
Pengikut	:	Oce Baymau
Waktu Pelaksanaan		
a. Mulai	:	17 Desember 2020
b. Berakhir	:	16 Desember 2021

Dengan ketentuan yang harus ditaati, sebagai berikut :

1. Sebelum melakukan kegiatan penelitian, terlebih dahulu melaporkan kedatangannya kepada Bupati/Walikota Cq. Kepala Kesbangpol/DPMPTSP setempat yang akan dijadikan obyek penelitian;
2. Memaluhi ketentuan peraturan yang berlaku di daerah/wilayah/lokus penelitian;
3. Tidak dibenarkan melakukan penelitian yang materinya bertentangan dengan topik/judul penelitian sebagaimana dimaksud diatas;
4. Peneliti wajib melaporkan hasil penelitian kepada Gubernur Nusa Tenggara Timur Cq. Kepala Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu Provinsi NTT;
5. Surat Izin Penelitian dapat dibatalkan sewaktu-waktu apabila tidak sesuai dengan ketentuan yang berlaku.

Demikian Izin Penelitian ini dibuat untuk dipergunakan sebagaimana mestinya.

[redacted]

Kupang, 16 Desember 2020

a.n. GUBERNUR NUSA TENGGARA TIMUR
KEPALA DINAS PENANAMAN MODAL
DAN PTSP PROV. NTT,

Drs. Marsianus Jawa, M.Si
Pembina Utama Muda
NIP. 19650808 199503 1 003

Tembusan :
1. Gubernur Nusa Tenggara Timur di Kupang (sebagai laporan);
2. Wakil Gubernur Nusa Tenggara Timur di Kupang (sebagai laporan);
3. Sekretaris Daerah Provinsi Nusa Tenggara Timur di Kupang (sebagai laporan);
4. Kepala Badan Kesbanggpol Provinsi NTT di Kupang;
5. Pimpinan Instansi/Lembaga yang bersangkutan.

KEMENTERIAN RISET DAN TEKNOLOGI / BADAN RISET
DAN INOVASI NASIONAL
DEPUTI BIDANG PENGUATAN RISET DAN PENGEMBANGAN
Gedung II BPPT Lantai 19 – 20, Jalan M.H. Thamrin No. 8, Jakarta 10340
Telepon 021-3162222 Ext. 9702, 9782, 9707; Faksimile 021-3101728

No. : 460 /FRP/E5/DiLKI/VIII/2020
Lampiran : 1 (satu berkas
Perihal : Penyampaian Teleks Otorisasi VITAS C315

Jakarta, 12 Oktober 2020

Kepada Yth:

Kepala Kantor Imigrasi Kelas I Jakarta Pusat

Jl. Merpati No.3, RW.10, Gn. Sahari Utara, Kec. Kemayoran, Kota Jakarta Pusat, Daerah Khusus Ibukota Jakarta 10720

Phone : (021) 6541213

Dengan Hormat,

Bersama ini kami sampaikan teleks otorisasi visa peneliti sebagai berikut:

Nama	[redacted]
Mr. Christopher Bailey Raymond	

adalah peneliti dari Flinders University dan bermaksud melakukan penelitian selama 12 (dua belas) bulan, mulai bulan Oktober 2020. Ditinjau dari segi ilmiah, Kementerian Riset dan Teknologi / Badan Riset dan Inovasi Nasional tidak berkeberatan atas maksud tersebut. Telex Otorisasi Visa yang bersangkutan telah diterbitkan oleh Ditjen Imigrasi (terlampir).

Sehubungan dengan hal tersebut, kami mohon bantuan serta kebijaksanaannya agar yang bersangkutan dapat diberikan **VITAS indeks C315 di Kantor Imigrasi Kelas I Jakarta Pusat.**

Atas perhatian dan kerjasamanya, kami mengucapkan terima kasih.

a.n. Direktur Pengelolaan Kekayaan Intelektual/
selaku Sekretaris TKPIPA

Sri Wahyono, S.IP.
Kepala Subdirektorat Perizinan Penelitian

FRM.APP.14/IX-12/Rev.00

KEMENTERIAN RISET DAN TEKNOLOGI/
BADAN RISET DAN INOVASI NASIONAL
DEPUTI BIDANG PENGUATAN RISET DAN PENGEMBANGAN
Gedung B.J. Habibie Lantai 19 – 20, Jalan M.H. Thamrin No. 8, Jakarta 10340
Telepon 021-3162222 Ext. 9702, 9782, 9707; Faksimile 021-3101728

Nomor : S/ 1369 /E5/E5.4/2020 Jakarta, 13 Oktober 2020
Lampiran : -
Hal : Permohonan **KITAS dan MERP**

Yth. Kepala Kantor Imigrasi Kelas I Khusus Jakarta Selatan
J. Warung Buncit Raya No.207 Rt/ Rw.001/001 Kel.Duren Tiga, Kec.Pancoran, Jakarta Selatan, 12760
Telp.(021)79170912, 79170910
Faks.(021)-79170907,79170910

Merujuk persetujuan Tim Koordinasi Pemberian Izin Penelitian Asing (TKPIPA) Nomor : [redacted] dengan ini kami memberitahukan bahwa :

Nama : **Mr. Christopher Bailey Raymond**
Warga Negara :
Nomor Paspor : [redacted]

adalah peneliti dari *Flinders University* yang akan melakukan penelitian di Nusa Tenggara Timur (Kab. Alor, Kota Kupang) dalam bidang Kesehatan publik dengan judul penelitian *"Coronavirus Contingencies: an ethnographic case study of community responses to the Covid-19 pandemic in East Nusa Tenggara, Indonesia"*. Penelitian ini bertujuan untuk mengeksplorasi komunitas lokal dan tanggapan resmi terhadap krisis Covid-19 di NTT dengan tujuan meningkatkan intervensi kesehatan masyarakat, dengan mitra kerja di Indonesia adalah Institute of Resource Governance and Social Change (Dr. Dominggus Elcid Li PhD).

Penelitian tersebut diperkirakan akan memerlukan waktu 12 (dua belas) bulan, mulai 13 Oktober 2020, dan ditinjau dari segi ilmiah Kementerian Riset dan Teknologi/Badan Riset dan Inovasi Nasional tidak berkeberatan atas maksud tersebut. Sehubungan dengan hal tersebut, kami mohon kerjasama Saudara, agar kiranya kepada yang bersangkutan dapat diberikan **KITAS** sesuai dengan visa yang dimiliki dan ***Multiple Exit Re-Entry Permit (MERP)*** selama masa berlaku KITAS yang dimilikinya, bilamana hal tersebut tidak bertentangan dengan peraturan yang berlaku.

Demikian, atas perhatian dan kerjasamanya selama ini, kami mengucapkan terima kasih.

Direktur Pengelolaan Kekayaan Intelektual/
selaku Sekretaris TKPIPA

Prof. Dr. Heri Hermansyah, ST., M. Eng., IPU

KEMENTERIAN RISET DAN TEKNOLOGI/
BADAN RISET DAN INOVASI NASIONAL
DEPUTI BIDANG PENGUATAN RISET DAN PENGEMBANGAN
Gedung B.J. Habibie Lantai 19 – 20, Jalan M.H. Thamrin No. 8, Jakarta 10340
Telepon 021-3162222 Ext. 9702, 9782, 9707; Faksimile 021-3101728

Nomor : S/ 1368 /E5/E5.4/2020 Jakarta, 13 Oktober 2020
Lampiran : Satu set SIP
Hal : Permohonan **Surat Keterangan Jalan**

Yth. Kepala Badan Intelijen Keamanan POLRI
u.p. Kabid Yanmas
Jl. Trunojoyo No. 3 Kebayoran Baru, Jakarta Selatan

Merujuk persetujuan Tim Koordinasi Pemberian Izin Penelitian Asing (TKPIPA) Nomor : [redacted] dengan ini kami memberitahukan bahwa :

Nama : **Mr. Christopher Bailey Raymond**
Warga Negara : [redacted]
Nomor Paspor :

adalah peneliti dari *Flinders University* yang akan melakukan penelitian di Nusa Tenggara Timur (Kab. Alor, Kota Kupang) dalam bidang Kesehatan publik dengan judul penelitian *"Coronavirus Contingencies: an ethnographic case study of community responses to the Covid-19 pandemic in East Nusa Tenggara, Indonesia"*. Penelitian ini bertujuan untuk mengeksplorasi komunitas lokal dan tanggapan resmi terhadap krisis Covid-19 di NTT dengan tujuan meningkatkan intervensi kesehatan masyarakat, dengan mitra kerja di Indonesia adalah Institute of Resource Governance and Social Change (Dr. Dominggus Elcid Li PhD).

Penelitian tersebut diperkirakan akan memerlukan waktu 12 (dua belas) bulan, mulai 13 Oktober 2020, dan ditinjau dari segi ilmiah Kementerian Riset dan Teknologi/Badan Riset dan Inovasi Nasional tidak berkeberatan atas maksud tersebut. Sehubungan dengan hal tersebut, kami mohon kerjasama Saudara, agar kiranya kepada yang bersangkutan dapat diberikan **Surat Keterangan Jalan (SKJ)**, selama waktu penelitian di Indonesia, bilamana hal tersebut tidak bertentangan dengan peraturan yang berlaku.

Demikian, atas perhatian dan kerjasamanya selama ini, kami mengucapkan terima kasih.

Direktur Pengelolaan Kekayaan Intelektual/
selaku Sekretaris TKPIPA

Prof. Dr. Heri Hermansyah, ST., M. Eng., IPU

KEMENTERIAN RISET DAN TEKNOLOGI/
BADAN RISET DAN INOVASI NASIONAL
DEPUTI BIDANG PENGUATAN RISET DAN PENGEMBANGAN
Gedung B.J. Habibie Lantai 19 – 20, Jalan M.H. Thamrin No. 8, Jakarta 10340
Telepon 021-3162222 Ext. 9702, 9782, 9707; Faksimile 021-3101728

RISTEK-BRIN

Nomor : S/ 1370 /E5/E5.4/2020 Jakarta, 13 Oktober 2020
Lampiran : Satu set SIP
Hal : Permohonan **Surat Pemberitahuan Penelitian**

Yth. Dirjen Politik dan Pemerintahan Umum
u.p. Direktur Kewaspadaan Nasional
Kementerian Dalam Negeri
Jl. Medan Merdeka Utara No.7 Jakarta Pusat 10110
Tlp. (021) 3450038 Fax. (021) 3851193

Merujuk persetujuan Tim Koordinasi Pemberian Izin Penelitian Asing (TKPIPA) Nomor : [redacted] dengan ini kami memberitahukan bahwa :

Nama : **Mr. Christopher Bailey Raymond**
Warga Negara : [redacted]
Nomor Paspor :

adalah peneliti dari *Flinders University* yang akan melakukan penelitian di Nusa Tenggara Timur (Kab. Alor, Kota Kupang) dalam bidang Kesehatan publik dengan judul penelitian *"Coronavirus Contingencies: an ethnographic case study of community responses to the Covid-19 pandemic in East Nusa Tenggara, Indonesia"*. Penelitian ini bertujuan untuk mengeksplorasi komunitas lokal dan tanggapan resmi terhadap krisis Covid-19 di NTT dengan tujuan meningkatkan intervensi kesehatan masyarakat, dengan mitra kerja di Indonesia adalah Institute of Resource Governance and Social Change (Dr. Dominggus Elcid Li PhD).

Penelitian tersebut diperkirakan akan memerlukan waktu 12 (dua belas) bulan, mulai 13 Oktober 2020, dan ditinjau dari segi ilmiah Kementerian Riset dan Teknologi/Badan Riset dan Inovasi Nasional tidak berkeberatan atas maksud tersebut. Sehubungan dengan hal tersebut, kami mohon kerjasama Saudara, agar kiranya kepada yang bersangkutan dapat diberikan **Surat Pemberitahuan Penelitian (SPP)**. Sebagai bahan pertimbangan Saudara, bersama ini kami lampirkan salinan Surat Izin Penelitian.

Demikian, atas perhatian dan kerjasamanya selama ini, kami mengucapkan terima kasih.

Direktur Pengelolaan Kekayaan Intelektual/
selaku Sekretaris TKPIPA

Prof. Dr. Heri Hermansyah, ST., M. Eng., IPU

PEMERINTAH KABUPATEN KUPANG
DINAS KESEHATAN
JLN. TIMOR RAYA KM. 37 - OELAMASI

Nomor : 443 / 149 / P2P / 2021
Lampiran : 1 (satu) lembar
Perihal : Undangan Pertemuan

Oelamasi, 9 Maret 2021

Kepada

Yth. 1. Bpk. Direktur RSUD Naibonat
2. Bpk/Ibu Kepala Puskesmas
Daftar terlampir
Masing-masing
di,-
Tempat

Dengan Hormat,

Menindaklanjuti surat permintaan untuk melakukan penelitian oleh Sdr. Christopher Bailey Raymond dari Universitas Flinders - Australia tentang Pengetahuan dan Tanggapan Masyarakat Mengenai Covid-19 di Kabupaten Kupang, maka melalui surat ini, kami meminta untuk menugaskan salah satu staf pengelola penyakit menular khususnya yang terlibat langsung dalam penanganan Pandemi Covid-19 untuk mengikuti pertemuan yang akan dilaksanakan pada :

Hari/ Tanggal : Rabu, 9 Maret 2021
Waktu : 10.00 Wita
Tempat : Kantor Dinas Kesehatan Kab. Kupang

Demikian penyampaian kami, atas perhatian dan kerjasamanya disampaikan terima kasih.

An. Kepala Dinas Kesehatan Kabupaten Kupang
Kepala Bidang P2P,

dr. Kuji L. K. Riwu Kaho
NIP. 19760909 200501 2 015

Appendix 3: Letters of Agreement IRGSC & UNDANA, Signature Pages

LETTER OF AGREEMENT
BETWEEN
INSTITUTE OF RESOURCE GOVERNANCE AND SOCIAL CHANGE
AND
COLLEGE OF MEDICINE AND PUBLIC HEALTH
FLINDERS UNIVERSITY OF SOUTH AUSTRALIA

This agreement is made and entered into by the Institute of Resource Governance and Social Change (IRGSC) of Kupang, NTT, Indonesia and the College of Medicine and Public Health, Flinders University of South Australia, Adelaide, SA, Australia, hereinafter referred to as 'the Parties.'

Desiring to strengthen research cooperation based on the principle of mutual benefit and for the potential to develop research projects arising from this cooperation between IRGSC and Flinders University, and pursuant to the prevailing laws and regulations of the Republic of Indonesia, as well as the Indonesian government's procedures and policies on international research cooperation, the Parties shall agree as follows:

Article 1
Objective

The objective of the research cooperation under this Letter of Agreement (hereinafter referred to as 'LoA') is to promote mutual research cooperation and develop research capabilities of the two Parties under the research project entitled 'Coronavirus Contingencies: an ethnographic case study of community responses to the Covid-19 pandemic in East Nusa Tenggara, Indonesia.' Executive Director Dominggus Elcid Li, PhD will be the researcher representing IRGSC. Mr. Christopher Bailey Raymond, a doctoral student at Flinders University, will conduct this research as a component of the degree of Doctor of Public Health.

Article 2
Scope of Activities

The DrPH student research activity in the field of public health will include the following activities:

1. Conducting public health research into Covid-19 pandemic perceptions and responses of local communities in kabupaten Alor, NTT, as part of a doctoral student research project, which may include
2. Conducting focus group discussions with the local community, and collecting and analysing data
3. Conducting interviews with members of the local community, and collecting and analysing data
4. Engaging in participant observation by the principle investigator and research assistants during a period of two months field data collection.

commercial purposes free of royalty. Should the intellectual property rights, data, or information resulting from research activities under this LoA be used for commercial purposes by one Party, the other Party shall be entitled to royalties obtained from the use of such property on the basis of the principle of equitable distribution.

The Parties are entitled to use the results of their scientific cooperation for further educational and scientific purposes, including the right to publish the results. The proposed Party shall inform the other Party regarding publication and discuss the potential to draft the publication jointly, allowing for co-authorship. Publication in Indonesia will be the responsibility of Dr. Dominggus Elcid Li PhD, Executive Director, IRGSC. The researcher has the right to publish selections from the research results, or the results as a whole, outside Indonesia in any medium.

Termination of the LoA shall not affect the rights and/or obligations under this Article during a period of 5 years after such termination.

Article 7
Dispute Clause

Any dispute arising out of the interpretation or implementation of this LoA shall be settled amicably using the prevailing Indonesian laws.

Article 8
Amendments, Duration, and Termination

1. Any amendment to this LoA can be made in writing by mutual consent of both Parties.
2. The LoA shall be effective from the date of its signing and is valid for the duration of the research project.
3. The termination of this LoA shall not prejudice the completion of any ongoing programs that have been agreed upon by the Parties.

In Witness thereof, the undersigned Authorized Representatives of the Parties have signed this LoA (two original signed texts are equally authentic).

Signed,	Signed,
[redacted]	[redacted]
Prof. Dr. Paul Ward, PhD, MA Professor College of Medicine and Public Health Flinders University Adelaide, Australia	Dominggus Elcid Li PhD Executive Director Institute of Resource Governance and Social Change (IRGSC) Kupang, NTT, Indonesia
Date: 29-6-2020	Date: 27 June 2020

Flinders UNIVERSITY
ADELAIDE • AUSTRALIA

LETTER OF AGREEMENT
(SURAT PERJANJIAN KERJA SAMA)
BETWEEN
(ANTARA)
COLLEGE OF MEDICINE AND PUBLIC HEALTH, FLINDERS UNIVERSITY
(FAKULTAS KEDOKTERAN DAN KESEHATAN MASYARAKAT, UNIVERSITAS FLINDERS)
AND
(DAN)
PROGRAM PASCASARJANA, UNIVERSITAS NUSA CENDANA
(POST-GRADUATE PROGRAMME, NUSA CENDANA UNIVERSITY)

This agreement is made and entered into by the College of Medicine and Public Health, Flinders University of South Australia, Adelaide, SA, Australia, and the Post-Graduate Programme of Universitas Nusa Cendana (UNDANA), Kota Kupang, Nusa Tenggara Timur, Indonesia, hereinafter referred to as 'the Parties.'

Desiring to strengthen research cooperation based on the principle of mutual benefit and for the potential to develop research projects arising from this cooperation between Flinders University and UNDANA and pursuant to the prevailing laws and regulations of the Republic of Indonesia, as well as the Indonesian government's procedures and policies on international research cooperation, the Parties shall agree as follows:

Article 1
Objective

The objective of the research cooperation under this Letter of Agreement (hereinafter referred to as 'LoA') is to promote mutual research cooperation and develop research capabilities of the two Parties under the research project entitled 'Coronavirus Contingencies: An ethnographic case study of community responses to the Covid-19 pandemic in East Nusa Tenggara, Indonesia.' Dr. Andreas Umbu Roga, Chair the Public Health Department of the Post-Graduate Programme, will be the researcher representing UNDANA. Mr. Christopher Bailey Raymond, a doctoral student at Flinders University, will conduct this research as a component of the degree of Doctor of Public Health.

Perjanjian kerja sama ini dibuat dan ditandatangani oleh Fakultas Kedokteran dan Kesehatan Masyarakat, Universitas Flinders, Adelaide, Australia Selatan, Australia, dan Program Pascasarjana Universitas Nusa Cendana (UNDANA), Kota Kupang, Nusa Tenggara Timur, Indonesia, yang selanjutnya disebut 'Para Pihak'.

Berkeinginan untuk memperkuat kerja sama penelitian berdasarkan prinsip saling menguntungkan dan berpotensi untuk mengembangkan projek-projek penelitian yang timbul dari kerja sama antara Universitas Flinders dan UNDANA ini, dan sesuai dengan hukum dan perundang-undangan yang berlaku di Republik Indonesia, serta prosedur dan kebijakan tentang kerja sama penelitian internasional pemerintah Indonesia, Para Pihak menyetujui hal-hal sebagai berikut:

Pasal 1
Tujuan

Tujuan kerjasama penelitian berdasarkan Perjanjian Kerja Sama ini (selanjutnya disebut 'PKS') adalah untuk mempromosikan kerja sama penelitian dan mengembangkan kemampuan penelitian kedua belah Pihak melalui projek penelitian yang berjudul 'Coronavirus Contingencies: An ethnographic case study of community responses to the Covid-19 pandemic in East Nusa Tenggara, Indonesia'. Dr. Andreas Umbu Roga, Ketua Program Studi Ilmu Kesehatan Masyarakat Program Pascasarjana akan menjadi peneliti yang mewakili UNDANA. Mr. Christopher Bailey Raymond, mahasiswa program doktor di Flinders University, akan melakukan penelitian ini sebagai komponen dari gelar Doktor Kesehatan Masyarakat.

publish the results. The proposed Party shall inform the other Party regarding publication and discuss the potential to draft the publication jointly, allowing for co-authorship. Publication in Indonesia will be the responsibility of Dr. Andreas Umbu Roga, Chair the Public Health Department of the Post-Graduate Programme, UNDANA. The researcher has the right to publish selections from the research results, or the results as a whole, outside Indonesia in any medium.

Termination of the LoA shall not affect the rights and/or obligations under this Article during a period of 5 years after such termination.

untuk mempublikasikan hasil. Pihak yang diusulkan harus menginformasikan kepada Pihak lain mengenai publikasi dan mendiskusikan potensi untuk menyusun naskah publikasi bersama. Publikasi di Indonesia akan menjadi tanggung jawab Dr. Andreas Umbu Roga, Ketua Program Studi Ilmu Kesehatan Masyarakat Program Pascasarjana, UNDANA. Peneliti memiliki hak untuk mempublikasikan pilihan dari hasil penelitian, atau hasil secara keseluruhan, di luar Indonesia dalam media apa pun.

Pengakhiran PKS ini tidak akan mempengaruhi hak dan/atau kewajiban berdasarkan Pasal ini selama periode 5 tahun setelah berakhirnya perjanjian ini.

Article 7
Dispute Clause

Any dispute arising out of the interpretation or implementation of this LoA shall be settled amicably using the prevailing Indonesian laws.

Pasal 7
Klausul Perselisihan

Setiap perselisihan yang timbul karena interpretasi atau penerapan dari PKS ini akan diselesaikan secara damai menggunakan hukum yang berlaku di Indonesia.

Article 8
Amendments, Duration, and Termination

1. Any amendment to this LoA can be made in writing by mutual consent of both Parties,
2. The LoA shall be effective from the date of its signing and is valid for the duration of the research project,
3. The termination of this LoA shall not prejudice the completion of any ongoing programs that have been agreed upon by the Parties.

Pasal 8
Amandemen, Jangka Waktu, dan Pengakhiran

1. Setiap amandemen terhadap PKS ini dapat dibuat secara tertulis dengan persetujuan bersama dari kedua Pihak,
2. PKS ini mulai berlaku sejak tanggal penandatanganannya dan sah selama pelaksanaan projek penelitian,
3. Pengakhiran PKS ini tidak akan mengurangi penyelesaian setiap program yang sedang berlangsung yang telah disepakati oleh Para Pihak.

In Witness Thereof, the undersigned Authorized Representatives of the Parties have signed this LoA (two original signed texts are equally authentic).

Menyaksikan dari padanya, Perwakilan Resmi dari Para Pihak yang bertandatangan di bawah ini telah menandatangani surat perjanjian kerja sama ini (dua dokumen yang ditandatangani sesuai dengan asli).

College of Medicine and Public Health
Adelaide, Australia

[redacted] Paul Ward, Ph.D., MA
Professor/Guru Besar
College of Medicine and Public Health/
Fakultas Kedokteran dan Kesehatan Masyarakat

Date/Tanggal: 11-09-2020

Post-Graduate Programme
Kota Kupang, Indonesia

[redacted]

Prof. Dr. Mangadas Lumban Gaol, MSi., Ph.D.
Professor and Director/Guru Besar dan Direktur
Post-Graduate Programme/Program Pascasarjana

Date/Tanggal: 22 September 2020

Page 4 of 4 pages/Halaman 4 dari 4 halaman

Appendix 4: Information Sheet, Informed Consent & Research Protocol (SBREC-approved)

PARTICIPANT INFORMATION SHEET AND CONSENT FORM

Title:
'Coronavirus Contingencies: An Ethnographic Case Study of Local Knowledge and Community Responses to Covid-19 in Kupang City and Kupang District, East Nusa Tenggara, Indonesia'

Chief Investigator
DrPH Student Christopher B. Raymond, MPH
College of Medicine and Public Health
Flinders University
[redacted]

Supervisor
Professor Paul Ward, PhD
College of Medicine and Public Health
Flinders University
[redacted]

Description of the study
This project will investigate community perceptions and responses during the Covid-19 pandemic in Nusa Tenggara Timor, Indonesia, using an ethnographic methodology and including community participation, interviews with community members, and group discussions. The project will explore in depth understandings, thoughts, opinions, and feelings related to the social and economic restrictions during the Covid-19 crisis, comparing rural and urban contexts in Kupang City and Kupang Regency. The information gathered during this research can then be used to improve public health outreach, communication, and cooperation within the community. This project is supported by Flinders University, College of Medicine and Public Health, Adelaide, Australia in collaboration with the Indonesian Institute of Resource Governance and Social Change and the Public Health Studies Program Universitas Nusa Cendana Kupang Postgraduate Program in Kupang, NTT, Indonesia.

Purpose of the study
This project aims to investigate how communities in NTT understand the Covid-19 pandemic situation, how it affects them personally and socially, and the reasons underlying individual and community responses to social and economic restrictions. A significant goal will be to improve public health programs in this region by providing a deeper understanding of the local context of the Covid-19 pandemic in NTT.

Benefits of the study
The sharing of your personal thoughts and experiences will help the researchers to understand the context of how the community perceives and responds to pandemic threats like Covid-19. This valuable information can help guide decisions about public health communications and approaches to social restrictions and other impacts from this pandemic.

Participant involvement and potential risks
If you agree to participate in the research study, you will be asked to:

- attend a one-on-one interview with a researcher that will be audio recorded
- potentially have your photograph taken during the interview or during the course of the research in the community
- share your thoughts and opinions related to Covid-19 and other health issues in your community

The interview will take about 30-45 minutes and participation is entirely voluntary.

The researchers do not expect the questions to cause any harm or discomfort to you. However, if you experience feelings of distress as a result of participation in this study, please let the research team know immediately. You can also contact the following services for support:

- Health Center Oebobo Kupang City: 0813-3879-8953
- Batakte Health Center, Kupang Regency: 0821-4570-6121/0821-4516-8288
- UNDANA Psychology Study Program, Kupang: 0822-3574-8514

Withdrawal Rights
You may, without any penalty, decline to take part in this research study. If you decide to take part and later change your mind, you may, without any penalty, withdraw at any time without providing an explanation. To withdraw, please contact the Chief Investigator or you may refuse to answer any or all interview questions. Any data collected up to the point of your withdrawal from the study will be securely destroyed.

Your decision not to participate or to withdraw from this research study will not affect your relationship with Flinders University and its staff and students.

Confidentiality and Privacy
Only researchers listed on this form have access to individual information you have provided. Your privacy and confidentiality will be assured at all times. The research outcomes may be presented at conferences, written up for publication or used for other research purposes as described in this information form. However, the privacy and confidentiality of individuals will be protected at all times. You will not be named, and your individual information will not be identifiable in any research products without your explicit consent.

No data, including identifiable, non-identifiable and de-identified datasets, will be shared or used in future research projects without your explicit consent.

Data Storage
The information collected may be stored securely on a password protected computer and/or Flinders University server throughout the duration of the study time frame. Any identifiable data will be de-identified for data storage purposes unless indicated otherwise. All data will be securely transferred to and stored at Flinders University for at least five years after publication of the results. Following the required data storage period, all data will be securely destroyed according to university protocols.

Recognition of Contribution / Time / Travel costs
If you would like to participate, in recognition of your contribution and participation time, you will be provided with a per diem reimbursement of 200,000 IDR, upon completion of the interview.

How will I receive feedback?
Upon project completion, the researcher will convene a community meeting to share the results of the study with the *kepala desa* and community members. A written, brief summary will also be provided to participants, as well as sharing any relevant media (photographs, films, etc.).

Ethics Committee Approval
The project has been approved by Flinders University's Human Research Ethics Committee (2219), the Ethics Committee of the Indonesian Research and Development Agency and the UNDANA Kupang Ethics Committee.

Queries and Concerns
Queries or concerns regarding the research can be directed to the research team. If you have any complaints or reservations about the ethical conduct of this study, you may contact the Flinders University's Research Ethics & Compliance Office team via telephone [redacted] or the Health Research Ethics Committee UNDANA Kupang, Secretariat : 2nd Floor Integrated Laboratory Building Jl. Adisucipto Penfui- [redacted]

Thank you for taking the time to read this information sheet and if you accept our invitation to be involved, please sign the enclosed Consent Form.

CONSENT FORM

Consent Statement

☐ I have read and understood the information about the research, and I understand I am being asked to provide informed consent to participate in this research study. I understand that I can contact the research team if I have further questions about this research study.

☐ I am not aware of any condition that would prevent my participation, and I agree to participate in this project.

☐ I understand that I am free to withdraw at any time during the study and that my withdrawal will not affect my relationship with Flinders University and its staff and students.

☐ I understand that I can contact Flinders University's Research Ethics & Compliance Office if I have any complaints or reservations about the ethical conduct of this study.

☐ I understand that my involvement is confidential, and that the information collected may be published. I understand that I will not be identified in any research products.

I further consent to:

☐ completing a questionnaire
☐ participating in an interview
☐ participating in a Focus Group discussion
☐ having my information audio recorded
☐ having my information video recorded
☐ having my photo taken
☐ sharing my de-identified data with other researchers
☐ sharing my identifiable data with other researchers
☐ my data and information being used in this project and other related projects for an extended period of time (no more than 10 years after publication of the data)
☐ being contacted about other research projects

Signed:

Name:

Date:

NASKAH PENJELASAN DAN INFORMASI PENELITIAN KEPADA RESPONDEN

Judul:
Kontingensi Coronavirus : Studi Kasus Tanggapan Masyarakat terhadap Pandemi Covid-19 di Kabupaten dan Kota Kupang, Nusa Tenggara Timur, Indonesia

Peneliti:
DrPH Student Christopher B. Raymond, MPH
College of Medicine and Public Health
Flinders University
[redacted]

Pengawas Akademik:
Professor Paul Ward, PhD
College of Medicine and Public Health
Flinders University
[redacted]

Penjelasan tentang penelitian:
Penelitian ini akan meneliti tanggapan masyarakat selama pandemi Covid-19 di Nusa Tenggara, Indonesia, menggunakan metodologi wawancara dengan anggota masyarakat dan diskusi kelompok. Penelitian ini akan menggali lebih dalam pemahaman, pemikiran, pendapat, dan perasaan yang terkait dengan pembatasan sosial dan ekonomi, penerapan protocol kesehatan selama krisis Covid-19. Informasi yang dikumpulkan selama penelitian ini selanjutnya dapat digunakan untuk upaya peningkatan kesehatan masyarakat, komunikasi, dan kerja sama dalam masyarakat. Penelitian ini didukung oleh Fakultas Kedokteran dan Kesehatan Masyarakat Universitas Flinders, Program Studi Ilmu Kesehatan Masyarakat Program Pasca Sarjana Undana Kupang dan IRGSC Kupang.

Tujuan penelitian:
Penelitian ini bertujuan untuk menggali lebih dalam bagaimana masyarakat di NTT memahami situasi pandemi Covid-19, bagaimana pandemi covid-19 mempengaruhi mereka secara individu/pribadi dan sosial, dan alasan yang mendasari respon individu dan masyarakat terhadap pembatasan sosial dan ekonomi. Tujuan penting adalah untuk meningkatkan program kesehatan masyarakat di wilayah NTT dengan memberikan pemahaman yang lebih mendalam tentang konteks lokal pandemi Covid-19 di NTT. Studi ini adalah bagian dari disertasi doktor di bidang kesehatan masyarakat pada Flinders University, Australia.

Manfaat yang akan diperoleh dengan berpartisipasi dalam penelitian ini:

Berbagi pemikiran dan pengalaman pribadi anda akan membantu untuk memahami konteks tentang bagaimana persepsi dan tanggapan masyarakat terhadap ancaman pandemi seperti Covid-19. Hasil penelitian ini akan dibagikan dengan pemangku kepentingan lokal dengan tujuan meningkatkan respons dan intervensi secara keseluruhan terhadap pandemi Covid-19. Informasi berharga ini dapat menjadi salah satu acuan pengambilan keputusan tentang komunikasi kesehatan masyarakat dan pendekatan terhadap pembatasan social,penerapan protocol kesehatan dan dampak lain dari pandemi ini.Penelitian ini juga dilakukan dalam rangka menyelesaikan program doctoral peneliti sebagai mahasiswa di Universitas Flinders, Australia.

Karakterisitik dan jumlah responden:

- Wawancara akan dilakukan dengan 12-15 orang anggota masyarakat di Kota Kupang dan 12-15 orang anggota masyarakat di Kabupaten Kupang.
- Kriteria anggota masyarakat yang diwawancarai yaitu: orang dewasa berumur diatas 18 tahun, orang asli NTT, tinggal di kelurahan/desa tersebut minimal 10 tahun, tidak mempunyai hubungan kekeluargaan dengan pihak berwenang di kelurahan/desa kecuali teridentifikasi sebagai tokoh agama, kader atau Ketua RT/RW.
- Karena jumlah responden yang terbatas maka Tim akam memastikan keterwakilan aspek lain seperti usia, pekerjaan, laki-laki dan wanita bekerja, lansia, ibu rumah tangga, dan individu dengan pekerjaan lain.

Keterlibatan responden dan resiko:
Jika Anda setuju untuk berpartisipasi dalam studi penelitian, Anda akan diminta untuk:

- Berpartisipasi dalam wawancara langsung dengan seorang peneliti dan Asisten peneliti yang akan direkam secara audio
- Nama anda anonim dan informasi yang diberikan tentang persepsi dan pendapat Anda terkait Covid-19 dan masalah kesehatan lainnya di komunitas Anda bersifat rahasia

Wawancara akan berlangsung sekitar 30-45 menit dan partisipasi anda sepenuhnya bersifat sukarela.

Risiko potensial dari penelitian ini mungkin termasuk ketidaknyamanan emosional yang timbul dari diskusi tentang masalah kesehatan pribadi, atau diskusi seputar penyakit dan kematian di keluarga atau komunitas Anda. Pandemi Covid-19 memiliki konsekuensi serius bagi komunitas di seluruh dunia, dan diskusi selama proyek penelitian ini mungkin menyentuh topik sensitif atau menyedihkan.

Para peneliti tidak berharap pertanyaan-pertanyaan menimbulkan bahaya atau ketidaknyamanan bagi Anda. Namun, jika Anda mengalami perasaan tertekan karena partisipasi dalam penelitian ini, beri tahu tim peneliti segera. Anda juga dapat menghubungi layanan berikut untuk mendapatkan dukungan:

- Puskesmas Oebobo Kota Kupang : 0813-3879-8953
- Puskesmas Batakte, Kabupaten Kupang: 0821-4570-6121/0821-4516-8288
- Prodi Psikologi UNDANA, Kupang: 0822-3574-8514

Hak Penolakan/Pembatalan
Anda bebas setiap saat tanpa syarat, menolak untuk berpartisipasi dalam studi penelitian ini. Jika Anda ikut berpartisipasi dan ditengah-tengah penelitian kemudian berubah pikiran, Anda dapat tanpa syarat menarik diri kapan saja tanpa memberikan penjelasan. Untuk pembatalan ini, silakan hubungi Asisten Peneliti atau Anda dapat menolak untuk berpartisipasi dalam diskusi kelompok atau wawancara. Semua data yang dikumpulkan sampai penarikan diri Anda dari studi ini akan dimusnahkan dengan aman.

Keputusan Anda untuk tidak berpartisipasi atau menarik diri dari studi penelitian ini tidak akan mempengaruhi hubungan Anda dengan Universitas Flinders, staf serta mahasiswanya.

Kerahasiaan dan privasi
Hanya peneliti yang tercantum dalam formulir ini yang memiliki akses ke informasi pribadi yang anda berikan. Privasi dan kerahasiaan Anda akan terjamin setiap saat. Hasil penelitian ini kemungkinan dipresentasikan di konferensi, ditulis untuk publikasi atau digunakan untuk penelitian lain seperti yang dijelaskan dalam formulir informasi ini. Namun, privasi dan kerahasiaan individu akan dilindungi setiap saat. Anda tidak akan disebutkan namanya, dan informasi pribadi Anda tidak akan digunakan dalam penelitian lain apa pun tanpa persetujuan resmi Anda.

Tidak akan ada data, termasuk data yang masih dapat didentifikasi, tidak teridentifikasi, dan yang telah diolah menjadi kumpulan data, akan dibagikan atau digunakan dalam penelitian lain di masa yang akan datang tanpa persetujuan resmi dari Anda.

Penyimpanan data
Informasi yang telah dikumpulkan akan disimpan dengan aman di komputer yang dilindungi kata sandi dan/ server di Universitas Flinders selama penelitian. Setiap data yang dapat diidentifikasi akan dibuat anonym untuk keperluan penyimpanan data kecuali dinyatakan sebaliknya. Semua data akan ditransfer dengan aman ke dan disimpan di Universitas Flinders setidaknya selama 5 (lima) tahun setelah publikasi hasil penelitian ini. Setelah periode penyimpanan data ini, semua data akan dihancurkan dengan aman sesuai dengan protokol universitas.

Kontribusi / Waktu / Biaya Perjalanan

Jika anda ingin berpartisipasi, sebagai tanda terimakasih atas kontribusi dan waktu Anda, anda akan diberikan penggantian uang harian, setelah menyelesaikan wawancara sejumlah Rp. 200.000 (dua ratus ribu rupiah).

Bagaimana saya mendapatkan umpan balik/tanggapan?

Setelah penelitian selesai, peneliti akan mengadakan pertemuan di komunitas/masyarakat untuk berbagi hasil penelitian dengan kepala desa dan anggota masyarakat. Rangkuman tertulis, juga akan diberikan kepada peserta, termasuk berbagi media yang relevan (foto, film, dll).

Persetujuan Komite Etika

Proyek ini telah disetujui oleh Komite Etika Penelitian Manusia Universitas Flinders (2219), Komite Etik Badan Litbangkes RI dan Komite Etik UNDANA Kupang.

Pertanyaan dan tanggapan
Pertanyaan atau tanggapan terkait penelitian ini dapat disampaikan langsung ke ke tim peneliti. Jika Anda memiliki keluhan atau keberatan tentang perilaku etik penelitian ini, Anda dapat menghubungi tim Kantor Etika & Kepatuhan Universitas Flinders melalui telepon [redacted]

Terima kasih telah meluangkan waktu untuk membaca lembar informasi ini dan jika Anda menerima undangan kami untuk terlibat, silakan menandatangani formulir pernyataan kesediaan berpartisipasi dalam penelitian, terlampir.

Flinders
UNIVERSITY
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FORMULIR PERNYATAAN KESEDIAAN
BERPARTISIPASI DALAM PENELITIAN *(INFORMED CONSENT)*
Wawancara

Pernyataan Persetujuan

☑ Saya telah membaca dan memahami informasi tentang penelitian, dan saya mengerti saya diminta untuk memberikan persetujuan untuk berpartisipasi dalam penelitian ini. Saya mengerti bahwa saya dapat menghubungi tim peneliti jika saya memiliki pertanyaan lebih lanjut tentang penelitian ini.

☑ Saya merasa tidak ada halangan untuk partisipasi saya, dan saya setuju untuk berpartisipasi dalam penelitian ini.

☑ Saya mengerti bahwa saya bebas untuk menarik diri kapan saja selama studi dan bahwa penarikan diri saya tidak akan memengaruhi hubungan saya dengan Universitas Flinders, staf serta mahasiswanya.

☑ Saya mengerti bahwa saya dapat menghubungi Kantor Etika & Kepatuhan Penelitian Universitas Flinders atau Komite Kaji Etik Balitbangkes jika saya memiliki keluhan atau keberatan tentang perilaku etik penelitian ini.

☑ Saya mengerti bahwa keterlibatan saya dijamin kerahasiaannya, dan bahwa informasi yang dikumpulkan kemungkinan dipublikasikan. Saya mengerti bahwa informasi dari saya tidak akan digunakan dalam penelitian lain apa pun.

☑ Saya mengerti bahwa saya dapat menarik data dan informasi saya dari penelitian ini. Saya juga mengerti bahwa data ini bisa dipakai untuk studi penelitian ini.

Bila terjadi perbedaan pendapat dikemudian hari kami akan menyelesaikannya secara kekeluargaan.

Saya selanjutnya menyetujui:

☑ berpartisipasi dalam wawancara
☑ informasi yang saya berikan direkam

Nama	Tanda tangan	Tanggal/bulan/tahun
[redacted]		

Penanggung Jawab Penelitian :

[redacted]

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FORMULIR PERNYATAAN KESEDIAAN
BERPARTISIPASI DALAM PENELITIAN *(INFORMED CONSENT)*
(FGD/Diskusi Kelompok Terarah)

Pernyataan Persetujuan

☑ Saya telah membaca dan memahami informasi tentang penelitian, dan saya mengerti saya diminta untuk memberikan persetujuan untuk berpartisipasi dalam penelitian ini. Saya mengerti bahwa saya dapat menghubungi tim peneliti jika saya memiliki pertanyaan lebih lanjut tentang penelitian ini.

☑ Saya merasa tidak ada halangan untuk partisipasi saya, dan saya setuju untuk berpartisipasi dalam penelitian ini.

☑ Saya mengerti bahwa saya bebas untuk menarik diri kapan saja selama studi dan bahwa penarikan diri saya tidak akan memengaruhi hubungan saya dengan Universitas Flinders, staf serta mahasiswanya.

☑ Saya mengerti bahwa saya dapat menghubungi Kantor Etika & Kepatuhan Penelitian Universitas Flinders atau Komite Kaji Etik Balitbangkes jika saya memiliki keluhan atau keberatan tentang perilaku etik penelitian ini.

☑ Saya mengerti bahwa keterlibatan saya dijamin kerahasiaannya, dan bahwa informasi yang dikumpulkan kemungkinan dipublikasikan. Saya mengerti bahwa informasi dari saya tidak akan digunakan dalam penelitian lain apa pun.

☑ Saya mengerti bahwa saya dapat menarik data dan informasi saya dari penelitian ini. Saya juga mengerti bahwa data ini bisa dipakai untuk studi penelitian ini.

Bila terjadi perbedaan pendapat dikemudian hari kami akan menyelesaikannya secara kekeluargaan.

Saya selanjutnya menyetujui:

☑ berpartisipasi dalam FGD/Diskusi Kelompok
☑ informasi yang saya berikan direkam

Nama	Tanda tangan	Tanggal/bulan/tahun
[redacted]		

Penanggung Jawab Penelitian :

[redacted]

inspiring achievement

Ringkasan Protokol Penelitian

Judul :

'Kontingensi Corona Virus: Studi Kasus Pengetahuan Lokal dan Respon Masyarakat terhadap Covid-19 di Kota Kupang dan Kabupaten Kupang, NTT, Indonesia'

Biodata Peneliti:

Nama : Christopher Bailey Raymond, MPH, BA
Fakultas : College of Medicine and Public Health
Universitas : Flinders University of South Australia, Adelaide
Bidang Penelitian : Public Health Social Science
Email : raym0065@flinders.edu.au

A. Latar Belakang

Diakhir tahun 2019 muncul virus SARS-CoV2 selanjutnya disebut Covid-19 dengan penyebaran yang luas dan telah menjadi pandemi. Tidak hanya masalah kesehatan, pandemi Covid-19 telah berdampak pada bidang social,politik dan ekonomi. Kasus Covid-19 telah terdeteksi di 34 Provinsi di Indonesia dengan jumlah kasus yang terus meningkat.

Pandemi global COVID-19 yang terjadi saat ini memerlukan analisis kritis terhadap sistem kesehatan masyarakat, wacana komunikasi kesehatan, produksi dan legitimasi serta membuka kesempatan akan adanya ilmu dan pengetahuan terkait ancaman baru terhadap kesehatan masyarakat. Kemunculan, penyebaran yang cepat, dan mitigasi kontroversial COVID-19 menggambarkan bagaimana wacana global dibuat, disusun, dan disahkan oleh pemerintah, dan bagaimana kebijakan kesehatan dirancang oleh kepentingan global yang jauh dari masyarakat lokal yang paling terdampak. Ketimpangan sosial adalah faktor penentu utama kesehatan; masyarakat inegaliter memiliki masalah kesehatan yang lebih buruk dibandingkan dengan masyarakat umum yang lain, terlepas dari pengaruh kemiskinan. Sebuah pendekatan untuk ketidakmerataan aspek kesehatan harus menghubungkan ke konteks lokal dengan "konteks geopolitik yang lebih luas" dan analisis "faktor penentu biologis atau faktor penentu sosial harus mencakup kompleksitas penuh dari interaksi biososial".

Penelitan sosial kesehatan masyarakat ini akan mendalami respon masyarakat dan pemerintah terhadap Covid-19 di Kota Kupang dan Kabupaten Kupang, Nusa Tenggara Timur.

Kabupaten yang diusulkan untuk pengambilan sampel /lokasi lapangan untuk pengumpulan data adalah Kota Kupang dan Kabupaten Kupang. Lokasi-lokasi ini telah dipilih karena merupakan daerah multietnis dengan infrastruktur

kesehatan dan penerapan standar kesehatan yang relatif kurang memadai, dan mereka menganut konsep adat tradisional, menganut praktik religius sinkretis yang darinya muncul fondasi ontologis dan epistemologis berbeda dengan paradigma biomedis pada kelembagaan sistem Kesehatan; Kota Kupang dan Kabupaten Kupang akan memungkinkan perbandingan antara konteks pedesaan dan semi-perkotaan di NTT; Kabupaten/Kota ini juga menyajikan berbagai beban penyakit menular dan tidak menular endemik, yang memungkinkan analisis tambahan COVID-19 sebagai sindrom kompleks yang diperburuk oleh kemiskinan dan infrastruktur kesehatan yang kurang memadai.

Eksplorasi bagaimana anggota masyarakat lokal membingkai pandemi Covid-19 dalam konteks pengetahuan lokal dan paradigma biomedis akan mendapatkan rekomendasi untuk meningkatkan program intervensi kesehatan dalam konteks ancaman patogen yang baru muncul serta menggali dinamika intervensi-intervensi lembaga kesehatan dalam masyarakat dalam sistem desentralisasi seperti Indonesia. Dalam penelitian ini, konteks lokal persepsi akan COVID-19 didefinisikan sebagai sosial, budaya, komunikasi, politik, ekonomi dan individu yang mempengaruhi pengendalian atau penangulangan terhadap pandemi di NTT.

Hasil penelitian ini dapat membantu Pemerintah daerah meningkatkan dampak intervensi kesehatan dengan mengintegrasikan informasi yang sesuai konteks lokal ke dalam program yang ditujukan untuk masyarakat lokal di NTT.

B. Tujuan :

Penelitian ini bertujuan untuk :

- Menggali lebih dalam pemahaman masyarakat di Kota Kupang dan Kabupaten Kupang, NTT terkait situasi pandemi Covid-19
- Menggali konteks lokal persepsi terhadap Covid-19 dan respon masyarakat diantara masyarakat yang rentan di Kota Kupang dan Kabupaten Kupang
- Menggali bagaimana pandemi Covid-19 mempengaruhi masyarakat secara individu dan masyarakat
- Menggali respon masyarakat terhadap pembatasan sosial
- Mendapatkan rekomendasi untuk meningkatkan intervensi program kesehatan masyarakat dengan menggunakan kearifan lokal dalam pandemic.

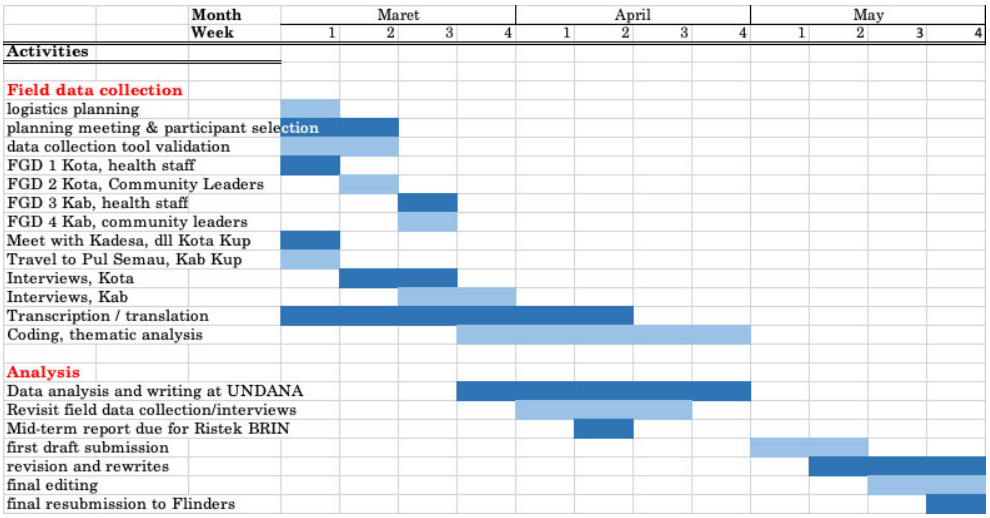
C. Metodologi Penelitian dan pengumpulan data :

- Penelitian ini adalah penelitian kualitatif /etnografis participatory. Metodologi Etnografi terfokus akan digunakan untuk menggali tanggapan masyarakat, dan pemerintah di tingkat lokal dengan melakukan wawancara dan FGD/Diskusi Kelompok Terarah.
- Wawancara akan dilakukan dengan 12-15 orang anggota masyarakat di Kota Kupang dan 12-15 orang anggota masyarakat di Kabupaten Kupang, dan 2 Diskusi Kelompok Terarah (FGD) bagi tokoh masyarakat dan tenaga kesehatan masing-masing 10 (sepuluh) orang.

- Data selama wawancara dan FGD akan direview, termasuk revisi berkala untuk pertanyaan dan topik.

D. Lokasi :
Kelurahan di Kecamatan Oebobo/ Kelapa Lima dan Kota Raja Kota Kupang dan Desa di Pulau Semau/Camplong di Kabupaten Kupang, Provinsi Nusa Tenggara Timur, Indonesia

E. Durasi Penelitian :
Februari 2021 s.d Juni 2021



F. Jadwal Pengumpulan Data :
Pengumpulan data di Kabupaten Kupang dan Kota Kupang di rencanakan selama 2 (dua) bulan Februari s.d April 2021 setelah semua tahapan perijinan di selesaikan. Tim Penelitian akan memastikan dalam pengumpulan data akan mematuhi dan menerapkan protokol kesehatan baik dalam wawancara dan FGD serta Rapid test Antigen bagi Tim penelitian.

G. Analisa Data :
- Semua catatan hasil wawancara dan Diskusi kelompok terarah serta hasil rekaman akan ditranskripsikan segera setelah pengumpulan data dan direviu oleh Tim Penelitian. Jika selama analisis data dibutuhkan klarifikasi, Tim akan mengunjungi kembali responden tertentu sesuai kebutuhan.
- Semua data hasil traskripsi, akan dianalisa dengan metode analisis narasi/tematik. Data primer dan sekunder akan dianalisis menggunakan *Computer Assisted Qualitative Data Analysis licensed by Flinders University* yaitu Software seperti 'nVivo' dan Microsoft excel.

H. Keamanan Data

Data akan disimpan menggunakan OneDrive yang dilindungi oleh kata sandi di layanan internal Universitas Flinders serta IRGSC selama proyek penelitian. Semua Data akan diubah identitasnya dan hanya bias diakses oleh Tim Peneliti langsung setelah menandatangani perjanjian non-disclosure/kerahasiaan.

I. Mitra Kerja di Indonesia :
Proyek Penelitian ini bermitra bersama Institute of Resource Governance and Social Change (IRGSC) di Kupang- Jl. RW Monginsidi II No.2 Kelapa Lima, Kota Kupang dan Program Pasca Sarjana Fakultas Kesehatan Masyarakat Universitas Undana.

J. Etika Penelitian :
Ijin Etika Penelitian ini sudah disetujui oleh Komite Etik Universitas Flinders, Australia dan sedang diproses di Komite Etik Bapelitbangkes dan Universitas Nusa Cendana di Kupang, NTT.

K. Supervisor :
Supervisor untuk penelitian ini adalah:
- Prof. Dr. Paul Ward, PhD, MA dari College of Medicine and Public Health, Flinders University, Adelaide, Australia

L. Mitra Penelitian dan pendampingan di Lapangan :
- Dr. Elcid Li, PhD dari IRGSC Kupang
- Dr. Andreas Umbu Roga, Prodi Pasca Sarjana Fakultas Kesehatan Masyarakat, Undana Kupang
- apt Oce Boymau, MScPH

M. Informasi terkait penelitian ini di Indonesia dapat menghubungi:

NAMA	**TELP**	**EMAIL**
CHRISTOPHER RAYMOND	[redacted]	[redacted]
OCE BOYMAU	[redacted]	[redacted]
DR. ELCID LI	[redacted]	[redacted]
DR. ANDREAS UMBU ROGA	[redacted]	[redacted]

Appendix 5: Focus Group Discussion and Interview Guides (SBREC-approved)

Focus Group Discussion Guide

Title:
'Coronavirus Contingencies: An Ethnographic Case Study of Local Knowledge and Community Responses to Covid-19 in Kupang City and Kupang District, East Nusa Tenggara, Indonesia

Chief Investigator
DrPH Cand. Christopher B. Raymond, MPH
College of Medicine and Public Health
Flinders University
[redacted]

DrPH Supervisor
Prof. Dr. Paul Ward, PhD, MA
College of Medicine and Public Health
Flinders University
[redacted]

Focus Group Discussion Questions for Health Officials

Focus Group Discussion: divide into 2x groups of 4 or 5 pax each. Using sticky notes, each group will identify the key themes or areas for each research question topic area around Covid-19, in their own terms/vocabulary. Using large paper or wall space, each group will create a montage of themes arranged according to individual, family, and community

Once complete, the groups will then discuss and compare/contrast in order to create a more comprehensive group understanding (not necessarily 'agreement') of what the experiences are, the context, perceptions, economic impacts, trust, and other topics.

	Research Questions	**What needs to be understood?**	**Questions for District/Sub-district Health Staff at PKM, Posyandu, RS: n=10 60-75 minutes' duration**
1	What are the experiences of district public health providers and local community members in the context of Covid-19 social restrictions and uncertainty in Kupang City and District, NTT, Indonesia?	Contextual factors influencing perceptions and understanding of Covid-19 Social, economic and other impacts	Guiding topic questions: What is the official government policy around Covid-19? Can you explain how this policy is implemented here in Kupang? In what ways is Covid-19 policy uniquely adapted for the Kupang context? In your role as a health provider, what have been the challenges of getting people in Kupang to understand and abide by the government's Covid-19 rules? What have been your personal experiences as a member of the

			community regarding social restrictions around Covid-19? Could you give me some examples of what you observe in the community regarding Covid-19? What are some of the examples of misunderstandings or ways that the community is not following the regulations?
2	How have the Covid-19 global health guidances and recommendations been prioritized and integrated into the local community's responses?	Health provider position in relation to production, reproduction, and legitimation of Covid-19 knowledges Hegemony, paradigm 'integration'?	Guiding topic questions: For this topic, health officials will create a 'montage of Covid-19 control responses' and a 'spectrum of priority' and arrange their answers on a continuum or cloud of importance, and how Covid-19 fits into this spectrum. We will then discuss why different groups prioritize different health or non-health challenges in the community and discuss where and how they arrived at these answers. What are the global (WHO, etc.) recommendations as compared to the Indonesian recommendations? Please arrange according to priority or importance. Within the community, what are the health and non-health priorities as you see them? Where does Covid-19 fit along this spectrum of priorities? And to what extent is the community level policy in line with these? Was it easy to integrate WHO and national guidelines into the local policy? Were there obstacles, challenges, difficulties? What were they, and how were they overcome? When you consider the need to implement Covid-19 policy in this community, what are some of the challenges?
3	How does Covid-19 influence and shape the relationships between the local government health officials and the local community?	Lay and 'expert' understandings Health risk communications Explanatory models & paradigms Tensions, trust, mistrust, uncertainty	Guiding topic questions: For this topic, we will explore the spectrum of how Covid-19 is understood by health officials in the context of implementing health policy in the community. We will discuss from the biomedical perspective and personal perspectives about the extent to which the community trusts and adheres to health recommendations and identify reasons why.

			As in the other exercises, 2x groups will create a 'spectrum of trust' and a 'cloud of explanation' montage based on their answers for further discussion between the groups. Can you explain how the Covid-19 social and medical policies and regulations are implemented in this community? How does your perspective differ from the perspectives of people in the community? How does this difference affect the government's ability to design and implement health policy here? Do you trust the guidance you receive from the district or provincial government to carry out your duties related to Covid-19? What is the process of developing and implementing local Covid-19 policies when using guidance from provincial or national level? How prepared are you to interpret guidance and make appropriate health decisions for the community? Can you describe the relationship between the health facility and the local community? How could this relationship be improved? Do they always trust what your official guidance is?
4	How does an imbalance of power in relationships within and between public health institutions and local communities affect health outcomes and community responses?	intermediary factors such as the distribution and control of power in the community government authorities, and how these factors may influence or cause 'ethnographically visible' outcomes such as increased disease incidence, social mistrust, blame, uncertainty, or other tensions arising from disarticulated health policy health inequities	Guiding topic questions: This topic explores how health officials perceive their relationship with the community, especially power dynamics, authority, and community autonomy. Ideally, the group will make a matrix of relationships based on how much authority that person/group has…it can either be hierarchical or 'egalitarian' depending on how they see it. We will also discuss the role of traditional medicine including sorcery and its influence on community responses and relationships between the 'biomedical' explanation of health authorities and local knowledge. How is the local community consulted before you adopt and implement a health policy? What is the forum for these types of discussions and feedback? How does this community explain where Covid-19 came from? What are some of their 'health beliefs' as you understand them? How do these beliefs result in behaviors and responses to Covid-19?

			In this community, who are the ones who have the biggest impact on whether a health policy is understood and shared with the rest of the community? If you compare between the government health officials or leaders in the local community, who has more influence over how the community responds to Covid-19 rules?
5	To what extent is local knowledge and community participation incorporated into government health program design and implementation?	Local cosmology, *adat* traditions, legitimation and what characterizes 'authoritative' knowledge? How does symbolic and local knowledge circulate? Social relations	Guiding topic questions: This topic area will examine the perceptions that health officials have around relationship with the community, incorporating local knowledge and community participation or consultation in the design of health policy around Covid-19. Can you walk me through how the Covid-19 policy was developed for Kupang? Where did the guidance originate (province, national, global, local)? What is the process to roll this out and implement it in the community? What do the local community members believe about how this disease is caused? In your experience, do the local beliefs help or hinder your ability as a health professional to manage Covid-19? Can you tell me about the local adat, and how religious or traditional beliefs have influenced the way the community understands the Covid-19 problem? I'm interested to hear any stories from before Covid-19 where the community provided ideas on the best way to approach a health problem from their perspective. How does the government or health facility incorporate this information? To what extent are the local health beliefs valid or reliable? Who in your facility is responsible for communicating things like 'health risk' and information about Covid-19 to the community? Can you explain how information gets from the government to the community? Normally, how receptive is the community to receiving health guidance from you?
6	What are the opportunities for social change and	Refining communication and strategies	Guiding topic questions: This topic serves to give voice to concerns expressed by health officials

	improvements in health through the case example of Covid-19 as identified by communities and public health institutions?	Empirical data for use in health planning and community engagement/participation	based on the above discussions, and an opportunity to explicitly state areas for improvement of relationships with the community. We will discuss 'what should be done' as well as reasons why there may be 'resistance' in adopting all the Covid-19 social restrictions in the community. We will critically evaluate the 'status quo' to idealise what the health officials feel is important in future pandemic responses. Using Covid-19 as an example, what are your thoughts on how to improve communications with the local community? Why has the community responded the way they have? In your opinion, how is the community understanding and adherence to the Covid-19 social restrictions? What is missing in the relationship between the health facility and the community? What are some ideas to engage with the community better? How do you think they would respond if I asked them about the relationship between the community and the health facility staff?

Ethnographic Interview Guide

Title:
'Coronavirus Contingencies: An Ethnographic Case Study of Local Knowledge and Community Responses to Covid-19 in Kupang City and Kupang District, East Nusa Tenggara, Indonesia'

Chief Investigator
DrPH Cand. Christopher B. Raymond, MPH
College of Medicine and Public Health
Flinders University
[redacted]

DrPH Supervisor
Prof. Dr. Paul Ward, PhD, MA
College of Medicine and Public Health
Flinders University
[redacted]

Ethnographic Interview Questions

	Research Questions	What needs to be understood?	Questions for Community Members: n = 10
1	What are the experiences of district public health providers and local community members in the context of Covid-19 social restrictions and uncertainty in Kupang City and District, NTT, Indonesia?	Contextual factors influencing perceptions and understanding of Covid-19 Social, economic and other impacts	When you first heard of Covid-19, what were your impressions about what causes the disease and where it came from? Have your thoughts changed since then? Based on what? What other health problems did Covid-19 remind you of that you had experienced before? What concerns did you have about Covid-19 after hearing about it and discussing with your friends and family? What were your impressions when you heard about social distancing and closing places of business and tourism? How did this affect you and your family? To what extent were you willing to adhere to Covid-19 rules? Did (Do) you feel unwillingness to 'obey' the rules? Where does this come from? In what ways were you able to adapt to the social restrictions? Did you break the rules? When? How? Why? Did you or your family get ill during this time? How did you react? Where did you seek help? How is it possible to have physical distancing and other PSBB within the community? How do you feel about the need to be separate from other people in this community, your friends, or family? Can you explain how these restrictions have affected relationships with your family, neighbors, and other community members and relatives?

			How has your work situation changed since Covid-19 restrictions began? Could you explain more about how Covid-19 has impacted your financial situation? How has this affected relationships with your family and friends?
2	How have the Covid-19 global health guidances and recommendations been prioritized and integrated into the local community's responses?	Community position in relation to production, reproduction, and legitimation of Covid-19 knowledges Hegemony, paradigm 'integration'?	When you first heard of Covid-19, what was the source of information? Do you usually trust this source of information? How was it communicated to you? How confident were you that the information was valid and correct this time? Could you explain to me how important Covid-19 is when you compare it to other health concerns you have? What other community issues do you feel are more or less important or urgent? Can you explain this more? What perspective do your community leaders and dukun have on Covid-19? Are they different from yours? Where do you get information about Covid-19? Do you think that Covid 19 affects your community in a different manner than other places? How?
3	How does Covid-19 influence and shape the relationships between the local government health officials and the local community?	Lay and 'expert' understandings Health risk communications Explanatory models & paradigms Tensions, trust, mistrust, uncertainty	In your opinion, what is the best way to respond to Covid-19? Is this in line with your traditions or *adat*? Who do you trust the most to provide information and guidance on Covid-19? How do you explain what Covid-19 is and where it comes from? What are the best ways to prevent it or treat it? [questions about sorcery/magic] Are you confident in what your dukun tells you about Covid-19? Does the information from your village leaders agree with what the *puskesmas* or *posyandu* staff say? Who provides better information? When you think about Covid-19, how concerned are you that it may come to this village or even affect your home? What does your spiritual leader/pastor tell you about Covid-19? When you consider all the different sources of information, how do you know which ones to believe? How did you feel about the restrictions? Did you feel they were justified, too lenient, too strict, or just right? Please explain in detail. What other situations remind you of people from outside your

			community trying to control or change the way the community functions? What language do you use when you communicate with staff from the health facility? How well do they understand you and respond to you?
4	How does an imbalance of power in relationships within and between public health institutions and local communities affect health outcomes and community responses?	intermediary factors such as the distribution and control of power in the community government authorities, and how these factors may influence or cause 'ethnographically visible' outcomes such as increased disease incidence, social mistrust, blame, uncertainty, or other tensions arising from disarticulated health policy health inequities	When it comes to health matters, who has the biggest say in this community? Do you think that is right? What does that mean to you? Do they always agree with what the public health officers advise? What happens if you refuse to follow the PSBB instructions or other rules that the health officials make? Normally, if you have health problems, who do you seek for help? Are there situations where you will go to the *posyandu* or PKM, or to a pastor or to a dukun? Can you give me an example of this? When you go to a health facility, do you feel like they listen to your opinion and respond to you? Does the advice and treatment they give make you feel respected and equal to them? Can you explain this more? Whose fault is it that Covid-19 came to NTT? Do you agree with the information that the PKM staff tell you? How do you feel about people with Covid-19? What are some explanations about how they became ill?
5	To what extent is local knowledge and community participation incorporated into government health program design and implementation?	Local cosmology, *adat* traditions, legitimation and what characterizes 'authoritative' knowledge? How does symbolic and local knowledge circulate? Social relations	What types of rituals are performed to deal with Covid-19, based on your spiritual tradition or *adat*? What is the purpose of these rituals? Who participates in these traditions? Do the health staff think these traditions are effective against Covid-19? What explanation does your community have for why diseases like this come here? In the past, what did your community do to respond to major health threats? Can you give me an example? How does your dukun, pastor, or village head communicate with you, your family, and your community? Do the staff at the health center share the same beliefs that you do about what causes disease?
6	What are the opportunities for	Refining communication and strategies	When you think about how the health officers have communicated about

	social change and improvements in health through the case example of Covid-19 as identified by communities and public health institutions?	Empirical data for use in health planning and community engagement/participation	Covid-19 with your community, how could they have improved their approach? What did you like and what didn't you like about how they wanted to implement PSBB? When you disagree with the health regulations from the government, what can you do about it? How do you feel if you decide not to follow the rules? To what extent were the rules adhered to in your community? What were the main cause of non-adherence? Can you provide some examples? What would you recommend to health officers regarding their approach and their messages? What improvements would you suggest? Do you think that adherence would have been better? Why?

	Research Questions	**What needs to be understood?**	**Questions for District/Sub-district Health Staff at PKM, Posyandu, RS: n=10**
1	What are the experiences of district public health providers and local community members in the context of Covid-19 social restrictions and uncertainty in Kupang, NTT, Indonesia?	Contextual factors influencing perceptions and understanding of Covid-19 Social, economic and other impacts	What is the official government policy around Covid-19? Can you explain how this policy is implemented here in Kupang? In what ways is Covid-19 policy uniquely adapted for the Kupang context? In your role as a health provider, what have been the challenges of getting people in Kupang to understand and abide by the government's Covid-19 rules? What have been your personal experiences as a member of the community regarding social restrictions around Covid-19? Could you give me some examples of what you observe in the community regarding Covid-19? What are some of the examples of misunderstandings or ways that the community is not following the regulations? What do you think influences the way the local community responds to government policies and regulations on Covid-19? Are there any economic impacts in the way that your health facility functions during Covid-19? How have budget priorities changed? Have these changes reflected community priorities or are they

			driven by government? Could you explain this a bit more?
2	How have the Covid-19 global health guidances and recommendations been prioritized and integrated into the local community's responses?	Community position in relation to production, reproduction, and legitimation of Covid-19 knowledges Hegemony, paradigm 'integration'?	How has the policy to address Covid-19 in this community been developed? Where do the policy decisions come from, who is making them? What is your understanding about the global response, such as WHO policy or others, and the official policy of the Indonesian government? And to what extent is the community level policy in line with these? Was it easy to integrate WHO and national guidelines into the local policy? Were there obstacles, challenges, difficulties? What were they, and how were they overcome? When you consider the need to implement Covid-19 policy in this community, what are some of the challenges? What priority does Covid-19 have for you, when you compare with other health issues in this community? Can you explain this more?
3	How does Covid-19 influence and shape the relationships between the local government health officials and the local community?	Lay and 'expert' understandings Health risk communications Explanatory models & paradigms Tensions, trust, mistrust, uncertainty	Can you explain how the Covid-19 social and medical policies and regulations are implemented in this community? In your understanding, can you explain a bit more about the Covid-19 health problem, such as what causes it and how it should be handled? How does your perspective differ from the perspectives of people in the community? How does this difference affect the government's ability to design and implement health policy here? Can you explain the level of confidence you have that the information and policies coming from the government are accurate and appropriate? Do you trust the guidance you receive from the district or provincial government to carry out your duties related to Covid-19? What is the process of developing and implementing local Covid-19 policies when using guidance from provincial or national level? How prepared are you to interpret guidance and make appropriate health decisions for the community? Can you describe the relationship between the health facility and the local community? How could this relationship

			be improved? Do they always trust what your official guidance is?
4	How does an imbalance of power in relationships within and between public health institutions and local communities affect health outcomes and community responses?	intermediary factors such as the distribution and control of power in the community government authorities, and how these factors may influence or cause 'ethnographically visible' outcomes such as increased disease incidence, social mistrust, blame, uncertainty, or other tensions arising from disarticulated health policy health inequities	In your professional role in this health facility, are you responsible for making policy or implementing it? Explain to me how you normally negotiate with the provincial health department when you disagree with a policy? What procedures or forums do you use to express and resolve difference of opinion? How do you normally communicate with other PKMs, health posts, RS in Kupang? Who is responsible for facilitating communication? Who in this facility decided to adopt and implement the current Covid-19 policy? How often is the local community consulted before you adopt and implement a health policy? What is the forum for these types of discussions and feedback? In your opinion, who is responsible for the current pandemic in Indonesia? Who or what caused this Covid-19 situation? What are the reasons why the people in Kupang have so many health problems? What explanations can you give, based on your understanding, for the difficulties in maintaining good health here? How does this community explain where Covid-19 came from? What are some of their 'health beliefs' as you understand them? How do these beliefs result in behaviors and responses to Covid-19? In this community, who are the ones who have the biggest impact on whether a health policy is understood and shared with the rest of the community? If you compare between the government health officials or leaders in the local community, who has more influence over how the community responds to Covid-19 rules? Can you provide some ideas of how this works and why this is?
5	To what extent is local knowledge and community participation incorporated into government health program design and implementation?	Local cosmology, adat traditions, legitimation and what characterizes 'authoritative' knowledge? How does symbolic and local knowledge circulate? Social relations	Can you walk me through how the Covid-19 policy was developed for Kupang? Where did the guidance originate (province, national, global, local)? What is the process to roll this out and implement it in the community? In your opinion, how comprehensive is the Covid-19 government policy? How

			does it align with WHO or other global policies? In your opinion, how relevant is the information from WHO and other international policymakers for Kupang? Can you provide me with some ideas about how the local situation is different than it is in Kupang or Jakarta? What do the local community members believe about how this disease is caused? In your experience, do the local beliefs help or hinder your ability as a health professional to manage Covid-19? Can you tell me about the local adat, and how religious or traditional beliefs have influenced the way the community understands the Covid-19 problem? I'm interested to hear any stories from before Covid-19 where the community provided ideas on the best way to approach a health problem from their perspective. How does the government or health facility incorporate this information? To what extent are the local health beliefs valid or reliable? Who in your facility is responsible for communicating things like 'health risk' and information about Covid-19 to the community? Can you explain how information gets from the government to the community? Normally, how receptive is the community to receiving health guidance from you?
6	What are the opportunities for social change and improvements in health through the case example of Covid-19 as identified by communities and public health institutions?	Refining communication and strategies Empirical data for use in health planning and community engagement/participation	Using Covid-19 as an example, what are your thoughts on how to improve communications with the local community? Why has the community responded the way they have? In your opinion, how is the community understanding and adherence to the Covid-19 social restrictions? What is missing in the relationship between the health facility and the community? What are some ideas to engage with the community better? How do you think they would respond if I asked them about the relationship between the community and the health facility staff?