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MENEGOSIASIKAN AGENSI REPRODUKTIF: REGULASI SOSIAL DAN PENGETAHUAN TUBUH DALAM RESPONS PEREMPUAN BUGIS-MAKASSAR TERHADAP RISIKO KEHAMILAN

NEGOTIATING REPRODUCTIVE AGENCY: SOCIAL REGULATION AND EMBODIED KNOWLEDGE IN BUGIS-MAKASSAR WOMEN'S RESPONSES TO PREGNANCY RISK

Cindy Israeni Ansar

Universitas Hasanuddin Fakultas Ilmu Sosial dan Ilmu Politik Departemen Sosiologi

*email Koresponden: Cindyisraeniansar@gmail.com

Abstract

This study explores how Bugis-Makassar women construct and navigate plural reproductive knowledge in response to abortus imminens (threatened miscarriage), drawing on Talcott Parsons' AGIL framework to analyze the sociocultural functions of care practices. Based on ethnographic fieldwork in Makassar, Indonesia, including interviews and participant observation with ten pregnant women, the study reveals that reproductive behavior is shaped by adaptive strategies (A), collective goals (G), moral integration (I), and intergenerational transmission of norms (L). Rather than following a singular medical logic, women mobilize syncretic forms of care that blend biomedical treatment, spiritual rituals, and ancestral taboos. These plural responses reflect not only epistemic hybridity but also reproductive governance enacted through kinship, religious authority, and clinical institutions. Women's agency is expressed not through open resistance, but through strategic moral navigation and embodied alignment with normative expectations—a form of what Mahmood terms the ethics of self-formation. The findings challenge biomedical-centric approaches to maternal health and highlight the need for culturally responsive interventions that respect local logics of risk, protection, and care. This study contributes to sociological debates on medical pluralism, moral regulation, and the reproduction of gendered knowledge in the Global South.

Keywords : *reproductive governance, AGIL, medical pluralism, Bugis-Makassar, threatened miscarriage, embodied agency, maternal health, Indonesia, moral regulation*

Abstrak

Studi ini mengeksplorasi bagaimana perempuan Bugis-Makassar membentuk dan menavigasi pengetahuan reproduktif yang plural dalam merespons kondisi abortus imminens (ancaman keguguran), dengan menggunakan kerangka AGIL dari Talcott Parsons untuk menganalisis fungsi-fungsi sosiokultural dari praktik perawatan. Berdasarkan kerja lapangan etnografi di Makassar, Indonesia—yang mencakup wawancara dan observasi partisipatif terhadap sepuluh perempuan hamil—studi ini mengungkap bahwa perilaku reproduktif dibentuk oleh strategi adaptif (A), tujuan kolektif (G), integrasi moral (I), dan transmisi norma secara antargenerasi

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(L). Bukan semata-mata mengikuti logika medis yang tunggal, perempuan justru mempraktikkan bentuk-bentuk perawatan yang sinkretik, menggabungkan pengobatan biomedis, ritual spiritual, dan pantangan leluhur. Respons plural ini mencerminkan tidak hanya hibriditas epistemik, tetapi juga bentuk pengaturan reproduksi yang dijalankan melalui jaringan kekerabatan, otoritas keagamaan, dan institusi klinis. Agensi perempuan diekspresikan bukan melalui bentuk perlawanan terbuka, melainkan melalui navigasi moral yang strategis dan penyesuaian tubuh terhadap ekspektasi normatif—suatu bentuk ethics of self-formation sebagaimana dikemukakan oleh Saba Mahmood. Temuan ini menantang pendekatan kesehatan maternal yang berorientasi pada biomedis, dan menekankan perlunya intervensi yang responsif secara kultural dengan menghargai logika lokal mengenai risiko, perlindungan, dan perawatan. Studi ini memberikan kontribusi pada perdebatan sosiologis mengenai pluralisme medis, regulasi moral, dan reproduksi pengetahuan bergender di kawasan Global Selatan.

Kata Kunci : Pengaturan reproduksi, AGIL, pluralisme medis, Bugis-Makassar, ancaman keguguran, agensi tubuh, kesehatan ibu, Indonesia, regulasi moral.

1. Introduction

In contemporary sociological and anthropological scholarship on gender and health, the reproductive body has emerged as a critical site where norms, power, and agency intersect. Global maternal health interventions remain predominantly shaped by biomedical paradigms that emphasize universal protocols and measurable outcomes. However, such frameworks often obscure the plural epistemologies and embodied practices through which women interpret and navigate reproductive risk—especially in postcolonial and culturally diverse societies.

In Southeast Asia, and particularly among Bugis-Makassar communities in South Sulawesi, Indonesia, pregnancy is not merely a biological condition but a deeply moral, spiritual, and social experience. The risk of abortus imminens (threatened miscarriage), for instance, is not understood solely through the lens of clinical pathology but as a liminal event that requires moral vigilance, ritual intervention, and kin-based care. Responses to reproductive crises typically involve a combination of medical visits, herbal remedies, dietary taboos, collective prayers, and ancestral wisdom—practices that reflect both cultural continuity and strategic adaptation to contemporary realities.

This article employs Talcott Parsons' AGIL framework—focusing on adaptation, goal attainment, integration, and latency—as a structural entry point to analyze how reproductive care practices function within and sustain the broader social system. It integrates this with Pierre Bourdieu's theory of habitus and the concept of reproductive governance (Morgan & Roberts, 2012), to explore how Bugis-Makassar women exercise agency through what Saba Mahmood (2005) calls an "ethics of self-formation": a process of navigating normative expectations not through overt resistance, but through embodied compliance, moral alignment, and tactical hybridity.

Rather than positioning these women as passive recipients of either biomedical authority or cultural tradition, we argue that they actively construct plural logics of care that respond to reproductive vulnerability with epistemic creativity. Their decisions—whether to combine herbal infusions with progesterone pills or to follow both a midwife's advice and a mother's ritual prescriptions—illustrate a form of syncretic rationality grounded in lived experience and moral responsibility.

Such pluralism is not unique to Indonesia. Similar patterns have been documented in Tamil Nadu (Van Hollen, 2003), Brazil and West Africa (Béhague & Storeng, 2008), and Bali (Bennett, 2005), where women inhabit overlapping domains of authority that blur the lines

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between science, spirituality, and social obligation. By situating the reproductive experiences of Bugis-Makassar women within this global comparative field, this study advances a culturally grounded, theoretically engaged account of how reproductive knowledge and agency are relationally enacted and symbolically governed in plural medical landscapes.

2. Theoretical Framework: Reproductive Agency in Sociological Perspective

This study conceptualizes women's reproductive responses as embedded within overlapping social structures, symbolic norms, and regimes of power. To analyze these dynamics, we employ Talcott Parsons' AGIL functionalist model, complemented by Pierre Bourdieu's theory of habitus and the concept of reproductive governance (Morgan & Roberts, 2012).

Parsons' AGIL model posits that all social systems must fulfill four functional imperatives for survival:

- Adaptation (A): How individuals or systems respond to external conditions or threats.
- Goal Attainment (G): How goals are defined and mobilized by actors within a shared system.
- Integration (I): How solidarity, norms, and values are maintained to ensure cohesion.
- Latency (L) or Pattern Maintenance: How cultural meanings are transmitted to reproduce a shared worldview over time.

Applying AGIL to the case of abortus imminens, we analyze how women adapt (A) to reproductive uncertainty by mobilizing plural care strategies, define goals (G) such as fetal survival or moral motherhood, maintain social cohesion (I) through ritual and kinship norms, and reproduce cultural logics (L) via intergenerational teaching and embodied routines.

However, the AGIL model's structural-functionalism is not unproblematic. To address its limitations, especially its tendency to obscure agency, we draw on Bourdieu's concept of habitus—the internalized dispositions that shape perception and action. In this view, reproductive behavior is not simply functional but structured by social history and embodied through practice. Women's responses are informed by learned ways of being, feeling, and caring, rooted in their socio-cultural environments.

We further employ reproductive governance theory (Morgan & Roberts, 2012) to illuminate how female bodies are regulated through decentralized mechanisms—religious authority, family expectations, customary law, and biomedical intervention. These overlapping systems of control are not external impositions alone but are internalized and negotiated by women through reflexive acts of self-discipline and care. This view resonates with Saba Mahmood's (2005) critique of liberal agency, highlighting how power and piety are not necessarily opposed.

Together, these frameworks allow us to understand reproductive knowledge not as static belief, but as a dynamic, morally negotiated, and socially situated practice. The reproductive subject here is neither entirely autonomous nor entirely controlled, but a moral actor navigating multiple logics of care and authority in pursuit of reproductive and social wellbeing.

3. Methodology

3.1 Research Design and Epistemological Orientation

This study employs a qualitative ethnographic approach, situated within a constructivist and interpretive sociological paradigm. Ethnography is not merely used as a methodological tool, but as a lens through which to understand how women make meaning of reproductive risk

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through social interaction, embodied practice, and symbolic systems (Spradley, 1979; Hammersley & Atkinson, 2007).

Rather than testing predetermined hypotheses, this approach seeks to uncover how Bugis-Makassar women construct symbolic orders around miscarriage prevention. Inspired by Berger and Luckmann's (1966) theory of the social construction of reality, the research explores how knowledge of abortus imminens is externalized, objectified, and internalized within gendered moral economies.

3.2 Study Site and Participants

Fieldwork was conducted in Makassar, a coastal urban center in Eastern Indonesia, where biomedical infrastructures intersect with deeply rooted Bugis-Makassar kinship norms and religious-cultural logics (Acciaioli, 2000; Millar, 1989). The city offers a rich context for studying the coexistence of modern medical authority and traditional epistemologies.

The study involved 10 Bugis-Makassar women, aged 25–40, selected purposively based on the following criteria:

- They had experienced early pregnancy symptoms (e.g., bleeding, cramps) suggestive of abortus imminens.
- They engaged with both biomedical and traditional care systems.
- They were willing to share sensitive reproductive knowledge in either Bahasa Indonesia or Bugis.

Participants represented diverse backgrounds in education, parity, and antenatal care access. The Makassar Health Office reported 466 cases of abortus imminens in the year prior to fieldwork (Dinas Kesehatan Kota Makassar, 2023), underscoring the urgency of culturally grounded reproductive research.

3.3 Data Collection

Data were collected over a three-month period through:

- In-depth semi-structured interviews (60–90 minutes), focusing on risk perception, care strategies, moral reasoning, and social influences.
- Participant observation in domestic, ritual, and clinical settings to capture embodied practices such as herbal preparation, dietary taboos, and interactions with kin or healers.
- Fieldnotes and analytic memos, written reflexively to document not just what was said, but how meaning emerged in situated contexts.
- Informal conversations with husbands, elders, and dukun bayi to understand relational and normative influences on women's reproductive decisions.

All interviews were audio-recorded with consent, transcribed, and translated into English. Data saturation was reached when no new themes emerged.

3.4 Ethical Considerations

The study received approval from the Institutional Review Board at Universitas Hasanuddin. Given the intimate nature of reproductive loss, a trauma-informed and culturally respectful approach was applied (Liamputtong, 2007). Informed consent was obtained verbally and in writing, and pseudonyms were used to protect identities.

Engagement with local religious and community leaders preceded data collection to ensure ethical alignment with customary norms.

3.5 Data Analysis

Thematic analysis was conducted using NVivo 12, following a flexible coding scheme that combined inductive and deductive logic:

- Initial open coding focused on patterns of risk interpretation, ritual practice, and decision-making.

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- Higher-order categories were derived from the triadic construction model of externalization, objectification, and internalization (Berger & Luckmann, 1966).
- Themes were analyzed in relation to AGIL functions, medical pluralism, and reproductive governance to understand how sociocultural systems structure maternal agency.

Special attention was given to discourses of morality, care, and obedience—seen as reflections of both social control and subjective positioning.

3.6 Researcher Reflexivity

The primary researcher, a Makassar-born academic trained in medical sociology, occupied a liminal position—as both insider and outsider. While cultural familiarity facilitated rapport, her biomedical background also positioned her as part of a system often perceived as dominant.

This dynamic shaped access and disclosure. Some participants narrated selectively, while others expressed ambivalence about modern care. To mitigate this, prolonged engagement, triangulation, and member checking were used to enhance trustworthiness and interpretive accuracy.

This reflexive stance aligns with critical ethnography and feminist anthropology, recognizing that knowledge is co-produced in field encounters and embedded in structures of power, language, and representation (Abu-Lughod, 1991; England, 1994).

4. Findings

4.1 Adaptation: Navigating Crisis Through Plural Epistemologies

In responding to the threat of abortus imminens, Bugis-Makassar women demonstrate adaptive strategies that are not solely medical, but also symbolic, spiritual, and relational. Adaptation—in Parsons' AGIL framework—refers to the capacity of a social system (or individuals within it) to respond to external stressors by mobilizing available resources. In this context, the pregnant woman's body becomes a site of crisis and response, where multiple health epistemologies intersect and are negotiated.

Rather than choosing between modern and traditional medicine in binary terms, these women respond to reproductive risk through a plural logic of care. They take prescribed medications from the puskesmas (community health center) while simultaneously engaging in local practices—avoiding "hot" foods, drinking bali-bali herbal concoctions, or participating in accera (a ritual for fetal strengthening). As one informant explained:

"Kalau saya melihat ada sedikit saja bercak darah, saya langsung pergi ke bidan. Tapi malamnya, ibu saya menyiapkan air bunga yang sudah didoakan. Keduanya penting dijalankan agar perawatannya lengkap."

meaning:

"If I see even a little blood, I go straight to the midwife. But that night, my mother prepares flower water that's been prayed over. You need both, to make it complete."

This statement reflects an understanding of care not merely as clinical intervention but as a socially and symbolically meaningful act. Caring practices become a way to soothe anxiety, fulfill moral obligations to kin, and maintain cosmic harmony.

Such strategies embody the concept of bricolage (Lévi-Strauss, 1966)—the creative use of available cultural knowledge and resources. Bricolage enables women to assemble meaning and action from fragments of tradition, religion, and science. In this process, biomedical knowledge is not rejected, but reinterpreted within a local cultural framework.

Moreover, adaptation is relational rather than individualistic. Decisions about which forms of care to pursue are often shaped by the advice of mothers, mothers-in-law, or religious

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figures. Thus, adaptation cannot be separated from broader social structures, including age hierarchies, gender relations, and spiritual authority.

Adaptation also reflects meaning-making in the face of uncertainty. As Berger and Luckmann (1966) argue, crises such as the threat of miscarriage prompt individuals to externalize meaning—crafting symbolic acts to cope with the loss of control. In this context, avoiding pineapples or bathing in floral water is not merely ritualistic but represents a strategy to reclaim agency over one's body and the fate of the pregnancy.

Hence, adaptation is not merely about physical survival; it is about creating an epistemic space where body, spirituality, and community converge to protect vulnerable life. Adaptation, in this sense, is a deeply meaningful social act—one that enables women to endure not only biologically but also morally, emotionally, and symbolically.

4.2 Goal Attainment: Reproductive Objectives and Moral Alignment

Within the AGIL framework, the function of Goal Attainment concerns how individuals or social systems set objectives and mobilize resources to achieve them. In the case of Bugis-Makassar women facing the threat of abortus imminens, the primary goal is clear: to sustain the pregnancy until the baby is safely born. However, this goal is not framed solely in biomedical terms but is deeply embedded in moral, spiritual, and social logics.

For many women, successfully maintaining a pregnancy is not merely a personal achievement but a moral accomplishment—demonstrating piety, adherence to ancestral norms, and readiness to fulfill the role of a future mother. Several informants linked the ability to protect the fetus with obedience to inherited taboos:

"Kalau kita patuh pada ajaran orang tua, insyaAllah bayi akan selamat. Yang penting jangan sombong, jaga sikap dan jaga makanan. Itu juga bagian dari ibadah."

meaning:

"If we follow what our elders taught us, insyaAllah the baby will be safe. The important thing is not to be arrogant, to watch our behavior and our food. It's part of worship too."

This statement illustrates how reproductive objectives are internalized as part of an ethical project of self-formation. Drawing on Saba Mahmood's (2005) concept of ethical self-formation, such practices are not necessarily acts of resistance but expressions of agency shaped through adherence to moral norms that women perceive as legitimate.

Goal attainment is also a collective project. A woman's success in preserving her pregnancy is not only celebrated as a personal triumph but as a familial and communal achievement. This explains why interventions such as visiting ancestral graves, inviting spiritual healers to recite prayers, or organizing small thanksgiving rituals (syukuran) are often enacted in concert with, or at the behest of, family members—particularly mothers and mothers-in-law. Pregnancy and its safe progression are thus not private matters but socially shared responsibilities involving multiple actors.

Nevertheless, in urban contexts like Makassar, women frequently find themselves caught between traditional moral expectations and biomedical recommendations. One younger informant remarked:

"Dokter bilang tidak perlu pantang makanan apa pun, tapi ibu tetap melarang saya makan udang. Jadi saya jalankan dua-duanya."

meaning:

"The doctor said there's no need to avoid any particular food, but my mom insisted I stop eating shrimp. So, I just follow both."

This response highlights the non-linear, non-rationalistic nature of goal pursuit. Women navigate between overlapping normative systems—traditional and modern—not merely to

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avoid miscarriage but to avoid blame. Failure is not perceived solely as a biological misfortune but as a moral shortcoming.

Therefore, the function of Goal Attainment in this context reflects women's efforts to achieve reproductive safety in ways that are morally and symbolically meaningful. They seek not only to "avoid miscarriage" but to become "good mothers" as defined by culturally sanctioned ideals. This underscores that pregnancy is not merely a biological event but a moral and social project.

4.3 Integration: Negotiating Norms through Kinship and Ritual

Within the AGIL framework, the function of Integration refers to the alignment of norms, values, and social institutions to ensure societal coherence. In the context of Bugis-Makassar women experiencing abortus imminens, integration entails more than psychological stability or compliance with biomedical protocols; it involves the negotiation of social and spiritual norms through kinship relations and ritual practices.

Pregnancy—especially one marked by risk—is never experienced in isolation. One of the study's most salient findings is the central role of the extended family—particularly mothers, mothers-in-law, and female relatives—in organizing, supervising, and even directing preventive practices against miscarriage. As one informant shared, her mother moved in with her during the first trimester "to make sure I didn't eat the wrong things or sit the wrong way."

This form of supervision is not merely an act of care; it is also a mechanism of moral and symbolic discipline. Norms such as not sweeping at night, avoiding wet hair at dusk, or refraining from verbalizing discomfort are examples of symbolic codes enforced through kinship-based oversight. Here, the family functions as an ideological institution of reproduction—not only in the biological sense, but also in the reproduction of normative structures.

Rituals also play a vital role in this integrative process. Specific prayers, flower-water baths, or the carrying of talismans are not only protective measures but also symbolic practices that affirm social belonging. When families organize a small selamatan (communal blessing ritual) for early pregnancy, they are not merely invoking safety, but reinforcing kinship solidarity. As Durkheim (1912) argued, collective rites reinforce not only spiritual beliefs but also social cohesion and collective consciousness.

However, this integration is marked by intergenerational tensions. Younger informants often expressed ambivalence toward certain traditional practices they neither fully understood nor believed in. Yet, many complied in order to maintain family harmony. As one participant noted:

"Saya memang tidak sepenuhnya percaya dengan pantangan itu, tapi saya tetap mengikutinya supaya tidak mengecewakan ibu."

meaning:

"I don't fully believe in those taboos, but I follow them so I don't hurt my mother's feelings."

This statement illustrates what can be termed symbolic compromise, where women serve as mediators between tradition and modernity—not through outright rejection of norms, but through subtle negotiation and accommodation that balances obedience with autonomy.

Integration, in this context, is not a passive state of stability but an active process of reconciling sometimes contradictory values. What is maintained, therefore, is not merely social order but also the continuity of gendered and moral expectations that bind women within complex webs of social accountability.

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4.4 Latency: Cultural Transmission and Reproductive Habitus

In the AGIL model, the function of Latency refers to the maintenance of cultural patterns—how values, beliefs, and symbolic structures are transmitted and reproduced across generations. In the context of Bugis-Makassar women's experiences with abortus imminens, this function is manifested through everyday practices, rituals, and utterances that internalize moral and symbolic logics of pregnancy care.

This transmission does not occur solely through explicit knowledge transfer, but through repeated symbolic interactions—mothers advising daughters, subtle corrections of behavior deemed inappropriate, and the repetition of rituals that bind body and belief. One respondent recalled:

"Saya tahu kalau sedang hamil sebaiknya tidak minum air es atau makan nenas itu dari nenek saya, meskipun saya tidak pernah bertanya alasannya."

meaning:

"I learned not to drink iced water or eat pineapple during pregnancy from my grandmother, even though I never asked why."

This statement illustrates that inherited knowledge is not always critically examined but rather internalized as part of bodily and moral dispositions. In Bourdieu's (1977) terms, this forms a reproductive habitus—a set of socially embedded behaviors and perceptions enacted as if they were natural.

This habitus not only governs practices of eating, resting, or socializing but also shapes how women assess the legitimacy of care modalities. Many informants combined biomedical treatment with inherited taboos—not because they viewed them as scientifically equivalent, but because both formed complementary moral and existential worlds. In this sense, culture is not merely transmitted but actively renewed and negotiated through embodied experience.

Importantly, this process is not a form of static conservatism. Latency in this context is dynamic and adaptive. Younger generations of women do not uncritically replicate their mothers' behaviors. Instead, they selectively reinterpret or even reconfigure meanings embedded in particular practices. For instance, the use of amulets may be replaced with digital prayers or dzikir accessed via smartphone apps, demonstrating symbolic transposition in cultural reproduction.

Thus, the function of latency within the reproductive social system of Bugis-Makassar women is not simply a mechanism of cultural conservation but a flexible process that ensures continuity amid change. It provides a foundation for social stability while allowing space for symbolic and moral transformation in response to evolving conditions.

5. Discussion

This study set out to explore how Bugis-Makassar women construct, negotiate, and enact plural reproductive knowledge in response to abortus imminens—an early pregnancy complication that evokes both biomedical urgency and sociocultural anxiety. Drawing on Talcott Parsons' AGIL framework, the analysis interprets women's reproductive strategies as functional responses that sustain both biological life and sociomoral order. Rather than treating cultural practices as residual or irrational, the discussion highlights their embeddedness in a dynamic system of meaning-making, care, and governance.

What emerges is not a simple dichotomy between modern and traditional knowledge, but a complex interplay of epistemologies in which women engage actively and reflexively. These engagements reflect what Lock and Nguyen (2010) call local biologies—ways in which the body is experienced, understood, and managed through culturally specific frameworks.

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Women do not merely receive reproductive knowledge; they curate and embody it, performing care not only for their fetus but also for social harmony, moral virtue, and spiritual security.

The discussion proceeds by mapping the four AGIL functions onto women's reproductive experiences: Adaptation (how women marshal resources and strategies in the face of uncertainty), Goal Attainment (how reproductive success is defined and pursued within moral economies), Integration (how shared norms and obligations structure behavior), and Latency (how these practices are culturally sustained and transmitted). Each subsection situates the empirical findings within broader theoretical debates on medical pluralism, reproductive governance, agency, and the cultural politics of health.

5.1 Syncretic Rationalities and the Adaptation Imperative

Within the AGIL framework, Adaptation refers to how individuals or systems respond to environmental challenges in order to sustain their existence. For Bugis-Makassar women facing the reproductive risk of abortus imminens, adaptation is not merely biological or clinical, but also symbolic, emotional, and relational. Women construct a responsive system that combines multiple sources of care: biomedical prescriptions and clinical vitamins, herbal remedies passed down through generations, ritual prayers from religious leaders, and customary prohibitions inherited through kinship and tradition. This is not an arbitrary mixture, but rather a coherent expression of syncretic rationality—a mode of reasoning that fuses multiple epistemologies into a singular, contextually meaningful response.

Such practices reflect what Claude Lévi-Strauss (1966) termed bricolage: the creative assembly of available cultural elements into new, adaptive strategies. Rather than adhering exclusively to either biomedical or traditional systems, women draw from an accumulated reservoir of experiential knowledge, community wisdom, and emic logic to fashion their responses. In Arthur Kleinman's (1980) terms, these women navigate a "healthcare system" that is not limited to formal institutions, but constitutes a meaningful world in which the body, illness, and care are socially interpreted.

Here, the maternal body becomes a site of convergence, where multiple domains of authority intersect: the clinic, the home, the kitchen, the mosque, and increasingly, digital platforms. A woman's response to early pregnancy bleeding—a key symptom of abortus imminens—is not merely a clinical act, but also a moral and spiritual one. Avoiding sweeping the yard or refraining from consuming pineapple are not superstitions, but expressions of a moral logic tied to the protection of nascent life. These acts are not just preventive—they are performative, embodying adherence to a shared cosmology of care.

In this context, adaptation entails more than biological survival—it reflects social belonging and moral alignment. By strategically navigating across care regimes (traditional midwives, biomedical clinics, mothers-in-law, religious figures, and online sources), women exhibit a high degree of adaptive capacity within a plural and often conflicting field of social expectations. Adaptation, in Parsons' sense, involves not only managing physical risk but also responding to social pressure and cultural codes of conduct.

Moreover, these practices should not be dismissed as mere obedience to tradition. Rather, they represent what Annemarie Mol and John Law (2004) call embodied rationality: a form of logic grounded in bodily experience, relational interaction, and contextual assessments of what is meaningful, effective, and right. Women engage these practices not just because they are inherited, but because they are proven—both empirically and symbolically—in their lived experience and communal knowledge.

Thus, the function of Adaptation in this reproductive context is not simply a reaction to physical threats. It is a cognitive, emotional, and social process embedded in everyday actions

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that may seem mundane but are rich in meaning: drinking boiled betel leaf water, summoning a spiritual healer, or postponing household chores when the body "sends a signal." These practices reveal a complex ecology of care, where adaptation is simultaneously material and symbolic, rational and affective, individual and collective.

5.2 Reproductive Morality and the Goal-Integration Imperatives

Within the AGIL framework, the imperatives of Goal Attainment and Integration are central to understanding how Bugis-Makassar women not only strive to sustain their pregnancies but also navigate the complex moral and social expectations that accompany reproductive risk. On one level, these women clearly articulate a reproductive goal: to maintain a healthy pregnancy leading to a safe delivery. Yet this objective is never pursued in isolation or purely through technical means—it is embedded within a collective moral universe.

Actions such as avoiding "hot" foods, refraining from going out at night, reciting dzikir before bed, or following the advice of a mother-in-law exemplify a dual imperative: to achieve biological success (pregnancy continuation) while maintaining social harmony (normative coherence). In this context, reproduction is not merely a physiological event—it is a moral enterprise, intimately tied to questions such as: Who deserves to be a mother? What does a good mother do? Whose voice carries authority?

The concept of reproductive governance (Morgan & Roberts, 2012) is highly relevant here. Women operate under a dispersed system of moral and spiritual regulation—not just clinical control. Authority figures such as midwives, mothers, religious leaders, traditional elders, and even online maternal support groups participate in producing normative expectations about how pregnant bodies should be treated, disciplined, and interpreted. While not overtly coercive, these networks exert considerable normative force, shaping the symbolic landscape of pregnancy care.

Reproductive action, then, is embedded in a moral economy where decisions are judged not only by clinical outcomes but by their alignment with shared social values. For instance, a woman who continues strenuous physical labor despite bleeding may be seen as "irresponsible," while one who observes prohibitions and performs rituals may be praised as a "good mother"—regardless of scientific efficacy. What matters is moral alignment, not just medical logic.

Within AGIL, Integration refers to how social norms and values are coordinated to maintain solidarity. In this study, integration occurs through the symbolic reproduction of gender roles and kinship obligations. Women's obedience to parental advice, adherence to customary taboos, and submission in prayer are not simply signs of docility—they are social strategies to maintain intimacy, demonstrate virtue, and affirm one's moral eligibility for motherhood.

Importantly, this does not imply that women lack agency. Following Mahmood (2005), we can understand agency not merely as resistance but as ethical self-formation—the capacity to act within and through structures of normativity. Women may choose silence, compliance, or ritual observance not from ignorance but as intentional strategies to align themselves morally with communal expectations. These behaviors are not passive but performative, enacting belonging through culturally recognized forms.

Thus, the imperatives of Goal Attainment and Integration are not discrete; they work in synergy. Biological and moral success are pursued simultaneously through culturally embedded acts of conformity. The seemingly mundane—avoiding pineapple, applying medicinal oils, offering alms on sacred days—becomes a dual form of care: for the fetus, and for the web of social relationships that surround and sustain the pregnant woman.

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5.3 Cultural Transmission and the Latency Function

Within the AGIL framework, the Latency function emphasizes the long-term maintenance of cultural patterns—values, norms, and symbolic systems that sustain social cohesion across generations. In the context of Bugis-Makassar women's responses to abortus imminens (threatened miscarriage), this function is enacted through the intergenerational transmission of reproductive norms and embodied knowledge, often conveyed through informal, everyday practices.

Knowledge concerning dietary taboos, protective prayers, herbal preparations, and signs of gestational danger is rarely taught through formal instruction. Rather, it is learned through subtle forms of socialization: observation, whispered advice, symbolic correction, and the repetition of rituals in the domestic sphere. A young woman learns to avoid pineapple, eggplant, or muddy paths not from medical literature but by watching her mother or neighbor—whose successful pregnancies become the referent of trusted practice.

Elder women—mothers, grandmothers, birth attendants (dukun bayi), and ritual specialists—play a crucial role as custodians and transmitters of these traditions. Yet transmission is not a static act; it is dialectical. Younger generations do not passively receive ancestral knowledge. Instead, they negotiate it against the backdrop of modernity: parental advice is weighed against midwives' recommendations, spiritual counsel is juxtaposed with ultrasound results, and ancestral rituals are reframed through generalized Islamic spirituality.

This dynamic suggests that pattern maintenance does not imply cultural conservatism. On the contrary, the values that persist are those that exhibit flexibility and adaptive resonance. Drawing on Bourdieu's (1977) notion of habitus, we understand this transmission as embodied disposition—socially inculcated practices that feel "natural" but are historically and relationally constructed. A pregnant woman who avoids traveling at night may not know the origin of the prohibition but senses it as a form of appropriateness and protection embedded in communal expectations.

This reproductive habitus forms a loose structure of action—not rigid, but responsive. As women adapt ancestral practices to urban work schedules, biomedical appointments, or the expectations of in-laws, they are performing the Latency function in contemporary form: preserving core meanings while reconfiguring their expressions. In this sense, culture is not a fixed code but a living system—renegotiated through everyday gestational practice.

Therefore, Latency in this context not only ensures cultural continuity but also provides a symbolic framework for the articulation of identity and moral legitimacy. A woman who adheres to reproductive ritual is not merely demonstrating obedience but also claiming her place within the community—as a bearer of tradition, as a moral subject, and as a worthy mother in the Bugis-Makassar moral landscape. These practices bridge past, present, and future, establishing a form of social sustainability enacted through the gestating body.

5.4 Comparison with Other Studies

The findings of this study align with a growing body of global literature that demonstrates how reproductive knowledge and practices are deeply embedded within local systems of meaning, social structures, and moral frameworks that govern women's bodies. As Van Hollen (2003) revealed in her ethnography of childbirth in Tamil Nadu, India, pregnant women are subject not only to biomedical regimes but also to spiritual, familial, and communal expectations that shape their choices of care. Similar patterns emerge in Béhague and Storeng's (2008) work in Brazil and West Africa, where women navigate reproductive risks through a fusion of medical logic and moral-cosmological reasoning.

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In the Indonesian context, Bennett's (2005) study of birthing practices in Bali emphasizes how social norms and spiritual guidelines significantly structure women's reproductive experiences. Intergenerational knowledge is not a residue of the past, but an active component in how women construct responses to risk and health. A comparable insight is found in Kusnadi's (2015) work on women fishers in Indonesia, where traditional practices and kinship values are central to coping with economic and ecological pressures.

This study offers a novel contribution by employing Talcott Parsons' AGIL framework to functionally analyze these dynamics. While few studies explicitly apply AGIL in reproductive health contexts, the framework proves analytically productive for elucidating how individual actions are systematically embedded in social structures. For instance, the Adaptation function expands our understanding of how Bugis-Makassar women mobilize multicultural resources in response to reproductive crises, while the Integration function illustrates how these practices also serve to reproduce social solidarity and collective values.

Moreover, the study enriches the literature on embodied knowledge and strategic agency in gender and health research. Rather than viewing women as passive victims caught between conflicting systems, these findings support the perspective that women are reflective agents who engage in moral and epistemic negotiations amid plural authority structures. This echoes Mahmood's (2005) argument that agency need not be expressed through overt resistance, but can take the form of strategic navigation of norms—a mode of ethical self-formation grounded in piety and relational ethics rather than rebellion.

Finally, the study contributes to the broader conversation on medical pluralism as a form of everyday governance. As Janes and Corbett (2009) argue, in much of the Global South, health systems are inherently plural and non-monolithic. Women must navigate between medical advice, local beliefs, familial pressures, and economic constraints. This study demonstrates that such navigation is not merely a matter of practical adaptation but reflects a culturally deep orientation toward life, death, and the moral meaning of motherhood.

5.5 Implications for Reproductive Health Policy and Cultural Sensitivity

The findings of this study underscore the critical importance of culturally embedded approaches in designing reproductive health interventions, particularly in societies characterized by plural epistemologies such as the Bugis-Makassar. Biomedical paradigms that ignore local cosmologies, spiritual norms, and social structures are likely to fall short in addressing the full spectrum of needs, experiences, and beliefs held by communities. In contrast, culturally sensitive responses can build trust, enhance participation, and foster meaningful dialogue between medical authorities and local communities.

The first implication concerns the urgent need for cross-cultural training for healthcare professionals working in public health systems. In cases of abortus imminens, for example, healthcare providers often dismiss traditional practices—such as food taboos or pregnancy rituals—as irrational or superstitious. However, this study demonstrates that these practices function as moral and psychosocial regulatory mechanisms that provide pregnant women with a sense of control and emotional reassurance. Medical personnel must be trained to understand the symbolic and affective significance of such practices rather than evaluate them solely through the lens of clinical efficacy.

Second, maternal health programs should create collaborative spaces that include non-biomedical actors—such as traditional midwives, community elders, and religious leaders—in shaping hybrid care models that do not marginalize local knowledge systems. This approach aligns with the concept of epistemic inclusion (Smith, 1999), which calls for the recognition of the legitimacy of diverse knowledge sources embedded within lived experiences. In the long

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term, such collaborative models may reduce tensions between modernity and tradition and strengthen informal referral systems that have proven effective in reaching women at the grassroots level.

Third, this study highlights the need for a policy framework grounded in everyday reproductive governance. Interventions must not be limited to regulating the body through clinical protocols; they must also account for how women's bodies are already governed by social norms, spiritual cosmologies, and kinship relations. As such, reproductive health education and communication strategies should be tailored to reflect local narratives about pregnancy, suffering, and maternal responsibility.

Finally, at a theoretical level, this study challenges the persistent dichotomy between the "rational" and the "traditional" in health development discourses. By showing that Bugis-Makassar women are not passive recipients of care but active navigators of diverse moral and epistemic authorities, the study advances an analytical framework that combines structural functionalism (AGIL) with social constructivism and feminist theories of agency. This integrative approach offers a pathway toward imagining health systems that are more responsive, participatory, and epistemically just.

6. Conclusion

This study has examined the plural logics of reproductive care among Bugis-Makassar women facing the threat of abortus imminens, with a specific focus on how cultural practices, moral frameworks, and biomedical knowledge converge in everyday strategies of maternal survival. By applying Talcott Parsons' AGIL model, the research has shown that women's responses to reproductive risk are not merely individual acts of coping, but patterned actions that fulfill essential social functions—adapting to uncertainty, achieving culturally meaningful goals, maintaining social cohesion, and transmitting normative systems across generations.

At the heart of these practices lies a form of syncretic agency, in which women do not passively submit to external prescriptions but actively negotiate between different regimes of authority: spiritual, familial, clinical, and ancestral. This agency is not framed as resistance in the liberal sense, but as what Saba Mahmood (2005) calls an ethics of self-formation—the embodied navigation of moral expectations through acts of care, avoidance, and belief.

Crucially, the study highlights how medical pluralism in Makassar is not a transitional phase toward biomedical hegemony but a durable and adaptive mode of reproductive governance. The coexistence of dukun bayi, bidan, and obstetricians reflects a social system in which care is both diversified and moralized, and where maternal behavior is subject to continuous negotiation within kinship networks and spiritual cosmologies.

By re-framing local reproductive knowledge as a form of functional rationality rather than superstition, the findings challenge dominant models of public health that prioritize biomedical compliance while overlooking sociocultural legitimacy. Recognizing the cultural intelligibility of these practices is essential not only for anthropological theory, but also for designing health interventions that are ethically responsive and contextually grounded.

In closing, the study contributes to broader debates on reproductive governance in the Global South by demonstrating that the politics of pregnancy are embedded in culturally distinct but globally resonant struggles over bodily authority, moral accountability, and epistemic legitimacy. Future research may deepen this analysis by exploring how these dynamics shift across generational cohorts, urban–rural divides, or in response to national maternal health policies

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