

Social Science & Medicine Manuscript Number: SSM-D-13-02581R1

Title: Rapid Response: Email, Immediacy, and Medical Humanitarianism in Aceh, Indonesia

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Acknowledgements: I thank the Fulbright and Wenner-Gren Foundations, as well as the Indonesian Institute of Sciences (LIPI, *Lembaga Ilmu Pengetahuan Indonesia*) and the Center for the Development of Regional Studies at Syiah Kuala University (PPSK-UNSYIAH, *Pusat Pengembangan Studi Kawasan*) for their support and sponsorship of my field research in Aceh, Indonesia. Participants of a seminar held in the Division of Sociology at Nanyang Technological University, especially Kwok Kian Woon, Michael M.J. Fischer, Susann Wilkinson, Sulfikar Amir, and Patrick Williams provided valuable suggestions on an earlier presentation of this paper; so did the participants of a workshop on the anthropology of intervention sponsored by Wenner-Gren and McMaster University (Hamilton, ON). I also thank Bobby Anderson, Greg Beckett, Mary-Jo DelVecchio Good, Michelle Bunnell Miller, and Pierre Minn, as well as three anonymous reviewers and the editors at *Social Science & Medicine* for their close readings and critical feedback. Finally, I thank the Indonesian and international staff at IOM's post-conflict reintegration program in Aceh for welcoming an anthropologist among their ranks.

Rapid Response: Email, Immediacy, and Medical Humanitarianism in Aceh, Indonesia

Abstract

After more than 20 years of sporadic separatist insurgency, the Free Aceh Movement and the Indonesian government signed an internationally brokered peace agreement in August 2005, just eight months after the Indian Ocean tsunami devastated Aceh's coastal communities. This article presents a medical humanitarian case study based on ethnographic data I collected while working for a large aid agency in post-conflict Aceh from 2005-2007. In December 2005, the agency faced the first test of its medical and negotiation capacities to provide psychiatric care to a recently amnestied political prisoner whose erratic behavior upon returning home led to his re-arrest and detention at a district police station. I juxtapose two methodological approaches—an ethnographic content analysis of the agency's email archive and field-based participant-observation—to recount contrasting narrative versions of the event. I use this contrast to illustrate and critique the immediacy of the humanitarian imperative that characterizes the industry. Immediacy is explored as both an urgent moral impulse to assist in a crisis and a form of mediation that seemingly projects neutral and transparent transmission of content. I argue that the sense of immediacy afforded by email enacts and amplifies the humanitarian imperative at the cost of abstracting elite humanitarian actors out of local and moral context. As a result, the management and mediation of this psychiatric case by email produced a bureaucratic model of care that failed to account for complex conditions of chronic political and medical instability on the ground. [Keywords: Aceh; Indonesia; email; communications; medical humanitarianism; narrative; post-conflict; psychiatry]

Introduction

In this article I show how the immediacy of the humanitarian imperative and the immediacy of email technology conspire to produce an astonishing set of generative effects and unacknowledged erasures. I start with a description of the humanitarian context in Aceh and a brief literature review, then provide an account of a medical humanitarian event during the early days of the International Organization for Migration's post-conflict reintegration program that challenged the mission's medical and negotiation capacities to provide psychiatric care to a recently amnestied political prisoner whose erratic behavior upon returning home led to his re-arrest and detention at a district police station. This case was a pivotal moment for the program that illustrated the importance of medical humanitarian interventions in a post-conflict reintegration setting, and in particular secured crucial buy-in within the organization for supporting mental health interventions. I reproduce the history of this event as it unfolded over the course of a few days in late 2005 in two comparative but complementary discursive frames, first in the email archive and then in a more traditional, thickly described, ethnographic mode of field-based participant-observation. Taken together, the case reveals a set of enduring double binds that characterize the humanitarian industry (Redfield 2012), such as the tension between value-rationality, an impulse toward moral action and advocacy, and instrumental-rationality, an impulse toward effective program routinization and delivery (Calhoun 2008). Other double binds include the differential valuations of technical expertise and local knowledge, the humanitarian agency's prevailing orientation toward its beneficiaries or its donors, and the humanitarian figure as effortless mobile sovereign (Pandolfi 2003) or caught up in local

resistances on the ground. Frequently these double binds turn upon the distinction between the expatriates and national staff who work for humanitarian agencies (Fassin 2007; Redfield 2012). In this case study I trace out the paths by which the immediacy of email amplifies and reinforces these humanitarian double binds but also renders them invisible to the IOM staff and their managers who rely most upon this communication technology to do their jobs.

The Indian Ocean Tsunami and The Immediacy of Humanitarian Crisis in Aceh

Aceh is the northwestern-most province of Indonesia on the island of Sumatra, with the Indian Ocean to its west and the Malacca Straits along its northeast coast (see Map 1). The capital city of Aceh province is Banda Aceh, located at the northwestern tip of Sumatra. On the morning of 26 December 2004, an enormous earthquake just off the west coast of Aceh unleashed a tsunami across the Indian Ocean that killed between 130,000 and 180,000 people in Aceh alone and displaced 500,000 more.

[Insert Map 1 here]

The tsunami was not only a natural disaster unprecedented in recorded human history, it was also a textbook example of how Peter Redfield defines crisis, a “turning point, a moment of decisive change, or a condition of instability... a sense of rupture that demands a decisive response” (2005, pp.335-336), compelling and propelling what is frequently called the “humanitarian imperative.” In describing a logic of this imperative, Mariella Pandolfi draws upon the theoretical work of Arjun Appadurai (1996) and Giorgio Agamben (2005) to argue that international humanitarian organizations are driven from one place to the next by what she calls

a “planetary logic” of crisis and exception that legitimizes “supracolonial” intervention with little or no regard for political, institutional, and social actors in any one location. She calls this “mobile sovereignty” (Pandolfi 2003, 2008). Didier Fassin argues that the humanitarian imperative is now a prevailing form of governmentality built upon and justified through the deployment of moral sentiments in solidarity with the victims of catastrophe (Fassin 2007, 2012; Fassin & Vasquez 2005). The urgent call to save lives and alleviate suffering has become institutionalized and politicized, but the temporality and discourse of urgency that characterizes the humanitarian imperative lends a veneer of ethical purity to the endeavor, as if humanitarian interventions stand outside of politics (Calhoun 2008, p.91). Within weeks of the tsunami, hundreds of international and national humanitarian missions (including several military forces from other nations) responded to this imperative, arriving in Aceh to assist first with emergency response and then longer-term recovery efforts.

Separatist Conflict and the Chronicity of Humanitarian Crisis in Aceh

As thousands of humanitarian workers poured into Aceh, many learned for the first time about an armed ethno-nationalist separatist group called GAM, from *Gerakan Aceh Merdeka* (Free Aceh Movement), and quickly understood they were in a militarized zone under martial law. Expatriate humanitarians found themselves housebound by curfews at night and required to travel by convoy with advance security clearance for every trip outside of Aceh’s cities. Areas not affected by the tsunami, and especially the conflict areas called “black zones” in Aceh’s interiors were strictly off limits.

GAM was first founded in 1976, and Aceh’s densely populated northern coast was the movement’s ideological heartland and base of operations (Reid 2006; Aspinall 2009). GAM’s

founder and leader Hasan Tiro comes from Pidie district (see Map 2). The event I highlight in this article took place in the nearby district of Bireuen to the east of Pidie. The Indonesian military's first major counter-insurgency operations against GAM—notoriously recalled for the disproportionate violence perpetrated against civilian populations—were restricted to these north and northeastern districts throughout the 1990s until shortly after Indonesia's long-reigning dictator, President Suharto, resigned in 1998. GAM took advantage of Indonesia's chaotic period of reform and decentralization to expand its recruitment across Aceh until May 2003, when the Indonesian government declared martial law and the military launched its largest invasion since the occupation of East Timor. For the next two years, counter-insurgency operations were widespread across Aceh and featured a long list of human rights violations against civilian populations, including spectacular displays of violence and degrading acts of humiliation (Good et al. 2007).

[Insert Map 2 here]

The military's counter-insurgency operations against ordinary Acehnese, even after the tsunami, presented humanitarians with another kind of crisis in which the everyday violence of conflict had become thoroughly embedded into Aceh's social fabric. Aceh's prolonged conditions of instability define this crisis more in terms of chronicity rather than rupture (Vigh 2008). In these situations, the normalization of crisis also attenuates the humanitarian imperative, and the world's attention to Aceh's emergency situation before the tsunami went largely unnoticed except among a select group of human rights activists. Although progress toward a peace settlement had already been made before the tsunami, the humanitarian

imperative after the tsunami generated the moral force to complete negotiations and formally conclude hostilities in August 2005. Dozens of international donors and humanitarian organizations already working on tsunami recovery in Aceh were now prepared to assist with humanitarian efforts that would facilitate the implementation of the peace agreement.

IOM in Aceh and the Immediacy of Email in Humanitarian Context

At the forefront of post-conflict reintegration and recovery efforts in Aceh was the International Organization for Migration (IOM), a large inter-governmental organization based in Geneva with a longstanding tradition of working closely with UN organizations, host governments, and non-governmental organizations. IOM was in a particularly strategic position to get involved in post-conflict recovery in Aceh because the organization already had a presence there before the tsunami providing support to the Indonesian government with the relocation of communities that were forcibly displaced from their villages under martial law. Given this earlier and trusted relationship, IOM was not only able to provide some of the largest humanitarian assistance after the tsunami, it was also the first agency that Indonesia's government relied upon to discreetly provide transitional reinsertion and reintegration services to GAM ex-combatants and amnestied prisoners, as well as to conflict-affected civilian communities. These services included health care, small transitional cash grants to assist with the initial reinsertion of amnestied prisoners and former combatants into their home communities, followed by vocational assistance in the form of training and in-kind goods. To implement these programs, IOM quickly opened ten satellite offices across Aceh to support this work: one in Banda Aceh, four along the northeast coast, two in the central highlands, and three along the southwest coast. Each office had a full-time staff of at least eight people responsible

for delivering the various components of the program, including one medical doctor and one nurse.

IOM excels at rapid emergency response, and their logistical protocol includes establishing and maintaining reliable email communication networks in sites of natural and man-made devastation. All of IOM's offices across Aceh had at least one desktop computer with a satellite link to IOM's email servers, and a generator to keep computers running during Aceh's frequent power outages. National program officers in Jakarta and senior level project managers in Aceh carried IOM-issued Blackberry smartphones encrypted with a secure connection to the IOM server so that they could respond to crisis situations at a moment's notice when they are outside the office, underscoring the immediacy of the humanitarian imperative that characterizes the industry. These costly investments guaranteed efficient communications across a vast and complex humanitarian landscape where tsunami-damaged roads were under repair and inter-city travel required elaborate security clearances and expensive convoys. The email network ensured that program managers in Banda Aceh could reliably coordinate program activities and rapidly circulate documents among their staff in the field.

The most salient and apparent mediation effect that email technology brings to a humanitarian agency like IOM is its immediacy, enabling all relevant stakeholders in Aceh, Jakarta, and Geneva to receive and respond to messages at once. In Benedict Anderson's *Imagined Communities* (1991), late colonial era newspaper consumers imagined a community of readers like themselves sharing the same temporal and spatial experience of readership. In the 21st century, an imagined community of humanitarians shares in the immediacy of a temporally instant and seemingly deterritorialized global communication platform because email does not require a lengthy process of print production and distribution. The immediacy of email,

accessible anywhere and at anytime, admirably performs and amplifies the urgent immediacy of the humanitarian imperative.

But the immediacy of email masks other mediation effects, and here I refer to William Mazzarella's definition of immediation, "a political practice that, in the name of immediacy and transparency, occludes the potentialities and contingencies embedded in the mediations that comprise and enable social life" (Mazzarella 2006, p.476). Just as the urgency of the humanitarian imperative obscures the politics of intervention, the immediacy of email projects a neutral and transparent transmission of content and effaces its mediating capacity to "transform, translate, distort, and modify the meaning or the elements they are supposed to carry" (Latour 2005, p.39). Building upon insights from the anthropology of documents and bureaucracy, I argue that the immediacy of email technology is constitutive of particular bureaucratic rules, ideologies, knowledge, practices, subjectivities, objects, and outcomes at a humanitarian agency like IOM (Hull 2012, p.251).

Despite the recent growth in anthropological studies on new communication technologies, online communities, and their mediation effects (Boellstorff 2010; Engelke 2010; Gershon 2010), my review of the literature shows, with one exception (Skovholt 2009), no sustained ethnographic account of the structure and practice of email, much less in conditions of instability where humanitarians work. In the broader social science and professional literature, discussions about the use of new communication technologies in complex humanitarian emergencies typically focus on the challenges of information dissemination to the public and coordination among agencies, culminating recently in a report by the United Nations Office for the Coordination of Humanitarian Affairs titled *Humanitarianism in a Network Age* (OCHA

2013), but these analyses and reviews do not address internal communications and they rarely mention email.

Methods

A content analysis of the IOM email archive offers a novel methodological point of entry to apprehend the everyday practices and administration of a large humanitarian agency. The email archive captures with remarkable fidelity the timeline of IOM's activities and negotiations, successes and failures. The archive also bears witness to the wider context of post-tsunami and post-conflict developments in Aceh. News articles and digests, press releases, research findings, and security incidents all found their way into my inbox. My archive contains two years (2005-2007) of content, none of which I ever deleted. To maximize email content from a diversity of sources, I included my email address on all the internal distribution lists related to IOM's health and post-conflict work in Aceh, as well as on distribution lists designated for both international and national staff. This archival material has been just as valuable as my own private field notes for reconstructing both the micro-particularities of my fieldwork in Aceh and the macro-historical unfolding of the peace process.

This article presents two ethnographic narratives of the same event, each with their own methodological approach. In the first, I follow Bruno Latour's methodological injunction to stick to the framework and limits indicated by the users themselves (Latour 1996). My method here is to trace the linked paths of email threads, one message after the other, delivered through IOM's email system, and follow the mediations at every point that effected and affected the outcomes of a particularly troublesome medical humanitarian event. In short, I produce an

ethnographic content analysis (ECA) among a Latourian “actor-network” of email users. David Altheide defines ECA as “the reflexive analysis of documents” (1987, p.65); ECA iteratively draws out themes and trends “reflected in various modes of information exchange, format, rhythm, and style” (p.68), and in this case study I use ECA to identify novel mediation effects that email and its digital infrastructure for transmission and archivization introduce into social relations. The second approach relies upon fieldnotes in which I document my own participation-observations in a subset of the events recounted below. These two methods and their respective results each provide only partial narratives, but contrasting them highlights the immediacy of email in humanitarian practice.

As the email exchanges below suggest, this case study served as a kind of stage-setting device, an event that secured crucial buy-in within IOM’s Indonesia country mission, marking the beginning of a lengthy collaborative engagement between IOM, a team of researchers from Harvard Medical School (HMS), Aceh’s mental health system, and communities recovering from conflict (Good et al. 2010). IOM first hired me as an intern for their post-tsunami health program in summer 2005, then promoted me to consultant, and later to full time staff, to coordinate a psychosocial needs assessment in Aceh’s conflict-affected communities. This assessment was part of a larger five-year IOM-HMS partnership in which teams of anthropologists, psychiatrists, other doctors, and students provided technical support to IOM for the development of post-disaster health interventions in Aceh. All research conducted under this partnership is protected under an academic freedom clause. Research proposals were submitted for ethics review and approved by the Committee for the Use of Human Subjects at the Faculty of Arts and Sciences, Harvard University. I have changed all names and removed specific characteristics to protect the identities of the actors involved.

A Medical Humanitarian Encounter by Email

In early December 2005, shortly after IOM opened its post-conflict field offices across Aceh, Dr. A, the Acehnese IOM doctor at the Bireuen office, informed the management team in Banda Aceh about a recently amnestied GAM political prisoner who had been re-arrested and detained at a local police station due to his erratic behavior since returning to his rural home. His sister, who reported his arrest to IOM because he was a beneficiary of the program, suggested that her brother had a mental illness, and she asked for Dr. A's help. I had just moved to Banda Aceh to plan the upcoming psychosocial needs assessment, so the program managers solicited my input. In what follows I reproduce the case as it unfolded over IOM's email network among expatriate and national staff based in Aceh and Jakarta. In the nine email excerpts quoted below I occasionally shorten the text but preserve the writer's intent. Figure 1 provides an organogram of the six IOM staff directly involved in these email conversations, including their job titles and duty stations, but a total of 23 people—in Bireuen, Banda Aceh, Jakarta, Geneva and Cambridge—were at least partially included in a total of 21 emails related to this case that arrived in my inbox over the course of four office days.

[Insert Figure 1 here: Organogram of IOM Staff with Job Titles and Duty Stations]

Dr. E Announces the Case

Dr. E, the expatriate country director of IOM's health programs, sent an evening email from Jakarta to Dr. B, the post-conflict medical program manager, an Acehnese doctor who

worked with me at our Banda Aceh office. Dr. E cc-ed D, a British specialist in post-conflict disarmament, demobilization and reintegration programs who was the head of IOM's Aceh post-conflict operation based in Banda Aceh. Dr. E also cc-ed several senior managers in Jakarta, including the Chief of IOM's Indonesia Country Mission, suggesting the importance of her message, which had as its subject line: "One amnestied prisoner with mental illness in Bireuen prison."

Dear Dr. B,

Thank you for flagging this situation and for discussing it with Dr. A in Bireuen. One of our amnestied prisoners named Bayu is currently in jail because of mental problems. Our initial intake exam and registration of Bayu in August 2005 when he was released from prison does indicate Bayu has severe mental health problems.

In cases such as this, the next of kin becomes the legal guardian of the patient. We are not able to treat without informed consent from a family member or legal guardian. Can we arrange for [our part-time psychiatrist] Dr. C to go to Bireuen as soon as possible for one day to make a proper assessment? IOM will provide medications. Depending on Dr. C's diagnosis and plan of action, we can facilitate the patient's transfer to the psychiatric hospital in Banda Aceh, but only if necessary; I'd rather he stay in Bireuen so family and friends can visit him.

Please send me updates whenever available. Regards, E

D Weighs In

The next morning, D replied immediately with enthusiasm, addressing his email directly to Dr. E and Dr. B, with a cc to all the original recipients plus several more post-conflict program managers that reported to him, widening the circle of interest in this case. D correctly anticipated the question of Bayu's reinsertion assistance payments:

From the program perspective we are not in a position to pay the family the reinsertion assistance, at this stage. We will have to wait until the psychiatrist's assessment and suggested treatment. This raises a number of ethical questions for the program to consider:

If the psychiatrist concludes that the beneficiary is not able to make informed decisions, for his own good, can we pay the family? The reinsertion assistance is for the individual. How do we ascertain that the family will make decisions for the good of our beneficiary?

Is it ethical for us (an international program) to make decisions for the beneficiary, in place of his family? If the psychiatric exam suggests that the beneficiary will, with treatment, be in a position to make informed decisions for his own good, should we wait to pay the cash benefit?

We will await the medical opinion before we answer the above questions. My main priority is to get this guy out of prison, it is not the place for him, and as a beneficiary we have a responsibility to ensure that is achieved.

It is not surprising that Dr. E's concerns are about treatment and informed consent, or that D's concerns are about how the program proceeds with its cash reinsertion assistance if Bayu is compromised in his ability to make informed decisions. Nevertheless their concerns talk past

each other, and according to the ethical conventions of their respective fields of expertise, their positions on how to engage with next of kin contradict. What they agreed upon, at least, was that the psychiatrist Dr. C should go to Bireuen and examine Bayu as soon as possible. Offline D and Dr. B asked me to join Dr. C. A description of our visit appears later in the article in order to keep us within the discursive frame of the email archive. Apart from Dr. C and me, none of the other email correspondents directly witnessed and evaluated the situation in Bireuen.

Dr. C's First Medical Exam Report

We returned to Banda Aceh late that night, and the following day Dr. C sent his psychiatric evaluation to Dr. E with a cc to only the senior medical staff based in Banda Aceh and me, suggesting he only felt accountable to the medical team. In his report, Dr. C reviews Bayu's medical history based upon his clinical interview and what two police officers and Bayu's sister told him. Bayu's sister described his strange behavior since returning home from prison in mid-August. In early November, Bayu was caught stealing a cow. In the evenings, he would walk quietly behind the neighbors' houses wearing a backpack, making the community restless. He occasionally threatened his sister and her child with violence; she was fearful living in the same house with him. The two policemen and Bayu's sister all report that a few days prior to our visit, Bayu stole the village head's motorbike, who in turn reported Bayu to the police for arrest. At the bottom of Bayu's medical history, Dr. C inserts Bayu's own perspective with one sentence: "He expressed feelings of sadness and regret." Dr. C then reports the results of his psychiatric exam with a list of symptoms and a prescription that suggest a depressive disorder, but the diagnosis Dr. C reports is Post-Traumatic Stress Disorder (PTSD).

Dr. B's Perspective

Within hours of receiving Dr. C's report, Dr. B added her questions and feedback in two emails sent only to Dr. E and D. In the first, she reports: "I asked Dr. C whether Bayu should be in jail or the psychiatric hospital and he said: 'There is no need to transfer him to the hospital. Right now he is a criminal.' Need your advice." In the second email, she offers her opinion:

After hearing from Dr. A, Dr. C, and Jesse, I assume this patient needs further medication and help from his family who can take care of him and will manage his money. I don't think he can hold the money himself, but his close family will. They can use that money for his further treatment, start a small business, etc. [Citing precedent within the program...] If we gave cash to the family of a schizophrenic in South Aceh, and if we also gave money to the family of a prisoner who is in jail for corruption, why should we make an exception for this case? That's from my perspective.

D's Main Concern

The next morning D forwarded Dr. B's consecutive emails with her considered opinions and shared his thoughts above them in light of Dr. C's diagnosis. He sent his message to Dr. E and the Chief of Mission, with a cc to the Deputy Chief of Mission and the Senior Project Development Officer. He notably did *not* include Drs. B or C in the conversation. All of the recipients are expatriate staff based in Jakarta with direct access to IOM's international donors, scaling up the discourse and raising the stakes:

My main concern is that Bayu has been diagnosed with PTSD, what are we going to do about this? I have already said this to the Harvard team: PTSD is likely to

be the main challenge to the programme effectively assisting reintegration. This is the first example of the challenges that we are going to face; we need to address this issue, starting with this individual.

I am not aware of any post-conflict reintegration processes globally that have taken PTSD seriously; we are going to cut new ground with this programme.

“Sent from my BlackBerry Wireless Device”

The Chief of IOM’s Indonesia country mission replied to all from his Blackberry with one sentence praising the expertise of IOM’s national medical team and IOM’s collaboration with Harvard, effectively giving his blessing to pursue project development that will create, in his words, “an international best practices model.” The automatic tagline—“Sent from my BlackBerry Wireless Device”—excuses the brevity of his message, and assures his staff that he is monitoring the situation as it unfolds.

My Bireuen Report

Shortly afterwards I sent my single-spaced, three-page report about our Bireuen trip to D and the four doctors E, C, B, and A. I wrote it as a more polished version of the ethnographic field notes that I would write for myself, which is to say that it was a thickly described moment-by-moment account, with explanatory back-stories and revelatory interpersonal dynamics. I return to these local details below, but in the email archive it had little traction because no one replied to it apart from Dr. E who used it as a reference for her medical report on Bayu’s case.

Dr. E’s Last Word

Dr. E had the last word in this extended conversation about Bayu when she sent her finalized medical report. Replying to the Chief of Mission's encouraging email sent from his Blackberry, she addresses D and includes only senior IOM officers in Jakarta. She informs D she will arrive in Banda Aceh soon, but her priority is to meet with Doctors B and C, who are "asking for some guidance from me on how to streamline our PTSD/mental and other general health cases." Her attached report on Bayu, she adds, will be used as a sample case for discussions with the field doctors and nurses, because: "We will come across similar cases. This is hands-on training for our team." In contrast to my dense narrative report, Dr. E wrote hers in outline form with bullet-point comments. She incorporated findings not just from Dr. C, but also from Dr. A and myself, though she generously ascribed Bayu's psychiatric symptoms originally reported during his amnesty registration in August to Dr. C. She also changed Bayu's diagnosis from PTSD only to PTSD and mild depression. After summarizing our three sets of findings, she adds three additional comments of her own:

1. Bayu is suffering from a mental problem that is likely the reason for his odd behavior that disrupted the community.
2. He was arrested and sent to jail because he stole the village head's motorbike.
3. Due to his mental illness, Bayu is not supposed to be in jail. He requires treatment.

In her plan of action, Dr. E writes in bold-faced print: "**in Bayu's best interest, it is highly suggested that he be transferred to the psychiatric hospital as soon as possible for at least seven to ten days of observation and proper treatment, with nearest of kin to give consent.**" She then instructs Dr. C to coordinate Bayu's referral and admission to the hospital, while his actual transfer from Bireuen to Banda Aceh with a family escort will be handled by

Doctors B and A with all medical, transportation, and administrative costs covered by IOM. Apart from two follow-up exam reports sent by Dr. C over the next three months, this is the last we hear of Bayu in the email archive.

Inboxes and Black Boxes

Before we look offline to see what happened to Bayu in Bireuen, we can already see the extent to which IOM's email network structures the work environment, reproduces organizational hierarchy, and mediates decision-making processes for its employees. The overall flow of communication moves up the organizational hierarchy to IOM's expatriate officers in Jakarta as the conversation moves away from the professional ethics of what to do with Bayu and toward new questions of how to leverage Bayu's case toward the routinization of medical referral protocols and the development of cutting edge post-conflict reintegration projects that take PTSD seriously. Dr. A's own voice from Bireuen is absent from the discussion even though he and his colleagues in Bireuen all had email addresses of their own and, as I show below, knew more about Bayu's case than anyone else at IOM. By paying attention to the presence or absence of voices and the direction of interactions in the email archive, we discern the contours of a differential network of actors and learn who is authorized to speak, or even who is authorized to change another's medical diagnosis.

Dr. E and her medical team reached consensus and implemented a plan of action following this thread of emails concerning Bayu. Her report shows mastery of bureaucratic aesthetics with its bullet lists and numbered conclusions that mediate social action far more effectively than long form ethnographic field notes (Strathern 2006). She also brings together Dr. C's, Dr. A's, and my assessments of Bayu into a single document that she went on to use as

an exemplary case study that the medical teams in all ten offices studied and assimilated into their treatment and referral protocols, with Dr. C on retainer by telephone and email for cases that required his psychiatric expertise.

Dr. E's final medical report assumes the sociological status of what Latour calls a "black box," which designates any combination of ideas, objects, and people whose output is assumed to be truth. The inner workings of the black box become invisible through its own success because "one need only focus on its inputs and outputs and not on its internal complexity" (Latour 1999, p.304). When Dr. E uses her report to train her staff, there is no need to revisit the messy details surrounding Bayu's case that brought disparate stakeholders together to deliver this document. In turn Dr. E's eventual report to IOM's donor would become a higher order black box within which the treatment protocol based on Bayu's case is just one of the objects inside it that enabled the apparent success of IOM's post-conflict medical humanitarian program.

Returning to the email archive allows us to not only reopen IOM's black box products and trace out the threaded conversations and negotiations among a network of actors that came together to produce success; the archive also allows us to revisit and ask how dozens of other problems that IOM faced failed to produce black box reference points throughout the duration of the post-conflict program. Dr. E successfully developed a referral and treatment protocol for mental health cases, an important early step in the life of IOM's post-conflict medical program and a credit to Dr. E's administrative skill, but D and the Chief of Mission never developed an international best practices model for incorporating PTSD treatment into post-conflict reintegration programs. Moreover, even though both Dr. E and D strongly agreed that IOM should do everything to get their client out of jail, he nevertheless served a 14 month sentence for stealing his village head's motorbike. For this we can partly blame the IOM management team

turning their collective online attention away from Bireuen and toward Jakarta in the email archive, but now we also have to step outside the inbox to find out how a different set of actors offline conspired to keep Bayu in jail.

A Medical Humanitarian Encounter Offline

Within 12 hours of Dr. E's first email, our last minute security clearances to travel were approved and we started our five-hour trip to Bireuen. Upon arrival late in the afternoon, Dr. C and I first picked up Dr. A at IOM's newly opened office, and then went to the police station to meet and examine Bayu. We were originally under the impression Bayu had an uncontrollable psychosis and putting him in jail was his sister's ad-hoc solution, but when the officers brought him out of a bedroom-sized cage full with other men to meet with us, we were surprised that he was capable of participating in a fairly coherent conversation, albeit in a slow motion, weak and resigned, manner.

We sat on a bench in a quiet area of the station. Bayu looked disheveled and his skin was covered with a common fungal infection. His face was empty of emotions and he avoided eye contact. He could not speak Indonesian. Dr. C gave Bayu a cigarette and conducted his clinical interview in Acehnese. In what struck me as a self-defeating capitulation to the prevailing narrative regime—in which more powerful actors in Bireuen charged with saying what counts as true (Foucault 1980) determine “what Bayu did” for everyone else—Bayu freely admitted that he stole the village head's motorbike, perhaps due to lack of insight into his own condition. As Dr. C reported later, Bayu acknowledged regret. Dr. C did not spend more than ten minutes with Bayu, then he spoke with some police officers who confirmed that the village head had Bayu

arrested for stealing his motorbike. They told us the easiest way to get Bayu out of jail would be if the village head retracted his charges.

Eager to return to Banda Aceh, Dr. C quickly concluded that Bayu merely had a mild depression and knowingly committed a crime, so it would be hard to get him out of jail on ethical or medical grounds. But something felt amiss. The Bayu we met at the police station did not match the description that brought us so urgently to Bireuen on his behalf. During a break for the *magrib* evening prayers, I conferred with Dr. A and the head of IOM's Bireuen office, M. They suggested we go to Bayu's village to meet with his sister and the village head. Dr. C relented when we presented him with the new plan. Following security procedures for traveling outside city limits after dark, we took two IOM-marked vehicles to Bayu's village twenty minutes away. Fancy cars rarely travel off the main roads in Aceh, much less two of them at night, so Upon arrival, the rare sight of our little convoy off the main road attracted a crowd, especially as it brought a tall foreigner and a psychiatrist in city clothes. As a large group gathered, I worried that any information we heard from Bayu's sister might be biased toward an inoffensive public narrative. This was when Dr. A and M proved indispensable. M has a background in journalism, and he reported extensively on conflict events before the peace agreement; his reporter's instincts kicked in and he quietly withdrew from the crowd and did some private crosscheck with other neighbors.

The story that emerged was significantly different from what the police or Bayu himself had told us earlier. No one in the village believed that Bayu was ever a member of GAM during the conflict. Rather, they described Bayu in those days as a kind of quiet village simpleton who harvested coconuts for a living, a task usually handled by young adolescents, but they emphasized that he was otherwise fine before his incarceration. As a political prisoner, he was

beaten severely on the head at least once that resulted in major swelling of his head, which suggested to me some kind of organic head trauma. Bayu exhibited odd behavior that did in fact disrupt the community only after his release from jail. When he received his first reinsertion cash grant immediately upon amnesty, Bayu's sister was unsettled to discover that he "gave all the money away" before he even got home. In the village, he started to take things and put them somewhere else; small things like coconuts and chickens, and big things like cows and motorbikes. He never kept the objects or tried to sell them, nor did he try to hide what he was doing, and he was frequently caught. At night, Bayu would take off his shirt, sling it over his shoulder, put on a backpack and go walking through the village, back and forth behind people's houses. His behavior disturbed the community but they also understood his condition as *stres* sustained during his incarceration. *Stres*, a misleading colloquial Indonesian gloss of the English word stress, typically suggests a serious, long-term, and debilitating condition that may require psychiatric care at a hospital (Grayman et al. 2009, p.299). When Dr. C asked if Bayu had ever shown signs of violence, his sister told us that Bayu had threatened her with a stone and once hit her daughter.

Then one day Bayu took the village head's motorbike, put it behind an empty house, and just left it there. The village head's brother is a military officer; he found Bayu, beat him, and delivered him to the police station for arrest. When we asked to meet the village head to hear what he had to say, the neighbors warned us that a conversation with him would quickly complicate matters, involving not just the police but also the military, and inevitably ending with a ransom demand for removing the charges he pressed against Bayu. Apart from their dismay about the village head's drastic action against Bayu, there was apparently some collective

malcontent with his leadership and the neighbors did not want to draw him into the conversation, so they called the village secretary instead.

Our visit to the village raised enough questions to persuade Dr. C to change his diagnosis to PTSD, which we hoped might justify dropping the charges and allow IOM to arrange treatment. Nevertheless I was struck by how Dr. C was at first so convinced by the self-evident truth of the police charges against Bayu that he never considered anything other than pure criminal intent once he discovered that Bayu could articulate answers to his questions and express remorse. As we drove back to Bireuen from the village, Dr. C told us the story of how he got his start in psychiatry as a doctor in the Indonesian military. As an Acehese Indonesian, Dr. C left the army as soon as possible to avoid the pressure of divided loyalties during the GAM insurgency. Dr. C's admission helped me understand how in the face of Indonesian security forces, police included, he too found it easier to capitulate to the prevailing narrative regime rather than involve himself in a humanitarian effort to get Bayu out of jail.

Our trip to Bireuen introduced us to a complicated narrative about the parochial spoils of peace that converged upon Bayu and created a stalemate that left him in jail to serve a complete 14-month sentence. Bayu's sister asked us repeatedly about his next cash installment instead of his psychiatric condition. She argued that she should assume responsibility for his cash before someone else did. Just outside her house, a process of rapid political transformation had consumed her village (and all of Aceh) as GAM's amnestied prisoners and ex-combatants publicly returned to their communities and asserted their newly established rights to participate in local governance. A village head with family connections to the military may have protected the community during the conflict, but under the new peacetime conditions it had turned into a liability. This village wanted to replace their leader, not least for sending his soldier-brother to

beat and arrest a vulnerable member of their community whose strange behavior required a particular sort of blind spot similar to Dr. C's to label it criminal.

Based on what the neighbors and the police told us about what it would take to get Bayu out of jail, it was clear to us that the village head and his military brother, perhaps together with the local police, were engaging in the same predator economy that prevailed during the conflict, knowing they might siphon off Bayu's peace dividend in return for dropping the charges. Local elites finding ways to capture the spoils of peace is a well-documented phenomenon among practitioners of post-conflict disarmament, demobilization and reintegration programs (Knight & Özerdem 2004; Willibald 2006), hence D's insistence that reinsertion assistance should only be handed over to individual beneficiaries. In this case, however, IOM's insistence contributed to a frosty standoff in which Bayu simply remained in jail without psychiatric care.

Discussion: Patients Lost in the Inbox

Dr. E's new treatment and referral protocol that used Bayu as a case example relied heavily upon email as the reporting instrument. IOM's doctors across Aceh routinely sent patient reports to Dr. B in Banda Aceh who sorted and compiled them for Dr. E's reports to IOM donors. For psychiatric cases, Dr. C made routine road trips and prepared reports for each of the dozens of patients he met in the field. A focus on referral, documentation, compilation, and circulation over email enhanced the routinization and bureaucratization of medical practice at the expense of humanitarian advocacy for individual patients whose details were lost in the many reports attached to emails that accumulated downward in the inbox.

It was only while preparing an earlier draft of this article in 2013 that I discovered Bayu's fate, buried and overlooked in an 80-page email attachment that lists Dr. C's patient exam reports. Despite her lack of psychiatric training, the IOM nurse in Bireuen conducted Bayu's first follow-up exam at the jail. She reported that Bayu was mentally stable, noting only his hygiene as a sign of poor self-care. When she asked him what he did with his first reinsertion payment, he told her that he used most of it to pay off debts, and the rest to buy coffee and cigarettes for all his friends in the village. This accords with how most of the amnestied prisoners in Aceh reported using their reinsertion assistance, and serves as a defense against Bayu's sister's less sympathetic assertion that he "gave all the money away." Dr. C conducted Bayu's third exam in late February 2006, long after specific attention to Bayu's case had disappeared. His report begins with the news of the judge's 14-month sentence. Then he lists Bayu's symptoms: blunted affect, poor hygiene, loose association, disturbed judgment, and auditory hallucinations. Dr. C diagnoses Bayu with an unspecified psychotic disorder, prescribes medication, and refers Bayu to the psychiatric hospital, "if it is possible."

In their review of the Inter-Agency Standing Committee's *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC 2007), Sharon Abramowitz and Arthur Kleinman (2008) have argued that international humanitarian interventions operate simultaneously at two levels to produce unique structural and cultural contexts of suffering and care. There are global operations where international agencies fund and organize the provision of services, and local operations where practitioners engage directly with beneficiaries in settings of instability. The two contrasting representations of Bayu's case using IOM's email archive and my participant-observations correspond to these levels of humanitarian practice and illustrate how their prevailing narrative regimes rarely overlap.

IOM staff in the field with the most knowledge about their beneficiaries turn out to be the voices least authorized to speak through a communication technology that closely reproduces organizational hierarchy and favors the voices of elite decisions-makers. These managerial conversations emphasize project policies, proposals, and reports over actual program dynamics on the ground. The routinization and bureaucratization of care through email relies upon the creation of black box products that ensure the smooth operation of IOM's post-conflict medical program but result in less accountability to individual patients. Discussions by email that shift away from actors on the ground toward managers in Jakarta and feature the compilation and packaging of summary reports reflect IOM's competing accountability to another set of beneficiaries: its donors.

Email communication technology productively generates and reproduces the image of the mobile sovereign as IOM managers conduct business across global distances by rapid, always available telecommunication technologies, enacting durable tropes of humanitarian immediacy. The email archive preserves the traces of a rapid investigation and programmatic response less than a week after the identification of a problem. The urgent velocity of these rapid communications briefly linked a powerful network of stakeholders in Jakarta, Geneva, and Cambridge to a particular case in Aceh, which in turn consolidated the support needed within IOM to ensure that mental health would be a part of the post-conflict reintegration agenda for the next four years. But this global-level operational success came at the expense of local operational support. Upon completion of her new patient protocol in Jakarta, Dr. E confidently instructed her staff by email to prepare an all-expenses-paid referral for Bayu's psychiatric care in Banda Aceh without accounting for the enduring conditions of chronic instability in Bireuen, including her own staff's tactical (and understandable) refusal to challenge official narratives

purveyed by the police and military about “what Bayu did.” These mediated exchanges in the email archive record and project IOM’s seamless management of their humanitarian bureaucracy, but also produce fields of invisibility that mask a range of local complexities on the ground.

A discussion of these complexities might begin with Bayu’s changing diagnosis. Recent studies of violence and mental health in post-conflict settings have aimed to clarify the links between traumatic experiences of the past and daily stressors in the present (Miller & Rasumussen 2010, Panter-Brick 2010), but Bayu’s case illustrates another challenging dimension to consider: psychiatric sequelae born out of organic head injuries sustained during conflict, or in Bayu’s case, while in prison. In this respect Bayu’s case is hardly unique; reports of changed behavior in the wake of injuries to the head were a persistent leitmotif of our fieldwork. In a random, population-based sample of high-conflict communities in Bireuen, 29% of men and women over age 17 (N=180) reported beatings to their head during the conflict, and 68% of men in Bayu’s age cohort (17-29, N=23) reported any type of head trauma, including beatings, suffocation, strangulation, and drowning (Good et al. 2006, p.16, p.35). Head trauma may have long-term effects on behavior and other cognitive functions, which can be mistaken for criminal behavior (Sarapata et al. 1998, León-Carrión 2003). Bayu’s case—and Aceh’s post-conflict landscape more generally—illustrates the relevance of psychiatric symptoms associated with head injury for humanitarian actors and health professionals working in post-conflict settings, but IOM’s incipient program and Aceh’s available psychiatric resources in 2005 did not yet have the capacity to assess much less effectively treat cases like Bayu’s.

Instead IOM relied upon the more familiar discourse of trauma, a shorthand diagnosis that designates Bayu as a victim worthy of humanitarian compassion. By reframing Bayu’s

behavior within what Erica James calls the “compassion economy,” part of a larger “political economy of trauma” (2010, p.107), we hoped Bayu’s PTSD diagnosis might facilitate his release from jail. But IOM’s humanitarian argument did not gain persuasive traction against Bireuen’s entrenched “terror economy” (ibid.) that held Bayu for ransom as a criminal and arguably prevented Dr. C from pursuing Dr. E’s directive to get Bayu out of jail and into treatment. Bireuen’s post-conflict complexities caution against easy conclusions that assert “local knowledge” as an alternative to the unattended prescriptions purveyed by humanitarian experts. Dynamics in Bireuen utterly resisted our (admittedly insufficient) efforts at compassionate intervention, highlighting the limits of intervention and its sustainability, particularly in settings where strong state institutions assert their control.

IOM’s protocol for mental health cases in post-conflict Aceh was an ad-hoc exercise in telemedicine in which field doctors consulted by phone and email with Dr. C in Banda Aceh. Dr. E designed it this way not just because tsunami-damaged roads and security concerns complicated travel, but also because Aceh faces a critical shortage of specialists. In 2008 there were only 3.45 specialist doctors for every 100,000 people in Aceh (Meliala et al. 2013), and at the time of Bayu’s arrest in late 2005, there were only 4 psychiatrists in Aceh for a population of 4 million people. Dr. C worked only part-time for IOM because he also had to teach at the local university, conduct rounds at the provincial psychiatric hospital, and run his private practice. Remote consultation offered a temporary solution in a setting of widely unmet psychiatric needs following Aceh’s twin disasters of conflict (Good et al. 2006, 2007, Grayman et al. 2009) and tsunami (Irmansyah et al. 2010, Musa et al. 2014). But I would also argue that the deterritorialized immediacy afforded by IOM’s ever-reliable email network contributed to the organization’s distorted perception of what it could achieve across a vast and unstable landscape.

As lessons from the field eventually revealed the shortcomings of their approach, IOM reoriented its clinical psychiatric model of care to mobile outreach with an emphasis on psychiatric training for general practitioners and community mental health nurses.

Conclusion

The first goal in this article is to illustrate the productive analytical possibilities of conducting an ethnography of medical humanitarianism through a content analysis of the email archive. As a dominant communication technology, it is easy to take the everyday use of email for granted as a neutral and transparent purveyor of content. Email's speed and efficiency brings powerful and decisive immediacy to office communications but this technological advantage masks mediation effects in crisis settings such as the amplification of the humanitarian imperative, the emphasis on acute over chronic crises, and the reproduction of organizational hierarchies. The second goal of this article is to draw attention to email's mediation effects in medical humanitarian settings. Email produces a false sense of proximity to the field, as if doctors in Jakarta and Banda Aceh were intimately involved in the delivery of post-conflict medical services in Bireuen. Instead we see that email further abstracts distant doctors away from local contexts of suffering and care. The recommendation is not to abandon such a useful management tool but rather to actively train and empower staff on the front lines of program implementation, ensuring their voices and data provide meaningful contributions that will not slip down the inbox.

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Map 1: Indonesia with Aceh Highlighted in Green



Map Source: <http://en.wikipedia.org/wiki/File:IndonesiaAceh.png>

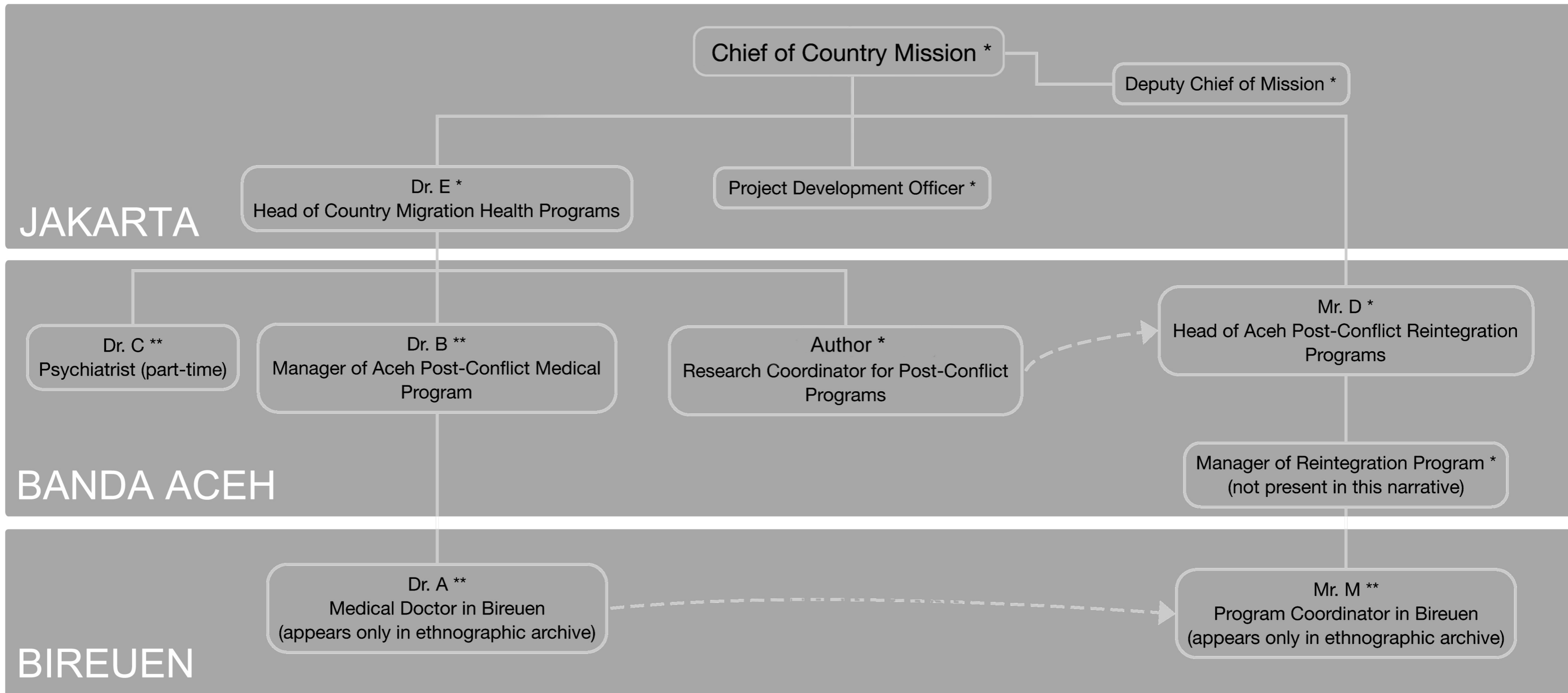
Map 2: Aceh, by Districts (*Kabupaten*) and Municipalities (*Kota*)



Municipalities include: Banda Aceh, Langsa, Lhokseumawe, Sabang, Subulussalam

Map Source: http://en.wikipedia.org/wiki/File:Aceh_Regencies.png

Figure 1: Organogram of IOM Staff with Job Titles and Duty Stations



* Expatriate IOM staff in Indonesia

** All Indonesian IOM national staff on this chart are originally from Aceh, speak Acehnese as their first language