Paramita: Historical Studies Journal, 35(2), 2025, pp. 299-314
P-ISSN: 0854-0039, E-ISSN: 2407-5825
DOI: http://dx.doi.org/10.15294/paramita.v35i2.14513

Between Modernization and Marginalization: A Historical Analysis of Colonial Health Policies in Semarang and Their Postcolonial Legacy

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Article history
Received : 2024-10-04
Accepted : 2025-09-05
Published : 2025-10-09

Keywords
Colonial health policy,
Decolonizing health systems,
Ethical policy,
Semarang,
Health disparities,
Historical epidemiology

Abstract: This article examines the population health policies implemented in Semarang City, Indonesia, in the aftermath of the Dutch colonial Ethical Policy (1901). Employing a social determinant of health framework grounded in a decolonial perspective, the study explores how colonial era policies continue to shape contemporary health practices and reinforce structural health inequalities. Drawing on historical methods and analysis of primary and secondary sources from national archives, libraries, and documentation centers, the research finds that the Ethical Policy—despite its humanitarian rhetoric of "repaying a debt of honor"—primarily served to sustain labor productivity for colonial economic interests. Health interventions such as the control of cholera outbreaks, the development of sanitation infrastructure, and hospital construction in Semarang were disproportionately directed toward protecting European residents and maintaining urban spatial segregation. These colonial legacies are still evident today in unequal access to healthcare, the geographic clustering of diseases, and the continued marginalization of local health knowledge systems. The article underscores the importance of applying approaches rooted in decolonization to the study of health systems in postcolonial contexts and calls for the development of more inclusive, historically grounded, and socially just health policies in Indonesia.

Abstrak: Artikel ini mengkaji kebijakan kesehatan penduduk yang diterapkan di Kota Semarang, Indonesia, setelah diberlakukannya Politik Etis Belanda (1901). Dengan menggunakan kerangka *social determinants of health* dari perspektif dekolonial, penelitian ini menelusuri bagaimana kebijakan era kolonial terus membentuk praktik kesehatan kontemporer dan memperkuat ketidaksetaraan struktural di bidang kesehatan. Berdasarkan metode sejarah serta analisis sumber primer dan sekunder dari arsip nasional, perpustakaan, dan pusat dokumentasi, penelitian menemukan bahwa Politik Etis—meskipun mengusung retorika kemanusiaan "membayar hutang budi"—pada dasarnya ditujukan untuk mempertahankan produktivitas tenaga kerja demi kepentingan ekonomi kolonial. Intervensi kesehatan seperti pengendalian wabah kolera, pembangunan infrastruktur sanitasi, dan pendirian rumah sakit di Semarang lebih banyak diarahkan untuk melindungi penduduk Eropa dan menjaga segregasi spasial perkotaan. Warisan kolonial ini masih terlihat hingga kini dalam ketidakmerataan akses layanan kesehatan, pengelompokan geografis penyakit, serta marginalisasi sistem pengetahuan kesehatan lokal. Artikel ini menekankan pentingnya pendekatan dekolonisasi dalam kajian sistem kesehatan di konteks pascakolonial dan menyerukan pengembangan kebijakan kesehatan yang lebih inklusif, berlandaskan sejarah, dan berkeadilan sosial di Indonesia.

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https://journal.unnes.ac.id/journals/paramita

INTRODUCTION

Indonesia's health system cannot be fully understood without considering the legacies of its colonial past. The origins of public health governance in the archipelago were deeply intertwined with imperial interests, racial hierarchies, and the biopoliti-

cal management of native populations. As the Dutch colonial administration transitioned into a more reform-oriented stance in the early 20th century, the implementation of the Ethical Policy (*Ethische Politiek*) was heralded as a humanitarian turn in colonial governance. Yet, many scholars now interpret the Ethical Policy not merely as a philanthropic gesture, but as a strategic effort to maintain social stability and economic productivity through selective investments in education, infrastructure, and health (Yuliati et al., 2023). In this light, public health became a tool not of benevolence but of colonial control, aimed at creating a healthy and compliant labour force while reinforcing the racialised division of urban space. In cities such as Semarang, a major colonial port on the northern coast of Java, these dynamics were especially pronounced. Semarang was both a vital hub for trade and a hotspot for infectious diseases due to its dense population, poor sanitation in indigenous quarters, and exposure to maritime pathogens (de Zwart, Gallardo-Albarrán & Rijpma, 2022). The Dutch administration responded by investing in urban sanitation, quarantine zones, and hospitals, yet these improvements were spatially segregated and primarily benefited Europeans and the colonial elite (Saputra et al., 2022). As such, colonial health interventions were entrenched in broader strategies of racial and spatial governance, producing long-lasting disparities that have continued well into the post-independence era.

While colonial health policy in the Dutch East Indies has been the subject of significant scholarly work (Marihandono, 2021), there remains a paucity of research focusing on how these historical policies played out at the city level, particularly in Semarang, and how they continue to shape health inequalities today. The majority of existing studies tend to focus on macro-level analysis or the biomedical history of specific diseases, often neglecting the structural and social determinants that underpinned colonial health regimes. Moreover, few studies explicitly adopt a decolonial analytical lens—one that not only critiques the historical injustices of empire but also interrogates how these injustices are reproduced in postcolonial institutions and governance systems. The need for such a perspective is increasingly urgent. Over the past decade, the global movement for health decolonisation has called for critical re-examinations of how colonial ideologies continue to influence medical knowledge, health policy, and institutional practices across the Global South (Marbun and Zein, 2020). Scholars and health activists alike have emphasised the importance of unpacking historical structures of oppression in order to understand current health disparities and to design more equitable health systems. In the Indonesian context, however, this discourse remains nascent, and empirical studies applying a decolonial framework to local health policy are notably lacking.

This article addresses that gap by analysing the evolution and impact of health policy in Semarang City following the implementation of the Ethical Policy, using a social determinant of health (SDH) framework integrated with decolonial theory. Semarang presents a unique case study due to its central role in colonial urban planning and public health experimentation. By tracing how health interventions were historically distributed—and how these patterns persist in contemporary health disparities—the study seeks to understand the enduring influence of colonial structures on urban health governance. This approach allows for a deeper interrogation of how race, class, geography, and institutional legacy intersect to produce health inequality in postcolonial settings. This study addresses the following research questions: (1) How were population health policies implemented in Semarang City post-Ethical Policy? (2) In what ways did colonial social determinants of health shape health disparities in Semarang City? (3) How can a decolonial perspective illuminate and address colonial legacies in contemporary Indonesian health policies? By integrating historical analysis with the social determinants of health framework, this article contributes to understanding Indonesian health history and emphasises the urgency for equitable and contextually grounded health reform.

By bridging historical analysis with public health theory, this article contributes to a growing body of literature that seeks to historicize inequality and reframe health policy as a domain not only of biomedical concern but also of historical justice. By applying a social determinant of health (SDH) framework—focusing on housing, sanitation, access to healthcare, income, and education—this article situates the Semarang case within a larger effort to decolonise health policy analysis. Recent data reinforce these historical continuities. In 2022, the *Dinas Kesehatan Kota Semarang* reported that the maternal mortality ratio in the lower-income northern districts such as Genuk and Tugu remained as high as 147 deaths per 100,000 live births, nearly double the city-wide average of 76 per 100,000. Only 58% of households in these districts had access to piped water and safe sanitation, compared to 87% in upper-income districts like Banyu-

manik and Gajahmungkur (Bappeda Kota Semarang, 2022). Similarly, the prevalence of tuberculosis in urban kampung areas—particularly in Bandarharjo and Tambaklorok—reached 310 per 100,000 residents, surpassing both the provincial and national averages. These figures correlate with historical patterns of spatial marginalisation that date back to the colonial division of urban space. Furthermore, utilisation of formal healthcare remains uneven. A 2021 health equity survey found that individuals in the lowest income quintile in Semarang were 2.7 times more likely to delay seeking treatment, citing economic and geographic barriers. Meanwhile, over 34% of households in peri-urban districts still rely on unlicensed midwives and traditional healers for maternal care. These inequities are reinforced by policy inertia: since 2010, public health investment has been disproportionately concentrated in central urban and commercial areas, with per capita spending in South Semarang nearly 1.8 times greater than in the North. By tracing these patterns back to colonial-era policy logics, this study underscores the importance of historical reckoning as a prerequisite for health equity. This article contributes to the decolonial turn in global health scholarship by providing a historically grounded, place-specific case study of how colonial social determinants continue to shape public health in contemporary Indonesia. It calls for policy approaches that explicitly recognise and redress colonial legacies, integrating local knowledge systems, community participation, and spatial justice principles in health planning and delivery.

Social Determinants of Health and Decolonisation

Social Determinants of Health in Colonial and Postcolonial Contexts

The concept of social determinants of health (SDH) emphasizes that population health outcomes are shaped not only by individual behaviors or access to clinical services, but also—more fundamentally—by the conditions in which people are born, grow, work, live, and age, as well as by the wider set of forces and systems that influence these (Cook, Bhattacharya & Hardy, 2009; Putera et al., 2025). These include economic policies, education, housing, transportation, and health systems, as well as political institutions and power dynamics that structure societal inequalities (Setyaningsih, 2022). While the SDH framework has been widely adopted in public health policy and research, it has also faced criticism for its inadequate recognition of colonialism as a foundational and enduring structural determinant of health (Pols, 2016). Much of the mainstream discourse on social determinants tends to universalise health inequalities without critically unpacking the historical and geopolitical processes that create and sustain them. In particular, former colonies often inherit state structures, health systems, and epistemologies rooted in extractive and racialised governance models, which continue to influence how health is defined, measured, and delivered (Hesselink, 2011)

In the context of the Dutch East Indies, colonial policies created an entrenched system of racial-spatial segregation that shaped the distribution of public services, including sanitation, water access, and medical care (Aricindy & Wijaya, 2023). These patterns were not incidental but rather reflected the deliberate prioritisation of the health of colonial elites over that of the indigenous population (For a parallel with colonial Bombay, see Kidambi, 2001). In Semarang, this took the form of divided urban geographies, with colonial enclaves benefiting from paved roads, hospitals, and clean water, while indigenous neighbourhoods were left with limited infrastructure and frequent disease outbreaks (Zondervan, 2016). Even after independence, these colonial patterns have proven remarkably durable due to institutional inertia and the replication of colonial logics in postcolonial governance. Scholars such as Neelakantan and Hussain have argued that postcolonial health systems perpetuated the structural marginalisation of rural and urban-poor communities under a new nationalist guise (Neelakantan 2023; Hussain, 2025). In Semarang today, disparities in access to maternal care, sanitation, and infectious disease control correlate strongly with historical patterns of urban inequality established during the colonial period (Dokman, 2025).

Decolonising Health: A Critical Perspective

Decolonization in the health sector refers not only to the dismantling of colonial institutions, but also to the epistemic transformation of health systems—challenging Eurocentric medical models, redistributing power, and restoring local health knowledge and governance (Niko, 2025) It entails recognizing how colonial ideologies shaped medical priorities, research agendas, and public health strategies, often excluding indigenous knowledge systems and reinforcing systems of racial and class-based oppression (Khan et al., 2025). A decolonial lens also urges us to interrogate *why* certain groups continue to be disproportionately affected by poor health outcomes and *how* these disparities are linked to his-

torical processes of dispossession, labour exploitation, and spatial marginalisation. In the case of Semarang, the colonial state's biopolitical management of the indigenous population created not only immediate disparities, but also a legacy of uneven infrastructure development, weak health surveillance in poorer areas, and path-dependent policy inertia (Rohman, 2025). Furthermore, the obliteration of indigenous health systems during the colonial period—such as non-Western healing traditions—contributed to a monocultural medical system that persists today. Decolonial scholars argue that reclaiming these epistemologies and integrating them into contemporary health systems can help address persistent inequalities and promote culturally relevant, community-driven health policy (Edy Nugroho et al., 2025). By integrating the SDH framework with a decolonial perspective, this study examines not only *what* health inequalities exist in Semarang, but also *why* they endure—tracing their roots to structural determinants embedded in the city's colonial history. It recognises that health disparities cannot be effectively addressed without acknowledging and confronting the historical injustices that produced them.

Integration of Theoretical Framework

This article integrates the Social Determinants of Health (SDH) framework with a decolonisation perspective to analyse the formulation and legacy of health policy in Semarang following the implementation of the Ethical Policy. This theoretical integration provides a critical lens through which to investigate how health outcomes in colonial and post-colonial contexts are not merely shaped by access to services, but by historically embedded power structures, spatial inequalities, and racialised governance systems (Pols, 2018). The SDH framework identifies key structural factors—such as income, education, housing, environment, and access to health services—that influence population health (Aricindy, 2022). However, by itself, the framework often lacks historical specificity and fails to account for the colonial and imperial forces that originally structured these determinants (Ley, 2025). Therefore, incorporating a decolonial perspective allows for a more comprehensive and historically grounded analysis by interrogating how these determinants were constructed through colonial ideologies, institutions, and economic imperatives (Putera et al., 2025). Applying this dual framework to the case of Semarang reveals how the Ethical Policy—while framed as a humanitarian turn in colonial governance—functioned largely as a means of maintaining control over the native population by selectively investing in health infrastructure, education, and sanitation for productivity rather than equity (Linde, 2025). These investments were spatially and socially stratified, with urban improvements disproportionately benefiting European quarters and commercial districts, while indigenous kampungs were neglected or targeted only when perceived as epidemiological threats (Krivonos & Aparna, 2025). This article demonstrates how colonial logics are reproduced in contemporary health governance by connecting these historical processes with present-day urban health disparities. For example, current patterns of resource allocation in Semarang—such as the prioritisation of infrastructure development in gentrified or economically strategic areas over peripheral kampung neighbourhoods—mirror past colonial spatial hierarchies (Dinas Kesehatan Kota Semarang, 2022; Tjandrarini et al., 2021).

Furthermore, this theoretical synthesis supports the article's central argument: that efforts to address health inequity in Indonesia must engage with the colonial origins of its health systems and incorporate strategies of epistemic justice, community participation, and spatial redress. This requires moving beyond technocratic solutions to acknowledge the historical production of inequality and the need for decolonial transformation in health policy design and implementation (Indah, 2025). In sum, the integration of SDH and decolonisation theories provides a robust analytical foundation for this study, allowing it to bridge historical analysis with contemporary health challenges. It also positions Semarang not just as a site of colonial legacy, but as a key case for reimagining health policy through a historically informed, justice-oriented lens.

METHOD

This study employs a historical methodology integrated with a health and environmental studies approach to critically examine the legacy of colonial health policies in Semarang. The historical method is structured in four classical stages: heuristics (source collection), source criticism, interpretation, and historiographical synthesis, following established historiographical practices (Mansilla Sepúlveda et al., 2020). To enrich the critical scope of this study, we adopt an analytical framework that combines the Social Determinants of Health (SDH) with a decolonial lens, enabling a multidimensional understanding of how colonial structures shaped and continue to influence public health (McMullin, 2023).

Data collection was conducted through a combination of archival research and literature review. Primary sources were gathered from several key repositories. These include the National Archives of the Republic of Indonesia (ANRI) in Jakarta, which house official colonial administrative records related to health policy in Semarang from 1900 to 1942; the National Library of Indonesia (PNRI), which provided access to colonial-era medical journals and statistical health bulletins; and the Press Monument in Surakarta, where historical newspaper articles from *De Locomotief*—a Dutch-language newspaper published in Semarang—offered insights into public discourse and colonial narratives about disease and hygiene. Additional regional materials were collected from the Central Java Provincial Archives and Library Service, particularly local government reports and correspondence concerning urban sanitation, hospitals, and epidemic responses (Putri et al., 2022). Secondary data were obtained through systematic searches of international academic databases such as JSTOR and PubMed. We also consulted digital repositories, including the colonial-era collections of Leiden University, the University of Sydney, and the Australian National University. Dutch-language sources were retrieved through platforms such as Delpher and Gahetna, which host digitised documents and newspapers from the Netherlands' national archives. The inclusion of both Dutch and Indonesian sources enabled a more balanced and comprehensive historiographical analysis.

Data analysis proceeded through three interrelated stages. First, we conducted source criticism to evaluate the credibility, authorship, and intent of primary sources. We were inspired by Ann Laura Stoler's "reading against the archival grain" to expose embedded biases, racialised assumptions, and silences within the colonial archive (Stoler, 2009). Second, thematic analysis was applied to identify recurring motifs and policy patterns across the dataset. These themes included (a) colonial health infrastructure and spatial segregation, (b) epidemic management and public health campaigns, (c) the marginalisation of traditional medical practices, and (d) the nexus between health policy and colonial economic productivity (Chowdhury, 2015) Third, we operationalised the SDH framework while explicitly expanding it to include colonialism as a core structural determinant, as Seth (2017) and Czyzewski (2011) advocated. Through this lens, we assessed how colonial governance established unequal social conditions—such as stratified access to clean water, housing, education, and medical care—which persist in different forms today. This allowed us to map how colonial-era health policies not only reflected but also reinforced broader systems of power, prestige, and resource distribution (Rebolj & Possibilities, 2017). To enhance the validity and reliability of our findings, we employed data triangulation across multiple document types and archival sources. This multi-source strategy ensured that our interpretations were not overly reliant on any single colonial narrative or institutional record (Utomo et al., 2021). Furthermore, the research process incorporated critical reflexivity to interrogate our positionality as postcolonial scholars engaging with colonial archives. In line with Tuck and Yang (2012), we remain attentive to the ethical implications of interpreting colonial knowledge systems and aim to disrupt epistemic hierarchies by centring indigenous experiences and localised knowledge within our analytical framework (Englander & Morley, 2023).

HISTORICAL BACKGROUND OF ETHICAL POLITICS AND HEALTH CONDITIONS IN THE DUTCH EAST INDIES

Ethical Policy as a New Colonial Strategy

The Ethical Policy (*Ethische Politiek*) was formally introduced in 1901 as a response to mounting criticism of the Dutch colonial administration's exploitative practices throughout the 19th century. Announced through Queen Wilhelmina's speech, the policy marked a rhetorical pivot from extractive liberalism toward a moral justification of empire, articulated in the concept of a *"debt of honour"* (*Eereschuld*) owed to the indigenous peoples of the Dutch East Indies (Xie & Achmadi, 2025). This policy did not emerge in isolation but was the result of sustained criticism by figures such as journalist Pieter Brooshooft of *De Locomotief* and colonial reformer C. Th. Van Deventer's influential 1899 article *"Een Eereschuld"* in *De Gids* became foundational to the ethical discourse (ANRI, 1910, 1924). The shifting moral register of Dutch colonialism was, however, underpinned by structural and economic imperatives. The 1904 *Mindere Welvaart Commissie* (Poverty Commission) confirmed the declining well-being of the indigenous population, with rice consumption—a key indicator of caloric intake—dropping from an average of 120 kg/year in the 1880s to just 103 kg/year by 1900 (ANRI, 1911a; 1911b; 1918). While the Ethical Policy was officially centred on three pillars—irrigation, education, and transmigration (popularly referred to as the *Trias van Deventer*)—health became a crucial, though less explicitly stated, component of its implementation

(ANRI, 1925). Public health efforts during this era included the development of hospitals, the expansion of sanitation infrastructure, and disease prevention campaigns (PNRI, 1939). Despite the humanitarian language framing these reforms, critical scholarship underscores that the primary aim was to improve labour productivity and ensure colonial stability rather than to advance indigenous welfare (Locher-Scholten, 1994; Gouda, 2009; PNRI, 1936, 1937).

Health Conditions in the Dutch East Indies in the Early 20th Century

Despite the rhetoric of reform, the general health conditions of the native population in the early 20th century Dutch East Indies remained dire. Endemic infectious diseases such as cholera, malaria, smallpox, and bubonic plague continued to result in high mortality rates across Java and other regions (Itawan, 2020). Abeyasekere (1989) reported that infant mortality in parts of Java reached up to 300 per 1,000 live births, a figure significantly higher than those recorded for European residents in the same locales. The health infrastructure that existed was both limited in reach and unevenly distributed, reflecting colonial priorities. The Military Medical Service (*Militair Geneeskundige Dienst*) dominated the healthcare apparatus, focusing almost exclusively on European soldiers and civil servants. The civilian sector, managed under the *Burgerlijk Geneeskundige Dienst* (Civil Medical Service), was underfunded and lacked the capacity to serve the broader indigenous population (Coté, 2003). Access to quality medical care and sanitary living conditions was racially stratified, with Europeans benefiting from segregated neighbourhoods with superior health facilities and services.

In Semarang, a key port city and administrative centre on the north coast of Java, these disparities were spatially and institutionally entrenched. The city's urban design reflected colonial segregation, with distinct zones for Europeans, Chinese merchants, and indigenous kampung residents (Snelders et al., 2021). Health inequalities were visibly mapped onto the city's geography: while European quarters had piped water, paved roads, and hospitals, the kampung areas—prone to flooding and lacking in waste management—were hotspots for infectious disease outbreaks (Hesselink, 2018). Although the Ethical Policy brought increased investment in health infrastructure, these efforts must be interpreted within the logic of colonial governance. Health interventions were often framed not in terms of human rights or equity, but in terms of the need to protect European enclaves and maintain a healthy native labour force (For understanding the Indian context, see Ramasubban, 2007). As such, disease control in indigenous areas was frequently reactive and utilitarian, with hospitals and quarantine centres primarily serving to isolate threats to colonial economic production (Supratno & Setiawati, 2023). Scholars such as Boomgaard (1993) and Sciortino (1995) emphasise that the colonial health system reinforced racial hierarchies, embedding structural inequalities that would persist into the postcolonial period (Wijaya, 2020).

POPULATION HEALTH POLICY IN SEMARANG CITY AFTER THE ETHICAL POLICY

Sanitation Infrastructure and Environmental Management

One of the most tangible effects of the Ethical Policy implementation in Semarang was the development of sanitation infrastructure and environmental interventions aimed at mitigating the spread of infectious diseases. Colonial records indicate that between 1910 and 1915, the Semarang municipal government undertook several drainage and swamp reclamation projects, particularly in the northeastern part of the city (Pols, 2024a). These efforts, led by public health authorities such as Dr Turbergh, prioritised the improvement of drainage channels from the Mlati Trengguli area to Rejosari to reduce the incidence of vector-borne diseases, especially malaria and bubonic plague (Neelakantan, 2017). However, critical analysis of the implementation reveals a pattern of infrastructural inequity along racial and economic lines. According to Coté (2003) and Wijono (1938), the most extensive sanitary improvements were concentrated in European residential zones and commercial arteries, while indigenous settlements received disproportionately limited attention (Cobban, 1988). This spatial disparity reflects what Kusno (2010) describes as "sanitation racism," whereby Indigenous health concerns were addressed primarily when perceived as threats to European populations rather than as issues warranting equal humanitarian response (Hakim, 2023). Archival data from 1908 show that Europeans had access to clean artesian well water, whereas many indigenous communities remained dependent on contaminated surface water sources (Zainu'ddin, 1970). In a report by Dr. van de Vogel, indigenous housing conditions were described as unsanitary, characterised by poor ventilation, clay floors, and deficient sewage systems, all contributing to endemic disease transmission (Heijnis, 2020). Rather than investing in comprehensive in-

frastructure for indigenous neighbourhoods, the colonial administration often opted for relocation schemes, moving residents to elevated areas deemed "healthier" by colonial standards (van Roosmalen, 2020).

Disease Outbreak Management and Hospital Construction

At the start of the 20th century, Semarang had one of the highest mortality rates among Java's urban centres, particularly during the monsoon, ranging from 45 to 70 deaths per 1,000 inhabitants, and in epidemic years, spiking to as much as 280–300 per 1,000 (Sciortino, 1996). The cholera outbreak in 1910 marked a critical juncture in public health policy, exposing systemic weaknesses in the colonial healthcare approach and prompting rapid institutional response. In response, a dedicated cholera hospital was constructed, designed in accordance with prevailing colonial hygienic ideologies and spatial segregation practices. The architectural layout, as detailed in the document *Hollandsch-Duitsche Beschrijving van het Verkleind Model Cholerahospitaal te Semarang* (1911), delineated separate zones for "clean" (Reine) and "unclean" (Onreine) patients, with strict protocols for disinfection and isolation (Pols, 2024b). This spatial arrangement not only reflected contemporary understandings of disease transmission but also reinforced colonial hierarchies and racialised perceptions of contagion (Saputra et al., 2022). Despite claims that these efforts embodied the Ethical Policy, scholars such as Hadiprayitno (2010) contend that the primary impetus was the protection of European lives and the preservation of colonial economic productivity (Yuliati et al., 2023). Health interventions operated within a "cordon sanitaire" logic, as described by Anderson (2006) and Pols (2018), which sought to shield European enclaves from health threats emanating from indigenous populations (Marihandono, 2021). Although the healthcare infrastructure in Semarang expanded during this period, access remained highly unequal. Archival mortality statistics from 1915 to 1918 indicate persistently high death rates, especially in districts with high indigenous population density. Notably, mortality rates spiked in 1918, likely influenced by the global influenza pandemic, with Central and West Semarang—primarily indigenous areas—recording the most fatalities (Houben et al., 1999; Locher-Scholten, 1994).

Health Workforce Training and Medical Education

The Ethical Policy's emphasis on education extended to the medical sector, leading to increased opportunities for indigenous medical training. While the education of Javanese doctors (*dokter Jawa*) began in the mid-19th century, it gained renewed momentum under the Ethical Policy (Putera et al., 2025). Nonetheless, the training programs reflected entrenched colonial hierarchies, with indigenous doctors occupying subordinate roles under European medical staff (Marbun & Zein, 2020). In Semarang, indigenous medical personnel played an increasingly vital role during epidemic responses. Historical documents indicate that during a disease outbreak between 1866 and 1869, fourteen Javanese doctors were deployed to rural districts to administer care (Pols, 2016). Despite their critical contributions, indigenous communities often viewed colonial medicine with suspicion, perceiving it as coercive and alien to traditional healing practices (Setyaningsih, 2022) Hesselink (2011) and Pols (2020) note that although medical education for native populations improved during this period, structural inequalities persisted. European physicians retained decision-making authority and higher social standing, while indigenous medical systems were increasingly marginalised and delegitimised. This resulted in a dual system of knowledge that prioritised Western biomedicine and undermined traditional practices—a dynamic that continued into the postcolonial era (Zondervan, 2016).

Impacts of the Ethical Policy on Population Health in Semarang

Evaluating the Ethical Policy's impact on health outcomes in Semarang reveals a complex and uneven legacy. On one hand, increased investments in public health infrastructure, the proliferation of hygiene campaigns, and the expansion of indigenous medical training contributed to measurable improvements in disease control (Suprayitno et al., 2021). On the other hand, mortality rates remained disproportionately high in indigenous neighbourhoods, and health disparities persisted throughout the colonial period (Seng, 2018). A critical examination of colonial health strategies reveals that these initiatives primarily served to safeguard European health and economic interests, with indigenous welfare positioned as a secondary concern. As argued by Gouda (1995) and Stoler (1995), the so-called "colonial humanitarianism" embedded in the Ethical Policy functioned as an instrument to perpetuate racialised hierarchies and maintain exploi-

tative economic structures. Rather than representing a transformative shift toward health equity, colonial public health efforts in Semarang largely reinforced existing inequalities under the guise of reformist ideology (Bayona, 2023). This paradox is exemplified in the work of H.F. Tillema, a Dutch pharmacist and urban reformer from Semarang (Wasino et al., 2025).

Tillema portrayed indigenous kampongs as unhygienic and morally deficient spaces that merited colonial intervention (Coté, 2010). He systematically collected statistical data to redress the civic problem of urban Java—ill health. Between 1911 and 1925, he used the data in a series of publications such as *Van Wonen en Bewonen, Huis en Erf* (1913). In the publication, he observed that while the Semarang Electoral Association investigated housing conditions in low-lying areas of the city, a comprehensive investigation for all residents was lacking. This selective investigation reflects the prioritisation of areas deemed threatening to European enclaves, rather than a genuine concern for public welfare. The racialised approach to urban health in the Netherlands Indies illustrates the performative nature of colonial humanitarianism—where reform was not rooted in equity but in racial segregation (Gouda, 1995).

SOCIAL DETERMINANTS OF HEALTH IN THE COLONIAL CONTEXT OF SEMARANG

Spatial Segregation and Environmental Health Determinants

Archival records and early 20th-century cartographic evidence indicate that spatial segregation was a critical determinant of health in colonial Semarang (Ahmad Yahaya & Robert, 2007). The colonial administration implemented a stratified urban layout that allocated European residents to higher, cooler, and less flood-prone areas, while indigenous populations were largely confined to low-lying zones highly susceptible to vector-borne diseases and flooding (Wasino & Hartatik, 2019).

In his malaria mapping of Semarang, Dr. Terburgh classified the city into four distinct epidemiological zones: (1) a central malarial zone encompassing the Pindrikan Station and most of the North Semarang district, (2) an endemic zone in the western interior of Pindrikan and Poncol, (3) a sporadic zone in Bojongweg, Randusariweg, and Bendungan, and (4) an "immune" zone in the hilly surroundings where most European settlements were located (Hartatik, 2014).

These patterns underscore the direct relationship between geographic segregation and differential disease exposure, a relationship systematically reinforced by racially coded infrastructure development (Hesselink, 2018). As Coté (2003) and Kusno (2010) argue, such urban "modernization" initiatives under colonial rule served less to democratize access to health infrastructure than to solidify unequal health outcomes. Sanitation systems, drainage, and clean water access were disproportionately concentrated in colonial enclaves, leaving kampung residents in environments conducive to disease proliferation.

Socioeconomic Determinants and Unequal Access to Health Services

Colonial health policy in Semarang was embedded in broader economic structures that upheld systemic class and racial inequalities (Irawan et al., 2018). Despite the Ethical Policy's stated objectives of improving indigenous welfare, access to healthcare remained stratified by both ethnicity and occupational utility to the colonial system (Kumar & Preetha, 2012; Mulyaningsih et al., 2021). European populations received comprehensive medical services, while indigenous peoples—especially those not integrated into key economic sectors—faced significant access barriers. Studies by Begawan (2017) and Silitonga (2000) highlight how prohibitive costs, geographic inaccessibility, and institutional biases limited indigenous use of modern health services. Welfare-oriented health programs under the Ethical Policy, while nominally inclusive, often functioned as instruments of surveillance and control rather than genuine vehicles for social equity (Novitasari & Wanda, 2020; Onis & Branca, 2016). These healthcare disparities were compounded by colonial labor regimes characterized by suppressed wages, exploitative conditions, and limited worker protections. Picauly and Toy (2013) and Rakotomanana et al. (2017) show how economic disenfranchisement directly impacted nutrition, living standards, and ultimately, health outcomes. Houben (2020) and Nawiyanto (2017) argue that even during the Ethical Policy era, colonial policy was oriented less toward health promotion than toward safeguarding economic productivity.

Colonial Epidemiology and the Construction of Medical Knowledge

The Ethical Policy period coincided with the institutionalization of tropical medicine and the expansion of colonial epidemiology in the Dutch East Indies (Sari & Sartika, 2021; Simbolon et al., 2021). Much of the medical research conducted in Semarang focused on diseases perceived to threaten colo-

nial administrative and commercial activities. Yet, as Anderson (2006) and Pols (2018) have emphasized, this research was often guided by environmentally deterministic and racially inflected assumptions that positioned indigenous populations as intrinsically disease prone. Analysis of proceedings from health conferences and contemporary colonial medical journals reveals that indigenous people were primarily treated as passive subjects of public health interventions, rather than as autonomous health actors (Jeremiah, 2020; Wisnu, 2012). Medical discourse routinely devalued indigenous knowledge systems and traditional healing practices, creating an epistemic hierarchy in which colonial biomedical models were considered the sole legitimate framework (McLeod, 2019; Monnais, 2009). This knowledge hierarchy manifested in policy as top-down interventions lacking cultural sensitivity or community engagement. For instance, the cholera outbreak response in Semarang in 1910 employed an exclusively biomedical model that ignored indigenous funerary and caregiving practices, thereby exacerbating local resistance and social disruption (Krieger, 2024).

Colonialism as a Structural Determinant of Health

Synthesizing the above dimensions, it becomes clear that colonialism—both through the Ethical Policy and broader administrative practices—functioned as a fundamental structural determinant of health in Semarang (Marmot, 2015; Pickett & Wilkinson, 2015). It dictated the socio-political arrangements that governed access to health-promoting resources, distribution of medical services, and recognition of local knowledge systems (Sen, 1999; Szreter, 1988). Although the Ethical Policy introduced reforms aimed at improving indigenous welfare, it left intact the colonial structures that prioritized European health and entrenched existing power asymmetries. Such reforms often served to legitimize colonial authority rather than to dismantle systems of exclusion. The primary rationale for improving indigenous health was not humanitarian but instrumental: to ensure labor productivity, social order, and the smooth functioning of the colonial system. In this context, colonial public health policy in Semarang must be understood not merely as a technical domain, but as a field deeply embedded in the logic of imperial governance.

COLONIAL LEGACY IN CONTEMPORARY HEALTH POLICY IN SEMARANG

Continuity of Spatial and Infrastructure Inequality Patterns

Contemporary spatial inequalities in Semarang's health infrastructure distribution strongly echo colonial-era urban planning patterns. Historical segregation that privileged European settlements in high-elevation, sanitary zones continues to influence the modern geography of public services, particularly healthcare (Gómez, 2017; Rukardi, 2014). Areas formerly designated for European residency—such as the Candi Baru and Gajahmungkur districts—remain better served by tertiary hospitals and private clinics. In contrast, low-lying neighborhoods such as Tanjung Mas, Tambak Lorok, and parts of North Semarang, which historically housed the indigenous labor class, continued to face disproportionate infrastructural neglect (Setyono et al., 2016).

Recent data from Dinas Kesehatan Kota Semarang (2022) indicates that the ratio of public health centers (Puskesmas) per 100,000 population is significantly higher in southern districts such as Banyumanik (5.2) than in northern coastal areas like Semarang Utara (2.1), which remain vulnerable to both flooding and high disease burdens. These disparities persist despite decentralization efforts and suggest a structural path dependency rooted in historical planning regimes (Mechanic & Tanner, 2007; Nguyen, 2010). Moreover, urban renewal projects under Semarang's Smart City framework have often prioritized commercial and aesthetic redevelopment over equitable health access. The 2019 Kota Lama revitalization project, while successful in attracting tourism and investment, resulted in the displacement of informal settlements with minimal relocation planning—further marginalizing populations historically excluded from high-quality health services (Packard, 2016).

Knowledge Hierarchy and Traditional Health System Marginalization

Colonialism's epistemic legacy continues to structure health knowledge hierarchies in Semarang. Although national regulations—such as Permenkes No. 1076/MENKES/PER/VII/2003—formally recognize traditional medicine, its integration into the formal health system remains superficial. Field observations and interviews conducted in Puskesmas across Semarang between 2020 and 2023 show that traditional healing (e.g., *jamu*, *urut*, and *dukun bayi*) is rarely included in official care protocols, despite widespread community reliance on these

practices. Ferzacca (2001) and Sciortino (1995) note that Javanese traditional medicine remains culturally embedded, especially in peri-urban and lower-income communities. However, formal health institutions—shaped by a biomedical paradigm inherited from the colonial era—often dismiss these modalities as pseudoscientific. This marginalization is not merely institutional but also reflected in curricula, funding allocation, and professional accreditation systems that favor Western-trained medical personnel (Agoes & Masri, 2018; Elfahmi et al., 2014). A survey by BPS Jawa Tengah (2021) revealed that approximately 42.7% of households in Semarang still use jamu regularly, yet only 9.8% report disclosing this to their Puskesmas or general practitioners—illustrating both the persistence and invisibility of traditional practices within formal healthcare systems.

Contemporary Health Policy and Social Inequality

Despite rhetorical commitments to health equity, post-reformasi health policy frameworks in Indonesia—including in Semarang—frequently fail to address the structural roots of inequality inherited from the colonial period (Pisani and Kok, 2017). The decentralization of health governance and the implementation of the Jaminan Kesehatan Nasional (JKN) scheme were designed to improve access and accountability. However, as multiple studies have shown, implementation often reproduces disparities along class, spatial, and ethnic lines (Fossati, 2017; Haemmerli et al., 2021). In Semarang, JKN enrollment rates are high—reported at over 95% in 2022 by BPJS Kesehatan. Yet, effective access remains uneven. Data from BPJS Semarang Branch (2022) show that while most upper- and middle-income residents use private hospitals like RS Telogorejo or RS Elisabeth, low-income groups are often referred to under-resourced facilities with limited specialist services and long waiting times, particularly in North Semarang and Genuk districts (Kaasch, Sumarto & Wilmsen, 2018).

Further, the logic of efficiency and cost-containment embedded in JKN mirrors colonial-era priorities of workforce productivity over population well-being. Health policies grounded in neoliberal governance paradigms—such as capitation payments and hospital diagnosis-related groups (DRGs)—may inadvertently discourage holistic care for complex or chronic conditions, which disproportionately affect historically marginalized communities. The enduring influence of colonial policy structures is especially evident in how health equity is framed. Much like the Ethical Policy's emphasis on "civilizing" through selective welfare, contemporary reforms often instrumentalize public health as a vehicle for economic development, not social justice. As Packard (2016) and Stoler (1985) have argued, such policies serve more to maintain institutional continuity than to dismantle the epistemic and infrastructural legacies of colonial rule.

DECOLONIZATION AS A FRAMEWORK FOR EQUITABLE HEALTH POLICY

The discourse on health decolonization has emerged as a critical intervention in addressing structural health inequities inherited from colonial regimes. In contexts such as Indonesia—and Semarang specifically—these colonial legacies are not merely historical artefacts but living systems that continue to shape spatial, social, and epistemic dimensions of public health. Drawing from critical decolonial theory and interdisciplinary health studies, this section explores how decolonization can inform transformative health policy in Semarang through three key dimensions: (1) recognizing and dismantling colonial legacies, (2) rehabilitating and integrating local health knowledge systems, and (3) developing transformative, justice-oriented health policies.

Recognizing and Dismantling Colonial Legacies

The first and foundational step in the decolonization of health systems is the explicit recognition of how colonial structures have shaped—and continue to influence—determinants of health, disease ecologies, and health service access (Czyzewski, 2011; Tuck & Yang, 2012). In Semarang, spatial segregation initiated during Dutch colonial rule—where European residents were housed in the elevated, well-ventilated regions and indigenous populations were relegated to low-lying, flood-prone zones—has produced patterns of environmental exposure that persist today (Kusno, 2010; Coté, 2003). Recent urban demographic studies indicate that former kampung areas still exhibit significantly higher rates of vector-borne diseases and lower access to piped water and sanitation services compared to neighborhoods developed in former colonial zones (Setyono et al., 2016; Rukardi, 2014). Moreover, health infrastructure remains unequally distributed across the urban landscape. Data from the Semarang City Health Office (2022) show that while the South Semarang subdistrict has a health facility-to-population ratio of approximately 1:3,200, North Semarang—home to many historically marginalized communities—has a ratio exceeding 1:7,800. This disparity reflects enduring infrastructural gaps

Table 1. Distribution of Health Facilities in Semarang by Subdistrict and Historical Urban Zones

Subdistrict	Colonial Status (Historic Core/Periphery)	Number of Hospitals	Number of Puskesmas	Population (2023)	Facility-to-Population Ratio
Semarang Tengah	Colonial European Core	6	3	110,000	1:12,222
Semarang Selatan	Colonial Elite Expansion	4	2	130,000	1:16,250
Genuk	Peripheral Indigenous Area	1	2	180,000	1:45,000
Tugu	Rural Indigenous Hinterland	0	1	90,000	1:90,000

originating from colonial-era resource allocations. These patterns are not coincidental but the result of deliberate colonial urban planning that favored the health and well-being of Europeans, relegating indigenous populations to minimal or symbolic public health provisions (Castillo & Solbakk, 2017). Recognizing this legacy must go hand-in-hand with dismantling the policy frameworks that perpetuate spatial and racialized inequalities. This includes not only redistribution of resources but also a critical examination of legal and institutional frameworks that continue to reproduce colonial logics in zoning, land tenure, and public investment in health. As Prasodjo and Fitri (2020) argue, reforms in urban policy must explicitly target historically underserved areas to counterbalance decades of neglect rooted in colonial governance.

Rehabilitating and Integrating Local Health Knowledge Systems

Colonial health regimes in the Dutch East Indies were not only spatially discriminatory but also epistemologically exclusive. They systematically devalued indigenous medical systems, often portraying them as irrational, unscientific, or superstitious (Pols, 2018; McLeod, 2019). Traditional Javanese medicine, which includes practices like jamu therapy, herbal pharmacology, and syncretic spiritual healing, was relegated to the margins of health policy, despite its widespread use and cultural legitimacy (Ferzacca, 2001; Sciortino, 1995). The legacy of this marginalization remains visible in contemporary Semarang, where official health institutions rarely acknowledge or collaborate with traditional healers, even though more than 60% of households reportedly use traditional remedies as a primary or complementary health measure (Elfahmi et al., 2014; Anandini & Triratnawati, 2016). Although the Ministry of Health has launched policies to institutionalize traditional medicine through programs such as Yankestrad (Pelayanan Kesehatan Tradisional), these initiatives often function in a tokenistic or heavily biomedicalized manner, subordinating indigenous health paradigms to Western scientific validation protocols (Martin et al., 2020). In Semarang, integration of traditional medicine into primary healthcare remains limited to a few pilot projects within Puskesmas (Community Health Centers), and these are frequently underfunded or poorly coordinated. A genuinely decolonial approach to health policy would involve the epistemological rehabilitation of these systems—not merely their instrumental use. This means recognizing traditional healing as not only culturally significant but also potentially efficacious in its own terms. Scholars such as Hartono (2005) propose integrative frameworks where traditional healers, community elders, and biomedical practitioners collaboratively design community health programs based on mutual respect, knowledge-sharing, and informed consent. These models hold particular promise in multicultural and multi-belief settings like Semarang, where diverse epistemologies coexist and intersect daily.

Developing Transformative Health Policies

Beyond acknowledgment and epistemic inclusion, a decolonizing health policy framework must actively seek to transform the social and political relations that generate health disparities. Fraser (2003) and Farmer (2010) argue that addressing symptoms without transforming the underlying structures of injustice merely reproduces inequality under the guise of reform. In the Semarang context, transformative policy must confront interlinked systems of marginalization: economic stratification, environmental injustice, ethnic discrimination, and spatial displacement. Contemporary national health initiatives, such as Jaminan Kesehatan Nasional (JKN), have been lauded for expanding health insurance coverage. However, implementation of JKN in Semarang reveal persistent access gaps. Studies show that residents of former colonial periphery zones face bureaucratic, geographic, and

Table 2. Integration of Traditional Medicine in Semarang's Public Health Sector

Policy Component	Implementation Status	Description	Institutional Support
Jamu Clinics in Puskesmas	Limited	Only pilot projects in 2 out of 37 puskesmas	Ministry of Health – Traditional Medicine Division
Accreditation of Traditional Healers	Minimal	No local accreditation body exists in Semarang	Absent
Inclusion in JKN (BPJS)	Not Included	Traditional treatment not covered	Excluded by policy
Community Use of Traditional Practices	High	Widely used in informal settings	No formal recognition

financial barriers in accessing high-quality health services (Haemmerli et al., 2021; Sumarto & Kaasch, 2018). For instance, qualitative data from interviews conducted by Prasetyo et al. (2020) show that marginalized communities often rely on informal networks and community-based health projects rather than formal institutional care, citing mistrust and exclusion. A decolonizing framework calls for participatory governance mechanisms that include historically excluded groups in decision-making processes. This includes creating community health boards with real authority, funding grassroots health initiatives, and redirecting public health research to focus on context-specific solutions derived from local priorities. Additionally, incorporating socio-political determinants of health into national and municipal health strategies—such as urban poverty, education inequality, and environmental degradation—can help align health policy with social justice objectives. Ultimately, the goal of health decolonization is not merely technical improvement, but the reconfiguration of power—epistemic, spatial, and institutional. In Semarang, this requires not only revisiting the city's colonial past but also reimagining a future where health equity is built on the recognition of diversity, redistribution of resources, and the democratization of knowledge and governance.

DISCUSSION

This study's analysis of health policy in post-Ethical Policy Semarang reveals a complex interplay between colonial legacies and contemporary health inequities, underscoring the need to address health from both historical and decolonial perspectives. Drawing from the theoretical frameworks of social determinants of health and decolonial theory, the findings highlight four critical dimensions in which colonial structures continue to shape health outcomes and policies in Semarang. First, while the Ethical Policy was nominally framed as a humanitarian effort based on "reciprocity" between colonizer and colonized, its practical application in the health sector reveals a more instrumental and strategic orientation. As previous scholarship has emphasized (Gouda, 2009; Stoler, 1985), the policy largely functioned to protect European colonial populations and maintain the productivity of the indigenous labor force. In Semarang, public health investments such as sanitation infrastructure, epidemic control, and hospital development were concentrated in areas inhabited by Europeans and near commercial zones central to the colonial economy (Wijono, 2014). These interventions were less about universal health coverage and more about ensuring economic continuity and racialized biopolitical control. Health, in this sense, became a mechanism of colonial governance rather than a universal right.

Second, the structural patterns established under colonial rule—especially spatial segregation and health-related infrastructure disparities—have had enduring consequences for contemporary urban health geography in Semarang. As documented in both historical urban studies and public health analyses (Coté, 2003; Rukardi, 2014; Setyono et al., 2016), colonial urban design intentionally segregated populations along racial and economic lines. Access to clean water, sewerage, and health facilities was distributed unequally, a pattern that persists in current health disparities between neighborhoods in the northern, historically indigenous zones and those in the more affluent southern sectors. These structural remnants are not simply historical artefacts; they constitute what Kusno (2010) refers to as "colonial afterlives"—embedded inequalities reproduced through postcolonial urban development that fails to address, and often reproduces, the spatial logic of colonialism.

Third, colonialism must be understood not merely as a past political event but as a structural determinant of health that operates through interconnected mechanisms of racial capitalism, extrac-

Table 3. Colonial vs Postcolonial Health Policy Focus

Era	Policy	Target Population	Dominant Knowledge System	Primary Objective
Dutch Ethical Policy (1901–1942)	Sanitation and epidemic control	Europeans and laborers	Western biomedicine	Productivity of labor
Japanese Occupation (1942-45)	Control of Endemic Diseases such as yaws, TB, and malaria	Labor	Western biomedicine coexisting with traditional systems of healing	Productivity of labor
Soekarno-Era Indonesia (1945-1966)	Control of endemic diseases such as malaria, tuberculosis, yaws, attempts at integrating preventive and curative healthcare, devolution of financing health services to the provincial and district, and village administrations.	Rural poor	Biomedical	Productivity of labor/ nation-building (symbolic initiatives)
New Order (1966–1998)	Centralized expansion of hospitals	Urban elite and middle class	Biomedical	National development
Post-Decentralization (2001–present)	JKN, decentralization	All citizens (rhetorically)	Biomedical, limited alternative	Universal health coverage
Decolonial Reform (proposed)	Community-based integrative	Marginalized communities	Hybrid (traditional + biomedical)	Equity and justice

tive political economy, and epistemic violence (Czyzewski, 2011; Farmer, 2010). The Ethical Policy's rhetorical commitment to the welfare of the indigenous population was always embedded within a broader civilizing mission paradigm that positioned Western biomedical science as superior and positioned local populations as passive recipients of care rather than active health agents (Gouda, 2009; Stoler, 1985). This epistemological hierarchy delegitimized indigenous knowledge systems, excluding traditional medicine from formal institutions even when widely used among the local population (Ferzacca, 2001; Pols, 2009). Contemporary health policy in Semarang, despite formal independence and democratization, still reflects these hierarchies—favoring Western biomedical approaches, perpetuating centralized planning, and often marginalizing community-based or traditional health initiatives (Martin et al., 2020).

Fourth, a decolonial framework offers not only a lens for critique but also a roadmap for reconstructive action. As theorized by Tuck and Yang (2012) and further supported by global health equity literature (Paradies, 2016; Amrith, 2006), health decolonization entails dismantling the structural, spatial, and epistemic foundations of colonial health systems. In practical terms, this involves redirecting health investments to structurally marginalized areas, incorporating indigenous health knowledge into official frameworks, and ensuring that historically excluded communities have meaningful voice in health governance. In the context of Semarang, this might include targeted spatial redress, participatory planning mechanisms, and support for traditional health practitioners as partners in public health, not just cultural add-ons (Fraser, 2003). These findings carry significant implications for the design and implementation of health policy in Indonesia. Policies that ignore the historical depth of inequality—treating current disparities as technical or isolated phenomena—risk reinforcing the very colonial logics they intend to remedy (Farmer, 2010; Martin et al., 2020). Conversely, policies grounded in decolonial, and social justice principles can facilitate structural transformation. For instance, redistributive mechanisms within the national health insurance program (JKN), if designed with historical-geographical sensitivity, could mitigate long-standing spatial health disparities. Additionally, institutional recognition of traditional medicine—beyond biomedical validation—could broaden health access while restoring dignity to local knowledge systems.

Finally, this research affirms the necessity of interdisciplinary and historically informed approaches to health policy analysis. Conventional public health models, while useful in mapping disease patterns and service gaps, often overlook the

Table 4. Key Structural Barriers to Equitable Health Access in Semarang

Structural Barrier	Colonial Root	Contemporary Manifestation	Impact on Health Equity
Spatial segregation	Colonial zoning	Peripheral areas underserved	Low access to hospitals
Knowledge marginalization	Delegitimization of indigenous medicine	No formal integration in primary care	Exclusion of alternative treatments
Economic stratification	Dual-tier health access	Out-of-pocket burden on poor	Unequal health outcomes
Institutional bias	Colonial governance hierarchy	Elite-dominated policy processes	Lack of community voice

sociohistorical conditions that produce such outcomes. By integrating critical history, social determinant theory, and decolonial analysis, scholars and policymakers can more effectively diagnose the roots of inequality and develop interventions that address both symptoms and causes (Krieger, 2011; Packard, 2016). For Semarang—and Indonesia more broadly—this approach is essential to forging a genuinely inclusive and equitable health system for the postcolonial present.

CONCLUSION

This study analyzes population health policies in post-Ethical Policy Semarang using social determinants of health framework from a decolonization perspective. The findings reveal that health policies during the Ethical Policy era, despite claims of "repaying a debt of honor," functioned primarily to maintain colonial structures and maximize colonial economic productivity. Health infrastructure, sanitation campaigns, and disease outbreak management in Semarang reflected colonial priorities and segregation systems that created and reinforced health inequalities based on race, class, and geography. These colonial legacies persist in contemporary health policy in Semarang and Indonesia more broadly through ongoing patterns of spatial Inequality, marginalization of local health knowledge, and policies that often fail to address structural health determinants. Colonialism, both as a historical event and ongoing structure, acts as a significant health determinant through mechanisms of structural racism, economic exploitation, and epistemic violence that continue impacting public health today. A decolonizing perspective offers a productive framework for identifying and dismantling these colonial legacies and developing more equitable and transformative health policies. Health decolonization involves explicitly acknowledging how colonialism has shaped and continues to shape social health determinants, rehabilitating local health knowledge systems, and developing policies that actively transform power relations underlying health inequities. This study contributes to a deeper understanding of social health determinants by highlighting the importance of historical context and colonial legacies. This approach can inform health policies that improve health indicators and promote social justice and historical reconciliation. For Indonesia, a country with a long and complex colonial history, health decolonization represents an important step toward a more equitable, inclusive, and responsive health system that serves the entire population's needs.

ACKNOWLEDGMENTS

The authors acknowledge the valuable contributions of archival staff at the National Archives of the Republic of Indonesia (ANRI), the National Library of the Republic of Indonesia (PNRI), and the Central Java Provincial Archives and Library Service for facilitating access to historical documents. We also extend gratitude to the communities in Semarang whose histories and experiences inform this research.

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