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**Bakti and Sayan traditions among the Tenggerese people in East Java:
the role of indigenous institutions in integrated elderly care
development in Indonesia**

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CHAPTER II THEORETICAL ORIENTATION

This chapter presents the concept of care of the elderly based on the plural elderly care system: traditional institutions, and transitional and modern organisations. Traditional institutions refer to the local traditions of *bakti* and *sayan* which are a key concept of the indigenous institutions. Additionally, transitional organisations such as *Karang Werda* and *Posyandu Lansia* refer to community-based care which involves the community's initiatives and the government's support. Moreover, modern organisations refer to the concept of organisational care of the elderly, such as *Panti Jompo* ('Old Age Home'), *Pusat Kesehatan Masyarakat Santun Lansia (Puskesmas Santun Lansia)*. They are based on modern knowledge and managed by external parties, such as the government or the private sector.

The following sections will describe the concept of care of the elderly, particularly related to the utilisation of the elderly care system. The concept of care of the elderly will be explained in the larger context of conceptual and theoretical approaches from a wide variety of references and disciplines. This chapter also describes the kin relationships and the family system which affects the social care and support system provided for the elderly, as well as the living and care arrangements.

The research is based on a bottom-up oriented perspective of the 'Leiden Ethnosystems' Approach' to integrate Indigenous Knowledge System (IKS)-based decision-making processes in the care of the elderly. This research seeks to identify alternative strategies which apply knowledge systems and practices of local communities and their institutions. The integrated care based on the Indigenous Knowledge Systems Integration Model (IKSIM) is used to formulate recommendations based on the integrated community-managed development (ICMD) approach in the provision of care of the elderly to enhance their well-being. The ICMD approach aims at achieving sustainable development by integrating local and global systems of knowledge and technology in all sectors of the community through capacity building and local people's participation. The popular model of integrated care at the service delivery level is the case management approach. The approach attempts to integrate care systems to provide comprehensive services for the elderly in the community. Moreover, this study aims to analyse the use of elderly care institutions and organisations in a developing country, Indonesia. The research is designed for the Javanese, particularly those living in East Java, including the Tenggerese people. Analysis of the utilisation of elderly care institutions and organisations can also be applied to identify alternative strategies to promote the security of the elderly in their old age.

2.1 Theoretical Approaches to Elderly Care Research

This research focuses on the elderly's care and support services viewed from various approaches and perspectives, such as gerontological, sociological and anthropological perspectives. Traditionally, sociologists study people in their own society while anthropologists study people in other societies. Gerontologists study ageing and older adults. Keasberry (2002) conducts an interdisciplinary collaboration to study the elderly and partition removal between anthropology, sociology, and gerontology. The study also focusses on the ethnoscience perspective, a cross-disciplinary orientation of knowledge. At the Leiden Ethnosystems And Development Programme (LEAD) the 'Leiden Ethnosystems' Approach' has been redefined and operationalised as a combination of ethnographic fieldwork with an analysis of the interaction between individuals within their environment. Ethnoscience refers to a scientific perspective based on how humans perceive their environment and how they adapt to their environment as reflected in their own daily words and actions (*cf.* Saefullah 2019). Specifically, ethnoscience emphasises the perspective of how indigenous people, knowledge, and systems contribute to society.

In this context, ethnoscience uses an 'emic' perspective in science and development (*cf.* Slikkerveer 1990, 1995; Slikkerveer & Dechering 1995). An 'emic' view in this research also takes into account the economic activities to measure the fulfillment of care of the elderly. In sum, ethno-economics deals with economic activities implemented by local people and institutions, based on bottom-up approaches, and involves local peoples' participation in the use of local resources.

Umoh-Akpan (2000) states that ethnographics provide an in-depth understanding of the sociocultural contexts involving economic phenomena or processes known as ethno-economics. Ethno-economics provides the necessary descriptive and analytical baseline for understanding the local communities' values, ideas, attitudes, perceptions, and options. Moreover, ethno-economics has unique implications in the local ecosystems implemented by a social organisation (such as the religion and kinship) to make sustainable utilisation of local resources. Hence, this study collaborates various scientific disciplines, looking at various phenomena in society, focusing particularly on the elderly's care and support services based on the adult children's perceptions.

2.1.1 The Users' Perspective of Care

Using 'emic' and 'etic' perspectives, the research highlights care from inside and outside cultural situations. Warren, Slikkerveer, & Brokensha (1995) indicate the importance of cultural inclusion in development and the importance of the 'emic' perspective in development. In this context, the 'emic' perspective refers to adult children's perceptions towards care and support services provisions for the elderly. It also can be called an 'inside view.' On the contrary, the 'etic' perspective refers to the 'outside view' brought by the researcher to the analysis based on scientific perspectives. Holmes & Holmes (1995) state that the 'etic view' is an objective and controlled procedure for weighing and sifting facts and theoretical viewpoints. Culture is a particular example of how an 'emic' view differs from one community to another. Thus, an 'emic' perspective is critical in this research; it not only gives new meanings and different assumptions about reality, but also enables the creation of instruments which accurately measure variables, including the cultural aspect.

Moreover, endogenous development is also important in the development approach. It starts from peoples' worldviews and livelihood strategies to reflect sustainable development as a balance between material, social, and spiritual well-being. The spiritual aspect becomes an important dimension in the endogenous development approaches which make it different from other development approaches (*cf.* Millar *et al.* 2008). Boonzaaijer & Apusigah (2008) also state that endogenous development posits local cultures as a critical starting point for development. In practice, endogenous development is mainly based on indigenous initiatives, institutions, resources, strategies, knowledge, and values. In this context, the meaning of care and support services and the utilisation of elderly care institutions and organisations can only be understood and evaluated in terms of the cultural contexts where adult children utilise care of their elderly.

Keith (1992) conducts a set of 'queries' to obtain information about the social and cultural characteristics which most likely affect care-giving relationships between the elderly and their family members. The first query concerns the course of life as a cultural unit such as how it is perceived and old age defined, and how these perceptions affect views about who will provide and receive the care. The second inquiry relates to functionality requirements such as the requirements for an adult person to participate in society, how aging affects the ability to fulfil these requirements, and 'built in' support for social and domestic arrangements required for functionality in any communities. The third query concerns access to status and resources such as how ageing promotes or impedes access to status and resources, when and how resources are transmitted from across generations, and how status and resources affect the care-giving relationship. The fourth query relates to kinship and residence such as how family, kinship, and residence patterns interact with each other to determine which potential caretakers are likely to be living with or near elderly persons.

The last questions relate to caretaking roles such as who is an appropriate caregiver, other expected roles of these people, and how these other roles affect their availability as caretakers. This research considers some aspects of the sociocultural contexts presented by Keith (1992). Moreover, the research focuses on the perceptions of adult children towards providing care of the elderly based on their knowledge, belief, and opinions in their daily life practices.

2.1.2 An Advanced Theory of Elderly Care Development

Warren, Slikkerveer, & Brokensha (1995) introduce the importance of incorporating cultures into development which underscores the approach of sustainable development. In this context, Tronto (1993) attempts to develop and qualify the ethics of care as a moral and political theory. Moral refers to the value developed in the attitude towards and the activity of caring, while political refers to the dimension of caring which should be the point of departure for the organisation of a society (*cf.* Tronto 1993). Tronto's theory emphasises the relations among people themselves, and people and their environment. The definition of 'care' is given by Tronto & Fisher in Tronto (1993: 103): '*as a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible.*' Tronto insists that the caring activity is largely defined culturally, and will vary among different cultures, making his theory applicable in developing countries, particularly Indonesia (*cf.* Keasberry 2002).

Tronto (1993) distinguishes four phases in the caring process: caring about, taking care of, care-giving, and care-receiving. 'Caring about' involves the moral element of 'attentiveness,' recording the existence of a need and making an assessment that should be fulfilled. Moreover, 'caring about' will often involve the position of another person or group to recognise the need. 'Taking care of' requires the moral element of 'responsibility' involving some responsibilities for the identified need and determining how to respond to it. 'Taking care of' also means understanding that one should act to meet these unmet needs. 'Care-giving' requires the moral element of 'competence,' involving meeting the needs directly for care which requires physical work and comes in contact with the objects of care by care-givers. 'Care-receiving' requires the moral element of 'responsiveness' of the care-receiver. It refers to the object of care responding to the care received. It is important to understand the care-receiver perspectives as an element of the caring process to understand that the needs for care have been fulfilled. It can be said that caring is an ongoing activity process consisting of four analytically separate, but interconnected phases (*cf.* Tronto 1993). All humans have needs which other people help to fulfill, and the care degree that others provide depends on the culturally constructed norms. In this context, 'care' refers to the care given to the elderly.

Many elderly receiving care and support are sometimes not involved in decision-making related to the care services they need and want. It creates gaps in the care provision. Many care-givers fail to understand the basic needs of their elderly and the support structures and skills they need. However, the biggest gap related to care of the elderly is not only about care itself but a lack of social support, meaning social care of the elderly (*cf.* HelpAge International 2013). The social care provision is related to the 'stakeholders,' who may have different perspectives towards social care provision, such as perceptions of the users, providers, parents, government managers, and practitioners (*cf.* Waive *et al.* 2005). User interests relate to the nature, quality, and terms of access to provided services. Carers share this interest but also have concerns with the specific support offered to them. The government focuses not only on the implementation of values but also service outcomes, the costs of service provision, and their broader implications related to the services' operational level and budget for public spending allocation. Regulators look at service provision from the perspective of evaluating current standards and proposals framed to improve such standards. Managers and practitioners are involved as service providers and have their own approaches to implement values and improve standards (*cf.* Waive *et al.* 2005).

Moreover, care can be based on the care's place (locus) and provider. The care's place can be at home, in the community, or in an institution, while the care's providers can be family, voluntary, private, or state (*cf.* HelpAge International 2013). Residential and institutional care both refer to care provided by state or private organisations, such as nursing or old-age homes. Furthermore, a care's place in the community can be based on the provider: state or private, and family or voluntary. Care of the elderly is provided by state/private in some types: continuum, integrated, formal, and long-term care. Meanwhile, some care types are provided by a combination of state/private and family/voluntary, such as day care, community care, and community nursing.

According to the World Health Organisations (WHO) in HelpAge International (2013), integrated care is a concept that brings together inputs, delivery, management, and organisation of services related to diagnosis, treatment, care, rehabilitation, and health promotion. Integration aims to improve services related to access, quality, user satisfaction, and efficiency. At home, the elderly can get care services from state/private such as domestic and home care. Home help and home nursing are located between state/private and family/voluntary. Meanwhile, care of the elderly provided fully by family/voluntary at home is regarded as family care and filial care or filial piety. Figure 2.1 shows the dimensions of care to illustrate the typology of care more easily.

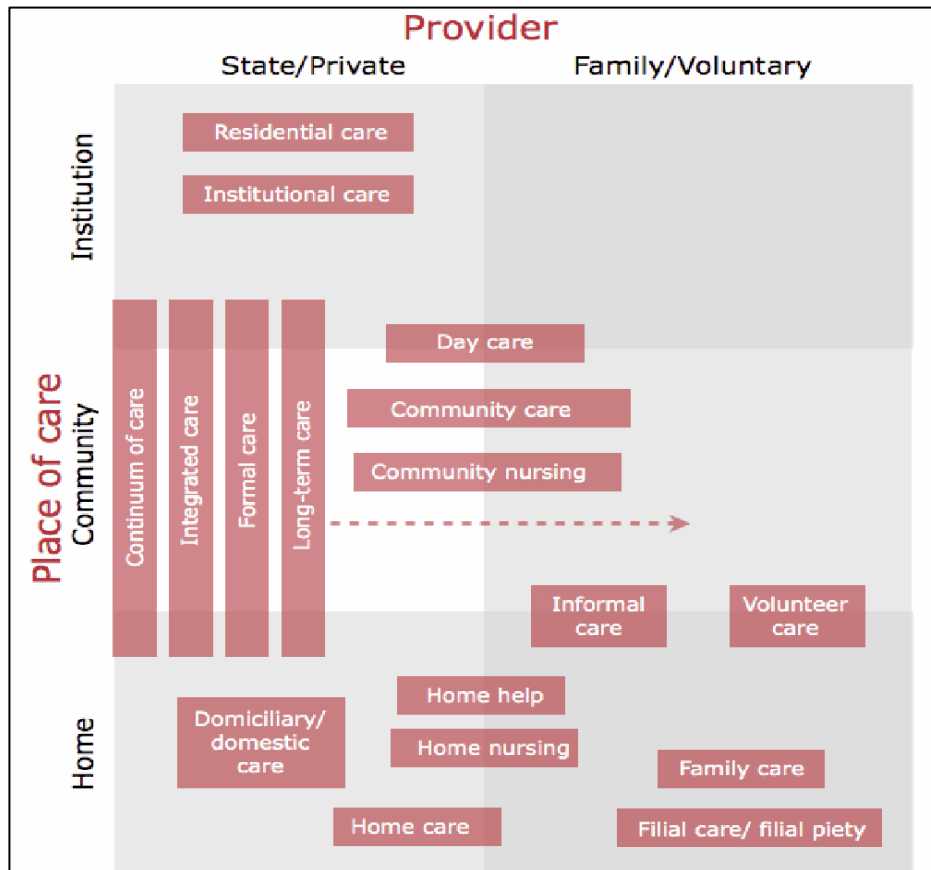


Figure 2.1 Schematic Representation of the Dimensions of Care
Source: HelpAge International (2013).

This research will attempt to give a clear understanding of terms and services about care of the elderly based on the representative dominant position of care locations and providers.

Firstly, this research takes into account the types of institutional state or private care services. Specifically, it refers to *Panti Jompo* ('Old Age Home') and *Puskesmas Santun Lansia*.

Secondly, as regards the place of care in a community, this research takes into account the type of community care which is combining service providers between state/private and family/voluntary care.

Thirdly, the terms of family care, filial care, or filial piety are often used interchangeably to denote care of the elderly at home. However, family care refers to the care provided by family or close relatives, usually a spouse or adult children, including personal, social, health, and financial support which usually occurs over a prolonged period of time (*cf.* HelpAge International 2013). This research regards family care and filial piety as a culturally-based moral obligation to the elderly, and by consequence seeks to introduce at the national level an integrated configuration of traditional, transitional and modern forms of culturally appropriate care of the elderly with a view to improve the health and well-being of the elderly in the communities in the research area and beyond.

2.2 Kinship

The kinship concepts describe kinship groups and the norms that govern marital forms, family structure and organisation, inheritance, authority, and residence. The kinship and residence patterns are tangible manifestations of more individual or collective cultural orientations (*cf.* Keith 1992). Olson *et al.* (2011) state that all cultures recognise kinship- the relatedness of certain individuals within a group - and have norms and expectations that govern kin behaviour. Kinship groups range from nuclear to extended families. The nuclear family, the smallest of the elementary kinship units, usually consists of two parents and their dependent children. The nuclear family is also known as a conjugal family system that emphasises marriage relationships. Meanwhile, the consanguineal family system emphasises blood ties more than marital ties. In the consanguineal system, married couples and their children are embedded in a larger kinship group of three or more generations related by blood. It also includes extended families. In a nutshell, an extended family consists of a nuclear family and those people related to its members by blood ties, such as aunts, uncles, cousins, grandparents, etc. (*cf.* Olson *et al.* 2011).

Cultural norms influence concepts of lineage or lines of descent: who holds authority in a family, and where newly married couples should reside. Lineage is important to determine membership in a particular kinship group, patterns of inheritance, and kinship obligations or responsibilities (*cf.* Olson *et al.* 2011). Das Gupta (2009) states that kinship systems shape the relative value of girls and boys largely through rules of inheritance. Moreover, Keith (1992) states that residence patterns are strongly related to kinship types which often determine sponsorship into households. In general, kinship systems can be divided into two types: lineal and bilateral kinship. Lineal kinship emphasises interactions among lineally related kin, perceived as common descent from an ancestor through the male line in patrilineal systems, and the female lines in matrilineal systems. Meanwhile, bilateral kinship traces the relationship of an individual through both parents (*cf.* Keith 1992). Bilateral kinship makes children tied equally to relatives of both mother and father. The differences in those types are also related to inheritance and residence patterns.

The patrilineal system focuses on inheritance through the male line and tends to occur in the patrilocal residence: a newly married couple live with or near the husband's patrilineal relatives or kin, usually his father's kinship group. In contrast, the matrilineal system focuses on inheritance through the female line and has a parallel relationship to matrilocal residence. Newly married couples normally live with or near the wife's kin, especially her mother's kinship group. Furthermore, bilateral systems recognise people inheriting from either the father's or mother's side. Moreover, bilateral kinship often occurs with neolocal residents which encourage newly married couples to have considerable choices in their household. Newly married couples can establish a separate, self-sufficient residence, living far from each partner's kinship group (*cf.* Keith 1992; Olson *et al.* 2011; Das Gupta 2009). Keith (1992) argues that the relationship between kinship, household formation, and care-taking are relevant to consider on what basis a person is recruited or sponsored into a household, and what relatives are likely to live together which may be potential care-givers and receivers.

2.3 Family System

Olson *et al.* (2011) describe three characteristics of family systems to understand and improve people's quality of life. The three dimensions of family systems that have been found are: (1) cohesion, (2) flexibility, and (3) communication. Family cohesion is the emotional closeness a person feels to other family members, which include commitment and spending time together. First, commitment to the family means trust, honesty, dependability, and faithfulness. Moreover, spending time together means commitment to sharing activities, feelings, ideas, and enjoying each other's company. Second, family flexibility is the ability to change and adapt when necessary, to resolve family matters and spiritual well-being, including the spiritual beliefs that guide family members through life's challenges. The ability to address family matters means using personal and family resources to help each other, accepting crises as challenges rather than denying them, and working together to settle family matters.

Furthermore, spiritual well-being includes happiness, optimism, hope, faith, and a set of shared ethical values that guide family members through life's challenges. Third, family communication is related to sharing of information, ideas, and feelings with each other showing positive communication, appreciation, and affection. Positive communication includes having open, straightforward discussions, being cooperative rather than competitive, and sharing feelings with each other. Moreover, appreciation and affection include kindness, mutual caring, respect for individuality, and a feeling of security. Olson *et al.* (2011) concludes that strong families are those that have good family cohesion, flexibility, and communication.

Olson *et al.* (2011) emphasise not only the family systems but also the sociocultural characteristics where families live. The sociocultural aspect is important because each ethno-cultural group has a culture which makes it easy to understand families. The cultural contexts can influence a wide variety of aspects, such as family values and behaviours, communication between parents and children, power and gender roles, work and the family, ethical and religious values, and the role of the extended family and people outside the immediate family in helping out in family matters (*cf.* Olson *et al.* 2011). Moreover, Olson *et al.* (2011) describe three sociocultural characteristics related to the family system: (1) the extended-family system encompasses relatives, kin, and other family members connected to the family system, (2) the social system includes the economic, educational, and other related resources, and (3) the belief system refers to a family's spiritual beliefs and values. Figure 2.2 shows how the family system characteristics and the sociocultural features can be synthesised.

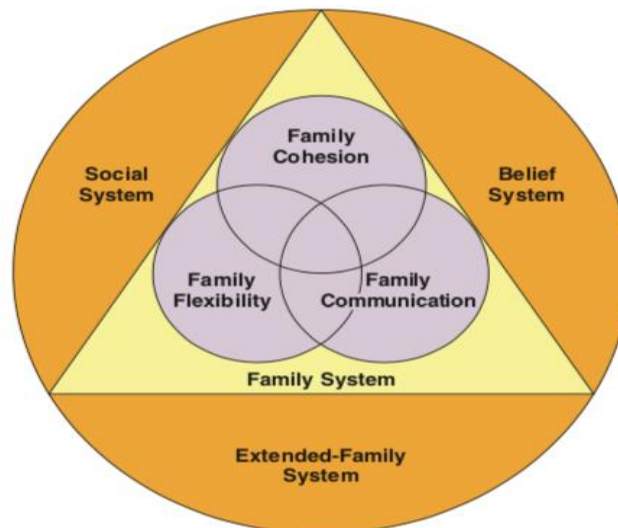


Figure 2.2 Socio-cultural Context and Family System Characteristics.
Source: Olson *et al.* (2011).

2.4 Social Support System

Social care is defined as assistance in three main areas: (1) activity of daily living (ADL), (2) instrumental activities of daily living (IADL), and (3) social support. ADL refers to basic self-care tasks, such as walking and moving around, bathing, dressing, toileting, and eating. Meanwhile, IADL refers to activities for an independent lifestyle, such as helping with the house cleaning, cooking, shopping, getting around, accompanying someone to go to a doctor, managing communications, finances, and medication. Finally, social support means assistance to foster more significant social interactions and emotional well-being, provided when delivering ADL and IADL assistance. The social support includes activities which entertain and maintain relationships with each other, joining social communities and religious activities (*cf.* HelpAge International 2015). Social support which is included in the component of social care is important. HelpAge International (2015) reports that many elderly, particularly in East and South-East Asia, present even greater challenges associated with social interactions than with their practical daily activities, such as ADL or IADL. It is because the financial

support and health care offered by health professionals highlight more their physical health needs than their psychological needs. Providing social support to the elderly such as companionship, community interaction with each other becomes an essential part of meeting overall care needs and positively affects physical health for the elderly.

Related to social support, Cantor's model (1977) as cited in Cantor & Brennan (1999) has conceptualised the social support system of the elderly as a series of concentric circles, each containing a different type of support element or sub-system. In this model, the elderly are the centre and the sources of support based on the degree of social distance from the older person (*i.e.* nearest to farthest) and the organisation of the support element (*i.e.* informal to formal). The primary informal support comes from those who are closest and most involved in the elderly's daily life such as spouse, children, children-in-law, and grandchildren. The second circles are the informal support relationships from other kin such as friends and neighbours. The next circle is the quasi formal, known as mediating structures such as religious organisations, ethnic, cultural, or social and neighbourhood groups. These groups often serve a link between the individual and society. In the two outer circles are the public and voluntary service organisations, including the formal support system (*cf.* Cantor & Brennan 1999). Figure 2.3 presents the social support system, which is a part of the social care system for the elderly.

Furthermore, the concept of social support consists of three aspects: (1) structural aspects, (2) functional aspects, and (3) appraisal support (*cf.* Chen & Silverstein 2000). The structural aspects of social support constitute the social network and the availability of people in the network to help the individual; the functional aspects represent the amount of instrumental, emotional, and financial help; and the appraisal of social support represents the subjective evaluation of the degree of satisfaction with the support. Cutrona & Suhr (1992) define five general categories of social support, consisting of: (1) informational, (2) tangible, (3) emotional, (4) esteem, and (5) social network support. Cutrona & Suhr (1992) also divide these support types into two broad categories: action-facilitating and nurturant support. Action-facilitating support is intended to help the stressed individual resolve or address the matter causing the stress, including informational and tangible support.

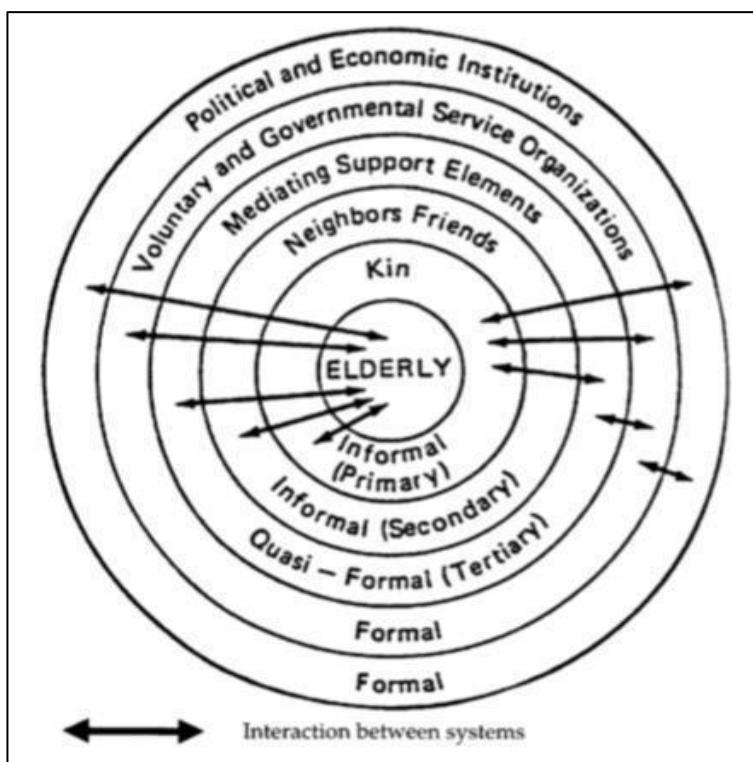


Figure 2.3 The Social Care System of the Elderly by Cantor's Model.
Source: Cantor & Brennan (1999).

Informational support refers to messages that include knowledge or facts, such as advice, factual input, and feedback in actions. Tangible assistance includes offers to provide needed goods (*e.g.* money, food) and services (transportation, housework) to recipients.

Meanwhile, nurturant support encompasses efforts to comfort without direct efforts to resolve the matter causing the stress. Nurturant support includes emotional, network, and esteem support. Emotional support includes expressions of caring, concern, empathy, and sympathy. Social network support emphasises the message that enhance a sense of belonging to a specific group with similar interests, situations, or concerns.

Finally, esteem support refers to expressions shown for people related to one's skills, abilities, and intrinsic values. Tang (2008) also describes three types of social support related to elderly caregivers, such as (1) informational support, (2) tangible assistance, and (3) emotional support. The informational support refers to others' guidance and advice, which help the family caregiver understand and manage stressful situations. Tangible assistance is the instrumental behaviours and goods which directly subsidise the primary caregiver's caregiving responsibilities. The emotional support that caregivers receive refers to others' behaviours that promote the primary caregiver's feelings of comfort, ease, and security.

2.5 Institutions and Organisations of Elderly Care

As mentioned in the Introduction, the concept of institutions encompasses different socio-cultural and individual formations in the community or society, which is created by people over generations in order to structure their collective rules, norms, beliefs, values, interactions, and behaviours (*cf.* Slikkerveer 2014). This research replicates Slikkerveer's concept (1990) of plural medical systems where he introduced the traditional, transitional, and modern medical system used by various ethnocultural groups in the Horn of Africa. In this context, the concept of the plural elderly care system relates to care for the elderly: traditional elderly care institutions, and transitional, and modern elderly care organisations. In order to explore and understand the role of the traditional elderly care institutions within the overall plural elderly care system, this study seeks to collect and document local knowledge, practices, and beliefs in the utilisation of elderly care institutions and organisations in the research area.

Incorporation of the cultural dimension in societal development became a foundation for an ethno-science perspective in sustainable development studies (*cf.* Warren, Slikkerveer & Brokensha, 1995).

2.5.1 The Traditional Elderly Care Institutions

The word 'traditional' in this context refers to the elderly's home care where they can receive care and support services in their home. Backman & Hentinen (1999) and Železnik (2007) state that home care is much less expensive than organisational care, and the elderly living at home are considered to improve their life quality. In the context of care, the elderly can handle all of their daily activities by themselves, including their health or illnesses. It is called self-care when the care is provided by her/himself in response to her/his needs. In this case, both the care provider and receiver are the same person. Železnik (2007) states that self-care is associated closely with both the past and future life of an old person. Moreover, older people's self-care knowledge contribute to the understanding of many aspects of self-care and its associations with vulnerability in future life.

Backman's model in Backman & Hentinen (1999) focuses on precondition, activity, and the meaning or purpose of self-care in the home-dwelling elderly. Self-care preconditions mean the elderly's life experiences including their background, personality, health and ageing. Furthermore, self-care activities include taking care of the elderly's health, illnesses, and engaging in daily activities. Finally, the self-care purpose is composed of attitudes towards other people, ageing, and the future (*cf.* Backman & Hentinen 1999). Backman's model presents four different types of self-care: (1) responsible, (2) formally guided, (3) independent, and (4) abandoned self-care. Each type implies a

specific self-care behaviour style, life experiences, and orientations towards the future. In the model developed by Backman (Backman & Hentinen 1999), responsible self-care is defined as activities and responsibilities in daily activities about health and illnesses. The precondition for responsible self-care is to have a positive outlook for the future and a positive experience of ageing. For example, the elderly can understand why they receive treatments or medication, and they have the right to decide. People also believe that in the future if they need any help from others, they will receive it.

The second type is formally guided self-care which consists of regular but uncritical observance of medical instructions and routine performance of daily tasks. The elderly may do something as instructed but they do not know the reason for doing it. The elderly obey all instructions concerning their health care including taking medicine and food. However, they do not know why they have to do it. Formally guided self-care also means a tendency to accept life as it comes. The elderly hope to stay at home as long as possible, but they also understand that someday they would probably go to one of the institutions or organisations (*cf.* Backman & Hentinen 1999).

The third type is independent self-care based on the elderly's desire to listen to their own internal voice. They have original ways to take care of their daily activities, health, and illnesses. The precondition of independent self-care aims to manage the elderly's life independently. The meaning of independent self-care is an attempt to maintain life's constancy. In this context, if the elderly notice that something is wrong with their health, they may not seek help, but rather find out what to do on their own. Life experience is the best teacher for them. The elderly may think that their home is a safe place, thus they want to stay at home now and forever. They resist ageing and deny the prospect of growing old. The elderly also compare themselves to others and think that they are much healthier than others (*cf.* Backman & Hentinen, 1999).

Abandoned care, on the other hand, is characterised by helplessness and a lack of responsibility. The elderly may not care about themselves. They are no longer able to manage their daily activities and feel helpless for different reasons. For example, some elderly may be unable to read anymore, lose their ability to hear, and do not remember things. These inability are associated with a desire to give up, leading to a situation where the elderly have a negative attitude towards ageing. Many factors affect the self-care of the elderly which are divided into external and internal factors. External factors consist of living conditions, different services, and social support, while internal factors consist of the elderly's health and sufficient functionality (*cf.* Backman & Hentinen 1999).

Strain (1991) finds that health beliefs may affect the use of the health care system including health services by the elderly person while the health locus of control appears to be unrelated to health service utilisation.

In traditional elderly care, the elderly may stay at home alone, with their spouse, or family and receive the family's care and support at home. Families play an important role in the process of care of the elderly, starting from planning, implementation, and decision making. Fan (2007) reports that the elderly prefer to receive care from the family to care institutions for five reasons: (1) family care embodies the character of love, intimacy, sincerity, warmth, and security, (2) the elderly feel more dignified, individualised, autonomous, free, and flexible, (3) the elderly can receive more personal care suitable to their particular personalities and religion practiced, (4) family care is particularly good for the elderly suffering from dementia because it is easier for them to recognise their family faces and to adapt to the familiar environment, and (5) family care at home is cheaper than organisational care, such as an old age home.

Most Javanese think that children must take care of their parents (*cf.* Koentjaraningrat 1957). It includes respect toward parents who become one of the categories of action of filial piety. However, for the elderly who do not have children, they can receive support and care from other family members or kin, such as friends and neighbours. Traditional elderly care involves the provision of care and social support provided by friends and neighbours, including informal care. Cantor (1979) states that although family structure has changed and is continuing to change, informal support networks still exist and are composed of kin -children, spouse, and relatives- friends, and neighbours. However, interaction between the elderly and their informal social support network varies across urban and rural areas, and ethno-cultural and socioeconomic strata (*cf.* Cantor 1979).

2.5.2 The Transitional Elderly Care Organisations

Transitional elderly care denotes the elderly's care provided by the local community and government. It can also be called community-based care, providing the elderly and their families with supplemental care and offering respite care and other needed support which adult children cannot provide. The desired goal of community-based services is to decrease service costs and improve care quality. However, Xu & Chow's (2011) research in China finds that a western assumption cannot be fully implemented in the eastern related to community service delivery due to social, political, and traditional differences. Western community-based service delivery is primarily organisation-centred where the elderly can receive the care service in the community. An organisation's services to the community are not only limited to fill a service gap provided by family or to substitute when no family takes care of the elderly but also to design and develop programs for the elderly independently.

The western community-based service delivery depends on professional providers, mainly non-governmental social service organisations. In contrast, Eastern community-based services tend to rely on the transformation of quasi-governmental community organisations. Moreover, the maturity of non-governmental social service organisations for the elderly is not the same between east and west. For example, in China, quasi-governmental organisations in urban neighbourhoods and rural villages are more developed than non-governmental social service organisations (*cf.* Xu & Chow 2011). Jette *et al.* (1995) state that informal community services include care provided by family members and/or friends for the elderly, whereas formal community services reflect care provided by private and public agencies or privately hired individuals.

China is one of the Asian countries that tends to take care of older people based on family care. China has designed community-based services for delivering care and support for the elderly focusing on shared responsibility among individual, family, local community, private sector, and government at the local, provincial, and national level. Xu & Chow (2011) state that the primary motivation of providing community-based care in China is to fill in the gaps between needs and support services which the family or the government are unable to provide. Community-based care can supplement traditional family care. Moreover, Siegler *et al.* (2015) also state that community-based care are designed to help older adults to remain safely at home within their community and avoid institutionalisation.

Xu & Chow (2011) differentiate the model of community-based services in China based on the following three characteristics: (1) using a mixed vertical-horizontal structure instead of the agency-centered social services model adopted in the West, (2) managed and/or organised by quasi-governmental community organisations instead of non-governmental social service organisations, and (3) provided primarily by private small business service providers and/or volunteers rather than professionals. Community-based care mixes both vertical and horizontal models (*cf.* Xu & Chow 2011). In the vertical model, service implementation involves the role between city government and the relevant agencies. Furthermore, services delivered in the vertical model are funded directly by municipal governments, and most services are free or with minimal fees. Xu *et al.* (2003) established a community health service centre model where nearly all services are funded by local public health departments, provided by professionals associated with local state-owned hospitals. In Indonesia, the implementation of community-based care of older people is through health care activities in the *Posyandu Lansia* and social care activities in as *Karang Werda* (*cf.* Kadar *et al.* 2013).

On the other hand, community-based care refers to the horizontal model whose number and quality of services depend on local funding, the residents' needs, the community's resources, and capacity to deliver services. It requires local community initiatives, a high level of community participation, and deep involvement of community organisations and volunteers (*cf.* Xu & Chow 2011). The transitional elderly care combine local community and government to give care of the elderly, which is called quasi-governmental community organisations (*cf.* Xu & Chow 2011). In some cases, the elderly in the community initiate to pay the services they received with relatively low cost, and sometimes also free of charge.

Social services in communities aim to supplement traditional family care and to fill in the gaps between needs and the care that the government and the family are unable to provide (*cf.* Xu & Chow 2011). Hence, community-based care can be the solution to the limited organisational care such as old-age home and help the family to fulfil the elderly's care and services.

2.5.3 The Modern Elderly Care Organisations

Modern elderly care means the elderly's care provided by the government or private organisations. It refers to organisational care, which is often delivered in hospitals for health care or in residential centres such as old-age homes for social care (*cf.* HelpAge International 2015). For social care, the elderly stay in a place other than their living environment, such as *Panti Jompo*. The provision of care and support for the elderly in *Panti Jompo* is classified into two types: old-age homes managed by the government, and the private sector.

Old-age homes managed by the government focus on care and support provision for the elderly who are neglected or do not have families. *Dinas Sosial* ('Social Affairs Office') has a role to manage, support, and control the implementation of care and support-giving in government old-age homes. The government covers the elderly's needs such as clothing, food, socialisation, religion, and recreation. Moreover, *Dinas Sosial* cooperates with *Dinas Kesehatan* ('Health Office') to give services for the elderly on medical aspects such as health checks, medication, medical resources, *e.g.* nursing and doctor (*cf.* Sumini *et al.* 2020). Old-age homes fully managed by the government are generally intended for the elderly who are under the abandoned category and do not have family or relatives who can take care of them. The government fully manages and funds old-age homes.

On the contrary, old age homes owned by private organisations are fully managed by the private sector. To access care and support in private old age homes, people must be willing to pay (*cf.* Sumini *et al.* 2020). In other words, the elderly need families, relatives, or people responsible for paying the service cost. Operational funding in private old-age homes is charged to the elderly's family. However, the operational management of service provision is fully managed by private old-age homes. Hence, the family's role in the elderly's care in private old-age homes is limited or not as much as the family's role in traditional elderly care (family care).

Zhan *et al.* (2006) found unfair competition between governmental and non-governmental elderly homes in China which can be seen in the home facility, quality, and client composition. Government-funded old-age homes have buildings and land, and require no additional investment or payment. Meanwhile, private old-age homes tend to have simpler and lower quality facilities, and need to receive payment for reinvestment. Furthermore, the facilities of government-owned old-age homes are much better than their private counterparts for the following reasons. First, government old-age homes can affiliate with hospitals. Second, government-funded old-age homes are far more likely to involve social activities including social interactions offered to residents, such as interaction with students, community residents, volunteers, and the media because they attract more attention from government officials. On the other hand, in non-governmental old-age homes, social activities depend on the arrangements made by the administrators, personal, and social networks that they have. Third, only rich families, upper class, or retired government employees will get such services from old-age homes, while poorer people have fewer options in choosing old-age homes (*cf.* Zhan *et al.* 2006).

The elderly can also receive health care in modern elderly care organisations through hospitals: care is delivered by trained professionals and organisations for the elderly, known as formal care (*cf.* HelpAge International 2013). Modern elderly care includes formal care because it involves a professional person who gives health care services for the elderly. In this context, the modern elderly care organisation related to health care is *Puskesmas Santun Lansia*. The implementation of care of the elderly in modern care organisations has binding and compelling rules for anyone involved because the care authority for the elderly is fully managed by the management of the modern care organisations.

2.6 Towards Integrated Care of the Elderly

2.6.1 Indonesia's Introduction of the Decentralisation Reform

The ageing population increases the elderly's need for care. Care focuses not only on health care but also social care. Increasing numbers of older people require the government to prepare a better health care system that accommodates elderly health care needs. Unmet health care needs for older people are generally found along with elderly people's health matters (*cf.* Kshetri & Smith 2011; Herr *et al.* 2014). The factors that allow elderly health care needs to be met will be classified into three points: (1) availability, (2) accessibility, and (3) acceptability. Availability refers to the waiting time to get the service, an unavailable service when it is required, or unavailable service in the area. Accessibility also includes cost of services and transportation concerns. Acceptability also includes attitudes towards and knowledge about health care, and the reasons for attitudes and responsibilities about health care (*cf.* Chen & Hou 2002).

The Government of Indonesia applied the decentralisation reform in 1999, which also impacted all citizens' health services. The decentralisation of the health system brings about changes in planning and service delivery management from the Ministry of Health to local governments. It has a role to impose a regulation to ensure resource availability, including personnel to supervise social insurance schemes. Moreover, the Ministry of Health also continues to operate some tertiary and specialist hospitals. Meanwhile, the health service at the local government is divided into provincial and district/municipality levels. The provincial governments own provincial hospitals, and organise health matters within the provincial level and across the district/ municipality. Moreover, the district/municipality governments own district/municipality hospitals and organise health services provided through primary health centres. However, the relationship between the Ministry of Health, provincial, and district/municipality health offices is not hierarchical because each level has its own mandates and areas of authority (*cf.* Mahendradhata *et al.* 2017). The elderly can get health care through primary and secondary health care centres including *Pusat Kesehatan Masyarakat* (*Puskesmas*) in the sub-district level and *Pos Pelayanan Terpadu* (*Posyandu*) in a village area.

The Government of Indonesia has established health care centres for the elderly known as *Puskesmas Santun Lansia* and *Posyandu Lansia*. Secondary health care centres refer to hospitals at the district/municipality level. The implementation of health care centres at the sub-district level and in the villages is controlled by *Dinas Kesehatan* ('Health Office') at the district level.

The elderly also need to receive social care which includes social support and psychological well-being for the elderly. East Java proposes an empowerment organisation which supports the elderly by *Karang Werda*. The Governor of East Java issued a *Surat Keputusan* ('Decree') Number 65 of 1996 about guidelines for the formation of as *Karang Werda*. It was then followed by another Decree Number 188/309/SK/014/1999 about the formation of a supervisor team to empower the elderly from the province to the village or urban village levels in East Java.

In Indonesia, social security was initiated in 2004 through *Sistem Jaminan Sosial Nasional* (SJSN) ('National Social Security System') which covers all Indonesians including the elderly. On the one hand, social security schemes include pension, old-age savings, health insurance, working accident protection, and death benefits (*cf.* Bappenas & GTZ 2008; Widjaja & Simanjuntak 2010). However, BPS (2017) reports that elderly households who are under social security accounted for 18.83% in the cities and only 6.47% in the village. This amount covers a small percentage of elderly in Indonesia both in rural and urban areas. *Badan Penyelenggara Jaminan Sosial* (BPJS) ('Government Social Security Agency') carries out the distribution of social security for the elderly.

On the other hand, the Government of Indonesia also gives social assistance to the elderly who are categorised as poor and vulnerable through some programs, such as *Program Keluarga Harapan* (PKH) ('Hope Family Programme'), and *Asistensi Sosial Lanjut Usia Terlantar* (ASLUT) ('Assistance to Displaced Older People'). However, BPS (2017) reports that there were only 2.99% of elderly living in urban areas and 5.50% in rural areas who accepted PKH. Moreover, 30,000 elderly as ASLUT recipients are found all over Indonesia.

Moreover, *Badan Kependudukan dan Keluarga Berencana Nasional* (BKKBN) ('National Population and Family Planning Board') has initiated the *Bina Keluarga Lansia* (BKL) programme ('Elderly Family Development'). BKL was established to fulfil the elderly's needs through a family-based approach. It focuses on the family and community capacity building of family resilience, particularly the elderly's health, economic productivity and social interactions to create quality life for its members, including the elderly and their family members (*cf.* Perdamaian *et al.* 2000). The aim of BKL is to assess the family's knowledge, attitudes, and practices in implementing the elderly's well-being. Moreover, BKL comprises seven dimensions of elderly well-being: spiritual, physical, emotional, social community, environmental, vocational professional related to economic and financial aspects, and intellectual (*cf.* Astuti & Winarni 2018).

2.6.2 Integrated Elderly Care for Sustainable Development

The innovative strategy of *Integrated Community-Managed Development* (ICMD), introduced by Slikkerveer, Baourakis & Saefullah (2019) has introduced a solid contribution to current 'human development approaches' of the United Nations through the promotion of the integration of local and global systems of knowledge and technology with a focus on the instrumental role of indigenous institutions for increased community participation. Since such approach provides a community-based contribution to the realisation of the *2030 Agenda for Sustainable Development Goals* (SDG) of the United Nations (2015a), it has immediate relevance for sustainable integrated elderly care development in Indonesia.

Indeed, following the previous *Millennium Development Goals* (MDG) of the United Nations (2000), the *2030 Agenda for Sustainable Development Goals* (SDG) of the United Nations (2015a), further elaborated the objectives including the focus on good health and wellbeing being essential to achieve sustainable development. Although recently, certain advancement has been made in the study of key factors associated with good health and quality of life, progress is globally yet uneven. The Sustainable Development Goal no. 3 shows the complexities of care, health and well-being, there is still a need of interdisciplinary evidenced-based research on the indicators operational in this goal (*cf.* Springer Nature 2022).

Collaborative evidence-based approaches to public policy and healthcare policy and practice are essential not only in addressing inequalities, but also in building trusted sustainable ways forward in which to ensure good health and wellbeing for all. Through the research we publish we hope to play our role in not only supporting researchers in both the publication and development of their work in this area, but also in enabling greater access to high-quality content to assist policy-makers, governments and humanitarian organisations, in making research-backed decisions to advance the international wellbeing agenda.

While a growing number of older people in the developed nations, such as the United States are posing a challenge to the providers of elderly care as health care demands high quality care in an economic environment of decreasing financial resources, the situation in Indonesia provides the opportunity to overcome similar challenges in a less-financial but rather socio-cultural approach in a nationwide reorientation towards the integration in a unique cultural context of the community-based traditional institutions of *gotong royong*, *bakti*, *sayan* and similar traditions which have rendered the health and well-being of the elderly functional over many generations at the community level.

The approach of the Indigenous Knowledge Systems (IKS) of local people has shown to be very important to contribute to the above-mentioned *2030 Agenda for Sustainable Development Goals* (SDG) of the United Nations (2015). As mentioned above, the 'Leiden Ethnosystems' Approach' introduces the study of Indigenous Knowledge Systems (IKS) by linking the cognitive aspect of investigating the local systems of knowledge, practice, and belief to the behavioural components in the development process and changes in the community over generations.

The Leiden Ethnosystems And Development Programme (LEAD) has taken one further step to attain sustainable community development in several sectors of the society, by designing the IKS-based Integration Model (IKSIM). Slikkerveer, Baourakis, & Saefullah (2019:15) emphasise that IKSIM:

‘embarks on the integration and interaction of local and global systems of knowledge, practices and institutions as a stepping stone for the newly-developing concept of Integrated Community-Managed Development (ICMD).’

Moreover, the IKSIM of ICMD encompasses the three interrelated worlds as the foundation: indigenous knowledge systems, institutions, and cosmology, which focus on the decision-making processes of the community members and developing the vertical ‘bottom-up’ approach towards sustainable community development (cf. Slikkerveer 2019a). The position of indigenous institutions is important to develop a strategy process to implement ICMD.

Indigenous institutions involve the perspectives of local people on their culture and life. In Indonesia, the indigenous institutions have existed for many generations with local values such as cooperation, mutual aid, and neighbourhood support at the community level, Slikkerveer *et al.* (2019:19) state: *‘the approach of Integrated Community-Managed Development (ICMD) is dedicated to attaining sustainable development through the integration of local and global systems of knowledge and technology among all sectors of the community through capacity building and participation at the village level.’*

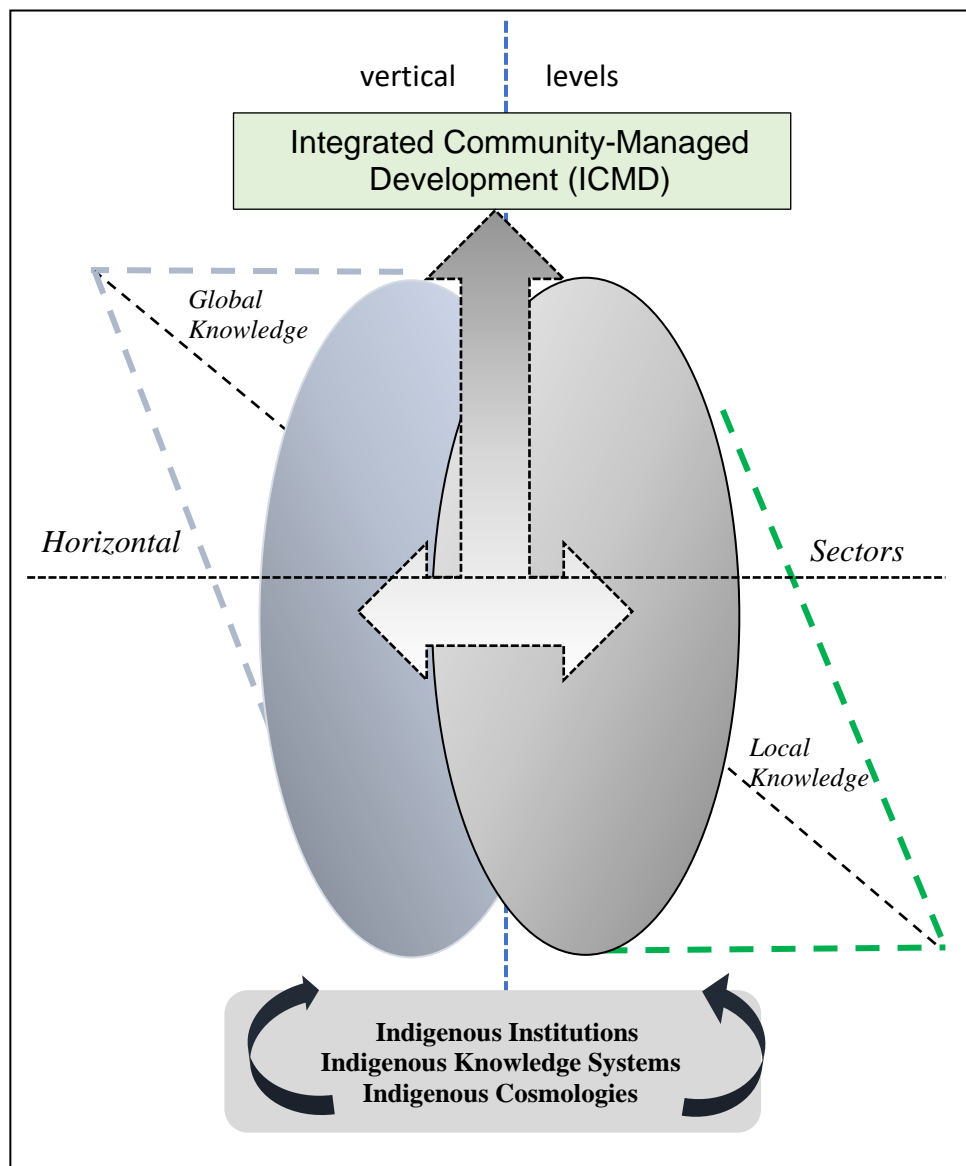


Figure 2.4 Representation of the *IKS-Based Integration Model (IKSIM)* of Integrated Community-Managed Development (ICMD).
Source: Slikkerveer (2019a).

Given the significance of the conceptualisation of this IKS-based integration approach of integrated elderly care development in Indonesia, Figure 2.4 shows the *IKS-Based Integration Model (IKSIM)* of Integrated Community-Managed Development (ICMD) (*cf.* Slikkerveer, Baourakis & Saefullah 2019).

In this context, the particular situation of the age-long practice of elderly care among the various ethno-cultural groups in Indonesia, including the Tenggerese people in East Java, rooted in the indigenous institutions which have been practiced to maintain and prolonged the care and support of the elderly, provides a unique opportunity to propose an evidence-based ‘bottom-up’ strategy of integration of the traditional institutions with the transitional and modern organisations care of the elderly in the Tengger Region of East Java.

2.6.3 The Case Management Approach for Integrated Elderly Care

Integration is a coherent set of methods and models on funding, administrative, organisational, service delivery, and clinical levels which is designed to create connectivity, alignment, and collaboration (*cf.* Kodner & Spreeuwenberg 2002). In this context, the case management system approach is also functional for the development of integrated elderly care in Indonesia. Goodwin (2016) states that integrated care is characterised by complexity involving five points: (1) the type of integration (*i.e.* organisational, professional, cultural, technological), (2) the level at which integration occurs (*i.e.* macro, meso and micro), (3) the process of integration (*i.e.* how integrated care delivery is organised and managed), (4) the breadth of integration (*i.e.* to a whole population group or specific client group), and (5) the degree or intensity of integration (*i.e.* the linkages between informal care and managed-care coordination with fully integrated teams or organisations).

Moreover, integrated care takes some forms, such as horizontal, vertical, sectoral, people-centred, and whole-system integrations (*cf.* Goodwin 2016). Horizontal integration means integrated care between health and social services, and other care providers based on the development of multi-disciplinary teams and/or care networks that support a specific client group. Vertical integration means integrated care across primary, community, hospital, and tertiary care services. Sectoral integration means integrated care within one sector which combines horizontal and vertical programmes. People-centred integration means integrated care between providers, patients, and other users of care to engage and empower people through health education, shared decision-making, supported self-management, and community engagement. Whole-system integration means integrated care that embraces public health to support both a population-based and person-centred approach to care (*cf.* Goodwin 2016).

Many developed countries, such as England, Canada, and Australia, attempt to integrate case management approaches into their elderly care systems to provide comprehensive services for community-based older people (*cf.* You *et al.* 2012). The Case Management Society of America (CMSA) (2010:8) defines case management as: ‘*a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost-effective outcomes.*’ Case management focuses on two primary purposes: quality and costs of care (*cf.* Long 2002). Case management aims to improve the coordination of health and social care which needs interventions from case managers. Those who may be involved in case management are health professionals (*e.g.* nurses) and social workers (*cf.* Long 2002). If social workers are the case managers, they are more likely to use the social work perspective which encourages workers to incorporate the elderly’s strengths, family (spouse, children, etc.), friends, and the community to make independent living possible (*cf.* Early & GlenMaye 2000).

Moreover, Wodarski & Williams-Hayes (2003) state that professional case managers and social workers should be familiar with the community’s resources in order to make an effective link between the elderly clients’ needs and existing resources. Health professionals have more constraints to pick up unmet social needs for the elderly than social workers who are well trained and prepared for it (*cf.* Keigher 2000). To sum up, case management is one approach to maintain the elderly in the community.

