Community-Based Support for the Elderly in Indonesia: The Case of PUSAKA

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Paper presented at the 2002 IUSSP Regional Population Conference on "Southeast Asia's Population in a changing Asian Context",
Bangkok, Thailand, 10-14 June 2002

I. INTRODUCTION

1) Background

As a consequence of demographic transition during recent decades, the Indonesian population is ageing rapidly. One indicator of this new phenomenon, the number of persons aged 60 years and over per 1000, was estimated at 54/1000 in 1980 and 76/1000 in 2000 (CBS, 1983 & 1998)[1]. It is projected that the proportion of the elderly will reach about 8.5 per cent of the total population in 2005 (Ananta, 1995). Although this figure is still quite modest compared with that of societies in more developed countries (18.3 per cent, Neville, 2001), the absolute numbers are significant. With such an increase in the absolute number of the elderly in Indonesia, this age group will reach almost 18 million within the next few years. Many of these will be poor, especially as there is no sign of a speedy economic recovery in Indonesia.

Despite the increase in the number of elderly people, ageing has not yet been identified as an important policy issue in Indonesia. The Government has paid little attention to this group, as can be seen from the lack of access to social security and social services for the elderly. The population priority is still lowering the Maternal Mortality Rate (MMR), the Infant Mortality Rate (IMR) and the Total Fertility Rate (TFR). Even during the last four years, Government efforts have mostly focused on economic recovery.

Actually, awareness of the seriousness of population ageing came rather late – in the 1990s – even among Indonesian demographers and demographers of Indonesia[2]. The dominant demographic discussion at that time warned of an 'aged boom', and focused on the implications of the demographic characteristics of the elderly due to the demographic transition. Medical doctors also focused their attention on the 'aged population' from the medical perspective, concerned with diseases suffered by the old people[3]. Professional organizations dealing with the elderly did/do exist and were/are also active in responding to the needs and concerns of their elderly members. All appealed to the Government to pay attention to the well-being of the elderly and to see population ageing as an integral part of the development process.

It is true that adverse effects of population ageing are not immediately apparent. Consequently, the issue is often overlooked. However, not only is the Indonesian population ageing rapidly in terms of absolute numbers, but

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[1] Appendix 1 provides some demographic data on ageing in Indonesia.

[2] The late Djuhari Wirakartakusuma, Aris Ananta, Evi Nurvidya Anwar and Gavin Jones to mention just a few.

[3] In recent years, more and more efforts from various disciplines work together dealing with aged population issues, as can be seen from various join-seminars.

the social and economic problems that will result from this are considerable. The impact on the socio-economic, psychological and familial aspects of Indonesian society is potentially serious, since Indonesia does not have a comprehensive system of social security, health care and social services for the elderly. Existing services do not cover the needs of the majority of the aged population, especially in the face of recent experience of multiple crises. With the move toward regional autonomy; population ageing is even less of a priority for provincial and local governments, which are struggling to deal with economic recovery and to increase regional income. As a result, one of the most critical demographic and social problems facing contemporary Indonesia is being largely ignored by policy makers.

Existing government programmes for the elderly are limited in terms of funds and resources, rather sectoral, centralized and target oriented. They focus mainly on the poor elderly with specific problems, in particularly those who are neglected with or without families. Such programmes treat the elderly as if their needs and concerns are the same, based on standardized and centralized guidelines for implementation that do not respond to the diverse and changing needs of the elderly population.

Programmes managed by the Department of Social Affairs cover the elderly through nursing homes as well as home-care. Nursing homes are not popular because they are considered expensive to run and have limited coverage. Families also hesitate to use nursing homes, because most Indonesians consider it shameful to send elderly relatives to a nursing home, especially if there are still family members who could provide care. At present, there are approximately 141 nursing homes for the elderly throughout Indonesia, covering 8,308 persons (ASEAN, 2000), a tiny number compared with the size of the elderly population.

By contrast, home-care – allowing the elderly to remain in their own homes and communities while receiving a range of support services – is more acceptable. Home-care is also more cost-effective, and can thus cover more elderly, as well as creating a sense of self-reliance and solidarity within communities. Since the services provided are developed by and for the community, it is expected that they more closely meet the needs of the people concerned.

The Department of Health, Population and National Family Planning Coordinating Board and Department of Manpower also have programmes for the elderly. In general, services for the elderly can be broadly classified into two categories: social care (meals, recreation/sport, and spiritual guidance); and health care (health monitoring, health education, and health services). All Government programmes are coordinated by the State Ministry for People's Welfare and the Alleviation of Poverty, yet it seems that each sector works in isolation. Coordination in programme design and

strategies is weak, and the capacity to build and manage programmes is limited in terms of both funds and resources[4]. As a result, programmes have been limited in scope and impact and fragile in terms of sustainability.

This was particularly evident when Indonesia was hit by the economic crisis in mid 1997. All programmes implemented and/or subsidized by Government, including programmes for the elderly, were severely affected; many were closed and others seriously reduced in scope and coverage. Social programmes were cut at precisely the same moment when they were most needed due to the social and political instability that was created by the economic crisis. As a result, many elderly found themselves among the poorest of the poor. The economic crisis showed clearly that the Government is not yet able to provide a sound institutional care system for its old people[5].

Recognizing its limitation and acknowledging the important role of the community in social development, the Government encouraged the involvement of civil society through NGOs and social organizations in activities for the elderly. Community-based support was also seen as a component of good governance in terms of popular participation in development and self-reliance. In 1998, Law No. 13 on Elderly Welfare was promulgated. It notes among others *'Community has the right and opportunity to play a role in improving the welfare of the elderly'.* The reform era and democratisation also saw a paradigm shift in development programmes, including programmes for the elderly, toward increased community and civil society participation in governance in which government would act only as a facilitator. This resulted in various programmes to promote a healthy and independent elderly population through support from the family and community.

The speed with which this paradigm shift was adopted was also due to the lack of funds and human resources for government actions, and the influence of several international conferences, namely: the 1982 International Plan of Action on Aging, Vienna; 1994 International Conference on Population and Development, Cairo; 1995 Fourth World

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[4] Recently, sponsored by UNFPA and coordinated by the State Ministry of Population/Family Planning Coordination Board, a National Plan of Action for Family Activities in support of the Aged was formulated but is not yet widely socialized.
[5] Currently, Indonesia has no comprehensive national social security scheme. It was only during the monetary crisis that social security was widely discussed by civil society, academicians, activists and donor agencies. In general, there was agreement that a social safety net is needed urgently in the short term. In the longer term, a need for a more sustained national social security scheme was recognized. Existing social security schemes only covered those who have regular jobs and incomes, and are thus limited to government officials, the military and employees in the formal sector. A national scheme was established by Government Regulation No.33/1977 on worker's rights. It has two components: short term security programmes for accidents at work; and long-term security for old age pensions, health and life insurance (Raharjo & Hadianto, 2001).

Conference on Women, Beijing; 1999 United Nations International Year of the Older Persons, and 2002 the Second World Assembly on Ageing – International Plan of Action. A further factor was the new regional autonomy law, which was seen as an aspect of democratisation.

Thus, there is a growing sense of urgency in civil society to support the elderly, as reflected in active participation of the community in programmes for the elderly during the recent economic crisis. The role and contribution of community-based care to support the elderly has long been recognized and appreciated in Indonesia. Indeed, traditional forms of support provided support to the frail and poor elderly even before government programmes were initiated.

More than 400 social organizations dealing with the elderly have been registered in Indonesia. Most are run by Non Government Organisations (NGOs), and nearly all are united under the Indonesia Elderly Institute or *Lembaga Lansia Indonesia*. Their missions are varied: some target the better-off elderly, others are professional organizations, and a few cover the elderly among public servants, and army retirees etc. (Raharjo & Do-Le, 2001). Women initiated the majority of these interventions. All activities are managed and funded by the communities themselves on a basis of community solidarity and voluntary participation, sometimes with help from individuals or donor agencies. These organizations are independent, self-reliant and many continue to flourish despite the economic crisis. In fact, many reinforced their position during the crisis when formal institutions were collapsing.

Thus, community-based care for the elderly has demonstrated its viability as a sustainable alternative to institutional care, even in the context of social and economic instability. PUSAKA, one Home-based Care Centre, has been chosen for this study for several reasons. First, it is one of the oldest and one that is generally considered as successful. Second, it is a community-based care scheme that provides assistance and services to disadvantaged and/or poor old people in the neighbourhood. Third, it both expanded during the period of government control and survived and even flourished during the crisis when government schemes were collapsing. This it has also proven itself as a sustainable alternative to institutional care.

2) Objectives

What lessons we can learn from PUSAKA?

This paper examines how a community-based care system operates in support of the elderly in Indonesia and, more specifically, how it fared during the economic crisis. The paper reviews the origins and history, organization and programmes of PUSAKA. Recognizing that the needs of and obstacles faced by elderly men and women are of different natures, the paper adopts

a gender perspective to examine the impact of PUSAKA on elderly women and men. Its strengths and weaknesses are evaluated in the context of the social and economic changes involved in the recent Indonesian crisis.

Learning from this experience, the study aims to provide insights and some suggestions to assist in initiating, reviving or facilitating community-based care in the country. By doing so, our hope is not only to improve the well being of the elderly but also to ensure the sustainability of the system.

3) Data collection

The paper uses both primary (largely qualitative) and secondary data. The primary data was collected through observation and interviews with organizers, managers and caregivers of some PUSAKA units in Jakarta. How the PUSAKA approach to community-based care responded to or fulfilled the needs of, and addressed the obstacles faced by, the elderly, both men and women, was examined through in-depth interviews with recipients. In addition, the views of some family members of the elderly and some professional organizations on gerontology were also obtained to complete the picture.

Secondary quantitative data were taken from the 2000 National Population Census and the 2000 National Health Survey, while secondary qualitative data was obtained from the literature on the elderly population in Indonesia and elsewhere to better understand the problems and concerns of the elderly in Indonesia.

4) Outline

Section II of the paper describes population ageing issues in Indonesia in the current context. It reviews the demographic basis of population ageing in Indonesian, examines the gender dimensions of ageing, and the socio-economic and political changes associated with the paradigm shift in attitudes to policy and programmes for the elderly in Indonesia.

The case study of PUSAKA examines the community response to the needs of its elderly members, especially those who are poor. The paper shows how demographic, socio-economic and political changes have tended to strengthen and reinforce community solidarity in the multi-faceted crisis that Indonesia has had to deal with in the last few years.

Finally, the paper identifies some issues relating to community-based services for the elderly.

II. THE CONTEXT

The elderly are those aged 60 years and above. The elderly are as heterogeneous as any other population age group both in terms of demographic variables such as cohort, sex, ethnicity, place of residence, and social-economic status, as well as the more qualitative dimensions of their social and economic situation and needs. The majority of the Indonesian elderly entering the 21st century were born in the late 1930s and 40s. The ageing processes involved and their socio-demographic characteristics are quite different from their counterparts born before that time. For example, those elderly are products of public health programmes and modern medical technologies. As a result, their life expectancy and survival rate will be higher; and their educational attainment higher than for earlier generations. However, educational attainment is still relatively low, in particular for women. The majority of the elderly today have at least some education. They have fewer adult children that earlier generations, due to the intensive family planning policies implemented after 1970. Unlike earlier generations, rural-urban migration of their children has resulted in more living without children living with them or nearby. They are thus potentially more dependent on community rather than family, compared to earlier generations. They have also been more directly or indirectly exposed to rapid socio-economic changes, including urbanization/ globalisation.

With an increasingly older age structure, Indonesia's biggest challenge lies in providing support to these elderly, especially the needy. Since the elderly population is diverse in terms of resources, needs and abilities, certainly not all elderly need financial support and/or are dependent in terms of physical assistance. However, poverty remains significant in Indonesia: the number of people living in poverty increased from 17.7 per cent in 1996 to 24.2 per cent in 1998 then 18.2 in 1999 (BPS, 1999). Although individual statistics on the poverty of the elderly are not available, these figures can be assumed to generally reflect the poverty status of the elderly[6].

There are several reasons to emphasis these issues. First, most elderly lack reliable sources of income, and for those with fixed sources, such as pensions or rent, the amounts are inadequate, particularly after the crisis. The largest proportion of the poor elderly in Indonesia worked in agriculture or the informal sector, and belonged to families with low and uncertain incomes with little or no savings (Raharjo & Do-Le, 2001). The traditional stereotype of elderly supported by the family is increasingly irrelevant in Indonesia. Second, there is a general lack of institutional care for old people in Indonesia. The existing system covers a tiny proportion of the elderly (footnote no.5). Third, the current economic crisis in Indonesia has affected most segments of the Indonesian population. But the crisis most seriously threatens the livelihood of vulnerable groups, to which many

[6] Poverty data are collected at the household rather than the individual level.

elderly belong. The poor elderly, many of whom are no longer economically active and are dependent on family support, find themselves in an increasingly precarious situation as poor families seek to survive in a situation of high unemployment and scarce resources.

In a country like Indonesia, the family remains the primarily source of care for the elderly for cultural, as well as economic reasons. Indonesian society places a high value on the traditional role of the family in supplying care to the elderly, who were traditionally honoured. However, for the 16 million persons aged 60 and over in 2000 (expected to increase to 18 million in 2005) dependence on familial care is threatened by the spectre of poverty, as well as other demographic changes linked to migration. Due to the demographic dynamics, as the burden of care increases with the proportion of the elderly in the total population; the capacities of families to care for older parents actually tend to decrease. The social and demographic changes that occur with modernization, in Indonesia as elsewhere, tend to alter the structure of the family. Families decrease in size, due to changing norms promoting smaller family, and to become increasingly nuclear in structure. The secular processes of development and commercialisation also tend to diminish the availability of familial support by promoting the outmigration of better educated children and those seeking formal sector employment, especially from rural areas. Traditional familial ways of caring for older people are increasingly challenged culturally, demographically, and economically. Thus the elderly in Indonesia today can no longer count on kin support to the same degree as earlier generations.

Certainly the secular process of modernization/development may not always have a negative impact. In some instances, the elderly have more choice, more autonomy, a greater degree of individual independence, and increased privacy compared to their counterpart from older generations. Unfortunately, such choices are not necessarily available to the majority of elderly who live in poverty. The processes of modernization, development and commercialisation have a significantly negative impact on the family's role in acting as caregivers for the elderly in rural as well in urban areas.

The same processes may also have an impact on the role of the elderly themselves. An increase in the number of family members –particularly women – working in the formal sector corresponds to a decline in the traditional role of the family as the main caregiver for vulnerable family members, including the vulnerable elderly. Where poverty is severe and urbanization and increasing mobility –nationally as well internationally – intense, more family members (especially young adults) may not live in the same household or in the same area, leaving the elderly and small children in increased poverty. In regions marked by increasing migration of women workers, the elderly themselves may have to undertake caregiver tasks, such as child minding and management of household chores, to enable

other members of the family to focus on their work (Purwaningsih, 1998). The stereotype of the elderly as a predominantly dependent group may not always hold. Instead, the poorest of the elderly may still have to contribute to the collective needs and well being of the family, as long as they can – in some cases, until the day they die, and at the expense of their own care and welfare.

Compared with rural areas, the conditions of the poor elderly living in urban areas may be even worse (Raharjo & Do Le, 2001). Living in shanty areas, with poor living conditions, a deteriorating environment, scarce resources and lacking family and social support, not to mention the difficulty to find jobs in a more and more formalized, selective and competitive labour force, the needy elderly in urban areas are in a more vulnerable situation that those in rural areas who may still be able to resort to a subsistence existence in communities that retain some of the values of and capacity for mutual support.

In short, the family is no longer in the position to provide support to the aged as traditionally expected. Traditional systems of familial care for the elderly in Indonesia are likely to become increasingly problematic. However, the government will not yet be in a position to ensure comprehensive care for the elderly population in need. During the current economic crisis, the majority of government interventions for the elderly also collapsed. With the capacity of the family and the government both in doubt, the best hope for support for the poor elderly in Indonesia seems to be the community.

Community involvement in handling the social and economic problems of its members has strong cultural roots in Indonesia, especially in relation to the elderly. If one's family could not meet its traditional responsibilities, including support of the elderly, the community was expected to step in and provide the necessary support. Social efforts for the welfare of the elderly in Indonesia can be traced back to Indonesian cultural values, regardless of the extent of ethnic diversity. Some expressions to show respect to elder people can be found in the local terminology of virtually all ethnic groups.[7]

However, societal efforts for relief almost disappeared in Indonesia during the New Order regime, which was characterized by very strong and heavily centralized government. During the 32 years of New Order rule, the government monopolized most initiatives and left little room for community participation. Studies suggest that there was little sense of belonging among members of the community in programmes initiated by government, which

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6 The Javanese concept of *'Mikul duwur mendem jero':* respect and honour the elderly for their wisdom, and apologize for their weakness. It is the duty of the younger generations to care for the elderly. The concept *pinisepuh/sesepuh, pepunden* (in Sundanese as well as Javanese) refers to the elderly as wise people and the place to seek for advise and blessing.

were considered as ‘government projects’, ‘government owned’, or ‘government obligation’. This development coincided with a period during which, as noted previously, the traditional institutions were being weakened by demographic change and development that also weakened community solidarity. Traditional societal support for the elderly was similarly weakened by the strong emphasis on government programmes.

Despite the impact of the New Order regime on community self-reliance, when government mechanisms failed to function effectively during the economic crisis, it was the community that responded most quickly to the emerging problems faced by its members. Although democratisation and community development has been far from smooth in the post-New Order era in Indonesia, some members of the community remain concerned about other neglected or disadvantaged individuals or groups. The sense of community solidarity spontaneously revived during hard times. One of the community initiatives that seems to have been strengthened during the economic crisis addressed the need for support to the elderly[8].

The role of women has been prominent in Indonesia in such community efforts, especially those dealing with the needy elderly. One factor in this is certainly the influence of traditional gender stereotypes in emphasizing caring and nurturing roles for women. Perhaps equally important is the nature of caring work, which is done on a voluntarily basis, is not considered to have an economic value, and therefore is considered appropriate for women. This was reinforced by the role of the New Order regime in emphasizing “social” and caring roles for women through such institutions as Dharma Wanita, an organization of wives of civil servants that initiated “social” projects, and the Family Welfare Movement (PKK), which promoted social development activities at the community level.

III. PROFILE OF PUSAKA

1) History[9]

Inspired by the “Meals on Wheels” concept, a home care system initiated to support the elderly in London, a similar care model was implemented to support neglected and poor old people in Jakarta in the early 1970s. The scheme responded to a perceived the lack of residential and community care facilities while encouraging community concern and promoting community action to address the needs of this vulnerable group. The concept provides care to the needy elderly in a neighbourhood through volunteers from the same neighbourhood. A home care system is

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[8] Other community initiatives dealt with other disadvantaged groups such as refugees, displaced persons and victims of flood, conflicts and violence.

[9] This section is based on Sunardjo, B. (2002); Yayasan Among Lansia (2001) and personal communications.

considered relatively cheap as well as manageable and appropriate because it *operates in the community and is run by the community and for the community*.

The Coordinating Body for Welfare (BK3S), an NGO operating nursing homes for the elderly, first adopted the concept of Home Care in Jakarta in 1974. A rented house in one of the populous areas in Central Jakarta served as both office for the NGO and 'kitchen' for the needy. This pilot project was handed over to local social workers and renamed PUSAKA 1, the first PUSAKA[10].

The name PUSAKA was first used in 1987 when it was felt necessary to use Indonesian terminology, instead of the English term Home Care, which was considered too difficult to pronounce for most Indonesians. The word PUSAKA sounds indigenous and was chosen because of two related meanings. First, PUSAKA is the abbreviation of ***Pu****sat* ***SA****ntunan* dalam ***K****eluarg****A*** meaning 'Home-based Care Centre'. Second, Pusaka also means 'old and respected'.[11]

2) Organizational Structure

Any individual or organization (formal/informal) or foundation can establish a PUSAKA provided they have sufficient funding for the activities. However, in order to become an official PUSAKA unit, caregiver(s) operating such a centre for the poor elderly should be active for at least two years before their activities can be evaluated and accredited with the status of PUSAKA by BK3S. The benefits for accreditation by BK3S are a modest subsidy, access to training in the management of home care, supervision and net working. In turn, accredited PUSAKA have to submit progress reports quarterly and annually to BK3S, the local authorities and relevant donors. Otherwise, PUSAKA are free to manage and run their activities and programmes as they wish. The activities of each PUSAKA are usually integrated with those of local communities in cooperation with the Village or Ward Office. PUSAKA also have links with other coordinating bodies nationally, as well as internationally, including *Lembaga Lansia Indonesia* (the Indonesia Elderly Institute), *Among Lansia* and HelpAge.

3) Selection Criteria

The criteria for eligibility for support by the PUSAKA are:

- Aged 60 and over;

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[10] In 1976 and 1978, another two home care projects were established. Eventually, 73 PUSAKA units were established in Jakarta. In other provinces, community-based home care units supporting the elderly operate under different names, although their mission and objectives are similar. All are registered and coordinated by B3KS. Each PUSAKA is numbered in chronological order of registration – PUSAKA No.1, PUSAKA No.2 etc.

[11] Some PUSAKA extend their service to the children and grand children of their main client group.

- Widowed and from a poor family.;
- Holding a Residence Card (KTP) and a letter of recommendation from the Head of the Neighbourhood Association (RT/RW) and the Head of the Village (Lurah).
- Living within walking distance of the home of the caregiver.

In practice, the programme is open to needy elderly who do not necessarily fulfill all the criteria. For example in one PUSAKA, the age of members ranges from 35 to 101 years of age. However, priority goes to those who do meet the criteria. Most (85-90 per cent) PUSAKA members are women whose ages range from 60-90 years old. Most are widowed or, if not, their husbands are also very old or ill. They are not homeless but they are poor: recipients are predominantly from very poor working-class families. If they are living with their children and/or grand children, they are also too poor to be capable to support their elderly. Most are involved in the informal sector without fixed income. They may work as unskilled construction workers, poorly paid security guards, daily labourers or garbage cleaners.

Women play a predominant role in both care-giving and care-receiving. Although the programme is open for elderly men and women, nearly all PUSAKA members are women. This partly reflects strong gender stereotyping identifying PUSAKA as a women's business, to be run by women and something to do with the 'kitchen'. Due to gender stereotypes, elderly men are also more likely than elderly women to remarry after the death of their spouse, and to marry younger partners who will care for them. Elderly women tend to remain widowed (Raharjo & Do Le, 2001).

4) Services

PUSAKA provides free services to the elderly. Each PUSAKA serves approximately 45-60 elderly. PUSAKA also try to put some joy and creativity into the lives of their elderly clients. They not only provide meals and basic health services but also teach them handicrafts and physical fitness or provide entertainment and recreation.

The range of services include:

- Meals are provided to the recipients at least 3 times a week to a maximum of 7 times a week. The elderly have to come to the house of the coordinator to collect their food, thus encouraging them to get some exercise, get out of their homes and meet other people including their peers. In some PUSAKA, the elderly also cook their own food and in some, extra foods such as milk, green beans or cookies are also provided once a week through private donors.
- Home visits if the elderly fail to come to the Centre.
- Health care through routine monthly medical check-ups and distribution of vitamins or medicines.

- Spiritual/religious guidance is provided once a week, usually on Friday.
- Clothing is provided once or twice a year during special occasions such as *Ramahdan* or *Mother's Day.*
- Improvements to housing such as clean water, ventilation or repairs.
- Provision of small sums as working capital for small businesses.
- Assistance in case of death.
- Physical fitness programmes, usually on Sunday at the Centre or outside the home.
- Recreation: 1-2 times a year.
- Handicrafts, baking or cooking courses for the elderly or for their family members for income generating activities.
- Some PUSAKA also provide support to the children or grandchildren of the poor elderly by seeking scholarships for drop-out children (from primary or secondary school) to continue their education under a foster children programme. Adult family members may receive grants of working capital to start a small business using their creative skills.
- In collaboration with clinics and community health centers in the local area, some home care centers also provide basic health care for the elderly by establishing a *Posyandu Lansia* (Health Post for the Elderly).

Following the onset of the crisis in Indonesia in mid 1997, the negative impact only really became apparent after some months. The assistance, both cash and services, provided by the PUSAKA, was reduced as many donors were also in a difficult situation. In some PUSAKA, for example, rice from donations that was 4 litre per person before the crisis fell to only 2 litre per person. The Ied gift (to celebrate the end of Ramadhan) fell to Rp5,000/head from Rp12,500/head. Meals were provided twice a week instead of 5 times per week, and house repairs could not be carried out due to the lack of funds.

Despite these reductions, PUSAKA have continued their operations. The most difficult time was 1998-1999, when all coordinators had to adjust very quickly to the new situation and to find alternatives, including donations from private sources as well as among expatriates. Many succeeded and can still offer the elderly at least 5 meals a week, milk, medical check-ups and other activities within a reduced budget.

5) Staffing/Personnel

In general, women initiated the PUSAKA programme and work on a volunteer basis. Only the staff members of the Coordinating Body for Social Welfare are fully paid, and they handle administrative work. The health personnel also provide their services free of charge. Most of the staff involved in the programme are women who are involved in daily

management or as officials and advisors. Some PUSAKA also recruit women within the community who work on voluntarily basis. In return, they are provided with free meals and a very modest fee for transportation. As a result of the hardship created by the economic crisis, PUSAKA found it increasingly difficult to recruit volunteers. At the same time, more and more elderly needed their help. To meet the gap, some home care centres recruited low-paid staff to clean and to cook meals for the elderly. Others relied on dedicated women willing to contribute something to society. For example, Madam Sunardjo, in charge of PUSAKA 3, used her connections and network to continue providing meals 5 times a week during the crisis. Due to her wide networks she was also able to obtain free health services for her clients once a month from two different sources. The medicines prescribed by the doctor were also provided free of charge by a drugstore in her neighbourhood

6) Training

As PUSAKA are relatively inexpensive and easy to run in comparison with a nursing home, no formal training is required for new caregivers. An individual wishing to initiate a centre needs only to make provision for an operational budget, identify clients, report to the relevant institutions and organize her own activities. However, if assistance is needed it is available from organizations such as HelpAge Indonesia, HelpAge International or BK3S that seek to help PUSAKA to improve their services. BK3S also organizes a SWAT workshop for PUSAKA caregivers to assess their strengths and weaknesses so they can improve programmes[12].

Although the elderly need more PUSAKA, some are concerned about their rapid increase, especially since last year when many were established in a short period.[13] Some PUSAKA also expand their activities and membership by establishing branch PUSAKA in other districts. One concern is that these centres often do not meet the requirement of a two-year trial period. The trial period is considered necessary to provide the new coordinator with ample time to learn and improve services until the unit can be granted PUSAKA status.

7) Funding

The majority of PUSAKA funds come from private sources including individuals, social organizations, foundations, companies and communities. The government, through BK3S, also subsidies about 40 per cent of the cost of meals provided to the elderly. Before the economic crisis, each PUSAKA received modest funds from several foundations, as well as rice and other basic foods such as milk, green beans and cookies. Although some sources of support dried up due to the economic crisis, support from

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[12] There are also plans to establish an Indonesian Training Centre on Ageing in partnership with the Asia Training Centre on Ageing Chieng Mai to address training needs.
[13] Between 2001 and 2002, 23 additional PUSAKA units were established.

personal donors continued and may even have increased. However, funding remains a challenge for PUSAKA and caregivers must constantly seek means to raise funds for their activities. Fund raising from communities also contributes to a sense of shared responsibility and solidarity. The idealism, motivation, creativity, and networking of caregivers are therefore keys to the success of a home care, especially during the current hard times.

IV. COMMUNITY SOLIDARITY: The Issues

This section highlights the critical role of community solidarity in addressing the problems of the poor elderly in the current crisis in Indonesia. Without it, the goals of the International Strategy for Action on Ageing and the commitments outlined under Law number 13/1998 on Elderly Welfare would not be achieved.

Despite its importance, policy makers pay little attention to community solidarity. Under regional autonomy, provincial governments tend to neglect the issues of aging (and other social issues) and to focus on economic recovery. However, Indonesia is facing both an increase in the number of its old people and their related problems. Despite the other major socio-economic and political experienced in Indonesia in the last four years, including ethnic and religious conflict, community initiatives to revive community solidarity – not only for aging –
are important. Community solidarity is based on indigenous cultural, moral and ethical values.

This is evident in the operations of PUSAKA. They operate locally and spontaneously and are managed by dedicated women with or without the involvement of other community members. A major challenge is how to ensure that this community solidarity and responsibility is sustained and shared. This question is significant for two reasons. First is the gender issue: since women are predominant in care-giving to the elderly, there is a tendency to strengthen and institutionalize the traditional gender stereotype that considers caring for the elderly is women's domain and responsibility. Social work and volunteer work are widely considered as appropriate spheres for women. Second, community solidarity and responsibility needs social commitment, support and concern expressed through the participation of community members, regardless of age, sex or socio-economic characteristics. The involvement of other actors, including the elderly themselves, is necessary to promote dynamic and energetic local communities. To provide a sustainable basis for volunteer activities, improvements are needed in effective cooperation with regional, national and international bodies. Training, seminars, and educational opportunities

provide incentives for volunteer leaders and coordinators. Social recognition of volunteer activities also contributes to sustainability.

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Annexe 1: Profile of the Indonesian Elderly Population

I. General information on the Republic of Indonesia

- Very complex and diversified developing country in terms of geography, ethnic, social and cultural conditions.
- Archipelago of more than 17,000 islands, of which 3,000 are inhabited.
- The fourth most populous country in the world with a population of 220 million in 2001.
- Java represents 7 per cent of the territory of Indonesia but 2/3 of the population.
- Administratively, the Republic of Indonesia was divided into 27 provinces (including East Timor). Following reform in 1998 and decentralisation, there are now 32 provinces.
- 5 have an aged population structure; among these, DI Yogyakarta has the highest proportion of older population (13.72%).
- Life Expectancy at Birth: Male 63, Female 66 (1995-2000)
- Life Expectancy at age 60:
    - Male 16.7, Female 16.9 (2000)
    - Male 18.3, Female 19.3 (2020-2025)

II. Profile of the Elderly in Indonesia

- The tenth largest elderly population in the world.
- The most populous country in ASEAN with the highest absolute number of elderly.
- By 2012, the number of elderly will equal the number of children under five.
- The number of elderly will double in twenty years.
- Between 2010 and 2020, the growth rate of the elderly population will be 3.7 per cent, compared with a population growth rate of 0.8 per cent.
- According to the 1995 Household Health Survey, the five major diseases affecting older persons were:
    1. Circulatory disease (29.5%)
    2. Respiratory disease, (12.2%)
    3. Cancer (12.2%)
    4. Tuberculosis (11.5%)
    5. Anaemia (57%)
- An aged dependency ratio of 6.9% in 1995, increasing to 10.1% in 2020
- Older women have lower education levels than older men.

- More older men than women are married; more older women than men are divorced, single or widowed.
- There are more older women than men in the population. However, more older men than women are in work. The wages earned by older women who do work are lower than for older men.
- Government operated 141 homes with a capacity of 8,304 people.
- There are no general pensions for the elderly.

Table 1
Indonesia: Elderly Population by Place of Residence, 1971-2020

Year	Urban		Rural		Urban + Rural	
	N	%	N	%	N	%
1971	726,633	3.73	4,544,241	4.64	5,306,874	4.48
1980	1,452,934	4.42	6,545,609	5.75	7,998,543	5.45
1985	2,916,271	5.26	8,361,286	6.75	11,277,557	6.29
1990	4,209,999	5.88	8,568,213	6.96	12,778,212	6.56
1995	4,027,515	5.76	9,271,073	7.43	13,298,588	6.83
2000	7,793,880	7.60	9,973,829	8.29	17,767,709	7.97
2005	9,572,274	8.22	10,364,621	8.74	19,936,895	8.48
2010	12,380,321	9.58	11,612,232	9.97	23,992,553	9.77
2020	5,714,592	11.20	13,107,927	11.51	28,822,879	11.34

Source : BPS, Laporan Sosial Indonesia 1997; Lanjut Usia (Lansia), BPS,Jakarta, March 1998, Table 2.1, p.12.

Table 2
Elderly of Population in Developed and Developing Countries, 1971-2020

Year	Developed Countries		Developing Countries	
	Total	%	Total	%
1950	63,566	7.6	64,242	3.8
1960	80,250	8.5	79,817	3.8
1970	101,007	9.6	99,129	3.7
1980	130,858	11.5	133,129	4.0
1990	145,614	12.1	182,018	4.5
2000	172,820	13.7	251,696	5.0
2005	185,644	14.4	290,319	5.3
2015	210,735	15.9	387,136	6.1
2025	257,028	19.0	571,136	8.0

Source: Population Studies No. 122. United Nations, New York 1991.

Table 3

Indonesia: Elderly Population by Province, 2000 (in 1.000)

Province	Total Population	Percentrage	Total Elderly	Percentage	Proporti of Elder
Sumatera					
DI Aceh	4,213.4	2.01	247.2	1.55	5.87
Sumatera Utara	12,155.7	5.80	771.5	4.85	6.35
Sumatera Barat	4,657.3	2.22	422.7	2.66	9.08
Riau	4,383.4	2.09	199.9	1.26	4.56
Jambi	2,642.4	1.26	138.5	0.87	5.24
Sumatera Selatan	7,858.5	3.75	412.6	2.59	5.25
Bengkulu	1,593.8	0.76	92.6	0.58	5.81
Lampung	7,178.7	3.43	494.0	3.10	6.88
Jawa					
DKI Jakarta	9,720.4	4.64	509.3	3.20	5.24
Jawa Barat	43,089.3	20.56	2,850.3	17.91	6.61
Jawa Tengah	31,386.0	14.98	2,995.9	18.82	9.55
DI Yogyakarta	3,086.1	1.47	423.5	2.66	13.72
Jawa Timur	35,478.0	16.93	3,740.8	23.50	10.54
Nusa Tenggara					
Bali	3,091.2	1.48	302.7	1.90	9.79
Nusa Tenggara Barat	3,990.8	1.90	235.6	1.48	5.90
Nusa Tenggara Timur	3,915.7	1.87	261.5	1.64	6.68
Kalimantan					
Kalimantan Barat	4,015.1	1.92	206.9	1.30	5.15
Kalimantan Tengah	1,805.4	0.86	81.4	0.51	4.51
Kalimantan Selatan	3,152.7	1.50	184.8	1.16	5.86
Kalimantan Timur	2,643.1	1.26	110.0	0.69	4.16
Sulawesi					
Sulawesi Utara	1,841.5	1.36	194.0	1.22	6.83
Sulawesi Tengah	2,176.2	1.04	120.2	0.76	5.52
Sulawesi Selatan	8,218.6	3.92	626.9	3.94	7.63
Sulawesi Tenggara	1,781.1	0.85	103.3	0.65	5.80
Maluku	2,252.4	1.07	141.9	0.89	6.30
Irian Jaya	2,219.5	1.06	48.3	0.30	2.18
Indonesia	209,546.3	100.00	15,916.3	100.00	7.60

Source: BPS, Proyeksi Penduduk Indonesia per Propinsi 1995-2005, Jakarta 1998.

Table 4
Indonesia: Population Aged 60+ by Relationship to Head of Household (HH) and Sex, 1995

Relationship to HH	Male	Female	Total	%
Household Head	5,469,416	2,155,209	7,624,625	57.33
Wife/Husband	10,522	2,294,341	2,304,863	17.33
Child	841	8,150	8,991	0.07
Child-in-law	5,558	727	6,285	0.05
Grandchild	-	-	-	-
Parent-in-law	575,885	2,255,318	2,831,203	21.29
Other relative	85,328	385,397	470,725	3.54
Housekeeper	2,921	18,244	21,165	0.16
Others	9,517	21,214	30,731	0.23
Total	6,159,988	7,138,600	13,298,588	100.00
Percentage	46.32	53.68	100.00	

Modified from: BPS, Laporan Sosial Indonesia 1997; Lanjut Usia (Lansia), BPS,
Jakarta, March 1998, Table 3.1, p.23.

Table 5
Indonesia: Distribution of Working Elderly Population by Sex, 1996

	Elderly	Working Elderly	%
Male			
60-64	2,523,652	2,036,438	80.69
65+	3,849,797	2,182,039	56.68
Female			
60-64	2,733,789	1,240,460	45.38
65+	4,121,633	1,128,161	27.37

Source: BPS, Laporan Sosial Indonesia 1997; Lanjut Usia (Lansia), BPS, Jakarta, March, Table 5.2, p.44.