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Community Volunteers' Care for Older Adults (*Lansia*) in Indonesia: The Symbolic Efficacy of Community Health Meetings (*Posyandu*)

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ABSTRACT

Community healthcare in Indonesia relies on volunteers who engage their clients outside fixed health facilities with limited resources and formal training. These volunteers are called cadres who learn their tasks to improve community wellbeing through ongoing engagement and without prior formal skills. They are drawn from the community to serve the community. This paper is based on field research carried out with cadres through interviews and visits to integrated health meetings (*posyandu lansia*) held by primary healthcare centres for older adults in villages in Jakarta and Yogyakarta. The paper first discusses the recruitment requirements and incentives for being a healthcare volunteer. It suggests that both recruitment and incentives are rooted in community values of helping and doing good for the community. Volunteer cadres must have a direct normative and semiotic connection with clients, as they must be members of the community who speak the same language and understand local norms. In line with this community-centred approach, the paper then focuses on the health efficacy of *posyandu* by viewing them as a recurring, structured symbolic event held in the village. The argument is made that a more qualitative approach should be taken to understanding the efficacy of these meetings, drawing on research methods from the anthropology of ritual (symbolic and therapeutic) healing.

Keywords: *cadres; community healthcare; voluntarism; symbolic/therapeutic healing*

INTRODUCTION

Community healthcare and its reliance on volunteer outreach workers (cadres) emerged in Indonesia, as elsewhere in low- and middle-income countries, within a healthcare environment with scarce human and financial resources. The community health care approach was initially guided by the WHO and gained its full impetus following the Alma Ata conference in 1977. There has

been growing body of literature attesting to the positive influence that community health workers (CHWs) have on the health of local populations (Perry et al., 2014; Scott et al., 2018). CHWs are a diverse category of health workers with limited formal training, often working in communities outside fixed health facilities (Perry et. al, 2014). Schneider et al. (2016) define CHWs, following Naimoli et al. (2014), as a health worker who receives standardized training outside the formal nursing or medical curricula to deliver a range of basic, promotional, educational, and outreach services, and who has a defined role within the community system and larger health system. These definitions are incomplete as they exclude professional health workers living in the community, such as nurses, midwives, and doctors, who might also be part of the army promoting community health work to a community.

It has been argued that by being in the midst of the people they serve, CHWs (both paid professionals and volunteers) help in improving population health by extending care to underserved groups, monitoring people's health and disseminating health knowledge and advice (Scott et al., 2018). CHWs who are living in the community or volunteering can empathize with their clients, But only volunteers drawn from the community, supporting primary healthcare centre, can engage in specific health issues as members of civil society. Healthcare volunteers are 'straddlers' (Berenschot et al., 2018) standing between the state institutions and civil society who can form bridges between the formal healthcare system and the community they extend services to (Standing et al., 2008; Schneider et al., 2016; Schaaf 2020).

In this study, we understand volunteerism as a form of human labour that can be classified into three types: unpaid work in structured organizations, activism in self-help groups, and leisure activities in art and cultural venues (Rochester, Payne, and Howlett, 2010). These types are non-exclusive and can sometimes blend into each other. Cadres that are recruited by the primary healthcare centre (*puskesmas*) and non-government organizations (NGOs) who are concerned with older people's issues are the first variety of volunteerism. These non-professionals and voluntary cadres are guided by professional nurses (midwives or village nurses) living in or close to the community they serve. A hospital nurse might become a cadre in healthcare for older peopleand bring her professional knowledge to bear, but may not have prior expertise in gerontological health or elder wellbeing. In her capacity, she can also provide volunteer labour.

METHOD

This paper will examine three main issues relating to Indonesian community health volunteers (hereinafter referred to as cadre). After providing a general introduction to the history of CHW in Indonesia, we will discuss recruitment and incentives for healthcare volunteers for older adults. The article suggests that cadres are drawn from particular moral/social attributes, requiring a moral ethos rooted in serving the community and appreciating values that support the community's wellbeing. Further observation reveals that material incentives in volunteer work could potentially undermine the ethos by attracting individuals who hold non-communitarian values. The cadre is a fundamental component in organising and maintaining monthly integrated health meetings (*posyandu*) for older adults in village wards. By supporting healthcare professionals, like a village nurse, in the running of *posyandu*, cadre translate the 'health goods' into local symbolic idioms. To understand the usefulness of *posyandu* and other gatherings for older adults' wellbeing, a

particular methodological approach should be taken due to the volunteers' works rooted in idealised moral values. Given that *posyandu* is a recurring structured event for older people, it shares certain similarities with village symbolic healing rituals. Anthropological studies of symbolic/therapeutic rituals can therefore provide valuable insights into the health efficacy of *posyandu*. This qualitative understanding of social gatherings could have positive ramifications for healthcare delivery to culturally and religiously traditional older adults in regionally diverse communities.

FINDINGS AND DISCUSSION

The Rise of Cadres for Older People

The community healthcare volunteer system is part of President Suharto's legacy. Community health meeting mushroomed during his 32 years of office. In 1965, and just before Suharto came into office, the previous government headed by President Sukarno, which showed more socialist dispositions in governance, tried to endorse the first legal provision to create a social security system for 'neglected and incapable' older adults. Although the law remained on the legal books, it was never implemented after Suharto (1966-1998) came into office a year later. Suharto's government was development and market focused, and the state refrained from developing a government social security system. Suharto's regime relied on community participation in health and other matters and developed the primary healthcare centre in the community (*puskesmas*). The *puskesmas* is a health unit that serves the subdistrict with the aim of providing health services to people (Heywood and Harahap, 2009). It evolved during the 1950s out of an earlier more fragmented system of health delivery system that was planned to be dependent on heavy government public spending (Heywood and Harahap ibid.). The 1951 Bandung Plan laid the template for the national health system that would integrate both curative and preventative medicine. This led to the establishment of a network of public health facilities in each subdistrict of the country. These centres were to be staffed by at least one doctor and a few nurses and midwives, and the aim was for it to be easily accessible by patients and also serve as a point of referral.

During the late 1960s, community health volunteers (cadre) started appearing on the public health scene attaching themselves to the primary healthcare clinic. They became more visible in different parts of the country during the 1970s and 1980s. Volunteers were initially dispatched to provide support in family planning and to help with mother and child healthcare (Shelley et al., 2017). Whereas initially, reliance on community volunteers fell in line with Suharto's inclination to put the burden of care solely on the community and the individual, after the 1977 Primary Health Care conference in Alma Ata, the policy also fell in line with the WHO's directives for distribution of primary healthcare within a context of scarce and minimum resources. The WHO acknowledged the potential of CHW in Indonesia in its 1975 global report edited by Newell (1975) on the benefits of community healthcare, which later led to the famous directives of the Alma Ata Declaration on primary healthcare in 1978 (WHO, 1978).

If Suharto's community-based preventative approach with cadre seems to have stood the test of time and the collapse of his regime, the primary healthcare cadre for older adults is a recent phenomenon. The cadre initiative emerged in response to the emerging awareness and concern with Indonesia's senior citizenry, a few years subsequent to the World Assembly on Ageing in

Vienna in 1980. During the 1990s, there was a growing awareness of the needs of older people as citizens of Indonesia.

In 1996, just before his political ousting, President Suharto gave a nod to Indonesia's senior citizenry by declaring that 29th of May would be celebrated as Senior Citizens' Day (*Hari Lansia*). Indonesia ended the decade with a piece of legislation titled Old Age Welfare Law (Law no.13/1998) which was endorsed by President Habibie's new government. The 1998 law is focused on older people as a social group called Lansia who are defined as people aged sixty years and over. In many respects, the 1998 law combined aspects of earlier legislation from both the Sukarno and Suharto eras. As Arifianto (2006) points out, this law recognises that the responsibility for improving the welfare of the nation's older citizens should be divided between the government, community and older citizens themselves (p. 8). It stipulates equal rights for *lansia* who are also entitled to various public services, such as religious services, health service, employment service, education, and training. The law divides older citizens into two groups, 'potential' and 'non-potential', where the latter term refers to *lansia* who are destitute, vulnerable and unable to make a living and who have no family to care for them. Whereas older citizens are encouraged to be active and participate in social activities and perform social functions in the community (Rahardjo 2009, Ananta 2012, Nurvidya et al. 2012), the law recognises that many seniors can be dependent on the community and even the government. The 1998 law was followed by other legislations which, although not directly concerned with older adults, stipulate the rights of all Indonesian citizens to a decent standard of living.

Subsequently, new provisions were undertaken to allow community healthcare to emerge targeting older adults. A number of NGOs also started operating within this climate of greater rights and freedom. Indonesian authors recognise that the organisation of community health workers and NGOs for the promotion and dissemination of health information and health activities accords with the series of legislation promulgated since 1998 to improve the health and wellbeing of the older population (Simbolon and Simbolon 2018, Putri and Ilyas 2019, Sumini et al. 2020)

To date, there has been no investigation of how community volunteers in Indonesia who provide community health services for older people perceive their role, nor how volunteer-enacted health activities fit within the wider moral and symbolic context of health and healing. In this paper, we draw on data from a comparative, ethnographic study of older people's care networks in five disparate communities across Indonesia[1]. Data collection took place between 2020 and 2023, and included interviews and observations with 10-15 older care dependent people per community and their family carers, and interviews with around 30 community health volunteers (cadre) across the five sites. In this paper, we draw on a sub-sample of data, focusing on interviews with cadre in Jakarta and Yogyakarta and on observations of community health clinics (*posyandu lansia*) in these sites.

Cadre Recruitment and Ethos

In Indonesia, cadre has a specific meaning that goes beyond simple volunteering. It usually refers to a small group of volunteers, drawn from the community they service who do not need prior skills for the activities they are dispatched to do, but learn through ongoing engagement (they might receive some general training when it is available). Their purpose is to help improve the wellbeing of people in the community. Cadre are therefore not mere volunteers but bring with

them a value system of moral commitment and duty to the community which already exists in community relations.

Cadre are volunteers drawn from the community. They are usually brought into the team when a senior cadre invites or persuades a person to join. The recruiter might have particular reasons for recruiting people, for example, they need an older person to help out because the person comes from a specific hamlet or simply more volunteers are needed as *posyandu* meetings and other gatherings become larger. All primary health cadre interviewed who discussed their recruitment provide an image of themselves being casually invited to a *posyandu* and agreeing to participate, but not knowing what to expect. Once attending their first *posyandu* meeting, the volunteer starts learning the basics by observing their peers who show them how to measure blood pressure and how to register information about the older people attending. Cadre Yanti recalled her first days as follows:

> "You do not receive special training to become a cadre but only learn what you need directly from the more senior cadres by observing them. Before measuring the blood pressure of others, the cadre-initiate first tries it out on their own body. Then they observe the senior cadre. This also applies to reporting and doing the paper-work."

She added:

> "I felt nervous when I had to measure hypertension for the first time. The gauge was a manual one and its usage required me to be focused so as not to make a mistake and then have to repeat the check again."

Cadre are not recruited for their personal knowledge or experience, although sometimes having some useful knowledge such administrative or book-keeping skills can be an asset. If becoming a cadre does not need any special skills, it seems that certain predispositions are nonetheless needed. According to Cadre Yuli,

> "The only skill one needs is ability and desire to be a cadre."

This might seem a simple statement, but it is morally loaded;. As we shall see, the conditions needed to being a cadre are all moral in intent. For example, according to Cadre Rina from Yogyakarta, "To be a cadre one must be sincere because our purpose is to serve the community."

She added:

> "If a person is not sincere and does not want to devote themselves to the community, then they cannot carry out their duties to the full."

Being a cadre does not only entail devotion to the cadre role, but also requires dedication to the community. Sincerity and self-sacrifice carry with them a responsibility to the community as well as to other cadres. In addition to being sincere, a further necessity is motivation and willingness to work, learn, and develop as a cadre for practically no material reward. According to Cadre Santi, the cadre must be disciplined in their work and must also be open to learning.

> "A cadre should have the motivation to learn. You don't need to be clever, but with motivation over time a cadre can learn their tasks needed through various trainings."

It is not prior knowledge that is important, but an openness to new experiences which comes with commitment and interest. Every activity requires the division of tasks, and cadre must be committed to follow up on their tasks. For example, as one cadre illustrated:

> "A cadre who is in charge of cooking must wake up early in the morning, sometimes at 4 am, to cook for the meeting. This entails a commitment. A cadre who constantly fails to turn up could be asked to reconsider their post."

Behaviourally, a cadre should show good manners in front of older people. In Javanese communities, where hierarchic speech registers signify rank and seniority (*krama*), there is the special cultural requirement that a cadre should be aware of the speech codes and avoid talking to an older person in a lower register (*ngoko*). Further, the cadre should not lose patience and show negative emotions when the older person exhibits a negative attitude. Instead, cadre have to be attentive to their clients' needs, friendly and encouraging, and always positive. Cadre should exhibit a light-hearted approach, and be willing to chat when people tell stories, and to listen patiently to their concerns without being judgmental. Thus, patience is another important factor necessary to be a cadre working with older adults.

Cadres' comments on what is needed to become a cadre may seem simple: patience, respect, motivation to learn, and giving up free time for unpaid work. Overall though, their comments entail a sense that only specific people with a certain predisposition can become cadre, and especially cadre for older people, which demands a particular attitude. This becomes important when we consider the incentives for becoming a cadre and the issue of remuneration.

Incentives to Being a Cadre

Part of the disposition for being a cadre covers the very reason why someone would want to volunteer their private time to the community to care for older people. This is best reflected in the following quotes.

In Cadre Nana's words,

> "Although we receive very little in return for our services, seeing the elders smile makes us really happy. It is a pleasure in posyandu to see the elders meet each other and watch them chat."

She goes on:

> "We are happy to see the older people laughing. It is really nice. Especially if they can tell a story. We don't even expect material rewards. What is important is that they are alive and they are happy."

Cadre Yuli reflects,

> "What I receive (in being a cadre for lansia) is happiness in my heart by being a useful person. I enjoy meeting older people and joking with them."

Satisfaction in doing good and seeing other people happy is the incentive. What is being expressed in these quotes is precisely how cadre see the values of being a cadre. They are not just saying things about themselves, but about what it means to be a cadre and the values that make

up the predisposition. Cadre thus have an idea of what it takes to be a cadre. One must be imbued with a certain disposition towards the community one is from. This also shades into the unease and ambiguity surrounding financial remuneration.

Cadre Intan on being given a monetary reward pointed out:

> "It is a job that should not be used as a source of income. It should be considered social work by residents of a neighbourhood for their community."

She adds:

> "If cadres are rewarded with a basic monthly salary, then the community nature of cadre work will decline, and what will appear is an atmosphere of dissatisfaction among the cadre themselves that they are only paid a low salary when the workload is a lot."

In recent years, primary health centres started providing cadre with small stipends, not an amount that would attract people to join, but enough to cover certain costs that the volunteers sometimes incur. If being a cadre becomes a paid job, those applying to it might not have the same predisposition as volunteer cadre. Monetary incentives could invite a different type of person who is attracted to the financial reward rather than someone who is imbued with the dispositional values needed. A salary will, in the long-term, invite people to join the ranks of healthcare for the reward itself. This could lead to a change in the disposition of the people who join and how they respond to older adults.

A number of authors have pointed out that older people who visit *posyandu/posbindu* appreciate it when the healthcare worker is friendly, warm, gives time to them, and listens to their needs (Simbolon and Simbolon, 2018; Azana et al., 2019). Being served by unfriendly and disinterested healthcare workers can push the client away. Setiawan et al. (2017) write that the older adults they interviewed in an urban Indonesian setting preferred to be served by a less educated and brilliant healthcare worker but one who has a good attitude to them, rather than someone who is brilliant in her profession but shows no real interest in the needs of her clients. Being a cadre for *lansia* is not the same as being a cadre for another health issue. There are certain needs and expectations that have to be met for which professionalism might not be able to cater. One of these needs is to listen to older people (who are usually side-lined in society), feel their softer presence, honestly banter and laugh with people, and help restore to people a certain sense of dignity of self. This requires a certain moral disposition that does not come natural to everybody.

Thus, if there has to be a certain disposition in being a cadre as Gadsden et al. (2021) have pointed out, incentives and the response to incentives is most likely influenced by values held by people. What this also suggests is that although some people might be ready to be cadre if they were giving greater monetary award, these people will not be predisposed with the same ethos needed for being a volunteer cadre. Cadre work is embedded in the values of community sociality.

The *Posyandu* as a Preventative Therapeutic Endeavour

If cadre work is embedded in the values of community sociality, biomedically, the most important activity that is carried out in a health meeting for older adults (*posyandu lansia*) is checking for non-communicable diseases (NCDs) or their risk factors. It must be remarked that at present in

Indonesia, these meetings are varied in their potential to disseminate the same 'health package' as they are not all equipped with the same resources or follow the same programmes. Whereas some *posyandu* do monitor people's blood pressure and cholesterol levels, many do not provide this service for lack of resources. Those that do provide this service might charge a small fee. Ongoing monthly measurement of waist and belly circumference and recording of height and weight (which is really a spill-over health check from the child and maternity *posyandu*) is more common in the *posyandu*. It gives the cadre and the meeting a semblance of health authority. Global knowledge on health and ageing, in understandable forms, is also disseminated to clients in the *posyandu*. Venues for active ageing, such as exercising or some other activities, are also sometimes arranged. However, those that organise an active ageing forum are an exception, as not all *posyandu* provide these services at present. Usually, these are held in areas which have a high concentration of older adults and where there is greater awareness of issues concerning older people.

As for global health directives, we do not really know how much of this advice is really embodied by people and how much people conform to what cadre tell them in their daily living. Cadre know full well that most elders do not always listen to their advice, particularly when they are told to refrain from doing certain traditional activities, for example, chewing betel nut, or smoking. Further, following the health directives might be easier for certain older adults, for example, those who worked for the state bureaucracy, where conformity to certain modes of living was part life.

Yet aside from health checks, there is qualitatively more going-on in *posyandu lansia* meetings than is initially apparent. First, these gatherings are moments of dissemination of health information to the elders. They are structured moments of semiotic representations and communication. In many Indonesian settings today, language can still be a barrier for communication. If professionals speak in Bahasa Indonesia, the national language, which is also the language of modern professionalism, for many older adults this can be a communicative barrier (Pratono and Maharani, 2018). Not all Indonesian elders are proficient in the national language. Even for those who are proficient in Indonesian, professional health-speak is professional Indonesian-speak and is simply too far removed from the everyday communication of many people and particularly rural elders. Health professionalism can come across to older adults (who are already socially marginalised but want to talk about their issues) as disinterested and distancing. The cadre therefore semiotically re-represent health discourse in a local semiotics and within a context of proximity that medical and health professionals simply cannot or might not want to indulge themselves in.

Cadre Yanti of Yogyakarta, who is also a professional nurse, reveals:

> "older people like to be touched and feel an affectionate hand. It is important to listen to their complaints. In return, they pray for the cadre"

The 'touch' Cadre Yanti refers to is 'comforting touch'. Touch is a well-known therapeutic-generating procedure that eases people and provides personal recognition through physical contact. It is a gesture of care, support and informality. It is a moment of intimate sociality. In return, the cadre receives a prayer.

According to Cadre Rina, also from Yogyakarta:

Figure 1. Posyandu meeting in Yogyakarta, where a cadre guided older people to do 'senam otak' (brain exercise) as part of exercise to prevent dementia. This section was done before health checks and only required about 10 minutes. Photo by: Ciptaningrat Larastiti

> "Our elders have a lot of fun. In one exercise the people had to carry out some hand exercise. We told them how to move their hands but some people couldn't do it. The older people laughed at themselves and everybody else laughed along as well."

In the second quote we learn that the exercise is not always done properly, and some people may not even be able to do it at all. Further, this cadre noted that she was worried she would make a mistake in the higher speech register, which younger people have to use with their elders. Laughter dissolves this distancing effect. What is important here is fun and laughter, and being able to laugh at oneself with others in an unthreatening situation and later to share the funny moment with others. In this context, one gains the impression that fun and laughter have as much, if not more, therapeutic effect than the physical exercise itself, which people do not always do properly. These quotes reveal that there is a subtle symbiosis between the cadre and their older client which can take on a more personal nature. The pleasure of laughing together and seeing the elders rejuvenate and laugh at themselves and at each other becomes a major reward, as is being blessed by the clients.

Cadre Yuli who organises exercises for the elders in her community in Yogyakarta recalled:

> "There is one older person in the village who rarely went out of her house and slept all day. When we started with the exercises, her family members brought her to the exercise classes. By the fourth meeting, she walked on her own to the meeting. Seeing this gave me so much satisfaction."

Here, Cadre Yuli captured the very therapeutic nature of the event. It is not that the elder could not walk to the event, and suddenly after the fourth meeting she was healed by some spiritual force and was now full of energy. Instead, the fun of its engagement reconnected her to in the community and brought her back to her physical and social body. It gave her a purpose to

walk in the village and be part of the community again.

The Efficacy of Health-Meetings for older Adults, an insight from Anthropology of Healing

Cadre are people from the community with a strong communitarian ethos, but, by operating under a local primary health professional, usually a village nurse or midwife; they are also primary healthcare agents who are part of the community's 'formal health system'. For their clients, their activities exist in a melange of available health and medical possibilities existing in the village ward and beyond it (plural medicine). If we are to look at the *posyandu*, which is a monthly village event, as having some immediate and long-term efficacy, we should also consider that it entails a qualitative therapeutic side to it. Here we are alluding to the anthropological studies on the therapeutic efficacy of symbols generated for healing and improvement of health. For this, we have to return to the original 1977 Alma Ata conference. In this milestone of global health, which promoted the development of primary healthcare, certain stipulations were provided of what should be done to advance primary healthcare. CHW volunteers who were from the communities were an important element in this system. What was somewhat forgotten or at least downplayed though, and which was radical in its day, was that the declaration also stipulated incorporating certain traditional healers within the framework of health if they could qualify. So radical was this statement that the Director General of the Indonesian medical healthcare system at the time maintained: 'it is not easy for a Western-trained Doctor to make the mental-switch [...] sometimes we wish to think it is not necessary but it should be done' (Soebekti, 1979).

In subsequent years after the conference, a flurry of fascinating literature based on long term ethnographic research on the efficacy of symbolic healing in different cultural and religious settings appeared. Although there were some classic pieces published before the conference, most notably a paper by Levi-Srauss (1963) who tried to show the similarities between shamanic symbolic healing techniques and psychotherapy, as well as the psychiatrist Frank (1961) who elaborated on the role and efficacy of symbolic persuasion in healing, the post-Alma Ata ethnographic literature brought the study of the efficacy of symbolic healing onto a different level.

Whereas much of this literature might seem exotic and even opaque to students of healthcare and gerontology, this literature has direct theoretical and methodological bearings on the efficacy of symbols in structured events to convey health discourses. It should also be stressed that this body of literature never tried to show a cause-and-effect relationship between a ritual and the cure of a disease in a falsifiable methodology, although sometimes a hypothetical connection was made between healing symbology and neuronal functioning. What the literature showed was how various forms of semiotic techniques and performative actions therapeutically aided patients giving meaning to their illness and making them see their condition in a different light, thereby inducing a behavioural response to manage their ailment or condition (Moerman 1979, Dow 1986, Laderman 1987). Although this literature was focused on the efficacy of healing, the symbolic healing events studied were shown to work within an ongoing continuous symbolic whole over a period of time, and their influence developed by increment (Csordas, 2002).

It is suggested here that the various 'gatherings and events for health and wellbeing' for older adults share certain general features with community and village healing rituals that contribute to therapeutic efficacy in plural medicine. It does not matter if the structured event is conveying

signs and symbols referencing a religious or spiritual environment or biomedical knowledge, animist or naturalist. What is important is that both types of events are performed for health management that has as its purpose the amelioration of people's health and wellbeing through persuasive symbolic means that aim for the generation of meaning and induction of a change in behaviour. The bedridden villager, mentioned above, who after four meetings started walking to the *posyandu* herself is a case in point.

Like 'Healing Rituals', the *posyandu lansia* and NGO *posyandu*-type gatherings provide a structured context for the purpose of health. They share all those social and semiotic features that provide some form of efficacious transformative guidance in health, conveyed through a recurring structured event. During these events, certain activities are caried out within knowledge-frames, which gain their authority from some external institution and its specialised body of knowledge. In the context of *posyandu lansia*, the knowledge frames are biomedicine and global health.[2] These frames of knowledge are beyond the full understanding of those attending and for whom they are performed. Someone in the event is authorised to (mimetically) speak in the name of this body and disseminate the therapeutic information for health within a symbolic discourse that is understood (connotationally) by the lay people present (see Borsch-Jacobson, 1992; Porath 2011). In both types of structured events, health *posyandu* and ritual healing, knowledge is performed in both senses of the English word— performance as practical action and performance as a theatrical mode of action. When cadre make a little dance or explain something with exaggerated gestural movements, sing a song, or speak in a certain tone of voice or banter, they are disseminating health information through performative means. In the process of interaction, the performance of health knowledge (an expression we take from Laderman and Roseman's (1996) edited book titled 'The performance of Healing', semiotically (mimetically) aligns recipients with representations of health and the healthy body presented in the event (Porath, 2011).

In *posyandu* and other gatherings, knowledge understood to be vital for people is disseminated through various forms of discursive representations. The knowledge is sieved into manageable communicative modalities to the village clientele present. The formality of health knowledge further interplays with discursive informal modes of interaction, such as particular ways of speaking and the use of tropes such as metaphors (Kirmayer, 1996), the sensuality of presence and touch (Porath, 2011), joking, and intergenerational banter. Much of the discursive interaction entails forms of persuasion (Frank, 1961) and rhetorical speech in some form or other (Csordas, 2002), suggesting to people to reconsider their actions relating to health as well as provide a sense of empowerment through meaningful understanding (McGuire 1983). The use of imagery for health through pictures or verbally induced imaginings is central to the dissemination. Important in this is the generation of archetypal tropes. In symbolic healing, whether spirit-based or naturalist, archetypal images are symbolic conduits for meaning action and response (see Laderman, 1991). In every society, old age has its archetypal imaginings around which meaning for action is generated. At present, in the meetings for older adults' health and wellbeing (*puskesmas* or NGOs), there seems to be two types of archetypes of old age utilised, that of the 'frail' older person and that of the older person seeking rejuvenation by taking their condition into their own hands and actively ageing through exercises and other recommendations (Schröder-Butterfill et al., 2023). The second type, Featherstone and Hepworth (1989) recognise as being a modern version of the 'search for the elixir of youth' rejuvenation archetype. The duo (frail and active)

is also found in state policy narrative (Lestari et al., 2021). This archetype seems to underlie the *posyandu* practice.

The use of medical equipment has a magical authoritative quality surrounding it, be it simple weight scales or blood measuring devices. These not only indicate that aid in health is available, but persuade the client that something is being done. Such tools serve as symbolic devices of health authority in the presence of the clients no more or no less than the spirit-based healer's rattler, cloth, or wooden knife. It is for this reason Cadre Yuli, who started her career as a cadre for *posyandu*, but later went on to form her own highly successful village NGO promoting health, wellbeing, and active ageing, referred to the basic apparatuses in the *posyandu* as 'toys' and the cadre there merely playing with them. Cadre Yuli's point was that the *posyandu* was not doing enough when it had the attention of older people and the potential to do more than just measure their belly circumference. But toys and play are important, and unwittingly, by introducing a variety of active ageing activities for her own NGO's health and active ageing meetings, Yuli merely expanded the semiotic playground necessary for the promotion of older adult health in her village.

Finally, there is one aspect to these structured gatherings that was seen as central to the healing event, sociality or the realignment of the client/patient with the social group under the knowledge that they are being cared for. In *posyandu lansia* and other such health gatherings, older people can reconnect in a shared social space. In this social space, cadre and clients together create what Janzen called 'a therapy management group' (Janzen, 1987). The group in *posyandu* and other gatherings for health held for older adults are 'health ageing management groups'. People come together for a health cause and provide support. These modes of interaction have a bearing on the efficacy of creating a transformation in patient/clients by persuading them to change how they feel about their health, their bodies and themselves, and providing them with new possibilities of being.

To fully understand the health efficacy of a *posyandu* event and other gatherings for the wellbeing of older adults, such events should be methodically studied over a long period of time as if they were symbolic healing rituals.

CONCLUSION

Indonesia is at a crossroads in relation to its senior citizens. There is an awareness concerning the needs of older people. Exactly in what direction this awareness will lead the country is difficult to tell, although there is much talk about improving the various forms of healthcare in the country. In recent years, there have emerged in the larger cities elite resorts for older adults which provide all the amenities for health checks, healthy living, and pleasurable active ageing for those older adults who can pay for it. For the majority of Indonesian seniors, these homes are too expensive and might as well be in Geneva. Other old-age homes which have been around since the Suharto era are usually places for homeless, itinerant, and destitute elders and are seen by most as a shameful place to end up in. The majority of Indonesian seniors prefer to and expect to be allowed to age in place.

In Indonesia, healthcare and NGO volunteers bridge the knowledge gap between those with technology access; and those without, promoting health, ageing, and other important matters for older individuals (Ariani, 2020). Not only do these community relations bring older adults into

the picture, but they foster a more positive and less dependent attitude in older people (Malik et al., 2020). The community healthcare workers can go further by providing psychological support through culturally appropriate means. Through such support, significant relationships can develop that can also reduce feelings of isolation and the feeling of being side-lined in the community (Ariani, 2020). They thus can help older adults in the community to keep socially connected.

Volunteers must have a direct normative and semiotic connection with clients and understand local norms to effectively engage with them. By being members of the community who speak the same language and understand the local norms, inroads can be made. Material incentives may affect the temperament needed for becoming a cadre, potentially affecting their ability to connect with older people. Despite resources for professionalized cadres, volunteer cadres are necessary for maintaining an ethos for community outreach with clients with health-related social needs.

The importance of this last point has to be understood in qualitative terms. Good health means good incorporative sociality and has always been seen as a crucial determinant in therapeutic procedures in the village context. In this, the growing awareness of older people's needs in Indonesia has become crucial in enframing action towards older people for maintaining and improving health. One of the most important features of '*lansia* awareness' (ageing awareness) is that it tries to reconfigure older people at centre stage for themselves.

Posyandu/NGO cadre meetings and particularly some of the extra-curricular health activities they engage in, bring people together in an authoritatively-structured health-promoting context, which reconnects people in space, is important for the generation of people's wellbeing and might facilitate a transformation in time to a healthier sense of self. In this, as we have suggested, they resemble village-based healing rituals. More to the point, these gatherings *<u>are</u> modern-day health-promoting rituals whose main practitioners are local villagers chosen socially with the right temperament for the task.*

At present the most important aspect of *posyandu* in strict biomedical health terms is the monitoring of NCDs, which is not even always conducted in these events. A greater understanding of cadre and the nature of cadre activities for elder health and wellbeing in Indonesia is needed that goes beyond the study frames that merely position them as an extension of the primary healthcare outreach. Cadre should be repositioned as members of the communities they serve with shared understandings and general norms. Although Cadre activities are a manifestation of global and national health discourses and directives, their potential for health should be restored to the meaningful backdrop of the community's understanding of health, wellbeing, and (communal) village life. It is within this backdrop that cadre activity can be evaluated and developed to its fullest capacity.

To this end, the researcher who conducts research on *posyandu* has to be versed in the global health knowledge disseminated in *posyandu* and its aims, but will also have to be capable of understanding how this knowledge is conveyed in local discourse and semiotics. For this, the researcher would have to participate in the *posyandu* over a period of time as well as interview the organisers (cadre) and the older adults who participate in them as well as those who do not. Why is this important? At present, the study of such gatherings for health and wellbeing is reductively stale. There might be a lot semiotically going on in the health meetings for older adults, which is simply unrecognised or ignored and swept under the health mat. Even if NCD health monitoring will be more commonly established as the main part of *posyandu* practice, far more is happening in

these events which is significant for the client's wellbeing. Even a medicinally active pill prescribed by a doctor or nurse does not cease to induce what Moerman (2002) calls the 'placebo response' in patients and health clients. Thus, NCD health monitoring alone may not raise the level of health of all older adults to its fullest potential. By taking a more qualitative ethnographic approach, our findings direct health workers to establish how their activities meaningfully help older adults maintain better health and in what way the *posyandu* can serve the community in improving people's quality of life. In this, our qualitative research contributes to a better understanding of the efficacy of community healthcare volunteers and the health gatherings they organise for older adults.

ENDNOTES

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2) In spirit-based healing rituals the medicinal efficacy and advise based on this is conveyed from the spirit-based source to the client through the medium.

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