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BIJDRAGEN TOT DE TAAL-, LAND- EN VOLKENKUNDE 181 (2025) 255–289

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'Lansia Awareness' and the Challenges Faced by Community Volunteers (*kader*) Servicing Indonesian Elders during the First Year of the Covid-19 Pandemic

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Received 28 February 2024 | Accepted 25 August 2025 |
Published online 25 September 2025

Abstract

Before the Covid-19 pandemic, Indonesia had a strong focus on supporting older adults through community involvement and health initiatives. The development of this support, which occurred over a period of 25 years, we call '*lansia* awareness'. During this period, older adults were encouraged to exercise and actively participate in their communities. Community health volunteers and non-governmental organizations (NGOs) proliferated throughout the country to assist the senior population. However, in April 2020, the introduction of pandemic restrictions halted these efforts, significantly reducing access to healthcare and social services for older adults. Interviews with healthcare volunteers revealed that the suspension of community services adversely affected the quality of care for seniors. Although some volunteers continued to assist informally, better training and resources could have enhanced their support during this challenging time.

Keywords

lansia (senior citizens) – healthcare volunteers – Covid-19 – Indonesia – long-term care – community engagement

1 Introduction

In 1995, Anke Niehof published a seminal paper on ageing in Indonesia in the *Bijdragen tot de Taal-, Land- en Volkenkunde*, which addressed the implications of demographic transition policies on the senior population, particularly in light of reduced household sizes, changing family structures and village demographics, and increasing longevity. Another author, Hugo, a demographer by discipline, had already published an article (Hugo 1992) a few years earlier. These publications were significant for Indonesian gerontology and the study of ageing, a field that was then still in its early stages of development. Despite Indonesia's commitment to the Bali Declaration of 1992, which aimed to prioritize the care of older adults, state policy remained focused on population growth and unemployment. One of Niehof's proposals was to develop squadrons of healthcare volunteers particularly dedicated to the care of older people from the existing community of healthcare volunteers who at the time were focused on family and reproductive health.

Niehof's and Hugo's publications reflected the growing influence global discourses were having on Indonesia's awareness of issues concerning its senior

citizenry during the late 1980s and early 1990s. From the second half of the decade and in the two decades leading up to the Covid pandemic, Indonesia witnessed a rising '*lansia* awareness', with *lansia* meaning 'senior citizens' in some discourses and 'the elderly' in others. This awareness entailed growing public concern for older adults aged 60 and above, emphasizing their legal, social, and cultural rights, and their healthcare needs. *Lansia* awareness emerged alongside broader health and human rights demands and led to ongoing developments in senior care. However, during the pandemic, many of these advancements were disrupted and even inverted. In this article, we first discuss the development of *lansia* awareness in terms of senior care in Indonesia up until the pandemic. Following a short methodology section, we then relate the situation during the first year of the pandemic based on interviews conducted with volunteer healthcare workers and NGOs. We ultimately conclude by suggesting that there should have been greater utilization and support of community health workers and NGOs in order to assist the elderly population in areas under strict lockdown.

2 The Development of *lansia* Awareness during the Two Decades Leading Up to the Covid-19 Pandemic

The term *lansia* is a neologism. The term did not appear in legislation from 1965 under President Sukarno; the phrase *orang jompo* was used instead. The compound noun *lanjut usia* first appears in an English context in a supplementary dictionary compiled by Schmidgall-Tellings and Stevens in 1981. This dictionary included new Indonesian words that the editors had compiled from various government and popular discourses prominent during the years leading up to its publication. Notably, the term *lanjut usia* was translated as 'senior citizen', as it was being used discursively, rather than as the literal 'advancement of age', as one would translate the less formal *lanjut umur*. The abbreviated word *lansia* appears in the Stevens and Schmidgall-Tellings 2004 edition as 'lansia → orang lanjut usia' (p. 557).

In his 2004 publication, where the abbreviation *lansia* is used in the title, Hugo observed that ten years previously the term had not been widespread, but that it had become popular by the turn of the millennium. Hugo noted that the use of the portmanteau reflected the increasing number of discourses occurring in Indonesia at the turn of the millennium concerning the senior population. This suggests that the term *lanjut usia* emerged (and became the term of choice in discourses about senior citizenship) sometime between 1965 and 1980. Once this had happened, Indonesia's policymakers and civil society

were ready to start reconstructing senior society through use of the term *lanjut usia* and, later, and more colloquially, *lansia*.

The term *lanjut usia* or *lansia* helps to connect local discussions on ageing with global-health and gerontological discourses. It gives the subject of concern a proper name in Indonesian. Under the *lansia* 'banner', older adults have become the focus of specific global-health and behavioural policy discourses and practices that provide guidance on enhancing their quality of life as they age. The term is also prevalent in media and online platforms when referring to the older demographic of the country.

The term *lansia* provides a self-identifying label for older Indonesians through which their demands for '*lansia* rights' and '*lansia* health' can be articulated. However, this categorization based on age can lead to ageist stereotypes and the objectification of seniors by younger members of society.

In 1996, a year after Niehof's publication, President Soeharto, then president of Indonesia, officially acknowledged the importance of senior citizens in the country by designating 29 May as 'Hari Lanjut Usia' (Hari Lansia) or the National Day of Senior Citizens (Hari Lansia Nasional). Since then, Indonesia has used this day to celebrate its older citizens, wishing them strength and happiness, as well as being an opportunity to make suggestions to older people on how to live a healthy life. Lansia Day has raised awareness about older adults on a cultural level. A few *lansia* anthems have been composed, which include phrases such as 'Kita para lansia seluruh Indonesia' (We are the elderly of Indonesia) and 'Siapa bilang lansia tidak ada berguna?' (Who said the elderly have no purpose?). Even a boy band, Sheila on 7, felt compelled to write a song on this topic, 'Saat saya lanjut usia' (When I'm a Lansia/Old), which echoes the Beatles song 'When I'm sixty-four'. The ways in which *lansia* are portrayed can sometimes reflect a patronizing or infantilizing form of ageism. This is evident in popular cartoon videos on the Internet that address various issues concerning older adults, made by both well-wishing amateurs and professional agents. The narrators tend to speak about *lansia* and how they should live using 'child speak', as if addressing a younger audience and not an imagined audience of older adults. Older people are thus rarefied as '*lansia*'.

Also in 1996, the Perhimpunan Gerontologi Medik Indonesia (Indonesian Society for Medical Gerontology) was established to raise awareness about the specific health management needs of *lanjut usia*. In the early 2000s, when it was decided to incorporate geriatric services into the national health programme, some hospitals began offering training in geriatric health management (Soejono 2010). Already in the early 2000s, primary healthcare services had expanded and were being aided by volunteers and community health workers who promoted healthy lifestyles and social engagement based on global health insights among seniors (Rahardjo et al. 2009).

After the fall of Soeharto in 1998, many politicians discovered that platforming for *lansia* rights was politicly rewarding. B.J. Habibie's government enacted the Old Age Welfare Law (Law no. 13/1998),[1] which protects senior citizens' rights to services such as religion, health, employment, education, and training. This follow-up law to the 1965 legislation introduces the term 'Lanjut Usia' (both words capitalized). The document begins by referencing the 1965 law, which uses the term 'Orang Jompo'. It declares that the 1965 legislation, which was concerned with providing assistance to 'Orang Jompo' (incapable and destitute 'elderly') was now obsolete and the focus of the 1998 law is on the welfare of 'Lanjut Usia'. The opening passages thus also signal a transition in the terminology. The 1998 law distinguishes between 'Lanjut Usia Potensial' or 'potential' seniors (those who can work and are relatively healthy) and 'Lanjut Usia Tidak Potensial' or 'non-potential' seniors (those who are weak, frail, vulnerable, and destitute). Whereas the Orang Jompo law, written within a more socialist spirit, only emphasized the latter and that the government should make welfare provisions for them, the 1998 law, written within the spirit of human rights, emphasizes shared responsibility among the government, community, and older citizens for their welfare (Arifianto 2006). Provincial governments later issued their own legislative versions of Lanjut Usia.

At the turn of the millennium, a five-year development plan acknowledged the significance of the older population, and the necessity of implementing policies for their health and wellbeing (Hugo 2004:299). This led to the establishment of a Komisi Nasional Lanjut Usia (National Committee on Ageing) by President Megawati in 2004, which was mandated to assist the president in coordinating the implementation of the National Strategy to Improve the Welfare of Lansia (Arifianto 2006:10). In the following year, and under President Susilo Bambang Yudhoyono, the Komnas Lansia (Commission for the Elderly) was established. This was a committee of 25 members, with 15 representing government agencies and 10 representing civil society, whose task was to coordinate policies for older people in Indonesia. It was dissolved by President Joko Widodo in 2020 and 2021, and under the same president a Strategi Nasional Kelanjutusiaan (National Strategic Plan for the Elderly), referred to as STRANAS, was introduced. This plan outlines the national and regional development planning and budgeting documents that are related to ensuring the realization of senior citizens' independence, prosperity, dignity, and quality of life. This legislation also designated Pusat Kesehatan Masyarakat (Puskesmas, primary health clinics) as key healthcare providers for older adults.

1 Undang-Undang No. 13 Tahun 1998 tentang Kesejahteraan Lanjut Usia.

Over the years, since the turn of the millennium and in the lead up to the Covid-19 pandemic, public health campaigns aimed at older adults in Indonesia disseminated a fanfare of brochures and short films on social media platforms promoting healthy eating and active lifestyles. Central to these initiatives is the concept of 'active ageing', suggesting that maintaining an active lifestyle enhances health and independence and reduces societal burdens. The campaigns feature colourful imagery and repetitive slogans such as 'Makan Makanan Bergizi' (Eat nutritious food); 'Lansia Bersemangat dan Berdaya' (Energized and empowered senior citizens); and 'Lansia Berdaya dan Mantap' (Empowered and strong older people). These slogans encourage older adults and their carers to prioritize diet and exercise, reflecting a shift in the portrayal of older individuals in society away from the traditional image of the *orang jompo* (elderly person) with a stooped back and clinging to a stick to balance and walk, a common-to-all Indonesian cultural representation of old age. Older individuals are informed that by staying active they can enhance their health, maintain their independence, and avoid becoming a societal burden (this is usually implied rather than said.) Short films and cartoons depicting elderly characters exercising in gyms or public spaces are broadcast on television and shared on the internet to promote similar behaviours among older adults.

Senior citizens are invited to participate in public events (*kegiatan lansia*) celebrating older citizens. These are usually events entailing physical exercise and beauty pageants as part of active-ageing celebrations. An example of this type of event is the *lansia* beauty pageant, where women in their mid to late sixties participate by walking up a catwalk, wearing either a hijab or traditional hair buns (*sanggul*), some with a hand on the hip, culminating in a posed turn before returning up the catwalk, passing by the next strutting participant. All enjoy the frivolity of the event.

One major event for older adults before the pandemic was a celebratory festival held in Kabupaten Kediri (East Java) in November 2019.[2] Many older adults from across the regency attended the exercise parade which was part of the festival. All were dressed in tracksuits, looking sporty. The reporter described it thus:

> The period of old age is usually used by the elderly to stay quietly at home. But not for those *lansia* who attended the festival. They looked like they

2 Danang (2019). 'Festival lansia, tetap semangat untuk hidup sehat', 23-11-2019. https://arahjatim.com/festival-lansia-tetap-semangat-untuk-hidup-sehat/ (accessed 21-3-2025).

> were 17 years old. These older people's energetic movements lift the atmosphere.[3]

During the festival, an official gave a speech in which he succinctly repeated much of the information conveyed in the cartoon videos, brochures, and posters:

> I urge you, fathers and mothers, to take care of your health by exercising and eating healthy nutritious food. Maintain physical and mental health through religious activities, arts, etc. And maintain mental health through relaxation activities and gathering with your beloved family, etc.[4]

The report also mentions that according to an official from the Kabupaten, which helped organize the festival, 'the purpose of holding this event was so that *lansia* can remain enthusiastic about living healthily. The hope is that older people will not just stay at home but be active.'[5]

In the officials' words, given in the report:

> Older people in Kediri Regency must remain enthusiastic. With age, vulnerability increases, but (good) spirit and healthy living are what we must always prioritize.[6]

By promoting active ageing, which is a version of successful ageing, a theory and practice of improving the health and quality of life of older adults developed in the discipline of gerontology, the goal is to delay the onset of the deterioration of health as much as possible or to rehabilitate individuals into a healthier condition, if possible. However, at present, justification for this positivity is based on a problematic, mythical supposition that underlies *lansia* awareness on the popular level. This supposition is that, by default, *lansia*, if left to their own devices, will deteriorate because by nature they want to stay at home and do nothing. This is why there is all the fanfare and commotion of getting them out into the public space.

More importantly, other than getting *lansia* up and out of their beds and their homes to be active in public spaces, as those involved seem to imagine themselves to be doing, a number of NGOs have made efforts to locate impov-

3 Danang (2019). 'Festival lansia, tetap semangat untuk hidup sehat'.
4 Danang (2019). 'Festival lansia, tetap semangat untuk hidup sehat'.
5 Danang (2019). 'Festival lansia, tetap semangat untuk hidup sehat'.
6 Danang (2019). 'Festival lansia, tetap semangat untuk hidup sehat'.

erished older adults living alone and in inadequate conditions, who are referred to as *lansia tertinggal* (the abandoned elderly). These frail individuals are perceived as having been abandoned by their families and society. At times, such missions are documented for TV. A significant moment occurs in such TV programmes when a volunteer from a concerned NGO assists or carries a frail elderly individual out of their home to an assembled audience. This emotionally charged scene symbolizes the reintegration of the socially neglected older person back into society and national life. Consequently, similar to the legal distinctions that categorize older adults as either having 'potential' or being 'without potential', public awareness has created a dual perception of older individuals in Indonesia as being either active and healthy, or unhealthy, deteriorating, and bedridden (Schröder-Butterfill et al. 2023; Lestari, Stephens, and Morison 2022). The so-called *lansia tertinggal* provide the stereotypical image of the 'senior citizens without potential', the default position of the *lansia* if they stay at home, sleep, and deteriorate.

The 'potential' and 'without potential' dichotomy fits in neatly with the ideology of development that has been promoted in the country for many decades. In Indonesia, individuals who have recently entered the *lansia* age group have been encouraged throughout their lives to fulfil their duty to the nation's development by engaging in self-improvement (Li 2007). Li interprets this continuous encouragement through Foucault's theory of governmentality, which places the responsibility of governance on each individual citizen. This model is also applied to new healthcare systems, where the responsibility for health is placed on the patient, making personal risk reduction an essential aspect of health management (Petersen and Lupton 2000). Since the emergence of *lansia* awareness, the state has made efforts to develop improved health and social security systems for Indonesian senior citizens, and the community is encouraged to support the older people in their midst, but the onus of responsibility is still on the shoulders of the older adult. Indonesian older adults are still encouraged to continue their national duty by remaining physically active and healthy for as long as possible, and not by staying quietly at home (*diam di rumah*); hence the *kegiatan lansia* (activities for senior citizens) mentioned above.

However, as observers have noted, this positive approach, while beneficial for those who wish to (or can) participate, could result in the stigmatization and neglect of those individuals who are unable to meet these recommendations, potentially making them feel like failed citizens at the end of their lives (Schröder-Butterfill et al. 2023). Additionally, many poorer Indonesian senior citizens continue to work in the informal sector beyond retirement age due to financial necessity; hence they may not have time for activities such as going

FIGURE 1
Typical cartoon illustration 'MENJAGA KEBUGARAN LANSIA', *TRIBUN JATENG*. HTTPS://JATENG.TRIBUNNEWS.COM/2021/03/09/MENJAGA-KEBUGARAN-LANSIA (ACCESSED 18 AUGUST 2025)

to the gym or engaging in fanciful hobbies. Many only retire after significant incidents, such as being involved in a traffic accident or falling over in the field.

There is a gap between health recommendations for Indonesian senior citizens, particularly in rural areas, and their actual experiences. Those defined as *lansia* are a very diverse group in Indonesia and cannot be reduced to a two-pronged categorization. Creating *kebahagiaan* (happiness) for older adults is a good thing, but younger society must be very careful in what they communicate as part of any well-meaning happiness campaign. Hypothetically, well-pensioned, middle-class individuals are likely to benefit the most from these recommendations, but further research is necessary to understand the broader implications for all Indonesian older adults in their social economic and cultural diversity; from those who were once part of the world's jet set to those who were once living in tribal communities.

Since Niehof published her paper, there have been significant developments in Indonesia concerning its senior citizens. Individuals in this age group have been combined into an objectified and rarified *kaum* (social group). For the past 25 or so years, senior citizens have been the recipients of ongoing repetitive, and now cliched, public recommendations based on global health and gerontological knowledge regarding how older people should enhance their quality of life and maintain their health. Throughout their lives, those who are today classified as *lansia* have been encouraged to contribute to the nation's development and progress. Currently, they are advised to remain active and energetic in their later years and to continue to contribute to society by being visibly engaged as exemplary older citizens in the form of super *oma* (grannies) and *opa* (grandads).

Then, on 2 March 2020, President Jokowi officially announced that Indonesia had recorded its first infection of SARS-CoV-2 (Covid-19) and the world turned upside-down.

With this context in mind, the rest of this article will focus on the first year of the pandemic, starting in March 2020, when Covid-19 was first detected in the country, and ending on 13 January 2021, when the vaccination campaign com-

menced, with President Joko Widodo being the first to be vaccinated. During this year, older adults were requested to stay at home and avoid contact with others. Primary healthcare volunteers and NGOs were prevented from holding meetings with older people in many places where there were strict lockdowns (see below). In many respects, a reverse image was created of older adults, portraying them as vulnerable people who now had to stay at home for their own protection. This article suggests that suspending formal health and NGO services for older adults in high-density areas during the pandemic significantly reduced care capacity, especially for those with fewer facilities. The growing squadrons of healthcare volunteers and NGOs, which had been at the vanguard of *lansia* awareness over the past 20 years and who provided essential healthcare and other services directly to this segment of the population in many places, were now required to navigate around them, and a lot of social pressure was placed on older adults to stay in their homes and reduce face-to-face socializing to a minimum.

3 Methodology

The following analysis is based on data drawn from interviews with healthcare providers, volunteers, NGOs, and local officials in two Indonesian communities that were under strict lockdowns. These interviews were conducted online or by phone during the pandemic. They form part of a wider project that takes a comparative ethnographic approach and utilizes in-depth interviews and participant observation in five Indonesian locations: a poor urban neighbourhood in Jakarta, peri-urban villages in Sleman and Malang, a village on Alor island, and a locality near Batusangkar. The project's goal was to understand older people's care needs and their care networks in these communities.[7]

The Covid-19 pandemic delayed the start of our original research project, requiring methodological adjustments. We used this delay to interview people about their pandemic experiences. This article includes data from various sources. Data were primarily drawn from interviews with 22 community health workers and NGO volunteers in Jakarta and Yogyakarta. These areas have pro-

7 The project, titled 'Care Networks in Later Life: A Comparative Study of Five Communities in Indonesia Using Ethnography and Surveys' was funded by the Economic and Social Research Council (ESRC, UK), grant number ES/S013407/1. The project has ethics approval from the University of Southampton (ERGO52712) and Lembaga Ilmu Pengetahuan Indonesia (LIPI). All Indonesian researchers conducting data collection received permits from the appropriate authorities to collect data during the period covered in this article, although some were restricted to meetings via social media.

gressive services for older adults but were severely affected by the lockdowns. The interviews revealed disruptions to routines, leading us to design additional guides to understand pandemic experiences better.

Our research team in or near the study sites listed above then provided first-hand reports on life under the 'new normal' in Indonesia throughout the year. The third data element comes from initial interviews with older adults or family carers, which were conducted where face-to-face meetings were possible due to a more limited impact from Covid.

4 When Covid-19 Entered Indonesia

Before Covid-19 was officially detected in Indonesia, there were doubts about the country's claim of being virus-free and concerns over its preparedness to deal with the pandemic.[8] With the first confirmed case, worries about community transmission grew. Government ministers gave daily speeches, likening the pandemic to an impending war (Fithry and Schröder-Butterfill 2020), but many criticized the government's slow response and the then health minister's downplaying of the threat (Najmah et al. 2021). Managing an infectious virus in a populous, dispersed country such as Indonesia, which is a 'respiratory disease tinder box' under ordinary conditions, required advanced preparation.[9]

Masks and hand sanitizers began appearing in public places, and security personnel started checking temperatures. Schools closed, and a stay-at-home policy was encouraged. Non-essential travel faced restrictions, especially before Eid ul Fitr (which fell on 23–24 May). The government gradually promoted health measures, with the accompanying slogans promoting the 'three Ms' of social distancing: 'Memakai Masker' (Wear a mask), 'Menjaga Jarak' (Keep your distance), and 'Mencuci Tangan' (Wash your hands). Later still, two more Ms were added: 'Menjauhi Kerumunan' (Avoid crowds) and 'Mengurangi Mobilitas' (Reduce your mobility).

8 T. Lindsey and T. Mann, 'Indonesia was in denial over coronavirus. Now it may be facing a looming disaster', 9-4-2020. https://theconversation.com/indonesia-was-in-denial-over-coronavirus-now-it-may-be-facing-a-looming-disaster-135436 (accessed 12-1-2022); D. Rochmyaningsih, 'Open the doors for us: Indonesian scientists say government snubs offers to help fight coronavirus', *Science*, 18-4-2020. https://www.science.org/content/article/open-doors-us-indonesian-scientists-say-government-snubs-offers-help-fight-coronavirus (accessed 1-3-2023); Olivia, Gibson, and Nasrudin 2020.

9 Lindsey and Mann, 'Indonesia was in denial over coronavirus. Now it may be facing a looming disaster'.

In mid April, the government declared the spread of Covid-19 a public health emergency and a national disaster.[10] A presidential decree established the Gugus Tugas Percepatan Penanganan Covid-19 (Covid-19 Response Acceleration Taskforce; hereafter 'Covid-19 taskforce'), which included provincial mayors, regional administrations, ministries, and various national agencies. This taskforce created a hierarchical structure that extended down from provincial heads to neighbourhood leaders, with each reporting to their immediate superior. Each province's taskforce was granted wide-ranging authority to manage the virus's spread while adhering to central-government guidelines when implementing regional policies (Buchanan 2020). Under this system, healthcare volunteers accountable to health centres were also made accountable to neighbourhood heads.

The Indonesian government introduced Pembatasan Social Berskala Besar (PSBB, large-scale social restrictions) instead of a total national lockdown. Provinces or cities had to get approval from the Ministry of Health to introduce PSBB based on the numbers of Covid-19 cases and deaths. Once approved, PSBB could be enforced for 14 days and extended as needed. Police were authorized to enforce these restrictions, disperse crowds, and impose curfews. This policy limited religious, social, and non-essential activities to control the spread of the virus. First implemented in Jakarta in April 2020 (Sare and Schröder-Butterfill 2020), PSBB were periodically lifted and re-enforced. Other regions soon followed suit (Buchanan 2020; Suraya et al. 2020).

While these measures were being developed, health officials raised concerns about the safety of senior citizens (*lansia*). *Lansia* awareness, which had always been influenced by global discourses, went into a higher gear. Older adults were now defined as a highly vulnerable group. Measures were taken through various media (often riddled with ageist stereotyping) to inform older people in society about how to protect themselves. Messages on how to shield older people from contracting the disease were also disseminated to the public. Videos circulated which portrayed older adults as highly vulnerable and in need of total protection. While in the pre-pandemic videos older adults had been portrayed as active and independent individuals surrounded by their children and grandchildren, they were now portrayed as frail and needing to be protected through physical isolation. Gone were the images of super *opa* and *oma*. A far more vulnerable and feeble representation of older people appeared, as in the health video discussed below (Fig. 2).

10 C. Morris, 'Governing a pandemic: Centre-regional relations and Indonesia's COVID-19 response'. https://www.newmandala.org/governing-a-pandemic-centre-regional-relations-and-indonesias-covid-19-response/ (accessed 12-1-2022).

FIGURE 2 Stills from a government ministry health video on how to protect *lansia* during the pandemic 'BAGAIMANA CARA MELINDUNGI LANSIA DAN ORANG TUA DARI COVID-19?', KEMENTERIAN SOSIAL (KEMENSOS). AVAILABLE ON YOU TUBE (ACCESSED APRIL 2021)

The first image shows that *lansia* already have a poor (damaged) shield against the disease. The second shows that their immunity levels have been further reduced and their shield has fallen. The third shows a couple behind a powerful shield and asks, 'how then, can we protect *lansia* during the Covid-19 period?' The rest of the video provides nine social recommendations on how to 'boost their protective shield', a shield which ideally isolates older adults behind a glass wall.[11]

Younger relatives not living with their elders were exhorted to avoid visiting them. Instead, social media were suggested as the preferred mode of communication and money was to be sent via the post office. These suggestions were made with extra emphasis during the month of Ramadan. It was not really considered how many present-day Indonesian senior citizens knew how to use the technology on which social media depend or whether they felt comfortable with it, a point we shall return to later in this article.

Measures to control the virus and restrictions on public gatherings greatly impacted health and social-care services for older adults. Village-based integrated health services and NGO services were suspended from April 2020 onwards, particularly in Jakarta and throughout Java. These services remained suspended for most of 2020 and 2021. Due to their presumed vulnerability, the health policy for older adults was for them to self-isolate with minimal face-to-face contact with others, including healthcare workers.

Attempts to resume services in a modified form were inconsistent. However, primary healthcare workers occasionally provided other health services, such as disseminating information about social distancing to the general public in the street, which older adults would come out to watch. Other care groups

11 'Bagaimana cara melindungi lansia dan orang tua dari Covid-19?'.

focusing on general health would pass by the houses of their older adult clients, but those specializing in *lansia* care were kept on a tight leash in terms of service delivery. They were not properly utilized or allowed to provide care in line with social-distancing guidelines, in areas with stricter lockdowns.

It was the PSBB, where implemented by the regional Covid-19 taskforces, which caused the most disruption to the volunteer healthcare (*kader*) services to older people, as they prohibited all gatherings deemed unnecessary. In places where the regional authorities did not make use of the PSBB, and where there were functioning *kader* systems in place, such as in our field site on Alor, health services supported by *kader* were quickly resumed within a precautionary framework. Yet in various parts of Java (including the capital, Jakarta), which had a large population of older adults, healthcare volunteers had to suspend their usual services. In the next section we shall elaborate further on the role of healthcare volunteers in relation to Indonesia's older population, before examining the impact of the restrictions on their activities.

5 The Volunteer Healthcare (*kader*) System in Indonesia

As alluded to in the introduction, Indonesia has long had community-based integrated primary health services, known as Posyandu (Pos Pelayanan Terpadu, integrated service post). They were first used in the 1970s to support Indonesia's family planning programme and mother-and-child primary health (Niehof and Lubis 2003; Reis et al. 1990). They are an extension of the community health centres (Pusat Kesehatan Masyarakat or Puskesmas), which exist throughout Indonesia and provide primary and population health services at the village (*desa*) or urban neighbourhood (*kelurahan*) level. Nowadays there are several types of Posyandu, some of which serve specific target groups (for instance, people at risk of stroke). The most common are the Posyandu Balita, which monitor the health of mothers and children under five, and the Posyandu Lansia, which look after people from age 60, although they also give support and preparatory advice to adults between the ages of 45 and 59. As has already been mentioned, Posyandu Lansia services (also referred to as Pos Bindu Lansia) began to mushroom as a consequence of the *lansia* awareness that emerged in Indonesia during the 1990s. They have been operating in many communities for around 20 years (Pratono and Maharani 2018). Importantly, all Posyandu rely on local volunteers (*kader*) to deliver the services.

Most *kader* are women. They can be professionals (such as nurses or teachers) who volunteer in their spare time; civil-servant retirees; housewives; or

people with lower educational backgrounds who have free time and an interest in health and being involved in the community. When asked about the incentives for volunteering, they answer that it is a thing that comes from 'the heart' and recognize that volunteering in care is not for everyone (Porath et al. 2024). The volunteers assist a professionally trained community nurse or midwife (*bidan*) in the Posyandu, providing basic health services in the village or neighbourhood wards where they live. Typically, the *kader* start with very little knowledge of how to serve their target groups, but they quickly learn the essentials as they participate in the health meetings (Posyandu), where they monitor the health of service users. Usually, it is only after joining the *kader* team and having participated in *kader* meetings for some time that volunteers attend short training courses about topics relevant to their service, assuming the primary health centre, a local nursing college, or an NGO makes them available.

During the Posyandu for *lansia* (which concern us here), older people routinely have their weight recorded, blood pressure measured, and cholesterol, sugar, and uric acid levels checked. Sometimes the *kader* also use the meetings to convey information about diet and exercise. These Posyandu for *lansia* take the form of a modern health ritual (Porath et al. 2024). Some *kader* visit older adults in their homes, if they are too weak to visit the Posyandu, but if this is done, it is usually on an individual's initiative. By conducting basic health monitoring, the *kader* identify health problems and encourage people to engage with the primary community health centres (Puskesmas), which offer outpatient curative health services and have the authority to refer patients to hospitals and specialist health services. As older Indonesians are often hesitant about utilizing medical services or do not have family to accompany them, *kader* sometimes help older people by accompanying them to the health centre or helping to arrange their health insurance (BPJS) for them. Thus, *kader* play an important role in making healthcare accessible to older people alongside keeping an eye on their well-being (Berenschot, Hanani, and Sambodho 2018).

Although under the national programme *kader* are spread unevenly across the regions (Pratono and Maharani 2018), the Posyandu Lansia are also not present in all neighbourhoods. In areas where the service is established and active, *kader* teams serve as extensions of the primary health centre within the village, essentially acting as its representatives in the local community. They promote health using accessible language and help to reduce non-essential visits to the primary health centre (Van Eeuwijk 2021). For those who utilize their services, these volunteers are approachable and provide valuable social support within a complex and at times overwhelming health system.

Another group of *kader* are those who work for NGOs. There are several NGOs working to improve the quality of life of older adults in Indonesia. The NGO *kader* work with designated groups of older adults for specific purposes, such as assisting poor and neglected senior citizens or those living with dementia. Prior to the pandemic, some NGOs in Yogyakarta provided training on ageing issues and elder care, aimed at older individuals, their carers, or *kader* from other organizations, including primary healthcare volunteers. Some of these organizations have a national vision, aiming to establish branches throughout the country.

Kader who support older people in communities, whether through primary health centres or local NGOs, are volunteers with basic healthcare skills and local knowledge. They act as mediators, translators, and brokers, connecting state health institutions, NGOs, and local residents to improve the quality of life for older Indonesians (Jakimow 2018). They have become key figures in promoting *lansia* awareness.

6 Primary Healthcare and Older Adults during the Pandemic

During the Covid-19 pandemic, general medical services at Puskesmas (primary health centres) continued to operate, albeit with some restrictions. Older adults were permitted to visit a primary health centre in person, though accessing health services was strongly discouraged unless absolutely necessary. At the health centres, older patients could receive the health checks typically conducted during Posyandu meetings in the village. Services were consolidated, moving from the neighbourhoods into the health centres, which are often located some distance away. In rural areas, primary health centres are usually situated in sub-district capitals rather than villages. This posed challenges for older adults residing more rurally, particularly for those lacking the practical and financial resources for such visits.

Additional restrictions on space and time deterred older individuals from attending. For instance, patients were required to wait outside before consultations, with seating often limited or unavailable, causing frustration among older visitors. The number of patients seen within a given period was also reduced, and doctors could refuse to take consultations beyond the set times and quotas.

Kader Ratri (pseudonym) in Jakarta mentioned that 'many older people feared visiting the health centre due to the large crowds; this contrasts with the Posyandu service, which caters specifically to a small group of older adults'. At one of the Yogyakarta sites, an informal carer (relative) emphatically stated:

> During this time with so much Corona I am simply not courageous enough to accompany [the older person] to the health centre. I am just not courageous enough to go to a place [of service] like that.

There was another, deeper fear that prevented older adults from visiting the health centre. According to *kader* Ratri,

> if [older adults] are sick, especially if they have a cold or cough, they fear that they will be suspected of having Covid-19 and then will be hospitalized alone, without their carer.

This fear was corroborated by some of our initial interviews with older adults and family carers. As one adult daughter in East Java said about her elderly father: 'If we take our father to the hospital, there they will certainly say it is Covid.' The same view was expressed at the Yogyakarta sites. This prompted the development of a novel term on Java: *di-covid-ke* (*dicovidkan*, 'to be covidized'). What is meant by this is that the health centre or hospital would automatically diagnose an ailment as Covid-19, even if it were not the correct diagnosis. In our West Sumatran study community, a similar wariness towards health services existed. Here, it was also rumoured that health institutions had a financial incentive to diagnose people with Covid-19: the more individuals diagnosed, the more financial aid they would receive from the government. Whether there was any truth in this, or whether it was simply a misunderstanding of financial procedures, is not for us to say. However, hearsay examples of false diagnoses reflected and fed into people's fears, leading to mistrust in medical institutions.

The fact that many older adults and their carers were discouraged from pursuing and following up on routine health checks during this period led to concerns among the *kader*. On noting that several older people in her jurisdiction had died during the pandemic, *kader* Ratri disclosed: 'Most seniors prefer to buy drugs from the pharmacy if they feel unwell.' She added: 'I am very worried that many older people in the ward are taking drugs incorrectly during the pandemic because they are too scared to have their routine checks at the health centre.' Also in Jakarta, *kader* Ernawati expressed similar concerns: 'As most older people stay at home, they do not know if they are healthy or not.' She added that 'there are older people who have just died but who, before the pandemic, were healthy and diligently attended the Posyandu meetings'. This supports the suspicion that some older people died during the pandemic due to the poor management of underlying health problems, of which high blood pressure and diabetes are the most common in Indonesia (Khoe et al. 2020; Turana et al. 2021).

We have numerous accounts from *kader* that when they met older people in the street, the latter always expressed their regret that the health checks had been suspended and asked for their resumption. It seems that many of the older adults who made use of the local Posyandu service needed this intermediary connection in order to access primary health centres.

7 Contradictions and Difficulties in Combining *lansia* Awareness and Social-Distancing Protocols

Despite disruptions due to Covid-19, *kader* did continue with health promotion work, sometimes contradicting social-distancing protocols, albeit they did not directly work with older adults in this period. Donning masks, they were sent out in teams to promote social-distancing rules and teach people how to wear masks and wash and disinfect hands in the prescribed manner. *Kader* would invite an older person on the street to don a mask and would then adjust it for them. *Kader* would then take a photo of the person wearing the mask in front of their house as proof (to the masks' donors) that they had received it. *Kader* also demonstrated hand washing in front of people. At our Jakarta site, *kader* would sing a song as they performed the hand washing to help older people to remember the process and to encourage children to emulate them. While one person sang, another would demonstrate the seven steps of how to wash hands, and a third would explain what was happening. Posters detailing the seven steps were then pasted on walls at the end of the demonstration. From photographs we were able to obtain, it seems that these promotional events did not fully follow social-distancing protocols, as they were often carried out in densely populated streets and alleyways.

A volunteer from Jakarta explained that the government's promotion of hygiene did change older people's attitudes towards the pandemic, leading to more people wearing masks and following protocols. However, some older adults either did not believe there was a pandemic or ignored the rules. Practical reasons also prevented them from adhering strictly to the rules: masks were uncomfortable for people with breathing issues, and many older people still worked in the informal economy, making drastic behaviour changes difficult. Older people would also avoid wearing masks when near their homes or in familiar areas, viewing them as personal spaces where masks were unnecessary. One older person at our East Javanese study site responded: 'This is my village, so I don't need to wear a mask here.' *Kader* Andriana courteously referred to such lapses as 'forgetfulness'.

FIGURE 3
Teaching an older person how to wear a mask in a neighbourhood in Jakarta
PHOTO OBTAINED BY Y. SARE FROM SITI HAPSAH, 2020

Another problem which the *kader* noted was that hygiene promotion did not always reach the poorer and more vulnerable older adults, particularly those living alone or those who were unfamiliar with the national language. Furthermore, many older people in Indonesia do not use mobile phones or computers, and those who do may have struggled with apps such as WhatsApp. Individuals with hearing or vision impairments may have been less informed about the pandemic due to reduced TV viewing, relying on others for information. Another group of older adults who it can be assumed did not receive proper information were neglected older adults living with cognitive disabilities. Older people living with dementia were often oblivious to the pandemic and might still have wandered the streets unprotected. To illustrate this concern, *kader* Ernawati reported the case of one woman living with dementia in her ward. The woman was exposed to cruel teasing by children, who admonished her to wear a mask, shouting 'corona, corona!', and then running away giggling as though she was a source of infection. In some instances, *kader* tried to communicate with older adults living with cognitive disabilities through their carers, but this

FIGURE 4 Elderly vendor selling spices in Condongcat Market, Yogyakarta. One of the challenges was keeping the mask from dropping to the chin
PHOTO BY HEZTI INSRIANI, 13 MAY 2020

was not always possible. Furthermore, the NGOS that take care of vulnerable older adults with cognitive impairments, such as Alzheimer's Indonesia (ALZI), had their own activities restricted, if not suspended. This was the case for the Yogyakarta branch of ALZI at our research site.

From the comments made by various *kader* in our interviews, it is apparent that a proximal method of communication was needed to reach certain older people in the community. Knowing how to communicate without putting people at risk was crucial. Not being able to do so left a large group of older adults out of the communication flow about the pandemic and in a socially vulnerable position.

8 Being in the Neighbourhood during the Pandemic and Feeling a Duty to Engage

In areas with PSBB in place for most of 2020, *kader* services for older people were suspended. *Kader* Ratri from Jakarta described her activities as being carried out in a 'vacuum', while another from Yogyakarta said it was 'very quiet'.

Although *kader* understood the reasons for pausing Posyandu services, they still felt that continuing the meetings would have been more beneficial. In Ratri's words:

> If the Posbindu services had continued, a system could have been created that would keep every older person attending at a distance from the others. Only the person being examined would have been allowed to enter the post, with the rest waiting outside on benches. They would have been masked and given disinfectant for their hands before entering.

Ratri also stressed that the Posyandu would have been able to better inform older adults about the pandemic and how to protect themselves. At one field site, the *kader* suggested this to their superiors, who seemed to reject the proposal by not responding.

Over time, some volunteers' sense of duty led them to new ways of adjusting to the situation, and they found alternative methods to keep an informal eye on the older population living in their communities (Insriani and Porath 2020). As one *kader* from Jakarta revealed:

> I always greet older people I know when I meet them (on the streets) and ask them how they are doing. Other *kader* do the same. Then we all share our stories about them and try to determine who seems to be in a bad condition. Then an appointed *kader* will directly ask the person or his or her carer about their health.

At our Jakarta site, older people often sat outside their homes at midday, following public health injunctions to soak up some sunlight every day. This novel practice encouraged one *kader* we interviewed to keep in touch with the older people in her area by taking certain routes to pass by their homes as she went around carrying out her own activities. When encountering older people in the street, *kader* reported that they took the opportunity not just to ask them about their health but to promote the three Ms of the social-distancing protocol mentioned above. Sometimes *kader* allocated to specific population healthcare programmes, such as dengue fever prevention, were sent to wards to conduct weekly inspections, for instance, for mosquito larvae. The *kader* dedicated to the *lansia* would then request that these *kader* also ask about the conditions of the older adults in the households and report back via WhatsApp.

It is clear that the *kader* working with the *lansia* feel a duty to those they serve. Many senior citizens view their local *kader* as 'being like us' and being approachable and supportive in health and personal matters. There is even an

expectation that *kader* will help with economic issues, such as securing assistance for older people omitted from government subsidy lists. *Kader* typically refer health queries to local health centres. This informal relationship helps maintain communication between older adults and healthcare providers, despite many interactions being ad hoc and driven by the *kader*'s sense of moral duty rather than formality.

9 Developing a 'Virtual Clinic' and the Sociality of '*jamu Covid*'

During the Covid-19 pandemic, the internet and social media spread information quickly. In 2020, the WHO even recommended the use of social media for keeping in touch.[12] Health professionals and the public quickly adapted. *Kader* used WhatsApp and Zoom to create 'virtual clinics', essential for their work. WhatsApp, already popular in Indonesia, helped *kader* and their patients to communicate, share information, organize mask distribution, and report community deaths.

In order to impress upon people the importance of social distancing, some *kader* made their own health-promotion videos, demonstrating how to wear a mask, disinfect hands, maintain a healthy diet, and make home-made disinfectants and herbal medicines. But as *kader* Ernawati stressed, 'we are mainly limited to communicating via WhatsApp groups, which constrains us in communicating with older people who do not have mobile phones'.

During the first year of the pandemic, herbal medicine, or *jamu*, became widely used in Indonesia to boost immunity against Covid-19. Despite some criticism from health professionals (Lim and Pranata 2020), *jamu* remains popular. It can be bought from street vendors, shops, and pharmacies, or made at home. Older adults in Yogyakarta learned to make *jamu* through NGO initiatives promoting active ageing. Many shared *jamu Covid* recipes on social media, creating drinks from herbs, spices, and common cooking ingredients, such as lemongrass, cinnamon, Javanese ginger, turmeric, garlic, cardamom, eucalyptus oil, lemon juice, honey, or coconut milk. There is no fixed ingredient list for *jamu Covid*.

Since *kader* are local community members and share in many of the local predilections of the people in their neighbourhood, they also became involved in the flow of information about *jamu*. At our field site in Jakarta, according to

12 World Health Organization, 'Mental health and psychosocial considerations during the COVID-19 outbreak', 18-3-2020. https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf (accessed 21-7-2025).

FIGURE 5
A *jamu* vendor at a seasonal market in Yogyakarta, which operates according to the Javanese calendar, making and selling *jamu* tonics intended to help prevent Covid-19
PHOTO BY CIPTANINGRAT LARASTITI, 20 DECEMBER 2021

Ratri, a message revealing how to a make a good *jamu Covid* drink entered the WhatsApp group text-messaging conversation. From there it was passed on to others, who started sharing videos on how to make *jamu* as a complimentary medicine. Ratri herself had doubts about whether these herbal remedies were really efficacious in preventing infection from Covid-19. However, according to her, this was irrelevant, as people enjoyed making *jamu* and sharing their results with others.

In a period when people were asked to physically distance, making *jamu Covid* and disseminating recipes and knowledge about it proved to be a socializing phenomenon that brought people together and kept them connected through social media.[13] The fact that *jamu Covid* has no set ingredients list allowed people to maintain a conversation around sharing novel herbal possibilities. We can call this '*jamu Covid* sociality'. Through *jamu Covid* sociality and having a shared personal interest in *jamu* production, some *kader* were able to

13 A. Swastika, 'Revolution from the kitchen: Women and ecological responses to COVID-19', *New Mandala*, 26-10-2020. https://www.newmandala.org/revolution-from-the-kitchen-women-and-ecological-responses-to-covid-19/ (accessed 21-7-2025).

maintain contact with older people in their neighbourhood. The intermediary position of the *kader*, as promotors of science-based public health information on the one hand and their intuitive understanding of grass-roots traditional knowledge and interests on the other, was reflected in their ability to participate in this *jamu Covid* sociality and helped them to keep some of the older people they served (who were able to use social media) connected.

10 The *kader* Serving *lansia* as a Poorly Tapped Resource

In the community health system serving *lansia*, there is normally one community-based nurse and about five *kader*. As noted above, *kader* are not professional healthcare providers. They are local volunteers who follow the orders of their professional superiors in the health centre. During the pandemic, they also had to follow the orders of their village heads, who were at the bottom of the Covid-19 taskforce hierarchy. As we observed, when a *kader* from the Jakarta site made a reasonable suggestion about how health check-ups (Posyandu) for older adults could be implemented during the pandemic, this was ignored. That *kader* for *lansia* were viewed as being a dispensable task group is reflected in another incident that occurred at the Jakartan study site. When the Jakartan municipality delivered a limited number of masks for distribution to the most vulnerable senior citizens in a particular ward, the task of giving them out was given to the 'Dasa Wisma *kader*' rather than the volunteers dealing with *lansia*. (Dasa Wisma is a well-known community-based women's organization which exists throughout Indonesia, and their *kader* are sometimes used for statistical data collection.) The *lansia kader*, who personally knew the older people in their wards, felt sidestepped, as Ratri explained:

> The *Kader* Dasa Wisma are not in a position to provide assessments about which *lansia* are vulnerable. Their activities are only to monitor and register the condition of households in each ward. *Kader* Dasa Wisma do not know the medical history of the older people in the neighbourhood, who is sick with diabetes, who has high blood pressure or who has heart problems. This is the responsibility of the *kader* serving the *lansia*.

According to Ratri, the distribution of masks should have been carried out by the Posyandu *kader* who know who the 'vulnerable' are in their respective wards. To add insult to injury, the *lansia kader* were then sent into the wards as mere 'couriers' to distribute the masks as, after all, they knew where the older adults lived.

In places where the Posyandu *lansia* service had been officially suspended, *kader* were occasionally sent into crowded neighbourhoods to promote health protocols. This was done without PPE, without training, and with a 'jump to it' attitude. The evidence from our interviews with *kader* suggests that they were not only unprepared for a pandemic situation but were not trained to their fullest capacity to monitor the health and well-being of older adults.

Despite wanting to resume health check services for older adults, the *kader* recognized the challenge of maintaining social distancing. The risk of *kader* contracting the virus could have halted Posyandu meetings. For example, an over-enthusiastic but ill *kader* in Jakarta attended a mask-promoting event with a fever, endangering others. Although she did not have Covid-19, no checks had been performed before the *kader* went into neighbourhoods. One *kader* admitted: 'We were all irresponsible for not being tested.' Greater precautions were necessary. In Yogyakarta, a Posyandu meeting was cancelled early on in the pandemic when a *kader* tested positive, disappointing many older adults. In late 2020, at our East Java site, the combination of an integrated health post for older adults with Posyandu meetings for mothers and children led to overcrowding. Older individuals had no seats, and their meeting ended 30 minutes early, forcing some late arrivals to leave unexamined.

The interviews and anecdotes from the *kader* reveal several points. Firstly, the volunteers generally expressed enthusiasm about continuing their work with older adults. Secondly, many older villagers still needed Posyandu meetings, which could have served as an effective platform for distributing reliable information about the pandemic. Any shortcomings in maintaining health protocols were due to a lack of training in organizing meetings during the pandemic. This lack of training indicates that their superiors viewed their contribution to the health service as relatively minor and therefore they were not prioritized during the crisis.

11 The Need to Manage the Stress of a Pandemic

In the second week of March 2020, two of our research team attended what turned out to be the last meeting of an important, 'age friendly' NGO with its older clientele in Sleman (Yogyakarta). The organizers, who were also lecturers at a local university, took the time to explain to the older people gathered what was then known about the pandemic and how to protect themselves. During the talk, one older man in the audience raised his hand and asked a provocative question: [given these new conditions,] 'Who will protect us from our fears?'

From the early days of the pandemic, concerns had arisen about the impact of the 'new normal' on mental health (Kola et al. 2021; Torales et al. 2020:318). Lockdowns and restrictions harmed family incomes and disrupted social support, leading many older adults to be dependent on community initiatives such as those run by NGOs and volunteers. During a crisis and without proper management, many older people could become neglected (Nagarkar 2020). Feelings of loneliness and abandonment could lead to depression, weight loss, and disruptive behaviours (Darmayanti, Winata, and Anggraini 2020; Gardner, States, and Bagley 2020), which, it should be remembered, *lansia* awareness was intended to prevent.

Different understandings of the pandemic in society led to different behavioural approaches, resulting in the formation of various 'pandemic social factions'. Their existence further generated stress and anxiety among people and gave rise to various forms of stigma towards health professionals, individuals infected with the virus, and those with different behavioural responses to the pandemic (Gunawan, Aungsuroch, and Fisher 2020; Sulistiadi, Rahayu, and Harmani 2020). As one Jakartan *kader* observed, 'people become *parno* (paranoid)'. Older individuals' responses to the pandemic may have prompted ridicule and stigmatization from those holding opposing views, leading to negative outcomes (Yuan et al. 2021). For example, a person living with dementia wandering about without a mask may have been ridiculed, and the same may have been the case for older people wearing masks and visors. Additionally, older individuals found themselves caught up in the activism and vigilantism of others, which placed them in anxiety-inducing situations.

Stress can also arise from misunderstanding health information, especially for social media users. Issues related to 'health literacy' are complex (Paakkari and Okan 2020). Identifying reliable sources of information was a significant challenge during the pandemic. Various social media platforms distributed information about the pandemic with the intention of enabling people to access, understand, and responsibly follow the guidelines provided. Among those older adults with the ability to access the internet this may have led to a phenomenon that has been dubbed 'cyberchondria' (Muse et al. 2012).

A further complexity, as noted by Widiyanto (2020) following Nichols (2017), is the issue of this era being referred to as the 'post-truth' era. This denotes a time in which the global internet democratizes professionally popularized medical knowledge, placing it in the same technological spaces as other information and opposing perspectives that are also easily accessible. While professional health information, promoted by governments, is disseminated to the public through simplified semiotics such as informative journalism or cartoons for easier comprehension, this essential health information is just one

option in a semiotic space filled with multiple truths. In medical health literature, these competing claims to health facts are often termed 'infodemics'. The relationship between popular medical health knowledge and people's various understandings and responses might be better seen as forming 'semiotic chasms' between the various knowledge systems.

Kader Ratri provided a further explanation as to why many older people did not always comprehend the need for social-distancing protocols. Older people in local communities often view health and disease differently, seeing illness as a personal issue rather than something contagious. They attribute disease to factors such as fate, mental stress, or past actions, which makes the concept of asymptomatic illness hard for them to grasp. Since many older Indonesians did not witness severe Covid-19 cases, they struggled to understand the significant impact of the disease on their economy, social lives, and stress levels. Many religiously minded older people might also have followed the dictum that 'death is Allah's affair' as justification for dismissing suggestions for them to take better precautions. To counter this religious fatalism, *kader* Haji Amina said she always responded with:

> Indeed, (the length of) one's age is determined by Allah's provision. But we humans must try as well. If Allah wants something else, then this for sure will be. And if we reach the end of our time, then this for sure is our destiny. But the important thing is to try our maximum to be active and do what we have to do and not give up. To do so (give up) is ridiculous.

This is where intermediaries such as *kader* have a role to play, assuaging the community's anxieties and fears and bridging the 'semiotic chasms' (Gunawan, Aungsuroch, and Fisher 2020). In non-pandemic conditions, it is the role of the *kader* (be they primary health *kader* or NGO *kader*) to use simple language to explain the complicated health issues that concern local community members. Our evidence suggests that *kader* in Indonesia were and are fully aware of this role. *Kader* Ernawati from Jakarta explained:

> Even though the communication from the government is clear [...] many seniors still do not understand what Covid-19 really is, so it is the *kader* who have to explain it to them in the local language.

Evidence indicates that *kader* roles could be expanded. Kola et al. (2021) highlight that some countries have trained non-specialists to provide psychological support following WHO guidelines, emphasizing the importance of grass-roots institutions in mental health crises. Moreover, the WHO recommended train-

ing carers for older adults to enable them to deliver basic psychological first aid during the pandemic.[14]

12 Discussion and Conclusion

This article opened by briefly examining how over the past 30 years *lansia* awareness has resulted in the shaping of the older-adult age group in Indonesia into a social category known as *lansia*. We then discussed how *lansia* awareness brought in new representational imagery for elders, encouraging older Indonesians to remain active in public and involved in their communities. *Lansia* awareness also highlighted the importance of community support for older people through primary healthcare volunteers (*kader*) and specific NGOs. With the arrival of the Covid-19 pandemic, we observed how *lansia* awareness moved to align with global recommendations for protecting the older population, which was now seen as highly vulnerable. 'Super' *opa* and *oma* became 'vulnerable' *opa* and *oma*, who needed to stay at home and keep out of the public space, while younger people not living with them were encouraged to keep their distance. In addition, the Indonesian healthcare volunteer system for *lansia*, which had developed as part of the *lansia* awareness concept over the past 25 years and become part of older people's health and care networks, was also abruptly disrupted by the stricter lockdown measures, which defined Posyandu health meetings as unessential gatherings, and was also unprepared for crisis management.

The disruption caused by the pandemic exposed issues with older people's access to the health service in Indonesia. Whereas some Posyandu resumed activities after a period, others remained closed due to the stricter PSBB lockdown rules in their areas. Some of the wards with previously very successful healthcare services, such as some of those in Jakarta and Yogyakarta, introduced the PSBB, suspending those services. The cessation of regular health-check meetings during these stricter lockdowns temporarily halted essential healthcare and monitoring for older adults, leading to disparities in access to healthcare for this age group, which under normal conditions was one of the best served. A well-regulated Posyandu should not have been seen as an 'unnecessary gathering' but as an essential for the health and well-being of older people.

14 World Health Organization, 'Mental health and psychosocial considerations during the COVID-19 outbreak'.

The pandemic has also underscored significant communication and trust issues between formal healthcare services and older adults in Indonesia. Many older adults avoided clinics (which preferred that they did not visit anyway) out of fear of contracting Covid-19 or of being misdiagnosed. Many older people continue to mistrust modern medicine, preferring traditional village remedies instead. The pandemic highlighted the need for disaster-specific health services that maintain a strong connection with the senior population and address their concerns and preferences even in the most extreme conditions.

In the wards under stricter lockdowns, attempts were made to keep some communication open via social media. Nevertheless, the rapid advancement of digital health technology exacerbated intergenerational disparities, as many older individuals struggled to adapt. At the start of the pandemic, even some of the community volunteers in Jakarta had to learn to use social media platforms such as WhatsApp and Zoom before they could facilitate the flow of communication between themselves and older adults. In Jakarta, a *faux pas* occurred when the head nurse of the community volunteer group attempted to conduct a video call via Zoom for the first time with volunteers. Those unfamiliar with how to operate Teams visited the homes of other volunteers who did know how to use it. When the head nurse began the video call, she was surprised to see multiple enthusiastic volunteers in the same video tiles as others, indicating they were not adhering to the social-distancing protocols and defeating the whole purpose of the exercise. Eventually, the village volunteers learned how to conduct video calls while maintaining social-distancing measures, though not without receiving stern reminders about the importance of following the guidelines.

During the pandemic, some policymakers overlooked the impact that their decisions would have on senior citizens. A good example of this was the initial idea of prioritizing vaccinations for the younger working population in order to boost the economy, while delaying those for older adults, who were the most vulnerable. This strategy, partly based on the assumption that senior citizens were less likely to be economic contributors, failed to recognize that many still worked in the informal economy and faced significant challenges during the pandemic. This approach exacerbated the health and social difficulties experienced by older adults, who were advised to stay at home and who had their vaccinations postponed. Furthermore, once the vaccination rollout started, the state ordered its citizens to register for the vaccine online without considering that many older Indonesians are unfamiliar with, or do not have access to, digital technology. They are citizens, but most are not, as yet, netizens. To overcome this problem, one minister suggested that younger individuals should each assist three older adults in the registration process. This did not address

the potential feelings of discomfort and alienation that this could cause among some *lansia*. The role of volunteer health workers and NGOs was crucial in helping to overcome these barriers and, fortunately for the *lanjut usia*, they were ready to help.

The Covid-19 pandemic underscored the importance of community healthcare providers.[15] Some countries, such as Thailand (see, for instance, Bezbaruah et al. 2021), effectively utilized primary health volunteers during the pandemic, while others disrupted NGO volunteer activities by deeming them non-essential. Studies show that community health workers (CHWs) enhance local health by bridging gaps between formal healthcare and communities, particularly for older adults.[16] Studies suggest that CHWs can play a critical role in disaster situations, including pandemics, by improving preparedness and community resilience through training. In Indonesia, the *kader* system could and did demonstrate its importance during the pandemic, the result of its local roots and mediation. Locally recruited *kader* knew their communities well, could identify health problems, and were able to promote engagement with professional health services.

The key weaknesses of the Indonesian *kader* system stem from the insufficient authority, resources, and training provided by the state and the professional health system. In many respects, *kader* are regarded more as 'gofers' than essential front-line workers. Generally, they receive minimal, if any, training and are perceived as expendable. Nevertheless, when required, they are placed at the forefront with inadequate protection. These community healthcare volunteers are intended to work in tandem with health centres and hospitals. However, failing to take this parallel service seriously and utilizing it only as needed undermines the government's and healthcare system's reliance on *kader*. This represents a missed opportunity for effective grass-roots health management, especially during pandemic situations and other disasters, when their activities may be restricted.

In 1995, Anke Niehof predicted that healthcare volunteers would be a crucial safety net for older Indonesians but also suggested that the quality of the

15 Nacoti et al. 2020; Rasanathan and Evans 2020; Singh and Topp 2021; N. Sabina, Z. Hussain, and M.V. 'Uribe Bangladesh should use its community health workers to respond to the Covid-19 pandemic', *DhakaTribune*, 28-4-2020. https://www.dhakatribune.com/feature/2020/04/28/bangladesh-should-use-its-community-health-workers-to-respond-to-the-covid19-pandemic (accessed 21-7-2025).

16 Van Eeuwijk 2021; Schaaf et al. 2020; Lloyd-Sherlock et al. 2017; Schneider, Okello, and Lehmann 2016; Standing and Chowdhury 2008; Perry, Zulliger, and Rogers 2014; Scott et al. 2018.

service and its adaptability during novel situations would be vital to its success. This community healthcare system is essential in connecting global and national health policy and culture with local communities. The Covid-19 pandemic accentuated the important role of *kader* in providing healthcare access for older adults. The disruption of the services provided by *kader* and their committed efforts to provide some care for older people who expressed the need for them during the pandemic proves that the *kader* system has become an important grass-roots health resource for older adults in Indonesia. This consideration is relevant not only under normal conditions but also with regard to future epidemics and other disasters, provided that Posyandu meetings are acknowledged as 'essential' and *kader* are invested in with the proper training and preparation. Recognizing the importance of volunteer services for older people and making the most of *kader* by harnessing their full potential are essential for enhancing *lansia* awareness and the quality of life of *lanjut usia*.

Acknowledgements

The authors are grateful to Dr Nelly Tina Widjaja, Benidiktus Delpada, Jelly, Dyah Rahayuningtyas, Tresno, Robi Mitra, Eef Hogervorst and Philip Kreager for their invaluable contributions to the research.

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