"GROWING OLD IN THE CITY. HEALTH TRANSITION AMONG THE ELDERLY IN NORTH SULAWESI, INDONESIA. AN ANTHROPOLOGICAL APPROACH TO OLD-AGE RESEARCH".

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Research Project and its Scope

This research project focuses on chronically ill elderly people (≥60 years) including psychological ageing disorders such as sensory (e.g. vision and hearing problems) and mental disorders (e.g. dementia). The study population lives in three urban and semi-urban areas in the Province of North Sulawesi (Indonesia), namely Manado (Kota Manado), Tomohon (Kab. Minahasa) and Tahuna (Kab. Sangihe-Talaud), and comprises all ethnic and religious groups as well as all socio-economic strata to be found in these study localities.

The five principal research objectives are the study of:

1. chronically ill old people in different urban household compositions and their corresponding networks,
2. their health care seeking patterns in an urban setting,
3. their perceived health disorders and their corresponding coping strategies and functionality,
4. their emic perception of 'old age', and
5. their understanding of 'health' and their corresponding behaviour.

Qualitative and quantitative research methods such as interviews and questionnaires, participant observation, and age cohort focus group discussions as well as biomedical diagnosis, medication and monitoring/follow-up are the tools to conduct four major research steps comprising a community study, a household study and a cohort study. Finally, a so-called 'tracer illness' study (i.e. investigating one specific illness of selected elderly people in a very focused way) completes this research project.

The project involves international research partnership with an Indonesian State University (*Universitas 'Sam Ratulangi'* [UNSRAT], Manado, North Sulawesi) consisting of seven team members (6 Indonesians [i.e. 3 Anthropologists and 2

Medical Doctors plus 1 field assistant] and 1 Swiss [the author as Medical Anthropologist]). The study lasts over a period of two and a half years (30 months, from January 2000 until July 2002); its operational beginning was in April 2000.

Keywords: Medical Anthropology, Health Transition, Ageing, Elderly People, Urban Health, Chronic Illnesses, Indonesia

1) Introduction

Background Information/Rationale

One hundred years ago, modernization and general progress have led in Western Europe and North America to a substantial health transition. Since nearly two decades, developing countries also undergo this process, which comprises not only biomedical, but also cultural, economic, ecological and behavioural components. Health transition is closely linked to demographic (e.g. decline of mortality and fertility rate) and epidemiological change (e.g. increase of non-communicable diseases). This occurrence is above all felt in 'modern' and urbanizing areas of developing countries, that is to say in the cities and towns. Indonesia where this research is conducted does not yet fully perceive and anticipate these future problems, which will arise from the rapid growth of the country's cities as well as from the fast ageing of its 205 million people.

Changing lifestyles in connection with the break down and dissolution of 'traditional' social networks and economic securities can result in bad or even disastrous effects on vulnerable groups in communities such as elderly people with their manifold dependencies. Moreover, old-aged people living in an urbanizing or transitional environment may suffer from communicable, i.e. infectious diseases (e.g. malaria) as well as from non-communicable diseases such as high blood pressure, diabetes or cardiovascular diseases.

Scientific Justification of the Subject

Old-age research in developing countries is only at its beginning in the Social Sciences and particularly in Anthropology. Since a long time, Medical Anthropology has focused its scientific interest on other vulnerable groups such as children or pregnant women, but until today very seldom on disabled or elderly people.

This project makes a major contribution to not yet widely investigated and implemented perspectives in different sciences concerned with old people such as the shift from deficit to potential orientation, from a health to an illness oriented view and from a provider to an user perspective. Furthermore, this study underlines the assumption that old people have other demands in regard to health care than

younger people, and that major health determinants of especially chronically ill elderly people's health care lie outside the medical system. The research project produced important factors concerning the study of heterogeneity and thus vulnerability among old urban dwellers in developing countries. By applying a time dimension in looking at the conditions of elderly in cities, this research has much contributed to process-oriented approaches in age research.

In addition to it, this research study makes a contribution to old age research, particularly concerning elderly people's own perception and assessment of 'ageing', 'health' and 'well-being' and the influence of three main factors, namely the urban environment, the provision of services and the social support on these core phenomena.

Scientific Justification of the Research Area

Important criteria for the selection of the study area were the following:

1. The Province North Sulawesi shows the second highest percentage of elderly in population in Indonesia (after Province Lampung on Sumatra) outside the main island of Java and one of the highest urbanization rates. Moreover, it has the second highest rate of 'age 65+' people in urban areas in Indonesia. At the same time, North Sulawesi shows the highest morbidity rate of urban people in Indonesia. Thus, the study of urban health, especially of elderly urban dwellers, becomes an important research field in this eastern province and is best studied in this region.

2. Because of these on-going processes, epidemiological transition (e.g. a high prevalence of chronic diseases) and change of life-style (e.g. many western behavioural habits) already occur largely in the province's urban areas. Theses changes have progressed in North Sulawesi much further than in other Indonesian provinces (except of urban Java).

3. The Province North Sulawesi is a very prominent 'out-migration' area in Indonesia, where usually younger better-educated people are leaving the province and older people remain there. In North Sulawesi, by the way with the highest school leaving level and qualifications in Eastern Indonesia, this dynamic has a crucial impact on social and economic structure of households and communities. These different kinds of burden of systematic 'brain drain' and its impact on social structure can be best studied in a province with a traditionally high level of education and schooling and a high migration rate.

4. The Province North Sulawesi shows an amazing ethnic and religious heterogeneity. In no other Indonesian province, we can find an almost fifty-fifty ratio between Moslems and Christians (including a great number of Chinese households in cities) - a situation, which is very true for the province's big cities such as Manado. It will be therefore an important perspective to find cultural

similarities and differences in elderly care concerning existing kinship structures and filial ties. Such comparative study is only possible in a quiet and peaceful social, political and religious environment, a crucial fact, which is only given in North Sulawesi.

5. North Sulawesi is currently pioneering an elderly care scheme, which does not yet exist in other Indonesian areas (except of the capital Jakarta and two other cities on Java). This so-called 'home nursing for old and handicapped people' scheme bases on household, political community and congregation level. The provincial health authorities and the Christian churches have recently developed and implemented it. It is important to be able to monitor such a new scheme in a user-oriented research approach. The concerning conditions are only given in North Sulawesi.

6. The urban world cannot be divided from rural reality. We can only fully understand these on-going interactions by considering both the rural and the urban surrounding. Elderly people play an important role in this relationship through their active 'commuting' between the two environments (in North Sulawesi). The author has already studied the rural social, cultural and medical reality in North Sulawesi. Thus, it suggests itself to combine concrete findings from the villages with urban issues in order to achieve a better and broader understanding of the elderly persons’ situation in cities and of rural-urban interactions in North Sulawesi. It is interesting fact that in North Sulawesi the Minahasa *adat* concerning filial piety or children’s support (towards their elderly parents) knows the rotation principle, which includes children living in rural as well as in urban areas.

Reviews on Other Studies

Scientific up-to-date literature on age, ageing and elderly people in South-East Asia is very scarce. The very few studies mostly reflects situation in Singapore. The most comprehensive and complete book on ageing in Pacific Asia comes from Phillips (2000) and describes on-going demographic processes and their effects on health care, social security and economic welfare in several East and South-East Asian countries (including Indonesia, see Hugo [2000]).

Hugo (2000) in his national overview on elderly people in Indonesia concludes that A) the importance of traditional support systems decreases, B) the resources provided by the Indonesian government are insufficient to compensate this loss of traditional support, and C) the resources accumulated by the elderly people themselves are not sufficient, too, to compensate the existing insecurities. Future life of senior citizens especially in urban areas will be a life of manifold hardships and further insecurities in a highly elderly people’s unfriendly environment.

The qualitative study of Listyaningsih et al. (2000) in urban Yogyakarta (Java) is based on case studies and interviews on economic conditions and health care of elderly people. They come to the conclusion that A) a great part of the elderly people is still active in productive daily work, B) ¾ of their monthly earnings comes from own sources of income, and C) old people's home *(panti jompo)* would be the ideal institution especially for ill and disabled old people in an urban area like Yogyakarta.

The field study of Keasberry (1998) in rural Yogyakarta (Java) was carried out with participant observation and in-depth interviews exploring the effects of on-going social and economic changes for elderly care. She concludes that the inter-generational ties, which determine obligations and responsibilities, have loosened and as a consequence conflicts between parents and children occur more frequently. The traditional care-giving role of daughters and women has changed because of migration, schooling, job opportunities and individualization. On the other hand, elderly people have access to new sources of financial income, and more professionalised health care schemes are offered for them.

GMIM Health Foundation (1998), which has carried out a quantitative study on health status of elderly people in Tomohon (Kab. Minahasa, North Sulawesi), made use of questionnaires. It shows that more than 50% of the elderly people in this urban area live - according to biomedical diagnosis - in a healthy status. It is an interesting fact that the illnesses they are suffering from are mostly problems of vision, hearing, teeth and physical motion. These three mentioned ailments are seldom taken into consideration when we look at the daily disturbances and hardships of elderly people.

Eeuwijk (1999) has carried out vast field research in three rural Minahasa communities. He finds out that social and economic status, influence and authority of elderly people in Minahasa villages is gradually declining because of new and so-called 'modern' attributes that shape status (for example school leaving degree and academic title, property of money and land, connections to prominent and important government people, and owning material objects of high prestige). Nevertheless, social and economic security is still guaranteed; traditional schemes of filial piety are partly maintained (e.g. a rotation system), but also new schemes of elderly people's care-take are developed (e.g. send money from abroad).

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Hypothesis to be tested

In regard to growing old in the city in Indonesia, the following six major hypothesis were encountered and identified as a result of the preceding discussion:

1. There is no absolute social security or reinsurance anymore for elderly. My hypotheses are that A) in contemporary Indonesian cities, old people will look more often for intragenerational relations than for intergenerational support, and B) new public or private welfare and insurance providers will not replace the rapidly eroding familial network during the next years.
2. There is no absolute economic security or reinsurance anymore for elderly. My hypotheses are that A) more and more older people are working in the informal urban work sector (mostly service sector) to have their own monetary income, and that B) older people in low-income households contribute a big part to the overall household portfolio.
3. An elderly person has to fulfil new responsibilities in his/her new life course, which is not determined by his/her physical condition. Old age is a period of increased personal authority and respect, but which are mainly restricted in an urban setting to the private, but not to the public sphere. My hypothesis is that the sick role of older people is according to their social role they usually hold as (healthy) elderly persons in their (urban) society.
4. Elderly people are a group with increased health risks (through the presence of both communicable and non-communicable diseases), but they are not a vulnerable (i.e. to have the prospects to become socially excluded) group per se. We have to look at the intra-age cohort heterogeneity in respect to time, place and person. My hypothesis is that particular elderly people are vulnerable because their social capital is low and their household welfare is poor.
5. Old people in Indonesian urban areas can be affected from infectious (e.g. malaria, diarrhoea) as well as from chronic-progressive (i.e. expected to be long-term or permanent) illnesses (e.g. hypertension, diabetes). Chronic

disorders are mostly 'diseases without illness' (i.e. only biomedical diagnosed). My hypotheses are that A) old urban people consider a physical or mental disorder a serious sickness when their daily social routine life is disturbed and they are themselves threatened by social exclusion, B) by that, to a great extent, they underestimate the effects of chronic illnesses on their physical ageing, and C) health maintenance of older urban dwellers comprises more than pure medical acts.

6. Urban areas are heterogeneous entities, thus reflecting a broad medical pluralism. Coping strategies, as a behavioural response or cognitive reaction to chronic sickness, do not only comprise medical care seeking, but also social and psychological 'solutions'. My hypotheses are that A) sick people with chronic illnesses are looking for coping strategies, which comprise more than the health care sector, and that B) old people in the city do not make extensive use of traditional medicine.

2) Objectives

The overall objectives of the proposed research was to gain a broader and deepened understanding of the process of health transition by comparing and analysing emic perceptions and individual experiences and behaviour of chronically ill elderly people in three different urban environments over a particular period. Moreover, this study consolidated the specific constraints and deficits of old urban dwellers as well as their potentials and resources. By that, this research has resulted in portraying the complex interplay of physical-medical aspects with social, economic and psychological determinants in regard to healthy and sick elderly people in an urban setting in Indonesia.

Specific Objectives

The following were the specific objectives of the research project in Indonesia:

1. Identify different urban household compositions and compare among them the corresponding social networks and economic environment of old people suffering from a chronic disease.
2. Explore the curative patterns (how) and cultural and system factors (why) of chronically ill elderly people when utilizing - or non-utilizing - one or several of the existing three health sectors in an urban setting.
3. Identify old people's perceived health disorders and study the coping strategies of old people with chronic, mental and psychological illnesses and how they deal with their functionality ('Activities of Daily Life') and social life.
4. Investigate how old people perceive and experience 'old age' and evaluate their ageing process in the given urban setting.

5. Find out what elderly people understand by 'health' or 'well-being' and how they actively deal with maintaining health and preventing illness in their environment.

2) Implementation

Description of Research Sites

Manado is the provincial capital of North Sulawesi with about 440’000 inhabitants and forms an own municipality (*Kota* Manado). This town shows an amazing heterogeneity in ethnic, religious, language groups as well as in socio-economic differentiation. A (even small) majority of its inhabitants are Christian Minahasa, but there are big ethnic communities of people from Sangihe-Talaud, Gorontalo, North Moluccas (Ternate and Tidore), South Sulawesi (Bugis and Makassar), people from Java and Sumatra as well as from neighbouring Mindanao (South Philippines) and not to forget a big number of Chinese born people. Manado has become more and more an important centre in northeastern Indonesia especially because of its well-developed service sector (transportation, banks, schools, administration, tourism) and its geographically strategic position at the Western Pacific rim. By the way, we should not forget to mention that since 1999 Manado has become an important shelter and refuge for thousands of refugees e.g. from North Moluccas (Ternate, Halmahera), Moluccas (Ambon) and Central Sulawesi (Poso, Tentena). *Kelurahan* Wenang Utara (Kec. Wenang) is located in the inner city of Manado and comprises the most important shopping centres and supermarkets as well as important service offices (e.g. telephone, post, travel, banks); but behind this booming, glittering scenery, we may find also slum areas with very pitiful living conditions. *Kelurahan* Calaca (Kec. Wenang) encompasses the harbour area and the biggest market area of Manado as well as *Kampong Cina* (the Chinese Quarter) with a lot of small trader houses. *Kelurahan* Pinaesaan (Kec. Wenang) encompasses the traditional shopping centre of Manado and thus mainly consists of shops, restaurants and small hostels; at its margins, several streets are well-known workshop areas (e.g. car maintenance, blacksmiths, and electronics repair shops). All three areas are densely populated and are constantly suffering from heavy car traffic, overcrowded streets and not functioning waste disposal.

Tomohon, the capital of *Kecamatan* Tomohon (Kab. Minahasa), has around 76’000 inhabitants. It is located on the Tondano Plateau and has thus a very mild climate. Being situated between several still active volcanoes, the Tomohon area is traditionally an agriculture-oriented area. Since the arriving of the Dutch Protestant missions last century, it has changed more and more from a peasant society to a

semi-urban, service sector oriented community because of its schools and medical services. Tomohon is until today the administrative and intellectual centre of the Protestant Minahasa Church (GMIM). The town centre encompasses a rapidly booming shopping area *(pertokoan)*, several banks, a big bus station, an important daily market and several tourist accommodations. Tomohon comprises 34 villages, which are predominantly occupied by the Tombulu tribe, whose members are mostly Protestant or Roman Catholic. *Kelurahan* Matani II and Matani III (Kec. Tomohon) are semi-urban political communities, whose inhabitants are still engaged in agriculture (irrigated rice fields *[sawah]* and gardens *[kebun]*), are employees, private entrepreneurs or civil servants. The inhabitants of both communities are predominantly (±90%) Christians and Minahasa.

Tahuna is the capital of *Kabupaten* Sangihe-Talaud, an archipelago situated between the northeastern tip of Sulawesi and the Philippine island of Mindanao. Tahuna is located on a deep bay at the west coast of Sangihe Besar Island and has about 32'000 inhabitants. For the whole area this town has important functions in the service sector (e.g. harbour, airport, bus station, banks, government offices and private shops, markets, banks) as well as in the primary sector (i.e. fishery). Tahuna shows a rich heterogeneity in respect to cultural origin of its inhabitants (e.g. Sangihe, Talaud, Siau, Chinese, Minahasa, Gorontalo, Makassar, Ternate and Tidore, Halmahera and Phillippinos), who, according to their belonging, live to a great extent in own political communities or quarters. The town is also an important starting-point for to migrate to other towns on Island Sulawesi or other parts in Indonesia (e.g. Java, Bali, Kalimantan, Papua). *Kelurahan* Tidore (Kec. Tahuna) is located at the seashore between the harbour and the town centre. Its inhabitants are mostly Moslem people from Northern Moluccas (±75%) and Protestant Sangihe people (±25%). Most households are still carrying out daily fishing (men) and market activities (women), nevertheless, in most families, one or more members are engaged in the service sector as shop employees, civil servants or private entrepreneurs. It is therefore a typical semi-urban community in a fast growing East Indonesian town. *Kelurahan* Sawang Bendar (Kec. Tahuna) comprises the principal shopping centre, the town main market, the main bus terminal, the general post office and banks as well as the GMIST Church administrative offices. Most shopkeepers are of Chinese origin; the majority of the community inhabitants are Christian Sangihe people being employed as Government or Church employees or working as private entrepreneurs and traders. This part of Tahuna is commonly considered the town's city centre.

Research Approach

Approach: This research consisted of the following five general study steps encompassing different society levels:

1. Review of the recent and current literature on age, ageing, health and illness and urban health in Indonesia and especially in Province North Sulawesi was carried out to identify relevant findings and to avoid duplication.
2. Community Study in 3 towns (encompassing 7 political communities *[Kelurahan]* altogether) has collected background information on the selected study population on, for instance, recent history, cultural background, economic situation, demographic details/dynamics, education status, basic services and their infrastructure, political and administrative structure, ecological conditions, transport, religious life, and measured health status.
3. Household Study (50 households *[Rumah Tangga]* per town to be studied) has investigated the multifaceted relationship and interdependence of caregivers and caretakers in households. Furthermore, this study identifies concepts of 'ageing', 'old/aged', 'well-being/health' and 'illness' and attitudes of (healthy) elderly and sick old-aged people. Data collection also comprises information on the social, economic, ethnic, education and religious background of household members and on household income, income allocation, spatial housing conditions, and food production. Specific questions on health management (including health maintenance and prevention) and experienced illness episodes/cases have provided first basic answers on perceived medical reality in households.
4. Cohort Study (25 individuals *[Perseorangan]* per town to be investigated) has focused on a selected sample of chronically ill elderly individuals (>60 years old) from the household sample. The purpose of this study was to make a more detailed analysis of health seeking behaviour and treatment choice of chronically ill elderly people, of quality and scope of their social network and support system and of management of 'Activities of Daily Life' (ADL). This was achieved by observing and monitoring for example illness episodes, social interactions as well as well-being and household activities over a period of two months, and investigating perception of health risk and vulnerability of members of the same age cohort.
5. ‘Tracer Illness’ Study (15 individuals *[Perseorangan]* per town to be investigated) has emerged out of the Cohort Study as a result of the executed biomedical and (medical) anthropological research on elderly people. The above-mentioned Cohort Study was the research scope for this study, which focuses its scope in a very narrow sense on one selected chronic illness of elderly people. The purpose of this study was to gain a broader biomedical and anthropological understanding of the suffering, the expression, and the perception of elderly people concerning one special illness and its socio-economic impact on old persons’ daily life. This ‘tracer illness’ was an illness of perception (i.e. vision and hearing problems including dental illness) or another non-communicable ailment such as diabetes, hypertension or rheumatics. As a

first step, we had to identify elderly people suffering from this specific illness (according to our present biomedical files on our cohort study group) and to carry out a more accurate biomedical diagnosis of the concerning older persons. The next step has comprised of interviewing these elderly people, for instance, on their experience and their perception of this tracer illness, of observing their daily life such as 'Activities of Daily Life' (ADL) and social life, and of monitoring their health related behaviour such as food intake, bodily activities or biomedical compliance.

Research Methods

The following research methods ought to be applied to achieve the five defined objectives:

Objective 1. Identify different urban household compositions and compare among them the corresponding social networks and economic environment of old people suffering from a chronic disease.

➔ Methods: semi-structured interviews with questionnaire; direct participant observation; focus group discussion with the chronically ill people; group discussion with visualizing techniques; biomedical screening of sick elderly (with their consent)

Objective 2. Explore the curative patterns (how) and cultural and system factors (why) of chronically ill elderly people when utilizing or non-utilizing one or several of the existing three health sectors in an urban setting.

➔ Methods: direct participant observation; EMIC and semi-structured interviews with questionnaire; comparison of interview records and medical files (with their consent); key informant interviews

Objective 3. Identify old people's perceived health disorders and study the coping strategies of old people with chronic, mental and psychological illnesses and how they deal with their functionality ('Activities of Daily Life') and social life.

➔ Methods: social network analysis; participant observation; EMIC and semi-structured interviews with questionnaire; self-reporting (of the sufferer) with diaries; scaling and ranking methods; measuring functional activities; focus group discussion with caregivers and caretakers cohorts; group discussion with visualizing techniques

Objective 4. Investigate how old people perceive and experience 'old age' and evaluate their ageing process in the given urban setting.

➔ Methods: EMIC and structured interviews with questionnaire; focus group discussion with age cohorts; informal discussions; multiple in-depth interviewing; life history interviews

Objective 5. Find out what elderly people understand by 'health' and 'well-being' and how they actively deal with maintaining health and preventing illness in their environment.

➔ Methods: EMIC and structured interviews with questionnaire; direct participant observation; focus group discussion with age cohorts; key informant interviews; informal discussions

Main Scientific Methods Applied in the 'Field' and their Main Topics to be Investigated

1. Semi-Structured Questionnaires (on household level)
   ◎ Household composition and their economic condition
   ◎ Housing situation and infrastructure/physical environment
   ◎ Supporting network when fallen ill
   ◎ Health behaviour and preventive measures
2. Structured Interviews (on individual level)
   ◎ Self-anamneses
   ◎ Knowledge on health and sickness
   ◎ Attitude towards health and social environment
   ◎ Health and illness behaviour
3. In-Depth Interviews (with selected key persons)
   ◎ On specific themes (i.e. local culture and traditions, community history, special events)
4. Direct Participant Observation
   ◎ Social and economic activities of elderly persons
   ◎ Everyday life in households with elderly people
   ◎ Health and illness behaviour of elderly persons
5. Case Studies
   ◎ Everyday course of elderly people
   ◎ Illness episodes and courses of elderly persons
6. Initial Biomedical Diagnosis and First Extensive Check-ups plus Monthly Follow-up during 4 Months inclusive Monthly Medication (on strength of ‚Informed Consent'-form; on individual level)
   ◎ Anamneses and general check-ups
   ◎ Current health status
   ◎ Previous illnesses/symptoms
   ◎ Blood test in laboratory
   ◎ Drug medication and following drug compliance
7. Diary of Elderly People during 4 Months (on individual level)
   ◎ Way of life in everyday life
   ◎ Physical and mental state of health
   ◎ Social and economic activities
8. Life Course History-Interview (on individual level)
   ◎ According to 4 prominent life stages
   ◎ Chronological life course (i.e. education, work, family/household)

◎ Health related experiences and perceptions
◎ Assessment and judgement ‚past-present'

9. Focus Group Discussion/FGD (on individual level)
◎ Knowledge, attitude und measures of elderly people concerning health and illness
◎ Life experience and everyday problems of elderly people

10. Photo and Film Documentation
◎ Social and economic activities
◎ Physical environment and housing
◎ Community portraits

11. Verbal Autopsy Interviews (with families of deceased elderly persons)
◎ Cause of death from their point of view
◎ Interventions and therapies before death
◎ Course of dying (the last days, hours and minutes)
◎ Reactions of social environment

4) Provisional Results and Discussion

Provisional Results
We shall discuss the most important findings by the corresponding given objectives:

Objective 1. Identify different urban household compositions and compare among them the corresponding social networks and economic environment of old people suffering from a chronic disease.

General results:

- Household composition and general vulnerability: A very distinctive gender bias is felt in this study: Unmarried elderly women, widows without children or widows without any child support and without regular monetary income share the greatest risk to fall out of their (once) existing social and economic network and, as its consequence, to fall seriously ill. In Indonesia, children and kinship bonds are still considered a prominent insurance for old age: It secures filial piety and family support. Household structures which consist of intact two- or three-generation families offer a certain shield against social and economic deprivation and thus against poverty determined health disturbances (including communicable diseases), in sharp contrast to, for instance, female-headed households whose social networks have mostly become stunted. We may conclude: Loneliness and social deprivation mean the most immediate threat for urban senior citizens in North Sulawesi.

- Economic environment: Impoverishment of the senior citizens age group has become a sad reality. In order to prevent mere poverty, most senior citizens in urban areas are engaged in daily, mostly physical activities to generate monetary income and to contribute to the daily household needs. In 30% of our sample households, the elderly family member contributes an important share in household income. We may generally derive from our data that poorer older urban citizens (based on weekly expenditure) share a higher incidence of illness episodes, however, not only in old age, but also during their lifetime (for example due to unhealthy environment). We may conclude: The world of urban senior citizens is one of work and labour, and the poorer they are, the higher their health risk (for instance: morbidity rate of poor old people in our sample is 29% higher than the rate of well-off senior citizens).
- Ethnic and religious differentiation: Except of several elderly Buddhist Chinese people who enjoy a relatively secured live in wealthy extended family households, we cannot derive any clear-cut socio-economic differences according to cultural-ethnic and religious affiliation. There are other prominent factors such as household economy, education, and social embeddedness, which determine social coherence on household level.

Objective 2. Explore the curative patterns (how) and cultural and system factors (why) of chronically ill elderly people when utilizing or non-utilizing one or several of the existing three health sectors in an urban setting.

General results:

- Curative pattern: Senior citizens with persisting chronic illness such as hypertension, diabetes or rheumatism tend to make regular use of professional biomedicine. Drug consumption is widespread and quite high. Senior citizens usually recognize the persisting effect of drugs and injections by stabilizing their progressive illness. Elderly people with access to home-gardens and fields (Tomohon and Tahuna) make widely use of herbal medicine as an initial curative resort. Nevertheless, different urban ‘traditional’ healers are visited as a way to cope with long lasting suffering and degenerative illnesses. Even various methods of complementary and alternative medicine such as kinesiology or urine therapy are applied. Popular health measures include e.g. food and rest regulations.
- Cultural factors: The aetiology of chronic illnesses is considered as a main cultural factor affecting health-seeking behaviour. Most old-aged individuals explain their ailment as a result from A) their personal life style in preceding years (e.g. smoking, drinking, hard physical work, deprivation during times of war), from B) the on-going inevitable biological ageing process, and from C) current changing behaviours such as food habits and physical exercise.

- System factors: The most frequently mentioned factors for utilizing or non-utilizing the professional health sector (e.g. nurse, district health centre, outpatients' clinic, private practice) are as follows: affordability (i.e. costs, loss of income), accessibility (i.e. distance, transport), and acceptability (i.e. degree of satisfaction with treatment incl. medication). In reality, the most limiting reasons of non-utilization (of biomedical services) are lack of cash money and difficult transport circumstances as well as dissatisfaction with the experienced treatment.

Objective 3. Identify old people's perceived health disorders and study the coping strategies of old people with chronic, mental and psychological illnesses and how they deal with their functionality ('Activities of Daily Life') and social life.
General results:

- Perceived health disorders: Senior citizens are objectively suffering from chronic illnesses (in order of frequency): 1. eye disease and problems of vision, 2. dental and mouth problems, 3. gastric complaints, 4. hypertension, 5. heart trouble and complication related to blood vessels, 6. lung disease incl. tuberculosis, 7. rheumatism and arthritis, 8. ear disease and hearing difficulties, 9. diabetes, and 10. asthma. In contrast to these mentioned biomedical diagnosed sufferings, elderly people distinguish three categories of illness perception: A) disturbing (e.g. eye and dental problems), B) worrying (e.g. chest pain, persisting fever), and C) threatening illnesses (e.g. hypertension, diabetes). Disturbing illnesses (A) hinder daily household work as well as social and economic activities; worrying illnesses (B) show indistinct causes, unclear effects and an uncertain course; threatening illnesses (C) are related to further future physical and mental complications and deterioration.
- Coping strategies: Coping strategies depend strongly on economic and social conditions of the individual senior citizen and his/her household situation: They define the scope of variety. There are strategies, which are based on individual (i.e. by the elderly person) or on collective decision-making (i.e. by the social reference group of the older person). The various strategies range from children's or grandchildren's support, intragenerational support, church or mosque based age groups, rotating saving and credit associations, professional medical support by private organization to 'deportation' to hospitals, neglect, and suicide.
- 'Activities of Daily Life' (ADL): Senior citizens consider the carrying out of ADL (such as shopping, washing, cooking) an essential mark for their personal independence and their general physical and mental fitness. ADL manifest therefore the context of action, which allows older people to assess their current functionality and to react with concrete strategies on progressing and/or degenerative illness processes.

Objective 4. Investigate how old people perceive and experience 'old age' and evaluate their ageing process in the given urban setting.

General results:

- Perception of ‘old age’: Generally speaking the perception of ‘old age’ (by senior citizens) is represented through the individual ‘control over body and mind’ and not by a concrete age limit (e.g. 60 years) or a biomedical diagnosis. The gradual reduction or deterioration of physical and mental competence and capability of an ageing person is perceived through the following transformations: decreasing eyesight and hearing, falling out of teeth, declining physical agility, and diminishing mental receptivity and memory. The assessment of these mentioned manifestations differ sometimes between the subjective perception (of the senior citizen) and the perception of his/her social environment.
- Evaluate ageing process: ‘To become old’ is not determined by a clear-cut break or turning point such as formal job retirement. Daily productive work and social activities of elderly people continue in their common course and are only reduced in case of bodily or mental disorders. Nevertheless, a transitional period occurs in most cases of people becoming old: They retire systematically from public to domestic sphere (e.g. withdraw from formal positions in community or parish matters), they hand over household authority to the next generation, and they are more engaged in intragenerational social relations. Indeed, many elderly persons feel also overburdened by current technical progress (e.g. use of modern telecommunication, car traffic) and development in service sector (e.g. bank, post and government service). Because of this ‘no longer able to cope’-attitude, some senior citizens deliberately renounce these modern processes and conditions leading to indirect dependence, or shut themselves off.

Objective 5. Find out what elderly people understand by 'health' and 'well-being' and how they actively deal with maintaining health and preventing illness in their environment.

General results:

- Perception of ‘well-being’: Generally speaking, the senior citizens’ perspective of ‘well-being’ represents a cognitive concept of harmony and well balance, which is widespread all over South-East Asia. It comprises a broad scope of personal characteristics such as well balance, regularity, moderation, and reserve as well as independence and intactness. This attitude is manifested by behavioural measures such as living in social harmony (e.g. family, neighbourhood, quarter), not suffering from economic and financial hardships,

to avoid stress situations, to conduct a sound religious life, to carry out activities of daily life, and not to be obstructed by illness so that to move free and easy.

- Maintaining health: Senior citizens are usually conscious of the effect of active health maintenance, but concrete health-maintaining actions and steps are rather performed by coincidence or by order of a health professional. Nevertheless, urban senior citizens in North Sulawesi emphasize the following health maintaining activities: daily bodily work, balanced nutrition and regular food intake, enough sleep and rest, keep body and physical environment clean, and leading a social and spiritual life in harmony. Moreover, many senior citizens regularly consume herbal medicine (home made or ready-to-use) as a body- and mind-strengthening step.

Discussion of Provisional Results

1a. Household composition and general vulnerability: Vulnerability in the given health transition context means that certain people at a certain time and at a certain place share a higher risk to fall ill and/or to fall out of the social network. For instance, we have detected that elderly women living in a female-headed household as well as elderly persons in urban slum areas show low health status and live in social and economic insecurity compared to still intact families living in healthy surrounding. It came clear that most of the non-intact households live in poverty as well as in bad, unhealthy surrounding; therefore, household composition (intact/non-intact) has a direct influence and impact on elderly persons' vulnerability (share a higher/lower risk to fall ill).

1b. Economic environment: The less well off older people are, the higher their morbidity rate in our sample communities (i.e. sharing an increased risk of 29%). Poverty and economic environment influence therefore health status of elderly people. Nevertheless, elderly persons are still productive members in their corresponding households and make an important portfolio contribution to them. Old age does not mean a time of relaxation and pleasure, but mostly a life of permanent work. Most of them work in the informal service sector, which provide only small income, physical strains, and low job security. Illness means at the same time loss of important income for the household as well as unexpected costs with financial burden.

1c. Ethnic and religious differentiation: We could not detect clear-cut ethnic and religious differentiation or ascription concerning the fate of elderly people. Social and economic hardships as well as health disturbances strike and afflict senior citizens of every ethnic group and religious community. Cultural-ethnic and religious factors related to filial piety and family support only show normative importance and ideal behaviour, the reality shows a different picture. We may conclude that in Indonesian urban society socio-economic factors dominate over ethnic-religious determinants.

2a. Curative pattern: Senior citizens prefer professional biomedical treatment; this is true all the more for persons with chronic, persisting illnesses. They strongly expect that treatment includes drug medication; therefore, drug consumption incl. drug from physicians, from kiosks or shops or from nurses is high. As a first curative step, senior citizens tend to see a medical professional, but as following steps, traditional medicine (e.g. herbal medicine, local healers), alternative medicine and popular medicine (e.g. food and rest regulations) are widely utilized.

2b. Cultural factors: We have investigated the culturally influenced illness concepts incl. aetiology/causality of illness and illness knowledge. It is still at question whether the corresponding cultural origin of the elderly people shapes these concepts or the corresponding social environment that is the heterogeneous urban society. Indeed, most of the senior citizens share a similar popular or lay knowledge (on the illness they are suffering from), which we found in all three cities and all seven communities.

2c. System factors: Money and distance determine the initial therapy choice of senior citizens. For further therapies, treatment satisfaction shapes their choice. The treatment of chronic illnesses is mostly a long-term therapy, which asks for quite a lot of money. Not to forget that the professional health care offers a wide range of curative offers and that elderly people thoroughly compare the offered quality of treatment with its price. Therefore, people do often shift from one curative provider to an another one, which helps save money, but very often do not support regular treatment and compliance.

3a. Perceived health disorders: There is an evident difference between subjective (i.e. by the elderly person him-/herself) and objective perception (i.e. through biomedical diagnosis) of disease and illness. Elderly people consider vision, dental, hearing and motion problems the most frequent and most disturbing illnesses, whereas medical professionals tend to emphasize hypertension, diabetes and cardiac problems the most dangerous diseases. Therefore, senior citizens are most worried about illnesses, which are limiting their independence and everyday activities.

3b. Coping strategies: They are very individually applied and implemented and comprise of kin members as well as of non-kin groups and associations. Social competence is an important factor, which determines how far one’s social network reaches (that is in a vertical and a horizontal sense). Poor socialisation of senior citizens results in a very limited choice of strategies; this is also true for elderly people with economic hardships: Financial obstacles limit the scope of coping strategies.

3c. 'Activities of Daily Life' (ADL): ADL are an important mark of individual social and economic independence as well as of physical and mental strength. Therefore, it is understandable that chronic illnesses that hamper ADL are considered the most disturbing sufferings by senior citizens.

4a. Perception of 'old age': This perception is strongly shaped by one's physical and mental well-being. It does not depend on age and medical diagnosis, but on the individual assessment of bodily and psychic capabilities. To be able to control 'body, mind and soul' is an important mark for senior citizens.

4b. Evaluate ageing process: Ageing is not only a biological, but also a social and a psychological process. For instance, social processes comprise retirement from public to private/domestic sphere and of handing over authority and competence to the next generation. Psychological processes consist of changes of attitude and opinion, for example from an aggressive to a more defensive, out-balanced and less tempered behaviour. These processes are induced by the elderly person and by his/her social environment.

5a. Perception of 'well-being': The senior citizens perception of 'well-being' is culturally shaped, but still following a concept of general harmony and balance, which is very common in South-East Asia. It is again a normative or ideal regulation that often does not correspond with real life. Especially social and economic hardships and persisting (chronic) illnesses prevent elderly people to live in 'full harmony'. Therefore, they transform 'well-being' into the process of hardship reduction and problem avoidance.

5b. Maintaining health: Social and economic obstacles and unhealthy physical environment are a main reason to make health maintenance a difficult task. We may conclude that rather passive illness prevention than active and direct health maintenance is applied. Furthermore, most elderly people know about a healthy life, but it is rather difficult for them to put it into concrete steps. In this sense, we have to look for solutions, which lie outside the biomedical scope such as poverty reduction or housing improvement.

Directions for Future Studies

The following statements may be taken into consideration for future studies:

- Further studies in urban areas in Indonesia have to be carried out.
- Further studies on elderly people *(lansia)* have to be carried out in Indonesia.
- A special focus should be laid on elderly women.
- Chronic illnesses become widespread in urban areas in Indonesia; it is advisable that this phenomenon is investigated not only from a biomedical point of view, but also from social, economic and ecological aspects.
- Research on elderly people should not be limited to a strict age limit.

- Old-age research in Indonesia should more emphasize and consider social and economic factors than ethnic and religious factors.
- Interdisciplinary research teams are best suited to investigate on elderly people in urban areas.

Benefits for Indonesian Development Programmes (Provisional)
The findings of this scientific research project can give the following advices:

A) In urban areas, Health Centres (Pos'Yan'Du) and in a second step Health Posts (Pos'Yan'Du) have to implement the already developed special health care programmes for elderly people. This is best applied with a 'come'-structure (i.e. at certain days and hours elderly people can attend consulting hours) as well as with a 'go'-structure (i.e. home visits or in health centre branches during fixed dates and hours).

B) Long-Term Care (LTC): Out-clinic LTC services have to be established in close cooperation with bigger health providers such as hospitals or health centres. Professional support is necessary because family support is not sufficient in case of LTC. A voluntary rotational system may serve as a starting point, but it has gradually to be professionalised and therefore managed and run by professional health providers. The author was directly involved when a first pioneer system called PPRJ *(Perawatan Penderita di Rumah Jemaat)* was implemented (in Tomohon).

C) Simple health insurance system (for old people) already well known as *dana sehat* has to be established in order to cover the health care costs. This needs a careful management as well as the willingness of elderly people to participate in a regular way and the readiness of health providers to accept this kind of health insurance. The author was involved in establishing such an insurance system (in Tomohon).

D) It may be stated that research on elderly people or gerontology as an important future interdisciplinary subject in Anthropology (Faculty of Social and Political Sciences) and Public Health (Faculty of Medicine) is now established at least at two faculties at UNSRAT Manado.

E) Indonesia's cities show a highly 'elderly people unfriendly' environment such as most public infrastructure (government buildings, bus terminals), main streets (narrow, overcrowded, traffic, holes) and public transport (narrow, steep, overcrowded, dangerous, not safe). We have suggested certain measures to some government institution; but its realization depends on money allocation and on consciousness of the decision makers.

F) Together with local people (in Tomohon), the author has planned, developed and established two elderly people groups, one on political community level (government run through PKK *[Pembinaan Kesejahteraan Keluarga]* organisation) and one on church parish level (NGO run through Protestant

Church). Beside orderly health care provision at home, we developed social services (e.g. regular meetings, exchange visits, excursions, hobby groups such as traditional dancing or handicraft making) and economic activities (income generation by rotating UMB system *[Usaha Modal Bergilir]*) in order to empower senior citizens and to utilize their capabilities and experiences.

5) Conclusion

Important Points

- Vulnerability, Heterogeneity and Elderly People in the City: The study has shown that one third of the elderly people in our sample are healthy and not obstructed by sickness. That means that senior citizens are not an ill age cohort per se. We have to consider the risk of individual elderly people, which is determined by certain events, times and places. For instance, elderly people living in urban slum areas share a higher risk to fall ill than senior citizens living in middle-class residential areas. We have also observed that excessive and partly inappropriate food consumption some time around Christmas, *Idul Fitri* and New Year lead to a higher mortality rate among elderly people than around other times. Nevertheless, chronic illnesses may generally strike every older person, but again we have to investigate the individual background and reason including anamnesis and life history why it has happened. The heterogeneity of Indonesian urban society leads to the conclusion that elderly people are not a homogeneous age group in itself with the same level of health risk, but an age cohort whose members have to be screened as individuals with their own personal vulnerability.
- Socio-Economic Factors and Ethnic-Religious (=Cultural) Factors: Cultural factors influence and partly determine elderly people's behaviour (e.g. family support or health decision making) and cognitive concepts (e.g. causality concepts of illness), but it is to a high degree a normative stipulation. Social (e.g. filial piety, social network, social competence) and economic factors (e.g. income, living costs) have a formative influence on life style, health status and/or school degree; it shapes everyday life and by this the real life of elderly people. Indeed, it is an interplay between these two kinds of factors both shaping the world of senior citizens. Nevertheless, we should not be too much inclined to look for differences between the various ethnic and religious groups, but rather looking for similarities among elderly people of the same ethnic or religious group. Intracultural comparisons lead to more useful results than a conventional intercultural view. In this sense, social and economic factors play an important role as parameters by comparing different elderly people of the same ethnic group. We may assume that the socio-economic dimension is

more crucial when investigating similarities and differences among elderly people. In reality, we have found out that elderly people sharing the same economic conditions, but are of different ethnic and religious groups go through the more or less same destiny.

- Synchronic View and Diachronic Approach: 'Look at now and look back' may be the motto of old-age research. When doing research on current life conditions of senior citizens we should never forget that there is a personal history behind it, and this history shapes the current life reality. For instance, many chronic illnesses are a result of longstanding habits such as food habits or drink and tobacco abuse, or experienced times of scarcity or suffered injuries. As a second example, we have concluded that low school leaving degrees of elderly people mostly resulted from persisting periods of war and conflict as well as from financial hardships of their parents; all these events have happened decades ago – but they are still very important and alive because they shape today's life of elderly people. By this, we postulate that in old-age research also methods of diachronic nature should be applied.
- The Concept of Age and Ageing: Ageing is a lifelong process, which is perceived and experienced in a very individual way. It consists of biological, social and psychological changes that shape the individual's life. Therefore, a concrete age limit such as 60 years or a biomedical diagnosis have only an artificial meaning in defining 'old'. Elderly people in our sample assess their 'old age' in reference to the active control over their body, mind and soul. In this sense, to see, to hear, to smell, but also to bite and to move are important marks in defining the mentioned control. They mark independence and autonomy of every elderly person. With decreasing power to control his/her own body and mind - for instance because of progressing vision, hearing and motion problems the 'Activity of Daily Life' cannot be carried out any longer - the corresponding elderly people will gradually loose his/her independence. As a result, he/she as well as his/her social environment consider him/her an 'old person'. Chronic illnesses may accelerate these ageing processes; that means that they are an important factor, which determines the degree of control (over body and mind) an ageing person has.
- Social Security, Elderly People and Urban Life: The social situation of elderly people in Indonesia is strongly linked with the cultural value of filial piety and family responsibility. Generally speaking, filial piety includes that Indonesian children are supposed to show respect to their parents and to acknowledge their authority and it is an obligatory duty to take care of them in their old age. Family responsibility means the ability of families to act cohesively and perform their duties of provision and service. These normative phenomena are still highly esteemed and acknowledged in the Indonesian society and children still play key roles in securing safe and dignified living conditions for elderly people.

Nevertheless, socio-economic erosion and changes in living conditions are gradually undermining these norms. Several causes for this crucial transformation (of eroding filial piety) may be stated: urbanization, migration, decline in fertility, trend to nuclear family structure (e.g. by means of family planning), increased workforce participation of women, better education of younger generation, influence of mass medias (e.g. projecting western life style), new housing schemes, development of national pension scheme, and emerging professional caring schemes of elderly. Consequently, the social safety net and material support usually provided by family or kinship structures are becoming less available and certain for many elderly people in Indonesia. Finally, we may rise the crucial question, which points to a fundamental process whose effects are experienced by most Western societies: Who will take care of the (Indonesian) senior citizens when fertility declines and less children are born and the number and the longevity of older persons increase? On the other hand, we can emphasize some positive aspects of decreasing filial piety: less inter-generational conflicts, more economic independence (of parents and children), and development of more professional caring institutions and social security schemes. Of course, new forms of elderly care and support will be designed and developed in the near future, challenging the senior citizens' potential and resources. New solutions depending on individual or family ability may be developed such as increased intra-generational networks, founding of formal self-help groups, member of a private insurance company, modification of existing 'traditional' care systems, or personal savings arrangements.

- Senior Citizens, Economy and Poverty: The economic situation of elderly persons in Indonesia shows a remarkable and, at the same time, sad trend from bad to worse. Whereas 25 years ago poverty was widespread in mostly rural, but also urban areas, we now see that poverty in Indonesia is predominantly found among elderly people in rural and increasingly in urban environments. Married couples without children, single women and widows are the poorest. The economic crisis of 1997/1998 has resulted in rapidly increasing living costs in the cities and has therefore put increased pressure on the aged people. Moreover, due to the country's economic collapse as a result of the mentioned Indonesian crisis about 20 million younger people have become jobless and, as a consequence, they crowd in the informal sector where the struggle to survive turns to the older generation's disadvantage. Generally speaking, older people who are on an average less well educated cannot compete with younger generations – a fact which is all the more important in the formal sector. The on-going impoverishment of the elderly age group is considered a bigger threat for its independence and autonomy than changing social patterns, for instance, family structures. We should not only consider elderly people in a medical sense, but also their socio-economic reality they are living in: Poverty, poor

living conditions and poor health are a vicious circle and they have mutual influence on their vulnerability.

- Gender gap: Recent research on poverty in Indonesia shows a distinct gender gap. There is statistical evidence, first, that more elderly women migrate from rural to urban areas in Indonesia than older men (for instance, widows joining their children after their husband's death, better access to work opportunities [e.g. housekeeper, baby sitter]) and, second, that more older women live in slums and squatter communities than old-aged men. The urbanization level of women is significantly higher than for men in the age group of 60 years and older. First preliminary outcomes of the National Census in August 2000 provide additional evidence and seem to confirm our assumption that the 'new poors' in Indonesia are to be found above all among A) senior citizens and B) women. Older women, in other words, have become the weakest members of the Indonesian community. A closer look at these women shows that those who are unmarried, widowed and childless or widowed with children who do not support them are most vulnerable, that is threatened by socio-economic insecurity and increased risk of illness, both of which commonly lead to social exclusion. Linked with the above-mentioned higher life expectancy of women in general, this implies that many older women will have to live alone and in poverty at the end of their lives. To be married, to have children and to have good relationships with your children and grandchildren as well as with your husband's kin are still important cultural values for Indonesian women, even more so than for men. Children and kinship bonds are still considered as women's insurance for advanced age; women who do not correspond to this ideal cultural image will certainly face negative effects of their gender-determined vulnerability. But this phenomenon also points to the special need for support and gender-specific services for older women, particularly those who are widowed or single heads of families.
- Senior Citizens and Urban Life: Unfriendly Environment: Let us jump to a first conclusion: The environment in most Indonesian cities is highly elderly unfriendly. Inappropriate internal conditions, namely accommodation, were identified as the most crucial constraints with regard to home environment of elderly people. Living in very cramped conditions, poor hygiene and sanitation at home, crowded and narrow bedrooms without privacy, steep stairways, noisy atmosphere, and unhealthy cooking and washing facilities are some deficits elderly people have to live and to cope with. Moreover, most houses in Indonesia are not suitable for disabled people. The external environment in most towns is also hostile to older people. Dense traffic, crowded public transports, uneven surface and sidewalk obstacles are some prominent examples for elderly unfriendly conditions. Activities of daily life such as shopping in supermarkets and boarding small commuter buses may become

major ‘adventures’ for elderly people, especially if they suffer from eye or hearing problems or are otherwise physically disabled. Often, modern technologies applied for example in electronics (video and audio system), telecommunication (hand phone), or banking (cash dispenser) do not meet the expectations and needs of elderly people whose English knowledge is very limited, too. Therefore, they become easily excluded from many urban achievements.

- Resources and Empowerment of Elderly People: The (Indonesian) ‘National Day of Elderly People’ *(Hari Nasional Lansia)* celebrated on each May 29th enthusiastically proclaimed the full empowerment of elderly people by making use of their experience and their resources. Before putting it into concrete actions, we may state some weak points of elderly people as a whole group: a very low organisational degree; difficulties to articulate their aspirations, also in a political sense; low educational degree; a lack of persistence and perseverance; retreat into domestic or private sphere. Nevertheless, we have also to mention the precious resources elderly people possess: cultural (e.g. bearer of local knowledge and traditions), economic (e.g. there are also wealthy elderly people), social (e.g. important for social coherence and balance) and psychological resources (e.g. as peace-keeper or intermediate) – and not to forget life experience! The problem is: how can we tap these mentioned resources? It may happen from external bodies and younger persons (as initiators) in order to encourage elderly people to organize themselves, but in a second phase organisation management should be handed over to the elderly themselves. Doing so, we have seen that elderly people activate and encourage other senior citizens to follow their example. According to our experience from North Sulawesi, it is rather difficult to move and activate singular elderly individuals; it is best done in a group-oriented approach and not on individual base.

Hypotheses Testing

1. There is no absolute social security or reinsurance anymore for elderly. My hypotheses are that A) in contemporary Indonesian cities, old people will look more often for intragenerational relations than for intergenerational support, and B) new public or private welfare and insurance providers will not replace the rapidly eroding familial network during the next years.

➔ Tendency: A) No and Yes: Both intergenerational as well as intragenerational ties are still strong; it is rather as mixture of both relations (vertical and horizontal) than only one single generational orientation. Kinship relations are responsible for most of the intergenerational contacts (for example family feasts), whereas intragenerational bonds are generally tied in non-kinship relations (such as Church or Mosque groups). Indeed, intragenerational

networking of senior citizens is nowadays increasing and intensified; B) Yes: generally speaking, welfare and health insurances are still very seldom met in our sample population (about 7%); thus, it is difficult and too early to speak about a replacement through insurances. Moreover, it is a question of financial affordability and the willingness to pay for a health insurance; both factors may become increasingly important.

2. There is no absolute economic security or reinsurance anymore for elderly. My hypotheses are that A) more and more older people are working in the informal urban work sector (mostly service sector) to have their own monetary income, and that B) older people in low-income households contribute a big part to the overall household portfolio.

➔ Tendency: A) Yes: Indeed, the great majority of still productive and therefore still healthy elderly persons work in the informal service sector as well as in the primary sector (agriculture and fishery); moreover, people who have formerly worked in a formal sector (for instance, government employees) are engaged in the informal sector because of economic hardships; B) Yes: their own income guarantees them not only a certain autonomy and ensures them a broader independence, but also means an important contribution to the general household portfolio. This is all the more true where an elderly household member gets regular monthly cash income for example as government pensioner.

3. An elderly person has to fulfil new responsibilities in his/her new life course, which is not determined by his/her physical condition. Old age is a period of increased personal authority and respect, but which are mainly restricted in an urban setting to the private, but not to the public sphere. My hypothesis is that the sick role of older people is according to their social role they usually hold as (healthy) elderly persons in their (urban) society.

➔ Tendency: Yes and No: This assumption is partly verified in the sense that older sick people are be freed from certain social and economic obligations; but this conditions is linked together with a general loss and decrease of competence and authority, a fact that does not support the sick role theory. It is sometimes shocking how their own household members treat badly seriously ill elderly people or even neglect them.

4. Elderly people are a group with increased health risks (through the presence of both communicable and non-communicable diseases), but they are not a vulnerable (i.e. to have the prospects to become socially excluded) group per se. We have to look at the intra-age cohort heterogeneity in respect to time, place and person. My hypothesis is that particular elderly people are vulnerable because their social capital is low and their household welfare is poor.

➔ Tendency: Yes: In fact, old people are not ill because they are simply old! They show low social capital (e.g. education, social network, life experience,

competence, adaptation), have generally a worse household welfare (e.g. hygiene, housing, environment, nutrition) and are therefore more vulnerable to social exclusion and consequently to physical and/or mental harm. Strict ethnic and religious categorization is not true of socio-economic aspects, that means in every ethnic or religious community we may find old people who are better off than other community members.

5. Old people in Indonesian urban areas can be affected from infectious (e.g. malaria, diarrhoea) as well as from chronic-progressive (i.e. expected to be long-term or permanent) illnesses (e.g. hypertension, diabetes). Chronic disorders are mostly 'diseases without illness' (i.e. only biomedical diagnosed). My hypotheses are that A) old urban people consider a physical or mental disorder a serious sickness when their daily social routine life is disturbed and they are themselves threatened by social exclusion, B) by that, to a great extent, they underestimate the effects of chronic illnesses on their physical ageing, and C) health maintenance of older urban dwellers comprises more than pure medical acts.

➔ Tendency: A) Yes: Actually, performing the ‘Activities of Daily Life’ is a crucial activity to ensure social integration, acceptance and independence; by this, disturbances such as hearing, vision or remember problems are subjectively perceived as more harmful and disturbing illnesses than chronic diseases such as hypertension and diabetes; B) Yes and No: these ‘diseases without illness’ are indeed underestimated by elderly people, but this is only true for an earlier stage or when not yet clinically diagnosed; C) Yes: pure biomedical oriented health maintenance is very poor developed with old people (e.g. smoking, food, body activities, sleep), but there is also a wider perception of ;health’ than the biomedical one (e.g. linked to social harmony, honouring ancestors or balanced daily activities).

6. Urban areas are heterogeneous entities, thus reflecting a broad medical pluralism. Coping strategies, as a behavioural response or cognitive reaction to chronic sickness, do not only comprise medical care seeking, but also social and psychological 'solutions'. My hypotheses are that A) sick people with chronic illnesses are looking for coping strategies, which comprise more than the health care sector, and that B) old people in the city do not make extensive use of traditional medicine.

➔ Tendency: A) Yes: As a fact, old people with chronic diseases look for ways of coping for instance in religion, in social activities and interactions, in self-reflection, in emotions (e.g. frustration, fatalism, depression), or in isolation. Biomedical influence is more or less weak on their behaviour compared to the important influence of household members on elderly persons’ selection of coping strategies; B) Yes and No: until today, we have not yet found the evidence that older people make more frequent or less frequent use of

traditional medicine (except of use of herbal medicine, which seems to be high) than younger generations. Because of intensive use of herbal medicine in younger years elderly people still have a broad knowledge on traditional medicine. Moreover, we have to specify that old-aged persons in the cities make regular use of herbal medicine for maintaining health (e.g. as tonics, spices, food). Furthermore, we have to look at every step of curative resort during an illness episode; that means we have to look at the initial therapy, at the second intervention, at the third treatment and so on. By this, we have found out that a majority of the elderly people prefer a biomedical treatment as an initial intervention, but following steps very often comprise of herbal medicine and traditional healers, which is all the more true when the illness is gradually progressing or degenerative.