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Multigenerational Caregiving for Older People in Bali: Combining Macro and Micro Perspectives to Understand Ageing, Family, and Caregiving

A thesis presented in partial fulfilment of the

requirements for the degree of

Doctor in Philosophy

in

Psychology

at Massey University, Manawatū, New Zealand.

Made Diah Lestari

2022

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Abstract

Most of the existing research on family caregiving focuses on the nuclear family, consisting only of parents and children as the research population and women as the primary caregivers. Research on family caregiving needs to take into account demographic and social-cultural contexts. Thus, I sought to explore caregiving and ageing in multigenerational households. As populations continue to age, older people's needs for special care has become a critical issue that affects families as the primary support of older people and sometimes presents a burden for families in terms of caregiving. While we are witnessing the development of public provisions to support our ageing population, at the same time, the cultural obligation to care for older generations may be reinforced by policies, effectively shifting state responsibilities to the private sphere. The study was framed by a critical gerontology approach to ageing issues from two perspectives: political-moral economy and humanistic gerontology. Critical gerontology provides space for a dialogue between macro and micro perspectives in understanding ageing and family caregiving.

The research was conducted in Bali, where most older people live in multigenerational households. At the macro level of caregiving, this study aimed to critically review the regional ageing policies in Indonesia. Using critical discourse analysis, this study explored constructions of older people's identities in regional ageing policies and found two identity constructions, namely "material ageing" and "cultural ageing". Such positioning has macro and micro effects on ageing and caregiving practices.

At the intersection between macro and micro levels of caregiving, individual narrative interviews were conducted from January until May 2020 with 49 members of 11 multigenerational households to explore the social construction of ageing and family

caregiving specific to Balinese culture. Thematic analysis, narrative analysis, and discursive positioning analysis were used to analyse the interview data, exploring: (a) important aspects of local knowledge about multigenerational caregiving reported by participants; (b) the role played by the local narratives in shaping family members' stories of multigenerational caregiving; and (c) how two dominant ageing discourses in regional ageing policies, "decline" and "successful ageing", were taken up by older people and their family members in constructing their stories on ageing and family caregiving. I discussed the collective implications of these findings for the micro experiences of ageing and policy and developed a theoretical model of multigenerational caregiving, including its opportunities and challenges by synthesising the findings into a socioecological model. This model provided the basis for an analysis of the intersection between private and public domains of multigenerational caregiving and suggestions for initiatives at the family, community, society, and cultural levels to ensure the sustainability of family caregiving in Bali as well as providing support for the family caregivers.

Acknowledgements

If there is a quote that states a PhD is a challenging experience that demands endurance and is full of threats, then I will definitely agree with that quote.

Based on my experiences, the challenges existed long before my PhD journey began. They started when I decided to change my career from being a practitioner to an academic staff member at a government university in Bali. I thought that academic life would provide a much more stable working life with less pressure regarding achieving targets and accomplishments. I thought that this career would be better suited to working mothers in general so that both roles as a mother and a career woman could be easily blended. However, I was totally wrong—and maybe I am still wrong. Do not underestimate a lecturer, especially the one who works as a government employee in Indonesia. For years, we have been stigmatised by society for our status quo and privilege. In reality, when I entered the system, academic careers do provide challenges. If you want to progress in your career, you have to upskill yourself, and you are the one responsible for your academic and competency growth. The competition is within yourself, not between you and others.

Similar to a PhD programme where you set your own timeline, so it is with your personal growth timeline as a lecturer working in a government institution. No one is there for you to dictate when you should start your PhD. No one is there for you to tell you what you should do to process the university admission and how to get the scholarships. Here, your autonomy and ability to make decisions are challenged, yet it is satisfying when you are able to overcome your procrastination and self-doubt. That is how I felt when I arrived in Aotearoa New Zealand three years ago.

I still remember the excitement when I sat down in front of Professor Christine Stephens' office and waited for her for our first meeting in late February 2019. I felt so

small and disempowered by my lack of academic English and knowledge of ageing and qualitative studies. However, her faith in my ability and strength has each day encouraged me to be a better researcher. I still remember the reason why, in the middle of 2017, I decided to send an email to her asking about a PhD opportunity. There were her articles about ageing experiences in Aotearoa and her narrative analysis approach that were similar to my own thinking and passion. After reading those articles, I did not have any doubt in choosing her as my supervisor. The same was true for Dr Tracy Morison, from whom I have learned so much about methodology and enthusiasm. I am more than lucky to have you both as my supervisors.

Beyond my supervisors, my interest in ageing studies has been shaped by many influencing scholars, and I have been blessed by their support during my study. Among them, there are Professor Tri Budi, Dr Suka Aryana, Dr Yanki Hartijasti, Dr Wai Chong, Dr. Leng Leng Thang, Ibu Wayan, Professor Jatie, Dr Tia, my colleagues at Udayana University who have given their thoughts and opinions about my research and points of view. My friends at *Konsorsium Psikologi Ilmiah Nusantara*, especially Indonesian Journal of Indigenous Psychology, have given me so many opportunities for learning about editing and managing scientific journals. Also, Pak Parta was an influencing figure who facilitated my engagement with the Indonesian Parliament at the policy level as well at the community level. To all of my PhD buddies and the Graduate Research School: thank you all for the sharing sessions during the past three years living in Palmerston North. Also, to the Indonesian scholars and community in Palmerston North, especially the Manawaroa girls—I could not imagine how life during the pandemic would have been without you. For my examiners: Prof. Matthew Parsons; Dr Rachael Pond; and Dr Ariane Utomo thank you for your contributions to my PhD research.

My decision to choose family caregiving as my research focus was so much inspired by my extended family experiences in providing care for my late grandmother. At that time, my parents and their siblings never tired of supporting one another in order to provide the best for my grandmother. After almost two years of being bedridden due to her brain injury, my grandmother passed away a month before I started my PhD. It seems like her soul wanted to be with me, flying across the sea to rest in peace. I do admire the teamwork, love, and obligations that my parents and their siblings have shown us during those unprecedented times. I am blessed that I received a similar amount of support from my husband and his family. For my sisters-in-law—thank you so much for your willingness to replace my role as a caregiver for my mother-in-law during my study. I could not be more blessed with all of your support.

For all of my research participants: your stories are inspiring and have a special meaning in my academic as well as spiritual journey. You have shown me the diversity of life that I used to think of as black and white. Beyond the publication targets and finishing my study, the meetings, sharing, and engagement with all of you are my biggest achievement in this journey.

For Bli Panca, Sekar, and Aru: thank you for being patient and supportive in the middle of this challenging journey. Being a wife and a mother is empowering, and I do feel I am able to negotiate both roles because of you. I would not be who I am now without you. Beyond my career, you are the reason why I decided to study toward a PhD. I want to be a role model for you, showing you about bravery, a love of learning, and encouragement to be better, regardless of our limitations. So, someday, you can say, “Here is our mom; we are so proud of her”.

Is a PhD not for everyone? I can tell you that a PhD is for everyone who is brave enough to challenge their ability because I believe that every person has their own strengths that are waiting to be discovered and shaped. In the end, you are the one who decides whether you want to accept the challenge or leave it.

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Preface

This thesis is based on five research manuscripts. The first manuscript was published in *Ageing and Society* in 2021. The second manuscript was published in *Journal of Intergenerational Relationships* in 2022. The third, and fourth manuscripts have been submitted and are currently under review in the *Journal of Aging Studies*, and *International Journal on Ageing in Developing Countries* respectively. Some findings in the second manuscript, especially about Balinese local knowledge on multigenerational caregiving, are available as a virtual booklet that was shared with the research participants. The third and fifth manuscripts have been disseminated at the Health and Ageing Research Team (HART) Massey Postgraduate Conference, Health Psychology Research Day, and NZAsia Conference. The fifth manuscript will be submitted to the New Zealand Journal of Asian Studies published by The New Zealand Asian Studies Society.

The formatting of the submitted manuscripts has been modified to maintain the consistency of the thesis structure as, for example, headings, citations, tables, and figures. However, the content of the manuscripts remains the same. The ideas presented in this thesis are the researcher's own. The supervisory team assisted with data analysis and the structure of the arguments and selected potential journals for publication. For these contributions, Professor Christine Stephens and Dr Tracy Morison were included as co-authors for the manuscripts presented in the thesis.

Chapter 1 Introduction

This chapter introduces the study of multigenerational caregiving for older people in Bali. It begins with a brief description of the global demographics of ageing and the diverse arguments about older people's health and needs for caregiving. Country differences in economic development is one of the reasons for this diversity. Adopting critical gerontology perspectives suggests that the macro conditions of the place where older people live influence the experience, status, and trajectory of ageing, including how older people and societies view the roles of the family in caregiving.

The second section of the chapter describes the ageing population in Indonesia from the perspectives of demography, public policy, and cultural values. The final section specifically explains the current study of multigenerational caregiving for older people in Bali that combines two levels of analysis: macro and micro conditions of family caregiving. The study's objectives, methods, and contributions are also explained.

1.1 The demographics of ageing

The ageing population is a global issue that has an impact on many aspects of life. It is characterised by an increasing proportion of the population aged 60 years and older accompanied by a decrease in the percentage of those aged under 15 years (Adioetomo et al., 2018; Adioetomo & Mujahid, 2014). According to a definition provided by the United Nations, the ageing population is a phenomenon that occurs when the median age of the population has increased due to lower fertility rates and higher life expectancy (Heryanah, 2015). The increasing proportion of older people in many countries is a reflection of development success in terms of improving nutrition, sanitation, technology, health

services, education, and employment opportunities, all of which help to increase welfare and life expectancy (Adioetomo et al., 2018). The phenomenon has significantly changed the demographic structure. It has been noted that the rapid decline in the fertility rate is a significant factor of the ageing population (Bloom et al., 2015; Diaconu, 2015; Heryanah, 2015). Thus, the proportion of older people increases whereas the proportion of the age group under 15 years old remains stable. These changes also affect the structure of families, which grow vertically but the number of family members within each generation decreases. Consequently, many families have transformed into three or more generation families (Roberto & Weaver, 2019).

These changes provide a challenge for a country. From an economic perspective, the proportion of older people influences the dependency ratio (Bloom et al., 2015), which is the total number of older retired people that the smaller working age group has to support (Adioetomo & Mujahid, 2014; Suardiman, 2011). Increased life expectancy in many cases is associated with an increasing need for health services and special care for older people. Older people's need for special care has become a critical issue that affects families as the primary support of older people. Some scholars argue that older people's increasing need for health services presents a distinct burden for families in terms of caregiving (Hazra et al., 2018; Hsu et al., 2018). However, Spijker and MacInnes (2013) argue that as life expectancy increases, older people become younger and healthier than those in the previous cohorts. Many people over the age of 65 years are still working and independent in terms of financial ability, social interaction, and medical conditions (Spijker & MacInnes, 2013).

Chatterji et.al. (2015) found that differing predictions of older people's health and its effects on services were caused by two factors. First, insufficient data about older people's health, especially in developing countries, is a major issue, which influences

research hypotheses as well as the results. Second, methods used to analyse morbidity patterns also differ, resulting in difficulty in making direct comparisons between countries. In general, patterns of disabilities and health conditions among older people vary among countries. It can be concluded that as long as the methods used to analyse health conditions are still non-standardised and research is not supported by sufficient data, world consensus on older people's health conditions is difficult to achieve.

Achieving consensus on older people's health is complicated by the recognition that older people have become more diverse in terms of their health compared to older people in the past (Biggs, 2005) and by the concept of "successful ageing" proposed by Rowe and Kahn (1987). Successful ageing focuses on the positive side of ageing. It is the direct opposite of the more traditional and widespread view of ageing as involving frailty, dependency, and physical and cognitive decline. Instead, successful ageing is about staying physically and cognitively active and autonomous and is believed to be effective in reducing ageism and negative stereotypes of ageing.

However, some authors suggest that the successful ageing concept has resulted in the polarisation of ageing into the third age and fourth age (Gilleard & Higgs, 2011, 2013; van Dyk, 2014, 2016) and is a form of unintended marginalisation of the fourth age during which people would need special care and support for the family as the caregivers (Gilleard & Higgs, 2011, 2013; van Dyk, 2014, 2016).

As older people become more diverse, the arguments and counterarguments around health and ageing could continue. The discussions are spread within the public sphere as well as in daily conversations between caregivers and recipients in the families' private sphere. Hence, research in this area should view ageing issues as global as well as related to specific countries or regions. Understanding ageing as a global issue will provide direction to scholars in setting a research roadmap that is relevant to global initiatives on

ageing. In addition, research on ageing that attends to contexts will provide useful evidence in developing policy that fits the needs of older people and families in particular regions, so, as the World Health Organization (WHO) states: "…no older person is left behind…" (WHO, 2021, p. 67, as cited in Keating, 2022, p. 3). Finally, the interaction between global and specific–contextual approaches will encourage the importance of collaboration and interdependency in understanding ageing, family, and caregiving.

1.2 Ageing in developing contexts

Not all countries in the world have the same level of readiness to face an ageing population. Although it is a global issue, there is a different pattern between developed countries and developing countries (the country level of development measured by per capita gross national income (GNI; United Nations, 2018)), both in terms of entry phase, speed, and most importantly in preparedness to face ageing issues. Furthermore, the economic development of a country is believed to be correlated with the wellbeing of the population in a country. For example, research has found that higher national income increased physical fitness among older people (Theou et al., 2013) or improved remaining years of healthy life expectancy (Kim & Kim, 2016). In other words, ageing is a macro and a micro issue. It is influenced by the macro condition of a country, and, at the same time, it influences the related microsystem. In the context of ageing, macrosystem consists of one location in the social structure, the economic, political, and socio-cultural factors that affect the status and resources of the older people (microsystem) (Minkler & Estes, 1999). Hence, analysing ageing issues from the perspective of developed and developing countries' differences is critical.

Developed countries experience an ageing population earlier than developing countries, but it occurs slowly over a more extended period along with increasing welfare and per capita income. Compared with developed countries, developing countries experience the ageing population later and have the steepest increase in the older population while per capita income remains low (Calvo et al., 2018; Chomik & Piggott, 2015; Faulkner et al., 2016). In other words, most developing countries "grow old before becoming rich" (Chomik & Piggott, 2016, p. 201).

These different patterns cause developed countries to have better preparation for ageing issues because the slow process provides space for developed countries to build policies that are relevant to empowering older people. Moreover, in some developed countries, older people have been considered economically important as they remain active and productive in later life. Improvements in public policy and technology regarding retirement age and older people's involvement as part of the labour supply has changed people's perceptions of older people as dependent people (Loser et al., 2017; Spijker & MacInnes, 2013).

For developing countries, the strategy cannot be entirely focused on empowering older people because, at the same time, the government is also focusing on policies related to improving the welfare of the whole population (Adioetomo et al., 2018; Adioetomo & Mujahid, 2014). Moreover, Adioetomo and Mujahid (2014) explain that developing countries experience ageing issues at lower levels of economic development and with limited resources, so improving the economic level in general has more priority than overcoming ageing issues.

This problem generally occurs in most developing countries. Consequently, developing countries need to develop priority policies related to the ageing population. However, policy systems in developed countries could be significantly different from

policies in developing countries (Ananta et al., 2005). One of the reasons for this is that cultural influences are powerful in developing countries so need to be a concern in policymaking (Calvo et al., 2018). It is believed that incorporating cultural factors in policymaking is essential to increase the sustainability of the policy (Danielson & Stryker, 2015; Hansen, 2011; Napier et al., 2017). In order to improve the way the nation deals with the ageing population, a government should have cultural sensitivity and awareness of its own ageing issues, these include economic, political, socio-cultural situations of a particular country.

The role of economic, political, and sociocultural factors in influencing the ageing process and ageing policies becomes the interest of critical gerontology (Estes, 1999a). Combining two perspectives—political economy and moral economy—critical gerontology proposes a new direction for ageing studies by viewing ageing as a product of structural and cultural forces in society rather than as an individual process (Estes, 1999a; Minkler & Cole, 1999). While the political economy examines ageing treatment in the context of economy (labour market and class, sex, race, age, and division in society), the moral economy understands the role of cultural beliefs, values, norms in societal institutions, and practices in the ageing issues (Minkler & Cole, 1999).

1.3 The ageing population and policy responses in Indonesia

Indonesia is a good example of a developing nation that has neglected ageing issues until recently and an example of how the structural and cultural forces shape ageing experiences and policy. In his review of the ageing population in Indonesia, Hugo (2000) states that ageing was not at the forefront of the national agenda until 1998. This situation derives from a government preoccupation with other more urgent issues, such as overall

annual population growth rates, population distribution, and underemployment and unemployment. In 1982, the Indonesian delegation at the World Assembly on Ageing in Vienna said that the issue of ageing was a nonsignificant problem in Indonesia compared to other economic and social problems (Niehof, 1995). As a response to International Older People Day in 1996, the government declared Indonesian Older People Day and the terminology of *lanjut usia* (*lansia*), which means advanced age (Noveria, 2006). Indonesian Older People Days aim to increase stakeholders' awareness regarding the importance of giving priority to older people. In 1997, interest in ageing issues among policymakers was slightly increased, although, according to Hugo (2000), it was more at the level of rhetoric than actual action.

It has only been in the past two decades that Indonesia has begun analysing older people's conditions using information from the national census (Adioetomo & Mujahid, 2014). Data related to older people has also been included in the Indonesia Family Life Survey (IFLS) since 1993, including self-assessed health, daily living activities, chronic illnesses, mental health conditions (Cao & Rammohan, 2016), and household consumption and living arrangements (Witoelar, 2012). The idea is that many types of research could be developed in the future to support government policy with a comprehensive database.

The demography of ageing in Indonesia

Based on the national census in 2010, the proportion of older people in Indonesia reached seven point six percent. The proportion increased dramatically from four point five percent in 1971 and is projected to increase to around 15.8% in 2035 (Adioetomo et al., 2018; Adioetomo & Mujahid, 2014). The United Nations predicts that the proportion of

older people in Indonesia will reach approximately 25% by 2050 (Adioetomo et al., 2018).

At the national level, the ageing of the Indonesian population has been influenced by a raise in life expectancy and rapid decline in fertility rate. In regard to the diversity of the regions across this country, the variation of ageing population at the regional level has been influenced by failing in fertility rate and transmigration (population migration to remote areas aimed at equal distribution of the population among provinces; Utomo et al., 2019). The rapid fertility rate decline was the result of a national family programme, namely *Keluarga Berencana* (two-child policy), launched by the government in 1970. As a result, the provinces that have successfully implemented a two-child policy and transmigration to destination areas have a higher proportion of older people compared to other provinces in Indonesia. The five provinces with the highest proportion of older people are D.I. Yogyakarta, East Java, Central Java, Bali, and North Sulawesi (Sari et al., 2020). Despite these two major influences, rural areas are relatively older to the urban areas due to high rates urbanisation among the younger generation (Utomo et al., 2019)

Policy history in Indonesia

Awareness of the impacts of population ageing in Indonesia came rather late, marked by the establishment of the national ageing policy in 1998. The government's lack of urgency led to a limited ageing policy. Before 1998, there was only one ageing policy that included only older people without family. Hugo (1992) argues that the primary barriers against ageing being the priority policy in Indonesia are tradition and religious beliefs, which ensure that the extended families play a vital role in older people's caregiving. Therefore, the government was initially less concerned about the problems caused by the increased

proportion of older people. Only in the last two decades have national surveys and research begun to be initiated for supporting government policies and programmes.

The Indonesian Government faces four critical issues regarding the ageing population: (a) increasing the assistance for older people with disabilities; (b) providing adequate living arrangements for older people; (c) ensuring income security for older people; and (d) meeting the growing demand for health services (Adioetomo et al., 2018; Adioetomo & Mujahid, 2014). The prevalence of illness and disability are known to increase with age, which may result in a growing need for health-care services and family support. The government needs to develop appropriate policies and programmes to ensure that older people receive adequate care, such as providing family incentives and developing social security schemes.

In dealing with these key issues, social security for older people is integrated into national social security schemes that are regulated by Law No. 40/2004 about The National Social Security System, known as *Sistem Jaminan Sosial Nasional* (SJSN). The SJSN was established to promote equality and universality in social welfare for citizens (Supriyanto et al., 2014). Eventually, SJSN is planned to provide financial (pension and saving schemes), nonfinancial (national health coverage and long-term care), and active ageing schemes (community empowerment programmes) for older people. Alongside SJSN, the government has developed some programmes that are coordinated by three ministries: the Ministry of Social Affairs; the Ministry of Health; and the State Ministry for Population/National Family Planning Coordinating Board (Djamhari et al., 2020; Kadar et al., 2013; Noveria, 2006).

The government's programme on ageing issues

The Ministry of Social Affairs is obliged to provide assistance and social protection for older people in both institutional and noninstitutional settings. Institutional settings are provided for older people who do not have family support for fulfilling their needs and rights or whose families are financially incapable. Older people who have family and relatives are expected to be assisted in noninstitutional settings. Social assistance for older people in noninstitutional settings consists of a cash-direct payment (known as *Program Keluarga Harapan*) and in-kind support (known as *Bantuan Pangan Non-tunai*). The institutional setting is the least likely to provide care for older people because, for most Indonesians, relying on formal services is unacceptable and considered shameful. Older people are seen and treated as respected figures in society (Kadar et al., 2013).

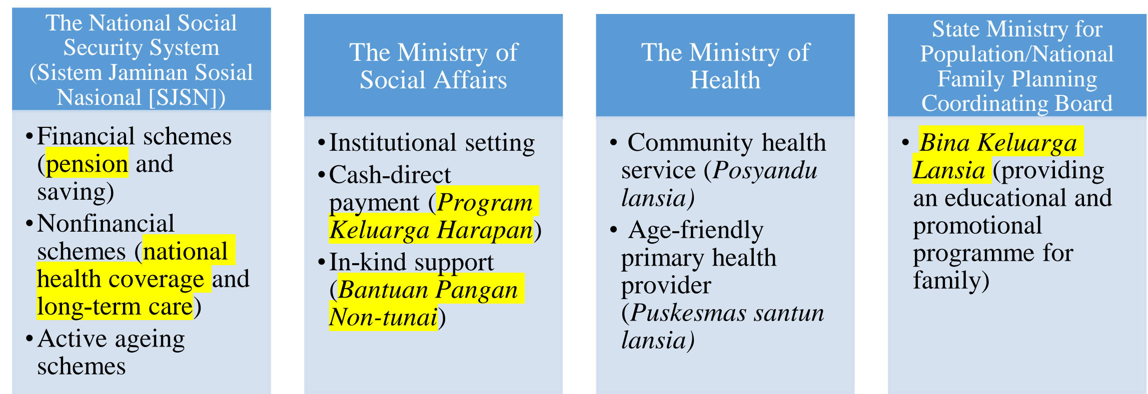
The Ministry of Health coordinates programmes related to promotional, preventive, curative, and health rehabilitation for older people. At the community service level, the Ministry of Health develops integrated family health services that cover mothers', children's, and older people's health, namely *Posyandu*. *Posyandu* is organised by the community with supervision from the nearest first-level health facilities (known as *Puskesmas*—Centre for Community Health; Kadar et al., 2013). There are age-friendly *Puskesmas*, namely *Puskesmas Santun Lansia,* in several regions; by 2015, the number of *Puskesmas Santun Lansia* had reached 824 (Pusat Data dan Informasi Kementerian Kesehatan Republik Indonesia, 2017). Unfortunately, long-term care and programmes for supporting family roles in caregiving still lack attention since government priorities focus more on promotional and preventive programmes (Kementerian Kesehatan Republik Indonesia, 2016).

The State Ministry for Population/National Family Planning Coordinating Board developed a programme focused on the family level and explicitly said that the support

for older people must be provided by the family. The programme was named *Bina Keluarga Lansia* (Directorate of Aged Family). The programme aims to increase the role of the family in providing support for older people to improve welfare. Its projects include increasing awareness, knowledge, and skills for family members in assisting older people, offering medical check-ups, and providing business funding for families to improve the family's financial capability to support an aged family member (Noveria, 2006). This programme is adopting a productive ageing perspective in their "eight pillars of resilient ageing", which refer to older people as autonomous, productive, and economically beneficial for the community. The summary of the government's programmes is presented in Figure 1.

Figure 1.

The Indonesian Government Programmes for Older People's Wellbeing



The implementation is still problematic, whether these examples are limited or not fully established, or applied means-tested for the eligibility

In addition to the national government programme, a regional autonomy system, which was established after 1998, means that each region has authority to develop their own policies, including a policy on ageing. Further explanation regarding regional ageing policies will be discussed in the last section of this chapter.

Policy implementation issues and challenges

The primary targets of the programmes delivered by the three Ministries are families and older people. Unfortunately, as most of the programmes focus on promotional and preventive health, programmes that support long-term care and caregiving in the family context are neglected and leave financial and practical burdens of caregiving in the private family domain. Prioritising promotional and preventive programmes is influenced by the dominant discourse of successful ageing in many ageing policies, including Indonesia. As a result, older people are viewed as individuals who potentially keep healthy and active in their later life. This discourse has eroded previous perceptions of older people as sick, frail, and dependent individuals. However, around 25% of Indonesian older people still need care and support due to medical decline (Silviliyana et al., 2018).

In terms of SJSN, there is great variability in the actual delivery of the schemes associated with it. Several schemes in SJSN, such as a contribution-based pension system for the informal sector and contribution-based long-term care, have not yet been implemented. Among the implemented schemes, social pension and long-term care in government residential care remain limited in terms of the coverage area and eligibility (Direktorat Perlindungan Sosial dan Kesejahteraan Masyarakat Kementerian PPN/Bappenas, 2015; Kidd et al., 2018; Supriyanto et al., 2014)

Difficulties also have arisen in implementing policy. The coverage of the programmes was limited, and the effectiveness of the programmes was less than expected due to a lack of coordination and overlapping goals. Djamhari et al. (2020) state that some of the programmes are not exclusively provided to support older people but are mainly developed to alleviate poverty. For example, *Program Keluarga Harapan* is a cash-direct payment that provides for families living in poverty to reduce the burden in financing women and childcare, education, and older people care. In reality, for most families

covered by *Program Keluarga Harapan*, the utilisation of a cash-direct payment for older people care was less than for childcare and education (Djamhari et al., 2020).

Moreover, the regional autonomy policy has given rise to inequality issues among regions in terms of budgeting, the distribution of resources, and the number, incentive, and productivity of the health-care workforce. Among regions with high resources and budgets, ageing issues are a priority and concern. On the other hand, among regions with low resources and budgets, ageing issues have been neglected. As a result, there has been a lack of implementation in the underdeveloped regions (Kadar et al., 2013). Furthermore, the government's programmes at the national level fail to answer specific social demographic features in a specific region. For example, the government budget for nursing homes might be replaced by home and community care that more closely meet the needs of Indonesians (Do-Le & Raharjo, 2002).

1.4 Ageing and family in Indonesia

The cultural values of ageing and family

Older people's care at the family level is influenced by the traditional values of the Indonesian family, according to which the support and care of older people are the responsibility of their children. Thus, older people automatically depend on their children. These values are similar to those of several Asian countries, such as Singapore and the Philippines (Ananta et al., 2005; Badana & Andel, 2018). Singapore strongly supports the needs of multigenerational families. According to Nga (cited in Ananta et al., 2005), citizens are allowed to utilise their insurance to cover parents' and grandparents' medical expenditure. Filipinos adopt *filial piety,* which means that families have the primary responsibility for older people's care (Badana & Andel, 2018). I discuss more detail about

cultural values related to ageing and family in Bali as one of regions in Indonesia with high proportion of older people, in Chapter 3.

Challenges in maintaining the values of ageing and family

In Indonesia, the traditional ways of caring for older people currently face four challenges, which are the declining fertility rate, high rates of migration, poverty, and a growing female labour force. These appear to be linked to a shortage of family members who can provide support for older people (Chomik & Piggott, 2015; Do-Le & Raharjo, 2002; Mi et al., 2018). First, as the fertility rate declines, the number of family members in one generation decreases. This, in turn, may be associated with the decreasing number of family members who can support aged family members. In traditional families, having many children means having many sources of support in old age, but increased awareness of family planning has changed this view. Many children are now seen as creating a burden on the family in terms of providing for children's needs (Hugo, 1991; Kreager & Schröder-Butterfill, 2008).

Second, the high rate of migration among those of productive age, especially from rural areas to urban areas, has been associated with an increasing number of older people who live alone in rural areas with fewer informal caregivers (McDonald, 2014b). Third, the level of poverty in rural areas may affect families' capability in terms of financial ability as well as knowledge and skills needed to provide support for older people (Kadar et al., 2013), and four, employment opportunities for women are also believed to be a challenge to the provision of caregiving for older people. Studies of family caregiving for older people reveal that the role of caregiving is mostly done by daughters or daughters-in-law (Alpass et al., 2013; Lee, 2001; Lee & Porteous, 2002; Nortey et al., 2017; Roth et al., 2009). The positive impact of working women is that women have the financial

capacity to help families. However, working women's time is limited in terms of providing care to families (Niehof, 1995).

The contradictory prediction about multigenerational households in Indonesia

Because of these four challenges, some researchers have predicted that families in Indonesia would switch from extended families to nuclear families (Hugo, 1991; Kreager & Schröder-Butterfill, 2007, 2008, 2015; McDonald, 2014a). Surprisingly, based on the Indonesian Central Bureau of Statistics data in 2018, the number of older people living in three-generation households reached 43.18% (Silviliyana et al., 2018). The proportion increased from 36.5% in the 2010 population census (Adioetomo & Mujahid, 2014) while Witoelar (2012) found that in the 14 years from 1993 to 2007, there had been no significant change in living arrangements. Three-generation households usually include grandparents, adult children with wives and husbands, and grandchildren, and these living arrangements represent an extended family system in terms of the number of family members. The 2018 proportion contradicts the predictions of some experts regarding the weakening of the existence of extended families in Indonesia due to the low fertility rate, high level of migration, and female labour force.

There are four possible reasons why three-generation households continue to exist in Indonesia. The United Nations Department of Economic and Social Affairs (2017) suggests that household living arrangements are influenced by social and cultural norms, economic conditions, available support systems, and individuals' health statuses. Moreover, increased life expectancy and the declining mortality rate can lead to a higher likelihood of three generations or more living in one family at the same time (Qualls & Williams, 2013; Roberto & Blieszner, 2015; Roberto & Weaver, 2019). In the context of Indonesia, the influences of increasing life expectancy, increasing household expenditure,

declining medical conditions, and maintaining family traditions are relevant in explaining the existence of three-generation households.

According to the Indonesian Ministry of National Development Planning, Indonesians' life expectancy increased around one point five years between 2015 and 2020. It was predicted that by 2020, the life expectancy would be 71.5 years (Adioetomo et al., 2018). Blieszner (cited in Qualls & Williams, 2013) mentions that some of the experiences that families in the ageing population will have are that adults will spend three times as long in their old age than in their childhood. Consequently, the longer adulthood increases the duration of the families' cross-generational relationship and the possibility of younger generations growing up not only with their parents but also with their grandparents and probably with their great grandparents as well.

Living in a three-generation household is driven by household expenditure (Johar & Maruyama, 2011). This pattern is common among cities in Indonesia where housing and some household expenditure are unaffordable. The support exchange is relatively downward from older people to the younger generation or is balanced; thus, cohabitation with parents was more related to the vulnerability of the younger generation (Arifin et al., 2012; Arifin & Ananta, 2016; Schröder-Butterfill, 2004). In this case, three-generation households become the best choice to control household consumption (Pensieroso & Sommacal, 2014).

Declining health is a possible reason for older people living with family. Although the morbidity trend has slightly decreased in the last four years, the morbidity decline was less than 50% of the government's target (Kementerian Kesehatan Republik Indonesia, 2016). The morbidity decline was down three percent from 28.62% in 2015 to 25.99% in 2018 (Silviliyana et al., 2018). According to Adioetomo et al. (2018), the number of older people who live in three-generation households increases with age due to increased

dependency caused by worsening medical conditions. In general, the percentage of older people who experience functional difficulties, including difficulty in vision, hearing, walking, and memory limitations, increases with age (Adioetomo et al., 2018). This raises the need for long-term care.

Indonesians believe that support and caregiving are the responsibility of family. Hugo (2000) states that there are two aspects of the Indonesian family tradition that relate to care of older people. First, is the existence of norms related to parental caregiving by children. Second, older people living in an extended family mean that the burden of caregiving can be shared among children and grandchildren. Thus, in traditional societies in Indonesia, support is from children to parents (upward), especially when parents become older and experience health decline.

What research about ageing and family in Indonesia can do

Recognising the cultural values and multigenerational households in Indonesia, it is important to understand caregiving patterns in the family, especially in cultures where the role of caregiving for older people is the responsibility of the family. Roberto and Blieszner (2015) suggest that research on family caregiving needs to take into account the demographic and social contexts that exist for a given period, and it is essential to examine social demographics, including living arrangements and cultural values (Bookman & Kimbrel, 2011).

Conducting research on family caregiving in specific contexts provides more complex and nuanced findings. For example, staying with the family provides a major source of social support for older people, but, on the other hand, there may be potential psychological conflicts resulting from intergenerational disparities. In terms of cultural values, how young generations view older people and an obligation to care are influenced

by social demographic aspects (Robinson & Howatson-Jones, 2014). Research has found some advantages and drawbacks of tradition and cultural values on older people's care. While cultural values of caring were a source of motivation, an obligation to care could be a strain for young generations in countries with a strong culture of family caregiving. Older people are considered a burden when social norms are perceived as strict (Hsu et al., 2018). Cultural values regarding older people's care should be supported by an established welfare system so that older people's care is not considered as a burden by the family (Chomik & Piggott, 2015).

A better understanding of how families deal with multigenerational caregiving in the Indonesian context will contribute to the government objective of maintaining the role of the family as primary support for older people's wellbeing. How to maintain the cultural values of multigenerational households is a significant issue that challenges Indonesia in this era of demographic transition. Research on multigenerational households can reveal their needs, strengths, barriers, and challenges in providing older people's care to provide information and evidence for policy improvement.

Adopting a critical gerontology approach to ageing issues means that the study of multigenerational caregiving can accommodate both individual processes and the structural and cultural forces of ageing. This lens includes economic, political, and sociocultural aspects of family caregiving and helps explain how these three aspects affect one another in producing the dynamic interrelationship of individual, family, social structures, and culture. Since political economy has been placed in opposition to moral economy in previous research, it is important to explore how family and ageing in Indonesia may be understood from these two perspectives. In addition, it is also important to adopt a cultural way of thinking in critical gerontology research that accounts for the diversity of ageing issues (Burton et al., 1992; Luborsky & Sankar, 1993).

From the perspectives of political and moral economy, older people are influenced by the macro conditions of the society in which they live. The second phase of critical gerontology, widely known as humanistic gerontology, holds that regardless of the pressure of macro conditions in older people's lives, ageing is an existential process (Baars et al., 2013; Minkler, 1996). This means that older people have the potential to overcome constraints and do not stop searching for meaning in life. Therefore, as older people have the potential to overcome constraints, a dynamic at the micro level could influence the macro conditions. Moreover, Baars et.al. (2013) believe that the concept of interdependency is more relevant than independency in explaining the pursuit of meaningful life among older people. Combining these two phases in critical gerontology could add to the holistic perspective of multigenerational caregiving. More detail about critical gerontology is discussed in Chapters 2 and 3.

1.5 Keeping cultural values alive: The case of Bali in maintaining family caregiving and multigenerational households

Adioetomo and Mujahid (2014) state that maintaining multigenerational households is one of the proposed policies for Indonesia to maintain this primary means of support for older people. However, maintaining tradition seems impossible if the government does not provide policies and programmes that support family caregiving. Conversely, maintaining tradition could be a burden for the family. Even though some regions in Indonesia have an established regional policy on ageing and wellbeing, they still lack supported programmes and implementation. For example, social security and welfare systems for older people are far from sufficient. One in three older people in Indonesia do not have health insurance, only 13 of 100 older people have social security, only

10.64% have pension funds, and recipients of health insurance subsidies are less than half of the population of older people in the lower economic strata (Silviliyana et al., 2018). There is an urgent need to address the role of government in supporting family caregiving in Indonesia.

As Indonesia implements regional autonomy systems after democratic reform in 1998, the governments at the regency level are more autonomous and independent from the national government (Bell, 2003). With this decentralisation approach, the regional governments have full authority in regulating political and administrative sectors (Smith, 2008), except for security and defence, foreign policy, monetary and fiscal, justice, and religious affairs (Syaiku, 2002). Regional autonomy aims to improve local government services and accountability based on the assumption that the understanding and familiarity of communities' needs are better at the local government level than the central government. Thus, with the regional autonomy system, local governments are expected to be able to create more appropriate public policies (Syaiku, 2002). Therefore, in dealing with ageing issues, each region in Indonesia has its own regional policy.

At least 17 regional ageing policies were established between 2014 and 2018. For most of Indonesia, ageing policies have been positively and unquestioningly accepted since older people's wellbeing is accepted as part of local knowledge. This means that there has been a very limited critical review of the ageing policies in Indonesia. A critical approach to ageing policy can provide broader understanding and recommendations for ageing policy improvement in the future, especially in the area of family caregiving and long-term care. The omission of long-term care from the government's health programme on ageing was admitted by the Ministry of Health Republik of Indonesia (Kementerian Kesehatan Republik Indonesia, 2016). Even though Indonesia has national health insurance, named *Jaminan Kesehatan Nasional*, it does not support long-term care and

the total cost of family caregiving (Kementerian Kesehatan Republik Indonesia, 2016; Kristanti et al., 2018).

Bali is one of the regions in Indonesia that has an established regional ageing policy. The ageing policy in Bali was driven by the demographics of ageing in Bali. Bali has the fifth largest proportion of older people in Indonesia (Sari et al., 2020). This Balinese feature of the ageing population was influenced by the successful implementation of the National Family Planning Programme (Adioetomo & Mujahid, 2014). The proportion of older people in Bali in 2020 was 11.58 % (Sari et al., 2020) and contributed to two point one percent of Indonesia's population of older people (Adioetomo & Mujahid, 2014). The life expectancy at birth in Bali was 72.7 years in 2010 and is higher than the national life expectancy at birth. The ratio of dependence of older people in Bali in 2018 was 16.73 (Silviliyana et al., 2018) with a higher support ratio in rural areas compared to urban areas (Adioetomo et al., 2018). With this situation, there was an urgent need to create a regional ageing policy.

Balinese cultural values of *suputra* (the concept of "a good child"), and *dadia* (family and kinship patterns and relationships in Bali) became the philosophical underpinning of the regulation. Almost 58% of Balinese older people are living in three-generation households, which is higher than the national percentage (Silviliyana et al., 2018). However, there is a concern from some policymakers that the trend will decrease in the future and affect family support for older people, as shown by a quote below from I Nyoman Parta, a member of the regional parliament who became the leader of regional ageing policymaking in Bali in 2018:

> It is time for Bali to have a local policy on older people. The rapid growth of development in Bali due to tourism had a negative impact on our cultural values. Nowadays, there is an increasing number of neglected and abandoned older people. There should be no problem like this in Bali because Balinese who are

> Hindus hold the concept of *suputra* (a good child) and *guru rupaka* (similar to filial piety). Maybe it was caused by the increasing demand for life and decreasing value of *menyama braya* (mutual help within the community; Devita, 2018)

In his statement, Parta showed his concern that the tradition of family caregiving will be abandoned. He influenced public opinion on older people's care in Bali that has been neglected because of changes in moral values among the younger generation. He emphasised the influence of tourism and modernisation in diminishing solidarity and community support. He also argued that Bali has cultural values that could motivate younger generations to provide care for older people. Thus, from the perspective of policymakers, there is an urgent need to maintain cultural values in dealing with ageing issues in Bali. Accordingly, the policy document highlights the importance of family and intergenerational relationships in maintaining older people's wellbeing.

Alongside family caregiving, the importance of the concept of ageing in place for Balinese is also worth noting. This refers to older people's desire to live and stay longer in the community along with their families, relatives, and friends. The role of community, which is organised as villages and *banjar* (Hamlets), is crucial for the Balinese in terms of social support. For the Balinese, *banjar* is the most important single set of people in their life, besides family, and is the main organisation responsible for developing policy, maintaining moral behaviour and virtues, and providing general public welfare (Geertz & Geertz, 1975). Further explanation regarding the role of *banjar* on ageing and family caregiving will be discussed in Chapters 3 and 5.

While the government used cultural and family values discourses as the underlying philosophy for ageing policy production, the ageing policy in Bali has been developed through a top-down approach in the policymaking process, especially in regard to the role of family and the responsibility for care of older people. This top-down approach includes a sceptical view of the future of multigenerational households.

Ironically, the government has paid less attention to the role of family caregiving in older people's health. Like most ageing policies in Indonesia, the government has adopted a successful ageing perspective, which views older people as having potential, and being productive and beneficial individuals. Thus, the policy contents highlight these issues rather than healthcare and rehabilitation needs of older people that may cause financial strain for the government. Consequently, caregiving remains in the family and private domain. Even though Bali is the second rated province in Indonesia with good access to health services, it is also important to explore the collaboration between family and public health services in providing care for older people. Therefore, working closely with the family to capture the cultural, physical, and relational aspects of caregiving in the context of multigenerational households will contribute to public understanding of family and ageing as well as provide a basis for ageing policy improvement in the future.

1.6 Research aims

To view multigenerational caregiving from the individual, family, social structural and cultural levels, this research has five aims:

1. To critically review the regional ageing policies in Indonesia and their impacts on older people's identity and caregiving practices.
2. To explore the cultural, and relational aspects of multigenerational caregiving.
    a. Cultural aspects of multigenerational caregiving relate to the local knowledge that underpins caregiving practice in Bali. This research will explore the ways in which local knowledge is perceived and shared by family members, and how family and individual voices describe local knowledge about caregiving for older people.

    b. Relational aspects of multigenerational caregiving include individual perceptions of multigenerational relationships, multigenerational relationship patterns in the family, and community-level family coordination with other systems, including ageing policies.
3. To understand family members' narratives on caregiving in relation to local knowledge.
4. To understand how the dominant discourses on ageing and family caregiving shape Balinese everyday talk and the implications for practices of caring for older people.
5. To develop a multigenerational caregiving model based on the findings from the above aims.

To achieve the research aims, a qualitative methodology using critical discourse analysis (CDA), thematic analysis, narrative analysis, and positioning analysis is used. More detail about these research methods is presented in each of the published chapters.

1.7 Significance

This research is expected to contribute to knowledge of caregiving and ageing, both at the micro and macro level. At the micro level, findings will contribute to the social practices of caregiving at the family level by providing information about physical and relational aspects of multigenerational caregiving in order to support families' and older people's wellbeing. At the interaction between macro and micro levels of ageing issues, this research is intended to reveal the role of local knowledge in multigenerational caregiving and the intersection and collaboration of private and public domains in older people's care. Using critical gerontology perspectives, this research will provide a

reference for public policy improvement by demonstrating how family caregiving is currently positioned between economic, political, and sociocultural forces in society.

1.8 Thesis structure

This thesis comprises five articles that will be discussed in detail in separate chapters. The five articles were based on two datasets: (a) policy documents and (b) narrative interviews with members of multigenerational families in Bali. The first article is a critical analysis of constructions of older people's identities in the regional ageing policies in Indonesia. The second article explores Balinese local knowledge on multigenerational caregiving for older people in Bali. The third article looks at the role played by local knowledge in shaping participants' personal stories of family caregiving, and the fourth article demonstrates the discursive effects of two dominant discourses on ageing—"decline" and "successful ageing"—to see how ageing and family caregiving are viewed. A separate chapter explaining the methods of the interview study is provided as a transition from the first article to the second to fourth articles on the experiences of ageing and family caregiving. Finally, the fifth article offers a Balinese family caregiving model that was developed by combining the findings from all articles in this PhD research. The thesis structure is presented in Table 1.

Each article is presented as a stand-alone manuscript; this means there is some repetition, such as data collection, table of structure of participating families, and participants' quotes, in parts of the manuscripts. However, this was considered necessary given the nature of the research and the importance of including the manuscripts as publications. The thesis concludes with a final discussion chapter.

Table 1.

Thesis Structure

Study	Research Aims	Article
Macro level		
Regional ageing policy documents	1. To critically review the regional ageing policies in Indonesia and their impacts on older people's identity and caregiving practices.	Chapter 2 Critical gerontology and critical discourse analysis. Lestari, M.D., Stephens, C., & Morison, T. (2021). Constructions of older people's identities in Indonesian regional ageing policies: The impacts on micro and macro experiences of ageing. *Ageing and Society*, 1-21. https://doi.org/10.1017/S0144686X20001907
The interaction of macro and micro levels:		
Narrative interviews with 49 members of 11 multigenerational households in Bali	1. To explore the cultural, physical, and relational aspects of multigenerational caregiving.	Chapter 5 Thematic analysis. Lestari, M.D., Stephens, C., & Morison, T. (2022). The role of local knowledge in multigenerational caregiving for older people. *Journal of Intergenerational Relationships*. http://dx.doi.org/10.1080/15350770.2022.2059606.
	2. To understand family members' narratives on caregiving in relation to local knowledge.	Chapter 6 Integrated narrative analysis Lestari, M.D., Stephens, C., & Morison, T. (2022). Local knowledge and unliveable narratives: How insights from family caregiving narratives can inform locally relevant ageing policy. Manuscript submitted for publication at Journal of Aging Studies
	3. To understand how the dominant discourses on ageing and family caregiving shape Balinese everyday talk and the implications for understanding and practices of caring for older people.	Chapter 7 Positioning analysis Lestari, M.D., Stephens, C., & Morison, T. (2022). Decline or successful ageing discourses: When local knowledge and dominant discourses intersect to shape personal stories of ageing. Manuscript submitted for publication at International Journal on Ageing in Developing Countries.
	4. To develop a multigenerational caregiving model based on the findings from the above aims.	Chapter 8 Socioecological model and discursive perspective as a guide for sustainable family caregiving Lestari, M. D. (2021, November 24). *Balinese family caregiving model: Opportunities and challenges*. 24th NZASIA Biennial International Conference 2021. 'Asia: Change, disruptions, and resilience', Massey University, New Zealand.

Chapter 2 Ageing Policy and Constructions of Older People's Identities

2.1 The rationale for the study

Ageing policies demonstrate the government's response to ageing issues and, at the same time, provide a significant influence on how older people are seen and treated in society. Ageing policies contribute to discourses on ageing that shape the experiences of ageing (Breheny & Stephens, 2019). Discourses on ageing play pivotal roles in constructing older people's identities, shaping categories, and affecting social impacts for targeted groups (Hacking, 2000). Combining critical discourse analysis (CDA) and critical gerontology, this chapter provides an understanding of the positioning of older people and family caregiving through regional ageing policies in Indonesia.

Aiming to critically review the regional ageing policies in Indonesia and their impacts on older people's identities and experiences of ageing, this chapter is framed by political and moral economy perspectives within critical gerontology. Critical gerontology has made a significant contribution to the study of ageing since this perspective emerged in the 1970s, especially its contribution to critiques of the influence of social, political, and economic structures on ageing experiences in society (Baars et al., 2013; Carney & Gray, 2015; Dannefer et al., 2008; Estes, 1999a; Phillipson, 1996). The scholars working within this perspective argue that the ageing population and related concepts are socially constructed and have economic and political effects in society (Carney & Gray, 2015; Minkler & Holstein, 2008). Minkler and Holstein (2008) suggest that critical gerontology is a perspective that helps people explore the social construction of ageing in socio-political and humanistic contexts.

2.2 Understanding ageing policy from the perspective of critical gerontology

Critical gerontology perspectives are built on two paths, namely the political–moral economy and humanistic gerontology paths (Minkler, 1996; Minkler & Estes, 1999). Dannefer et al. (2008) consider that critical gerontology was developed due to scholars' dissatisfaction with functional theories in sociology and maturation theories in psychology, which tended to be descriptive and did not provide space for critical thinking. This chapter focuses on the discussion about the political and moral economy perspectives and their contributions to understanding policy development. Further explanation regarding humanistic gerontology is presented in the section about the interview study in Chapter 3.

Political economy

Based on critical theory associated with the continental philosophical and political movement of the Frankfurt School (Luborsky & Sankar, 1993), critical gerontology views ageing issues at a structural rather than an individual level (Estes, 1999a). It emphasises the impacts of political, economic, and social relations on experiences and treatments of older people in society. In other words, a political economy approach assumes that the experiences, statuses, resources, and health of older people are influenced by the individual's location in the social structure (Estes, 1999a). The political economy has been recognised for its ability to highlight the intersections between race, class, gender, and ageing (Minkler & Estes, 1999).

The focus of critical gerontology is on how capitalism and public policy (on matters such as social security and medical programmes) affect dependency in old age (Townsend, 1981). Through this perspective, several studies related to ageing that

emphasise social critique, such as assessments of ageing industries and social security (Estes, 1999b; Street, 1999), have been produced. These studies help us to understand disability and dependency in later life as part of a process that does not only involve genetic and biological factors. The ageing process is socially constructed and influenced by the social environment, including existing political and economic conditions (Baars et al., 2013; Cole, 1992).

Originally, scholars within critical gerontology tried to critique the social structure and public policy that created dependence on older people, but, nowadays, they critique most research, programmes, and public policies that adopt the concept of "successful ageing" (van Dyk, 2014). Successful ageing is a concept that has been developed by Rowe and Kahn, based on their critique of research in ageing that emphasised the decline condition of older people and neglected the heterogeneity of ageing (Bülow & Söderqvist, 2014; Rowe & Kahn, 1987). Rowe and Kahn argue that the goal of ageing research is to identify the predictors of a high level of functioning. There are three components necessary to achieve successful ageing, which are low probability of disease, good physical and mental functioning, and active engagement with life (Rowe & Kahn, 1997). Successful ageing in the perspective of critical gerontology is a form of inequality that has marginalised older people with disability and medical decline (Baars, 2017; Biggs, 2005; Minkler & Holstein, 2008; van Dyk, 2014). For many people, including older people, successful ageing is considered as a solution to overcome various problems caused by the ageing population. Successful ageing is often associated with the concept of productivity, which, in a political economy perspective, has an impact on the extension of the retirement age so that social welfare obtained from the government is proportional to one's working life (Gilleard & Higgs, 2011, 2013). It is clear that successful ageing in

this context highlights the utilitarian terms of productivity, tends to exploit older people, and discriminates against older people who do not meet these criteria (van Dyk, 2014).

Furthermore, successful ageing emphasises productivity so has an impact on the social identity of older people who have changed and become more diverse than in the past (Biggs, 2005). Diversity appears from the dichotomy of the third age and fourth age (Gilleard & Higgs, 2011, 2013; van Dyk, 2016). Third age refers to groups of older people who are independent, healthy, able to contribute to society, and are often categorised as "young old" (Gilleard & Higgs, 2013; van Dyk, 2016). While third age is seen as a group that has characteristics similar to the middle adult in terms of ability, lifestyle, and other characteristics, the fourth age becomes increasingly isolated from social structure and the economic market, which, in van Dyk's (2016, p.109) term is called "radical othering". The fourth age is a group of dependent, helpless, and frail older people. According to the political economy perspective, this dichotomy has not radically changed our perception of ageing but has merely dismissed negative stereotypes related to ageing by promoting the healthy condition and ability of retired older people and othering older people with disabilities and medical decline (Gilleard & Higgs, 2011, 2013; van Dyk, 2016). Consequently, the fourth age becomes increasingly marginalised in public policies that prioritise personal responsibility in ageing issues (Minkler & Estes, 1999).

Moral economy

In its development, the political economy perspective has been strengthened by the addition of considerations of a moral economy, which Kohli (1987) defines as "the collectively shared moral assumptions underlying norms of reciprocity in which a market economy is grounded" (Kohli, 1987, p. 162). Here, the notion of a moral economy was developed from Thompson's analysis of Durkheim's studies regarding social norms and

obligations that underlie social practices. For example, crop prices are not only determined by impersonal market forces but also by the principles of justice and custom (Minkler & Cole, 1999). While the political economy approach discusses the influence of social structure, politics, and economic conditions on ageing issues, from a cultural point of view, the moral economy discusses the beliefs and values that underlie the social policies and practices related to ageing issues. A moral economy perspective holds that obligations to care for older people are implicitly articulated in society, which impacts how an ageing policy is formed. The moral economy perspective is widely used to explain the phenomenon of ageing in developing countries where it is understood that every member of the community has the right to live and has an obligation to care for older people (Minkler & Cole, 1999).

Kohli (1987) further argues that the moral economy perspective, although hugely relevant, is very rarely used in analysing ageing issues. However, in reality, the moral economy regulates not only the consumption market but also the labour market. This means that provision obtained from the government is a workforce reward from individual contributions in the labour market. This has developed two ideal types of moral economy: moral economies grounded in 'use value' (meeting human needs and creating social arrangements that maximise life chance for all); and moral economies grounded in 'exchange value' (utilitarian approach to the public goods and ignoring the principle of justice in the goods distribution; Kohli, 1987)

The interaction between the political and moral economy in determining public provision for older people

Combining the political and moral economy paths will deepen people's understanding of how social structures and cultural norms of obligations influence how ageing policies and

their provisions are developed. I have noted some implications of political and moral economy on policy framing. First, there is the global shift towards a successful ageing paradigm that emphasises personal responsibility and preventive programmes. The successful ageing paradigm has marginalised older people who need family caregiving and excluded them from society and policies that value health and the active representation of older people. Disabilities are seen as an individual failure in maintaining healthiness in later life. Second, due to personal responsibility, caregiving is seen as a private activity, and this results in the neglect of caregivers' social welfare in most ageing policies.

The moral economy grounded in 'use value' views that family caregiving is the right of every person and must be distributed based on the principles of justice, altruism, needs, and equal access. In contrast, the moral economy grounded in 'exchange value' views caregiving as a process of exchanging and reciprocating what was done in the past. Parents have obligations to raise and send their children to school; in return, children are obligated to provide care for older parents (Minkler & Cole, 1999). At the society level, the individual will get the rights they have contributed to in the past. In fragmented societies, these two values compete with each other and appear in ageing policy, whether it is underpinned by 'use value' or 'exchange value'.

In the context of broader society, pension schemes, social security, and national health coverage are some of the government policies that relate to caregiving for older people. These types of provisions exist in the public domain of caregiving, and the majority of the provisions are based on 'exchange value'. The dominant influence of exchange value is articulated in the concept of eligibility by dividing older people into "deserving" and "undeserving" groups. Pension schemes are eligible for pensioners whereas social security is eligible for older people who are not covered by a pension

system. It seems fair and equal for both groups; however, pension schemes in most public policies around the world are much more generous than social security in terms of the amount and provision coverage (Weinberg, 1999). Moreover, national health coverage is criticised by its form that resembles private insurance and does not cover long-term care that is mostly needed by disabled older people (Estes & Linkins, 1999).

The marginalisation of older people in the context of caregiving in broader society is also experienced by the family. As the family is subject to use and exchange values simultaneously, the roles of family members in older people's caregiving seem unseen and ignored by the government. The private and nonstructured natures of family caregiving mean it is not seen as a legitimate activity of the welfare state, part of public funds, or of benefit to society as a whole. As a result, caregivers are excluded and undeserving of public funds or benefits (Weinberg, 1999) even though caregiving has taken away caregivers' substantial autonomy in terms of material and nonmaterial issues.

The inequality of pension schemes, social security, and health coverage has been elevated by decentralisation or the regional autonomy system (Estes & Linkins, 1999). In this sense, regional governments are responsible for prioritising public funds based on regional characteristics and ability (Estes & Linkins, 1999; Syaiku, 2002). Thus, the benefits that older people gain will be diverse and depend on the region's capabilities. This also leads into the public discourse on multi-stakeholders in the caregiving of older people, which latterly attempts to divide government's responsibility into several stakeholders in order to decrease government expenditure on ageing issues (Estes & Linkins, 1999).

More discussion about the interaction between the political and moral economy in ageing policies will be discussed in the following published article.

Lestari, M.D., Stephens, C., & Morison, T. (2021). Constructions of older people's identities in Indonesian regional ageing policies: The impacts on micro and macro experiences of ageing. *Ageing and Society*, 1–21. https://doi.org/10.1017/S0144686X20001907

2.3 Constructions of older people's identities in Indonesian regional ageing policies: The impacts on micro and macro experiences of ageing

2.3.1 Abstract

As Indonesia experiences rapid growth of the ageing population, the government's attention has turned to the wellbeing of older people. In 1998, the government established a national ageing policy to maintain older people's welfare. As Indonesia has a system of regional autonomy, each local government began to develop a regional ageing policy. This study aims to critically review the construction of older people's identity and care within regional ageing policies in Indonesia. Working from a critical gerontology perspective, a critical discourse analysis of sixteen regional ageing policy documents identified two constructions, labelled 'material' and 'cultural' ageing, which were used to position older people. The analysis showed that 'material ageing' positions older people at the intersection of 'decline' and 'successful ageing' discourses, while 'cultural ageing' positions older people's welfare at the intersection of 'public responsibility' and 'family obligation' discourses. These discursive constructions in the policy documents have both micro (interpersonal) and macro (structural) constructive effects. At the micro level, the regional ageing policies stand at a crossroad between empowering and marginalising older people and their families. While the dominant discourse of 'successful ageing' encourages older people to be healthy, it marginalises those who do not, or cannot, meet its criteria, undermining a rehabilitative approach as a policy priority. In addition, the rights of the family are overlooked, despite being a pivotal element of cultural ageing. At the macro level, a moral dilemma appears in defining the public and private domains of older people's welfare. Eligibility requirements for state assistance (due to budgetary constraints) ensure that elder care is often relegated to the private sphere, without support. Recommendations for policy improvement are discussed including the recognition of families' rights and the importance of local cultural practices in providing care for older people.

Keywords: ageing policy, critical discourse analysis, critical gerontology, older people's identity, older people's care

2.3.2 Introduction

The proportion of older people in Indonesia reached seven point six percent in 2010, and this figure is projected to increase to approximately 25% by 2050 (Adioetomo et al., 2018; Adioetomo & Mujahid, 2014). This upward trend has been influenced by government policies resulting in rapid declines in the fertility rate and in transmigration (Adioetomo et al., 2018; Adioetomo & Mujahid, 2014; Hugo, 1991, 1992). These demographic changes, as in many developing countries, have been experienced in the context of limited resources in which ageing initiatives and programs compete with other social issues (e.g., maternal and childcare and unemployment). Although, improving the Indonesian national economy has been a government priority (Adioetomo et al., 2018; Adioetomo & Mujahid, 2014).

The rapid growth of the ageing population requires immediate government concern. An ageing population is believed to be an economic burden through an increasing dependency ratio and decreasing saving rates (Bloom et al., 2015), declining labour supply (Bloom et al., 2015; Hsu et al., 2018; Loser et al., 2017; Otsu & Shibayama, 2016), and increasing expenditure caused by pension schemes, social security, and health services (Bloom et al., 2015; Hazra et al., 2018; Otsu & Shibayama, 2016). Indonesia's recent policy response to these ageing issues has been positively and unquestioningly accepted by most Indonesians. This largely positive response is likely due to cultural understandings that render safeguarding older people's well-being a generally accepted part of local custom. Spirituality, family and kinship, balance and harmony, autonomy, social participation, equality, self-development, and dignity are accepted as the fundamental principles in maintaining older people's welfare.

Previous research on ageing policy in Indonesia (Abikusno, 2005; Arifianto, 2004; Kidd et al., 2018; Saputro et al., 2015; Yanuardi et al., 2017) has reviewed policy

content, implementation, and improvement, but overlooked the ways that older people are positioned in ageing policy and the impact of such positioning on older people's place in society. Operating on the premise that the ageing identities provided by ageing policy are believed to have implications for public attitudes towards ageing (Breheny & Stephens, 2019), this study aims to remedy this oversight. We use Critical Discourse Analysis, within a critical gerontology framework, to analyse the construction of older people's identities in regional ageing policies in Indonesia. In so doing, we seek to provide a broader understanding of the potential impacts of these policies at the micro level (older people and their families) and the wider social implications (policy priorities and institutions) and to provide recommendations for ongoing improvement of older people's welfare.

Policy background

The Indonesian government has developed social policies to respond to concerns about the growing ageing population. The national ageing policy (Law No. 13/1998) was introduced to regulate older people's welfare and Law No. 40/ 2004, *Sistem Jaminan Sosial Nasional* (SJSN), was established to promote equality and universality in social welfare for citizens (Supriyanto et al., 2014) providing for financial (including pension and saving schemes), non-financial (including national health coverage and long-term care), and active ageing schemes (including community empowerment programs). However, there is great variability in the actual delivery of the schemes associated with SJSN. Several schemes in SJSN, such as a contribution-based pension system for the informal sector and contribution-based long-term care, have not been implemented. Among the implemented schemes, social pension, long-term care in government residential care, remain limited in terms of the coverage area and eligibility (Direktorat

Perlindungan Sosial dan Kesejahteraan Masyarakat Kementerian PPN/Bappenas, 2015; Kidd et al., 2018; Supriyanto et al., 2014).

Furthermore, since Indonesia has a regional autonomy system, local governments are required to develop regional ageing policies (Kementerian Kesehatan Republik Indonesia, 2016; Saputro et al., 2015). This is in line with the spirit of regional autonomy system which provides autonomy to the local government to improve their public services and accountability assumed by the understanding and familiarity of community' needs are better at the local government level compared to the central government. Thus, with regional autonomy system, local governments are expected to be able to create more appropriate public policies (Bell, 2003; Syaiku, 2002). East Java became the first province with a regional ageing policy (Saputro et al., 2015) and by 2018 17 regional ageing policies had been established. The provisions covered by these regional policies are summarised in Table 2.

Table 2.

Provisions Covered by Regional Ageing Policies in Indonesia

Provision	Form	Aims	Eligibility
Religion and spirituality	Religion practice Provide access to facilities	Improving self-confidence Maintaining family and community respect to older people	All older people
Law	Training and consultation Services and support Assistance	Protecting and ensuring safety for older people	All older people
Social support schemes	Social assistance	Providing basic needs for older people Supporting business to improve autonomy	Poor older people
	Community support and social services	Providing basic needs for older people Providing age-friendly community services	All older people
	Insurance	Ensuring social protection	All older people
	Direct support	Providing basic needs for older people through social services or financial support	Neglected older people
	Allowance	Providing basic needs for older people	Meritorious older people
	Social security	Protecting older people from risks	Poor older people
Age-friendly district/region	Housing and environment	Improving older people' accessibility in the environment.	All older people
	Policy	Reducing discrimination for older people	
	Open space and building		
Convenience in public facilities and infrastructure utilisation	Travelling Civil documents and administration	Improving older people' accessibility in the environment.	All older people
	Cost reduction Recreational and sport Open space and building	Reducing discrimination for older people	
Health	Health education Posyandu lansia Puskesmas santun lansia	Promoting health and preventing diseases and physical limitation.	Third age
	Geriatric clinic and hospital	Providing curative and rehabilitation health services for older people	Fourth age
Working opportunity	Formal through job vacancy Informal through business supports financial support, training, and marketing Social empowerment through motivation, training, counselling, business support, and coaching	Increasing potential, workability, and autonomy	Third age (noted with regard to older people' physical condition, skill, education, knowledge, job vacant, and core business)
Education and training	For older people through formal an informal education	Increasing potential, workability, and autonomy	Third age
	Pre-pension program	Increasing potential, workability, and autonomy	Middle adult
	For the community through a curriculum about ageing	Reducing ageism	All people

Macro and micro effects of ageing policy

Ageing policies ultimately impact upon how society treats older people. These policies shape practice through their effects on social structures and on local cultural norms and obligations. In order to investigate both macro and micro dimensions, we combine political and moral economy perspectives. A political economy perspective provides a macro-level view, focussing attention on the broader socio-political and economic context. A moral economy perspective illuminates the micro level, attending to more immediate contextual factors (Estes, et al., 2001; Minkler & Cole, 1999).

From a political economy perspective, ageing is a socially constructed experience, influenced by the social environment and political and economic conditions (Baars et al., 2013; Baars & Phillipson, 2013; Cole, 1992). These macro conditions of older people's lives, along with provisions offered by the government, critical gerontologists argue, shape experiences, status, identity, and trajectories of ageing (Minkler, 1996). It is also important to note that since the ageing population is a global issue, national policy will be influenced by global initiatives on ageing (Phillipson, 2003, 2006).

From a moral economy perspective (Estes, 1999a; Giddens, 1991), social norms, reciprocal obligations and moral assumptions in local societies regulate the social integration of ageing discourses (Estes, 2001; Kohli, 1987). Obligations to care for older people are implicitly articulated in society, and these also impact on how an ageing policy is formed and implemented (Minkler & Cole, 1999). The moral economy perspective has had less influence on understanding ageing policy, especially in developed countries (Kohli, 1987), which usually emphasise the market economy. Kohli (1987) argues that the concept of moral economy is relevant for examining reciprocal obligations, both in the developing and developed societies. Conflicts and anomalies arising from government

welfare provisions are revealed by examining the intersection between the moral and political economies.

2.3.3 Methodology

A discursive approach to policy analysis understands social policy-making as a discursive practice with social and material effects (Fairclough, 1998). Discourses can be traced via written texts yet are also seen as operating more broadly beyond texts. According to Fairclough (1998), discourses, as a form of social action enacted primarily through texts and narratives, provide parameters for what can be known, said and thought about a particular topic, such as ageing. Discourse plays a pivotal role in constructing older people's identity, creating categories and social impacts for targeted groups (Hacking, 2000). Public discourses about ageing have practical effects on older people (Biggs, 2001; Fealy et al., 2012; Hodgetts et al., 2003; Rozanova, 2010) and these public discourses may be found in a variety of texts, such as newspapers, magazines, or television programs (Fealy et al., 2012; Hodgetts et al., 2003; Rozanova, 2010).

From the perspective of critical discourse analysis (CDA), policy production as a discursive practice provides a reflection of society as well as the potential for transforming society (Fairclough, 1998). As Biggs (2001) argues, social policy does not simply represent government responses to ageing issues, but contributes to shaping behaviour and expectations, including public constructions of older people's identity. Social policy impacts social identity, social relationships, and systems of knowledge and belief around particular issues (Biggs, 2001; Fairclough, 1998).

The broad analytical framework for this study was provided by CDA, taking policy documents as data. From a critical perspective, discourses that are drawn on in

policies make available subject positions (the ways that older people are positioned in the ageing policy), which collectively produce ageing—as a socially constructed experience—and age identities. In addition, actors often draw on multiple discourses, which may be contradictory (Fairclough, 1998). In line with the political and moral economy approach, the positioning of older people in ageing policy will contribute to understanding the construction of social identity, social relationships, and the systems of knowledge and belief around ageing.

Data collection

The research reported in the manuscript was conducted in accordance with general ethical guidelines in psychology. A systematic online search of legal documents and information provided by the Indonesian Ministry of Home Affairs (https://peraturan.bkpm.go.id/jdih/front/index/85), the Ministry of Justice and Human Rights (http://peraturan.go.id/peraturan/perlembaga.html), and the Indonesian Supreme Audit Institution (http://jdih.bpk.go.id/) yielded sixteen (16) retrievable documents. Three regional ageing policies were at the provincial level (viz., East Java, Central Java, and Bali) and thirteen at the regency level (viz., Magelang, Karanganyar, Pekalongan, Surakarta, Surabaya, Malang, Nganjuk, Madiun, Pasuruan, Mataram, Balikpapan, Bangka Barat, Bengkulu). Only four of the sixteen policies were established outside Java and Bali (viz., Mataram, Balikpapan, Bangka Barat, and Bengkulu), which reflects the rapid growth of the ageing population presently concentrated in Java and Bali. The date of publication ranges from 2007 until 2018. (See Table 3 for details.)

Table 3.

Regional Ageing Policies in Indonesia

Level	Author	Year	Title	Quotation
Province	The Government of East Java	2007	Regional Policy on Older People's Welfare No. 05/2007	Quote 1 -16
Province	The Government of Central Java	2014	Regional Policy on The Implementation of Older People's Welfare No. 06/2014	Quote 1 -16
Province	The Government of Bali	2018	Regional Policy on Older People's Welfare No.11/2018	Quote 1 -16
Regency	The Government of Bangka Barat	2012	Regional Policy on Older People's Welfare No. 11/2012	Quote 1 -16
Regency	The Government of Pasuruan	2013	Regional Policy on Older People's Welfare No. 03/2013	Quote 1 -16
Regency	The Government of Surabaya	2014	Regional Policy on Older People's Welfare No. 3/2014	Quote 1 -16
Regency	The Government of Madiun	2014	Regional Policy on Initiatives on Improvement Older People's Social Welfare No. 05/2014	Quote 1 -16
Regency	The Government of Magelang	2015	Regional Policy on Older People No. 01/2015	Quote 1 -16
Regency	The Government of Malang	2015	Regional Policy on Older People's Welfare No. 13/2015	Quote 1 -16
Regency	The Government of Balikpapan	2015	Regional Policy on The Implementation of Older People's Welfare No. 02/2015	Quote 1 -16
Regency	The Government of Bengkulu	2016	Regional Policy on Older People' Protection and Welfare No. 04/2016	Quote 1 -16
Regency	The Government of Pekalongan	2017	Regional Policy on The Implementation of Older People's Welfare No.14/2017	Quote 1 -16
Regency	The Government of Mataram	2017	Regional Policy on The Implementation of Older People's Social Welfare No.10/2017	Quote 1 -16
Regency	The Government of Karanganyar	2018	Regional Policy on The Implementation of Older People's Welfare No.13/2018	Quote 1 -16
Regency	The Government of Surakarta	2018	Regional Policy on The Improvement of Older People' Welfare No. 20/2018	Quote 1 -16
Regency	The Government of Nganjuk	2018	Regional Policy on Older People's Welfare No. 01/2018	Quote 1 -16

These documents are published in the Indonesian language and were translated into English by a professional translator. In order to increase the validity of the translation, the translated documents were back-translated by another professional translator from English into the Indonesian language. The back-translation version was then compared to the original documents and found to be sufficiently correct. The first author (a native

Indonesian speaker) used the original documents to examine the linguistic domains of CDA, ensuring that the meaning in the original language was the basis of analysis.

The 16 regional ageing policies reference a further ten policy documents that were also included in the analysis according to the CDA principle of intertextuality. These additional documents include nine national policies and one action plan, which were published from 1965 until 2018. These are listed in Table 4. The varied publication dates of these documents alongside an analysis of the text distribution shows the way regional ageing policies became part of an intertextual chain (Locke, 2004). In this case, the regional ageing policies may be influenced by previous texts.

Table 4.

Additional Documents for Intertextual Analysis

Author	Year	Title	Type
Indonesia Government	1965	Law No. 04/1965 about Social Assistance for Older People	Policy
Indonesia Government	1998	Law No.13/1998 about Older People's Welfare	Policy
Indonesia Government	2004	Law No. 40/2004 about The National Social Security System	Policy
Indonesia Government	2004	The Government Regulation on The Implementation of Initiative in Improving Older People's Social Welfare No. 43/ 2004.	Policy
Indonesia Government	2009	Law No. 11/2009 about Social Welfare	Policy
Indonesia Government	2011	Law No. 24/2001 about Social Security Agency	Policy
Ministry of Health	2014	The Ministry of Health Regulation on Geriatric Services in The Hospital Setting No. 79/2014	Policy
Ministry of Health	2015	The Ministry of Health Regulation on Older People Health Service in the Community No. 67/2015	Policy
Ministry of Health	2016	The Ministry of Health National Action Plan on Health and Ageing	Action Plan
Ministry of Social Affairs	2018	The Ministry of Social Affairs Regulation on The National Standard of Social Rehabilitation for Older People	Policy

Data analysis

The written text in the ageing policy documents was analysed across three dimensions, namely: (a) textual; (b) discourse practice; and (c) social practice (Fairclough, 1998; Locke, 2004). Textual analysis involved both linguistic analysis and intertextual analysis (Fairclough, 1998). For the linguistic analysis we attended to the ways the text draws from linguistic systems (vocabulary, grammar, cohesion, and text structure) in form and the content. For the intertextual analysis we considered the way in which other documents are referenced in the production of a given text (Fairclough, 1998; Locke, 2004). In terms of content, we found that 16 regional ageing policies were identical to one another. Moreover, the regional ageing policies relied heavily on the original national-level policies, often reproducing these verbatim. In presenting our findings, the quotes we provide are common to the sixteen documents.

We also attended to interdiscursivity in the ways that a text drew upon particular discourses that were available during the text's production, distribution, and interpretation. Texts may draw on one or many, sometimes overlapping, discourses (Fairclough, 1995). Intertextuality and interdiscursivity mediate the connection between language and social context (Fairclough, 1995).

Accordingly, to explore the construction of older people's identities in the regional ageing policies, we began by thematically coding the texts, then used common themes to identify the discourses that were drawn on by the authors. For example, under the theme 'decline' we found common references to limited capacity or financial dependence which we identified as belonging to a 'decline discourse' which constructs ageing as a process of physical decline. Then we examined the intersection of discourses and the implications of positioning older people in these ways. We found two main identities for an older person that were constructed through intersections among four

discourses (decline, successful ageing, public responsibility, and family obligations) which we named ‘material’ and ‘cultural’ ageing. The social practice dimension of the analysis (Evans-Agnew et al., 2016; Fairclough, 1998) and knowledge from critical gerontology research was used to discuss the implications of the regional ageing policies for ageing experiences in Indonesia.

2.3.4 Findings

The construction of older people’s identities in regional ageing policies

Our analysis identified two broad constructions of ageing: (i) material ageing; and (ii) cultural ageing. A ‘material ageing’ construction draws on contradictory discourses of ageing to provide shifting ageing identities, while a ‘cultural ageing’ construction defines the responsibility for older people’s care in either the private or public spheres. Each construction is described below using exemplary quotes.

Material ageing

In the construction of material ageing, older people are made visible primarily in terms of what Biggs (2005) terms bodily ageing: their physical condition, social mobility, and economic attributes. They were described in relation to physical features and processes, such as ‘physically change’, ‘60+ citizen’, ‘vulnerable’, and ‘prevention health’. Policies also made reference to their social activity, such as ‘limited’, ‘high risk’, ‘active’, and ‘autonomous’. Economic attributes were described, such as ‘had contributed’, ‘financially risk’, ‘productivity’, ‘important role in the national development’, and ‘actively contribute’.

The construction of material ageing positions older people at the intersection of 'decline' and 'successful ageing' discourses. The notion of 'decline' is a common image of older people associated with disability and disengagement, while 'success' is associated with fully functioning older people. The 'successful ageing' discourse developed as a challenge to the more entrenched 'decline discourse', including the ageism and negative stereotypes generally associated with ageing (Rowe & Kahn, 1987, 1997).

Decline discourse versus successful ageing discourse

The use of the dominant 'decline' discourse positions older people as vulnerable and regressing physically and socially. Indonesian regional ageing policy documents commonly draw on the 'decline discourse. For instance, it is stated that "Older people are a vulnerable group of people who are entitled to receive more treatment and protection due to their special condition". In such descriptions of older people increased age is associated with physical, social, and economic decline and with associated rights for protection and special treatment in society. The need for special treatment due to decline appeared in many provisions, as in the following extract.

> Quote 1: "Services to provide ease in the use of public facilities and infrastructure referred to, aims to provide accessibility, especially in public places where older people's mobility may be obstructed."

In contrast, a 'successful ageing' discourse contradicts the 'decline' discourse in many provisions. Drawing on a 'successful ageing' discourse, older people are constructed as autonomous, continuously active, and productive, as illustrated in the following statements:

Quote 2: “The administration of older people’s welfare is intended to lengthen their productive age.”

Quote 3: “Providing social welfare for older people is aimed at achieving autonomy.”

As these brief quotes show, the ‘successful ageing’ discourse in the regional ageing policies is reinforced by the utilitarian terms of productivity and health promotion discourses. In terms of economic development, regional ageing policies construct older people as potentially economically active and contributing to society, within policies of extended retirement age, workability, and provision of pre-retirement and long-life learning programs. For example:

Quote 4: “So that older people can be empowered, independent, and play an active role in development.”

Quote 5: “Older people have an important role in development, and therefore, they need to be given room to be able to increase their dignity so that they are not socially dependent, and they are able to develop themselves.”

Quote 6: “The employment opportunity service referred to aims to provide opportunities for ageing people to utilise their knowledge, expertise, abilities, skills and experience.”

In terms of health provisions, the policy documents emphasise illness prevention and health promotion for ageing people, while neglecting a focus on aged health care. In the text structure, promotional and preventive health issues are prioritised. Moreover, there are special sections that explain responsibilities for promotional and prevention programs at the community level, as the following extracts show.

Quote 7: “The community and non-governmental organization are expected to initiate and organise *posyandu lanjut usia*, *karang werdha*, and *graha werdha*

(primary health care for older people in the community) which are supported by the government."

Quote 8: "*Puskesmas santun lansia* [age-friendly primary health providers] are responsible for providing health services for older people which focus on promotional and preventive programs."

Many provisions reflect the intersections of 'decline' and 'successful ageing' discourses. While promoting productivity, the construction of old-age decline persists, resulting in constructions of older people as active contributors who also need special support. For instance:

Quote 9: "An older people-friendly job means jobs which provide opportunity in accordance with the ability of older people and also provide supporting facilities."

Quote 10: "Job requirements and job qualifications are determined by considering the physical condition of older people."

These quotes illustrate how regional ageing policies express the intention of promoting productive ageing by opening employment opportunities for older people, while stipulating that the job requirements should be adjusted to older people's physical conditions. A similar pattern appears in the age-friendly district and public facilities provisions which aim to encourage active ageing, while considering older people's limitations. Older people, therefore, remain positioned as having "a special condition" that makes them vulnerable and in need of protection or special considerations.

The intersection of discourses of 'decline' and 'successful ageing' can be understood as reflecting the broader national ageing policy since the regional ageing policies draw upon outdated Law No. 13/1998 and also reference The National Social Security System. The tensions are often resolved, as the following quotes show, by classifying older people according to "third age" or "fourth age".

Quote 11: "Third age includes those who are still able to work and/or carry out activities that can produce goods and/or services."

Quote 12: "Fourth age includes those who are unable to make a living, and thus they depend on the help of others."

These shifting age group definitions which define eligibility for provisions are based on chronological age rather than capacity. For example, a subsidised social security is limited to those in the 'fourth age' group, while working opportunities are provided for those in the 'third age'. Thus, the term third age and fourth age is used to classify older people by chronological age, which is then directly associated with frailty and dependency for all in the 'fourth age' (Kydd et al., 2018; van Dyk, 2016).

The discourses related to material ageing are located in wider global policy production. Our analysis reveals the ways in which regional ageing policies are influenced by an increasingly dominant discourse of 'successful ageing' adopted by many countries around the world (Biggs, 2001, 2005; Bülow & Söderqvist, 2014; Estes et al., 2001). This discourse understands older people as independent agents and underlines personal responsibility for ageing well (Estes et al., 2001; Phillipson, 2003, 2006; Walker, 2006)As in other contexts, the 'successful ageing' discourse functions alongside a 'decline' discourse of inevitable and negative physical change (Hodgetts et al., 2003; Rozanova, 2010).

Cultural ageing

The second construction of ageing identified in the regional ageing policies is a cultural construction of ageing. This rendition of ageing positions older people as respected community members for whom there is a duty to care. Caregiving occurs "in the context of respecting and giving appreciation to the older people". Older people are also described

as "respected people", a "source of wisdom", and "role models". Moreover, respect for older people is seen as an aspect of religion and spirituality. The policy states that providing access to religious practice and facilities is part of maintaining family and community respect for older people. Older people's care is depicted as being part of a cultural tradition that obligates everyone to provide care.

This obligation is constructed by means of two inter-related discourses: (i) a public responsibility discourse, and (ii) a family obligations discourse. Both of these discourses construct older peoples' care as maintaining the kinship system in society as shown in the following quote.

> Quote 13: "Every older person needs to feel respected and blessed by placing the family as the primary caregivers supported by the service system from the community, business world, and local government, as well as all stakeholders concerned with ageing issues."

Here caregiving is assigned primarily to the family as well as wider civil society so that older people's welfare is construed as both a community and a state interest. This construction appears in the regulations of various ageing institutions in the government and private sectors. Drawing on the public responsibility discourse, policies use words and phrases such as "community responsibility", "equality", 'older people's rights", "past contribution", and "national values". In this way of speaking, obligation is articulated in terms of universality; obligation to care is placed on the state and construed as needs based. Accordingly, older people are construed as deserving care regardless of their former contribution to the family or to society.

In contrast, words and phrases such as "family's role", "social exchange" are applied within the family obligations discourse. For instance:

Quote 14: “Guiding and giving advice kindly and wisely based on knowledge and experience, especially in the family environment**,** in order to maintain dignity and improve their welfare, becoming role models in all aspects of life to their next generations.”

This discourse grounds obligations to care for elders in cultural terms of reciprocity and familial obligation. Here the obligation to care is grounded in exchanges of moral economy, on an inter-generational basis, and older people are rendered as interdependent and interrelated individuals who are capable of giving as well as receiving care as part of a social exchange. Obligations grounded in exchange are illustrated by provisions that highlight older people’s rights according to their past contributions.

Public responsibility versus family obligations

The construction of cultural ageing positions older people’s care in the intersection between public and private obligation for their care. A tension is created between older and newer conceptions of caregiving for older people. On the one hand, traditional values emphasise the role of family as primarily responsible for older people’s welfare. Prior to the introduction of the ageing policy in 1998, the cultural norm of familial obligation to care for elders regulated older people’s care. On the other hand, however, ageing policy makes provision for public care by means of state provisions and subsidies. Business, industrial, and academic sectors are enjoined to support older people’s wellbeing by providing them with working opportunities, workshops, and training to increase their employability and entrepreneurship. Based on a newer understanding of older people’s care as part of national values, the achievement of equality and universality has become a moral obligation for the government.

The tension between public and private responsibility in Indonesia’s regional ageing policies suggests a moral conflict in the policy formulation. This tension is

resolved by drawing on a cultural construction of ageing with its emphasis on inter-generational obligation and the familial duty of care to respected elders. Government institutional care is limited to those older people who do not have family or are deemed to be "neglected". For instance, the regional ageing policy states that "Residential care is just provided for neglected older people". The neglected older person is defined as a person aged above 60 years-old who does not have a job, income, or family to help meet their daily needs and live a decent life. Family is thus rendered central to older people's care and allows for public responsibility to be limited to those older people who cannot rely on familial care. Public care is provisioned according to eligibility based on contribution and means-tested benefits, as illustrated by the following.

> Quote 15: "Social assistance is given to less fortunate third age so that they can meet their needs and improve their level of welfare."
> Quote 16: "To provide health services for less fortunate and neglected older people, exemptions or relief of costs of services is provided in accordance with the provisions of laws and regulations."

These quotes refer to meeting particular older people's "needs", offering "relief" and making "exemptions", on the basis of economic eligibility. Significantly, although family is positioned as the primary caregiver, the government's role and support of families is not well articulated in policy and largely overlooked.

2.3.5 Discussion

We identified two common constructions of ageing in the policies reviewed, which we labelled 'material' and 'cultural' ageing. Our analysis shows that 'material ageing' positions older people at the intersection of 'decline' and 'successful ageing' discourses,

while 'cultural ageing' positions older people's welfare at the intersection of 'public responsibility' and 'family obligation' discourses. These discursive constructions have both micro (interpersonal) and macro (structural) constructive effects, as summarised in Table 5. To explore the interconnections between constructions of material and cultural ageing and their micro and macro effects, we divide the discussion into three parts, discussing first the micro experiences, then the macro experiences, and finally considering the intersections between the two.

Table 5.

Micro and Macro Constructive Effects of The Construction of Ageing in The Regional Policies

	Material Ageing	Cultural Ageing
Micro experiences: Between empowering and marginalising.	1. Alternatives identities for older people. 2. Access to provision based on eligibility.	1. High social status in society. 2. Family as a primary support.
Macro experiences: Moral obligations and moral dilemma.	1. Policies prioritise provisions within 'successful ageing' discourse. 2. Strong demand on providing various forms of programs and institutions based on older people's conditions.	1. Moral obligations in providing equality and universal provisions. 2. Setting eligibility (means-tested benefits and contribution)

Micro effects of the construction of ageing: Between empowering and marginalizing

Older people's care is part of Indonesian local knowledge that values and respects older people. This is a positive value in the context of care and equality in ageing issues that commonly occurs in hierarchical societies determined by age distinctions (Katz, 2008). Indonesians commonly believe that caregiving is a family's responsibility, especially when parents become older and experience health decline (Hugo, 2000). The family

obligation discourse positions older people as needing to be looked after primarily by the family, and then by the community, and government.

Drawing on the construction of material ageing, with its intersecting 'successful ageing' and 'decline' discourses, regional ageing policies open alternative identities for older people that have been shown to have negative consequences. For example, the classification of older people into third and fourth age categories in policy documents, can result in inequality, marginalisation, and social exclusion for those in either category. 'Successful ageing' in the context of productivity and illness prevention, tends to promise a bright future for the third age, but discriminates against older people who do not meet these criteria (Baars, 2017; Holstein & Minkler, 2003; Minkler, 1990; van Dyk, 2014). This could be seen through the emergence of programs and institutions that are specifically limited to older people with certain conditions, among them working opportunity, education and training, and sport and social activities. These interventions could not be utilised by frail or disabled older people. However, social inclusion is needed to increase social interaction and prevent loneliness among older people (Pambudi et al., 2017)

International research has also demonstrated the damaging effects of the 'successful ageing' discourse. van Dyk (2014) argues that the purpose of the 'successful ageing discourse' is to achieve the re-valuation of old age, but that it has produced new forms of ageism and exclusion. Other scholars argue that when 'successful ageing' is framed in utilitarian terms of productivity, pressure is placed on older people to continue to be productive or to contribute to society (Gilleard & Higgs, 2011, 2013; Walker, 2006). Moreover, focusing on productivity in later life can result in the reduction of state support allocations to older people as they are instead made individually accountable for their own welfare (Estes et al., 2001). However, rather than simply adopting the concept of

successful ageing and its implications for productivity, we should re-evaluate it in the context of Indonesia. Almost 50 per cent of older people in Indonesia still work for financial reasons. Most of them are blue collar, did not finish their elementary education, and are the breadwinner in the family (Silviliyana et al., 2018). This means that working relates to basic needs fulfilment rather than self-actualisation.

The 'successful ageing' discourse also has implications for older people's social identities. Social identity is a result of the interplay of personal, social, and institutional demands (Biggs & Powell, 2001; Powell & Biggs, 2003) and social policies influence how older people can and should be seen in society (Breheny & Stephens, 2019). Under the influence of 'successful ageing' discourse, older people are required to be active and fit as part of a preventive approach to health care and declining health can be constructed as personal failure (Baars, 2017; Holstein & Minkler, 2003; Minkler, 1990; van Dyk, 2014). This demand, Biggs (2005) argues, influences the way older people can present themselves in public and private spheres. For example, recently, there is a growing number of financial planning and healthy lifestyle programs (Kemp & Denton, 2003; Murray et al., 2003; Pond et al., 2010) and the promotion of anti-ageing medicine in Indonesia (Pangkahila, 2007). A recent online news headline stated that Indonesia needs more research and courses on anti-ageing medicine due to rapid growth of the ageing population (Wulan, 2011). These shifts position ageing as a problem to be overcome, rather than recognised as an acceptable life-stage.

Macro effects of the construction of ageing: Moral obligations and moral dilemmas

At the macro level, practice priorities are influenced by constructions of material ageing, which emphasise the dominant discourses of 'successful ageing' and health promotion. The trend in shifting policy ideology from that of traditional welfare to 'successful

ageing'— proposed by Rowe & Khan—is experienced by many countries, especially western countries (Biggs, 2001, 2005; Bülow & Söderqvist, 2014; Stephens et al., 2015). This construction of 'successful ageing' has been critiqued for its effects of oppression of those who do not meet the ideal, and focus on individual responsibility for health (Biggs, 2005; Bülow & Söderqvist, 2014; Stenner et al., 2011; van Dyk, 2014). The 'successful ageing' discourse, with its focus on prevention and health promotion, provides no space for provisions of long-term care in older people's lives. The Ministry of Health Republik of Indonesia has admitted that caregiving is still neglected in the national action plans on health and ageing (Kementerian Kesehatan Republik Indonesia, 2016). This is a significant oversight, since around 25 percent of older Indonesians have health and physical problems (Silviliyana et al., 2018).

Though most ageing policy regulations draw on the 'successful ageing' discourse, Indonesia has not completely moved away from the former 'decline discourse'. Consequently, many provisions sound ambiguous, and a moral dilemma appears when a government struggles to provide universal welfare in the public sphere for all older people. Indonesia's budget deficit for social security, especially national health coverage, is the biggest challenge for granting universal and equal provisions to all citizens (Agustina et al., 2019; Andi, 2016; Kidd et al., 2018). Although Indonesia strives to achieve universal social welfare for all citizens, regardless of budgetary limitation, in practice, means testing and contribution-based benefits limit care to particular older people.

Eligibility for welfare support, as intimated earlier, is made available through means-tested and contribution–based benefits. For example, the national health coverage, which adopts a contribution system, only covers those retiring from military service, civil service, and formal institutions. Poorer older people are granted means-tested subsidies.

This results in a "missing middle", as the government is unable to cover older people who work and retire from the informal sector with low wages or non-working older people (Agustina et al., 2019; Kidd et al., 2018).

The principle of means-tested benefits re/produces inequality, limits public provision, and, discursively functions to limit the government's obligation to care; it positions public care as the exception, secondary to family care (Kidd et al., 2018; Priebe & Howell, 2014; Walker & Naegele, 2009). Alongside this limitation is the practice of contribution-based benefits. Provisions received from the government are defined by the level of contribution. In effect, public provisions become a personal investment and responsibility, rather than state assistance and government responsibility is limited. Importantly, the limitation of government obligation to provide care for older people is made possible by retaining the notion of familial obligation and the private sphere as the most appropriate space of caregiving.

Furthermore, the regional autonomy system has given rise to inequality issues among regions in terms of budgeting, the distribution of resources, and the number, incentives, and productivity of the health care workforce. Among regions with more resources, ageing issues are a priority and concern, while among regions with fewer resources, ageing issues have been neglected. As a result, there has been a lack of implementation in the underdeveloped regions (Kadar et al., 2013)

The intersections of material and cultural ageing

The effects of the intersections of material and cultural ageing on regional ageing policies is evident in the growing number of institutions related to older people's welfare. Attempts to separate public and family responsibility and third age and fourth age has produced institutions with specific scopes (e.g., only for "neglected" older people). There

are large numbers of institutions each with a different set of roles related to older people's welfare. In the context of health, there are primary and secondary health institutions, and in the context of social aspects of ageing, there are community care (day care) and residential care. Among those institutions, the government also facilitates the establishment of older people's commissions at the regional and national levels. Some of these institutions cater specifically for "neglected" older people only, because for most Indonesians residential care is considered taboo.

Estes (1999b, 2001, 2011) has referred to the growth of various ageing institutions as an ageing enterprise. While the ageing enterprise worldwide is influenced by material ageing, in the Indonesian context, it is also influenced by cultural constructions of ageing which legitimate the ideal picture of older people's care. Traditional views of elders hold that caregiving is a family responsibility, not an institutional one. Even though in certain occasions the family needs support for older people' care, then temporary care is offered, such as home care, foster care services, and day-care, which is limited to a maximum of eight hours and without overnight service. The question is whether this assembly of institutions could improve Indonesia's welfare provisions for older people.

2.3.6 Limitations

This study has provided a critical review of Indonesia's ageing policy, focusing on the positioning of older people in the regional ageing policies in Indonesia. However, some limitations are noted. First, the intertextuality method was limited to policy documents, and does not include data from newspapers and magazines that highlight public responses to the government's priorities and considerations. From the perspective of political economy, it is politics, not demography that defines the ageing process (Minkler & Estes,

1999) and considering this material as a source of data could enhance the understanding of discourse practices in society. Second, the evaluation of the implementation of the regional ageing policy is beyond this study's scope, but future research including this topic will further contribute to developing ageing policy in Indonesia. Third, Indonesia is a diverse country with 33 provinces and more than 600 ethnic groups. This study reviewed 16 regional policies from 17 established policies which probably do not cover the diversity in cultural values. To some extent, the way that regional ageing policies reproduce national policy produces national values of ageing and family. However, the uniformity of these values across ethnic groups only can be tested if there are more available and established policies from other regions outside Java and Bali.

2.3.7 Conclusions

Regional ageing policies in Indonesia have several strengths. Firstly, from a moral economy perspective, local values remain a strong foundation for regional ageing policies. Constructing older people from a cultural perspective reinforces the responsibility of the family for providing care for older people. Maintaining cultural ageing as a dominant discourse could be a strategic way of maintaining family and public concern about ageing issues in the era of ageing population and demographic transition. However, care should be taken that this does not operate as a way of minimising state responsibilities.

A second strength is that the regional ageing policies include broad provisions for religion and spirituality, law, social support schemes, age-friendly districts/regions, convenience in public facilities and infrastructure utilisation, health services, working opportunities, education and training, and social and civic participation. The policies

include the whole population of older people and demonstrate the government's intention to ensure social welfare in Indonesia. However, the sixteen regional ageing policies reviewed in this study have not fulfilled the aims of the regional autonomy system. The tendency to echo national ageing policy neglects regional needs and conditions and potentially renders regional ageing policy as simply a formality rather than fit-for-purpose guidelines that can respond to local situations.

The dominance of a global 'successful ageing' discourse across the policies, may influence practice priorities. For example, the curative and rehabilitative approach to health must not be neglected in regard to providing welfare for the whole population of older people. Indonesia's policies seem to have overlooked the roles of family, including family caregivers' rights and responsibilities in health care, even though the family is a central element of cultural ageing. At the same time as family is positioned as the primary caregiver, the government's role and support of the family is not clearly articulated. This oversight suggests that family matters are considered part of the private domain that lies beyond government authority. Strengthening families' capacity to care for older people would be beneficial. It is important to note that in ensuring social welfare for its older citizens, Indonesia stands at a crossroad between globalisation and cultural values.

Chapter 3 Introduction to the Interview Study

While the previous study focused on policy at the macro level and its impacts on the ageing world, the next set of articles explores multigenerational caregiving at the interaction between cultural meaning and the micro level, which includes the role of local knowledge, how local knowledge shapes everyday narratives on ageing and caregiving, and the subject positions provided by two contemporary ageing discourses. Emphasising the interaction between cultural meaning and the micro level, I start this chapter by presenting my understanding of humanistic gerontology and its cultural way of thinking. This section will be followed by information about the context of the studies, the paradigm that informs the studies, interview approaches used in the data collection, participant recruitment, and methods used in analysing the data. The chapter concludes by presenting the stories of the participating families. Three articles were generated from the interview data and will be discussed in detail in Chapters 5, 6, and 7.

3.1 Humanistic gerontology

Scholars of humanistic gerontology focus on perceptions of the meaning of life among older people (Baars et al., 2013). Martha B. Holstein, in her personal communication with Meredith Minkler, said that humanistic gerontology explores the aspects that contribute to a good later life and social supports for alternative forms of a good old age (Minkler, 1996). Scholars of this humanistic gerontology phase admit that political economy has contributed to our understanding of how social constraints produce personal responsibility for many significant problems of ageing. However, humanistic gerontology sees that ageing is also an existential process. Older people do face major challenges in

society related to social structures, but they also have abilities to overcome these challenges before the structural constraints have been changed (Baars et al., 2013). In the end, problems are usually personal and have to be faced individually, yet people need to be supported in dealing with problems (Baars et al., 2013). Accordingly, humanistic gerontology believes that connection plays a pivotal role in the pursuit of a meaningful life (Baars & Phillipson, 2013).

The critical concept in humanistic gerontology is interdependency, which suggests that how individuals construct meaning is also determined by their experiences of connectedness (Baars & Phillipson, 2013). In a neoliberal society, the duty to cope with the demands of society is a personal responsibility, which promotes values of individual autonomy. Based on the concepts of interdependence and experiences of connectedness, humanistic gerontology argues that approaching meaning in later life should involve mutual recognition rather than an individualistic perspective. This means that in order to understand the meaning of life for older people, an analysis of interdependent experiences in specific regions, countries, and cultures is critical.

Cultural dimensions are an imperative aspect in gerontology because this perspective sees that cultural and ethnic variations determine the response of older people when dealing with social structure forces in society (Burton et al., 1992; Luborsky & Sankar, 1993). This view came from Burton's opinion regarding the rapidly ageing society in the United States, which was defined by the broadest range of ethnic, racial, cultural, regional, religious, political, and economic diversity. In a multicultural society, using the Western concept of explaining ageing issues becomes irrelevant. Thus, studies on ageing should incorporate concepts that reflect the relevant contextual and developmental processes of the groups being studied (Burton et al., 1992). Luborsky and Sankar (1993) explain that critical gerontology studies accommodate cultural dimensions that contain a

clear definition of a key problem, a description of how the construct is conceptualised, several limitations of concepts in explaining the phenomena, and a process of research data gathering. Connecting two perspectives—political-moral economy and humanistic gerontology—requires a holistic understanding of societal and individual dynamics. Therefore, aiming to explore family caregiving for older people in the context of multigenerational households (Articles 2, 3, and 4), I accommodate cultural values that are shared by Balinese and how these cultural values influence narratives on ageing and caregiving and local knowledge in providing care for older relatives. Further explanation about what I understand as local knowledge will be presented after I describe Balinese cultural values.

3.2 The study context: Balinese cultural values about ageing and family

Balinese social, economic, and political development is characterised by cultural continuity. Tourism economic development and modernisation have not led to the destruction of the role played by culture in Balinese people's lives (Lietaer & De Meulenaere, 2003). This continuity makes Bali appealing to many researchers, offering a unique opportunity to explore connections between long-standing cultural constructs, social practices, and political–economic change (Warren, 1995). The following sections describe Balinese cultural values around older people's positioning in society, kinship systems, generational obligations, and gender roles in the Balinese family that are relevant to studies of the role of local knowledge in family caregiving and narratives of ageing and caregiving in the Balinese context. Figure 2 presents the summary of these cultural values

in facilitating our understanding about ageing, family, and caregiving in the Balinese context.

Figure 2.

Balinese Cultural Values about Ageing, Family, and Caregiving

The positioning of older people in Balinese culture: Age grading and **catur asrama**

The position of older people in Balinese society is defined by two major concepts, which are age grading and *catur asrama* (four developmental stages).

Age grading

In Balinese society, age grading and respect for older people can be seen in the application of teknonymy systems for names in a family (Geertz & Geertz, 1964, 1975; Ottino, 2003). Geertz and Geertz (1964, 1975) explain how the teknonymy system operates within the family domain. At first, when a child is born, they inherit several naming rules based on gender, birth order, and first name by which they are called until they marry and have a child. As soon as they have a child, they—as a parent—will be called by their child's

name (father or mother and employing their first child's personal name). To use an individual's childhood name instead of their teknonymous name is to imply that they are not fully adult. The individual's personal name gradually fades from view once an individual has a child. This process continues until an individual becomes a grandparent when the individual will be addressed by their first grandchild's personal name. A similar rule applies for the great-grandparents. For example, my husband is the first son in his family, so, when our first child, Sekar was born, I will be addressed as "*Ibu Sekar*", my husband as "*Bapak Sekar*", my father-in-law as "*Pekak Sekar"*, and my mother-in-law as "*Nini Sekar*". We are using these names in the public domain, in the context of *banjar*, that I will discuss more in the section about the kinship system.

In the context of generational strata, with teknonymy, a person's social status is very much determined by fertility and pronatalist values. Being a grandparent is related to high social status as a wise older person or individual who gives advice and leaves the parents to take actions. Power and political balance are concentrated in those of middle age, which is a role that exemplifies the strength and the success of the family, and, moving down to the minors once they are mature enough to take their turn. This leaves great-grandparents as an impersonal, dependent, senile, and physically weak group that needs family caregiving (Geertz & Geertz, 1964).

Catur asrama

Balinese age grading is very relevant as an introduction to the concept of *catur asrama* in Hindu Bali. *Catur asrama* is part of the ethical values for a Balinese Hindu and designates four development stages that an individual follows from birth until death. These four stages include *brahmacari, grahasta, wanaprastha, and bhiksuka/sanyasin* in that exact order. *Brahmacari* is a stage when an individual has to improve their knowledge

in formal and informal contexts. *Grahasta* is a stage when an individual is expected to start marrying and raise offspring. *Wanaprastha* is a stage when an individual gradually detaches themselves from world engagements. *Bhiksuka/sanyasin* is the last stage when an individual is fully detached from the mundane world and more focussed on the spiritual purpose of life (Sukerni, 2018; Suteja, 2018).

Family: Kinship system in the public and private domains

Public domain

There are three organisations enveloping a Balinese community, namely *dadia* (ancestral temple), *subak* (irrigation and agriculture system), and *banjar* (hamlet; (Geertz & Geertz, 1975; Lietaer & De Meulenaere, 2003; Warren, 1995). These three organisational aspects represent the Balinese Hindu value of harmony called *tri hita karana*. *Tri hita karana* consists of the harmony between individual and environment (*palemahan*), harmony between individual and other people (*pawongan*), and harmony between individual and God (*parahyangan*; Purana, 2016; Sukarma, 2016). Harmony has a pivotal role in Balinese welfare that will be achieved if harmony has been maintained between the macro and micro domains. *Banjar* takes the lead in ensuring equality and harmony in the Balinese community. While the household composition, the provision of economic needs, inheritance, and child rearing are located in the private family domain, legal, political, and social support during hard times (sickness, poverty, disaster) are considered as *banjar* responsibilities of its members (Geertz & Geertz, 1975; Lietaer & De Meulenaere, 2003; Warren, 1995).

Until now, *banjar* has been the highest social organisation in the Balinese community (Lietaer & De Meulenaere, 2003). Members of *banjar* should follow *banjar*'s

decision over their *dadia* or interest. *Subak* is a source of wealth that should be distributed to the whole of the *banjar's* members as well as maintained by the members (Geertz & Geertz, 1975). According to this hierarchical relationship, many scholars dispute Geertz and Geertz (1975)'s argument about equality in Balinese society, among them Connor and Vicker (2003), who argue that inequality exists in the context of village and state relations. Other evidence for inequality reported by Warren (1995) regulates gentry and commoner relationships during the death ceremony. In contemporary Bali, both *banjar* and the state government play pivotal roles in Balinese life. Balinese promote equality at the village level, which transforms into a hierarchical relationship at the state level. Warren (1995) defines it as a hierarchical order based on parallel sources of authority in the political and ritual domains.

Private domain

The Balinese kinship system in the private domain is articulated by patrilineage system, teknonymy, and extended family living arrangements. During their ethnography in Bali, Geertz and Geertz (1964, 1975) report that Balinese adopt a patrilineal system in which the descendant is determined from the husband's side, and after marriage, the wife lives with her husband and his family under the same roof, which is currently known as an extended family living arrangement.

Historically, most Balinese lived in a large compound that may consist of a single household or several households. A household is determined by the groups of people who share a single kitchen and a common source of food and live together in the same dwelling unit (Dommaraju & Tan, 2014; Geertz & Geertz, 1975). In line with the patrilineal norm, members of households are paternally related and worship a similar ancestor. The majority of households contain one or two nuclear families with some dependent adults,

such as old parents or siblings, living with them. This type of multigenerational household form remains common in contemporary Bali. Balinese tend to maintain their traditions because the compound and household play significant roles in their spiritual, economic, and social life.

In the context of the household, Balinese hold patrilineal and family existence is determined by the offspring, especially sons According to Geertz and Geertz (1975), only one son succeeds the father and should remain in the compound; the remaining sons might stay or establish their own compounds. Inheritances are divided equally among the sons with the largest proportion given to the successor as he must maintain the family temple and organise temple ceremonies and the parents' cremation because for Balinese, rights are always followed by responsibilities.

The Balinese patrilineal system has produced multigenerational households that reflect the extended family living arrangement. Within the private family domain, one of the sons is chosen to be the family successor and should stay in the original compound. As mentioned earlier in this section, he has responsibilities for maintaining the family temple, organising temple ceremonies, and leading his parents' cremation. There is no specific evidence regarding caregiving for older people in the literature, but it can be assumed by the living arrangements and successor's duties. Geertz and Geertz (1975) describe that the compound usually consists of one or two households with dependent older parents living within them. The description of *tri rna* and *panca yadnya* concepts in the next section support the idea that children are responsible for their parents' welfare. In the public domain, while *dadia* is a source of spiritual support and *subak* as an economic source for the family, *banjar* is the most important social support for the majority of Balinese.

Generational obligations in the Balinese family: The concept of tri rna

Tri rna is the three debts that must be paid to achieve balance in the lives of Balinese people. Everyone in Balinese society has three debts, which include *dewa rna* (debt to God), *rsi rna* (debt to *rsi* or religious leaders), and *pitra rna* (debt to parents and ancestors). *Pitra rna* is the basis for the concept of obligations in a family. The concept of *pitra rna* also regulates the obligations of parents and ancestors to the younger generation in the family. A child's debt to parents and ancestors is determined by previous obligations that have been earned by parents and ancestors (Suhardana, 2008).

Parents' obligations are material and nonmaterial and are grouped into five aspects called *panca vida*. *Panca vida* consists of *sang ametwaken* (obligation for childbearing), *sang maweh binojana* (obligation to provide healthy food and drink to children), *sang mangupadyaya* (obligation to provide education to children), *sang anyangaskara* (obligation to purify children with religious values), and *sang matulung urip rikalaning baya* (parents' obligation to save children when danger threatens; Suhardana, 2008).

Based on the five obligations that have been carried out by parents and ancestors, *pitra rna* regulates activities that can be done to reciprocate these obligations, namely organising cremation for parents, building the ancestral temple, organising temple ceremonies, respecting parents, supporting parents' needs, and having faith in religion. In terms of ritual, the relationship between rights, obligations, and debts is reflected in the implementation of the *manusa yadnya* and *pitra yadnya,* which cover the ceremonies at each stage of human development from childhood until the stages of death.

Gender roles in Balinese families

Balinese practice virilocal marriage, in which wife moves to the husband’s house right after the marriage. For Balinese married women, her responsibilities and rights are

attached to her adopted family. Many scholars argue that this type of virilocal marriage has produced marginalisation and inequality toward women (Gultom, 2017; Rahmawati, 2016; Rhoads, 2012; Widayani & Hartati, 2015). Women who arrive at the new families are considered to have less power and fewer rights as well as facing a major marital adjustment, mainly with the family members.

This is elevated by potential conflicts in the family, especially among women. Mother-in-law and daughter-in-law conflicts are the most frequent conflicts reported by Balinese women. This type of conflict has left the husband with a dilemmatic choice and sometimes diminishes bonding (Astasari & Lestari, 2016). Women are expected to preserve care and love for their adopted family as much as for their original family (Geertz & Geertz, 1975).

Hindu literature and some studies about women's position in Balinese society reveal different argument regarding women's statues, with some claims that the relationship between husband and wife, both in the private and public domain, is equal with full rights and responsibilities due to the view of a man and a woman as a single unit (Geertz & Geertz, 1975; Jha, 2004; Warren, 1995)both in the context of family and Hamlet (*banjar*). This view provides opportunities for a woman to participate in joint decisions. Household chores and *banjar* duties are spread equally between husband and wife. Through the teknonymy system, calling a husband and a wife with their first child's personal name has abolished gender hierarchy in the context of citizenship (Geertz & Geertz, 1964, 1975).

However, gender equality remains a prominent debate. Within *banjar*, both husbands and wives and men and women are expected to contribute to the community through *banjar* and temple ceremonies, and other socioeconomic issues. Here, men are responsible for decision making, problem solving, scheduling, and task delegation

whereas women's responsibilities are related to preparing offerings and doing tasks that are delegated by men. According to these gender task classifications, Jha (2004) argues that equality is an ambiguous concept in Balinese relationships. For example, even though wives have the role of deciding spiritual aspects of *banjar* ceremonies, Jha (2004) believes that this role is not as strategic as that of their husbands who are responsible for decision making. As modernity takes place and working opportunity is opened for women, gender inequality discourse has become dominant in contemporary Bali. This does not relate to Balinese cultural values, neither do Balinese promote conceptual opposition between masculinity and femininity, yet working women are challenged by triple roles (domestic, economic, and social) and struggle to balance those roles (Saskara et al., 2012) and expectations provided by the roles.

3.3 The implications of Balinese cultural values for research on local knowledge

Before I discuss the implication of Balinese cultural values to my research, I will share my understanding of local knowledge and its relation to cultural values. Local knowledge is the way of knowing and understanding the world that people develop over time in response to local culture and context. It arises as a result of living in a particular social–cultural context (Harvath et al., 1994; N. Smith, 2010) and is embedded in community practices, institutions, and relationships (N. Smith, 2010). My research sees local knowledge as rooted in culture and socioecology (Antweiler, 1998), which Canagarajah (2002) suggests shapes our social and intellectual practices in negotiating everyday challenges. In general, local knowledge can be understood as a cultural heritage of particular cultural groups that is acquired, generated, and applied by people in

communities to manage their natural and social environments (Agar, 2005; Antweiler, 1998; N. Smith, 2010; Y. Smith, 2017).

In detail, local knowledge is the informal or common knowledge that communities who live in a certain place have developed and continue to develop over time in order to make sense of life. It is place-based in the sense that it is attached to the physical spaces and locations where people live, work, and act, and is unknown by outsiders to particular communities. It is also diffuse and is generated through iteration and adaptation in day-to-day practices, co-constructed from shared cultural beliefs and lived experiences, and tacitly acquired through observation and interaction with one's immediate surroundings (e.g., other people, culture, religious settings etc; Nugroho et al., 2018). Put simply, it is tacit, shared knowledge "about how to act in our communities, what values are important in the societies in which we live, and what will give us access or make us outcasts" (Nugroho et al., 2018, p. 37). In this study, I confine 'local' to the district of Bali. We also prefer the term "local knowledge" to "indigenous" or "traditional" knowledge, as these may suggest that this knowledge is necessarily old and can also have pejorative connotations (Ngulube & Onyancha, 2017)

Local knowledge consists of social and practical dimensions about the way people in a particular group do daily activities (Antweiler, 1998) that are informed by shared cultural values. Therefore, in my study, local knowledge in family caregiving refers to cultural, social, and practical dimensions that are rooted in Balinese cultural values. The way I view local knowledge is also inspired by Balinese local knowledge on farming, called *subak,* that relates to cultural values of *tri hita karana*. Further explanation about local knowledge, including the differences between local knowledge and similar terms like indigenous knowledge, and previous studies on local knowledge and family caregiving are provided in my second and third articles.

My understanding on local knowledge and cultural values of the Balinese has provided several fundamental initial understandings for examining local knowledge on ageing and multigenerational caregiving for older people in the Balinese family. Firstly, there is no specific research about caregiving for older people in relation to the kinship system in the private domain. This may be because Balinese believe that what happens in private life should remain private. Thus, the research objective in exploring multigenerational caregiving for older people in terms of cultural, physical, and relational aspects will be beneficial. It will help in seeing caregiving as a structured activity so that it can be compensated for in public policy. Even though the kinship system does not explain much about family caregiving, it does describe the multigenerational relationships in Balinese families and the generational strata in the community. In the context of community, *banjar* is the highest level of social organisation and takes the lead in facilitating harmony and equality among its members. As Bali is a part of Indonesia, the polarisation of power between *banjar* and state government in influencing Balinese life is important to explore. Even though many studies in the context of the intersection between *banjar* and national government have been conducted previously, the study of family caregiving for older people is still limited. While the kinship system in the private domain does not provide sufficient evidence about family caregiving, the concepts of *tri rna* and *panca yadnya* highlight the relationships between responsibilities, rights, and debts in explaining family obligations in caregiving. These cultural values will inform me when I explore cultural, social, and practical dimensions on how Balinese provide care for older relatives.

Secondly, *tri rna* and *panca yadnya* provide evidence for a similar pattern of exchange as the value principle in a moral economy that emphasises the role of culture, social norms, beliefs, and values in policy and practices related to ageing issues (Minkler

& Cole, 1999). The dichotomy of use value and exchange value in the moral economy was formed from the analysis of Hendricks and Ledham (as cited in Minkler & Cole, 1999) related to the implicit diversity of norms and obligations in cultural and social practices. A moral economy grounded in a use value views family caregiving as the right of every person, which must be distributed based on the principles of justice, altruism, needs, and equal access. In contrast, moral economy grounded in an exchange value views caregiving as a process of exchanging and reciprocating what was done in the past. For example, parents have obligations to raise and send their children to school; in return, children are obligated to provide care for older parents (Minkler & Cole, 1999). At the society level, an individual will receive their rights when they have contributed in the past. In fragmented societies, these two values compete with each other in maintaining the hegemony and appear in the ageing policy, whether it is underpinned in use value or exchange value. The concepts of *tri rna* and *panca yadnya* will inform my third study about how local knowledge shape family members' stories about caregiving, especially the concept of obligations, reciprocity, and the legacy of sons in the family.

Thirdly, human existence, behaviour, and social relationships' code of conduct are determined by age grading—*wangsa*—and the concepts of *catur asrama*. As an individual grows old, they are expected to enter the *wanaprasta* and *bhiksuka/sanyasin* stages of development, defined by the time of spiritual purpose of life and detachment from mundane life. The teknonymy system has divided older people into grandparents and great-grandparents. Grandparents are described as wise people who have the highest social status whereas great-grandparents are described as dependent, senile, unproductive, and physically weak groups that need family caregiving. This dichotomy is very relevant to the concept of the third and fourth age. Balinese views of older people's identity will

be an important aspect of the study of the dominant discourses of successful, active, healthy, and productive ageing, that will be presented in my fourth article.

3.4 Studies of local knowledge and family stories

To explore multigenerational caregiving in the interaction between cultural meaning and the micro level, I undertook an interview-based study of families in Bali. The following sections describe the methods used in the study, which include explanations of research participants, data collection procedures, data analysis, and approaches used in maintaining the research credibility.

Methodology

In Chapter 2 and in the first section of this chapter, I have explained about the political–moral economy and humanistic gerontology. The explanation about these two paths in critical gerontology has provided a holistic view for me in understanding ageing, family, and caregiving, both at the macro and micro levels, and their interaction. Informed by my research questions, in which exploring the interaction between cultural meaning (at the macro level) and micro level (stories of family members), I draw on social constructionist paradigm in framing my methodology.

Social constructionism perceives knowledge as a result of daily interaction between persons and how language is utilised to construct reality (Andrews, 2012; Efran et al., 2014). Using language, discourses, and culture as explanations in constructing the reality, social constructionism stands in opposition to realism (Elder-Vass, 2012; Mouzelis, 2008). However, social constructionism does not deny reality or a physical material world but is more concerned with how knowledge is constructed and understood.

Social constructionists believe that reality can be deconstructed or constructed differently by different observers (Berger & Luckmann, 1991; Elder-Vass, 2012; Gorski, 2013; Willig, 1999a).

Informed by the social constructionist paradigm, this study emphasises the utilisation of language in exploring the contents ("what") of participants' narratives as well as the "how" and "why". It investigates the ways that language is used in participants' narratives to understand the social construction of ageing and family caregiving that is specific to Balinese culture. The following sections explain about methods that I used in each article.

Research participants

The study was jointly approved by The Research Ethics Committee of Faculty of Medicine, Udayana University and Sanglah Hospital (No. 2809/UN14.2.2.VII.14/LP/2019) in Bali and Massey University Human Ethics Committee (No. SOA 19/69) in New Zealand. Participants were recruited from several different hospital and community healthcare settings to engage with a range of families within a broad set of Balinese multigenerational households. In the hospital setting, participants were recruited from among older people who accessed the services of geriatric policlinic (outpatient department) at a government hospital in Bali during my first visit and from community health services organised by the Geriatric, Neurology, Psychiatric, Medical Rehabilitation, Ophthalmology, Ear Nose and Throat (ENT) and Nursing Unit at that hospital. Access for data collection in the hospital was granted by the Clinical Research Unit of the hospital (No. LB.02.01/XIV.2.2.1/6845/2020). In the community setting, participants were recruited from community health services held by the primary health provider and nongovernment organisations (NGOs), through the

nursing homecare services, and private practices. Access for research in the community was granted by The One Stop Integrated Services Unit of Bali Province (No. 070/11277/Izin C/DISPMPT). Utilising both the hospital and community settings enabled me to recruit a broader range of participants.

Older people volunteered for the study and were asked whether their family (children and grandchildren) were also willing to participate in this study. By combining the definition of family caregiving (American Psychological Association, 2010; Hermanns & Mastel-Smith, 2012; Kent et al., 2016; Olagundoye & Alugo, 2018), multigenerational caregiving (Orel & Dupuy, 2002), and households definition by Indonesian Demographic Health Survey's (DHS; Dommaraju & Tan, 2014), participants met these criteria:

a. They were living in a multigenerational household with an older person who needed care and assistance from family members in doing their activities and was using national health coverage (*Jaminan Kesehatan Nasional*).
b. All of the generations in the households (adult children, grandchildren) were involved in caring for the older person. Grandchildren were to be at least 16 years old.
c. This study included the generations in the households (grandparents, adult children, and grandchildren) that were able to talk to the researcher and give informed consent.

In the end, 11 multigenerational households were included in these studies. This number allowed for patterns to be identified across the data and answered the research questions. Among the 49 participants, 14 individuals were members of the first generation (grandmother and grandfather), 19 individuals were within the second generation (son, daughter-in-law, and niece), and 16 individuals were the third generation (grandchildren

and grandchildren-in-law) who were coresidents. Four families were recruited from the hospital setting and seven families from the community setting. The structure of participating families can be seen in Table 6.

Table 6.

Structure of Participating Families

Family	1st generation	2nd generation	3rd generation	Primary caregiver	Health and mobility
1.	Grandmother (Siring, 80)	Son (Puja, 45) Daughter-in-law (Yani, 43)	Two Granddaughters (Media, 21 and Widya, 17)	Son	Limited mobility due to decubitus ulcer
2.	Grandmother (Made, 72) Grandfather (Mardika, 75)	Son (Koming, 44) Daughter-in-law (Wayan, 37)	Granddaughters (None,18)	Daughter-in-law	Frailty Cardiovascular
3.	Grandmother (Tuniang, 75) Grandfather (Kakiang, 75)	Son (Ajide, 53) Daughter-in-law (Buaji, 45)	Two Grandson (Gustu, 25 and Gusde, 21)	Son	Frailty Hearing loss, Visual Acuity
4.	Grandmother (Luhtu, 75)	Son[a] Daughter-in-law (Darti, 42)	Granddaughter (Iwan, 18) Grandson (Wati, 23)	Daughter-in-law	Diabetes Mellitus, Hypertension, Frailty
5.	Grandmother[b]	Son (Pakde, 54) Daughter-in-law[a]	Two Grandson (Degus, 27 and Denik, 20) Granddaughter in-law (Yulia, 24)	Son	Parkinson's Frailty Decubitus ulcer
6.	Grandmother (Sadhu, 90)	Son (Bisma, 53) Daughter-in-law (Dina, 53)	Granddaughter in-law (Vita, 27)	Daughter-in-law	Diabetes Mellitus
7.	Grandmother (Rai, 75)	Son (Yande, 45) Daughter-in-law (Niluh, 40)	Grandson (Yoga, 23)	Son	Kidney diseases
8.	Grandmother (Pitaka, 95)	Son (Tutde, 56) Daughter-in-law (Minarti, 52)	Grandson (Masdi, 20)	Daughter-in-law	Frailty
9.	Grandmother (Padma, 80)	Son (Tibu, 49) Daughter-in-law (Ayas, 47)	Grandson (Indra, 16)	Daughter-in-law	Obesity, Mobility disability
10.	Grandmother (Sari, 80) Grandfather (Rimpen, 81)	Son (Kodi, 42) Daughter-in-law (Sutari, 43)	Grandson (Andri, 20)	Grandson	Kidney diseases Vertigo
11.	Grandmother (Ruki, 76) Brother (Suandi, 66)	Niece (Indira, 44)	Granddaughter (Dimar,17)	Niece	Vertigo Respiratory diseases Frailty

Note: [a] was not interviewed, [b] died after the initial meeting

Data collection

The data collection was conducted from January until May 2020. Information sheets describing the study were provided and explained to older people and their caregivers who attended public healthcare facilities. In private practices, health workers provided the information sheets to potential participants. Initial consent was followed by a meeting with the family members to explain the study. Individual narrative interviews were conducted with each family member after gaining consent from all family members. The interviews were held at the participants' house or office, or at the hospital.

During the interview, participants were asked general questions related to the narratives of ageing and caregiving as, for example:

a. Can you tell me about your experiences as a care recipient? Begin where you like and include whatever you want.
b. Can you describe how your life is affected by the caregiving?

In this main narration phase, interview questions were developed in order to give opportunities to participants to create their stories without any interruptions from the interviewer. Some prompt questions were prepared and were asked during the questioning phase. These provided opportunities to probe participants' stories. Three different interview protocols were prepared: for older people, adult children, and for grandchildren.

A tape recorder was used to record the interview session, and the recordings were translated verbatim afterwards. Therefore, the interview records are available for data analysis. Since interviews were conducted in Balinese or Indonesian, the quotes used in the analysis were translated and back-translated into English by professional translators so that the supervisory team had access in checking the accuracy of data analysis and also to contribute to joint analysis.

Data analysis

I positioned myself as a story analyst when working with the participants' narratives. According to Phoenix et al. (2010), the positioning as a story analyst enables the researcher to approach participants' narratives beyond retelling the stories but with analytical methods that enable the researcher to explore both the "what" and "how" of narratives. To achieve the research aims in this interview study, thematic analysis, narrative analysis, and positioning analysis (as part of discourse analysis) were used to analyse the data. The next section describes an overview of the research aims, the reasons why the method was used, and how the data was approached. More details about the research methods are presented in each published chapter.

Article 2: Local knowledge and family caregiving

The study of the role of local knowledge in multigenerational caregiving for older people used thematic analysis to capture the cultural, physical, and relationship aspects of family caregiving by examining the commonalities and patterns among the accounts of members of 11 multigenerational households. Thematic analysis consists of several steps, which are open coding, building sub themes and themes, and naming themes. These were done through iterative phases across individual, generational, and family comparisons as a hermeneutic spiral of data analysis (Ayres, 2000; Ayres et al., 2003). In this process, family caregiving was understood through the lens of Balinese cultural values so that the findings were attached to Balinese families. Braun and Clarke's (2006) thematic analysis approach was used in this study, following their 15-point checklist of criteria for good thematic analysis, including transcribing, coding, analysis, and report writing.

Article 3: Local knowledge shapes families' stories on caregiving

The third study used the integrated level of analysis by Stephens and Breheny (2013) in the interplay of personal and public narrative in participants' stories on family caregiving. The aim was to understand the role played by local knowledge as local narratives in shaping personal stories on ageing and caregiving. Narrative analysis is considered as discourse analysis by Parker (2013) as it applies the principle of discourse analysis in analysing the influence of master narratives in the construction of personal narratives. The discourse analysis principle, which focuses on public narratives of local knowledge as discursive resources that shape personal narratives on family caregiving, was applied.

Moreover, this study explored how local knowledge provides subject positions (moral dimension and expected behaviour for both parties) for each family member and how narratives of local knowledge are followed, resisted, and challenged within personal narratives. Paying attention to resistance and challenges illuminated certain life circumstances, which meant that some families could not position themselves as virtuous caregivers in local narratives of care for older relatives.

Article 4: Interlinking policy, culture, and the ageing world

The fourth study aimed to understand how Balinese older people with physical illnesses and their family members take up successful ageing and decline discourses. Using the same data set, the fourth study used positioning discursive analysis to explore older people's self-positioning and positioning by others within the decline and successful ageing discourses. Positioning is the discursive practice in which the self is located in conversations as observably and subjectively coherent participants in jointly produced story lines (Davies & Harré, 1990). Within this method, I paid attention to the way participants talked about ageing and caregiving, which provides subject positions for the

participants. Once participants take certain subject positions, they will see ageing from the vantage point of that subject position, including how they should be and act. Here, taking and resisting subject positions is related to a positive identity that individuals try to build in certain contexts and social situations (Breheny & Stephens, 2019).

3.5 The credibility of research

Several approaches proposed by Creswell and Miller (2006) were applied during the research process to enhance the credibility of my research. Firstly, there was prolonged engagement in the field and data triangulation. These were achieved by visiting each family at least three times to conduct an initial meeting, personal interviews, and maintain good relationships via online messenger and social media when the pandemic of COVID-19 restricted my research mobility and physical contact with the family. Data triangulation was conducted by comparing the coherency among individual interviews within one family. Secondly, member-checking was carried out by providing the family summary, which included a family genogram and initial coding, a summary of individual interviews, and the transcripts that could be checked by the participants. All participants who reviewed their summaries and transcripts agreed with the contents. All interviews were audio recorded. The transcripts were in the Indonesian language, and I was assisted by one transcriber in doing the transcription. Following transcription, I rechecked the final transcripts.

Thirdly, data analysis was overseen by the supervisor team. All of the representative extracts in the initial coding were translated and back-translated from Balinese to the Indonesian language and to English. These processes provide opportunity for joint analysis. Beyond that, the supervisors turned out to be the research buddies who

provided constructive feedback and challenged my knowledge, values, and beliefs that could influence the way data were approached. While I understood the data from the point of view of a Balinese native, the supervisors approached the data from the lens of their expertise in ageing and qualitative research. Lastly, both of the supervisors have provided coaching in presenting the research findings with thick and rich analysis and descriptions that were supported by representative quotes or extracts. They also helped balance the findings with disconfirming evidence or contrasting cases.

Reflexivity is one of the imperative elements in qualitative studies (Braun & Clarke, 2006; Parker, 2013). Reflexivity enables researchers to increase research credibility as well as improve the transparency of the researcher's role (Darawsheh, 2014; Rettke et al., 2018). Reflexivity is defined as an ongoing process, in which the researcher is actively involved in building awareness of the actions, feelings, and perceptions through the research process (Darawsheh, 2014; Mason-Bish, 2019). Finlay (as cited in Mason-Bish, 2019) summarises it as a process of subjective self-awareness. Here, the role of the researcher is pivotal in qualitative research in which the researcher's life experiences shape the research goals, design, and the research credibility (Keane et al., 2016). While many research projects highlight the importance of validation and an objective stance and researcher distancing to enhance research credibility, in contrast, the majority of qualitative studies acknowledge the relationship between the participant and researcher. Both of the concepts underpin the cocreated process between the participant and the researcher. A researcher needs to avoid multiple roles and understand their position in a study, including possible conflicts of interest caused by research affiliations in certain groups (Darawsheh, 2014; Eide & Kahn, 2008; Hohmann-Marriott, 2001; LaRossa et al., 1981; Mason-Bish, 2019). Therefore, the researcher's self-disclosure and self-awareness contribute to the credibility of the research (Keane et al., 2016). In order

to achieve self-disclosure, in the following section, I present my personal story as a native Balinese. These reflections highlight my awareness of my cultural identity that might influence the research process, both in negative and positive ways. The reflection is presented in the first-person voice.

My personal story and reflexivity

I am a Balinese woman and have spent most of my life in Bali. Even though my mother is Javanese, I identify more as a Balinese. Balinese Hindu values have become my principles of life. These affect the way I view the world and also the way I interact with others, including family. I grew up in an extended family, both from my father's and mother's sides. There was a process of assimilation of two cultures throughout my life, especially when I moved to Jakarta, the capital city of Indonesia, to study and work. However, these two cultures are quite similar, so I did not experience any issues with adjustment and cultural conflict.

Both Balinese and Javanese emphasise the importance of respect for parents, obligation, and reciprocity in interacting with older family members. I have experienced living in multigenerational households, both during my childhood and since I have been married to a Balinese man who also lives in an extended family. It can be concluded that I am an insider in the Balinese community.

On the other hand, in the context of family caregiving, I am an outsider. I remember when I was a child, my father and grandmother looked after my great-grandmother, who experienced frailty and physical decline. Three years ago, my grandmother passed away after being bedridden for almost three years. Nevertheless, I have never fully participated in the caregiving process of a family member. I was a five-year-old girl when my family provided care for my great-grandmother, and I was married

when my grandmother lived with a stroke and cardiovascular disease. In the context of a household, Balinese hold patrilineal and virilocal marriage—the daughter moves out to the husband's house straight after marriage—so my responsibilities and rights are attached to my husband's family.

The position as an insider reveals benefits in terms of building relationship and rapport with participants, understanding the participants' language, and linking Balinese terms into the broader concepts. At the same time, this position has disadvantages in terms of neutrality and objectivity of the findings. Here, reflexivity helps researchers in building self-awareness of their position and its impact on the research process. In my position as an insider, I should have an awareness of the values, positions, and perspectives that can affect the data and how these data are analysed, interpreted, communicated, and shared. For example, in my second study about local knowledge, my position as an outsider helped me to recognise the form of local knowledge, which is not usually covered by scientific knowledge. The insider is generally difficult to recognise because local knowledge becomes a habit that is only discerned when it is applied in daily life (Bremer et al., 2017; Keane et al., 2016)

Although I dominantly positioned myself as a story analyst, in order to be familiar with data and capture the dynamic at the family level, I also took a role as a storyteller. Therefore, Chapter 4 presents summaries of participating families as an opening gate to my analysis at the interaction between culture, policy, and families' stories.

Chapter 4 The Summary of Participating Families

This chapter provides summaries of the participating families, which include: (a) household structure; (b) older people's needs for care; (c) how care was provided; and (d) the dynamic of relationships among the family members. In presenting the family summary, I position myself as a storyteller, in which I retell the stories shared by my research participants through individual interviews. These summaries enable me to be more familiar with the data and understand the diversity across families.

4.1 Family 1

Siring has lived for many years with her illness. She has received many types of treatment, yet the illness cannot be identified. However, Siring continues to perform her daily activities and runs a small business making spring rolls at home to support her family. Her family has experienced both hardship and progress. In her interview, Siring shared a story about her success in investing in three houses for her three sons. Unfortunately, two of her sons neglect her. Siring sometimes feels hopeless and afraid to argue with and comment on her sons' attitudes because this will make the conflict between mother and sons worse. Siring lives with her second son, daughter-in-law, and granddaughters, who provide for her daily needs and health treatment.

Despite her limited mobility, Siring is able to perform self-care and treatment for her wound. Besides caring for Siring, Yani—the daughter-in-law—must also manage her usual tasks of domestic work, home industry, raising children, and social activities as a member of the *banjar*. Although Yani experiences fatigue and psychological distress, she does not perceive these as a burden—caregiving is part of giving back to parents and investing in good *karma*. Moreover, previous experience in caring for other family

members makes caregiving more manageable. Yani sometimes becomes exhausted with her many tasks, while Puja—Siring's son—focuses on seeking treatment.

The granddaughters are fully involved in providing care and running the home industry. They have no chance of avoiding these responsibilities because relying on one income is not enough to cover the household expenditure, school expenses, and Siring's care. Consequently, the granddaughters must manage their activities and, most of the time, sacrifice their teenage years. Siring's daughter routinely visits and provides care. While she is very proud of her daughter, Siring sometimes marginalises Yani, who is unemployed, undereducated, and unable to have a son—having a grandson is a symbol of a family's legacy.

Silence and acceptance are the best coping mechanisms for dealing with conflict among the Balinese. Puja also draws on this mechanism: he keeps silent and tries to do his best despite the difficulty in providing care without his brothers' support. He values the role of caring as an investment in *karma*; this and his responsibility as a son have forced him to survive.

Close relatives also help the family with emotional support and transport to access health services. Family care is provided within the principle of understanding and by utilising traditional recipes, such as *boreh*. The use of public health services depends on links with health providers and having relatives who have access to health services. Siring's family has such access, but it is limited to primary services and private practice. Limited access and a shortage of caregivers affect their decisions about treatment, resulting in an underutilisation of health services. Siring talks a lot about the interlinking of caring, inheritance, and living in harmony; the failure to integrate these concepts into caregiving has become a burden on the family.

4.2 Family 2

Made's health has been in decline since her first child was born. Her itchy skin makes her uncomfortable and interferes with her activities. All types of treatment, ranging from traditional to modern medical approaches, have been tried. Even though her illness has disrupted her life and activities, Made experiences overwhelming support from family, friends, and the community. Her husband, Mardika, is a responsible person who can be relied on for caregiving and household chores. Before she retired as a teacher, her coworkers always visited her, and the doctor was willing to write a recommendation letter for her employer so that she did not have to go to school every time she got sick. The doctor was caring, even though most of the time she also relied on traditional treatment.

When the treatment seemed to be having an effect, Made had a traffic accident that resulted in injury, and, at the same time, she had a heart attack. These events were the beginning of the continuous care that their family provides Made and Mardika. Mardika accepts this condition gracefully because, according to his values, older parents should rely on their children. Therefore, for Mardika, this is a time when children should care for their parents. All family members share these values.

Made and Mardika live with their third son, daughter-in-law, and grandchildren. The family balances caregiving with work, school, and social roles as members of the *banjar*. They experience no major issues in caring for Made and Mardika. Wayan, the daughter-in-law, presents as an individual who can be relied upon for domestic tasks and coordinating with health providers. Family members who do not reside with them also provide extraordinary support. The first son, who works in the countryside, willingly takes leave to look after his parents. The daughter comes almost every day to help, especially after Made’s surgery.

Caregivers experience physical as well as psychological burdens, especially when dealing with continuous tasks and caring for more than one family member at a time. Conflicts occasionally arise—mostly daily hassles between Made and Wayan. Such conflicts are faced with silence. Stress and conflict are not perceived as pressure by the family since support and mutual help are available. Providing care makes family members grow as persons, and caregiving has been facilitated by bonding among the family members.

Nony, the granddaughter, has a close relationship with Made and Mardika. The family accepts the view that having a grandson is meaningful in caregiving and the sustainability of the family but is not a necessity. While dependent on their children, Made and Mardika also want to appear as active and autonomous individuals who contribute to the family's household chores and finances. Made is covered by the national pension scheme, which allows her to contribute to the family income.

In terms of tasks, it is not difficult for the family to meet Made's and Mardika's needs. The family has developed the principles of understanding needs, promoting traditional recipes for nutrition and sharing in meeting Made's and Mardika's needs. Made, having retired from a government institution, is covered by national health insurance; thus, financing health care is not an issue for the family. They have an excellent relationship with health providers and friends who have access to health facilities to help the family, making this support more accessible. There is no issue of a shortage of caregivers, especially when Made and Mardika have to be hospitalised.

4.3 Family 3

In loving memory of Tuniang, may your soul rest in heavenly peace …

Tuniang and Kakiang underwent *nyentana* marriage because Tuniang's family of origin has no male offspring. *Nyentana* is a type of marriage where a husband follows the wife's family lineage to overcome the absence of male offspring in the wife's family so that the family legacy can be maintained. They returned to Kakiang's house when Tuniang's mother died, aiming to maintain the family's inheritance. This was the beginning of conflict among family members. The situation is even more complicated because Ajide, the second son and upon whom Tuniang and Kakiang depend, lives with diabetes. Ajide is thus unable to financially provide for his family.

Ajide's declining health condition affects all the family members. Buaji, the daughter-in-law, has taken over Ajide's instrumental role in the family. Ajide does not have many choices in living with his limitations. The grandchildren are not able to enjoy their childhood because the majority of the family's expenses go on Ajide's treatment.

Before becoming frail, Tuniang was able to work and earn an income from selling *banten*; however, according to other family members, Tuniang's income is often spent on personal needs. Buaji thus experiences burdens. Financially, she must cover family expenditure and treatment for Ajide and Tuniang, and, emotionally, she deals with a demanding mother-in-law and sibling conflict. Physically, she experiences fatigue due to an overload of tasks. Tuniang dislikes Buaji, who is marginalised despite doing her duties.

Support comes from close relatives and the community in terms of finance, transportation, emotional support, and health information. The first son is not reliable, even though the family believes that he should be the primary caregiver for Tuniang and Kakiang. Grandchildren can be relied on for simple tasks, but they prioritise their needs over their grandparents' needs. Grandchildren work only to meet personal needs, and

cover the family's tertiary education debt and the family's image in society, such as a house renovation for a grandson's wedding. There is no special provision for Tuniang. Scarce resources make it difficult for the family to fulfil Tuniang's needs; they often lie to cover their inability to provide these needs.

Family members are disengaged in terms of their relationships and practical help. Only Kakiang and Buaji are reliable in providing care, like traditional treatments and nutritious recipes. For Buaji, caring is an obligation, a giving back, and an investment in good *karma*, no matter how hard and painful it is.

In terms of public health services, finances and a shortage of caregivers leave government health insurance underutilised. The family argues that if they give Tuniang medical treatment for her frailty, they would give money for daily expenses to the hospital and sacrifice their daily income. They struggle with the shortage of caregivers who can accompany Tuniang and coordinate with the health provider.

Retaining inheritance is essential for this family, although it does present drawbacks, such as limited sources, conflicted relationships, and disengagement in relationships and the practical functioning of the family. Even though Buaji makes an effort to balance caregiving and work, in the end she has to choose one over the other due to scarce resources. Furthermore, excellent social connections are not enough if the family has limited internal resources.

4.4 Family 4

Luhtu lives with all of her sons in the same compound, with separate household buildings belonging to each son and his immediate family (wife and children). According to Luhtu, Balinese parents are cared for by the youngest son in the family, so Luhtu lives in her

youngest son's household. The main responsibility in providing care is his. However, all the sons and daughters support their youngest brother with family caregiving.

Luhtu has been hospitalised many times in the past. Currently, she depends on insulin and medication related to her diabetes mellitus that was diagnosed more than ten years ago. She is familiar with the insulin injection schedule and injects at the same time every day. She also has a regular doctor's appointment for medical check-ups to get new prescriptions. The national health insurance requires these regular appointments and new prescriptions so that the medicine can be covered by the scheme. Every time she goes to hospital, she is driven by Darti, her daughter-in-law, or Iwan, her grandson, who are both unemployed and whose time is flexible for providing care. They usually drive her, leave her at the hospital, and pick her up when the medical check-up is done.

Her daily needs are met by Darti, who decided to quit her job and does not accompany her husband, a policeman who works in the countryside. Darti understands providing care to be an activity in which caring for Luhtu is about investing in good *karma*. She now devotes her life to Luhtu and her family so that, in the future, this kind of devotion will provide her good *karma* so she can be cared for by a future daughter-in-law. Even though she sometimes experiences stress and burdens due to competing tasks, she never feels exhausted because she perceives caregiving as a responsibility.

She also took care of her father-in-law and brother-in-law, who passed away some years previously. This has given Darti much experience in family caregiving, especially in communicating with health personnel and dealing with hospital administration and national health insurance. In the interview, Darti talked about out-of-pocket expenses with the national health insurance and also the quality of health services among the various health providers.

Darti is assisted in her duties by Iwan, who has a lot of flexible time after he left his job at the restaurant. Iwan is responsible for accompanying Luhtu to the hospital when Darti cannot due to religious and *banjar* activities. Other family members help with financial and physical tasks when necessary. There is no issue regarding family conflict. Family caregiving is delivered through teamwork while the youngest son is relied on for decision-making.

Luhtu sees her later life as dependent on her children. She considers that she has invested a lot in her children's future, so she now deserves their care. In her interview, she talked a lot about obligation and reciprocity between parents and children. Luhtu is involved in community engagement for older people although she is not able to do the physical activities. She joins a club mostly for social engagement.

4.5 Family 5

In loving memory of Seda. May you find peace and love in the memories you cherish

In my first meeting with Pakde, he shared his memories about Seda's illness. Pakde felt guilty because his lack of knowledge makes him neglect his mother's illness. Seda's illness caused dramatic weight loss for Seda, but the family does not know the exact cause. The primary health provider said that the name of the illness was Parkinson's, but this was not explained clearly. As a result, the family does not have sufficient knowledge and skill to deal with Seda's illness. Despite their limitations, the family has tried many types of treatment, from medical to traditional approaches. One day, Seda fell down and could not walk; she was bedridden for many days, making her develop pneumonia and a wound on her back due to a nappy.

Seda was hospitalised for her wound, but the family reported that she was discharged by the hospital before her wound had been adequately treated. The family decided to hire a home-care service since the primary health provider could not provide adequate care. Pakde said that he will do everything to make Seda recover and did not want to repeat the same mistake in the future.

In doing his duties, Pakde is helped by his sisters who are already married. They always come to his house every afternoon to provide the daily needs for their mother. Pakde has two sons who also support the family's caregiving. His first son, Degus, is married with one daughter. Degus, his wife, and their daughter also live with Pakde. Both Degus and his wife work so that parenting is supported by Pakde's wife. Since his wife is focused on her grandparenting, she is not very involved in caring for Seda, except for preparing meals. Both Pakde's sons help with daily needs, and hospital and national health insurance administration.

Pakde lives in a region with established community support for older people. National health insurance is facilitated by the community leader, and the community has an ambulance facility for supporting medical access. However, the services sometimes lack quality. The region also provides family incentives for one family member to accompany older people to treatment in hospital. There is also a monthly stipend for older people. However, both Pakde and his sons said that they would feel ashamed if they asked for government and community support. For them, caregiving is about solidarity and family responsibility rather than financial matters.

4.6 Family 6

Sadhu has lived with her son and his immediate family (daughter-in-law and children) since her first grandson was born. At first, her son and daughter-in-law needed her help as a grandparent because he had to travel across the nation due to his military job. Both her son and daughter-in-law are doctors. It is now her turn to be cared for by her children and grandchildren.

In general, her health is good, but her blood sugar easily increases under stress or if she does not watch her food consumption. She also has gastritis, which gets worse if she eats the spicy food that she loves. She often sneaks around to buy street food and fizzy drinks. If she happens to get sick, she just tells her family, who are doctors, and they give her medicine. Access to health services is not a big problem for her since the majority of her family are doctors. She experiences privilege, for example, in that she does not have to be on a waiting list for medical check-ups and doctors' appointments. In her interview, she recalled that when she had cataract surgery, she just came to the hospital and walked into the doctor's examination room and did not have to queue. Her daughter-in-law's colleague helped her with national health insurance so that she could be transferred from her village to a hospital in the city.

The family relationship is a little messy. Dina, the daughter-in-law, talked about the disharmony between Sadhu and Bisma, her husband. Although Dina also has a complicated relationship with Sadhu, she tries to be an intermediary between her husband and mother-in-law. To Bisma, Sadhu is a neglectful mother who does not deserve any care from her children. There is also a difficult relationship among the siblings who usually blame one another for Sadhu's decline in health.

Despite the conflict, Dina keeps up her duties of covering all Sadhu's daily needs. For Dina, Sadhu can be relied upon for simple household tasks, such as preparing

offerings, wrapping meals, and looking after her great-grandchildren. In general, as a doctor and supported by a helper, Dina does not experience any financial and physical burden in providing care for Sadhu. Dina relies much on medical approaches while Sadhu sometimes uses traditional medicine, such as *boreh* for body massage. Although Sadhu's preferences do not bother Dina, it is not easy to tell Sadhu to maintain cleanliness. Sadhu is also very stubborn towards Dina.

Dina does feel exhausted by the conflict and bad relationship. Sadhu does not like Dina nor does Dina like her. However, obligations and *karma* motivate Dina to do her duties in providing care. Dina recalls how she took care of her father-in-law until his death from a chronic illness. Sadhu always sees her as a bad daughter-in-law, but this does not bother Dina because Sadhu did so much grandparenting when she was busy with her internship. Sadhu was not a good grandmother at that time but her help still made a difference. Sadhu loves her daughters more than Dina, who appears to Sadhu to be bossy and dominant.

4.7 Family 7

Rai is the third wife of Raka and was widowed before she married him. Rai has two sons from her previous marriage and a son and a daughter from her current marriage. Yande, her son from her second marriage, takes care of her and is the main caregiver. Rai is blessed because her children from both marriages live in harmony. They always visit her and support Yande in providing care. They provide financial, emotional, and physical support. Even though her husband has another two wives, they live together in the same compound with no significant conflict, supporting one another.

Rai lives with Yande, her daughter-in-law, and grandson. Yande recalls the time when his parents did not accept his marriage to Niluh, who became pregnant before their marriage. His parents do not like Niluh and regard Yande as a useless child who ruined his life by getting married at a young age and dropping out of school. Niluh has been very patient with Yande, and her family has helped him very much to be a better person. Yande is very close to his parents-in-law; it was his father-in-law who taught him about architecture and building so that he can now depend on his skills to be a breadwinner for the family. He was also able to build a house for his family.

When Raka got sick, he asked Yande to be the primary caregiver and to live with Yande until his death. However, Yande never forgot how Raka treated him and did not respect him. He could not forget how Rai did not like Niluh, but his obligations as a son motivate him to do his duty.

Supported by his siblings, Yande feels that caregiving has made him grow as a person. There was a time when he felt exhausted, burnt out, and wanted to cry aloud, but he knew that his siblings, his wife, and his son were there for him. He remembered a time when he had to take care of his father, mother, brother, and wife at the same time. He considers that those experiences have made him stronger.

Yoga, his son, is reliable and can contribute to the family expenses, as does Niluh, who works part time in a local food store. Rai and Niluh now love each other, despite the daily hassles that are common in every family. Rai said that she now enjoys her *karma*. In the past, she looked after her parents-in-law, so now all of her children live in harmony and care for her—especially Yande and Niluh—so she could not be more blessed because of them.

To cover health expenses, the community leader helped Rai and her family to get national health insurance from the government. Besides medical approaches, the family

also relies on traditional and spiritual approaches, such as herbal medicine and *titisan*. Due to her illness, Rai needs to watch her diet.

4.8 Family 8

In loving memory of Pitaka and Tutde. In my heart is where your stories live…

Pitaka has ten children. After her husband died, she had to assume the role of breadwinner for her family. She works at everything that can make money, such as part-time work in someone's rice field or scavenging. Tutde, her son, shared a memory about his hardworking mother. Her goal was that all of her sons should graduate from higher education. However, she sacrificed her daughters, none of whom finished their primary education. It was her hard life that made her frail in her later life and dependent on caregiving.

In her later life, Pitaka is enjoying her investment. She could not be prouder of her sons. All of her children care for her, even when they are busy with their families and jobs. She lives with Tutde, her daughter-in-law, and her grandson. Her relationship with Minarti, her daughter-in-law, used to be one of disharmony but has improved. Minarti is a reliable caregiver who always knows her mother-in-law's needs. Every morning before going to work, Minarti helps Pitaka with personal care and breakfast.

She is also proud of Masdi, her grandson, who has grown into a lovely young man. Both Minarti and Masdi work nearby, so they are able to go home at lunch time and provide a meal for Pitaka. At night, Tutde usually watches television with Pitaka. Traditional and spiritual approaches are accommodated in caring for her. Pitaka uses herbs and massage oil to stay warm at night and have strong teeth. She is a religious person who remembers all rituals and religious ceremonies. During Balinese ceremonies,

Minarti usually helps Pitaka with offerings and dresses her up to be ready when all her family visit her.

For health, the family is supported by the eldest son, who is a doctor, as well as by Tutde, who works at the hospital. Pitaka is covered by national health insurance, although it is underutilised because when Pitaka falls ill, the eldest son usually visits, checking her health and prescribing medicine. Tutde is familiar with prescriptions since he works at the hospital. All the siblings support one another in financial and emotional needs. Physical needs are mostly provided by Minarti, Tutde, and Masdi. Minarti sometimes wants her siblings to help her with the physical tasks, but she understands that they also have their own families that need their care and attention. Their support has been more than enough.

Both Minarti, Tutde, and Masdi experience growth through family caregiving. They talk much about obligation and *karma*. Masdi feels sorry for his grandparents from his mother's side who do not get appropriate care and attention from their family due to a lack of resources and disharmonious relationships. Sometimes, Masdi addresses the responsibility, trying to balance providing care for all his grandparents.

4.9 Family 9

Padma is the wife of a famous businessman in her city. Padma and her husband started their tailoring business, and Padma is a reliable marketer in expanding their business. The family believes that Padma's declining health is due to poor diet that results in obesity. Snacking has become a habit that has been difficult to change. Her obesity has limited her mobility.

After her husband died, the business was continued by the youngest son and daughter-in-law who live with Padma. She has nine children, four of whom are boys, but, unfortunately, they are in conflict. Ayas, her daughter-in-law, admits that it is not easy to understand Padma. Ayas is a placid person who always tries to adapt to Padma's personality. During the interview session, Padma refused to discuss her relationship with her sons.

Her daughters and granddaughters appear as proud and reliable people to Padma. She implicitly reveals her preference for daughters over daughters-in-law for caregiving. Their profession as doctors is beneficial in caregiving, especially for easy access to health services. In contrast, according to Ayas, support from her sisters-in-law is rare; even when they visit Padma, their assistance is limited to health-related issues, and they do not offer any support in daily tasks.

While busy with working and developing their business, Tibu—Padma's son (Ayas's husband)— and Ayas are assisted by a helper in caring for Padma. This helps the family fulfil their obligation of care, despite a limited amount of time and sibling support. Ayas ensures that all treatments run well; she supplies daily needs and covers all social activities as a member of *banjar*. Tibu focuses on health expenditure. Grandchildren are only involved in light tasks, such as preparing food, finding television channels, and sometimes telling stories.

Family members experience psychological and emotional stress. The hardest task is protecting their emotional states from one another. When there is conflict between Padma and Ayas, the latter chooses to be quiet and tries to understand Padma. The same mechanism of silence is also carried out by Tibu when dealing with conflicts among siblings.

Despite family conflict, it is not difficult for the families to meet Padma's needs. All her home care is provided with the principle of understanding needs and using traditional techniques, such as massage oil and modifying clothing to be more comfortable for Padma. In terms of medical care, costs do not matter, and having family members who are doctors has opened access to health services. There is no shortage of caregivers as long as the family is able to pay for a helper. Tibu hopes that his nuclear family learns from conflict and his children can be counted on to continue the multigenerational relationship and parent caregiving. In contrast, the grandchildren want to be seen as independent people.

4.10 Family 10

In loving memory of Sari. Life has to end, love does not … (Mitch Albom)

Sari and Rimpen live with their youngest son, daughter-in-law, grandson, and granddaughter. They have four sons in total, and all of them live in Bali but in different regions. Kodi, the youngest son, said that he prioritises communal values in which family takes precedence. He loves living in the village because it enables him to join many community activities. These provide Kodi with a sense of family and unity.

The same feelings are experienced when his siblings support him in providing care for their parents. Sutari, his wife, and he are so proud of their family teamwork. They never make demands about individual contributions; for them, everyone contributes in their own way. Rimpen, with his limitations, also tries to contribute. He always prepares traditional medicine from herbs for Sari. As a priest, Rimpen believes in spiritual and religious approaches, so he never skips praying and preparing offerings for Sari's recovery.

Kodi's children, Indri and Andri, contribute to the physical tasks associated with family caregiving. While Indri provides daily meals and personal care, the family can rely on Andri for hospital matters. When Sari was hospitalised, Andri arranged all of the administration and accompanied Sari to the hospital since other family members were working and taking care of their children. Kodi is very proud of Andri.

Andri can communicate with doctors and nurses and understands hospital policy and health insurance. Andri shares his experiences in dealing with hospital administration, especially national health insurance. Sari's membership is under the contribution scheme, so the family pays a contribution every month. Andri perceives it as a savings account that reduces the financial burden of health expenditure. However, Andri pays for other experiences when some medicine and medical treatment are not covered by the scheme.

Sutari has to balance her activities between working at the traditional market, social activities at the *banjar,* and household chores. She could not be more blessed because her children are reliable caregivers and also do household chores. Her siblings also come and help them. Compared to her parents, their family teamwork is much better because her parents do not have sons. Her sisters and she are married and moved to their husband's families, which leaves the parents living alone. Fortunately, her parents live in a region that provides social schemes for older people. Her parents' house was renovated by the local government, but both Sutari and Kodi do not want to rely too much on local government provisions. It will be a shame if they, too, focus on material matters and external support to fulfil their duties.

4.11 Family 11

In loving memory of Ruki. Your spirit lives within us …

Ruki is a single woman who is cared for by her brother—Suandi—and his family. In her interview, she talked much about how she is blessed by the care and attention that her brother and his family give her. It is Indira, her niece, who looks after her, including daily meals, personal care, and emotional support.

Indira is married and still lives with her father due to work. Her husband is from the countryside. Both work in the city, so living with her dad is more effective and reduces costs. By caring for her aunt, she repays her dad's help. Indira considers caring for parents as an obligation that should be followed.

Indira has never felt exhausted or burnt out because her family members support each other. She can also rely on her daughters to provide care. Her dad retired because of hospital-related health matters, but his health expenditure is covered by national health insurance. As a single woman who never married, Ruki is covered by the government, so Ruki's dependence on medical services and medicine do not burden the family.

It is only her dominant personality that the family sometimes feels to be exhausting and burdensome. For Suandi, Ruki never positions herself as an old and ill person but as interfering and dominant. This is why Suandi's wife cannot put up with her personality. Despite that weakness, Ruki is a good person who cares for her family and the community where she lives. She believes in traditional and spiritual approaches; Dimar, Suandi's granddaughter, shared a memory about when Ruki and the family prayed for Ruki's recovery and about her bad luck.

The last time Ruki was hospitalised was because she lost Suandi's grandson due to illness. It made her sad, so she did not eat for many days and became weak. This experience made Indira think again about her condition of having no son. She wonders

what her future will be like and who is going to take care of her husband and her. She only has two daughters, so she wonders who will continue the family legacy. However, she tries to remind herself that love and providing care are not determined by gender. Both girls *and* boys can contribute and have a similar amount of love. Material legacy and inheritance are different things that cannot compare to love and caring. She also still has many nephews who are willing to continue the family legacy and care for her.

Chapter 5 Local Knowledge and Family Caregiving

5.1 The rationale for the study

In Chapter 2, I provided context regarding ageing and family caregiving in Indonesia from the perspective of regional ageing policies. While the regional ageing policies demonstrated the role of macro structures in shaping ageing experiences, little is known about the actual ageing and family caregiving experiences at the micro level. So far, there is no universal definition of family caregiving (Kent et al., 2016), but, in general, family caregiving consists of two important elements: (a) the process of helping someone who has limitations, and (b) activities that require knowledge, skills, and emotional attachment between caregivers and care recipients (American Psychological Association, 2010; Hermanns & Mastel-Smith, 2012; Olagundoye & Alugo, 2018). This broad definition of family caregiving makes the concept difficult to compare across studies, family structures, and other sociocultural contexts. Thus, defining family caregiving in different culture and value contexts is imperative.

While the topics of culture and family caregiving are dominated by a focus on the importance of obligations and reciprocity between parents and adult children, there is limited research on the role played by local knowledge on caregiving practices. For example, Jacklin and Walker (2020) reviewed 8 articles to explore the cultural understanding of dementia in indigenous people. They found several themes that related to family caregiving. In their review article, two studies focused on the role of culture (e.g., familial interdependence, reciprocity, respects) on family perceptions of positive experiences and burden (Hennessy & John, 1995; Jervis et al., 2010). One focused on family members' attitudes towards caregiving (Chapleski et al., 2003), and another focused on the relationships between family and formal caregivers (Brown & Gibbons,

2008). Findings in these studies were different from the way I understand local knowledge. As discussed previously, I understand local knowledge in caregiving as the integration of cultural, social, and practical dimensions of caregiving that are rooted in cultural values and shared by local communities.

Moreover, previous studies on local communities and caregiving, usually used the term “indigenous knowledge”; knowledge that is shared by indigenous communities who usually marginalised and are oppressed by colonialisation. For example, a systematic literature review conducted by Racine et al. (2021) included 51 articles on the topic of indigenous caregiving and discussed their findings through the lens of the histories of assimilation and colonialism indigenous people have experienced in various degrees which later influenced their limited access to health services. In the following study, local knowledge is understood as something broader; it is not necessarily limited to indigenous people who were usually positioned as marginalised groups in the context of public policies and health services. Here, local knowledge is sometimes positioned as the opposite of the general knowledge, whilst I position local knowledge as a supplement to general knowledge for searching better approaches in the context of policy and caregiving practices. However, while both Racine et al. (2021) and Jacklin and Walker (2020) differed to the article presented in this chapter, they addressed similar issues around the position of women in family caregiving and the importance of integrating cultural understandings into caregiving practices in order to provide better care services and maintain the family and older people’s well-being.

In order to identify the form of local knowledge on multigenerational caregiving for older people in Bali, the article presented in this chapter used thematic analysis to look at the narrative interview data of members of eleven multigenerational households in Bali, to understand how Balinese view multigenerational caregiving.

This chapter is published as:

Lestari, M.D., Stephens, C., & Morison, T. (2022). The role of local knowledge in multigenerational caregiving for older people. *Journal of Intergenerational Relationships*. http://dx.doi.org/10.1080/15350770.2022.2059606.

5.2 The role of local knowledge in multigenerational caregiving for older people

5.2.1 Abstract

Little is known about how local knowledge informs the way that families provide care for older people beyond the role played by the cultural values of obligation and reciprocity. Better understanding of the role of local knowledge in caregiving practices can contribute to the improvement of support for family caregiving in particular contexts. Addressing this knowledge gap, this study identifies forms of local knowledge that play a role in the way care is provided for older family members in multigenerational Balinese households. Narrative interviews were conducted with 49 members of 11 multigenerational households in Bali. Using thematic analysis, four important forms of local knowledge were identified: (i) caring as intergenerational obligation; (ii) caring to meet needs; (iii) caring in harmony; and (iv) caring through social connections. These local findings contribute to the global discussion on family relationships, the role of social networks, and medical practices on ageing and policy.

Keywords: ageing; local knowledge; multigenerational caregiving.

5.2.2 Introduction

Research on culture and family caregiving has highlighted the role of cultural values of obligation and reciprocity (Cruz, 2017; Epps, 2014), but has overlooked the role of local knowledge in the way that families provide care for older people. This research aims to remedy the research gap. We examine the ways in which Balinese multigenerational households provide care for older people in terms of local knowledge.

Local knowledge and family caregiving

Local knowledge is the way of knowing and understanding the world that people develop over time in response to local culture and context. It arises as a result of living in a particular social-cultural context in which local customs and practices supplement global knowledge (Harvath et al., 1994; N. Smith, 2010) and is embedded in community practices, institutions, and relationships (N. Smith, 2010). This study sees local knowledge as rooted in culture and socioecology (Antweiler, 1998), which Canagarajah (2002) suggests shapes our social and intellectual practices in negotiating everyday challenges. Such knowledge is conveyed through subjectively constructed stories that explain and make everyday events meaningful (Lejano & Stokols, 2018; Setten & Lein, 2019). Local knowledge consists of social and practical dimensions including knowledge about the natural, social and political environments, agricultural, medical, and organisational systems, and knowledge of persons, structures, and relationships (Antweiler, 1998).

While there is much research on local knowledge in other fields of study (e.g., farming, natural disaster, business, health), there is little research in the context of family caregiving, which involves helping a family member who is unable to care for themselves physically, mentally, emotionally, or socially (Hermanns & Mastel-Smith, 2012).

Harvath et al. (1994) argue that family caregiving can be better supported by attending to the role of local knowledge in caregiving practices. For example, many ageing policies do not address the unique context for which they are designed owing to global influences. Demographic changes and ageing issues have affected the financial aspects of aged care, so many countries, including countries with more established public support like the Nordic countries, have encouraged family care and cut public expenditure. Therefore, in taking responsibility for their older relatives, some families have been challenged, burdened, and faced social inequality (Kodate & Timonen, 2017). As such, interventions related to older people's care would benefit from better understanding of how local knowledge shapes familial caregiving practices (Saint Arnault & Woo, 2018; Stadler et al., 2013).

A greater awareness of the role of local knowledge may also enhance professional healthcare (Anthonj et al., 2019; Chidarikire et al., 2020). Together with local organisations, researchers have looked at causes of illness both from local and general knowledge perspectives, which can be complementary. Thus, studying local knowledge can contribute positively to developing community care (Antweiler, 1998; Canagarajah, 2002).

Exploring local knowledge in the Balinese context

Local knowledge needs to be understood within its cultural and socio-ecological contexts. Bali offers an opportunity to explore connections between cultural constructs, social practice, and political-economic change (Warren, 1995). For example, social and political science scholars (Connor & Vickers, 2003; Hauser-Schäublin, 2017; Warren, 1995) have explored the influence of Balinese culture and social structures in different political settings over time. Economically, Bali has transformed from an agricultural society to

one dominated by the hospitality industry. However, the region remains a culturally rich sociocultural context, despite modernisation and the rise of tourism (Lietaer & De Meulenaere, 2003).

The agricultural system influences the socio-economic lives of Balinese. Customary Hamlets (*banjar*) based on ancient agricultural norms regulate resource distribution in society (Geertz & Geertz, 1975; Lietaer & De Meulenaere, 2003; Warren, 1995). Until recently, *banjar* have been the highest social organisation in the community (Lietaer & De Meulenaere, 2003), and legal, political, and social support during sickness, poverty, or disaster are considered *banjar* responsibilities (Geertz & Geertz, 1975; Lietaer & De Meulenaere, 2003; Warren, 1995). In contemporary Bali, both *banjar* and the state government play pivotal roles in Balinese life. Thus, there are two types of Hamlets in Bali: *banjar* and administrative Hamlets (Warren, 1995). While administrative matters related to Balinese identities as Indonesian are regulated by administrative Hamlets, *banjar* regulates customary, social, and religious activities.

Bali is one of 17 Indonesian regions that has an established regional ageing policy (Lestari et al., 2021). Ageing policy in Bali was driven by the demographics of ageing as Bali is among the provinces with the largest proportion of older people in Indonesia (11.58% in 2020, which is higher than the national percentage of 9.92% (Sari et al., 2020)). Almost 58% of Balinese older people live in three-generation households (Silviliyana et al., 2018).

Balinese local knowledge of multigenerational caregiving is part of a belief and meaning system. Narratives of local knowledge draw on Balinese Hindu values that regulate individual relationships inside and outside the family. Accordingly, Balinese people consider care for older people to be the responsibility of the family, particularly children. Balinese hold patrilineal kinship systems and virilocal marriage within which

older people’s care becomes the responsibility of the son and his immediate family (Geertz & Geertz, 1975). Balinese believe in the concept of reciprocity between parents and children or *pitra rna* (debts to our parents and ancestor) and *pitra yadnya* (provisions from children to reciprocate parents’ obligations to children) (Suhardana, 2008). These cultural expectations of familial care of older adults are supported in regional ageing policy, which uses means testing to priorities older people without family or those in poverty as eligible for public provisions. Care responsibilities therefore remain concentrated in the private family domain (Lestari et al., 2021).

Even though reciprocity between parents and children is well recognised, little is known about how these cultural values regulate family caregiving on a daily basis. Exploring local knowledge in this area will contribute to policy, interventions, and professional healthcare. Family caregiving has been studied within many cultural contexts, but local knowledge is more nuanced than the concepts of filial piety, or reciprocity, that have been explored in previous studies (Cruz, 2017; Epps, 2014). It includes cultural, social, and practical aspects of caregiving. We argue that local knowledge about family caregiving is part of the knowledge about persons, structures, and relationships which remains overlooked. Since Indonesia applied decentralisation, such knowledge can be applied to contextualised ageing policies, interventions, and healthcare for the regions that are diverse in terms of their kinship systems and social structures. Thus, studying local knowledge will assist in determining appropriate support for family wellbeing in particular regions.

5.2.3 Methodology

We adopted a narrative approach to explore Balinese local knowledge related to

caregiving practice (DeMarrais, 1998). Narrative interviews were conducted with members of multigenerational households about their experiences of caring for an older relative. The fieldwork took place in Bali and was conducted by the first author, a Balinese woman who identifies with Balinese Hindu values. The study was jointly approved by The Research Ethics Committee of Faculty of Medicine, Udayana University and Sanglah Hospital (No. 2809/UN14.2.2.VII.14/LP/2019) in Bali and Massey University Human Ethics Committee (No. SOA 19/69) in New Zealand.

Participants

In this study, multigenerational caregiving is specifically related to caregiving which is provided by members of three-generation households. Orel and Dupuy (2002) determine multigenerational caregiving as a family that consists of three generations living together under the same roof with one member of the family a dependent grandparent aged 60 years or older who has received assistance from the second and third generations for at least six months. We modified Orel and Dupuy's (2002) criteria with the Indonesian Demographic Health Survey's (DHS) definition. A household is defined as a person or a group of persons, related or unrelated, who live together in the same dwelling and share a common source of food (Dommaraju & Tan, 2014). This will include other ageing family members besides parents, such as siblings, aunts, or uncles who live together as is common in Bali. Participants in this study had to be: living in a multigenerational household with an older person who needed care and assistance from family members; and who was using national health coverage. All the generations in the households were involved in caring, in which grandchildren were to be at least 16 years old, and they were able to talk to the researcher and give informed consent.

Eleven multigenerational households were included. Among the participants, 14 individuals were members of the first generation (grandparents), 19 individuals were within the second generation (son, daughter-in-law, and niece), and 16 individuals were the third generation (grandchildren and grandchildren-in-law). This number allowed for patterns to be identified across the data and answered the research questions (Ando et al., 2014; Butina, 2015).

Participants were recruited from several hospital and community healthcare settings that engaged with a range of families. In the hospital setting, participants were recruited from among older people who accessed the services of a geriatric outpatient clinic at a government hospital in Bali during the first author's visit and from community health services organized by the Geriatric, Neurology, Psychiatric, Medical Rehabilitation, Ophthalmology, ENT, and Nursing Unit at that hospital. Access for data collection in the hospital was granted by the Clinical Research Unit of the hospital (No. LB.02.01/XIV.2.2.1/6845/2020). In the community setting, participants were recruited from community health services held by the primary health provider and NGOs, through the nursing homecare services, and private practices. Access for research in the community was granted by The One Stop Integrated Services Unit of Bali Province (No. 070/11277/Izin C/DISPMPT). Utilizing both hospital and community settings enabled recruitment of a broader range of participants. Four families were recruited from the hospital setting and seven families from the community setting.

In most cases, the first author provided information sheets and explained the study to the older persons and their caregivers. In some practices health workers provided the information sheets to potential participants. Participants either consented in person or contacted the first author or a healthcare professional, to agree to participate in the study.

Initial consent was followed by a home visit and meeting with the family members to further explain the study, answer questions, and gain consent from all family members. Thereafter, individual interviews with each family member were held at the home or office of participants or at the hospital. All participants and their relationships are summarised in Table 6.

Data collection

Narrative interviews were conducted with each family member about their experiences of caring for an older relative using a semi-structured interview guide (Esin, 2011). To begin the interview, participants were asked general questions related to caregiving, for example, "Can you tell me about your experiences as a care recipient? Begin where you like and include whatever you want". The aim of this approach was to let the participant lead and to follow them down their conversational trails (Riessman, 2008). Probing questions were prepared to elaborate on participants' stories.

Since narratives are viewed as co-created between the participant and the researcher, the first author (who conducted the fieldwork and initial analysis) maintained a reflexive stance recognising that her own values, positions, and perspectives that shape data analysis, interpretation, and communication. Such researcher self-disclosure and self-awareness contributes to the credibility of the research (Keane et al., 2016). In order to achieve self-disclosure and self-awareness, the following paragraph explains her values and positions as an insider and outsider.

The first author is a Balinese woman who has spent most of her life in Bali. Balinese Hindu values are her own principles. This affects the way she views the world and interacts with others, including family. She is aware that her cultural identity might have influenced the research process and the findings which are reported from a Balinese

perspective. Having lived in multigenerational households in Bali, she may be considered an insider of the Balinese community. This insider position was beneficial for building rapport with the participants, understanding the participants' language, and interpreting Balinese terms. While her position as a cultural insider makes her aware of the participants' meaning so that she could follow up on areas of interest, it also produced potential drawbacks, in that she may have not probed for details that were taken for granted by her and the participants. At the same time, the first author is an outsider in the context of family caregiving. This outsider position has the advantage of enabling her to recognise the forms of local knowledge not usually included in scientific knowledge production (Bremer et al., 2017; Keane et al., 2016), and probe participants' explanations. The first author attempted to balance these two positions during the research process to ensure research credibility.

All interviews were audio-recorded and were 30 minutes – 2 hours in duration. The recordings were in Indonesian language and were transcribed by the first author and one assistant transcriber. Following transcription, the final transcripts were checked by the first author. The family summary which includes a family genogram and initial coding, a summary of individual interviews, and the transcripts were provided for checking by the participants. All participants who reviewed their summaries and transcripts agreed with the contents.

Data analysis

Thematic analysis was used to identify common elements across cases (Riessman, 2008). To assist with generating a set of themes, analysis followed the process recommended by Braun and Clarke (2006): data familiarisation, initial coding, theme identification, themes and sub-themes review, and theme naming. This allowed for the inductive development

of conceptual categories of local knowledge.

The initial codes were generated by the first author and then discussed with the co-authors. In the coding process, data were analysed by moving back and forth between individual elements of text and the whole text, across individual, generational, and family comparisons. Before the initial coding was reviewed by the co-authors, the selected quotes were translated and back translated from Indonesian to English by two professional translators.

In the second stage of the coding process, 43 initial codes were compressed into 19 codes. The process was followed by identifying themes, reviewing subthemes and themes, and naming the themes. Naming themes was an iterative process, in which each author discussed their comments, feedback, and insights in interpreting the themes in relation to local knowledge and caregiving. While the first author understood the data from the point of view of a Balinese native, the co-authors approached the data with the lens of expertise in ageing and qualitative research.

5.2.4 Findings

The following section describes local knowledge, the underpinning values, and selected quotes to provide examples of the ways that local knowledge is applied and shapes older people's care in multigenerational families. We identified four key themes. 'Caring as intergenerational obligations' describes the importance of reciprocity in determining family motivation to provide care. 'Caring to meet needs' relates to the physical tasks of caregiving. 'Caring in harmony' illustrates the emotional aspects of caregiving, in which maintaining harmony and balance are imperative in reducing negative impacts of

caregiving. 'Caring through social connection' shows how care relationships are structured in the public sphere.

Comparison across generations within and between families revealed that these four forms of local knowledge are shared and practiced by all generations. All generations share similar experiences and sense of obligation toward caregiving, although, while the second-generation deals with both physical and emotional support, the third generation carries lighter responsibilities in terms of decision making and problem-solving.

Caring as intergenerational obligations

Participants framed their caregiving practices as an obligation to care for one's older family members, in relation to previous parental care that they themselves had been given. This aligns with the Balinese view of the reciprocal nature of rights and responsibility and is reinforced by the cultural view of children as investments, that is as costing the family financially or in parental time and energy. This 'instrumentalist' view of the value of children is common in the broader society and shared across cultures, especially in eastern countries (Bengtson, 2001). Accordingly, a good child is determined by their ability to fulfil their responsibility to repay the older generation as illustrated in the following quote.

> Yes, it's true. I think it's really our duty. We should do it, return the favour to parents. It is indeed our obligation. If it is not our duty, who else? (Darti, daughter-in-law, family 4).

The idea of recompense was also articulated by members of the older generation. Older people maintained that they were deserving of care as a result of the past parental care

they had provided as investment in their children. This sentiment is evident in the following quote.

> I can breathe easy now. As the head of the family, I was entirely responsible for the children's future. I used to cover their tuition fee and daily needs. Now, it is their duty to provide care for me (Mardika, grandfather, family 2).

Based on his previous investment in his children and their future, this grandfather describes caregiving as the children's "duty", as the younger generation to pay back to their parents. Hence, expecting care in old age is seen by participants as a form of reciprocity rather than dependency.

This notion of reciprocity, and the entitlement to care it secures, is reinforced by the prospect of the inheritance that will be passed down from the older generation to their children. In their accounts of family caregiving, participants referred to two forms of legacy or inheritance that shaped their understandings of caregiving: the first was the material inheritance (e.g., house or money) that would be passed on to younger generations. The second was spiritual legacy, or *karm*a as it is known in the Hindu tradition. All generations of the families described caring for older generations as involving both maintaining the family inheritance and maintaining good *karma*. These aspects of obligations between generations regulated caregiving by shaping children's motivations to care and recipients' expectations of care. The right to future inheritance establishes male children's and grandchildren's obligation to care for members of the older generation, as illustrated in the following story told by the son in the family 1.

> My mother wished that I would have a son. When my third child was born a girl, she cried. She was wondering why my life became like this, who would preserve and continue the family legacy? I think she was worried because there would be

> no one to look after me, and I alone take care of the family inheritance, while my brothers are in conflict with my mother. (Puja, son, family 1).

Here the inability to bear a son threatens the patrilineal family legacy and creates family conflict. Inheritance rights and caring responsibility are attached to privileged members of the family: the son and his immediate family. Thus, the prospect of future inheritance sets up a corresponding relationship between rights and responsibility.

Karma also provides a motivation to live a moral life and do good because actions determine the future modes of a family's existence. In the data, children's *karma* was seen to be part of their parent's. For example, family members believed that their parents' illness was a result of *karma* so that providing care was understood as undertaking parents' *karma* in order to abolish parents' sins and produce good *karma* for the next generation. The effect of this belief is to reduce family perceptions of burden and stress as explained in the following quote.

> As I said, my *karma*. This is what I always keep in my heart and mind, my *karma* and my mother's *karma*. I set my mind to it so that I keep trying my best to care. This is how I cope with stress (Pakde, son, family 5).

Given that current actions are understood to affect one's future, family caregiving is seen as a positive action that can secure a positive future outcome. The families articulate *karma* as the need to "do good for our good" (Darti, daughter-in-law, family 4) as shown in the quote below.

> My uncle and father always tell me about the law of *karma*. If I neglect grandma, maybe later when I become a grandfather, none of my grandchildren will look after me (Andri, grandson, family 10).

Karma regulates family ties and destiny in the cycles of the past, present, and future. As illustrated in the next extract, the responsibility to care has repercussions beyond the present and may be attached to the individual in his/her future life through reincarnation.

> At that time, my uncle who also lived in the house was sick, and I diligently looked after him. It is just that when he breathed his last in the hospital, I did not get a chance to say goodbye because I was sick. I regret it a lot, as we were close, and I was the one who looked after him. Finally, when we went to a medium, my uncle's spirit said that if he got reborn, he wanted to be my child (Koming, son, family 2).

Thus, intergenerational relationships shape Balinese caregiving practice, highlighting the importance of the care network within the family, which relies on the distribution of inheritance, particularly through the son and his immediate family. Caregiving is articulated as reciprocity between responsibility and the rights of inheritance, both material and spiritual, and this form of local knowledge determines family motivations for providing care.

Caring to meet needs

This form of local knowledge relates to physical tasks that family members undertake for the older person. Care for older parents includes meeting daily needs (e.g., meals, bathing, household chores, medicine), access and transportation to health providers, and financial support. There are two basic principles applied by the family in providing physical needs. First, awareness of the older people's physical condition is the basis of delivering care as this granddaughter learned:

> We must have the initiative to ask: "Have you showered, Grandma? Did you eat? Do your legs hurt today?" We must always pay attention to Grandma. Her legs have to move, but also not very often. If she stays too long or moves too much,

> her legs will hurt. And we must always remind Grandma and notice any change (None, granddaughter, family 2)

The second basic principle is providing care based on older people's needs. Families described meeting these needs by adjusting their standard of comfort to the older person's standard. For example, in responding to older people's need to keep active and contribute, one daughter-in-law allowed her mother-in-law to contribute to meals for the whole family, even though she had prepared meals for the same day. She recounts this story below.

> I finish cooking before I go to work. Once when I came home for lunch, I wondered why the taste of the dishes was different? Apparently, Mother-in-law modified my cooking; she added other spices to suit her. I just leave it how she wants it. We also have to close the kitchen' back door, so that she will not fall. (Wayan, daughter-in-law, family 2)

In meeting the needs of older family members, families rely on both medical and traditional knowledge. The traditional approach includes providing traditional medicine, seeing a traditional healer, and practicing religious rituals. Traditional medicine includes indigenous recipes such as *titisan* (rice broth), massage oils, and herbal drinks. These are prepared by the families, as explained in the following quote.

> I don't know why, but every time a family member is sick, *titisan* will be prepared. A hereditary recipe. Perhaps because it's easy to cook, easy to eat, no chewing is needed, and warm (None, granddaughter, family 2)

Part of the traditional wisdom related to meeting older people's physical needs is the belief that illness also has non-physical causes such as bad habits, past behaviour (*karma*), or an unbalanced relationship. In this case, both medical and spiritual approaches

are used to maintain the families' well-being. Providing care for the physical and health needs of the older family members is shaped by the interlinkage of modern-medical knowledge and traditional-spiritual wisdom.

> When grandma was hospitalised, we saw a medium. The medium said that grandma's illness is a result of her unfinished duty with our ancestor. The medium suggested that we pray and prepare offerings in our family temple. (Dimar, granddaughter, family 11)

This theme describes the local standards for providing care and consists of three types of awareness: physical condition; psychological needs; and traditional medicine. This form of local knowledge positions older people as the focus of concern and as the ones who determine their own needs. Thus, the family must provide the standard of care that meets those needs (rather than the family determining the standard required).

Caring in harmony

Besides physical tasks, families also deal with the emotional aspects of caregiving. Harmony has a pivotal role in Balinese welfare because it allows for cooperation between family members in providing care to the older people. Family wellbeing is facilitated when harmony is maintained among the family members. Within the households, conflict usually arises because the younger generations perceive older people as difficult to deal with (e.g., demanding, stubborn). This household conflict becomes more complicated in the relationship between mother-in-law and daughter-in-law. Stressors such as dealing with overlapping tasks, comparisons with sisters-in-law, mother-in-law's dislike, or inability to conceive a son may lead to marginalisation and disempowerment among daughters-in-law.

Local knowledge provides strategies for harmonious relations between caregivers. Harmony was maintained in a range of ways. One of these strategies is through communal caregiving with no formal roles assigned. This involves all co-resident and non-co-resident children and grandchildren making decisions, solving problems, and sharing tasks based on the principle of capacity as mentioned below:

> Anything that my brothers can help. We never set any rule and make a comparison. The contribution is based on our capabilities. Everything is more comfortable if we understand and sincerely support one another (Kodi, son, family 10)

All generations reported that family conflict reduces support and teamwork between co-resident and non-co-resident members. In families whose members reported conflict, decision-making and problem-solving related to caregiving became concentrated on one child: usually the family of the son who lives with their parents.

Another strategy to avoid conflict and maintain the older peoples' well-being used by both generations is silence. The quotes below illustrate the daughters-in-law's experience and perception of such conflict.

> I have never told my husband. I am afraid that I will be accused of creating conflicts between a son and his mother. So, I keep silence and cry alone (Yani, daughter-in-law, family 1)
>
> Whenever my mother-in-law starts to become fussy, I hide in my room and avoid her all day. I dislike conflict. If she confronts me with a lot of questions, I give short answers and do not argue with her. I do not want to prolong the problem (Wayan, daughter-in-law, family 2)

Thus, the families maintain harmony in various ways, including silence in the face of conflict. However, this demand may burden some family members more than others and it comes at the price of silence among the least powerful, such as daughters-in-law.

Caring in harmony represents the critical elements of relationships within the family. In terms of caring, achieving harmony reduces caregivers' burden and stress because harmony increases teamwork in providing care. To maintain harmonious relationships, local knowledge gives the highest priority to silence and conflict avoidance.

Caring through social connection

Balinese society is a communal society, and social networks are therefore an important source of support in family caregiving. Support for older people is provided within both the private and public domains. While 'caring as intergenerational obligations', 'caring to meet needs', and 'caring in harmony' regulate support in the private sphere, 'caring through social connection' structures care relationships in communal caregiving and provides families with access to social resources and support at the community level and beyond. There are two major sources of support in the public sphere: close relatives and friends; and the wider community, which includes Hamlets and health providers.

Close relatives and friends assist families with emotional, financial, and shared tasks, such as: giving advice and information on treatment-seeking; encouraging family resilience; connecting to the health providers; providing transport to health providers; offering loans and monetary support for medical treatment; and doing household chores. One daughter-in-law shared her experience in receiving support from her close relative:

> When my husband was hospitalised, and I had to accompany him, I asked my close relative who works at the hospital to visit my parents-in-law every day. So that it was easy for me to coordinate. She prepared meals for my parents-in-law

> so that parents-in-law did not have to cook. It helped since I could not manage my time between home and hospital (Buaji, daughter-in-law, family 3)

At the community level, support is provided through Hamlets (local authority, both *banjar* and administrative Hamlets) and health providers. They assist families with government programmes, health education and emotional support, and health services utilisation. Hamlets and primary health services function together to provide information about community charity, social security schemes and health provision that may be utilised by older people. The Hamlet provides a bridge between government' resources and older people. The following quote provided by a son illustrates the *banjar*'s roles in giving information and increasing programme coverage.

> The former *banjar* leader who had informed me about the provision and helped me proposed for the government donation. Finally, my mom received medical assistance (Yande, son, family 7)

Primary health providers as the first level of the health care system, play a critical role in health promotion and education, and psychological assistance. Home visits from health educators assist some families by providing care and understanding about their parents' needs as well as allowing bonding between health personnel and the families. Such services are not limited to medical support, as they also include material and emotional support. The quote below demonstrates how a nurse becomes a source of encouragement for a family experiencing financial burden in caregiving.

> A nurse at the primary health provider in this village visits us regularly and gives vitamins. She encourages me to do the best that I am able to do in providing care for my mom. This is my *karma*; I do not have enough resources in fulfilling my mom's wishes. I do what I can do (Ajide, son, family 3)

Trust and social connection between health providers and families play a key role in health services utilisation by older people. Forming a good relationship with health providers (e.g., doctors and nurses) is essential for the family. For example, families often included the name of the doctor and nurse when recounting their experiences as care recipients. Trust also serves to maintain continuous relationships between older people and particular caregivers. A son, for example, described the family's ongoing relationship with their doctor, who he mentioned by name.

> We usually went to Dr CP in Hasanudin. If my mom relapsed, she would definitely seek treatment there. Maybe if the doctor did not die, we would still go there (Puja, son family 1)

Bali has excellent health services, both in terms of facilities and access, yet for families, it is still valuable to have a personal connection (e.g., close relatives, friends) who work at the health providers or as health personnel, because it is believed to facilitate better services and expedite administration process, as the quotes below Illustrate.

> For control at the hospital, I registered online, and I happen to have a friend at the hospital who helped me to take care of the registration the day before. So, we do not need to wait long in the hospital, coming in accordance with the hours and registration numbers (Wayan, daughter-in-law, family 2)
> Many were already queuing; I just got there and immediately got service and entered the doctor's room. Others queued up and asked why I was able to get treatment right away. The doctor is my daughter-in-law's colleague (Sadhu, mother-in-law, family 6)

Here, network affiliation at the broader community relates to trust and efficacy in the context of health access; this contributes to a family's decision to use the services.

Caring through social connection influences the sources and type of support for family caregiving in the public domains. For Balinese, it takes a village to take care of their older generation. The support system at the wider community level, especially the *banjar,* connects families with available resources. The *banjar,* as a unique feature of Balinese social structure, has assisted the government in programme delivery and policy dissemination. This local knowledge shapes families' expectation of support from the wider community. The view of caregiving as communal is similar to the notion of familial obligation to care; going beyond the family level secures older people's access to care by the community and beyond and allows families to access needed support and resources.

5.2.5 Discussion

Multigenerational households remain the dominant living arrangement in eastern countries (Dommaraju & Tan, 2014; Silviliyana et al., 2018) and affect the way families act and feel about caregiving. However, changes in society (e.g., higher female employment or longevity) require local and state governments to contribute to care. Understanding local knowledge can assist in the development of appropriate support for families in particular contexts. This section discusses the capabilities that local knowledge provides for families in dealing with caregiving, the research gaps, and implications for medical practice and policy in the private and public domains.

Private domain

This study provides information about the members of the care network within the family, caregivers' motivations, care recipients' needs, and the strategies used to maintain

harmony. These findings highlight important factors for understanding the future of family caregiving.

Informal caregiving remains an important moral and practical obligation for family members and failing to follow the cultural expectation will produce moral dilemmas for individuals. This is not an isolated finding; Morgan, Ann Williams, Trussardi, and Gott's (2016) systematic literature review indicates that in many cultural contexts feelings of responsibility and reciprocity are two primary motivations for providing care. Caregiving is not just about providing for material needs, but also involves a personal investment in the future, which shapes individual commitment to providing care (Dombestein et al., 2020) and underlines the importance of caring to the caregivers. The provision of informal caregiving meets an important need in ageing populations and understanding these motivations provides the basis for public support. Despite the similarities of this study to previous studies, beyond responsibility and reciprocity, this study highlighted the importance of *karma* as a strong motivation in family caregiving.

At the same time, our study indicates that some women in the families are marginalised by the strategies used to maintain harmony. Ambivalence is experienced by daughters-in-law who are expected to provide care, but at the same time whose role competes with that of other family members, especially sisters-in-law. Further research the experiences of women in these situations would allow for deeper understanding of the gendered impact of family caregiving and the position of women in the context of patrilineal kinship system and virilocal marriage.

Public domain

The community (including local government) and health providers play pivotal roles in the support network in family caregiving. Previous research on the support network only focused on kin, while separate studies have included neighbors and friends (Ikkink & van Tilburg, 1998). While some studies have found that support networks in late-life determine older people's health (Muckenhuber et al., 2015; Phillipson et al., 2016), they have overlooked the way support networks influence family caregiving and the family's expectations of outside assistance. Conceptualising caregiving in terms of local knowledge provides an opportunity for us to study the interconnection of the support network, types of support, and family expectations.

Bridging networks connect the family with the available provisions at the community level (Keating et al., 2019). For the families in this study, close relatives, Hamlets, and primary health providers may be understood as aspects of such a bridging network. *Banjar* were revealed as a particularly important part of the bridging network for government provision. Thus, integrating *banjar* into government policy and programmes will increase community coverage. A regional policy about customary Hamlets in Bali established in 2019, has not been integrated into its regional ageing policy, which was developed in 2018.

Medical professionals may improve care by understanding the role played by local knowledge in older people's care. Similar to previous studies (Agyemang-Duah et al., 2020; Stewart et al., 2018), older people's satisfaction with health services were often determined by their sense of a personal relationship with health professionals (e.g. doctors, nurses, primary health providers) as a part of a wider support network beyond the family. In many cases, the families in this study also relied on the professional affiliations of the members of their support networks in facilitating access to health care

provisions. The families have an expectation that their support network' affiliations perform as a bridging network which provides better user experiences and increases efficacy in utilising the health services.

Bali has the second highest established health access and services of all provinces in Indonesia (Kementerian Kesehatan Republik Indonesia, 2019). Nevertheless, the present study shows that relying on support network affiliations remains valuable for the participating families because it provides privileges (e.g., faster access to services or more convenient administration procedures) at the health services and sometimes promotes self-confidence in accessing health services. Where health services are well-established, privileges experienced by certain groups produce social and economic inequalities (Malat, 2001). To counteract these practices, health providers could usefully include the bridging networks in their programmes. For example, using *banjar*, doctors, nurses, and hospital administration staff may disseminate health access information through home visits, community activities, and daily conversations with the aim of promoting equal access to health services regardless of the families' social or economic status and the affiliation of their own network. Thus, health service utilisation among families with no informal affiliations may be increased.

Health professionals must also recognise that the participants used traditional medicine alongside hospital care. Knowledge and recognition of the importance of the physical, emotional and spiritual care provided by these treatments can improve treatment. Bali is rich in traditional medicine, but formal recognition of those approaches remains undermined (Herman et al., 2013; Suatama, 2019).

5.2.6 Limitations

The findings are limited by some practical issues. First, some family members did not participate in the interviews due to their schedules and mobility. Second, our analysis did not classify family members into primary, secondary, and auxiliary caregivers which may provide additional information about diversity in caregiving experiences. Third, we did not involve family members who were not co-resident, although their caregiving contributions are also significant. Local knowledge is a dynamic system that can be negotiated in response to changes and challenges, so further study is needed that emphasises the diversity of families' experiences and the impacts of broader institutional discourses in the context of rapid changes.

5.2.7 Conclusion

Local knowledge functions in the interplay between tasks and relationships which support multigenerational caregiving within the family and by community, and health providers. Local knowledge enhances family resilience and buffers the negative impacts of caregiving. The multiple aspects of local knowledge—beyond simply reciprocity within the family—highlights multigenerational caregiving as a dynamic instead of static system. Examining the implementation of local knowledge in the context of rapid changes facilitates our understanding of how it competes with changes in shaping families' narratives on multigenerational caregiving. The thematic analysis of the participants' narratives of their caregiving experiences enabled the recognition of the importance of local knowledge to family experiences.

Chapter 6 Local Knowledge Shapes Families' Stories on Caregiving

6.1 The rationale for the study

Chapter 5 presents the four themes related to Balinese local knowledge on multigenerational caregiving, while this chapter demonstrates the role played by local knowledge in shaping personal stories on caregiving. The article presented in this chapter recognises local knowledge as a dynamic system that is continuously modified and reshaped in dealing with changes and challenges (Antweiler, 1998; Canagarajah, 2002). While some local practices and values may support families in providing care, some should be negotiated to enhance families' capabilities in caregiving. The central argument of this chapter is that if we would like to emphasise local knowledge as a core value in ageing policies, understanding how local knowledge works to support or hinder families in providing care is critical.

To address this issue, this study applied integrated narrative analysis as explicated by Stephens and Breheny (2013) to the same dataset used in the previous chapter. Focusing on the interplay between ideological and personal narratives, local narratives of local knowledge appear as discursive resources that shape families' stories of caregiving and whether local knowledge is followed, resisted, or challenged. Paying attention to the resistance and challenges in families' stories, the findings indicate that adversity makes local knowledge hard to be followed by some families in providing care for older relatives. This is evident in their stories because some life circumstances (e.g., poverty and being a woman) do not allow some family members to identify themselves as virtuous caregivers. Finally, the discussion provides implications of the findings to ageing policies that sometimes overlook the importance of families' voices in caregiving.

This chapter is under review as:

Lestari, M.D., Stephens, C., & Morison, T. (2022). *Local knowledge and unliveable narratives: How insights from family caregiving narratives can inform locally relevant ageing policy.* Manuscript submitted for publication at Journal of Aging Studies.

6.2 Local knowledge and unliveable narratives: How insights from family caregiving narratives can inform locally relevant ageing policy

6.2.1 Abstract

Accommodating local knowledge in national ageing policy demonstrates a country's intention to preserve local values, including cultural values of older people's care. However, including local knowledge must provide space for nuanced and adaptive responses to local knowledge so that ageing policies can support families in adapting to changes and challenges around caregiving. This study interviewed members of 11 multigenerational households in Bali to understand the ways family carers use and resist local knowledge about multigenerational caregiving for older people. Using qualitative analysis of the interplay between personal and public narratives, we found that narratives of local knowledge provide moral imperatives related to care, which shape expectations and a standard for evaluation of the younger generations' behaviour. While most of the participants' accounts fit comfortably with these local narratives, some described challenges in which their life circumstances prevented them from identifying themselves as virtuous carers. Findings provide insight into the role of local knowledge in constructing caregiving function, carers' identities, family relationships, families' adaptation, and the influence of social structure (e.g., poverty and gender) on caregiving issues in Bali.

Keywords: family stories, local values and practices, older people's care, policy implications.

6.2.2 Introduction

Policy emphasise on families as primary carers of older people has heightened in recent years as many countries face the challenge of ageing populations (Chattopadhyay, 2020). Multigenerational caregiving is a common feature of older-age security in countries without universal social safety nets, often buoyed by strong normative cultural traditions of familial responsibility for ageing family members (Frankenberg et al., 2002). In such contexts, the cultural obligation to care for older generations may be reinforced by national policies, effectively shifting state responsibilities to the private sphere and increasing the burden on family carers (Barczyk & Kredler, 2018).

The role played by family carers will likely grow as populations continue to age. Better support for family carers has therefore been emphasised in research (Dawson et al., 2020). Moreover, the importance of including stakeholder perspectives in designing support initiatives has been highlighted to enhance their local relevance and effectiveness (McCarron et al., 2019). Accordingly, N. Smith (2010, p. 221) emphasises the importance of "accepting local knowledge(s) as a legitimate and valued contribution" when developing support initiatives.

Local knowledge (rather than official or formal sources of knowledge) is a form of situated experiential knowledge tied to specific socio-cultural contexts and shaped by local 'embeddedness', histories, gender, ethnicities, and other context-specific factors (N. Smith, 2010). It also incorporates local customs and practices and may supplement general knowledge and practices. Local can be defined as local communities, social groups, or local institutions (e.g., districts, provinces, and administrative units). However, local is not restricted by topographical or location (Antweiler, 1998). Beyond location, local knowledge is culturally and ecologically integrated (Antweiler, 1998; Canagarajah, 2002). In general, local knowledge can be understood as a cultural heritage of particular

cultural groups that is acquired, generated, and applied by people in communities to manage their natural and social environment (Agar, 2005; Antweiler, 1998; N. Smith, 2010; Y. Smith, 2017). Put simply, it is tacit, shared knowledge “about how to act in our communities, what values are important in the societies in which we live, and what will give us access or make us outcasts” (Nugroho et al., 2018, p.37).

Local knowledge concerning caregiving—including the roles and expectations of family members—informs and shapes families’ experiences, knowledge, and perceptions of the meanings, values, and practices of caregiving (Harvath et al., 1994; N. Smith, 2010). For instance, in Bali, where our research was conducted (Lestari et al., 2022), we demonstrated how local knowledge plays a role in the ways that care for older family members is provided in multigenerational households. This first analysis highlighted four important forms of local knowledge about caregiving: intergenerational obligations; meeting needs; family harmony; and caring through social connections. “Caring as intergenerational obligations” described how caring is spread over one generation to the next, including the notion of reciprocity between parents and children’s rights and responsibilities. The son as a symbol of family legacy is prominent since caring responsibility is relegated to the son and his immediate family. “Caring to meet needs” highlighted the position of older adults as care recipients due to cultural values of respect for older adults. Older adults’ physical condition, psychological needs, and the utilisation of traditional medicine are a focus of providing care. “Caring in harmony” is influenced by *tri hita karana*, or harmony, which is the Balinese core value in maintaining relationships (Sukarma, 2016). Thus, conflict avoidance through silence and teamwork is very important in caregiving. “Caring through social connections” emphasises the role of close relatives and the wider community in providing support for the family in caregiving practices.

Although such important aspects of local knowledge have been identified, it is important to recognise that knowledge is not static, but continuously negotiated and constructed in response to the current situation (Antweiler, 1998; Canagarajah, 2002). Local knowledge must be understood as a dynamic system that may be resisted, questioned, and challenged to enhance capabilities at different times and settings. Understanding how local knowledge is resisted and questioned in the face of changes and challenges is necessary for a comprehensive understanding of the role played by local knowledge in caregiving practice, as well as providing appropriate support to family carers.

If local knowledge of family caregiving is to be positioned as a core value of ageing policies, then understanding the ways in which local knowledge works to support or hinder families as they care for their older family members is imperative. To achieve this, we explored personal narratives, which function to explain and make events in everyday life meaningful, drawing on local knowledge in the process. Accordingly, the analysis reported in this article goes beyond a description of local knowledge. We consider how local knowledge is *used* (and resisted) in personal narratives of caring for older family members, drawing on the case of multi-generational family caregiving in Bali.

Regional ageing policy and multigenerational family caregiving in Bali

As Indonesia implements a regional autonomy system following democracy reform in 1998, the governments at the regional level are more autonomous and independent from the national government (Bell, 2003), and the regional government has full authority in regulating political and administrative sectors (Smith, 2008), except for security and defence, foreign policy, monetary and fiscal, justice, and religious affairs (Syaiku, 2002).

Regional autonomy aims to improve local government services and accountability by assuming that the understanding of and familiarity with communities' needs are better at the local government level. Thus, with a regional autonomy system, local governments are expected to be able to create more appropriate public policies (Syaiku, 2002). Therefore, in dealing with ageing issues, each region in Indonesia has a regional policy to ensure that budgeting and implementation are run at the regional level. At least seventeen regional ageing policies have been established from 2014 until 2018. Unfortunately, the content of regional ageing policies tend to echo the national ageing policy and are less likely to accommodate the different regional demographic features and cultural values (Lestari et al., 2021). For example, while both national and regional ageing policies emphasise family responsibility for older adults' care, the role of the family, which is specific to particular regions, is less well articulated.

Bali is one of the provinces in Indonesia with established ageing policies. Balinese local knowledge of family caregiving is influenced by its demographics of ageing and cultural values that are rooted in an agricultural society. In Bali, almost 58 percent of older adults live in three-generation households (Silviliyana et al., 2018), of which the majority are in urban areas. Balinese cultural values explicitly encourage the responsibility of the family in providing care for older family members through the notions of *Suputra*, the concept of 'a virtuous/good child', and *Dadia*, patrilineal kinship patterns and relationships. Family is understood as a kinship system in the private and public domains (Geertz & Geertz, 1975). Within the private domain, older people's care is the responsibility of family, in particular, the son and his immediate family, who deliver care to meet older people's physical and emotional needs, with harmony as the most important value for Balinese welfare (Lestari et al., 2022). In the public domain, caring through social connections provides social resources at the community level, in which the

*Banjar/*Hamlet (as a customary and administrative entity) provides the bridging network between family and government provision. Cultural values around the position and roles of older people in society make family caregiving the default expectation in late life.

Regional ageing policy highlights the importance of family and intergenerational relationships in maintaining older adults' well-being and clearly draws on Balinese cultural values; however, this has been developed through a top-down approach; without stakeholder consultation, especially regarding the role of families in caring for older adults (Lestari et al., 2021). Little is known about how the policy relates to actual caregiving practices or how they are implemented by people as carers of older family members. Considering these knowledge gaps, our aim in this article is twofold. First, we aim to understand how local knowledge is used in personal narratives of family caregiving. Second, we seek to explore how these narratives relate to issues around caregiving (e.g., conflict, shortage of caregivers) to illuminate the role of the social environment in families' ability to mobilise resources and provide care. Studying local knowledge in the context of decentralisation and ageing policy in Indonesia is imperative to empower different regions to deal with issues around family caregiving for older adults.

6.2.3 Methodology

Recruitment

The study was conducted in Bali by the first author, a Balinese Hindu woman. Seeking to engage a range of families within a broad set of Balinese multigenerational households, participants were recruited through a hospital, community health services, and private practices in Bali. Participants in this study had to be living in a multigenerational household with an older person who needed care and assistance from family members,

and who was using national health coverage. All the generations in the households were involved in caring, in which grandchildren were to be at least 16 years old, and were able to talk to the researcher and give informed consent. We determined the participant criteria using the modified definition of multigenerational caregiving (Orel & Dupuy, 2002) and Indonesian Demographic Health Survey's (DHS) definition of households (Dommaraju & Tan, 2014).

The researcher provided information sheets describing the study and explained these directly to older adults and their family carers at the hospital and community health services who then consented to participate. Healthcare providers gave the information sheets to potential participants at private practices who then contacted the first author or the private practitioners to express their willingness to participate. Thereafter, a preliminary meeting was held with each whole family at their home to explain the study further and respond to questions or concerns. The study was jointly approved by The Research Ethics Committee of Faculty of Medicine, Udayana University and Sanglah Hospital (No. 2809/UN14.2.2.VII.14/LP/2019) in Bali and Massey University Human Ethics Committee (No. SOA 19/69) in New Zealand.

Participants

The study participants came from 11 three-generational co-resident families living in Bali. The final group comprised 14 first-generation family members (grandparents), 19 second-generation family members (sons, daughters-in-law, and niece), and 16 third-generation family members (grandchildren and grandchildren-in-law). All first-generation participants experienced declining health and received care from family members in the second and third generations. The households were from both urban (District of Denpasar) and rural (District of Gianyar, Tabanan, and Badung) areas in Bali.

This number of participants is considered sufficient for in-depth narrative analysis to answer the research questions (Butina, 2015; Guetterman, 2015; Vasileiou et al., 2018). An overview of the participants, including their age, the medical needs of the first generation, and their relationships to one another is summarised in Table 6.

Data collection

After gaining consent from all participants, the first author conducted a one-on-one interview with each family member at their home or office or at the hospital, depending on their preference. She used a version of narrative interviewing that invites participants to tell stories about a significant personal experience and social context, using the cultural resources available and significant to them (Jovchelovitch & Bauer, 2000). Participants were initially asked, "Can you tell me about your experiences as a care provider/recipient?". The first author then followed the participant's lead, providing minimal direction or intervention beyond probing or clarifying questions.

Narrative analysis

Integrated narrative analysis (Stephens & Breheny 2013) informed our analysis of the interplay between personal and public narratives. Narrative-based analysis is a method and a theoretical approach to interpreting people's talk. Using an integrated approach to different levels of narrative interpretation allowed us to notice the experiences and identities described in participants' stories in the intersection between personal, interpersonal, and public/ideological levels of narrative (Stephens, 2011).

Somer defined public narratives as "…narratives attached to cultural and institutional formations [which]…range from the narratives of one's family, to those of

the workplace (organisational myths), church, government, and nations" (Somers, 1994, p. 619). Publicly available narratives are a form of discourse that as Bruner (1991, p. 11) stated, have 'canonicity' and 'normativeness' features, in which "narratives provide a prescription for canonical behaviour in a culturally defined situation" and legitimate certain cultural expectations. In other words, public narratives provide subject positions, or moral identities, for story tellers (Stephens & Breheny, 2013) that become an evaluation standard for family members' practices as carers (e.g., good carer, bad daughter-in-law). Following an integrated approach to different levels of narrative interpretation, we refer to publicly available narratives of local knowledge as 'local narratives'.

Personal stories describe the personal experiences in ways that are diverse and illuminate personal meaning, while also providing insight into cultural expectations about how one should interact, react, and can be (Bruner, 1991) by drawing on publicly available narratives. This is because personal narratives are socially and interpersonally constructed; individuals use publicly available narratives to frame their own stories (Somers, 1994). Thus, personal stories must be analysed within the lens of the cultural resources used to construct them (Atkinson et al., 2003). Here, discourse and positioning analysis are used to understand how personal stories draw on local narratives and provide subject positions and moral standards to the story tellers (Bamberg, 2005; Stephens & Breheny, 2013). Narrative analysis is an effective approach to illuminating both similarities and diversity of stories people have told, whether the stories reflect the cultural resources or provide alternative narratives (Phoenix et al., 2010). Thus, analysing stories as the interplay between personal and local narratives is beneficial in two ways. The interplay enables us to understand how local knowledge shapes participants' stories

about family caregiving and also how certain participants adapt to or are limited by the local knowledge.

After the interviews were transcribed and reread by the first author, the analysis followed three stages. First, we described the participants' personal narratives. Personal narratives describe participants' caregiving experiences, in which participants make sense of their experience according to their social location, cultural background, and social purpose of their stories. Second, we explored the ways in which participants drew on local narratives to construct their own stories (Breheny & Stephens, 2011; Stephens & Breheny, 2013). We paid attention to the ways in which participants used the previously identified four themes of Balinese local knowledge (Lestari et al., 2022) in their personal stories. Here we applied discourse and positioning analysis to understand how local narratives provide subject positions for family members and define moral values and standards in caregiving. Third, we identified ways in which the personal stories followed, questioned, or resisted local narratives.

Our analysis showed that participants drew on local narratives related to caregiving to construct personal accounts of their own experiences as family carers. To answer the present research question, we highlight the ways that personal narratives may fit comfortably or not with the dominant local narratives. Recognising the interplay between personal stories and local narratives enabled us to understand the challenges, complexity of family caregiving, and consider how challenges might be tackled by policy makers. The findings are presented below with illustrative quotations. We edited extracts to focus on the unfolding storyline, used pseudonyms, and altered some quotations to maintain participants' anonymity.

6.2.4 Findings

Our findings demonstrate how local narratives are used or resisted in personal narratives of family caregiving. We identified three main ways that local narratives play a role in shaping caregiving: (a) determining how caregiving should function; (b) constructing care-recipient and carer identities; (c) prescribing family relationships.

We present our findings int two parts: part one describes the way local narratives permeate personal narratives, and how they were drawn upon by the participants in their personal narratives. Subject positions and moral imperatives are described to illustrate how local narratives construct function, identity, and relationships in multigenerational caregiving. In part two we demonstrate how local narratives are challenged, questioned, or resisted. Some personal narratives describe life circumstances that do not allow narrators to live comfortably within the local narratives. For these participants, local narratives are seen to be unliveable narratives. Four examples were chosen to illustrate both the comfortable and unliveable narratives.

Part 1: Local narratives permeate personal narratives

Here we draw on a single account from Mardika, the first generation of family 2, to demonstrate how local narratives permeate everyday narratives and construct caregiving functions, identities, and relationships. While all of the participants' stories provided clear examples of the result of the analysis, we used accounts from members of one family as an example here to enable detailed presentation of the interplay between personal and local narratives and demonstrate the family dynamic.

Mardika's story draws on the local narrative of *intergenerational obligations*. As illustrated in this extract, caregiving is construed as involving intergenerational reciprocity, prescribing caring for elders as the duty of younger generations.

> **Mardika:** Now, I am the one who depends on my children. Whatever they provide me, I accept all, good or bad. But compared to my previous life, when I was the head of the family, I had to be responsible to my children and family. At that time, I did anything so that my children could go to school and be independent. Now I have given up all responsibilities. At the moment, it's the opposite; I'm the one who is asking for care from my children. When I am sick, my children take me to the doctor; they take care of me as soon as possible, even in the middle of the night.

This personal narrative draws on the publicly shared social and moral values of the Balinese local narrative of reciprocity. Mardika depicts late-life as a transition period in the family in which responsibilities are transferred from parents to children, and caregiving roles are reversed ("the opposite"). His story is not merely about familial obligation but also reciprocity; the care he receives is his children's repayment for his past good care of them. Based on his previous actions as family head, he positions himself as someone deserving care and his children as obliged to provide it as needed. Just as Mardika "did anything" for his children's wellbeing, so they are expected to do the same for him. Likewise, None, his granddaughter perceives caring for her grandparents as the way to pay her parents back for what they have done for her.

> **None**: Right now, I do not have any influence on my family; I depend on my family's support. The best things I can do so far to reduce my parents' burden and pay them back are doing household chores and looking after my grandparents.

Her extract highlights reciprocity between parents and children. Using the phrase "best things that I can do so far", she tries to contribute. She is both a dependent family member who relies on family support, and an emerging young adult who must contribute to family obligations.

Caregiving is also structured by the Balinese local narrative of *family harmony*, which stipulates ideal familial relationships in caring for older adults. As the following extract shows, harmony is depicted as cooperation between family members and essential to wellbeing in older age.

> **Mardika:** The most important thing is that my children have a motivation to look after us. Their presence shows their care. My hope is they look after one another without any conflict. No anger, no envy. In Balinese, we call it *pakedek pakenyum* (laughing and smiling with one another). It is the source of my happiness.

The physical and emotional presence of the family members is important to caregiving, and their harmony is linked with Mardika's happiness. The implications of this local narrative and its ideal of "*pakedek pakenyum"* is that in order to provide the culturally expected and valued form of care, family members must avoid conflict or maintain a semblance of harmony when disagreements arise. Mardika's extract is supported by his wife, Made, who describes harmony as a virtue in maintaining relationships among family members. For Made, harmony is not merely about conflict resolution but also about sincerity, shown by her children who never compared one to another in terms of their contributions to caregiving.

> **Made**: I hope that my family members can be living in harmony. I want them to understand our health needs and take responsibility to look after family members who need care. I hope they can do their responsibilities in harmony. I do not want them to become *suyeng* (cynical) to one another and feel unfair when someone contributes less or more.

In terms of determining how caregiving *should* function, Mardika's account shows how the cultural narrative of the self-sacrificing virtuous child (*suputra*) provides a standard against which to measure family members' performance of care. This narrative is complemented by the local narrative of *meeting needs*, also evident in Mardika's account.

> **Mardika:** Everyone takes care of us: my sons, daughter, daughter-in-law, and grandchildren. My son, who lives in another city, visits us every weekend and holiday. On weekdays he calls me to ask about my health condition. I live with my second son, daughter-in-law, and grandchildren. My grandchildren usually help by preparing meals and providing for our needs. I am usually accompanied by my daughter-in-law when I visit the doctors. My son follows up on my health condition when he arrives from his office. Most of the time he just asks whether I've had my dinner or not, whether I feel good or not, just like that. When my wife and I were discharged from the hospital, my daughter, who has married, came every evening and provided for our daily needs. Now, when we are better, she visits once a week because she has to take care of her children.

Here Mardika describes the required standard of care and his expectations of specific family members. This extract shows how the local narrative of *meeting needs* encompasses both emotional (visits, interest) and physical (meals, healthcare) needs which are all essential to ageing parents' well-being. The roles of daughters-in-law, sons, daughter, and grandchildren are clearly prescribed by age, family position, and gender. In Mardika's story, sons provide financial care, and daughters/daughters-in-law provide active, practical care for "daily needs" (cooking, attending healthcare appointments).

Thus, local narratives position children as sources of care and structure these relationships, setting a standard for what is deemed to be 'good' and acceptable care. They also provide a standard for comparisons between family members. In particular, the local narrative of *the virtuous child (suputra)* provides a benchmark: the virtuous

daughter/son fulfils a reciprocal obligation to intensively care for ageing parents, places physical and emotional needs above their own, and enacts stipulated gender roles. Accordingly, daughters and sons can be compared to one another and positioned as, for instance, the most reliable or least favourite child. In this vein, Mardika's son reported that, unlike him, his wife is Mardika's favourite because she is a reliable daughter-in-law who always accompanies Mardika for medical appointments and as a result her advice is always heeded.

In contrast, his reputation as a difficult child has the opposite effect. Compared to his brother whom he depicts as an ideal and proud son, he has never gained Made's trust. Therefore, he always contacts his brother who lives non-coresident when he needs someone to persuade his mother. Even though he accepts the fact that he is the least favourite one, he tries to do his best for his parents' care. For example, when they got sick, he filed for office leave to look after them. He uses the word "irreplaceable" to explain why he always puts his parents' needs first.

> **Komang**: When my wife asked him to follow medical advice, "Dad, let's go to the doctor, you have to check your pulse and heart rate", My Dad followed it right after. […] My Mom often disobeys and does not buy my advice. For example, when she had a problem with her knee, I said, "Mom, shall we go to the hospital?" My Mom refused it without any explanation. Then, I called my brother, who lives in the countryside, I told him, "Mom did not want to go to the hospital; she did not listen to me. Can you please talk to her?" Then I gave the phone to My Mom so that my Mom and brother could talk to each other. My Mom has never listened to my advice because I was a rebel son. My brother is the opposite; he is the best one. […] Family is number one for me. If I got fired, we could rely on our rice field for living, but if I lose my parents, they are irreplaceable.

Failing to maintain the expected standard of care can mean unfavourable comparisons and reproach, as in the extract below where Mardika relates a story about his errant daughter-in-law failing to meet these expectations and the resulting censure, guilt, and capitulation.

> **Mardika:** There was one experience when my wife was hospitalised. My son, who lives in another city, came alone; he did not have his wife (my daughter-in-law) with him. I was angry at that time, and I called my daughter-in-law, "Why don't you come?" Then she said she wasn't allowed by her husband (my son) to visit the hospital because she had to look after her children. I replied angrily that my daughter-in-law did not need to visit me anymore in the future. / I: Why did you get angry? / Because I don't want to see them neglect their parents. Their parents are at the hospital, but they didn't visit us. I told my daughter-in-law that I didn't need her; I have many relatives who look after me. My daughter-in-law cried, felt guilty, and came to the hospital immediately. /I: Why is this important for you? / Because their presence is important for our recovery. Even though they only visit us for a couple of hours, we are happy. If they don't come, our mind wonders: 'Is there something wrong, so that they avoid us?' Their coming to visit us proves their attention and care.

In this account, Mardika again depicts his children's presence and active caregiving as proof of their care and failing to do so as unexpected and an indication of "something wrong". He draws on a cultural narrative of *the virtuous child* (*suputra*) who prioritises family over personal and working life. Consequently, despite his daughter-in-law's explanation (husband's instructions to stay home with their children), Mardika characterises her actions as neglectful of her obligation. Notably, it is Mardika's daughter-in-law who is characterised as failing, not his son, suggesting that her transgression is also related to the "neglect" of her prescribed gendered care role. Likewise, Made's extract highlights a similar point about the intersection between family matters and working life. She describes how ageing parents sometimes experience a dilemma between

their actual needs and avoiding being a burden for their family, emphasising that she does "not want to bother them".

> **Made**: I was always happy when they came and visited me. But I know they are busy, so I could not ask them to be there and do not want to bother them every time. When I recovered from my surgery, they rarely visited me. I sometimes felt sad and started to think, "What happened. Why did they not come?" It turned out to become a stressor for me.

Thus far, we have demonstrated how local narratives provide subject positions and moral imperatives related to care and how they are drawn on to produce personal narratives of ideal caregiving and a virtuous caregiver. We have also shown how local narratives shape expectations of the younger generations' behaviour and set standards against which they, as carers, can be assessed. For the most part, the stories of seven families in this study fitted comfortably with these local narratives of caregiving, leaving local knowledge unchallenged. In the following section, we turn to instances where this was not the case.

Part 2: Unliveable narratives

In some instances, the personal narratives of caregiving described challenges that prevented the personal narratives from aligning comfortably with the ideals and norms of local narratives. In these instances, local narratives became unliveable for the narrator. In this section we draw on three personal narratives that demonstrated how participants' life circumstances prevented them from identifying as a virtuous person in the local narrative.

'There is nothing I can do': Ajide's story (Family3)

As a son, Ajide is expected to care financially for his ageing parents. This gender role is prescribed by local narratives of *intergenerational obligation* and *meeting needs.* Ajide told of his inability to live up to these prescribed care practices—and thereby to enact the role of *the virtuous child* (*suputra*)—due to his chronic illness and scarce resources. He recounted an incident when he was unable to meet his ageing mother's expectation, resulting in conflict and family disharmony.

> **Ajide**: I am unemployed because of my illness. Sometimes I lie to my mom if she needs something that I cannot afford; for example, I say that the shop was closed. One day, she wanted to arrange a big ceremony for our house temple. She ran away from home because I couldn't afford the ceremony. It was too expensive for me and at that time I'd just been discharged from the hospital. She ran away for two days, spent nights in our relatives' house in another city nearby. I was silent. I did nothing. I hate conflict, but it turned out to be a stressor and my health got worse.

In this account, meeting his mother's needs is construed as Ajide's failure ("I cannot afford") and relates to cultural narratives that position men as family heads and breadwinners. He accounts for his failure to meet his gendered obligation to his mother as a result of living with a chronic illness and resulting unemployment. This obligation is described as a strain and a reason for further decline in his health. It has also caused conflict in the parent-child relationship, against which Ajide has no recourse other than avoidance (lying) or silence. Rather than an active carer, he is passive and a failed caregiver, who is unable to maintain family harmony.

Another local narrative evident in Ajide's narrative is that of *caring through social connections.* This local narrative supports Balinese communal values that allow a

family's social networks to provide support in family caregiving. However, Ajide describes this as an uncertain source of financial support in the following extract.

> **Ajide:** I thought that if my mother were to be hospitalised, our resources would be limited. Indeed, the treatment is fully covered by national health coverage, but no one can accompany her. No one is available; we are all working. Then those who accompany my mother at the hospital also need expenses such as buying meals. It costs at least one hundred thousand per day for those who accompany mother. Maybe some relatives would visit and give money, like when I was sick and hospitalised before, but we could not depend on it.

Here Ajide recounts his worry about being unable to meet his ageing mother's healthcare needs. Although treatment itself may be subsidised, the costs associated with appropriate family caregiving (accompanying mother, time off work) are beyond the family's means. The burden ultimately falls on the family and Ajide as the son and household head.

A consequence of Ajide's illness and incapacity to fulfil the prescribed breadwinner role for the family, is that the strain and burden are distributed to his immediate family. Buaji, his wife, told how she must deal with many overlapping tasks, adding to her burden as a female carer who should perform the practical care work:

> **Buaji**: I prepare everything if I have money. There is nothing I can do if I do not have money. Cash is only enough for food. My husband also has to pay attention to his diet and health. I need my husband for emotional support. While he is unable to work, I am the one who works for our daily needs. My friends also asked me to be patient. My life has been hard for so many years. I keep thinking, now I have a hard time and do everything sincerely, hopefully in the future I will be happy. I avoid conflict because my husband and mother-in-law get offended easily.

Buaji must take on both financial and caring obligations, while also maintaining family harmony by not criticising her husband or mother-in-law. These efforts to find a virtuous position within the local narrative in the face of financial and health stressors are a particular burden for women as further illustrated in the following section.

'I do everything, yet I'm never appreciated': Buaji's story (Family 3) and Ayas' story (Family 9)

Buaji's account demonstrates the clash between local caregiving narratives in which domestic work—including practical care work—is women's sole responsibility and the more contemporary public narrative in which women are expected to share responsibility for family income (Ba', 2014). While the son and his immediate family are expected to provide financial care for parents, practical tasks are the responsibility of the daughter-in-law:

> **Buaji**: … now I'm trying my best to take care of my parents-in-law so that it doesn't become gossip material in the future, especially by my future daughter-in-law. Now, the important thing is that I take good care of my parents-in-law so that later I will be taken care of by my son and daughters-in-law. Even if I am abandoned, I accept it, because nowadays many children don't care. Hopefully, I will have good daughters-in-law. Sometimes I get tired of working in the sun. I get easily dizzy, but I try to stay patient. […] when I get home, especially if it's a full moon tomorrow, there's a lot to do. I usually shower first, then have my dinner, and immediately prepare the offerings. I ask my mother-in-law to keep silent and be quiet, so I am able to concentrate and finish the tasks immediately. […] My son reminded me to be patient in doing my obligations as a daughter-in-law to my mother-in-law. Even though my mother-in-law doesn't like me, until now I still do my obligations like preparing porridge and buying the necessities.

Buaji describes the competing demands that her husband's illness creates for her and the resulting strain on her own health. According to the local narrative of intergenerational obligations, she must "take good care of my parents", which as a woman involves taking practical care of her mother-in-law and managing domestic duties. Her husband's unemployment means that Buaji also performs physically demanding manual labour to earn money. As the least powerful person in the family, Buaji must carry the additional work of caregiving. Yet, she endures stoically ("try to stay patient") and is urged to do so by her son too. Her story stresses the importance of maintaining her identity as a virtuous daughter-in-law not only in the eyes of her community (to avoid gossip), but also to ensure her own future care in old age. She draws on the local narrative of caring as an intergenerational obligation, underpinned by the Balinese view of the reciprocal nature of rights and responsibility. This local narrative supports indebtedness to parents for their past investment and care. As such, Buaji is obliged to care for her mother-in-law, but in so doing hopes to secure her own care in later life.

A similar story was told by Ayas, also a daughter-in-law. Ayas recounted a long story about pre-existing conflict between her husband and his parents that has meant family disharmony and lack of sibling support in providing care for them. Employing the local narrative of caring as an intergenerational obligation, she described her brothers-in-law and their immediate family's behaviour as demanding, neglectful of their parents, positioning them as generally not virtuous children. In contrast, Ayas positions herself as a reliable daughter-in-law, because she fulfils cultural expectations of caregiving, and as such is her parents-in-law's favourite carer.

> **Ayas**: I can accept all this and live in a complicated relationship because of mother-in-law's advice. That's why no matter how fussy she is, I am silent, and in my opinion, she is not fussy. My mother-in-law has never hesitated to ask

> everything and scold me if I am wrong. Whereas with other daughters-in-law, she is reluctant and avoids interactions.

Ayas's story is similar to Buaji's account of family disharmony and scarce support from other family members, but she positions herself as accepting caregiving as a positive experience facilitating personal growth as a virtuous daughter-in-law. This position is supported by the local narrative of caring in harmony describing her strategy of silence to promote a harmonious relationship with her mother-in-law and providing positive comparisons with other daughters-in-law.

Nevertheless, at the end of the interview Ayas expressed strong views about the difficult and unappreciated position for women prescribed in local narratives of care. Providing care becomes challenging when dealing with siblings-in-law who position her as wrong no matter how hard she has tried to fulfil her obligations.

> **Ayas**: Who runs the family matters? Daughters-in-law. But we're not appreciated. Everywhere, Balinese women are always oppressed. We left our family to become a family member of our husband's family. After that, we deal with our brothers-in-law and sisters-in-law. When we want to go back to our family, some people accept it, but we may also be rejected by many people. That's why, when I have a daughter-in-law, I'll treat and accept her as Lakshmi Goddess. My mother-in-law has done the right thing. So, now whoever is my daughter-in-law I'll accept her as my new-born. One more suggestion for Balinese women: you are valuable, but not appreciated. … I experienced it. I work but am not appreciated.

Caring in harmony is an imperative upheld by the Balinese local narrative and women are expected to maintain harmony in the family through their silence. Accordingly, asking for other family members' contributions, positioning others as not virtuous caregivers, and describing disharmony to someone outside the family contravenes the local narrative.

Here, within the anonymous interview settings, these two women were able to relate troubled personal narratives and show how the local narrative can be unliveable in circumstances in which families are impoverished and the imperative of family inheritance overrides the needs of women in the family.

'I am able, and I have to prove it': Yani and Widya's story (Family 1)

The importance of having a son is supported by the local narrative of intergenerational obligations for caregiving. The right to future inheritance establishes male children's and grandchildren's obligation to care for members of the older generation. The following stories describe the marginalised position of women in the family as prescribed by this local narrative in which, caregiving is understood as not only about here and now, but also the future legacy of the family. A daughter-in-law is positioned as a non-virtuous carer when she is unable to sustain family caregiving and inheritance by having a male offspring. Again, the problems caused by this expectation were expressed by women. The following story provided by a daughter-in-law shows how the local narrative of intergenerational obligations positions women as incompetent carers in situations beyond their control.

> **Yani**: It's my destiny not to have a son. It's already been defined by God. I used to be sad, but now, there's nothing I could change. I surrender and am grateful for God's blessing. My mother-in-law, on the other hand, was very sad. My husband kept telling her to accept the fact, but she never stops crying. Even though I was hurt, I never told anyone else. My mother-in-law always compared me to my sister-in-law and her daughter. I don't work so it's not appreciated. I've never told my husband. I'm afraid I'll be accused of creating conflict between a child and his mother. So, I keep silence and cry alone.

Here, Yani's identity as a carer has been simply determined by her reproductive ability, in which having no male offspring symbolises Yani's inability to meet intergenerational obligations of caring. Although the stories of the older generations aligned with this local narrative, the third generation sometimes questioned its expectations. Here, Widya, Yani's daughter protests about the position of a son in a Balinese family who is accorded special privileges.

> **Widya**: It is hard and challenging to be a girl. / I: What do you mean by that? / For example, when preparing offerings, I just arrive at home at night, and no one has prepared the offerings. My mom and sister were menstruating; then I was ordered to prepare the offerings, even though dad is there, and he knows how to do it. [..] according to the family tradition, if the female has done the tasks, then those are female duties. Also, Dad has been busy as a breadwinner for us. Actually, girls and boys are the same. But boys are treated differently; for example, when grandma found out about mom's pregnancy, grandma said, "if we get a baby boy, the ceremony will be held here". If the ceremony is held in the city, it must be more luxurious compared to being held in the hometown. Another example, before Mom's pregnancy, Grandmother only prayed on certain days, such as the full moon. But since she found out that Mom was pregnant, my grandmother prayed every day. I thought it shouldn't be like that, girls and boys are the same. Being born as a boy does not necessarily make you better than a girl. I have to prove it.

Widya also questioned the importance of the son in terms of legacy and inheritance in the local narrative. In the next extract she narrates a personal story which includes an identity for a good carer whose role is not dependent on gender.

> **Widya**: When my sister was born and was a baby girl, Mom was morose. I said, "what's wrong with a girl, you are also a daughter. How does it feel if your mother doesn't give birth just because you are a daughter?" Grandma also cried and was disappointed. What she thought about was my father's future, how he will be able to continue his descent and maintain his rights toward family

> inheritance. …. I have confronted my parents once, "If I were a boy, but my attitude was like my uncle who does not care about his family, would both of you be happy? It is better to be a successful woman like my aunt, who also cares about family, is it not?"

In this extract Widya uses her uncle and aunt as examples to show the contrast between the positions provided by the local narrative and her actual experience. She described her uncle as a neglectful son despite his inheritance rights, whereas, her aunt who is not expected to be a successor, is seen as a virtuous carer who is also successful in her career. While Widya reluctantly accepts role divisions based on gender, she resists intergenerational obligations that privilege the son over the daughter as a successor and primary carer for the older generation.

6.2.5 Discussion

Our analysis demonstrates the interplay between personal and local narratives, showing how local knowledge shapes practical, relational, and cultural domains of caregiving that must be followed by virtuous carers. We showed how local narratives are drawn on by families when recounting their personal narratives about caregiving and enable the construction of identities, as people position themselves in relation to cultural ideals of virtuous caregiving. For carers, local knowledge provides a moral basis for evaluating family members as virtuous or neglectful carers and these positions define the quality of relationships in the family. Similar to Breheny and Stephens' s (2011) findings about the dominance of family narratives in structuring social relationships, our study demonstrated how personal stories about family caregiving were dominantly constructed by local narratives.

In addition to demonstrating the importance of local narratives in constructing ways to be a good person, our study also provides examples of situations in which the local narrative is unliveable. Our analysis highlights instances of life circumstances which trouble participants' ability to position themselves as virtuous carers. These are important findings which highlight the ways in which local knowledge can be oppressive for some people (Lau & Seedat, 2015). Chronic illness and poverty provide challenges for families in providing the expected care for the older generations stipulated by local narratives and reinforced in public policy. Most government supports presently concentrate on older adults' needs without considering carers' contributions and the potential financial implications that arise in caregiving (Djamhari et al., 2020; Kaplan, 2018; Lestari et al., 2021; Yu et al., 2020). The growing number of the ageing population has affected the financial aspects of aged care. Many countries, including countries with more established public provisions like the Nordic countries, have encouraged family care and cut public expenditure to support older adults. Therefore, in providing care for their older family members, some families have been challenged, burdened, and faced social inequality (Kodate & Timonen, 2017).

To alleviate intergenerational poverty caused by family caregiving, policies and intervention should include increased support for family members to meet their obligations. According to a critical analysis of regional ageing policies in Indonesia (Lestari et al., 2021), even though the family is a central figure in older adults' care, family carers' roles, rights and responsibilities have been overlooked. This analysis was supported by the fact that long term care has not been included in the social security scheme (Kementerian Kesehatan Republik Indonesia, 2016). Public provisions in Indonesia for older adults' care are largely in the form of direct cash payment and limited to poorer families. Some scholars argue that direct cash payment provides benefits for

families which maximise consumer choice, rewarding the role of family carers, and increasing bonding between older adults and their family carers (Coyte et al., 2008; Okoye, 2014). In contrast, there is also a drawback when direct cash payment is used for general household expenditures rather than for providing care, which happened with one of the Indonesian government programmes called *Program Keluarga Harapan* (PKH). A review of the utilisation of this programme revealed that most of the funding was used for household expenditures and childcare. Here caregiving for the older family member was lower priority than other family needs (Djamhari et al., 2020).

Support for the family carers should be a critical government consideration because nearly 44 percent of older adults live in households with the lowest 40 percent of expenditure (Maylasari et al., 2019). Support for family carers may not be a silver bullet for eradicating poverty in Indonesia. However, previous studies have demonstrated the vicious cycle of poverty, chronic diseases, and family caregiving (Bozalek & Hooyman, 2012; Fast et al., 2018; Y. Lee et al., 2015) that should be considered by the government when defining support for family. Paying attention to family experiences in providing care enables us to understand the interplay of experience and local knowledge. This bottom-up approach will inform improved ageing policy.

A notable feature in our analysis was descriptions of women's marginalisation, the burden of overlapping tasks, and gender inequality in the family. These are not novel findings, as care has generally been found to be a women's task, even within a culture where sons are responsible for taking care their parents. Some have argued that women's role as the predominant carer may be caused by moral or ethical obligation, feelings of altruism and love, or cultural influences (Brewer, 2001; Lee & Tang, 2015) or that caregiving responsibility is often left to the most marginalised members of society who are unemployed, poor, and women (Weinberg, 1999). In most cases women are

marginalised by employment consequences and poverty as results of providing care (Ehrlich et al., 2020; Fast et al., 2018; Okoye, 2014). The challenge is to support this marginalised group in these gendered caregiving obligations. Furthermore, shifting constructions of caregiving toward a structured, valued, and accountable activity could transfer caregiving into the public domain where carers may be compensated by incentives based on their time and energy spent in providing care, and both men and women could participate equally in the process (Weinberg, 1999). While, this sounds promising and is believed to value women's position in caregiving (Okoye, 2014), in reality providing incentives for carers remains a policy debate. Besides financial incentives, supports for counselling, training, and respite services can be another type of support that is beneficial for women (Chen, 2014) since our study found that women also faced challenges around family conflict and overlapping tasks. Beyond the policy landscape, supportive environments (e.g., good family relationships, support from community and close relatives) are needed to maintain gender equality and recognise women's contributions to family caregiving.

6.2.6 Limitations

While women's voices are well articulated in this study, men's resistant voices were less prominent; although several primary carers were men (see Table 6). Men's personal narratives were more often supported by local narratives, so that they are less likely to question or resist local knowledge. It is also possible, that the female interviewer enabled women to voice their resistance to the local narrative, a resistance that they were willing to express only privately and anonymously. Further studies to explore men's experiences as primary carers are needed to support gender equality in family caregiving.

Secondly, increasing working opportunity among the younger generation has impacted the migration rate (Adioetomo et al., 2018; Adioetomo & Mujahid, 2014) and has contributed to discussions on issues around shortage of caregivers and how to combine working and caregiving. While our findings demonstrated an example of families who were not impacted much by this demographic change, further studies are needed to understand how families navigate transnational caregiving and the role of domestic workers in replacing family roles in caregiving that is common among countries in Southeast Asia (Mehta & Thang, 2017).

6.2.7 Conclusions

If local narratives are perpetuated and strengthened in public policy, without accounting for situated experience, such policy may doubly discriminate against those who are already disadvantaged in society. We argue that the sustainability of local knowledge could be achieved by augmenting support to enable families to perform their expected function in society. While policy highlights the importance of the application of local knowledge to caregiving, government must also ensure that families have sufficient capacity and competence. In doing so, the government could be utilising the strength of local knowledge, caring through social connection, while facilitating family resilience in caregiving.

For families who share personal narratives that fit comfortably with the local narratives, demonstrating virtuous caregiving identities is less challenging than for families or individuals with difficult life circumstances. Our study provides examples of circumstances (poverty, illness, and being women) that make dominant local narratives unliveable, however, there are other possibilities that further research in different cultural

contexts could explore. Considering these groups' voices and needs will improve ageing policy by increasing support for the family and distributing provisions throughout the public and private spheres of older adults' care.

In the context of Indonesia that has adopted a regional autonomy system, this study highlighted the importance of studying local knowledge to empower family carers in specific regions with distinct cultural expectations, suggesting that similar studies may be conducted in other regions to support contextualised ageing policies. At the global level, this study illuminated global discussions around the vicious cycle of poverty, disease, and caregiving, positioning of women in family caregiving, changes in providing care, public supports, and incentives for family carers.

Chapter 7 Interlinking Policy, Culture, and the Ageing World

7.1 The rationale for the study

The studies about regional ageing policies and Balinese culture have deepened our understanding of ageing and family caregiving experiences in Bali. The Balinese understand later life as a life period when dependency and an obligation for care are inevitable. These perspectives are reinforced by regional ageing policies, but, at the same time, the regional ageing policies are starting to adopt the global trend toward successful ageing. These two opposite discourses, "decline" and "successful ageing", are prominent in everyday life and have shaped the stories on ageing and family caregiving. Nevertheless, culture sometimes legitimises certain discourses and subject positions on ageing. Using the same dataset as in Chapter 5, the study in this chapter used positioning analysis to explore the discourse that considers the importance of the Balinese culture, and older people's self-positioning and positioning by others within the decline and successful ageing discourses. Since the older persons in the article presented in this chapter need family caregiving, there is a strong emphasis on medical aspects and findings are limited to the point of view of older people with physical illnesses. Therefore, the findings provide a discussion about cultural and medical perspectives, and approaches in understanding the subject positions and their impacts on ageing and family caregiving.

This chapter is under review as:

Lestari, M.D., Stephens, C., & Morison, T. (2022). Decline or successful ageing discourses: When cultural knowledge and dominant discourses intersect to shape personal stories of ageing. Manuscript submitted for publication at International Journal on Ageing in Developing Countries.

7.2 Decline or successful ageing discourses: when local knowledge and dominant discourses intersect to shape personal stories of ageing

7.2.1 Abstract

The decline and successful ageing discourses are key contemporary discourses of ageing, which provide contrasting identities for older people. Although the successful ageing discourse now appears to be globally dominant in policy and beyond, people's engagement with both these discourses varies by culture. People draw on discourses that are culturally available and legitimated in their contexts to produce ageing identities. This study aimed explores the interaction between local understandings and the dominant discourses of ageing, focusing on how these shape personal stories about ageing and the subject positions provided by the discourses among older people who need family care. Applying positioning-discursive analysis to the narrative data of older people and their family members who are co-resident in 11 multigenerational households in Bali, we identified culturally available discursive resources and their use in self-positioning and positioning by others. Four subject positions were identified, namely frail and vulnerable old person, disengaged and dependent family member, compliant patient, and unsuccessful ager. We found that both 'decline' and 'successful ageing' discourses were used to legitimate a positive identity for being an old person in decline. These findings contradict previous research from different socio- cultural context which described pressure and shame among older people who could not achieve successful ageing ideals. The policy implications and the importance of a life-course preventive approach to facilitate ageing well are discussed.

Keywords: ageing identities, cultural knowledge, decline discourse, positioning – discursive analysis, successful ageing.

7.2.2 Introduction

Globally, ageing is framed by two dominant and oppositional discourses: the decline discourse and the successful ageing discourse (Fealy et al., 2012; Sandberg, 2013). The decline discourse is part of more established and common-sense ways of understanding the life course. It is essentially deficit focused, emphasising increasing physical frailty, mental deterioration, non-productivity, passivity, and dependency. In contrast, successful ageing emerged in response to the deficit view of the decline narrative, and highlights activity, autonomy and responsibility (Caddick et al., 2018; Sandberg, 2013).

From the early 1980s, scholars in ageing began pointing out the disadvantages of the decline discourse, which cohere around its deficit focus. They argued that discourse exaggerates the negative aspects of becoming old and categorises older people as non-productive and a social and economic burden, encouraging their dependency on public provisions (Rowe & Kahn, 1987; Townsend, 1981). Ultimately, this discourse has been shown to be disempowering, limiting possibilities in later life and contributing to social stigmatisation of older people (Caddick et al., 2018).

To challenge the decline discourse's deficit view—and its resultant ageist constructions, stigma, and disempowerment—the successful ageing discourse was developed to focus on the positive aspects of ageing (Rowe & Kahn, 1987, 1997). While the decline discourse imagines older people as passive and dependent, the successful ageing discourse facilitates identities centred around the importance of healthy life, social contribution, and autonomy. While the decline discourse envisages loss of agency, the successful ageing discourse sees the older person as agentic, in control of their body and life (Jolanki, 2009; McGrath et al., 2016). Given these positive associations, the notion of successful ageing has been seen as beneficial to older people and also to countries seeking to reduce the negative impacts of population ageing (Bülow & Söderqvist, 2014;

van Dyk, 2014). It has thus been promulgated widely through public policy and the media (Breheny & Stephens, 2019).

Although successful ageing discourse offers more positive social identities than the decline discourse, several disadvantages have also been highlighted. Chief among these is the construal of successful ageing as a personal responsibility and, in turn, the inability to achieve successful ageing is considered an individual failing (Bülow & Söderqvist, 2014). This discourse highlights individual choice, planning, and positive health-related behaviours, but without consideration of the context of older people's lives (Rowe & Kahn, 1997). What is not recognised is that successful ageing is only available to those who are *able to* maintain a healthy life. The physical and material resources needed to age successfully are not equally available to all older people (Breheny & Stephens, 2019). Successful ageing discourse can therefore have marginalising effects on those who do not meet its criteria, because they do not have the means to age successfully, such as ill or disabled older people, those already requiring care, and those with fewer economic resources (Baars, 2017; Stenner et al., 2011; van Dyk, 2014, 2016).

Both these dominant ageing discourses (decline and successful ageing) circulate in society and are available for people to draw on when making sense of their and others' experiences of ageing. These discourses act as resources for constructing contrasting identities for older people. However, understandings of ageing are also shaped by local cultural understandings of ageing (M. Andrews, 2009; Corwin, 2020). For instance, research indicates that some cultures focus on individual responsibility for maintaining well-being in later life, while others emphasise interdependency and accept decline. Thus, people identify with discourses that are available within and legitimated by their socio-cultural context (M. Andrews, 2009; Liang & Luo, 2012). The decline and successful ageing discourses may co-exist, working in tandem with localised meanings to shape

ageing stories (Calasanti, 2016). Accordingly, there is always diversity in people's understandings and accounts of ageing (M. Andrews, 2009). However, research has tended to study the decline or successful ageing discourses independently from one another, paying little attention to how they interact with localised cultural understandings of ageing, and to what effect.

Addressing these oversights, we consider the interaction of local understandings of ageing with dominant ageing discourses (decline and successful ageing) and explore how they are drawn on in personal narratives about ageing recounted by older Balinese people and the family members who care for them. The Balinese is a useful case example because the decline and successful ageing discourses coexist in Indonesian regional ageing policies (Lestari et al., 2021). The Indonesian Government has followed global trends by incorporating successful ageing ideals while also preserving cultural understandings of ageing and family, which largely cohere with the decline discourse (Lestari et al., 2022). Balinese consider old age (*bhiksuka/sanyasin)* as a life stage centred on disengagement from the mundane world to focus on the spiritual (Sukerni, 2018; Suteja, 2018). Older family members relinquish power and responsibility to the younger generation, remaining as dependents requiring family care (Geertz & Geertz, 1964).

In the context of Balinese cultural values, and Indonesian regional ageing policy, we examined how the decline and successful ageing discourses are taken up in personal narratives on ageing. We included both older people's and their families' accounts to illuminate how older people who need family caregiving are positioned by themselves and others, and to highlight the rights, obligations, and expected behaviours attached to those identity positions.

7.2.3 Methodology

We used an approach to narrative inquiry that draws on positioning theory (Davies & Harré, 1990) to investigate the socially situated production of identity (e.g., Bamberg, 2004; Currie et al., 2007; Taylor & Littleton, 2006). B. Smith and Sparkes (2008) have named this a 'storied resource' approach in which "people do things with words, and they do things with narratives…Through them they construct their own lives and those of others…Such accounts are certainly not private, and they do not yield accounts of unmediated personal experience… [and therefore] we need to analyse them in terms of the cultural resources people use to construct them" (Atkinson et al., 2003, p.117). Accordingly, both discourses and localised meanings are considered discursive resources that are available for narrating experiences and constructing identities (Bamberg, 2004).

In the storied resource approach, the concept of positioning is used to connect the social construction of identity to larger discourses (e.g., ageing discourses) and dominant cultural storylines (e.g., Balinese life stages, including *bhiksuka/sanyasin*) (Morison & Macleod, 2015). According to this perspective, people "draw from a cultural repertoire of available stories larger than themselves that they then assemble into personal stories. [In so doing] …constructing certain kinds of selves and identities in specific social contexts" (B. Smith & Sparkes, 2008, p. 19). In this way, people negotiate their identity in everyday talk, including the context of the research interview (Breheny & Stephens, 2019; Morison & Macleod, 2015). How people talk about and make sense of experiences of ageing depends on the available discourses in their social milieu (Allen & Hardin, 2001; Hardin, 2001). Moreover, culture legitimates specific discourses per others (M. Andrews, 2009). Hence, people take up the subject positions provided by discourses (Wetherell & Edley, 1999) that fit to the cultural expectation of ageing (Pfaller & Schweda, 2019).

In the context of ageing, individuals negotiate multiple and contradictory discourses in everyday life that make various, sometimes contradictory, positions possible (Allen & Hardin, 2001; Fealy et al., 2012). For example, decline and successful ageing discourses position older people in opposing subject positions: passive/active, dependent/autonomous, and frail/fit (Fealy et al., 2012). Each position includes certain rights, obligations , and expected behaviors (Breheny & Stephens, 2019), so that ultimately the discourse facilitates or constrains what can be said and done by older people (Katz, 2000).

Since individuals usually negotiate a position that provides a positive identity in a specific context and certain situation (Currie et al., 2007), certain subject positions can be taken up or resisted. Moreover, one is positioned by others *and* can actively position oneself; selves and identities are therefore conferred *and* actively claimed and contested (Breheny & Stephens, 2019; B. Smith & Sparkes, 2008). In this study, we used interviews with older people and their family members to identify culturally available discursive resources and their use in self-positioning and positioning by others.

Participants and data collection

Interviews with members of 11 Balinese multigenerational households were conducted by the first author. Participants were recruited through a hospital, community health services, and private practices. Among the participants, 14 individuals are the members of the first generation (grandmother and grandfather), 19 individuals within the second generation (son, daughter-in-law, and niece), and 16 individuals as the third generation (grandchildren and grandchildren-in-law) who were co-residents. All members of the first-generation experienced declining health and received care from the second and third generation.

The first author provided and explained information sheets describing the study to older people and their caregivers attending public healthcare facilities. In private practices health workers provided the information sheets to potential participants. Initial consent was followed by a meeting with the family members to explain the study. Private interviews were conducted with each family member after gaining consent from all family members.

The interviews were held at the participants' house or office or at the hospital. Narrative interviews involved inviting the participant to share their own stories about family caregiving, for example: "Can you tell me about your life and experience as an older person/caregiver in your family?" Thereafter, prompts were used to probe participants' stories. The anonymised interviews were transcribed in Balinese and Indonesian by the first author and a professional transcriber. Interview segments were back-translated for quality assurance. The study was jointly approved by The Research Ethics Committee of Faculty of Medicine, Udayana University and Sanglah Hospital (No. 2809/UN14.2.2.VII.14/LP/2019) in Bali and Massey University Human Ethics Committee (No. SOA 19/69) in New Zealand.

Data analysis

The first author read and reread participants' interview transcripts in Balinese and the Indonesian language. She marked interview segments in which participants provided personal narratives about ageing and caregiving for an older family member, identifying how they those drew on the decline or successful ageing discourses. Identification of discourses involves noting patterned ways of talking represented by recurrent words, phrases, metaphors, imagery, and statements. For example, a decline discourse was identified by the use of words such as 'old', 'physically decline', 'dependent',

‘emotionally vulnerable’, ‘limited mobility’, ‘frailty’, ‘high risk’, ‘memory decline’, or ‘deteriorated’. Whereas, the use of a successful ageing discourse, was identified through descriptors such as ‘active’, ‘productive’, ‘healthy’, ‘autonomous’, ‘financial contributor’, and ‘socially active’. We then focused on positioning, exploring how older participants positioned themselves or were positioned by others within the identified discourses, which positions were taken up and resisted by older people, and how older people and their families viewed ageing from the vantage point of those subject positions.

7.2.4 Findings

We identified the primacy of the decline discourse in participants’ descriptions of ageing experiences. However, the successful ageing discourse was also drawn upon so that decline and successful ageing discourses were used together to construct participants’ stories. In this section, we demonstrate how the decline and successful ageing discourses were drawn on by participants to position themselves or their older family members as older people in ways that accord with local cultural and medical knowledge. We found overall that both decline and successful ageing discourses were used to legitimate subject positions that allow older people to be passive, dependent, and accepting their limitations. Table 7. provides an overview of the positions within each discourse that we identified.

Table 7.

Subject Positions, Discursive Functions, and Effects

Discourse	Positions	Discursive function & effect
Decline discourse	1. Frail & vulnerable old person 2. Disengaged and dependent family member	Legitimates a positive position as a care recipient within the family and can allow person to secure ongoing care by younger family members without negative identity (burden, drain on family, slack etc.)
Successful ageing discourse	1. Compliant patient 2. Unsuccessful ager	Reinforces subject positions provided by decline discourse and allows older people to accept their limitations.

Decline discourse

Participants drew on a decline discourse in constructing their stories about ageing, living with illness, and family caregiving. Older people positioned themselves and were positioned by others as a person subject to decline both in their physical functioning and their contribution to society. According to this construction, physical and productive decline are inevitable. Supporting the decline discourse, participants drew on local cultural knowledge of ageing and their health providers' advice to construct their narratives of decline, showing the role of culture and medical institutions in promoting the decline discourse among our participants. Older people were positioned/positioned themselves in two common ways: (1) as a frail and vulnerable person, and (2) as a disengaged and dependent family member. Each position is discussed in turn below.

Frail and vulnerable old person

Drawing on a decline discourse, older people positioned themselves as frail and dependent, as shown in an extract provided by Tuniang who relates her physical decline to her age.

> Extract 1: My daughter-in-law always goes to Banjar for doing exercise and aerobic. *I have never participated, I couldn't do physical exercise, I am old.* I stay at home, never go anywhere. At home, I make offerings from coconut leaves. If I have strength and energy, I will finish making the offering. If I don't feel well, I take a rest and do nothing. I can't do anything about it, *my condition has started to deteriorate*. Sometimes I have an appetite, sometimes I don't (Tuniang, Family 3)

Rather than illness, old age is drawn on here to explain physical limitations and poor functioning. Tuniang positions herself as weak and physically frail (lacking strength and energy, needing rest). This construction of the ageing self-aligns with the dominant Balinese cultural storyline of ageing in which the ageing person withdrawals from society ("never participated", "stay at home, never go anywhere") and responsibilities ("Rest and do nothing). Here withdrawal is explained in terms of bodily decline and physical limitations (weakness, lack of energy, illness, deteriorating condition).

This positioning becomes more salient when older people are similarly positioned by the family. The extract below shows how a son positioned his mother as physically and emotionally vulnerable due to old age.

> Extract 2: For example, when my mom fell down, my brothers and sisters *scolded Mom thinking that she was strong. When you are old, the stress level is high. If we respond angrily, she will be even more disappointed.* I usually make her happy first, then I advise her to be careful in the future, so that she won't fall again (Tutde, Family 8)

Tutde draws on the decline discourse in constructing his narrative about ageing and care provision. The positioning of his mother as a vulnerable person requires Tutde to adjust the way he interacts with her, for example, providing a careful and gentle approach, in order to support her. The subject position not only determines his mother's rights, but

also obligations and expected behaviors of the family members. Consequently, he criticises his siblings for failing to recognise and meet their mother's needs as an ageing person.

Beyond family, in the public domain, the medical institution legitimises the primacy of a decline discourse and educates participants accordingly. Medical discourse constructs ageing as a disease by associating old age with illness. For example, Pakde described how health personnel talked about his mother's illness:

> Extract 3: The doctor said the illness is because of her age, *"She is already old"*. For me, she is only 76 and many people in her age are still active if they are healthy (Pakde, Family 5)

In this extract, Pakde describes how the doctor accounts for his mother's illness and inactivity as related to her age. This example shows how health personnel may use ageing as an explanation of ill health, excluding older people from the category of healthy people. The label of 'old' that the health personnel attached to older people's illness was also experienced by Mardika.

> Extract 4: My doctor said that stress causes illness. It is the major cause of every type of illness, especially when you think too hard about something. My doctor said, *"You are already old, do not think too much unless you want to get S3: 'stress, stroke, and setra (cemetery)'*, don't you?". I think it is true (Mardika, Family 2)

Mardika repeats a joke told by his doctor about old age and stress which positions older people as susceptible to stress-induced illness and needing to take it easy. Agreeing with the doctor, he takes up a position of being "already old" and vulnerable. His extract shows the marginalization and exclusion of older people from being positioned as strong,

active and resilient persons. They are expected to be passive by following the prescription of "do not think too much" if they want to avoid worsening medical condition.

The position of being old ("already old" or "you are old") was repeated across data, both in older people's self-positioning and family and medical authorities' positioning of older people, in a way that was synonymous with physical decline, frailty, and vulnerability. The physically declining subject position excludes older people from social categories such as a healthy fit person and one engaged fully in society. Some older people accepted this subject position, accepted the medicalised view of ageing as a disease in itself, and conformed with expectations around the disengagement of older people.

The disengaging and dependent old person

Decline discourse includes expectations of disengagement from many social roles and responsibilities in later life, aligning with Balinese understandings. Participants understood ageing as a period of inevitable disengagement from active life while shifting responsibilities to the younger generations. Being dependent on the children and family is expected as one aged. For example, in the following extracts Luhtu and Sadhu explicitly use the words 'old age' to position themselves as someone who is disengaged from activities and dependent on family support.

> Extract 5: My life now, as I said earlier. *I'm old, I can't work anymore*. My life now *depends on my sons and daughters-in-law*. Since I'm no longer working, *I don't hesitate to depend on my children, whatever they provide for me* (Luhtu, Family 4)
>
> Extract 6: Now, *I do not have anything to be worried about*. I only think about eating and sleeping, nothing more than that. My children and grandchildren are already mature and independent (Sadhu, Family 6)

Both Luhtu's and Sadhu's accounts describe the shifting responsibility and reciprocity between older and younger generations in Balinese culture. As people age, it is time for them to be dependent on their successors. Their identity changes from provider to being provided for and from caregiver to care-recipient. Emphasising the normality of this ('I don't hesitate') in her account of family support, a disengaged and dependent subject position secures rights to family provision for Luhtu that she is able to depend on unreservedly and without guilt. Likewise, Sadhu perceives her later life as a detachment from responsibility which allows her to be a passive person who does not need to think about anything serious. This subject position is situated within the Balinese cultural ideal of older people as those who need care and local narratives of family caregiving that emphasise family obligations to care (Lestari et al., 2022).

Family members also drew upon the decline discourse to position older people in terms of their role in the family. For example, a brother explains in the following extract how the older person in the family should be less dominant and more dependent as they age.

> Extract 7: *She was interfering. She's never positioned herself as an ill and old person*. She did not understand the current situation, still she always interferes. … But because her hobby is making offerings, she felt that she has to follow her hobby. Even though she does the work, but still this becomes a burden for our family […] *As a parent, I am ready to lose my role*. For example, for kitchen matters, whatever my daughter-in-law serves for my meal, *I accept it. I am ready* (Suandi, Family 11)

Suandi positions his sister as a troublesome older person who would not follow the cultural norms, thus, creating trouble through her interference in family matters. He invokes the Balinese cultural norms (*bhiksuka/sanyasin*) that dictate the appropriate behaviour of older people as stepping away from important family roles, and positions

his sister as an older person who contravenes this norm, as she should now allow the younger generation to lead. Instead, his sister still tries to engage in the household affairs. Contrasting his sister's behaviour with his own, Suandi positions himself as passive and "ready to lose [his] role" of having a say in the household, relinquishing responsibility and control to the younger generation. He invokes the cultural ideal of disengagement and dependency to describe his own position as one who conforms to culturally expected behaviours.

Participants frequently constructed old age in terms of decline and disengagement, both in terms of physical activity and social roles. They positioned themselves as functionally declining persons and did not expect to be as active and fully contributing as in their earlier lives. Responsibilities were shifted from the older to the younger generation. Disengagement and dependency in late life, which were prominent in the participants' narratives, are supported by Balinese cultural values regarding older people's roles in the family and society.

Successful ageing discourse

Although the decline discourse is dominant, successful ageing discourse is also publicly available for participants to draw on. This section demonstrates how successful ageing discourse was drawn on by some participants, mainly in discussions of health and healthy lifestyles. Most older participants did not position themselves as successful agers. Rather, they were positioned by others as responsible for their own health in older age. We identified two further common positions that are resourced by the successful ageing discourse: (1) compliant patients who participate minimally in successful ageing, and (2) unsuccessful agers.

Compliant patients with limited engagement in successful ageing

Participants drew on the successful ageing discourse when describing medical advice about needing to maintain vitality and social participation when experiencing illness. We provide two extracts that illustrate participants' adherence to medical advice that drew on successful ageing discourse. Although these participants were excluded from successful ageing by their actual physical health decline, they were expected to engage in exercise and social activities.

> Extract 8: "You have to do more exercise, 30 minutes per day, to keep healthy, and maintain your stent, that is my *doctor's advice*. So now, I go to the rice fields only to maintain my vitality. Maximum one hour, can't do more than that. After that, I immediately go home and take a shower. *The goal is only to maintain my vitality*. I do not think about revenue and loss. In fact, I lost a lot (Mardika, Family 2)
>
> Extract 9: I sit down nicely in Banjar and watch my friends do activities. I have never joined the exercise. *My doctor told me that the importance of attending the community activity is for refreshing and meeting with friends*. If I can do the activity, I do it, if I can't, I just keep quiet and watch. Because if I fall, no one can help me (Luhtu, Family 4)

Mardika describes how he follows the doctor's advice to participate in health promoting activity following surgery. However, emphasising that he engages in work "*only* to maintain vitality" and repeats that 'the goal is *only* to maintain my vitality'. He therefore positions himself as still withdrawing from the world of work and commerce by emphasizing 'I do not think about revenue'. Similarly, Luhtu describes her doctor's advice about maintaining social inclusion in old age, which is part of the successful ageing discourse. Her extract shows how successful ageing discourse has penetrated the community and individual levels via health personnel and the community programmes.

Like Mardika, Luhtu follows her doctor's advice, while making it clear that she is not able to participate fully because of her physical decline.

For both Mardika and Luhtu, by focusing on the main goals of successful ageing (maintaining vitality and social engagement), they have positioned themselves as older people who obey the advice of their doctors, while at the same time, recognizing and accepting physical decline. These extracts demonstrate how successful ageing discourse is publicly available and provides expected behaviours that are articulated in medical advice and community programmes. They show that while medical advice included engagement in successful ageing activities, participants accept their productive or physical limitations.

Unsuccessful agers

Participants sometimes used the successful ageing discourse, particularly its construction of unhealthy lifestyles, to make sense their illness rather than using the decline discourse and its notion of 'old age'. In this section we demonstrate how successful ageing discourse, especially related to healthy ageing, was drawn on in participants' narratives. The emphasis on personal responsibility for healthy behavior as investments in successful ageing can lead to self-blaming and blame by others when older people are seen as ageing unsuccessfully. Successful ageing discourse emphasises personal responsibility for staying physically fit in later life. and participants drew on these constructions when they referred to being 'naughty', 'snacking too much', or their poor 'eating habits' as reasons for their declining health and drew on health promotion discourse to explain their present health. For example:

> Extract 10: Smoking is the cause. I quit smoking after I got a heart attack. I was hospitalized in the ICU for three days. *I was naughty*, I smoked, drank too much

> coffee, gambled, and enjoyed cockfighting. I joined cockfighting everywhere. Because of my illness, I stopped cockfighting, quit smoking, did less travelling. In the past, before my illness, I joined cockfighting in the morning and gambled at night. Non-stop (Mardika, Family 2)

In constructing his illness narrative, Mardika described his previous "naughty" lifestyle and attributes his subsequent heart attack to smoking and other poor ("naughty") health habits. He therefore positions himself as personally responsible for his poor health. Mardika's extract provides an example on how the successful ageing discourse works with health promotion discourse to construct illness as personal failure

Other family members also drew on the successful ageing discourse positioning their elders as unsuccessful agers. References to medical professional's advice lent authority to this positioning. Older people were therefore blamed by others for their poor health (becoming "overweight", frail, and diabetic) because of their bad habits (e.g., snacking, unhealthy food consumption) and not monitoring their health practices. Older participants themselves also recounted how others positioned them in this way. For example, Luhtu recalled her conversation with her doctor who drew on past unhealthy lifestyle to make sense of her current chronic illness.

> Extract 11: My doctor asked me, "Grandma you used to be a seller, right?" I was surprised how my doctor knew what my previous job was. *My doctor later said that most sellers have diabetes because they snack too much. I used to be like that, I bought whatever I wanted. There were many food sellers around me, and I had money to buy them* (Luhtu, Family 4)

Here, Luhtu accepts the doctor's explanation about the cause of her illness and so takes personal responsibility for her 'bad' behaviour and its consequences, saying "I used to be like that".

In contrast, for the younger generation the successful ageing discourse was used to construct healthy ageing as a lifetime investment and result of a healthy lifestyle.

> Extract 12: That's why I always pray, *I don't dare to be fat, because I don't want to be like my mother-in-law who can't walk.* If possible, *I want to be autonomous*. If it is possible, *I don’t want to get sick, that's all. But by staying up late until 12 my husband has started to worry because it is not good for health* (Ayas, Family 9)

In extract 12 Ayas positions her mother-in-law as a dependent older person because she had failed to maintain a healthy life when she was younger. She draws on the successful ageing discourse to emphasize autonomy (rather than dependence), which counteract traditional Balinese ideals of old age rooted in the decline discourse. She constructs poor health behaviours as a barrier to achieving health and successful ageing, which then compels her toward self-regulation (i.e., monitoring weight).

The co-existence of successful ageing and decline discourses in the participants’ accounts provides insights into the multiple subject positions that must be negotiated by older people when they position themselves or are positioned by others within these two discourses. However, although some older participants did draw on the successful ageing discourse, it did not necessarily change their identity. In fact, successful ageing discourse was often used to reinforce the subject positions provided by the decline discourse. We used extracts from Mardika and Luhtu as examples of both discourses used at different times for different discursive purposes. Both Mardika and Luhtu used decline and successful ageing discourses in their stories about ageing. Drawing on decline discourse, they positioned themselves as older people who are frail, disengaged, and allowed to be dependent on the younger generations. Drawing on successful ageing discourse, they positioned themselves as compliant patients, while maintaining a declining identity.

7.2.5 Discussion

Our participants mainly drew on a decline discourse to construct narratives about ageing and family caregiving. Beyond their own experience of bodily decline, the local culture, family, and medical institutions contributed to the construction of an inevitably declining older person. This construction fits with Balinese local knowledge on family caregiving in which dependency and disengagement is the accepted default position for older people (Lestari et al., 2022). It is also important to note that healthcare provider often use 'old age' to explain older people's health which is an aspect of the medicalisation of ageing (Estes & Binney, 1989; Robertson, 1997). The danger here is that old age is constructed as a process of decremental decline which must be controlled by biomedicine (Estes & Binney, 1989), and structured into social institutions and daily life (Calasanti, 2016).

Our findings contradict previous research which described pressure and shame, felt by older people when positioned as a frail and vulnerable old person (Bennett et al., 2017; Caddick et al., 2018; McGrath et al., 2016; Pack et al., 2019; Phoenix & Smith, 2011). From the perspective of Balinese cultural mores of family caregiving, self-positioning or being positioned as a declining older people is not necessarily negative. Drawing on decline discourse legitimates dependency, in which older people's need for help has positive connotations and there are no demands for older people to keep active and productive (Jolanki, 2009). Our findings have been supported by many studies which reveal situations in which decline is seen as a meaningful process (Corwin, 2020), old age is associated with privilege (Isopahkala-Bouret, 2017), and disengagement in late life is accepted as a sign of wisdom (Katz, 2008). Seeing illness and decline as part of a natural ageing process has also been found to facilitate older people's acceptance of poor health conditions (Hudson et al., 2015).

At the policy level, the decline discourse and its subject positions are supported by regional initiatives that promote the key role of family in providing care for the older generation. The subject positions provided by the decline discourse allow older people to be dependent on their family in meeting their needs. From the family's perspective, the decline discourse strengthens the obligation to care. However, the ageing population in Indonesia does provide challenges, both for family and the government in meeting future care needs which has led Indonesia to include successful ageing ideals in regional ageing policies (Chomik & Piggott, 2015; Do-Le & Raharjo, 2002; Mi et al., 2018; Niehof, 1995). Successful ageing is believed to be a solution for decreasing the burden experienced by the country in financing the Indonesian older generation (Ananta, 2012). However, despite these potential advantages, successful ageing also has limitations.

The aim of medical advice that draws on successful ageing discourse.is to increase healthy life expectancy and older people's quality of life (Calasanti, 2016). While older people in our study adhere to this advice, they are also aware of their actual physical limitations. Some studies conducted in clinical populations of older people found similar patterns (e.g., Caddick et al., 2018; Hudson et al., 2015). Caddick et al. (2018) highlighted the dangers of 'life-as-normal' successful ageing advice for older people with illness and disabilities where it, provides stress and pressure. They suggested activities that offer less physical demand and focus more on increasing social participation among older people. A focus on personal responsibility for health and financial consequences from a successful ageing perspective also means that physical decline may be regarded as a personal failure (Baars, 2017; van Dyk, 2014). Our findings show that illness and incapacity can result in blaming ourselves or others.

Drawing on successful ageing discourse that emphasises preventive health behaviours among the younger generation may be more positive. Certainly, the younger

generation in our sample draw on this discourse to construct their future ageing. A preventive health system is considered by public health proponents to be a good solution to decrease health expenditure in the long run (Agustina et al., 2019; Biggs, 2014). Successful ageing requires adequate financial, social, cultural, and physical resources (Jolanki, 2009) and a life-course approach, which is integrated with several policies (e.g., health, educations, economics, labour) and promoted earlier in the human development stages (Walker, 2013). From a future oriented perspective, a successful ageing approach may provide more Balinese and Indonesians in general with an opportunity to age successfully in the longer term.

7.2.6 Limitations

It is important to note that the participants in this study were all older people (and their families) who were recruited from medical centres and accordingly were receiving medical attention for physical illness. This will have a bearing on the kinds of stories participants told. A cohort of healthy older people may have engaged differently with dominant ageing discourses and local narratives. Further study that includes stories from older people who are functioning well, will deepen our understanding of the primacy of decline discourse in the context of Balinese culture and the influence of material and social resources in ageing well. In addition, it could be valuable to consider healthcare worker's perspectives in greater depth too. While we have discussed some examples of subject positioning by health personnel these were recounted by our participants and not firsthand. Further study is needed to understand how discourses of decline and successful ageing are integrated into the medical approach and are part of the relationships between

patient and doctor and what implications this has for older people to receive family care and live well.

Finally, our data set is limited to individual interviews, which has both advantages and drawbacks. We were able to probe and discuss personal experiences, which participants might be reluctant to do in other forms of data generation, like focus groups or family interviews. Other forms of data, for example, focus group discussions and conversations are able to capture everyday interaction between older people and others, so that interactive and reflexive positioning may be examined in more everyday situations.

7.2.7 Conclusions

For Balinese older people and their families, both ‘decline’ and ‘successful ageing’ discourses were used to legitimate a positive identity for an older person who needs care and support. This study has demonstrated ways in which ageing discourses interact with local knowledge to provide valued identities. While a decline discourse is supported by the Balinese culture, family, and medical institutions, successful ageing has been promoted through medical advice and community programmes. The two discourses were generally drawn upon to promote a culturally appropriate identity as an older person who is expected to physically decline, should resign from family responsibilities, and deserves care and attention from their children. Successful ageing was drawn upon by the younger generation to resist a future in which they declined physically like their parents and to include health promoting behaviours when they talked about their own future ageing. Rather than focus such successful ageing ideals on the behaviour of older people who

now need care, it will be fruitful to integrate a preventive approach across social policies to lifespan development that facilitates ageing well for future generations.

Chapter 8 Discourse Analysis as A Guide to Reform and The Socio-ecological Model

8.1 The rationale for the study

While focusing on critique, researchers using discourse analysis sometimes overlook the application of their analyses to social change. Thus, discourse analysis is sometimes criticised for providing evaluations without any solutions. Some researchers argue that discourse analysis should simply remain committed to providing critiques because when scholars try to provide recommendations, especially when their critiques are utilised by policymakers, they can be forced to support the powerful institutions that legitimate power, certain discourses, and social practices that were the point of their critiques (Willig, 1999b). The central argument of this chapter is that critique should be constructive and applicable and only with the goal of social change; otherwise, it is simply an accumulation of scepticism toward a world already in chaos. Discourse analysis should move beyond deconstruction to make recommendations for social practice. Here, discourse analysis is not merely about social critiques and empowerment, but also a guide for reform (Willig, 1999b)

The article presented in this chapter applied a discursive perspective as a guide for sustainable family caregiving by capturing it at the macro and micro levels. The previous chapters have discussed dominant and alternative discourses around ageing and family caregiving. The important thing is their impacts on older people and family in providing care. As a guide to reform, the recommendation is presented into the model of family caregiving that integrates the findings of discourse analysis into a Socio-ecological Model (SEM) as developed by the Centers for Disease Control and Prevention. The SEM is able to provide a holistic view of a phenomenon from individual, family, relationship,

community, and societal points of view (Centers for Disease Control and Prevention, 2015). The model provides resources, opportunities, and challenges in each system level in sustaining the family caregiving in the Balinese context. This PhD research on the discourses of ageing and family caregiving at the macro and micro levels has deepened the SEM and provides a more holistic understanding of family caregiving to create better ageing policy.

This chapter was presented at:

Lestari, M. D. (2021, November 24). *Balinese family caregiving model: Opportunities and challenges*. 24th NZASIA Biennial International Conference 2021. 'Asia: Change, disruptions, and resilience', Massey University, New Zealand.

8.2 Balinese family caregiving model: Opportunities and challenges

8.2.1 Abstract

As the fourth province in Indonesia with the largest proportion of older people, almost 58% of Balinese older people are living in multigenerational households. While the regional ageing policy highlights the importance of family and local knowledge in maintaining older people's well-being, little is known about the experiences of Balinese families in providing care for their older generation. This study aims to develop a theoretical model of family caregiving, which is derived by synthesising results from four previous studies (Indonesian regional ageing policies, Balinese local knowledge on family caregiving, and discourses on ageing and caregiving in the private and public domains) within a socio-ecological model. The model provides two things; firstly, it provides a space for alternative discourses on family caregiving to be heard, and secondly, the model can be used to inform ageing policy in the area of caregiving. While local and specific, this multidimensional model allows academic, practitioners, and policymakers to understand family caregiving more holistically, both at the micro and macro levels.

Keywords: ageing policy, local knowledge, socio-ecological model

8.2.2 Introduction

As the size of the ageing population grows, so does the demand for family care, which can thus face many challenges. In the private domain, family caregiving is challenged by the shortage of caregivers due to declining fertility rates, migration among younger generations, an increase in the female workforce (Chomik & Piggott, 2015; Do-Le & Raharjo, 2002; Mi et al., 2018), poverty (Kadar et al., 2013; Kaplan, 2018) and family conflict (Lestari et al., 2022). In developing countries, including Indonesia, public provision for older people can be fragmented, non-comprehensive, and offer minimum support for family caregivers (Djamhari et al., 2020; Lestari et al., 2021).

The lack of public support for family caregiving is influenced by the tendency that families rely on their internal resources before looking externally (Singer et al., 2010). Accordingly, governments assume that families can provide an optimal standard of care and need no external support (Brotman, 2003). In Indonesia, the strengthening of family responsibility for older people' care is the philosophical underpinning of its ageing policy (Lestari et al., 2021). However, while families are important for older people' caregiving, the role of the state should be in supporting families in exercising their responsibilities (Ananta, 2012). Without informed policy, family care will create burdens. I argue that it would be better if the private and public domains worked together to provide care for the older people.

To understand the interplay between the private and public domains in supporting family caregiving, I have developed a model of family caregiving for older people that applies the socio-ecological model (SEM) developed by the US Centers for Disease Control and Prevention (CDC). SEM can provide a holistic perspective on phenomena at the individual, relational, communal, and societal levels (Centers for Disease Control and Prevention, 2015). SEM has been used for many purposes, such as intervention and

evaluation (Lee et al., 2017; Palafox et al., 2018), health promotion (Palafox et al., 2018; Srivastav et al., 2020) and health access (Ma et al., 2017). In the context of family caregiving, SEM has been used to understand family experiences in providing care, informing public policy, and proposing better schemes of provision (Bowlby & McKie, 2019; Talley & Crews, 2007). The priority is to ensure the sustainability of family caregiving, which is the aim of this article.

In developing SEM, I used findings from my previous studies about the constructions of older people's identity in regional ageing policies, local narratives on family caregiving, and the discourses of ageing used in multigenerational households in Bali. My research into the discourses of ageing and family caregiving at the macro- and micro-levels will deepen SEM and provide a more holistic understanding of family caregiving to create better policy. Discourse analysis as a tool in critical psychology has allowed me to question and challenge the dominant constructions of ageing and caregiving. Furthermore, it has enabled me to explore alternative discourses of family caregiving that have not been previously heard by policymakers. Thus, discourse analysis can be utilised as a guide to reform, where broadening the utilisation of discourse from social critiques can contribute to recommendations (Willig, 1999b)

The demographics of ageing in Bali

Bali is the province with the fourth-hightest porportion of older people in Indonesia (Sari et al., 2020), which has been caused by the successful implementation of the National Family Planning Program (Adioetomo & Mujahid, 2014). The proportion of older people in Bali in 2020 was 11.58 % (Sari et al., 2020); life expectancy for Balinese at birth was 72.7 years in 2010, which was higher than the national life expectancy. The ratio of

dependence of older people in Bali in 2018 was 17.68% (Sari et al., 2020), with a higher support ratio in rural areas (Adioetomo et al., 2018; Sari et al., 2020).

8.2.3 Balinese family caregiving model

SEM is mainly used to understand the risk and protective factors of much disease and violence (Centers for Disease Control and Prevention, 2015). It captures the interaction between individual, relational, communal and societal determinants of individual behaviour. For example, in the context of violence prevention, examining the interaction of individuals with their environment enables us to capture several factors that might put them at risk of or protect them from violence. In this study, I have modified the level of interaction between family, community, society and culture to understand opportunities and challenges in sustaining family caregiving at each level of interaction.

Data and methods

I used two sets of data in developing SEM for family caregiving in Bali (or similar). The first set was 16 regional ageing policy documents that were written between 2007 and 2018. All of the documents are available online from Indonesian government websites and can be freely used and distributed. The second data set was interviews with 11 multigenerational households in Bali. Participants were recruited through a hospital, community health services and private practices. Of the participants, 14 were members of the first generation (grandmother and grandfather), 19 of the second generation (son, daughter-in-law, and niece), and 16 individuals were third generation (grandchildren and grandchildren-in-law) co-residents. All first-generation participants experienced

declining health and received care from younger generations. This study was approved by Massey University Human Ethics Southern A Committee (No. SOA 19/69) and The Research Ethics Committee of Faculty of Medicine, Udayana University (No. 2809/UN14.2.2.VII.14/LP/2019).

Some dimensions of critique in discourse analysis by Parker (2013) were used to understand the ageing and family caregiving experiences in the Balinese context. Parker suggested four dimensions of critique (and associated methods) that concentrate on micro interactions and context (conversation analysis and ethnomethodology), experiences (narrative and thematic analysis), beyond interaction (critical discourse analysis (CDA) and Foucauldian discourse analysis) and the production of analytic phenomena (semiotic and political discourse theory) (Parker, 2013). My aims were to understand the micro and macro experiences of caregiving. Firstly, within the micro experiences I used thematic analysis, narrative analysis and positioning analysis in discourse analysis. Secondly, I used CDA to explore the macro experiences from the perspective of ageing policy.

My first study used *critical discourse analysis* (CDA) by Fairclough (1998) to illuminate the construction of older people's identity in regional ageing policies. Understanding these identity constructions provided an overview of how the government positions older people and their rights to private and public provision. I also learned here about the structures of public provision for older people in Indonesia. The second study used thematic analysis by Braun and Clarke (2006) to explore Balinese local knowledge which contains cultural, relational and physical aspects of family caregiving. Using narrative analysis by Stephens and Breheny (2013), my third study sought to understand the role of local knowledge in shaping personal narratives of caregiving. Here, I found that, while local knowledge informs caregiving functions, caregivers' and recipients' identities and family dynamics, it also reveals life circumstances that hinder families in

identifying themselves as good caregivers. In my fourth study, applying positioning analysis by Davies and Harré (1990), I tried to understand how Balinese older people position themselves and are positioned by others. Positioning analysis allowed me to see how subject positions provide certain rights, responsibilities, and expected behaviours in particular cultures and situations. I also analysed points of fracture in public-sector provision to understand family experiences in accessing social security schemes and national health insurance provided by the government and also the challenges in family caregiving. I combined findings from all four studies to identify the resources, opportunities and challenges in family caregiving at each level of interaction in SEM.

Resources in family caregiving

In providing care for older relatives, Balinese families are supported by resources that are available within the family, community, society and culture. These resources consist of the cultural, material and emotional support that is available for family caregiving.

Figure 3.

Balinese Family Caregiving Model

Culture
- Cultural values
- Local knowledge

Society
- Regional ageing policy
- Public provision at the national level

Community
- Close relatives
- Wider community (*banjar* and primary health providers)

Family
- Living arrangement
- Standard in providing care
- Family dynamic

Culture

Balinese cultural values explicitly encourage the family's responsibility to provide care for their older relatives. My previous study using thematic analysis found four themes related to Balinese local knowledge for family caregiving: caring as an intergenerational obligation, caring to meet needs, caring in harmony, and caring through social connections (Lestari et al., 2022). The Balinese have a patrilineal kinship system; therefore, caregiving is attached to the son and his immediate family (Geertz & Geertz, 1975). Caring as an intergenerational obligation describes how caring is spread over one generation to the next. Families understand caring as an activity related to their material and spiritual legacy. The material legacy regulates rights and responsibilities between parents and children. Parents are responsible for raising children and children are responsible for their parents' care in later life. Rights include material items (house, inheritance) and the sustainability of the family. Thus, having male offspring is imperative for the Balinese to maintain the family and the tradition of caring. *Karma* as a spiritual legacy motivates family members to provide care for reciprocation later in life.

Caring to meet needs is influenced by *catur asrama* (four developmental stages) that determines the role of older people in the Balinese community (Sukerni, 2018). In this, receiving care is a default position due to respect for older people. Caring in harmony is influenced by *tri hita karana*, or harmony, which is the Balinese core value in maintaining relationships (Sukarma, 2016). Thus, conflict avoidance and teamwork are very important in caregiving. Care through social connections is influenced by the *dadia* (family in one-temple and one-lineage systems) and *banjar* (part of a hamlet) that regulate caring in the private and public domains. *Banjar* is paramount in ensuring equality and harmony in the community.

Society

Indonesia's national ageing policy was established in 1998 to incorporate all older people in Indonesia. At that time, Indonesia also began implementing a regional autonomy system in which governments at the regency level gained more autonomy and independence (Bell, 2003). Through this regional autonomy system, local governments are expected to formulate public policy more appropriate to their area (Syaiku, 2002). Therefore, each region in Indonesia has its own regional policy that deals with ageing issues. Bali is one of provinces with an established regional ageing policy.

When Indonesia's National Social Security System was established in 2004, provisions for older people were integrated into it, including a pension scheme and national health insurance established ten years later. All policies related to ageing in Indonesia highlight the importance of family values in older people's care (Lestari et al., 2021).

Community

Caring through social connections illustrates caregiving in the community which is provided by close relatives and the wider community, consisting of *banjar* and primary health providers. Everyone in the community is family because a village in Bali consists of several *banjars* comprising two or more *dadia*. While the domestic economic, inheritance and child-rearing responsibilities are located in the private domain, any social support required during hard times (sickness, poverty, disaster) is considered the *banjar'*s responsibility (Geertz & Geertz, 1975; Lietaer & De Meulenaere, 2003). In my second study, I found that the *banjar* has important roles in acting as a bridge between government provisions and their implementation in the community—this includes

coordinating with the primary health provider, a government institution that delivers health care at the community level.

The primary health provider's role has been imperative for the community, especially after Indonesia adopted universal health coverage in which health services are provided from primary care to the hospital level. The primary health provider is expected to be an active agent delivering promotional, preventive, and curative programmes. For older people, the Ministry of Health initiated *Posyandu Lansia* which is organized by the community and supervised by the nearest first-level health facility (known as *Puskesmas*—Centre for Community Health) (Kadar et al., 2013). In, Bali *Posyandu Lansia* consists of women cadres selected from amongst the *banjar*. Alongside *Posyandu Lansia* are age-friendly *Puskesmas Santun Lansia* in several regions. These numbered 824 by 2015 (Kementerian Kesehatan Republik Indonesia, 2016).

Family

Most older people in Bali live in multigenerational households which provide for their physical, emotional and financial needs. Local knowledge prescribes standards for providing care which explicitly state that: (1) the son and his immediate family will act as the primary caregivers for older people; (2) they should cater to older people's needs; (3) they should create harmony and good relationships; (4) they should be integrated into the community and social network.

I noted several impacts of local knowledge on family dynamics in providing care. Firstly, despite the imperative role of the son as caregiver, the women in the family still contribute more than the men. Secondly, how families provide care should follow older people's needs and consider their requirements for psychological, spiritual and traditional treatment. In other words, older people have a central and strong position in family

caregiving. Thirdly, silence becomes a strategy for maintaining harmony. I found that caring in harmony, especially silence, is burdensome for family members, especially the daughter-in-law; however, it is also effective for avoiding conflict, resolving disagreements and managing stress.

Opportunities and challenges

In this section, I describe opportunities and challenges in family caregiving. Opportunities refer to factors that facilitate the sustainability of family caregiving. Challenges relate to material and social circumstances that hinder a family's provision of care for their older family members or that make the resources at the community and societal level under-utilized.

In terms of opportunities, there are two dominant discourses at the cultural level which I have labelled 'decline' and 'family responsibility' that were drawn on by families when talking about ageing and caregiving. At the community level, there is a local knowledge about trust and personal connection in accessing medical services that is prominent among older people and families that could facilitate the interaction between the family and health providers.

There are some challenges that are faced by the families in providing care, both in the private and public domains. These illuminate alternative discourses that must be heard to create better ageing policy. My argument is that if there is less attention on these alternative discourses, they can, in the long run, constrain the sustainability of family caregiving because families will have insufficient support in exercising their responsibilities. I will explain about these opportunities and challenges further below.

Figure 4.

Opportunities and Challenges in Family Caregiving in Bali

	Opportunities	Challenges	
Culture	Decline discourse Family responsibility	Poverty Women marginalization Sandwich generation Labour force Children migration	Family
Community	Trust Personal connection	Inequality Limited coverage of provisions Limited services of primary health-care providers	Society

Opportunities: within culture and community

Balinese local knowledge and cultural values around ageing and caregiving support the 'decline' discourse. Being cared by their families becomes the default position for older people and confirms the family's obligation. In addition, the concept of *catur asrama* supports disengagement in later life, with older people transferring responsibility to the younger generation and letting them take the lead in social roles. I argue that these ways of thinking — "caring by default", "obligated to care" and "transfer responsibility"— become critical ingredients in the sustainability of family caregiving, which position older people as individuals who need care in their later life and the younger people as individuals who are responsible to provide care.

Older people are also more dependent on their family's ability to provide care than on public provision. Here, the discourse about 'family responsibility' has become a dominant discourse that could be heard by the government. When direct provision for

older people is limited, thinking about providing for families who care for their older relatives could strengthen the capability of those families to provide care. Without this, limited support in both domains—public and family—may burden the family (Kane, 1985). It is not desirable that the family value becomes an obligation that people must escape.

Trust in health personnel and personal connections with a health provider will increase the utilisation by older people and their families of health services. The utilisation of health services and national coverage will support and facilitate families to meet the needs of their older family members. On the other hand, if a family with scarce resources and personal connections delays seeking treatment, the result will be unmet needs.

Challenges: within the family and society

Philosophically, local knowledge is developed to facilitate a community to face any life challenges. However, the sustainability of local knowledge is not about its stability but about the ability of local knowledge to adapt to the changes and challenges in providing care. I found two types of stories that do not fit with local knowledge. Firstly, poverty is the biggest challenge for a family in providing care for older relatives. Even though public provision is made by the government for the poor and nearly-poor, the workplace issues faced by the younger generation means that caregiving sometimes must take second place—the alternative is the loss of the family's income from unpaid leave to provide care for older relatives. Secondly, in terms of the emotional task, harmony becomes the most important value for the Balinese in maintaining relationships, as it does in providing care. However, there is always conflict in every relationship, whether small or large, implicit or explicit, resolved or unresolved. The positioning of women becomes crucial in this

emotional domain. Despite women's positioning changing in the public domain, it remains stable and quite marginalised in the context of family relationships and the patrilineal kinship system. Women are expected to fulfil their responsibilities as primary caregivers, despite their roles being undervalued and invisible.

In terms of providing physical care, I found three fractures in providing care: the sandwich generation, combining working and caring, and children's migration. These fractures can be a challenge for families providing care, but they may be tackled if the family has a large enough support system. Examples are teamwork, flexible working hours, hiring helpers, and utilising information technology. However, sibling conflict and blue-collar employment will reduce the ability of the family to meet the needs of older relatives.

Some scholars argue that the social security system for older people in Indonesia is fragmented and non-exclusive (Cook & Pincus, 2014; Djamhari et al., 2020; Ramesh, 2014). Only older people who retire from government institutions, the military and the public sector are eligible for the pension scheme, whereas older people who worked in the informal sector and the unemployed are not eligible. Those classified as poor or nearly-poor are supported by cash transfers or other social security schemes (Cook & Pincus, 2014; Ramesh, 2014). Similar approaches are applied to the national health insurance. Consequently, the 'missing middle' becomes problematic in achieving universal coverage (Agustina et al., 2019).

Limited coverage that leaves families out-of-pocket is evident when older people and family members talk about public provision: limited coverage through the limited services offered by the national health insurance. Most of the limitations are related to limited budget. Indonesia spends very little on health and education (He & Tang, 2021). While some services are covered by the national health insurance, most are out-of-pocket.

For example, national health insurance does not support long-term care (LTC) or the total cost of family caregiving (Kementerian Kesehatan Republik Indonesia, 2016; Kristanti et al., 2018). Limited services include outpatient homecare due to the lack of competency within primary healthcare. Health services for older people are far from integrated and interdisciplinary (He & Tang, 2021; Noda et al., 2021). As a community health provider, *Puskesmas* personnel are not able to deliver their services for health education and homecare due to a lack of competency.

Moreover, the regional autonomy policy has given rise to inequality among the regions in terms of budgeting, distribution of resources, and the number, incentives for and the productivity of the healthcare workforce. Therefore, older people who live in underdeveloped regions do not have the same opportunities as those who live in better developed regions (Kadar et al., 2013). In addition, regional ageing policies very much echo the national ageing policy and most of the provisions for older people were developed at the national level (Do-Le & Raharjo, 2002). In Bali, *Posyandu Lan*sia provides health screening and additional nutrition for older people in the community. According to my study, there is some inequality in accessing the programme; there is a lack of implementation in regions with small budgets and resources.

8.2.4 The sustainability of family caregiving

Family caregiving is supported by Balinese cultural values and local knowledge (Lestari et al., 2022). Bali is a communal society: people rely on their community in resource distribution for individuals and families. It seems that the culture and community act as two supporting channels in sustainable family caregiving. However, there are some

challenges faced by family caregivers at the family and societal levels. What can be done to improve the regional ageing policy and promote family caregiving in Bali?

1. *Preventive programmes that accommodate a life-course perspective*. Those living in households with under 40% income (Maylasari et al., 2019) and with downward intergenerational transfer (Arifin & Ananta, 2016) illustrate other social problems faced by Indonesia: poverty, unemployment at the productive age, and the wide gap between family income and expenditure. These become structures that influence the ageing experience in Indonesia. To achieve a better outcome for ageing in Indonesia, preventive programmes must at least target the health, education and labour sectors.
2. *Financial, emotional, and social support that target families*. Financial support may be integrated with labour law about flexible working hours or paid leave for caregivers, (Kane, 1985; Martens, 2018; Minayo, 2021; Mudrazija & Johnson, 2020). Local government may utilize the community for emotional and social support. The role of cadres be included as 'shadow' caregivers who can provide assistance to, and act as a replacement for, the primary caregivers when needed. While this model of respite care has been modified in the USA (See. Kane, 1985; Mudrazija & Johnson, 2020), in Bali the volunteers may come from cadres who share similar *banjar*. Here, trust can be more easily developed between older persons, family and respite carers.
3. *Community integrated services*. Health services should be more holistic and accommodate interdisciplinary methods. These include strengthening the primary health provider's skills and knowledge to provide treatment for hospital outpatients. According to Noda et al. (2021), low to middle countries like Indonesia rely more on family and primary providers in elder care. However,

services are still fragmented, and an interdisciplinary approach is needed. Additionally, services may integrate spiritual-traditional approaches in meeting older people's needs.

8.2.5 Conclusion and limitations

This article illustrates the strong influence of culture in sustaining family caregiving in Bali, in which families can modify their decision-making and practice to make family caregiving sustainable. However, an informed policy is also needed to support these families. The strength of the Balinese is in their community structures and support. Thus, the policy should accommodate these strengths to fit the needs of the Balinese. My analysis is limited to older people with physical illness and family caregiving. Further study of the experience of older people in general or the younger cohort, who are believed to be more independent of family supports, will deepen our understanding of the sustainability of family caregiving in Bali. Further studies may include older people without families who are marginalised in the discussion about family caregiving and transnational family to recognise the impact of migration among younger generations.

Chapter 9 Final Discussion

The contents of this chapter return to the original research aims to summarise the main findings, and the contributions that have been made to the body of knowledge and the policy implications. Some limitations of the research and suggestions for future studies are also discussed.

9.1 Summary of findings

Four studies in this PhD project have demonstrated some major findings that related to ageing, family, and caregiving in multigenerational households in Bali.

To critically review the regional ageing policies in Indonesia and their impacts on older people's identity and caregiving practices

The policy study found that older people's identities are constructed in terms of "material ageing" and "cultural ageing" by the Indonesian regional ageing policies. The analysis showed that material ageing positions older people at the intersection of "decline" and "successful ageing" discourses, while cultural ageing positions older people's welfare at the intersection of "public responsibility" and "family obligation" discourses. In this study, combining critical gerontology and critical discourse analysis (CDA) provided opportunities to explore discourses and the discursive effects of those discourses to the macro and micro world of ageing. At the micro level, while the dominant discourse of "successful ageing" encourages older people to be healthy, it marginalises those who do not—or cannot— meet its criteria, undermining a rehabilitative approach as a policy priority. In addition, the rights of the family are overlooked, despite being a pivotal element of cultural ageing. At the macro level, eligibility requirements for state assistance

(due to budgetary constraints) ensure that elder care is often relegated to the private sphere, without support. Recommendations for policy improvement are discussed, including the recognition of families' rights and the importance of local cultural practices in providing care for older people. This focus on local cultural practice led to a second study on local knowledge.

To explore the cultural, physical, and relational aspects of multigenerational caregiving

The second study on the role of Balinese local knowledge found four themes related to multigenerational caregiving, namely "caring as intergenerational obligations", "caring to meet needs", "caring in harmony", and "caring through social connection". These four themes illustrated the cultural, physical, and relational (private and public spheres) of family caregiving. Local knowledge permeates everyday narratives on family caregiving in three ways: determining caregiving functions, constructing caregivers' and care-recipients' identities, and prescribing family relationships.

To understand the family narratives on caregiving in the interplay between personal and local narratives on local knowledge

Although important aspects of local knowledge were identified in study 2, it is also important to recognise that local knowledge is a dynamic system that can be modified and negotiated to enhance families' capabilities at different times and in different settings. The third study found that, while most family stories fit comfortably within the local narratives of Balinese multigenerational caregiving, some personal stories revealed life circumstances, such as poverty and the marginalisation of women, that do not allow the family members to identify themselves as virtuous caregivers. Paying attention to the

diversity of how local knowledge supports or hinders families is critical in order to provide appropriate supports to family caregivers. While the findings were local, both the second and third studies have contributed to the global discussion on family relationships, the role of social networks, and medical practices associated with ageing and policy.

To understand the dominant discourses on ageing and family caregiving in Balinese everyday talk

The fourth study found that the decline discourse in Balinese culture is of prime importance in positioning ageing and family caregiving. While the decline discourse is dominant, the concept of successful ageing is used to strengthen the positioning-discursive effects of the decline discourse. These findings contradicted previous research from different socio-cultural contexts which described pressure and shame among older people who could not achieve successful ageing ideals. However, within the younger generations, the successful ageing discourse has been drawn on to shape their stories about future ageing. These findings provided implications for policy and the importance of a life course preventive approach to facilitate ageing well among Balinese.

To develop a model of multigenerational caregiving based on the empirical findings in the previous studies

Lastly, synthesising the findings from discursive analysis into a socioecological model has deepened our understanding about ageing and family caregiving from the perspectives of family, community, society, and culture. Discourse analysis does not merely reveal the resources that families utilise in each level of interaction, but also reveals opportunities and challenges for the sustainability of family caregiving in Bali.

The strength of the Balinese is in their community structures and support. Thus, policy should accommodate these strengths to fit the needs of the Balinese.

9.2 Contributions to the literature, caregiving practice, and policy implications

The findings of this study have contributed new information about family caregiving in the context of multigenerational households and local knowledge. Their contributions to research agendas in the area of indigenous psychology, especially in Indonesia, and the implications for caregiving practice and policy development, are described below.

9.2.1 Contribution to literatures in family caregiving

This study has contributed to the family caregiving literature by providing new information about caregiving in the context of multigenerational households and the investigation of local knowledge in family caregiving. Previous research has mostly referred to multigenerational caregiving in terms of the Western notion of 'sandwich generations', which describes adult children providing care for their older parents and children at the same time (Patterson & Margolis, 2019). In this research, multigenerational caregiving is specifically related to traditional caregiving in a three-generation household. Accommodating the local context, this study has modified Orel and Dupuy' (2002) criteria with the Indonesian Demographic Health Survey's (DHS) definition—a household is defined as a person or a group of persons, related or unrelated, who live together in the same dwelling and share a common source of food (Dommaraju & Tan, 2014). This will include other ageing family members besides parents, such as siblings, aunts, or uncles, who live together—as is common in the Balinese context—and

type of caring for siblings that may become more important in the future as the population of older people without a partner or children increases (Patterson & Margolis, 2019).

While many studies have been conducted in the area of cultural values and family caregiving, most were focused on topics around obligations, filial piety, and reciprocity between parents and children. Exploring the role of local knowledge in family caregiving reveals the additional cultural, social and practical dimensions of caregiving.

9.2.2 Contribution to understanding types of local knowledge

Local knowledge consists of social and practical dimensions, including the natural environment, anthropology, social and political environments, agriculture, medicine, organization, and knowledge of persons, structures, and relationships (Antweiler, 1998). While there is much research on local knowledge in other disciplines, as already mentioned, research in the context of family caregiving is rare. Contributing to understanding local knowledge of family caregiving is this study's contribution.

In the context of Bali, for example, while there is abundant information and knowledge about Bali like culture, agriculture, socio-economic issues, and political studies offered by previous research or literatures that captured Bali in different historical frames, such as pre-colonial, the Dutch colonial era, centralization and decentralization eras in Indonesia (Connor & Vickers, 2003; Geertz & Geertz, 1975; Hauser-Schäublin, 2017; Lietaer & De Meulenaere, 2003; Warren, 1995), little is known about Balinese family caregiving. However, these previous studies have provided a general framework to understand socio-cultural aspects of the Balinese life that is rooted in their agricultural society.

The third study has demonstrated the positioning of local knowledge as a dynamic system that can be negotiated and reshaped to enhance families' capabilities at different

times and settings. Narrative analysis as a research method has facilitated a different way of thinking about local knowledge and culture, in which local knowledge was not always followed; it can be questioned and resisted by family when local knowledge hindered or provided burdens for a family in providing care. These local expectations are not static and free from reconstruction and, instead local knowledge must be continuously negotiated in dealing with change and challenges.

9.2.3 Contribution to a research agenda on Indigenous Psychology in Indonesia

In early January 2022, I attended an online presentation by one of the notable Professors in Psychology in Indonesia – Professor Johana E.P. Hadiyono. Her speech highlighted the urgency of developing theory and research that accommodates cultural values both at the national and regional levels. Until now, research in Psychology conducted by Indonesian scholars has not really accommodated local values; in fact, because of the diversity of Indonesia, more could be done if we have a sensitivity to, interest in, and willingness to explore this area of research. So that, newly developed psychological interventions, could meet the needs of Indonesian.

Her speech was promising in two ways. First, this PhD study is an example of how local knowledge has been included in research to understand ageing and family caregiving in the context of multigenerational households in Bali. The findings are expected to support caregiving practice and to provide implications for future policy that will be described in the next section. Second, based on my experiences as a psychologist who has been educated and trained in a national institution, it was true that Western literatures and approaches were dominant. The idea of developing Indigenous Psychology is not something new in Indonesia and globally, yet the tradition to utilise Western approaches in our curriculum continues when I work as a lecturer for a national university

in Bali. This PhD study will definitely enrich research and theory in this area. However, my approach to local knowledge and indigenous study is not exclusive. I understand local knowledge as knowledge that is not necessarily opposite or different from general knowledge, Western approaches, or theories that I have learnt in my formal education, instead both local and global knowledge should be integrated to support the well-being of older people and their families.

9.2.4 Contribution to caregiving practice

The second study provides information about cultural, physical, and relational aspects associated with multigenerational caregiving in Bali. These include information about family motivation, family teamwork, decision-making, conflict resolution, stress management, practical tasks in meeting older people' needs, spiritual needs, traditional approaches, and social supports provided by close relatives and the wider community. I summarised these research findings as a supporting material (a virtual self-help booklet) for caregivers.

9.2.5 Contribution to policy development

This study has contributed to policy development in several ways. Firstly, the policy study provided some recommendations around: (1) the recognition of families' rights, (2) the importance of local cultural practices in providing care for older people, and (3) the dominance of a global "successful ageing" discourse across the policies. In my research journey, these three recommendations were explored in detail in my second, third, and fourth studies.

While the regional ageing policies emphasise the role of family in providing care for older people, the government's role and support of the family are not clearly

articulated. Using narrative analysis has illuminated social circumstances around family caregiving that provided some policy implications. Two social circumstances highlighted in the third study were poverty and the marginalisation of women. Support for the family should be considered as a government priority because nearly 44 percent of older people live in households with the lowest 40 percent of expenditure (Maylasari et al., 2019). Furthermore, shifting constructions of caregiving toward a structured, valued, and accountable activity could transfer caregiving into the public domain where carers may be compensated by incentives based on their time and energy spent in providing care, and both men and women could participate equally in the process (Weinberg, 1999).

My critical review of regional ageing policies in Indonesia suggested that they have not fulfilled the aims of the regional autonomy system, but rather tended to echo the national ageing policy and neglected regional needs and conditions. In my second study, I argued that studying local knowledge in the area of ageing and family will be beneficial for Indonesia with its autonomous regional system. Local knowledge can be applied to contextualised ageing policies, interventions, and healthcare for the regions that are diverse in terms of their kinship systems and social structures. Studying local knowledge will assist in determining appropriate resources to support family wellbeing in particular regions. Thus, similar studies may be done in other regions in Indonesia.

My fourth study has challenged the dominance of global "successful ageing" in the regional ageing policies. Findings showed that at the micro level, decline discourse is still prominent and successful ageing is used to strengthen the positioning-discursive effects of the decline discourse. I argued that rather than focus such successful ageing ideals on the behaviour of older people who now need care, it will be fruitful to integrate a preventive approach across social policies to lifespan development that facilitates ageing well for future generations. Lastly, the socio-ecological model provides

information about opportunities and challenges in maintaining the sustainability of family caregiving in Bali. The information could be a reference point in developing a future policy that accommodates the needs of older people and their caregivers. For example, since the strength of Bali is in its social structure and systems, developing community-integrated services for older people would be suitable.

9.3 Study limitations

The reflection about the research process was conducted from the beginning until the end of the research journey. In doing so, the reflective journal was not organised systematically by date or month or specific research process but through critical insights that were revealed during the data collection, data management, data analysis, and research report and were written incidentally by the researcher. Both physical and electronic diaries were used to record the insights. Insights can be reflective thinking about the participants' responses, research procedures, or evolving perceptions regarding specific literature, theoretical frameworks, and methodology. Since I am a visual person, the majority of the reflective thinking is stored in physical diaries with colourful ink, symbols, illustrations, mind maps, and sticky notes. For electronic diaries, the Notes application, Word, and NVivo were used and appear as family summaries, genograms, mind maps, process flowcharts, things to do, things that have been done and the things that could have been done better, and reflective thinking about specific theories or methods. Some of these resources were used as a guide in the research process; some became the main data, but some were positioned as sources of self-awareness during the research process.

Self-awareness provided opportunities to challenge my personal assumptions, beliefs, and values during the research process. It facilitated critical thinking, curiosity, and conceptual thinking and, at the same time, revealed the limitations and challenges in conducting the research. Five such self-awareness themes emerged. Firstly, the nature of illness in older people seems to be diagnosed in many ways, is medically complex, and sometimes entails comorbidities so that focusing data collection in a geriatric outpatient clinics or hospital wards is not sufficient since older people could be accessing medical attention from other places. Thus, in the future, hospital access should allow the researcher to recruit participants from more than one outpatient clinic or use broader community recruitment, such as primary health providers and older people's community engagement programmes. Recruiting participants from broader community settings would be beneficial in two ways. First, according to Noda et al. (2021), developing countries like Indonesia rely more on family and community primary providers in older people's care. For example, doing participant recruitment through *posyandu lansia* (community health services for older people) which is organized by the community and supervised by the nearest first-level health facility. Here, there would be a chance to meet more potential participants compared to the hospital setting. Second, further study may include healthy older people, for whom recruitment within the community setting will be more promising since the majority of older people in Indonesia live in the community and access the government's programmes at the community level.

Secondly, it was challenging to conduct narrative interviews with people who live in poverty, have low levels of education, and are reluctant to respond due to family conflicts. The data collection process provided an opportunity for me to learn how to approach people with these characteristics or to modify the method in order to elicit their experiences. Based on my experiences, initial meeting with the family members were

important in order to develop and maintain trust and relationship with all the participants. Gaining trust is imperative, especially from the household head who usually becomes the role model for the family members. This influenced their trust of the research and increased their cooperation so that it became easier for the research to elicit participants' stories during the interview process. In some cases, I modified the interview schedule, for example, such as starting the interview with everyday talking about their jobs, hobbies, or social activities, so that the questions were less intimidating; following their activities while conducting interview; or observing the family interactions during the home visits. The informal setting sometimes revealed more data than what had been planned in the interview schedule.

Thirdly, greater abundance is part of the context of the literature review and methodology. Reading relevant literature has increased my understanding of the nature of specific methods. For example, in the confirmation report, I was planning to do the research using critical narrative analysis (CNA) by Souto-Manning (2014), but, as I journeyed, it has been replaced by positioning-discursive analysis as soon as I understood that action research is an element that would be missing in this study if I had followed Souto-Manning's (2014) analysis approach. Nevertheless, an additional analysis was conducted to support SEM but not as a published article for it will be included in a further study.

Fourthly, the most reflective journey is learning to share ideas systematically. The supervisors' roles were critical as coaches in developing and polishing my academic writing skills. At the same time, this study has provided opportunities for me to learn about how to present research findings, balancing analysis and the inclusion of quotes, which have sometimes been mixed up with knowledge and theories known prior to the analysis.

Lastly, it was quite challenging to respond to reviewers' and editors' feedback and comments about the articles, especially for the third study. One of the most significant feedback themes was about the explanation of the study context and how to present my approach on local knowledge for international audiences. These included Balinese cultural views and values that resonate in local narratives on ageing and caregiving. My study about local knowledge on multigenerational caregiving has brought together some related theories. The findings are explained by a broad range of theories from critical gerontology, family caregiving, Balinese culture, gender roles, feminism, and social support. The art is how to be sensitive to the diversity and authenticity, so that we can use the findings to enhance families' capabilities at different times, settings, and cultural contexts. At the same time, an ability to integrate local and general knowledge is needed so that we can contribute to the global discussions about ageing and family. These seem to be two competencies that I have to learn more. Other research limitations have been stated in each of the research articles.

9.4 Further initiatives: The positioning of research and policymaking

Willig (1999b) summarised Wodak's idea about three important elements of discourse analysis that can act as a guide to reform:

> "First, we make transparent inequality and domination. Second, we propose possibilities of change. Third, we identify the limits of possible emancipation through the new pattern of discourse alone" (Willig, 1999b, p. 17)

Later, Willig (1999b) added one more element—synergy—that is imperative to make sure that the recommendation is able to be implemented. Synergy includes teamwork between the policymakers, politicians, academics, and professionals in promoting changes. The

goal is not for radical change but compromise. It seems impossible to expect a radical change in a short time because, in facilitating change, we deal with a group of people who uphold the status quo and have the power and opportunity to reform policy. This group does not usually interact with the people themselves. During the research journey, I did policy advocacy that appears in research dissemination, workshops, and in the sharing of articles to several policymakers and relevant professional associations, including the Indonesian Parliament, the Ministry of Women Empowerment and Children Protection (MoWECP/KemenPPPA), the Indonesian Ministry of National Development Planning (Bappenas), the Indonesian Psychological Association (Himpsi), and local nongovernmental organisations (NGOs).

My engagement with the Indonesian Parliament started in early 2020 when I went back to Indonesia for data collection. A team from the Indonesian Parliament visited Udayana University, a government university in Bali where I work as a lecturer, to do a preliminary study about ageing experiences from sociological and psychological perspectives in several regions in Indonesia as part of the redesign of the national ageing policy. At that time, I had just finished my first study on regional ageing policies and was fortunate to have opportunities to share my findings with the policymakers. A year later, in early 2021, when the article from the first study was published, I shared the article link with the Indonesian Parliament. The article is expected to contribute as a supplement for redesigning the ageing policy in Indonesia.

The PhD journey is not merely about doing research, and writing articles and publishing them, but is also about the opportunities to disseminate research to the wider community and audiences through promotional and education programmes. In June 2020, my video about intergenerational relationships in family caregiving during the COVID-19 pandemic was selected as the third winner of a video competition that was organised

by MoWECP to celebrate the National Day for Older People. The video contains messages that promote the importance of generational bonding for older people's wellbeing during the pandemic. Also, in September 2021, I had an opportunity to share knowledge about mental health and family support for older people to the community teams and the primary health professionals in four villages in Jogjakarta and Bali as part of the Bappenas programme in developing community-integrated services for older people. Lastly, in October and December 2021, I actively disseminated knowledge about my research findings to educate community teams, NGO volunteers, and health professionals about family caregiving, local knowledge, ageing policies, and promotion of the importance of wellbeing among older people. These presentations have meant further opportunities to collaborate with other scholars at national and international levels, namely with Professor Norah Keating as a United Nations representative, New Zealand scholars, and a family caregiving pilot project in Bali initiated by Bappenas and Emblemed Heart, United States.

Within local communities, a virtual self-help booklet (see. Appendix 5.4) was developed and shared with the research participants in order to empower and support them in family caregiving. For example, I myself felt supported by the booklet when my mother-in-law had hip surgery in late 2021 and needed long-term care and family teamwork afterwards. However, these initiatives are just beginning, and there are many opportunities and channels that can be used in the future to allow the voices of the research participants to be heard by the policymakers. Other potential further studies have been discussed in detail in each of the articles.

9.5 Conclusions

This PhD study has demonstrated a dialogue between macro and micro perspectives in understanding ageing, family, and caregiving. At the macro level, study of regional ageing policies in Indonesia was the first to critically reviewed the constructions of older people's identities in Indonesian policies and linked these constructions to the rationale behind the policy priorities, public provisions, and the ageing world at the micro level. The findings provided some policy implications that have been explored in the second, third, and fourth studies. All of the findings in those studies have supported my idea about the urgency to develop contextualised ageing policies that accommodate the needs of older people, family caregivers, and local values.

Situated in the context of multigenerational households in Bali, the findings related to local knowledge have broadened our understanding of ageing and family caregiving from different cultural contexts. Local knowledge played an important role in the ways family members provided care for older relatives. Accommodating this cultural knowledge into general knowledge will enrich caregiving practices, both in the private and public spheres. However, local knowledge must be understood as a dynamic system that may be reconstructed and reshaped in response to changes and challenges so that future policy can be more attentive to the potential financial and social implications that arise in caregiving, such as poverty and the marginalisation of women. The Balinese family caregiving model provided information about resources that can be utilised by family caregivers at the family, community, societal, and cultural levels. It also revealed opportunities and challenges in sustainable family caregiving that may be considered by future policies.

The study findings have challenged policy priorities, previous research and literature in these areas. The discursive effects of the "successful ageing" discourse were

less impactful at the micro level. However, the younger generations have started to draw on the "successful ageing" ideal when they talked about their future ageing. Accordingly, preventive approaches should be systemic and adopt a life-course approach, to integrate several policies (e.g., health, educations, economics, labour) which should be promoted earlier in the life-course. Thus, there will be more Balinese and Indonesian in general, who have an opportunity to be ageing successfully in the future.

While many findings showed some variation from previous research in ageing and family caregiving, the goals of my study were far from making differentiations, excluding local from the general, nor prioritising local above the general. Instead, integrating the local to general becomes a never- ending task that will provide appropriate supports for family and our older generations. Therefore, while local, the findings are expected to provide contributions to the global discussion on ageing, family, and caregiving.

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Appendices

Appendix A. Ethics and approval letter for institutional access

Massey University Ethical Approval

Date: 18 December 2019

Dear Diah Lestari

Re: Ethics Notification - **SOA 19/69 - Multigenerational caregiving for older people in Bali**

Thank you for the above application that was considered by the Massey University Human Ethics Committee: **Human Ethics Southern A Committee** at their meeting held on **Wednesday, 18 December, 2019**.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand **T** 06 350 5573; 06 350 5575 **F** 06 355 7973
E humanethics@massey.ac.nz **W** http://humanethics.massey.ac.nz

Udayana University Ethical Approval

KOMISI ETIK PENELITIAN (KEP)

FAKULTAS KEDOKTERAN UNIVERSITAS UDAYANA/

RUMAH SAKIT UMUM PUSAT SANGLAH DENPASAR

Jalan P. Serangan Denpasar Bali (80114) Telp. (0361) 227911-15 (P.227), (0361) 244534

Nomor : 2895 /UN14.2.2.VII.14/LP/2019
Lampiran : 1 lembar
Perihal : Penyerahan ***Ethical Clearance***

Kepada Yth

Made Diah Lestari, S.Psi.,M.Psi

di-Tempat

Dengan hormat,

Bersama ini kami menyerahkan *Ethical Clearance*/Keterangan Kelaikan Etik Nomor: 2809/UN14.2.2.VII.14/LP/2019, tertanggal 08 Nopember 2019

Hal-hal yang perlu diperhatikan :

1. Setelah selesai penelitian wajib menyerahkan 1 (satu) copy hasil penelitiannya.
2. Jika ada perubahan yang menyangkut dengan hal penelitian tersebut mohon melaporkan ke Komisis Etik Penelitian (KEP) FK UNUD/RSUP Sanglah Denpasar

Demikian kami sampaikan, atas perhatian dan kerjasamanya kami ucapkan terima kasih.

Denpasar, 19 - 11 - 2019
Komisi Etik Penelitian (KEP) FK UNUD/
RSUP Sanglah Denpasar
Ketua,

Prof. Dr. dr. I Gde Raka Widiana,Sp.PD-KGH
NIP. 195607071982111001

Tembusan :

1. Koordinator Program Studi Psiologi Fakultas Kedokteran Universitas Udayana
2. Ka. Dinas Kesehatan Provinsi Bali
3. Arsip.-

RESEARCH ETHICS COMMITTEE
FACULTY OF MEDICINE, UDAYANA
UNIVERSITY/SANGLAH HOSPITAL DENPASAR

Jalan P. Serangan Denpasar Bali (80114) Telp. (0361) 227911-15 (P.227), (0361)244534

ETHICAL APPROVAL
FOR THE USE OF HUMAN SUBJECTS

No : 2809/UN14.2.2.VII.14/LP/2019

The Research Ethics Committee of Faculty of Medicine, Udayana University/Sanglah Hospital, after conducting review based on Nuremberg Code and Helsinki Declaration of the research protocol entitled :

"Multigenerational Caregiving for Older People in Bali"

Submitted on 10 October, 2019 by Made Diah Lestari, S.Psi.,M.Psi.

has hereby declared that the above protocol whereby human subjects will be used, has been approved for implementation.

Please note that this *ethical approval* is for the period of 1 year since approved date.

Should there be any modification and/or extension of the study, the Principal Investigator is required to submit the protocol for approval. The progress and final summary reports should be submitted to The Research Ethics Committee, Faculty of Medicine. Udayana University/Sanglah Hospital.

Denpasar, 08 November 2019
Research Ethics Committee,

Prof. Dr. dr. I Gde Raka Widiana, Sp.PD-KGH
NIP. 195607071982111001

Sanglah Hospital Letter for Institutional Access

KEMENTERIAN KESEHATAN RI
DIREKTORAT JENDERAL PELAYANAN KESEHATAN
RUMAH SAKIT UMUM PUSAT SANGLAH DENPASAR
Jalan Diponegoro Denpasar Bali (80114)
Telepon. (0361) 227911-15, 225482, 223869, Faximile. (0361)224206
Email : info@sanglahhospitalbali.com, Website : www.sanglahhospitalbali.com

Nomor: LB.02.01/XIV.2.2.1/ 6845 /2020 — 21 Pebruari 2020
Lamp : Surat Ijin
Hal : **Ijin Penelitian**

Kepada yth:
Dekan Fakultas Kedokteran Universitas Udayana
d/a Jl PB Sudirman Denpasar

Sesuai dengan surat Dekan Fakultas Kedokteran Universitas Udayana tertanggal 18 Desember 2019 Nomor: 9307/UN14.2.2/LT/2019 tentang perihal diatas, dengan ini kami memberikan ijin kepada

Peneliti Utama : Made Diah Lestari, S.Psi.,M.Psi
Departemen : Psikologi Fakultas Kedokteran UNUD

Untuk Melakukan Penelitian Di RSUP Sanglah Dengan Judul

Multigenerational Caregiving For Older People In Bali

dari tanggal **21 Pebruari 2020 s/d 2 April 2020** (dapat diperpanjang sampai dengan masa berakhir *Ethical Clearance*/7 November 2020) yang dikeluarkan oleh Komisi Etik FK UNUD/ RSUP Sanglah Denpasar), dengan ketentuan sebagai berikut:

1 Ijin Penelitian diberikan hanya untuk penelitian yang dilakukan di RSUP Sanglah
2 Melakukan penelitian sesuai dengan peraturan yang berlaku di RSUP Sanglah Denpasar
3 Menyimpan Informed consent penelitian untuk pemeriksaan sewaktu – waktu dan menyerahkan laporan perkembangan penelitian yang disyaratkan oleh Komisi Etik Penelitian FK UNUD/RSUP Sanglah dan Bagian Diklit RSUP Sanglah Denpasar (formulir laporan dapat diambil di Bagian Diklit)
4 Mengumpulkan hasil penelitian (soft copy) ke Bagian Diklit RSUP Sanglah Denpasar

Berdasarkan SK Dir.Utama RSUP Sanglah Denpasar Nomor HK.02.04/IV.C11.D.23/8171/2017 tertanggal 3 April 2017 kami informasikan pula biaya pelaksanaan penelitian di RSUP Sanglah yaitu sebesar Rp 2000 .000 /proposal (Dua juta rupiah/orang). Demikian kami sampaikan, atas perhatian dan kerjasamanya kami ucapkan terima kasih

A/n. Direktur Utama
Kepala Unit Penelitian Klinik

drg. Anik Udyani Sandy, GDCD, MHSM
NIP 196501191993122001

Tembusan (foto copy):
1 Ka Instalasi Geriatri RSUP Sanglah Denpasar
2 Yang Bersangkutan

Letter approval doing research in the community

PEMERINTAH PROVINSI BALI
DINAS PENANAMAN MODAL DAN PELAYANAN
TERPADU SATU PINTU
Jalan Raya Puputan, Niti Mandala Denpasar 80235
Telp./Fax (0361) 243804/256905
website: www.bpmp.baliprov.go.id e-mail: bpmp@baliprov.go.id

Nomor : 070/11277/Izin C/DISPMPT
Lampiran : -
Perihal : Surat Keterangan Penelitian

Kepada
Yth: 1. Walikota/Bupati
2. Kepala Badan Kesbang Pol Kota Denpasar
3. Kepala Badan Kesbang Pol dan Linmas Kabupaten Tabanan
4. Kepala Badan Kesbang Pol dan Linmas Kabupaten Jembrana
cq. Kepala DPMPTSP Kab/Kota Se-Tempat
di -
Tempat

I. Dasar
1. Peraturan Gubernur Bali Nomor 63 Tahun 2019 Tanggal 31 Desember 2019 Tentang Standar Pelayanan Perizinan pada Dinas Penanaman Modal dan Pelayanan Terpadu Satu Pintu.
3. Surat Permohonan dari Dekan Fakultas Kedokteran Universitas Udayana Nomor B/981/UN14.2.2/PT.01.4/2020, tanggal 24 Februari 2020, Perihal Permohonan Izin Penelitian.

II. Setelah mempelajari dan meneliti rencana kegiatan yang diajukan, maka dapat diberikan Surat Keterangan Penelitian kepada:

Nama	:	MADE DIAH LESTARI
Pekerjaan	:	PNS Dosen, Program Studi Psikologi, Fakultas Kedok
Alamat	:	Jalan Padma, Br. Bantas Peguyangan Kangin, Denpasar Utara, 80115, Bali
Judul/bidang	:	Multigenerational Caregiving for Older People in Bali
Lokasi Penelitian	:	Kabupaten/Kota di Wilayah Provinsi Bali
Jumlah Peserta	:	1 Orang
Lama Penelitian	:	6 Bulan (25 Feb 2020 s/d 01 Jul 2020)

III. Dalam melakukan kegiatan agar yang bersangkutan mematuhi ketentuan sebagai berikut:
a. Sebelum melakukan kegiatan agar melaporkan kedatangannya kepada Bupati/Walikota setempat atau pejabat yang berwenang
b. Tidak dibenarkan melakukan kegiatan yang tidak ada kaitanya dengan bidang/judul Penelitian. Apabila melanggar ketentuan Surat Keterangan Penelitian akan dicabut dihentikan segala kegiatannya.
c. Mentaati segala ketentuan perundang-undangan yang berlaku serta mengindahkan adat istiadat dan budaya setempat.
d. Apabila masa berlaku Surat Keterangan Penelitian ini telah berakhir, sedangkan pelaksanaan kegiatan belum selesai, maka perpanjangan Surat Keterangan Penelitian agar ditujukan kepada instansi pemohon.
e. Menyerahkan hasil kegiatan kepada Pemerintah Provinsi Bali, melalui Kepala Dinas Penanaman Modal dan PTSP Provinsi Bali dan Kepala Badan Kesatuan Bangsa dan Politik Provinsi Bali

Denpasar, 25 Februari 2020
a.n. GUBERNUR BALI
KEPALA DINAS PENANAMAN MODAL DAN PTSP PROVINSI BALI

DEWA PUTU MANTERA
Pembina Utama Muda
NIP. 19621231 198503 1 192

Tembusan kepada Yth :
1. Kepala Badan Kesbangpol Provinsi Bali
2. Yang Bersangkutan

Appendix B. Data Collection

Interview schedule

English version

The interview guideline is prepared for three-generations who live under the same household. Thus, there are interview questions for older person, adult children as the 2nd generation, and grandchildren as the 3rd generation in the family. The interview could be planned in two until three meeting with the informant.

1. **Preparing for older person (the 1st generation of the family as a care recipient)**

Exploring experiences as an older person in Bali

a. Can you tell me about experiences of living as a Balinese? Begin where you like and include whatever you want.
b. How about now in your current age?
c. What is the difference between the past and now?
d. How it feels to be you, here living in Bali? Tell me more about that.
e. What are your best experiences of being person in your age in Bali?
f. What are your worse experiences and the greatest challenge for you?

Exploring experiences as a care recipient

c. Can you tell me about your medical condition and its impact to your life?
d. Can you tell me about your experiences as a care recipient? Begin where you like and include whatever you want.
e. Can you describe how your life affected by the caregiving?
f. Can you describe how your family relationships affected by the caregiving?
g. Can you tell me more about the greatest challenges that your family have experienced around the family support and caregiving?
h. Tell me more about decision making process in the family regarding support and care for you.
i. How they handle disagreement?
j. What are your best memories about receiving care? Tell me more about that.

Exploring values in caregiving

a. Can you tell me more about your expectations on family support (type of support and information that you need)?
b. Tell me about your experience when your family try to meet the expectation.
c. Can you tell me about your experiences in the past as a caregiver to your parents? Begin where you like and include whatever you want.
d. Can you describe the difference between your experiences and your descendant in providing support for older people in the family?

2. **Preparing for adult children (the 2nd generation of the family, household's member, and provide care)**

Exploring experiences in providing care

a. Tell me more about how your parent's medical condition impacts your life? We would like to know more about your experience.
b. Can you tell me about your experience in providing care to your parents? Begin where you like and include whatever you want.
c. Can you describe how your life affected by the caregiving?
d. Can you describe how your family relationships affected by the caregiving?
e. Can you tell me more about the greatest challenges that your family have been experienced around the family support and caregiving?
f. Tell me more about decision that your family have made regarding your parent's care.
g. How you and the other family members handle disagreement?
h. What are your best memories about providing care? Tell me more about that.

Exploring values in caregiving

a. Can you tell me why caring for older parent is important for your family? Tell me more on how you meet that value?
b. Can you tell me more about your parent's expectation? Tell me about your experience when you try to meet the expectation.
c. Can you describe your parent's reaction regarding support provided? Tell me more about that.
d. Can you tell me about your expectation to your children in providing care for you in the future?

3. **Preparing for grandchildren (the 3rd generation of the family, household's member, and provide care)**

Exploring experiences in caregiving

a. Tell me more about how your grandparent's medical condition impacts your life? We would like to know more about your experience.
b. Can you tell me about your experience in providing care to your grandparents? Begin where you like and include whatever you want.
c. Can you describe how your life affected by the caregiving?
d. Can you describe how your family relationships affected by the caregiving?
e. Can you tell me more about the greatest challenges that your family have been experienced around the family support and caregiving?
f. Tell me more about decision that your family have made regarding your grandparent's care.
g. How you and the other family members handle disagreement?
h. What are your best memories about providing care? Tell me more about that.

Exploring values in caregiving

a. Can you tell me why caring for grandparent is important for your family? Tell me more on how you meet that value?

b. Can you tell me more about your grandparent's expectation? Tell me about your experience when you try to meet the expectation.
c. Can you describe your grandparent's reaction regarding support provided? Tell me more about that.

IMPORTANT for the interviewer

Ethical consideration research with family

Disclosing information (resource: Code of Ethics for Psychologist working in New Zealand, article 1.6.10 Privacy and Confidentiality)

Psychologists and researcher recognise that there are certain exceptions and/or limitations to non-disclosure of personal information, and particular circumstances where there is a duty to disclose. Some the conditions are:

1. Urgent needs: Where a situation arises when it is impossible or impracticable to seek consent to disclosure in time to prevent harm or injury to the person, persons, family, or community group.
   Comment: In these circumstances psychologists and researcher should report to the person, persons, or the person authorised to represent his/her interests, as soon as practicable, any information disclosed to a third party.
2. Legal requirements: Where a psychologist and researcher is compelled by law to disclose information given by a client or research participant.
   Comment: For example, mandated assessments and treatments, court order to disclose information from files or other records. In such circumstances psychologists and researcher inform the person or persons in advance, where possible, of such limitations to confidentiality that may exist.
3. Client or public safety: Where a psychologist/researcher believes that non-disclosure may endanger a client, research participant or another person but is denied permission to disclose, the psychologist/researcher exercises professional judgement in deciding whether to breach confidentiality or not.
   Comment: Psychologists and researcher should consult with senior colleagues before making their decision. Ultimately, they must be able to justify the decision made.

Psychologists/researcher, in disclosing information as allowed, provide only that information which, in their opinion, is accurate and relevant to the situation. Comment: Psychologists/ researcher should ensure that any limitations of the information provided are made clear to the recipient.

Prevent family conflict caused by the interview

Important: Research may become a trigger for further conflict and domestic violence

1. Using compromise language: e.g., **avoid** words 'abuse', 'neglect', or 'family conflict'
2. Instead of asking the conflict, the researcher should emphasis on how the family deal with decision making, problem-solving, and disagreement. The researcher is

interested in the strategies used by the family members to resolve differences and conflict.

3. Participants are fully informed of the implications of disclosure and the level of confidentiality that can be guaranteed (Berry, 2009)
4. Modify the interview guideline for each of family members. This prevents that they are providing information about one another (Margolin et al., 2005)
5. Control of access to sensitive information to the other family members (Margolin et al., 2005)

What can the researcher do when conflict and disagreement arise during the interview?

1. Avoid double roles: a researcher and psychologist (Eide & Khan, 2008; Hohmann – Marriott, 2001; LaRossa et al., 1981)
2. But the researcher is responsible for the family debriefing at the end of the session and at the end of a study, and to talk with the family about some of the emotional issues that were raised (LaRossa et al., 1981). If the disagreement still occurred, these some steps that could be followed by the interviewer:
    a. Assessing participants need and ability to debate and deal with these conflicting issues. The possibility of blending their stories and perspectives sometimes brought benefits to the family members and reduced the conflict level between them.
    b. Being an empathetic listener who does not offer advice or solutions to problems and who refrain for making moral judgements even when opinions challenge our own beliefs and understandings (Eide & Kahn, 2008)
    c. Asking in a neutral way if participants would like to comment further on a discussion in which there is obvious disagreement. The task of the interviewer was recommended to avoid taking sides (Voltelen et al., 2018)

Indonesian version

Panduan wawancara disipakan untuk anggota keluarga multigenerasi yang tinggal bersama dalam satu rumah. Karenanya terdapat daftar pertanyaan untuk lansia, anak, dan cucu. Interview direncananya berlangsung maksimal 2 pertemuan dengan masing-masing pertemuan berdurasi 1 jam.

1. Panduan untuk Lansia

Pengalaman sebagai lansia di Bali

a. Bisa Anda ceritakan tentang pengalaman Anda tinggal di Bali? Anda bisa memulai darimana saja yang Anda merasa nyaman.
b. Bagaimana dengan kondisi saat ini?
c. Apa perbedaannya kondisi hidup di Bali jaman dulu dengan sekarang?
d. Bagaimana rasanya menjadi Anda? Ceritakan lebih detail tentang hal tersebut.
e. Apakah pengalaman terbaik anda selama hidup di Bali, terutama pada umur Anda sekarang ini.
f. Sebaliknya apa pengalaman terburuk dan tantang terberat yang Anda hadapi selama ini.

Pengalaman sebagai anggota keluarga yang mendapatkan perawatan

a. Bisakah Anda ceritakan tentang kondisi kesehatan Anda dan dampaknya terhadap kehidupan anda?
b. Bisakah anda ceritakan pengalaman anda mendapatkan perawatan dari keluarga? Mulailah dari mana pun Anda suka dan sertakan apa pun yang Anda inginkan.
c. Bisakah Anda menggambarkan bagaimana kehidupan Anda dipengaruhi oleh perawatan/pengasuhan ini?
d. Bisakah Anda menggambarkan bagaimana hubungan keluarga Anda dipengaruhi oleh pengasuhan?
e. Bisakah Anda ceritakan lebih lanjut tentang tantangan terbesar seputar dukungan dan pengasuhan keluarga?
f. Apa kenangan terbaik Anda terkait dukungan tersebut? Ceritakan lebih detail tentang hal ini.

Nilai-nilai keluarga dalam perawatan/pengasuhan lansia

a. Bisakah anda ceritakan harapan anda terkait dukungan keluarga (jenis dukungan dan informasi yang anda butuhkan?)
b. Ceritakan lebih lanjut di saat anggota keluarga anda mencoba untuk memenuhi harapan anda.
c. Bisakah Anda ceritakan tentang pengalaman Anda di masa lalu sebagai pengasuh orang tua Anda? Mulailah darimana pun Anda suka dan sertakan apa pun yang Anda inginkan.
d. Bisakah Anda menggambarkan perbedaan antara pengalaman Anda dan keturunan Anda dalam memberikan dukungan untuk orang tua dalam keluarga?

2. Panduan anak dewasa (2nd generation)

Pengalaman sebagai anggota keluarga yang memberikan perawatan

a. Bisakah Anda ceritakan tentang kondisi kesehatan orang tua Anda dan pengaruhnya terhadap kehidupan anda? Saya ingin tahu lebih dalam tentang pengalaman anda.
b. Bisakah Anda ceritakan tentang pengalaman anda memberikan perawatan kepada orangtua Anda? Mulailah darimana pun Anda suka dan sertakan apa pun yang Anda inginkan.
c. Bisakah Anda menggambarkan bagaimana kehidupan Anda dipengaruhi oleh perawatan ini?
d. Bisakah Anda menggambarkan bagaimana hubungan keluarga Anda dipengaruhi oleh perawatan ini?
e. Bisakah Anda ceritakan lebih lanjut tentang tantangan terbesar seputar dukungan dan pengasuhan dalam keluarga anda?
f. Apa kenangan terbaik Anda tentang memberikan dukungan kepada orangtua? Ceritakan lebih lanjut.

Nilai-nilai keluarga dalam perawatan/pengasuhan lansia

a. Bisakah anda ceritakan mengapa merawat orangtua merupakan sesuatu yang penting bagi keluarga anda? Ceritakan bagaimana anda memenuhi nilai atau prinsip keluarga anda ini?
b. Bisakah Anda ceritakan lebih lanjut tentang harapan orangtua Anda? Ceritakan tentang pengalaman Anda ketika Anda mencoba memenuhi harapan tersebut.
c. Bisakah Anda menggambarkan reaksi orangtua Anda mengenai dukungan yang diberikan? Ceritakan lebih lanjut.
d. Bisakah Anda memberi tahu saya tentang harapan Anda kepada anak-anak Anda dalam menyediakan perawatan untuk Anda di masa depan?

3. Panduan untuk cucu (the 3rd generation)

Pengalaman sebagai anggota keluarga yang memberikan perawatan

a. Bisakah Anda ceritakan tentang kondisi kesehatan kakek/nenek Anda dan pengaruhnya terhadap kehidupan anda? Saya ingin tahu lebih dalam tentang pengalaman anda.
b. Bisakah Anda ceritakan tentang pengalaman anda memberikan perawatan kepada kakek/nenek Anda? Mulailah darimana pun Anda suka dan sertakan apa pun yang Anda inginkan.
c. Bisakah Anda menggambarkan bagaimana kehidupan Anda dipengaruhi oleh perawatan ini?
d. Bisakah Anda menggambarkan bagaimana hubungan keluarga Anda dipengaruhi oleh perawatan ini?
e. Bisakah Anda ceritakan lebih lanjut tentang tantangan terbesar seputar dukungan dan pengasuhan dalam keluarga anda?
f. Apa kenangan terbaik Anda tentang memberikan dukungan kepada kakek/nenek? Ceritakan lebih lanjut.

Nilai-nilai keluarga dalam perawatan/pengasuhan lansia

a. Bisakah anda ceritakan mengapa merawat anggota keluarga lansia merupakan sesuatu yang penting bagi keluarga anda? Ceritakan bagaimana anda memenuhi nilai atau prinsip keluarga anda ini?
b. Bisakah Anda ceritakan lebih lanjut tentang harapan kakek/nenek Anda? Ceritakan tentang pengalaman Anda ketika Anda mencoba memenuhi harapan tersebut.
c. Bisakah Anda menggambarkan reaksi kakek/nenek Anda mengenai dukungan yang diberikan? Ceritakan lebih lanjut.

PENTING bagi pewawancara

Penanganan laporan kekerasan dalam rumah tangga oleh partisipan:

1. Tetap menjaga *privacy* dan *confidentiality* dari partisipan penelitian.
2. Laporan ke pihak yang berwenang hanya boleh jika: ada kebutuhan yang mendesak dan membahayakan keselematan dari partisipan.
3. Dalam memberikan laporan, pewawancara harus berkonsultasi terlebih dahulu dengan kolega, himpunan psikologi wilayah, dan pihak yang relevan.
4. Dalam memberikan pelaporan, informasi harus bersifat ilmiah dan relevan.

Hindari konflik antar anggota keluarga yang dapat disebabkan oleh proses interview

1. Gunakan Bahasa dan pertanyaan yang netral.
2. Yakinkan partisipan bahwa kerahasiaannya akan tetap terjaga.
3. Kontrol akses untuk setiap pertanyaan yang bersifat sensitive.
4. Variasikan pertanyaan yang diberikan ke setiap anggota keluarga untuk menghindari mereka memberikan jawaban kepada anggota keluarga lainnya.

Cara berhadapan dengan konflik antar anggota keluarga

1. Hindari *double roles* sebagai pewawancara dan juga sebagai sebagai psikolog.
2. Interviewer tetap bertanggung jawab untuk melakukan *debriefing* kepada keluarga di akhir fase interview. Jika pada fase ini masih muncul konflik/ *disagreement* antar anggota keluarga, maka hal yang dapat dilakukan oleh pewawancara adalah:
   a. Mendeteksi kebutuhan dari anggota keluarga untuk mendiskusikan permasalahan mereka.
   b. Jadilah pendengar yang empati.
   c. Selalu bersikap netral.

Information sheet

English version

Information Sheet

Multigenerational caregiving for older people in Bali

Dear Family,

Thank you for expressing an interest in this research project about family caregiving for older people.

My name is Made Diah Lestari and you can call me Diah. I am a PhD student in Psychology, at Massey University, New Zealand. For the duration of the research I will have two supervisors, Professor Christine Stephens and Dr Tracy Morison who, along with me, can be contacted if you require any further information or have any questions, using the contact details below. This letter is to provide information about our research and to invite you to participate. You may choose whether or not to take part.

What is the study about?

The aim of this study is to understand more about the experience family caregiving for older people in Bali, where multigenerational households are still common. The study is being undertaken as part of the requirements of the PhD thesis at Massey University.

Potential benefits

The study provides the opportunity for older people and family to talk about their own experiences and to make suggestions that might assist with the family caregiving in the private and public domain in Bali. Therefore, it is anticipated that this study will be of benefit to people both receiving and providing care.

Who can take part?

You will be eligible to participate if:

d. You are living in a multi-generational household with an older person who needs long-term care and is using the national health coverage (*Jaminan Kesehatan Nasional*).
e. All of the generations in your home (adult children, grandchildren) are involved in caring for the older person.
f. All of the generations in your home (grandparents, adult children, and grandchildren) are able to talk to me and give informed consent.

g. Minimum age is 16 years old.

Please note that we do not require to see your medical records and medical screening.

What will you be asked to do?

If you would like to take part, you will be invited to take part in an initial family meeting and then an individual interview. The interviews will last about one to two hours (and could be separated into two meetings) and will be recorded. You may choose where the discussions take place, either in your own home or in an interview room. On the arranged day, I will phone to check that you are available. If not, then we can arrange an alternative time, or cancel the discussion.

For the older person: At the interview you will be asked to describe your life before and after any illness, the ageing experiences, and the family interaction during the caregiving. In particular, I am interested to know what your experience of care is like as a care recipient. For example, we may discuss the kind of support and information you need or are receiving.

For the family members: At the interview you will be asked to describe your life before and family interaction after and during the caregiving. In particular, I am interested to learn about your experiences as care providers. We may also discuss plans and choices you may have for your life and family.

Above all, this will be an opportunity for the family to tell me your story.

After the interview, I will also follow up the next week to ensure that you are comfortable with how the discussion went. Should you find the interview distressing in any way, support is available through the Centre for Applied Psychology, Udayana University, Denpasar, Bali, contact number +62361262275

What can participants expect?

Participation is entirely voluntary: it is your choice. If you do participate, you have the right to:

a. decline to answer any particular question(s).
b. withdraw from the study at any time, prior to the writing up of the thesis, without giving a reason.
c. ask any questions about the study at any time during participation.
d. provide information on the understanding that your name will not be used.
e. be given access to a summary of the project findings when it is concluded.
f. ask for the tape to be turned off at any time during the interview.
g. You may invite a friend and family member to help you understand the risks and/or benefits of this study and any other explanations you may require.
h. You may invite a support person to be present with you during the interview.

What will happen to the information?

a. The discussions will be recorded and transcribed.
b. You will be invited to read the summary of your interview before the results are written up.
c. Once the study is complete, you will be offered a summary of the results for all the participants if you wish.
d. The results will be published as a PhD Thesis.
e. They will be reported to scientific, medical and government policy meetings, and published in relevant journals.
f. We will do everything possible to ensure that your contributions to these summaries and reports remain confidential. Therefore, no material or direct quotes which could personally identify you will be used in any reports.
g. The information you provide will not be available to the other family members, any medical or nursing staff involved in your care in order to keep the privacy and confidentiality.
h. All digital data will be destroyed after transcription.
i. Transcriptions will be securely stored for ten years and then destroyed.

How do we participate and gather further information?

If you are interested in taking part please contact me to ask any further questions and arrange an initial meeting time if you wish:

By Phone: +6281236720876, By WA: +64226544553, By Email: mdlestari@unud.ac.id

If you wish to contact my supervisors their contact details are:

- Professor Christine Stephens (Lead Supervisor) – C.V.Stephens@massey.ac.nz, +64 (06) 356 9099 ext. 85059
- Dr Tracy Morison (Supervisor) – T.Morison@massey.ac.nz, +64 (06) 356 9099 ext. 86216

Thank you.

Made Diah Lestari

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 19/69. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz.

Indonesian version

Lembaran Informasi

Perawatan multigenerasi bagi lansia di Bali

Selamat pagi/siang/sore/malam Bapak/Ibu/Anggota Keluarga

Terima kasih atas ketertarikan anda pada penelitian tentang perawatan keluarga bagi lansia.

Perkenalkan nama saya Made Diah Lestari, dapat dipanggil Diah. Saya saat ini sedang menempuhkan pendidikan S3 di School of Psychology, Massey University, New Zealand. Selama penelitian ini dilakukan, saya dibimbing oleh dua orang supervisor, yakni Professor Christine Stephens dan Dr Tracy Morison. Anda dapat menghubungi kami bertiga ke personal contact kami yang tersedia di akhir lembaran informasi ini. Lembaran ini berisikan informasi terkait penelitian kami dan kami ingin mengundang anda untuk berpartisipasi. Keikutsertaan anda bersifat sukarela.

Tentang penelitian

Penelitian ini bertujuan untuk memahami pengalaman keluarga dalam merawat lansia di rumah tangga multigenerasi yang masih banyak ditemui di Bali. Penelitian ini adalah bagian dari persyaratan pada jenjang pendidikan S3 di Massey University, New Zealand.

Manfaat penelitian

Penelitian ini memberikan kesempatan bagi lansia dan keluarga untuk menyampaikan pengalaman dan aspirasi mereka yang dapat berkontribusi bagi ilmu pengetahuan dan praktek pengasuhan keluarga dan layanan kesehatan bagi lansia di Bali. Untuk itu penelitian ini diharapkan mampu memberikan manfaat bagi pemberi maupun penerima perawatan. Dengan ikut berpartisipasi di dalam penelitian ini, lansia dan keluarga terlibat dalam berbagi pengalaman kepada keluarga lainnya, memberikan rekomendasi bagi layanan kesehatan yang ada di Bali, dan perbaikan kebijakan publik terkaitan kesejahteraan lansia dan keluarga di masa yang akan datang.

Siapa yang dapat berpartisipasi di dalam penelitian dan perannya

Anda memenuhi persyaratan menjadi partisipan, jika anda:

1. Tinggal dalam rumah tangga multigenerasi dengan anggota keluarga lansia yang membutuhkan perawatan jangka panjang. Menggunakan layanan Jaminan Kesehatan Nasional.
2. Seluruh generasi di dalam keluarga (anak dan cucu) terlibat di dalam perawatan/pengasuhan.
3. Seluruh generasi di dalam keluarga (lansia, anak, dan cucu) bersedia untuk terlibat di dalam penelitian.

Mohon dicatat bahwa anda tidak harus memperlihatkan data kesehatan dan tidak ada prosedur pemeriksaan kesehatan dalam penelitian ini.

Kontribusi apa yang diharapkan dari anda dalam penelitian ini

Jika anda tertarik untuk berpartisipasi dalam penelitian ini, anda akan diundang ke sesi pertemuan awal dengan seluruh anggota keluarga anda dan kemudian diikuti dengan sesi wawancara perorangan. Wawancara akan berlangsung selama dua jam (dapat juga dibagi ke dalam dua sesi, masing-masing sesi berlangsung 1 jam) dan akan direkam. Anda dapat memilih dimana wawancara akan dilangsungkan, apakah di rumah anda sendiri atau ruangan interview yang disediakan. Pada saat waktu yang telah disepakai, saya akan menghubungi anda untuk menanyakan keadaan anda apakah anda cukup sehat untuk melangsungkan wawancara. Jika tidak, kita dapat mengubah jadwal wawancara, atau membatalkannya.

Untuk anggota keluarga lansia, pada saat wawancara anda diminta untuk bercerita mengenai kehidupan anda dahulu dan sekarang, sebelum dan sesudah perawatan diberikan/didapatkan, pengalaman sebagai lansia dan juga interaksi keluarga dalam perawatan. Secara spesifik saya tertarik untuk mendengarkan cerita anda menerima perawatan dalam konteks keluarga. Contohnya, dalam wawancara kita akan berdiskusi mengenai dukungan dan informasi yang anda butuhkan dan dapatkan dari keluarga.

Untuk anggota keluarga lainnya, pada saat wawancara anda akan diminta untuk becerita mengenai kehidupan anda sebelum dan setelah memberikan perawat serta bagaimana interaksi di dalam keluarga. Secara detail saya tertarik untuk belajar bagaimana pengalaman anda memberikan perawatan bagi anggota keluarga lansia. Kita juga berdiskusi terkait dengan rencana dan keputusan yang ambil berkaitan dengan kehidupan serta keluarga anda.

Saya tetap akan memastikan anda nyaman sebelum, pada saat, atau sesudah wawancara dilakukan. Jika ada merasa sedih, tidak nyaman, ataupun stres setelah proses wawancara, anda dapat menghubungi **Center for Applied Psychology (CAP), Program Studi Psikologi, Fakultas Kedokteran, Universitas Udayana dengan no telephone +62361262275** untuk mendapatkan bantuan konsultasi psikologi.

Apa yang dapat diharapkan oleh partisipan?

Partisipasi dalam penelitian ini bersifat sukarela. Jika anda memutuskan untuk berpartisipasi, anda memiliki hak untuk:

a. Menolak untuk menjawab pertanyaan tertentu.
b. Mengundurkan diri dari penelitian ini kapan pun, sebelum proses penyelesaian thesis, tanpa alasan apapun.
c. Bertanya mengenai penelitian ini kapan pun selama penelitian berlangsung.
d. Mengingatkan peneliti bahwa nama anda akan tetap rahasia, kecuali anda memberikan wewenang bagi peneliti.
e. Mendapatkan akses simpulan dari penelitian ini.
f. Meminta agar alat perekam dimatikan kapan pun saat wawancara berlangsung.
g. Anda dapat mengundang teman atau anggota keluarga untuk membantu anda memahami risiko dan manfaat dari penelitian ini atau informasi lainnya.
h. Anda dapat mengajak orang lain untuk menemani anda selama wawancara berlangsung.

Bagaimana informasi yang Anda berikan diproses?

a. Wawancara akan direkam yang kemudian akan ditransfer ke dalam bentuk transkrip wawancara.
b. Anda akan diundang untuk membaca ringkasan wawancara sebelum hasilnya ditulis.
c. Setelah penelitian ini berakhir, anda akan diberikan simpulan dari penelitian ini.
d. Hasilnya akan dipublikasikan dalam bentuk disertasi S3.
e. Hasil bisa juga dalam bentuk naskah akademik lainnya, artikel jurnal, maupun rekomendasi kebijakan publik.
f. Kami memastikan bahwa segala bentuk kontribusi anda, data personal, transkrip wawancara, dan laporan dalam penelitian ini bersifat rahasia. Untuk itu tidak akan ada kutipan langsung dalam naskah penelitian yang dapat mengidentifikasikan identitas anda.
g. Informasi yang anda berikan tidak akan diakses oleh anggota keluarga lainnya tenaga kesehatan yang terlibat dalam perawatan anda.
h. Seluruh data digital akan dimusnahkan setelah ditransfer ke dalam bentuk transkrip wawancara.
i. Transkrip akan disimpan secara aman hingga sepuluh tahun setelah penelitian selesai dilakukan di personal storage peneliti.

Bagaimana cara anda berpartisipasi?

Jika anda tertarik untuk berpartisipasi, dpat menghubungi saya untuk mendapatkan informasi lanjut terkait penelitian ini dan pertemuan awal dengan seluruh anggota keluarga.

Mobile phone: +6281236720876 atau WA: +64226544553 atau email: mdlestari@unud.ac.id

Anda juga dapat menghubungi supervisor saya:

- Professor Christine Stephens (Lead Supervisor) – C.V.Stephens@massey.ac.nz, +64 (06) 356 9099 ext. 85059
- Dr Tracy Morison (Supervisor) – T.Morison@massey.ac.nz, +64 (06) 356 9099 ext. 86216

Terima kasih dan salam,

Made Diah Lestari

Penelitian ini sudah disetujui oleh Komisi Etik Penelitian FK UNUD/ RSUP Sanglah No.2809/UN 14.2.2.VII.14/LP/2019 dan Massey University Human Ethics Committee: Southern A, Application 19/69 yang telah melakukan telaah proposal. Jika anda memiliki pertanyaan atau masukan terkait bagaimana penelitian ini dilakukan, anda dapat menghubungi Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz. Atau A/Dr. dr. Anak Agung Mas Putrawati Triningrat, Sp.M (K), Udayana University Ethics Committee, telephone +628123846995, email masputra@unud.ac.id

Informed consent

English version

Multigenerational caregiving for older people in Bali

PARTICIPANT CONSENT FORM - INDIVIDUAL

Thank you for your interest in this study. The data you provide today will be used only for the study proposes. As a participant in this study, you will never be individually identified in any outputs (e.g. booklet, reports, policy reports, or research articles) that derive from this study and your data will never be identified to anyone outside the research team.

For each of the following statements, please tick [√] either ***agree*** or ***disagree***:

agree	disagree	
[ ]	[ ]	I confirm that I have read and understand the information sheet for this study.
[ ]	[ ]	I have read the details of the study explained to me.
[ ]	[ ]	I have had opportunities to ask questions and my questions have been answered to my satisfaction. I understand that I may ask further questions at any time.
[ ]	[ ]	I understand that my participation is voluntary and that I am free to withdraw at any time, without providing any reason.
[ ]	[ ]	I have received enough information about the study.
[ ]	[ ]	I agree to have the interview audio recorder.
[ ]	[ ]	I agree that the transcript and extracts from this may be used in reports and publications arising from the research.
[ ]	[ ]	I agree to participate in this study under the conditions set out in the Information Sheet.

____________________ ____________________ ____________________

Printed name Date Signature

I have explained the study to the above participant, and she/he agreed to take part

____________________ ____________________ ____________________

Printed name Date Signature

Indonesian version

Multigenerational caregiving for older people in Bali

PARTICIPANT CONSENT FORM - INDIVIDUAL

Terima kasih atas ketertarikan anda pada penelitian ini. Data yang anda berikan hari ini hanya digunakan untuk kepentingan penelitian. Sebagai partisipan di dalam penelitian ini, anda tidak dapat diidentifikasi secara personal dari hasil dari penelitian ini (contohnya buku, laporan, *policy reports*, maupun artikel ilmiah) yang dibuat berdasarkan data penelitian. Kami pastikan anda tidak dapat dikenali oleh pihak lain di luar tim penelitian.

Untuk setiap pernyataan di bawah ini, bubuhkan tanda rumput [√] bila anda ***setuju*** atau ***tidak setuju***:

setuju	tidak setuju	
[ ]	[ ]	Saya memastikan bahwa saya sudah membaca dan mengerti isi dari *information sheet* dari penelitian ini.
[ ]	[ ]	Saya sudah membaca prosedur penelitian yang dijelaskan kepada saya.
[ ]	[ ]	Saya memiliki kesempatan untuk bertanya dan pertanyaan saya sudah dijawab dengan memuaskan. Saya memiliki kesempatan untuk bertanya kapan pun dalam proses penelitian ini.
[ ]	[ ]	Saya memahami bahwa partisipasi saya bersifat sukarela dan saya dapat mengundurkan diri kapan pun tanpa pemberitahuan.
[ ]	[ ]	Saya mendpaatkan penjelasan yang memadai terkait penelitian ini.
[ ]	[ ]	Saya setuju suara saya pada saat wawancara direkam.
[ ]	[ ]	Saya setuju transkrip dan ekstrak dari wawancara saya akan digunakan dalam penulisan laporan dan publikasi penelitian.
[ ]	[ ]	Saya setuju untuk berpartisipasi dalam penelitian ini sesuai dengan kondisi yang tertulis di dalam *information sheet*.

______________________	______________________	______________________
Nama	Hari/tanggal	Tanda tangan

Saya sudah menjelaskan penelitian ini kepada partisipan di atas dan beliau bersedia untuk berpartisipasi.

______________________	______________________	______________________
Nama	Hari/tanggal	Tanda tangan

Appendix C. Data Management

An example of interview transcript

Kode Recording : Menantu_200122_0523
Kode Verbatim : Daughter-in-law Family 1
Tanggal Interview : 21 Januari 2020
Interviewer : Made Diah Lestari
Interviewee : Yani
Durasi : 1 jam 32 menit 44 detik

Rangkuman interview:

Wawancara Yani berlangsung di rumah Ibunya karena Yani merasa lebih nyaman dibandingkan dengan wawancara dilakukan di rumah dengan kehadiran mertuanya. Yani bercerita tentang kehidupan rumah tangganya, bagaimana dia merasa tidak nyaman berinteraksi dengan mertua karena tidak bekerja formal, tidak memiliki anak laki-laki, dan selalu dibandingkan dengan adik ipar. Selain itu Yani juga bercerita tentang konflik yang terjadi antara ibu mertua dengan dua anak laki-lakinya yang lain. Karena konflik tersebut, perawatan ibu mertua dan juga rumah di kampung menjadi tanggung jawab yani dan suami sepenuhnya. Yani juga memiliki pengalaman merawat anggota keluarga lainnya seperti Bapak Mertua dan Tante pada saat bersamaan. Yani mengaku melakukannya dengan senang hati karena bagian dari karmanya. Sebagai perempuan, Yani harus membagi waktunya antara pekerjaan rumah, mengasuh 3 anak perempuannya, merawat ibu mertua, dan menjalankan usaha kecil rumah tangganya untuk mendapatkan biaya tambahan untuk keperluan rumah tangga.

Yani berharap, anak-anaknya mampu merawat dirinya di masa depan.

Catatan: rumah tradisional Bali, BPJS tidak terutilisasi dengan optimal.

1 D: 00:00:00-7 21 Januari 2020, iya. iya bu Yani ee.. bisa cerita tentang kondisi
2 kesehatan mertuanya nggih, seperti apa yang bu.. bu Yani tau? 00:00:11-9
3 Y: 00:00:12-7 Kondisinya ee.. seperti apa ya hehehe, ya sekarang masih agak mengeluh
4 kesakitan [D : hmm.. hmm..] seperti itu lah [D : hmm.. hmm..] anunya.. kakinya,
5 badannya gitu. 00:00:28-1
6 D: 00:00:28-4 ee.. kalo dari yang ee.. bu Yani pertama kali menikah sampe sekarang
7 seperti apa ya.. apa ada perubahan atau gimana gambarannya? 00:00:37-0
8 Y: 00:00:37-1 ohh.. kalo masalah itu ada banyak perubahan [D : he eh he eh] kalo baru
9 menikah tu kan masih kenceng dia [D : hmm.. hm.. hm..] masih... memang sih udah
10 sakit kakinya tu, tyang dari baru menikah tu udah, kakinya tu dah emang seperti itu [D
11 : hmm.. hmm..] trus tapi masih bisa kerja, masih kenceng lah [D : hmm.. hmm..] trus
12 setelah ck.. berapa ya.. eee.. mertua yang laki meninggal tu baru agak ee.. gini apa.. [D
13 : ee.. menurun?] ngga.. ngga menurun he eh.. kondisinya agak menurun [D : hmm..
14 hmm..] sakit.. sakit gitu serng kumat gitu lah [D : hmm.. hmm..] sakitnya. 00:01:19-6
15 D: 00:01:22-0 Kalo gimana beliau ee.. kalo itu kan dari kondisi fisiknya ya [Y : he eh]
16 ee.. kalo beliau sendiri me.. apa ya mee.. menghadapi kondisi yang perubahan seperti
17 itu gimana bu Yani melihatnya? 00:01:35-6
18 Y: 00:01:38-0 Banyak penyesalan sih.. [D : Bisa cerita?] kayak gimana.. mengeluh gitu
19 lo.. mengeluh apa.. "kenapa kok bisa seperti ini" kayak gitu, [D : hmm... hmm..]

20 gimana.. gimana cara hehehe apa keluhannya karena mungkin kepikiran ya, namanya
21 orangtua sakit, "kenapa kok bisa seperti ini, terus begini aja" gitu. [D : hmm.. hmm..]
22 ya.. gimana ya hehehe [D : iya] makanya ya sampe tensinya naik kan.. gitu dah
23 penyesalannya banyak [D : hmm..] mengeluh tentang dirinya gitu, menyalahkan diri
24 sendiri lah [D : hmm.. hmm.. hmm..] seperti itu aja. 00:02:21-0
25 D: 00:02:21-5 Penyesalan seperti apa yang pernah disampakan ke bu Yani?00:02:25-5
26 Y: 00:02:26-4 "kok sakit aja" gitu, gimana.. gimana ngga sakit orang kerja.. kerjanya
27 seperti itu kan [D : hmm] maklum aja, tak gituin aja sih. [D : hmm.. hmm..] cuman ya
28 namanya masalah keluarga tu kan pasti ada gitu [D : iya] masalah anak, itu dia kepikiran
29 kan jadinya orangtua tu banyak gimana.. penyesalan lah [D : hmm.. hmm..] seperti itu
30 lah ibunya itu. 00:02:52-1
31 D: 00:02:52-3 hmm.. hmm.. bisa cerita satu apa ya.. satu pengalaman bu Yani pernah
32 ngobrol sama mertuanya [Y : he eh] beliau pernah menyampaikan secara detail itu
33 kayak gimana ketika itu? 00:03:03-8
34 Y: 00:03:04-7 eee.... ya masalah kehidupannya sama hubungannya sama anak ya
35 kayak.. kayak gimana.. ga sinkron gitu lah sama anaknya yang nomer dua.. nomer tiga
36 jadinya [D : iya] karena anak.. adiknya bapaknya ini [D : hmm.. hmm..] ngga sinkron,
37 apa aja yang dilakukan salah, disalahin tu kan, [D : hmm.. hmm..] ya namanya orangtua
38 kan ada penyesalan juga [D : hmm..] kenapa ok selalu disalah, begini salah, begitu salah
39 digituin [D : hmm.. hmm..] gitu.. [D : iya] kenapa kok seperti ini, apa ibu yang salah
40 gitu [D : hmm.. hmm..] ya mau gimana hehehe 00:03:42-8
41 D: 00:03:43-3 Waktu itu bagaimana ee.. bu Yani ini menanggapi? 00:03:46-4
42 Y: 00:03:47-7 Menanggapi, "ya gimana orang emang karakternya dia memang seperti
43 itu, untuk apa mikirin, anak yang begitu" tak gituin aja sih [D ; hmm.. hmm..] cuman..
44 apa ya.. ee.. dimarahin ibunya, ngeluh sedikit, dimarah itu kan orangtua tu jadinya
45 tambah beban dia. [D : hmm.. hmm..] ee.. tambah sakit lah, ya kalo kita aja jadi ibu
46 digituin kan sakit hati gitu lah.. [D : hmm.. hmm..] ceritanya gitu, emang.. emang dari
47 belum menikah itu anaknya seperti itu. 00:04:26-2
48 D: 00:04:26-6 hmm.. hmm.. iya.. bu Yani pernah ee.. melihat langsung peristiwanya
49 gitu yang, anak yang ini saya nanya sedikit ini ya hehehe (Y tertawa) apa melihat
50 langsung, pernah melihat langsung peristiwanya seperti apa ketika itu? 00:04:41-9
51 Y: 00:04:42-4 ohh pernah sih, cuman itudah masalah-masalah keluarga.. apa ya..
52 masalah kecil di besar-besarkan, ngga sih sebenarnya masalah cuman salah tanggap aja
53 gitu. [D : hmm.. hmm..] ee.. kalo ibu ngomong gini, dia menanggapi seperti ini [D :
54 hmm.. hmm..] itu kan biasa masalah keluarga. 00:05:02-4
55 D: 00:05:02-7 Iya.. ada contohnya yang terkait sama kesehatannya ibu? 00:05:06-5
56 Y: 00:05:08-0 Kalo.. "ya berobat aja terus" gitu [D : hmm.. hmm..] trus mesuntik gen
57 gitu lah ceritanya [D : iya hmm.. hmm..] "terus ke dokter aja" ee.. artinya tetep juga
58 segitu aja gitu, modelnya kan ya namanya orangtua kan gimana perasaannya kalo
59 digituin sama anaknya kan [D : hmm.. hmm..] padahal ga di... dia yang dimintain uang
60 gitu. [D : hmm.. hmm..] gi-- gitu dah ibunya cerita, "ya jangan dah, biarin aja" tak gituin,
61 cuma.. gimana.. engga sih gini, ya mau dah... orang nangis aja sering kan.. kalo udah
62 gitu kan jadinya kepikiran ya orangtua [D : hmm..] "ngapain mikir yang gitu-gitu" tak
63 gituin, nah itu dah "tensinya tambah naik, komplikasi nanti sakitnya tambah berat, yang
64 ngerasa siapa? kan kita sendiri" tak gituin [D : hmm.. hmm.. hmm..] makanya sering
65 dah tak gituin, biar ndak soal itu dia kalo inget sama anaknya itu, dah dah mulai kayak
66 gimana cerita.. kalo pulang tu kan liat [D : hmm] anaknya tu, dah dah mulai [D : hmm..]
67 mungkin kan kalo sakit, semua sakit tu kan dari pikiran ya [D : hmm..] kalo udah pikiran
68 berat otomatis kondisi kan menurn dia.. [D : he eh] makanya tensinya naik dah, dah dah
69 mulai.. ngapain dah, sekarang udah sih agak-agak mau cuek [D : hmm..] "belajar cuek,
70 jangan mikir-mikir yang gitu" tak gituin [D : hmm.. hmm..] tanya.. tanya.. mau dah [D
71 : hmm..] sekarang kan udah agak-agak gini.. apa.. ga terlalu mikir [D : hmm.. hmm..]
72 ee.. kondisi apa.. suasanya yang seperti itu lo, anaknya, "ya mau gimana dia biarin aja,
73 terserah dia. Nanti kalo udah sadar nanti dia kan inget dia sama orangtua" tak gituin dah
74 [D : hmm.. hmm.. hm..] makanya mau dah sekarang ebih mengerti lah, kalo dulu kan

75 memang anaknya keras, ibunya keras.. kan otomatis apa [D : iya] sama-sama ga mau
76 ngalah gitu, makanya sering.. kalo saya kan diem aja. (D tertawa) saya ga seneng
77 soalnya bertengkar hehe (D tertawa) bapaknya diem aja dah [D : hmm..] tapi ibunya
78 memang agak cerewet kalo dulu masih kenceng itu [D : hmm.. hmm..] padahal
79 mantunya itu tu lebih.. disayang sebenernya, sama anaknya.. lebih apa.. di.. apa ya.. di..
80 apa namanya [D : apa namanya?] ujugange keto lo.. [D : oh iya iya iya] apa namanya
81 itu? [D : diperhatiin?] engga.. di.. lebih di he eh.. [D : diutamain] he eh lebih diutamakan
82 lah itu. Saya baru menikah dulu tu kan ndak.. ndak seperti itu gitu lo [D hmm..] kayak
83 kalo itu, anaknya tu kan, "oh ini gini" kalo bapaknya aja apa.. kalo dah dateng tu
84 anaknya, pasti dah dikasi uang gitu [D : hmm.. hmm..] itu lah yang saya liat gitu [D :
85 hmm.. hmmm..] kalo mertua yang cowok juga seperti itu nah gimana ya.. tapi suami
86 saya kan ndak.. pernah mikir yang kayak gitu [D : he eh he eh] jarang juga ngeliat, yang
87 ngeliat kan saya. (D tertawa) karena terus dirumah kan [D : he eh he eh] oh seperti ini
88 lah, begitu lah.. "ohh ternyata seperti ini" kita kan mempelajari juga ee.. keluarga-
89 keluarga disana tu baru-baru nikah. [D : hmm..] ohh seperti ini ternyata gitu, tyang kan
90 diem aja. Kalo tyang kan masih gini.. apa.. baru nikah itu ya gimana ya hehehe. 00:08:45-9
91 D: 00:08:46-1 Gimana? hehe bisa cerita bu Yani? 00:08:48-2
92 Y: 00:08:49-0 ee.. perasaannya ndak gini lah apa.. kayak tertekan gitu lo [D : ohh] kan
93 biasa orangtua masih bisa kerja [D : he eh] masih.. kalo kita ndak.. ndak kerja kan
94 suaranya tu masih gini lah, "ini kene kene kene, kalo saya dulu gini, masih ini" orang
95 namanya kita yang hamil tu kan sakit [D : hmm.. hmm..] ndak bisa bangun anu lah..
96 keras ngidamnya itu [D : hmm hmm..] makanya, "gini gini" ah nyengyeng nyengnyeng
97 gitu dah biasa orangtua kan [D : he eh he eh] gimana yang ngoceh tu hehehe (D tertawa)
98 kalo kita kan baru-baru sana, belum mengerti mungkin, belum memahami situasi
99 disana, itu kan merasa gimana gitu. Gimana ya agak tersinggung lah [D : hmm hmm]
100 dikasi modelnya kalo cerewet didengarkan kan tersinggung kita ya, orang kita ga tau
101 gitu.. ohh gitu.. makanya.. tapi tyang ndak pernah cerita sama suami hehehe.. kalo
102 sekarang baru dia gitu dah kadang-kadang ya namanya anak sama ibunya kan.. ada aja
103 yang gini.. "ini ibunya gini gini gini", "ohh iya emang gitu dari dulu kok baru tau ya?"
104 gitu hehehe 00:10:11-7
105 D: 00:10:12-0 Apa yang biasanya bu..bu Yani sampaikan ke su-- ke suami? 00:10:14-9
106 Y: 00:10:15-9 Kalo gimana ya.. kan biasa.. kalo marah-marah gitu lo ibunya itu kan,
107 ee.. diambil gini salah gitu umpamanya kan, "eh jangan gini" gitu, "gini aja ngga boleh"
108 kan biasa ngeluh gitu [D : iya iya] "kalo saya dari dulu sepeti itu dah, tapi saya ndak
109 pernah cerita" tak gituin dah [D : ohh] "oh gitu ya?", "gini dah sakit hati saya waktu
110 dulu" ee.. kalo ngomong kan biasa mertua di-- kita tu dibanding-bandingkan kan [D :
111 iya iya] gimana rasanya gitu lo, dibandingin gini gini.. dikirain dah menantunya itu
112 yang.. nanti lebih mau perhatian hehehe, karena dia kan kerja [D : hmm.. hmm..] kalo
113 saya kan ndak memang.. memang ndak kerja dari dulu [D : hmm] dari nikah tu dah dah
114 berhenti kerja dah [D : hmm.. hmm..] makanya, "ohh gitu, ya sampai kapan dia bisa"
115 seperti itu.. gitu lah kita punya perasaan [D : iya] kan.. apalagi kalo dateng dah
116 menantunya itu, lebih gini lah.. gimana ya, "oh gini gini gini" ah apa aja dah keluar gitu
117 [D : hmm.. he eh he eh], "oh gitu ya" gitu dah.. saya kan cuma mempelajari aja [D : iya
118 iya] masih diem.. baru ba-- ini baru-baru dah saya cerita sama suami. Kalo waktu itu
119 diadu-adu kan takutnya ngadu anak sama ibunya itu kan jadi masalah besar nanti dia
120 benci sama tyang [D : hmm.. hmm.. hm..] takutnya seperti iut, kan ndak pernah.. gini
121 cerita, "eh ibu gini lo" kalo saya paling nangis sendiri aja hehe. 00:11:53-9
122 D: 00:11:54-0 Apa yang bu Yani rasakan gitu ketika misalnya itu dah kan bu Yani se--
123 sering liat itu d rumah trus ada perlakuan yang beda yang bu Yani, meskipun ndak cerita
124 ke suami ya [D : he eh] apa yang bu Yani rasakan? 00:12:06-3
125 Y: 00:12:06-6 ya sakit lah hehehe (D tertawa) aduh.. ya itu dah pengalaman yang baru
126 gini.. [D : hmm] cuman tyang apa.. ngga mau dah cerita gitu. 00:12:19-6
127 D: 00:12:20-0 hmm.. hmm.. hmm.. trus momen yang inget ga, apa yang membuat ibu

128 berubah gitu ya.. kayak kemarin kan cerita Yani dah yang lebih saya andelin atau apa
129 gitu [D : ohh] apa.. momennya yang merubah? 00:12:31-8
130 Y: 00:12:31-8 ya semenjak.. kalo saya kan ga tegaan gitu [D : iya] kalo mau bales
131 dendam kan hehe (D tertawa) gimana gitu, tapi kalo saya.. kalo bapaknya aja kan
132 namanya.. kalo capek kan marah [D : he eh] "ngga boleh gitu sama orangtua" tak gituin..
133 [D : he eh] namanya orangtua kan pasti.. kita yang harus ngalah tak gituin [D : hmm..
134 hmm.. hmm..] biarin.. kapan sih orangtua tu bisa bahagia kan ndak.. waktu dah ndak
135 ada.. tak gituin dah makanya [D : hmm] sering dah bapaknya ketawa dah dia hehehe (D
136 tertawa) 00:13:01-1
137 D: 00:13:02-4 Apa yang biasanya kalo suaminya bu Yani sama ibunya apa yang
138 biasanya serig ini ya.. bikin marah [Y: kesel gitu?] kesel gitu? 00:13:10-2
139 Y: 00:13:11-2 ee.. apa ya.. kalo.. itu dah kalo apa namanya.. biasa bersodara.. orang
140 sodaranya tu ga ada yang sinkron gitu lo gimana ya [D : hmm.. hmm.. hmm..] kalo
141 tyang aja kadang-kadang ibunya juga .. mungkin gimana ya kalo sama anak itu.. ga..
142 maunya ibu tu kan sama, sama anak-anaknya, cuman caranya tu, karena mungkin ya
143 anaknya yang cewek ni karena apa.. punya anak cewek satu gitu [D : hmm] mungkin
144 ya, itu yang lebih diginiin lah. Kalo gimana ditegor anaknya yang cewek tu, marah dah
145 [D : hmm..] ibu gitu. apa namanya.. kakaknya kan agak gimana ya.. marah dia kalo
146 gimana-gimana, jadi kan kakaknya yang gini.. 00:14:06-1
147 D: 00:14:06-5 Kalo kakaknya negor adiknya [Y: he eh] ibunya marah? 00:14:08-5
148 Y: 00:14:08-8 iya gitu dah, "udah biarin aja" tak gituin dah, kalo sekarang sih ngalah-
149 ngahal aja [D : hmm] ngga pernah hehehe 00:14:16-2
150 D: 00:14:16-4 hehehe pernah ada satu peristiwa gitu yang kakaknya negor adiknya
151 karena apa trus ibunya cerita? 00:14:25-2
152 Y: 00:14:24-4 paling biasa.. biasa di rumah tu bersih-bersih tu kan [D : he eh] orang..
153 kalo tyang kan sibuk, dia dah.. gitu kan ga sempet bersihin kompor gtiu [D : he eh he
154 eh] ee.. orang kao dia udah dateng dulu masih.. masih ada pacarnya [D : he eh he eh]
155 mersihin "kompor ndak.. ndak gini apa namanya.. ndak ada yang mau" gitu dah
156 bapaknya, gimana itu ibunya marah dah.. [D : hmm] sampe.. tapi kalo suami saya yang
157 ngomong tu, ibunya langsung dah nangis [D : ohh] langsung marah0marah, ih sampe
158 gini lo dulu [D : ohhh] apa.. kayak ck.. orang gila gitu [D :ohh] sampe gitu. 00:15:10-4
159 D: 00:15:11-4 Seperti apa waktu itu kejadiannya? Bisa cerit bu Yani? 00:15:14-2
160 Y: 00:15:14-6 ee.. kayak apa.. ya ce-- cuma itu aja lah masalahnya, dia tu ibunya
161 tersinggung gitu. 00:15:19-2
162 D: 00:15:19-9 hmm.. tersinggung karena napi nike waktu itu? 00:15:22-0
163 Y: 00:15:22-0 Karena itu dah negor adiknya, ya karena masalah bersih-bersih gitu kan
164 [D : he eh] tu dah.. ngga usah dah, itu kan sama pacarnya dulu di rumah [D : he eh]
165 pacarnya tu udah ngga sama itu nikah [D : hmm.. hmm.. hmm..] diem di rumah dulu [D
166 : hmm.. hmm..] itudah, tau mungkin.. kan biasa deket dia sama itu pacarnya itu ibunya
167 gini-gini, cerita dah.. "gini apa" nanti kalo dateng suami saya, diem dah.. itu kan jadinya
168 gimana ya bapaknya gitu (D tertawa) trus di kamar aja, ndak mau gini tu.. "orang boleh
169 kok dbersihin kompornya ini" gitu, "ya siapa yang gini.. gini" gitu dah ibunya nyautin
170 gimana itu.. [D : hmm] pokoknya jadi lah ee. panjang [D : panjang] gitu.. "duh jangan
171 dah tu diiniin, diem aja dah" tak gituin dah bapaknya [D : hmm.. hmm.] duduknya udah
172 ee.. "ngoring keto gen sing dadi?" langsung dah ibunya pokoknya banyak ngoceh kan
173 [D : ohh ohh] ck.. ya diemin aja. Sampe gini.. gini hehehe (D tertawa) makanya ga
174 berani, kalo bapaknya gimana itu ibunya ndak berani.. [D : hmm..hmm..] ga berani
175 marah [D : oh ga berani marah] he eh.. takutnya nanti itu dah, tersinggung.. sebenarnya
176 ngga sih ada masalah apa, cuma ketersinggungan seperti itu aja, kan biasa dalam
177 keluarga [D : iya iya iya bener ya] seperti itu he eh.. ngga sih ada masalah. Kalo tyang
178 ndak pernah mempermasalahkan ini-itu ndak pernah, walaupun sama ipar, sama mertua
179 gitu ndak pernah.. [D : hmm.. hmm..] cuman mungkin dia yang mempermasalahkan
180 saya itu kan ga tau ya hehe 00:17:01-5
181 D: 00:17:01-4 iya.. iya.. kalo bu Yani, kalo marah gimana biasanya? 00:17:04-1

182 Y: 00:17:04-7 ndak sih pernah hehehe [D : ndak penah marah?] diem aja hehe.. diem
183 aja, paling nangis lah gimana [D : he eh he eh] atau gimana, nantikalo marah sama
184 suami kasian gitu hehehe 00:17:16-2
185 D: 00:17:16-5 hmm hehehe iya, untuk yang kondisi mertuanya bu Yani [Y : he eh] kalo
186 bu Yani sendiri apa tugasnya biasanya untuk bantu beliau ya dengan kondisi sekarang? 00:17:27-9
187 Y: 00:17:28-6 ya paling ngambil.. ngambilin makanan gitu [D : hmm] kan ndak bisa
188 gini.. jalan.. kalo mau ngambil nasi apa itu bawain [D : hmm..] kalo kencing tu kan
189 dikamar tu pake ember [D : hmm.. hmm..] bawain ember kadang, siapa yang sempet
190 gitu. [D : hmm] ndak sih ada tugas yang harus, kalo dia kan masih bisa sendiri soalnya
191 [D : hmm] ga terlalu.. kecuali kumat sekali baru [D : iya iya] mau biknin bubur pagi,
192 mau ngelap [D : hmm] gitu.. kalo anak.. anak saya ga sempat tu kan tyang gitu. 00:18:01-2
193 D: 00:18:00-6 iya iya, iya bisa cerita waktu kumat nike ya [Y : yang] kalo tugasnya bu
194 Yani dari pagi sampe inilah.. tidur lagi gitu untuk merawat beliau kayak gimana? trus
195 ngatur waktu dengan kesibukan bu Yani yang lainnya tu? 00:18:15-7
196 Y: 00:18:15-6 iya paling pagi bawain.. bikinin bubur [D : hmm.. hmm..] bawain
197 cuman... suruh minum obat, bawain air ke dalem tu kalo ga bisa keluar gitu kan mesti
198 di dalem, bikinin air hanget untuk ngelap itu [D : hmm hmm] udah.. 00:18:34-5
199 D: 00:18:35-0 hmm.. yang ngelap bu Yani juga? 00:18:36-1
200 Y: 00:18:37-1 iya kalo.. kalo ndak ada siapa tyang yang ngelap [D : hmm] kalo ada
201 anaknya, anaknya.. soalnya tyang kan sibuk d dapur hehe. 00:18:43-9
202 D: 00:18:44-1 iya iya si-- sibuk untuk lumpianya [Y : he eh] bikin tetep? 00:18:47-2
203 Y: 00:18:47-3 Bikin itu kan biar bisa jalan juga [D : hmm hmm] gitu. Makanya siapa
204 yang sempat, kalo bapaknya, bapaknya gitu [D : hmm.. hmm..] kerja sama lah [D : iya]
205 semua gitu. 00:18:57-9
206 D: 00:18:59-9 Berarti yang terakhir itu kumat yang kapan? 00:19:02-7
207 Y: 00:19:03-0 Yang kerasnya itu.. [D : yang sampe thypus sama DB itu?] he eh itu.. he
208 eh itu dah.. yang paling keras itu, makanya setelah itu dah kapok tyang, soalnya ini
209 semua bengkak, ngga bisa turun, harus di bawa ke rumah sakit tiap hari tu kan, makanya
210 sedikit aja udah kayak ga mau makan tu udah dah tak suruh nyuntik [D : hmm hmm
211 hmm] "suntik aja dah", suntik gitu [D : iya] biar ndak sampe kumat seperti itu, yang
212 repot kan kita juga. 00:19:28-9
213 D: 00:19:29-0 Hmm.. itu setahunn yang lalu ya bu atau kapan nike? 00:19:32-1
214 Y: 00:19:33-0 udah ada ck.. berapa ya.. dua tahunan itu 00:19:36-4
215 D: 00:19:36-4 udah dua tahun yang lalu? 00:19:37-4
216 Y: 00:19:37-7 Nyepi yang ini ndak, tyang yang sakit yang.. dua tahunan [D : dua
217 tahunan ya?] he eh dua tahun itu.. [D : hmm.. hmm..] tyang belum hamil. 00:19:46-9
218 D: 00:19:47-8 iya berarti waktu tu bu Yani juga nganter ke [D : he eh] rumah sakit? 00:19:52-5
219 Y: 00:19:52-6 Nganter rumah sakit tiap hari itu. 00:19:54-1
220 D: 00:19:54-5 hmm.. gimana ngaturnya, jadwalnya waktu itu? bisa ngga cerita bu Yani? 00:19:58-2
221 Y: 00:19:58-7 Bisa... apa ya.. pagi ngajak ke dokter kalo.. bisa kalo ngajak ke dokter
222 kan ga bisa sendiri [D : hmm] harus ada yang ngikutin kan, naik sepeda motor soalnya
223 kan [D: he eh] bisa anak tyang yang ikut atau ipar yang cewek [D : hmm.. hmm.. hmm..]
224 itu dah nganter ke Bakti RahYani, bisa.. bisa dua kali bisa hari itu. [D : hmm.. hmm..]
225 karena dikirim ke dokter apa itu waktu itu.. penyakit dalem [D : penyakit dalam?] hmm..
226 abis ke dokter penyakit dalem, dikirim ke dokter tulang [D : hmm] eh apa ya.. tulang
227 namanya? 00:20:39-2
228 D: 00:20:39-7 tulang. iya he eh.. [Y : yang] ada bedah tulang itu? atau apa? 00:20:43-5
229 Y: 00:20:43-7 apa Namanya dokter apa yang di sebelah itu yang dr tulang 00:20:48-1
230 D: 00:20:48-6 Orthopedi? [Y : he eh] ohh itu he eh 00:20:50-9
231 Y: 00:20:51-1 he eh itu dah.. trus dirujuk disuruh bawa ke sanglah kan [D : ohhohh]
232 tapi tyang ndak mau, takutnya itu dah nanti mau.. dulu kan mau nyari juga perawat

233 untuk kakinya itu [D : hmm.. hmm..] ada yang ngasi tau temennya [D : hmm.. hmm..]
234 "eh bawa kesana, nanti ada kok yang mau manggil, perawat untuk mersihin kakinya
235 itu" seminggu sekali [D : hmm.. hmm..] waktu itu bayar seratus [D : per?] per sekali
236 dateng. [D : oh per sekali dateng] he eh seratus.. seratus ribu kan, trus mau dia dateng
237 di.. bersihin dah di rawat [D : Hmm.. hmm..] berapa ada sebulan.. trus di suruh beli obat
238 gitu, trus diajak lagi disuruh, "coba ya ee.. ke dokter Astawa yang di [D : iyaa] apa
239 namanya ini.. aduh.. Puri Raharja itu 00:21:40-8
240 D: 00:21:40-8 iya iya iya Prof Astawa nike? [Y : he eh] iya orthopedi nike. 00:21:43-8
241 Y: 00:21:44-1 he eh itu dah [D : he eh he eh] disitu disuruh juga gini, nanti mau
242 dioperasi kan [D : he eh] "ini kalo gitu operasi aja" ee.. disuruh nyediain uang waktu
243 itu berapa ya.. 80 gitu [D : hmm.. hmm..] tapi tyang ndak gini [D : hmm] bapaknya,
244 "dimana nyari uang segitu" gitu [D : hm.. hmm..] ndak usah dah gitu nanti apalagi kalo
245 diamputasi kan gini.. kasian juga gitu, bapaknya ndak mau. Makanya ndak dah jadi [D
246 : hmm..] ndak mau ke dokter lagi gitu, bapaknya yang ndak mau. 00:22:15-8
247 D: 00:22:16-4 hmm.. setelah itu yang ozon itu berarti? 00:22:18-5
248 Y: 00:22:18-5 he eh.. setelah itu ozon, makanya takutnya itu dah kalo ke dokter
249 diamputasi itu dah bapaknya takut 00:22:27-7
250 D: 00:22:28-0 hehehe.. kenapa? apa.. apa namanya apa yang dipikirin kok bisa takut
251 gitu? pernah diskusi sama suaminya bu Yani? 00:22:36-0
252 Y: 00:22:36-6 ee.. bapaknya kan takutnya nanti itudah kakitnya ndak ada itu.. kasian
253 gitu lo [D: hmm.. hmm.. hmm..] ngeliat ibunya giut.. gitu maksudnya [D : hmm..
254 hmm..] "iya ibu kita rawat-rawat, ajak-ajak ke dokter aja dah, mesuntik-suntik gini aja"
255 gitu dia.. di.. juga terbentur biaya juga kan [D: hmm.. hmm..] dimana nyari uang segitu
256 kan, kita.. ndak.. ndak dah bisa trus jugaan ibunya juga ndak mau [D : hmm.. hmm..]
257 "ndak ibu, diamputasi" gitu [D: hmm..hmm..] oh iya gitu.. berpikir juga kita untuk
258 biayanya kan [D: hmm.. hmm.] 80 juta disuruh, dimana nyari uang segitu gitu. "oh iya
259 dah" 00:23:19-6
260 D: 00:23:20-2 Itu sudah dengan BPJS nike? 00:23:22-0
261 Y: 00:23:22-3 Ngga.. waktu itu kan belum ada [D : oh belum ada] he eh.. 00:23:24-5
262 D: 00:23:24-8 As.. askes juga ndak [Y : he eh] karena bukan ini ya.. ee.. pegawai ini ya
263 [D: he eh itu dah] formal ya? [Y: ndak ada gni] waktu itu belum ada hmm.. 00:23:33-1
264 Y: 00:23:34-4 Makanya BPJS kan baru..baru [D: baru] baru keluar itu heeh 00:23:37-9
265 D: 00:23:37-9 iya itu baru keluar tapi mungkin belum.. belum banyak yang pake atau
266 gimana ya? 00:23:43-3
267 Y: 00:23:42-7 he eh.. kalo udah keluar BPJS tu, tu dah waktu dapet apa.. yang sakit
268 keras tu baru pake BPJS terus. 00:23:49-7
269 D: 00:23:49-9 hmm.. waktu kapan? oh sakit yang thypus tu? 00:23:52-4
270 Y: 00:23:52-3 he eh.. thypus sama DB tu terus pake BPJS. 00:23:55-3
271 D: 00:23:55-6 oh jadi sebelum thypus DB tu sudah sempet mau ke sanglah nike? [Y:
272 he eh] oh jadi sebelum nike? 00:24:01-4
273 Y: 00:24:01-4 he eh sebelum ada BPJS itu. [D : hmm.. hmm..] makanya ndak gini..
274 ndak punya kartu apa gitu kan ndak gini.. ndak berani jadinya 00:24:10-2
275 D: 00:24:10-3 hmm.. hmm.. asuransi gitu-gitu waktu nike? [Y : belum] sudah ada
276 belum? 00:24:14-6
277 Y: 00:24:14-8 he eh.. belum ada apa, cuman biaya sendiri aja [D : hmm..] kan agak
278 gimana ya, agak berat juga dikit hehehe 00:24:22-2
279 D: 00:24:22-2 iya iya, bisa cerita kalo untuk kegiatan bu Yani sehari-hari tu jadinya
280 gimana gitu untuk ini ya apa.. ketika itu ya me-- merawat mertua juga, trus harus
281 mengerjakan yang lain 00:24:34-0
282 Y: 00:24:33-4 kegiatannya.. harus bisa sih semua.. kegiatan 00:24:37-9
283 D: 00:24:36-5 hmm..ya gimana waktu itu pengalamannya bisa cerita hehe? 00:24:40-7
284 Y: 00:24:41-7 aduh.. bisa ndak bisa harus bisa tu semua karena kita kan menyangkut
285 orang banyak [D : hmm] nyari jajannya itu [D : hmm.. hmm..] ya atur sambil.. sambil
286 lah, kerja sambil ngerawat gitu.. ndak.. ndak sih gini, cuman kita aja yang agak payah
287 hehehe. 00:24:56-9

288 D: 00:24:56-9 hmm.. apa yang bu Yani rasain ketika satu hari itu.. belum lag ibu jadi
289 ibu rumah tangga kan? 00:25:02-2
290 Y: 00:25:02-4 he eh.. semua harus urus semua waktu itu kan masih anak-anak masih
291 dianter jemput juga 00:25:07-1
292 D: 00:25:07-2 ohh.. nah itu dah bu, gimana bu? cerita bu gimana ye kalo ibu inget. 00:25:11-6
293 Y: 00:25:12-7 gimana ya [D : ngaturnya] ya.. pekerjaan dirumah kan bisa diatur ya [D
294 : hmm] nganter, dimatiin kompornya dulu, jemput siangnya hehehe.. lagi kerja, lagi
295 nanti kalo ibunya mau apa gitu dipanggil, sambil dah, sambil kerja kan bisa aja gitu [D
296 : hmm] ndak sih gini.. [D : hmm] ee.. gimana ya.. berat sih berat.. cuman biasa aja gitu
297 hehehe (D tertawa) ga sih sampe saya ngga kerja, ngga bikin [D : iya] lumpia tu engga..
298 engga sampe libur lah gitu, karena kan udah gimana udah satu rumah gitu, ngga sih
299 sampe terganggu juga [D : hmm.. hmm.. hmm..] kalo lain dulu sama itu.. wak nya [D :
300 iya] adik bapak saya itu [D : iya] baru syaa libur terus.. 00:26:04-1
301 D: 00:26:04-5 ohh.. gimana itu bu? yang.. yang di kampung kan nike? 00:26:08-1
302 Y: 00:26:07-8 he eh di kampung, karena nungguin di rumah sakit kan, ndak bisa [D :
303 hmm.. hmm.. hmm..] kan harus bolak balik dari rumah sakit Gianyar ke sini itu [D
304 :hmm] lagi ibunya disini, sakit gini kan harus diperhatiin juga gitu 00:26:21-8
305 D: 00:26:21-8 oh jadi waktu itu 2?[Y: iya] ee..ke Gianyar, disini juga? ohh.00:26:26-8
306 Y: 00:26:28-4 ee.. disini ibunya kan masih bisa sama cucunya, sama anak.. paling tyang
307 liat apa keperluan dapurnya, masih ada apa ndak gitu aja sih [D : hmm.] nadk.. kalo
308 waktu itu libur berbulan-bulan hehehe ga bisa kerja aduhh.. 00:26:48-5
309 D: 00:26:49-0 Waktu itu apa yang dirasakan bu? kalo inget-inget itu apa namanya..
310 pengalaman itu ya, me-- mengasuh dua lansia, merawat trus dengan ngatur pekerjaan
311 rumah juga, rumah tangga atau apa gimana itu? 00:27:01-1
312 Y: 00:27:01-6 Gimana ya.. hadeh.. ck.. agak gini sih.. ndak sih biasa tyang [D : biasa?]
313 he eh.. ndak.. ndak begitu beban lah [D : hmm..] gimana cu,am, mikir gimana caranya
314 ngatur waktu itu, "oh biar bisa kesini, biar bisa kesini" gitu aja dah, nadk sih terlalu gini
315 tyang. Kalo anak-anak kan udah dititip disini [D : hmm hmm] hehe.. sekolahnya deket
316 disini hehe. 00:27:24-9
317 D: 00:27:24-7 hehehe.. iya apa yang memuat ibu ini.. apa ya yang membuat ibu bisa
318 melalui itu kenten? 00:27:31-7
319 Y: 00:27:33-1 Pasrah aja sih hehehe (D tertawa) pasrah.. cuman gimana.. ya jalanin aja
320 [D : hmm] sesuai dengan jalannya apa yang kita bisa lakukan [D : hmm.. hmm..] kita
321 lakukan gitu, ngga sih terlalu.. kalo tyang gimana ya.. apa yang lebih utama itu lah yang
322 tyang lakukan [D : hmm.. hmm..] gitu "oh yang harus kita uta-- yang duluan kita
323 kerjakan, ni yang kita kerjakan" [D : hmm.. hmm..] gitu, ga sih terlalu gini ya.. biasa
324 aja [D : hmm hm] walaupun seperti itu ya keadaan seperti ini gimana, ya jalanin aja [D
325 : hmm.. hmm..] sesuai dengan gini alurnya hehehe 00:28:15-0
326 D: 00:28:15-3 hehehe kalo dari pelajaran hidup gitu, apa yang ib dapet dari ya itu lah
327 ee.. peristiwa seperti itu tadi ya [Y: he eh] apa.. harus ke Gianyar, disini juga harus
328 ngurus mertua? 00:28:26-8
329 Y: 00:28:26-2 ya kita pengalamannya, ya kita semakin dikuatkan lah.. gininya, gimana
330 ya.. lebih gini kita wawasan kita untuk merawat orangtua tu, "oh ternyata seperti ini"
331 gitu [D : hmm] pelajarannya, "oh ternyata merawat orangtua seperti ini, ini lah
333 kewajiban kita" ini kan termasuk kewajiban [D : hmm] bukannya kerjaan ya hehehe (D
334 tertawa) kewajiban kan harus dijalankan [D : hmm] gitu sih tyang ngga begini.. ndak
335 gimana.. kepikiran, "oh orangtua seperti ini" ndak sih [D : hmm] seperti itu hehe. 00:29:02-9
336 D: 00:29:03-7Pengalaman kalo paling capek biasanya kalo pas gimana bu?00:29:07-7
337 Y: 00:29:08-8 Pas kerja.. hehehe [D : hehehe gimana nike?] kerja dari pagi kan [D : he
338 eh] jam dua, jam setengah tiga tu dah harus bangun [D : ohh] bikin lumpiang trus.. kalo
339 apalagi hari minggu tu kan [D : he eh] hari sabtu, minggu tu udah.. udah [D : hmm]
340 drop sampe malem.. [D : hmm.. hmm..] kadang-kadang jam sepulu baru selesai, belum
341 lagi anak kan jam 12 bar tidur, besok lagi.. aling dapet tidur dua jam, tiga jam aja [D :

342 hmm hmm] yang itu dah payahnya hehehe (D tertawa) haduhh. 00:29:41-5
343 D: 00:29:42-4 Kalo merawat orangtua apa yang paling ini lah.. paling sulit gitu menurut
344 ibu? [Y: Paling sulit kalo..] pas.. pas.. seperti, pas kenken ne paling.. 00:29:50-3
345 Y: 00:29:50-8 Pas kalo lagi ngga bisa ke kamar mandi [D : ohh] itu yang paling sulit
346 untuk kita.. [D : kenapa nike bu?] iya.. kan kita harus ngelayanin utnuk buang air waktu
347 itu kan.. belum lagi kesibukan kita, itu yang paling sulit kalo tyang rasa.. 00:30:07-0
348 D: 00:30:07-6 hmm.. hmm.. hmm.. buat ibu itu yang paling sulit ya? 00:30:10-7
349 Y: 00:30:11-3 Kalo udah bisa.. ya walaupun gimana sakitnya yang penting udah bisa
350 kekamar mandi udah dah seneng hehehe 00:30:17-4
351 D: 00:30:17-5 hehehe... pernah ceri-- cerita bu satu pengalaman harus ibu lagi kerja
352 didapur gitu yang harus nganter ke kamar mandijuga itu gimana? 00:30:26-7
353 Y: 00:30:27-2 Ndak sih.. kalo mertua [D : ndak?] tyang untuk ke kamar mandi ndak
354 pernah dianter ngga.. bisa jalan [D : berarti ini ohh] artinya.. gimana ya.. ee.. bawa itu
355 dah kursi atau pake [D : ohh iya iya] cuman tyang ikutin aja, takutnya jatuh kan.. pelan-
356 pelan gituin aja sih [D : hmm.. hmm..] ndak sih pernah sampe.. ya mudah-mudahan sih
357 ndak ya [D : iya] jatuhnya itu di kamar mandi biar nda.. [D : iya] ndak sih. 00:30:50-9
358 D: 00:30:51-2 Iya.. berarti ni yang kemarin nganter ke kamar mandi tu yang adiknya
359 bapak nike sempet..bu Yani ada pengalaman ga nganter ke kamar mandi siapa yang itu?
00:31:02-4
360 Y: 00:31:01-8 oh yang itu uwaknya [D : iya] iya he eh nganter ke kamar manid tu..
361 orang apa.. yakan cowok [D : hmm] tapi kan kita agak gimana ya [D : ohh] dia ajak itu..
362 iwaknya itu ndak mau juga gitu [D : hmm] kan malu hehehe [D : hehehe kayak risih
363 kenten ya] he eh iya.. mau paling dianterin, ditaruin inpusnya, [D : hmm] mau ke kamar
364 mandi sendiri gitu.. soalnya ada sih sama yang d rumah tu diajakin [D : hmm hmm
365 hmm] ya seperti itu lah [D : iya iya] ndak hanya hehehe (D tertawa) kalo dulu bap--
366 mertua yang cowok baru sakit, di rumah sakit tu tyang yang nunggu [D : hmm.. hmm..]
367 juga tiga dah.. [D : tiga lansia dah ya] tiga lansia dah hehe pengalaman makanya iya ini
368 dah sebaga pengalaman kita [D : iya] kita tu lebih dikuatkan jadinya [D : hmm] pondasi
369 kita dikuatkan lah eheheh [D : hmm.. dikuatkan untuk napki nike bu?] untuk ya.. ngga..
370 ngaa.. apa terkejut lagi untuk merawat orangtua gitu [D : hmm] ga gimana.. ga beban
371 jadnya kan [D : hmm... hmm..] gimana.. jiwa kita yang kuat jadinya kan [D : hmm..
372 hmm..] oh ndak.. ndak sih.. harus beban kalo orang baru-baru pertama kali ngerawat
373 orangtua kan beban jadinya [D : iya] "ih kita harus gini lo, gimana.. kita ga bisa kerja,
374 ga bisa gini, ga ada penghasilan kan" emang kalo tyang ndak sih. [D : hmm] "ya ini
375 harus kewajiban kita, harus kita jalani" ya seperti itu lah hehe 00:32:35-2
376 D: 00:32:35-3 hehehe.. yang pertama ngerawat tu berarti yang ee.. bapak mertua ya?
00:32:40-2
377 Y: 00:32:40-4 he eh. ya itu yang pertama langsung meninggal 00:32:42-5
378 D: 00:32:42-8 Ohh itu gimana ketika itu? ibu kan itu pertama kali ibu [Y : he eh]
379 ngerawat yaa.. [Y : he eh] tu ma-- gimana pengalamannya? 00:32:48-2
380 Y: 00:32:48-6 Pengalamannya.. "ehh aloo ndak boleh" (Y berbicara pada anaknya)
381 gimana.. kan waktu itu ngajak ke rumah sakit [D :he eh] ke rumah sakit ditungguin,
382 ngga sih gini.. gimana ni.. gimana untuk wak-- waktu itu kan belum ada BPJS, ndak
383 ada.. kita biaya sendiri kan [D : he eh he eh] "nanti gimana ini biaya rumah sakitnya"
384 hehe kita ndak punya apa itu, masih.. untung masih bapaknya masih sih.. punya uang,
385 ibu.. (saudara Y berbicara) ibunya punya.. masih.. bayar rumah sakit berapa waktu itu,
386 sekitar tiga jutaan lah [D : hmm.. hmm..] yaa.. mau, bisa lah kita gini [D : hmm] trus
387 udah sampe dirumah ngerawat tu kan.. di pulangkan dari rumah sakit tu [D : hmm]
388 pulang, trus sampe rumah masih aja seperti itu kan [D: hmm] trus tambah parah lagi
389 hehe [D : hmm] waktu itu ee.. kan minta.. apa ya.. minta ee.. mie, [D : iya] minta sarimi
390 itu, tak kasi mie gitu, trus makan kan tak kasi ayam, daging ayam [D : hmm] daging
391 ayam diminta, digoreng.. abis itu, itu dah sekarat mertua tyang [D : hmm..] kejet-kejet
392 gini [D : he eh] kan bingung tyang, bingung trus tak telpon dah bapaknya masih kerja..
393 ndak gini.. belum gini, belum.. langsung koma dah waktu itu [D : hmm.. hmm..] tapi
394 udah dirumah, trus dateng dah ipar tyang nike marah-marah dia. [D : hmm.. hmm..] "ni

395 dah baru.. baru saya ndak punya uang, udah cepet-cepet diajak pulang gitu" [D : hmm]
396 trus, "oh ndak bukan saya ngajak pulang, ni udah dokternya ngasi rekomendasi. Kalo
397 ngga gitu tyang ngga berani ngajak pulang" gitu tyang [D : he eh he eh] itu dah marah-
398 marah dia, waktu itu yee baru tyang gimana ya.. mungkin karena saking kesel ya
399 digituin tu [D : hmm.. hmm.. hmm..] kan jadnya terpancing emosi kita [D : iya iya iya]
400 baru dah, "gini gini gini" tak gituin bapaknya, "ya jangan dah.. ya jangan itu didenger,
401 biarin aja dia ngomong" diem juga tyang.. trus waktu itu ada dah yang ngasi tau juga..
402 lagi mau sadar tu kan [D : hm.. hmm..] mau sadar bapak, biasa.. tapi udah gimana, udah
403 lemes gitu.. ga bisa duduk.. duduk gini [D : hmm.. hmm..] tapi ngga dibilang waktu itu
404 sakit padahal kanker.. kanker gini.. hati [D : hmm] trus diajak.. ada temen ya ngasi tau,
405 "coba di cek kesana aja, dokter profesor Wibawa" [D : hmm.. hmm.. hmm..] yang di..
406 Ponogoro itu, tau? [D : ndak sih] ndak? [D : he eh] disana itu.. trus saya ajak kesana,
407 pertama kali tu.. karena kesakitan terus sakit tu [D : iya iya] dah apa.. keras gitu [D :
408 hmm.. hmm..] dibawa kesana tu trus dipanggil sama dokternya ee.. "bu kayaknya ndak
409 bisa dah dirawat" 00:35:58-8
410 D: 00:35:59-6 he eh.. sebentar nggih (handphone D berbunyi) nggih trus? 00:36:09-1
411 Y: 00:36:10-2 trus ee.. gini.. ee.. "maaf ya ini bapaknya kalo ibu mau rawat ini bapaknya
412 juga.. ngga seberapa untuk meng-- pengaruhnya.. kalo diinpus tu cuma ngilangin rasa
413 sakitnya, itu pun ndak hilang sakitnya" gitu, [D : hmm.. hmm..] "ini nunggu waktu aja"
414 gitu dokternya. trus tyang nanti kasi dah obat, mungkin vit-- apa itu dikasi obat [D :
415 hmm.. hmm..] dikasi juga obat, "ini udah ee.. kanker hati ini namanya, kanker udah..
416 gininya udah sirosis apa.. udah sirosis udah keras" memang udah keras ininya, udah
417 keliatan gitu. 00:36:51-5
418 D: 00:36:52-5 Kaku dah ini.. perut atau apa tu ya? 00:36:54-8
419 Y: 00:36:55-3 Kaku trus.. "trus gimana dok solusinya?" tak gituin, "ya lebih baik dah
420 dirawat di rumah kalo ada apa-apa nanti kan semua keluarga liat, kalo ibu mau.. boleh
421 aja maudi bawa ke rumah sakit lagi, cuman ee.. terutama tyang pikir biayanya juga,
422 harus keluar biaya". gitu dah dokternya [D : iyaa] "ee.. trus yang kedua nanti kalo ada
423 apa-apa, ada ibu aja, siapa yang nunggu itu aja yang liat" gitu dokternya [D : hmm] "oh
424 gitu ya dok, oh nggih.. nggih" trus tak ajak pulang.. pulang ya memang bener sih, udah..
425 sampe rumah tu udah ngga sadar-sadar kan tiga hari ada koma.. [D : hmm.. hmm..] dah
426 ngga dkasi minum satu sendok gitu.. udah ndak.. ndak ini apa-apa dah.. trus sampe itu
427 dah muntah darah itu [D : hmm.. hmm..] pagi-pagi tu muntah darah. Anak tyang waktu
428 itu masih TK yang ini [D : hmm yang nomer dua] he eh yang nomer dua waktu itu..
429 muntah darah.. ya sampe.. satu ember [D : hmm..] sampe satu ember tu keluar darah
430 item-item gitu [D : hmm.. hmm..] muntah.. tu langsung meninggal. 00:38:06-0
431 D: 00:38:06-4 hmm.. hmm.. waktu nike yang merawat bu Yani? 00:38:09-4
432 Y: 00:38:09-8 iya tyang sama adk ipar yang.. cewek tu [D : ohh karena belum nikah]
433 he eh beum nikah, pas dia pulang [D : hmm] waktu itu kan masih kuliah di Malang [D
434 : iya he eh] he eh.. pulang, trus bapaknya kerja, ga tau bapaknya gitu [D : hmm.. hmm..]
435 waktu megatnya [D : iya iya] ga tau.. [D : kalo ibu mertua waktu tu?] iya ada.. [D : oh
436 ada..] he eh.. ada.. ada.. kalo ibu mertua kan ga bisa ngapa-ngapain, nangis aja hehehe..
437 karena ga bisa jalan ndak bisa kan [D : iya iya iya] waktu itu mandiin itu dah mertuanya
438 yang cowok tu tyang.. angkat dah bawa ke kamar mandi, di mandiin, tyang yang
439 mandiin sama itu adik ipar yang cewek [D : hmm.. hmm..] mandiin dah di kamar mandi,
440 disabunin waktu itu.. ada yang megang satu, ada yang nyabunin gitu [D : hmm.. hmm..
441 hmm..] tak angkat dah bawa ke kamar mandi hehe.. (D : tertawa)aduh.. itu dah
442 pengalamannya [D : hmm..] ya semenjak itudah, "ohh gini ternyata kita di keluarga"
443 unntuk.. kan tyang udah sering soalnya nunggu anak, ni kan sering sakit [D : hmm]anak
444 tyang yang nomer dua [D : hmm] tiap tahun masuk rumah sakit [D : hmm.. hmm..]
445 waktu itu punya kenapa kok.. kita setuju ternyata ini jawabannya.. mertua sakit
446 langsung gini [D : iya iya] kan kita udah terbiasa lah di rumah sakit [D :he eh] ngga
447 jadinya gini apa.. gimana kalo pertama di rumah sakit tu, kalo orangtua kan biasanya
448 ngga.. ngga enak gitu [D : hmm.. he eh] tyang biasa aja.. [D : iya] karena udah biasa
449 [D: iya] ngerawat orang sakit, anak tu kan sakit [D : iya] terus.. anak tyang niki emang

450 sering sakit [D : ohh] makanya kondisinya agak.. [D : hmm] kemarin aja pingsan [D :
451 ohh kapan nike pingsan?] kemarin [D : ohh] di sekolah hehe [D: ohh disekolah] aduh..
452 waktu SMP.. SMP delapan kan [D : iya iya] pernah juga pingsan, langsung sakit juga
453 itu [D : hmm.. hmm.] sebulan ndak bisa.. bangun 00:40:03-6
454 D: 00:40:02-7 hmm.. hmm.. apa bedanya bu merawat ee.. anak sama merawat mertua
455 gitu ya? napi? 00:40:09-6
456 Y: 00:40:10-5 Beda banyak.. [D : he eh] kalo anak kan bisa digendong (D tertawa) bawa
457 kemana-mana masih gampang [D : iya iya iya] kalo orangtua kan ndak bisa [D : hmm]
458 itu yang susahnya [D : hmm hmmm] makanya tyang kalau udah orangtua sakit tu
459 bingung [D : hmm] karena mau ngajak kemana tu susah harus ada yang nemenin, harus
460 [D : hmm..] ngga bisa sendiri lah [D : hmm] melibatkan banyak orang itu. 00:40:34-4
461 D: 00:40:34-6 iya hehe berarti se-- sekarang kan ibu merawat.. memperhatikan anak
462 juga [Y : he eh] dengan kondisinya seperti ini trus mertua juga gitu ya [Y : iya] gimana
463 itu ininya apa.. membaginya ya [Y : membagi waktu?] membagi waktu, pikiran lah apa
464 yang paling ini hehe paling apa.. 00:40:53-6
465 Y: 00:40:53-0 ngga sih ada gini.. biasa aja tyang kalo anak lagi sakit ya paling.. kalo
466 udah mau agak lemes itu dia kasih dah vitamin [D : iya] suruh.. biar ndak sampe jatuh
467 sakit gitu [D : iya iya] kalo mertua tyang udah gini.. udah ndak mau makan itu, udah
468 tak kasi dah vitamin, tak beliin dah vitamin dah beliin dah vitamin biar ini [D : hmm..]
469 ndak mempan juga, baru dah diajak ke dokter gitu aja sih.. ndak ada gini.. [D : hmm]
470 yang harus dipikir lagi [D : iya] hehehe udah gini.. apa.. udah terbiasa gitu. 00:41:28-4
471 D: 00:41:28-0 udah terbiasa ya.. kalo ee.. tugas-tugas dirumah itu siapa yang biasanya
472 ini bu.. apa namanya.. banyak bantu ibu? 00:41:35-6
473 Y: 00:41:37-3 Ngga ada siapa.. sendiri aja sihh [D : hmm.. dari pagi?] anak.. anak udah
474 ndak pernah di rumah kan [D : he eh] udah sekolah semua, trus suami udah kerja [D :
475 ohh] tyang aja sih sendiri [D : ohh he eh] dari nyapu, segalanya dah [D he eh he eh
476 hehehe] nyuci, nyetrika ya udah sampe malem.. kalo gimana ada selang waktu dikit..
477 ambil kerjaan nyuci [D : hmm.. hmm..] kalo nyuci kan udah mesin hehehe, nyetrikanya
477 dah yang susah.. 00:42:06-4
478 D: 00:42:06-6 hehehe iya nyetrika paling susah ya. 00:42:09-3
479 Y: 00:42:09-4 he eh.. paling malem hari dah diambl gitu.. tyang ndak sih pernah gini..
480 kalo udah segeran bayu bedik, jemak gae'e [D : iya hmm..] gitu, kalo udah gim-- nduk..
481 ya ndak dah [D : hmm.. hmm..] lebih baik dah tidur aja, besok pagi udah bangun lagi
482 hehehe 00:42:27-5
483 D: 00:42:28-0 iya hehehe.. bisa cerita satu pengalaman yang ibu merasa capek sekali
484 gitu, melakukan semuanya gitu ya.. 00:42:35-1
485 Y: 00:42:36-4 Capek ya.. [D: he eh] kalo capek sih terus ya hehe. 00:42:39-6
486 D: 00:42:39-5 ohh.. itu dah apa yang ibu ra-- atau ibu merasa, "aduh kayaknya udah
487 banyak sekali yang harus dilakukan gitu ya" 00:42:47-1
488 Y: 00:42:47-2 ohh. kalo pas capeknya tu kalo saya lagi sakit itu dah [D : ohh] kalo udah
489 saya yang sakit.. tapi pekerjaan karena harus beres semua [D : he eh] itu dah yang paling
490 beratnya [D : hmm.. hmm..] ngga bisa.. kalo tyang udah ngga bisa kerja semua dah ngga
491 jalan. 00:43:03-7
492 D: 00:43:04-2 hmm.. kapan terakhir tu bu, bisa cerita ngga? yang ibu ngerasa itu lah..
493 ibu sakit trus merasa bebannya udah.. 00:43:10-7
494 Y: 00:43:11-1 ee.. waktu hamil kemarin [D : ohh] waktu ini dah.. 00:43:13-9
495 D: 00:43:14-4 ohh kira-kira setahun yang lalu berarti ya? 00:43:16-6
496 Y: 00:43:17-7 iya [D : ohh] setahun yang lalu iya [D : he eh] ngga setahun.. iya
497 setahunan dah.. waktu Nyepi kemarin kan tyang opname [D : ohh he eh] he eh itu dah..
498 sebelumnya tu kan udah sakit terus.. [D : hmm.. hmm] ndak bisa kerja tapi.. terpaksa
499 harus.. kalo bisa ngelawanin, tak lawanin dah.. ke pasar, apa gitu [D : he eh he eh] trus
500 ngeliat di.. siapa yang disuruh ngga ada siapa hehehe [D : hmm.. hmm.. hmm..] anak-
501 anak itu dah paling berat. [D : hmm.. iya] kalo kita lagi sakit, semua pekerjaan harus
502 beres hehehe [D : ohh ohh] kerjaan rumah itu kan bisa... [D : nonstop?] di he eh.. ga
503 bisa ditinggal gitu [D : hmm..] di dapur masak gitu tu.. nasi tu harus ada lah.. [D : hmm..

504 hmm..] paling ya.. bangun bik-- anu nasi aja [D : hmm.. hmm..] kalo masak kan bisa..
505 ya telor apa lah itu anak-anak. [D : hehehe] aduh.. yang penting ada bahannya aja [D :
506 hmm.. hmm.. hm.] iya.. kalo udah sehat-sehat sih ngga.. [D : iya] ndak sih ginii.. kalo
507 kerja tu kan udah kewajiban ya [D : iya] ndak ada.. gini lagi hehehe. 00:44:39-0
508 D: 00:44:40-0 hehe..apa namanya waktu sakit nike napi yng ibu rasakan? 00:44:45-0
509 Y: 00:44:46-3 aduh ndak dah bisa berpikir hehe [D " ndak bisa berpikir?] ga bisa mikir
510 apa-apa sudah [D : he eh] pasrah aja karena udah saking gimana ya.. sakit bangun ndak
511 bisa.. mau gimana lagi [D : hmm.. hmm.. hmm..] paling disuruh anak ke pasar, paling
512 memantau aja di dapur seperti apa [D : hmm.. hmm..] ada apa aja, "oh gini beli, gini..
513 gini.." gitu aja sih suruh anak [D : ohh suruh anak mau mengerjakannya ya] jadi.. kalo
514 ada orang mau beli tepung gitu, paling nimbang gitu maksain dah [D : hmm.. hmm..]
515 kalo.. kasian kan orang mau beli ndak ada gitu. 00:45:25-4
516 D: 00:45:25-4 iyaiya hehehe (Y tertawa) dari tadi bu Yani ee.. bicara tentang kewajiban
517 berarti itu yang selama ini membuat kuat ya [Y : he eh hehehehe] bisa cerita, apa yang
518 ibu rasa, kewajiban apa yang ibu maksud nike? 00:45:39-7
519 Y: 00:45:40-6 ya kewajiban ibu rumah lah seperti apa.. misalnya ngerawat orangtua,
520 ngerawa3t anak itu kan [D : hmm.. hmm..] udah kewajiban itu ya.. itu dah gini.. ya
521 walaupun ndak.. capek juga ya hehehe [D : he eh hehehe] walaupun ndak menghasilkan
522 tu kan [D : he eh] kewajiban rumah itu aja dah.. [D : hmm..] kewajiban ibu rumah tangga
523 pekerjaan gitu-gitu aja hehehe.. 00:46:09-9
524 D: 00:46:10-5 Bener ni bu Yani ngga pernah ngeluh? 00:46:12-0
525 Y: 00:46:12-6 ndak (D tertawa) apa yang harus di keluhkan lagi hehehe 00:46:16-3
526 D: 00:46:17-1 Kenapa bu? ap-- kenapa ibu bilang, "apa yang harus dikeluhkan lagi?"
527 napi? 00:46:20-4
528 Y: 00:46:20-8 Ya kalo dikeluhkan juga seperti ini aja hehehe (D tertawa) ndak ada
529 perubahan.. aduhh.ndak sih tyang, ya biasa-biasa aja.. suami gitu ndak.. [D : hmm]
530 paling gitu dah.. bapaknya yang agak khawatir [D : iya] liat tyang, "mu istirahat, ada
531 aja kerjaan yang diambil" iya.. "kalo ga tyang yang ambil saapa lagi disuruh?" tak gituin
532 [D : hmm..] paling bapaknya yang lebih khawatir sama tyang [D : iya iya] gitu. 00:46:47-4
533 D: 00:46:47-7 Pernah.. bisa kasi contoh yang pas bapaknya khawatir biasanya napi yang
534 disampakan? 00:46:51-9
535 Y: 00:46:53-2 Paling disuruh istirahat lah.. ya sekali-sekali libur, disuruh jangan gimana
536 mau.. soalnya kita kan ngga bisa.. kalo libur paling ada acara apa dikampung gitu baru
537 tyang libur.. ndak pernah libur untuk santai gitu memang endak.. [D : hmm] kecuali
538 dagangnya yang libur baru tyang gini.. [D : ohh] soalnya kasian juga dagangnya tu kan..
539 gininya [D : hmm..] itu aja yang diandalkan [D : hmm.. hmm.. hmm..] kalo kita libur
540 nadak tu kan ndak bisa [D : ohh] untuk kerja, nyangkut orang banyak soalnya [D:
541 hmm..] kan kasian juga ya [D : he eh] hehehehe.. 00:47:34-1
542 D: 00:47:36-5 Jad ini ya bu ya.. apa. merasa ya kewajiban itu memang harus dijalani,
543 malah suami yang khawatir? [Y : he eh] kalo suami napi yang biasanya.. ikut kontribusi
544 napi biasanya untuk keperluan keluarga? [Y : maksudnya?] kalo dari suami ya.. ee..
545 bantu-bantu napi biasanya kalo di rumah? 00:47:55-4
546 Y: 00:47:55-6 Dalam kerjanya? [D: he eh] ohh ya bantu bikin itu dah.. kulit lumpia [D
547 : hmm] apa ja kalo anu mau kok dia bantu [D : hmm.. hmm..] kalo udah libur bantu
548 dah.. bikin kulitnya tu kan lumayan juga.. [D: hmm..] tyang bisa ngerjakan yang lain..
549 [D : hmm.. hmm..] kalo udah anu gitu.. 00:48:10-9
550 D: 00:48:11-0 iya.. iya... dari kulit lumpia tu apa sihbu yang didapet bu? sampe ibu
551 sekarang bertahan gitu ya mengerjakannya terus gitu? 00:48:18-7
552 Y: 00:48:19-2 iya itu yang.. untuk uang dapurnya hehehe [D : ohh dari sana?] iya.. kalo
553 uang dapur, bekel anak itu [D : hmm] kalo bapaknya ngga sih cukup.. pake itu, pake
554 bulanan aja hehehe [D : hmmm] adehh..kalo ngandelkan gaji bapaknya itu ndak.. paling
555 bayar UKT anak [D : ohh ohh] gitu, SPP.. dia yang.. bulan-bulanan tu bapaknya.. kalo....
556 gitu apa.. gajinya untuk makan setiap hari ndak lah cukup hehehe 00:48:52-6

557 D: 00:48:53-4 Gimana ibu ngaturnya? bisa cerita ngatur.. ngatur itunya lah dari lumpia
558 itu gimana? 00:48:58-7
559 Y: 00:48:58-9 udah.. kan ndak.. nadk gini apa.. ngga bisa.. tyang ndak, "ohh ini
560 untungnya" tu ndak.. [D : ohh] gimana orang uang tu kan berputar [D : iya] berputar iya
561 mau.. beli untuk apa.. beli beras kan dari sana [D : he eh] muter uangnya, ndak gini
562 kan.. sekarang beli beras, besok beli gini kan.. uang itu berputar dia [D : ohh] ndak
564 tyang.. kalo ditanya untungnya ndak bisa cerita [D : ohh ohh] ya berapa-berapa
565 penghasilan ngga bisa. 00:49:29-2
566 D: 00:49:29-4 he eh.. ibu simpen gitu uangnya dimana gitu ada apa.. 00:49:33-3
567 Y: 00:49:33-7 ndak.. [D : ndak?] hehe cuma muter disitu aja [D : ohh] belum bekel anak
568 itu kan [D : oh ohh hmm] bukannya.. apalagi itu yang.. kuliah itu uang.. bayar ini itu
569 kan ada aja itu [D : hmm.. hmm..] setiap minggu lah, setiap anu.. bayar gini gitu, itu ya
570 dari situ lah kita dapet gitu.. [D : dari situ dapet ya?] he eh.. kalo ngandalkan gaji aja
571 ndak bisa.. [D : hmm] kuliah itu hehehe. 00:50:02-5
572 D: 00:50:02-8 hehehe.. kalo diitung-itung gitu bu ya dari yang sudah keluar atau apa..
573 berapa kira-kira perbulan nike kalo lumpia nike? 00:50:09-8
574 Y: 00:50:11-2 ndak tentu lo.. [D : hmm] soalnya, orderannya itu kan ndak pasti [D :
575 iya] ndak pasti dia.. kalo setiap hari gini.. paling bikin.. ee.. berapa ya.. 500an lah [D :
576 hmm] kalo hari sabtu, kalo sabtu minggu itu baru bikin lebih.. kalo hari minggu bisa
577 sampe 2000an.[D ; hmm.. 200 buah?] biji ya [D : biji?] 2000 biji tu.. kalo hari biasa ni
578 ngga nutup, disana nutupin.. hari itu yang nutupin.. [D: iya] makanya kalo udah ada
579 uang baru belanja.. gitu [D :hmm] ndak bisa gini.. [D : hmm.. hmm.. hmm..] ndak
580 pernah tyang ngitung hehehe (D tertawa) paling bekel anak ya kalo yang itu yang kuliah
581 itu 50 ribu tiga hari [D : ohh] belum bensin lagi kan iya.. [D : hmm.. hmm..] mau sih,
582 ya untung juga anak-anak ngerti kan [D : iya iya] keadaanya 00:51:11-8
583 D: 00:51:12-4 Artinya perbulan nike ada aja ya? 00:51:14-4
584 Y: 00:51:14-7 iya.. bukan perbulan.. tiap hari itu harus [D : tiap hari] mengalir uangnya
585 hehehe [D :hehehe ada aja bu ya] iya harus ada pemasukkan.. kalo itu dah waktu saat
586 libur kita tu kan ndak ada... pemasukkan tu ya paling nutup-nutupin itu aja udah irit-
587 iritin lah dikit [D : hmm.. hmm..] hehehe makanya kalo beum.. kalo waktu masih SMP
588 SMP anak-anak kan masih bisa bantu.. bantu kerja itu, bisa lebih banyak bikin gitu..
589 kalo sekarang udah bikin sedikit-sedikit.. sendiri soalnya kan.. paling bapaknya kalo
590 diusahakan nyari libur sabtu minggu biar bisa bantu. 00:51:58-3
591 D: 00:51:58-5 biar ba-- karena yang banyak sabtu minggu nike nggih? 00:52:01-0
592 Y: 00:52:01-2 he eh iya.. itu dah yang nutup-nutupin sehari-hari hehehe 00:52:05-7
593 D: 00:52:05-8 hehehe tapi lumayan juga bantu-bantu ya 00:52:09-4
594 Y: 00:52:09-9 iya.. [D: hmm] lumayan hehehe (D tertawa) ada ndak ada harus gini [D:
595 iya] harus bisa ditutupin soalnya..[D: hmm] aduhh..kalo gini..bap-- ngandelin bapaknya
596 dah ndak bisa, dah pusing tujuh keliling hehehe (D tertawa) aduh.. 00:52:28-6
597 D: 00:52:28-7 iya.. waktu apa namanya ee.. kalo sekarang dengan kondisi ibu gitu ya
598 [D: heeh] apa namanya.. apa yang ee.. mungkin paling berat buat keluarga gitu ya..
599 mempersiapkan ininya.. apa pengobatannya atau napi nike dalam hal.. dalam hal apa
600 yang paling berat nike? 00:52:48-2
601 Y: 00:52:49-7 yang paling berat untuk sekarang? [D : he eh he eh] kalo sekarang.. yang
602 nganter kemana-mana itu yang berat [D : hmmm yang berat] he eh.. soalnya rumahnya
603 juga masuk gang kan [D : hmm.. hmm..] kalo mau jalan juga.. kalo mau naik ke motor
604 aja harus diangkatin [D : hmm] kan kakinya ndak bisa ditekuk [D : iya iya ohh] gitu..
605 berat [D : berat] berat dah.. mau ngajak ke.. berobat itu dah.. [D : hmm.. hmm..] mau
606 keluar itu susah [D : susah ya] sama.. kalo gitu kan jarang juga.. kalo engga ke rumah
607 sakit kan ngga bisa pake BPJS hehehe [D : he eh] belum obat harian [D : ohh] belum
608 mesuntik gitu kan lumayan juga. 00:53:34-4
609 D: 00:53:34-8 itu berati ndak.. ndak ndak tercover di BPJS ya? 00:53:37-5
610 Y: 00:53:37-7 he eh.. kan kita berobat sendiri soalnya [D : hmm.. hmm..] kan ndak
611 tercover jadinya. 00:53:41-7

612 D: 00:53:42-0 hmm.. kalo biasanya ke Perang sama ke Tampaksiring itu nak apa
613 jadinya, biasanya kesana? 00:53:49-5
614 Y: 00:53:49-5 Kemarin naik sepeda motor [D : ohh] kalo ke.. sana mobil di pake. [D :
615 le Tampaksiring?] he eh.. kalo ga bisa bawa kan disini.. disini Gede sering nganter hehe 00:53:59-8
616 D: 00:53:59-6 hmm..berarti itu juga harus keluar dari gang dumun nggih? 00:54:02-2
617 Y: 00:54:02-3 he eh.. iya itu dah susahnya makanya.. kalo udah agak ee.. turun dikit aja
618 masih bisa gerak itu udah diajak [D : hmm] biar ndak sampe [D : hmm..] parah sekali,
619 susah ngajak [D : hmm] gitu. 00:54:17-8
620 D: 00:54:18-1 hmm.. kalo suntik, vitamin, obat-obat yang ini tu berapa rata-rata habis
621 tiap bulan ya ininya [Y : tiap bulan?] apa biayanya he eh? 00:54:26-6
622 Y: 00:54:27-6 Kalo berapa ya.. kalo gininya inpus.. plaster.. 00:54:32-5
623 D: 00:54:33-0 hmm.. oh itu udah tiap hari harus ya? 00:54:35-0
624 Y: 00:54:35-1 he eh harus.. plester, perban sama obat ee.. [D : tensi?] salep, obat salep
625 [D: ohh salep] salep, obat tensi lagi [D : ohh] itu harus tiap hari tu ada [D : hmm.. hm..]
626 kalo gini obat tensi.. ee.. amplodiplin sih sekarang, ulu captropile tyang beli satu kotak,
627 satu kotak [D : hmm.. hmm..] dipak-- isi berapa tu ya satu kotak.. [D :hmm hmm..
628 berapa pepel gitu ya] isi sepuluh.. [D : oh isi sepuluh] he eh.. sepuluh.. [D : oh satu yang
629 kotak, satu pepel gitu berarti ya?] ng-- ngga ada yang kotakan.. [D : ohh] tyang satu
630 koatak biasanya beli isi 30 rasanya.. sebulan dah itu dipake [D : iya] satu kotak itu.. ee..
631 berapa ya jadinya.. kalo salep itu udah.. ee.. ada sebulan abis dah itu [D : hmm.. hmm..
632 hmm..] salep kakinya itu [D : hmm] kalo dulu masih pake Nebacilin Powder sih [D :
633 hmm oh yang] dulu.. ini baru diganti.. 00:55:34-4
634 D: 00:55:34-5 hmm yang dibilang sama odahnya serbuk itu? 00:55:37-4
635 Y: 00:55:37-4 he eh.. Nebacilin Powder itu [D : hmm.. hm..] serbuk.. itu sih cuman
636 harganya 25 an lah.. [D : hmm.. hmm..] 25 kan ad.. ngga.. ngga sama harganya itu 00:55:49-2
637 D: 00:55:49-3 iya, salep lebih mahal ya? 00:55:51-1
638 Y: 00:55:51-2 he eh.. 150.. yang sekarang hehehe tyang kira murah kemarin.. ih mahal
639 ya.. trus ditanya dirumah, berap-- mm.. "kude sik?", "ji karobelah tu" buih keto ye
640 hehehe.. terkejut tu.. ya gimana ya.. kalo ndak pernah ngitung-ngitung gitu tyang [D :
641 hmm..] kalo ada uang ya beli aja.. kalo gini ya berusahain lah gitu. 00:56:25-1
642 D: 00:56:25-3 hmm.. hmm.. hmm.. kalo yang dari untuk pengobatan ibu, perbulan nike
643 biaya yang keluar dari.. dari mana nike? dari gaji suami atau dari lumpia niki juga? 00:56:36-2
644 Y: 00:56:37-0 Campur [D : campur?] hehehe.. campur gimana kalo ya saling menutupi
645 lah.. gini.. kalo tu bapaknya ya udah ndak ada yaa dari.. itu dah lumpiangnya diatur-
646 atur dikit hehe [D : hehehe nggihh] tapi kebanyakan sih dari lumpiang, kalo bapaknya
647 sih gajinya udah abis disana [D : hmm] hehehe udah.. di.. udah habis di hotel dah
648 dipotong-potong, bawa kertas aja hehehe.. aduhh. [D : UKT juga mangkin ya] iyaa,
649 anak yang SMA tu kan SPP dah [D : iya] kena juga SPP.. lumayan juga SMA Negeri,
650 kalo dulu SMP baru sedikit.. 00:57:23-2
651 D: 00:57:23-6 Iya.. SMP sekarang free.. bebas, gratis sekarang kalo negeri.. [Y : baru
652 tu ya?] tapi bayarnya ya buku-buku atau apa beli trus.. [Y : gini apa ck..] seragam.. [Y
653 : dulu dapet] uang-uang ini, uang POM gitu istilahnya. 00:57:39-9
654 Y: 00:57:40-4 Dulu dapet ee.. di SMP delapan tu ee.. free [D : he eh] trus setelah pela-
655 - satu tahun aja dapet tu [D : ohh kenten? ohh] he eh seteah itu biasa bayar lagi [D :
656 ohh] tyang yang.. yang kelas tiga nya tu bayar 120.. [D : ohh] 120 bayarnya, yang baru
657 masuknya itu bayar ee.. 140 [D : ohh hmm] trus karena ada gitu, ndak bayar lagi.. [D :
658 hmmm] dapet setahun ndak bayar [D : hmm.. hm..] trus kelas tiganya lagi bayar gitu
659 [D: hmm hehe] kalo SMA nya bayar [D : iya] 275 SMA.. itu harus bayar gini.. di BPD
660 [D: ohh] enam bulan, sekalian. 00:58:25-4
661 D: 00:58:25-2 ohh sekalian enam bulan, per enam bulan jadnya bayar [Y : he eh
662 semesteran] iya iya. 00:58:29-6

663 Y: 00:58:30-2 kemarin ini belum bayar hehehe.. kemarin baru bayar UKT kakaknya aja
664 ehehe 00:58:34-5
665 D: 00:58:34-6 iya.. tapi kalo ndak ga disisihin juga berat juga nggih.. [Y : iya] langsung
666 kalo enam bulan itu ya? [Y : iya] harus memang perbulan tetep disisihin. 00:58:42-2
667 Y: 00:58:43-5 aduh.. sudah punya anak sekolah dah.. [D : hmm] tanggungannya mulai,
668 belum yang bayi lagi hehehe 00:58:51-1
669 D: 00:58:51-2 hehehe.. iya ngurus bayi lagi [Y : iya] gimana bu sejak ada bayi niki?
670 apa yang beda gitu? 00:58:59-5
671 Y: 00:59:00-1 Beda.. ga bisa bikin lumpia banyak-banyak hehehe (D tertawa) paling ya
672 dibatasi lah [D: hmm.. hmm..] orang order tu kan, ndak bisa.. soalnya sambil ngajak..
673 kalo iya kalo kakaknya libur, kalo sekolah ndak ada yang ajak dia.. susah hehehe
00:59:19-3
674 D: 00:59:19-1 hmm.. pernah ga setelah ee. melahirkan ini ee.. odahnya kumat gitu?
00:59:24-7
675 Y: 00:59:25-9 ndak sih ndak.. segini-gini aja [D : hmm] ngga terlalu parah sekali [D :
676 hmm.. hmm..] ndak.. ndak parah sekali, kalo ini dah yang sekarang ini dah kakinya
677 bengkak ini baru.. 00:59:35-8
678 D: 00:59:36-2 hmm.. hmm.. iya.. jadi belum.. belum.. belum ada yang parah ya setelah
679 lahir? 00:59:45-0
680 Y: 00:59:45-1 Belum parah sekali ndak sihh [D : hmm] cuman sekarang ini dah,
681 bengkak kakinya ni gimana ndak tau hehehe (D tertawa) udah sih diajak mesuntik gitu
682 [D : hmm] ngga gini.. ini lagi nanti disuruh ajak mesuntik. 00:59:59-6
683 D: 01:00:00-0 ohh kapan nike? 01:00:01-2
684 Y: 01:00:01-6 ya kapan je sempat bapaknya ni 01:00:04-0
685 D: 01:00:03-9 ohh. untuk mesunt-- untuk nyega-- pencegahan untuk ndak lebih gawat,
686 ini lagi ya.. tambah parah 01:00:10-7
687 Y: 01:00:10-2 ini sekarang kan sedang sakit sekali ni [D : ohh] hmm.. sedang sakit
688 sekali tu, makanya makan ndak mau [D : hmm] apalagi memang gimana.. ibunya
689 memang agak susah makan ya.. [D : hmm.. hmm..] agak.. gimana ya.. cerewetan lah
690 dikit (D tertawa) agak cerewet, cuma untuk makannya itu memang cerewet [D : hmm..
691 hmm..] gini ndak mau, gitu ndak mau.. [D : hmm..] makanya itu dah yang bikin kesel
692 hehehe (D tertawa) ndak mau makan. 01:00:38-7
693 D: 01:00:39-6 Gimana biasanya kalo udah kayak gitu, bu Yani gimana biasanya ke ibu?
694 hehe 01:00:44-2
695 Y: 01:00:44-5 Iya.. apa yang disenengin itu lah dibeliin [D : hmm] biar mau makan aja
696 hehehehe [D : hmm.. hmm..] apa yang dbilang, "ape mekite?" tak gituin dah [D : hmm..
697 hmm.] pengen apa gitu.. ya beliin, gini aja beliang ibunya.. itu aja ndak sih. 01:01:02-1
698 D: 01:01:02-2 Itu aja, akhirnya mau makan setelah itu? 01:01:04-4
699 Y: 01:01:05-4 beli apa.. ckk.. sehari-harinya sama orangtua kan biasa seperti itu [D :
700 hmm] agak cerewetan hehehe. 01:01:12-1
701 D: 01:01:12-4 hehehe.. untung bu Yaninya ini apa.. pasrah aja.. [Y : iya] kewajiban
702 hehehe 01:01:18-9
703 Y: 01:01:19-4 hehehe harus sabar. [D : he eh] adeh.. gimana. siapa suruh lagi orang
704 gitu.. ipar udah ndak ada yang mau, tyang ndak tega liat orangtua gitu [D : hmm..]
705 aduhh.. ibu saya aja ngga pernah gini.. tak tengok sana hehehe (D tertawa) aduhh.. disini
706 kan udah banyak ya [D : iya] kalo tyang sana kan sendiri [D : hmm.. hmm..]kalo ke
707 kampung, ajak ke kampung [D : hmm] ibunya.. 01:01:51-8
708 D: 01:01:52-0 hmm.. hmm.. kalo ibu disini pernah ga protes? pas bu.. bu Yani ndka
709 pernah kesini malahan kesitu? 01:02:00-3
710 Y: 01:02:01-3 ndak.. ndak.. kalo ibu disini saya.. gini, ndak bisa seperti ibu.. ndak
711 pernah ngeluh [D : hmm] anak, begini gitu ndak pernah [D : hmm] kalo ibu diem,
712 malahan tau begini kan tyang ndak pernah cerita [D : hmm..] nanti biar ndak dipikir kan
713 [D : hmm] kan biasa orangtua [D : iya] kalo anaknya lagi susah dipikir gitu hehe (D
714 tertawa) ndak tyang pernah cerita [D : hmm] keadaan, di rumah sana seperti itu dah.
01:02:30-3

715 D: 01:02:31-3 Ke siapa biasanya iu cerita? 01:02:32-5
716 Y: 01:02:33-0 Ndak ada.. hehehe [D : ndak ada? hehe ke saya] baru ini hehehe baru kali
717 ini hehehe. 01:02:36-8
718 D: 01:02:37-1 hehehe.. berarti sakti saya hehehe iya.. 01:02:42-2
719 Y: 01:02:42-2 cerita sama siapa harus gitu.. [D : iya] paling sama suami aja kalo gitu,
720 "ya ndak papa " tak gituin 01:02:49-2
721 D: 01:02:49-3 tapi orang bu Yani ndak ngeluh ke saya, orang ceritanya ini aja ap aya..
722 dijalani hehehe 01:02:53-6
723 Y: 01:02:53-4 iyaa.. kan namanya juga mengeluh hehehe (D tertawa) udah ya curhat
724 lah dikit-dikit [D : he eh] ndak pernah gini tyang [D : he eh] makanya.. kalo d kampung
725 ya biasa-biasa aja [D : hmm.. hmm..] hehehehe aduh.. 01:03:13-6
726 D: 01:03:14-2 Keluarga di kampung siapa yang masih bu Yani? 01:03:16-0
727 Y: 01:03:16-4 ngga ada.. [D : ngga ada yaa] memang sepi rumah sana [D : ohh] kosong,
728 makanya tyang bulak-balik [D : hmm] harus ngayah kayak kesana tu kan, ngayahnya
729 berat juga disana. 01:03:25-6
730 D: 01:03:25-9 hmm.. nah itu lagi bu Yani, tolong ceritain bu Yani, gimana bagi
731 waktunya lagi hehehehe [Y : Aduhh] pernah satu waktu harus kemu mai atau apa tu..
732 cerita pengalamnnya gimana? hehe 01:03:38-4
733 Y: 01:03:35-9 iya.. udah.. iya.. kalo udah ada orang meninggal, besok gni mau tedun
734 banjarnya.. kalo disana nguopin tu tedun namanya [D : iya iya] he eh.. tedun jam.. kalo
735 orang meninggal kan tujuh udah ada disana [D : he eh] tyang disini harus bangun tu
736 lebih pagi goreng lumpia [D : ohh] ya selesai... seumpamanya goreng lumpiang
737 pokoknya jam nam saya udah harus berangkat pulang pagi. 01:04:04-6
738 D: 01:04:05-1 ohh.. berarti bangunnya? 01:04:06-5
739 Y: 01:04:06-6 bangunnya bisa lebih awal.. [D : jam berapa?] jam dua gitu bangun, biar
740 gini apa.. selesai jam segitu [D : hmm] langsung dah pulang sendiri [D : hmm.. hmm..]
741 gitu.. [D : gitu trus?] nanti abis dateng dari rumah [D : he eh] kalo udah selesai gini..
742 pulang sampe sini baru kerja lagi [D : hmmm] harus kerja sampe selesai 01:04:29-6
743 D: 01:04:29-8 hmm.. kalo tedun itu apa yang dkerjakan disitu biasanya? 01:04:33-0
744 Y: 01:04:33-3 Itu bikin bantennya [D : hmm] bikin banten orang meninggal.. ya paling
745 gradag grudug gitu aja [D : hhmm.. hmm.] kan.. bikin.. yang penting hadir gitu [D : iya
746 iya] keliatan namanya kalo orang meninggal kan.. agak jiwa fanatik gitu [D : hmm..]
747 kita ngga hadir kan.. walaupun udah bayar gini [D : hmm.. hmm..] tetep medelokkan
748 itu kan udah adat namanya [D : iya iya] itu kan harus.. harus kita hadir gitu. Ndak bisa
749 kalo.. ee.. ada orang nikah itu kan masih bisa nyuruh ada yang ee.. bibinya disana tu [D
750 : iya] suruh, "tolong ada kundangan disana, bawain apa" kalo orang meniggal kan ndak..
751 [D : hmm..] ndak bisa seperti itu, makanya harus [D : iya] harus strong hehehe (D
752 tertawa) harus strong kondisinya.. harus bisa gitu. [D: hmm..] ya seperti itu lah setiap
753 ee.. setiap waktu. 01:05:29-5
754 D: 01:05:29-6 Setiap waktu, naik motor itu? 01:05:31-5
755 Y: 01:05:31-7 iya nak motor sendiri hehehe belum ngantuk lagi dijalan hehehe (D
756 tertawa) kalo bangun jam segitu itu memang kalo keluar dah ngantuk tu kan.. [D : hmm..
757 hmm..] di jalan naik motor tu pasti dah ngantuk hehehe 01:05:46-9
758 D: 01:05:47-1 hmm.. lewat.. lewat mana biasanya bu.. bu Yani kalo ke Tampaksiring?
759 [Y: lewat sini] ohh lewat dalem-dalem berarti ya? 01:05:54-1
760 Y: 01:05:54-4 he eh.. nyebrang-nyebrang.. di Angantaka tu.. [D : iya iya] langsung
761 Negari tau? [D : hm.. tau] he eh itu dah lewat Ubud [D : iya lewat Ubud] he eh.. sana
762 dah.. sendiri kalo apalagi kalo Ngaben massal tu satu bulan dah full, bulak-balik.
01:06:10-1
763 D: 01:06:10-8 ohh hehehe karena disini harus bikin lumpia ya? 01:06:14-1
764 Y: 01:06:14-2 iya.. harus bikin.. biar bisa lah bikin sedikit, kalo ndak gitu ndak ada
765 pemasukan [D : hmm.. hmm..] kecuali pas waktu urgent sekali mau apa.. besok ngga
766 bisa dari pagi sampe sore.. harus ngayah itu [D : hmm..] kan harus libur [D : hmm]
767 paling mau-mau hari h itu, tiga harian itu harus dah libur [D : hmm.. hmm..] ngga bisa,
768 ngga kuat kita hehehe [D : iya iya iya] ngambil kerja disini kan waktunya yang panjang

769 [D : hmm] ndak.. beratnya ndak.. cuman waktu yang.. [D : hmm..] yang apa.. kurang
770 waktu gitu lah [D : iya iya] makanya kalo tyang batasi order gitu. 01:06:58-8
771 D: 01:06:59-0 hmm.. ohh cara menyiasatinya batasi order? 01:07:01-8
772 Y: 01:07:01-8 Iya. [D : hmm] batasi order kalo.. kalo dulu berapa aja orang minta kan
773 kita usahakan bisa karena sekarang ada bayi kan ndak bisa [D : iya iya] harus.. waktunya
774 itu belum nangis, harus ngajak anak kalo .. dulu full kerja tu kan dari pagi sampe malem
775 tu kan ndak istirahat kan ndak papa [D : hmm.. hmm..] hehehe bisa ngambil gitu, kalo
776 sekarang udah ndak bisa. 01:07:28-2
777 D: 01:07:28-9 hmm.. resepnya gimana tu biar strong gitu? hehehe 01:07:32-3
778 Y: 01:07:32-4 Resepnya ndak sih ada hehe.. ndak pernah saya pake apa doping-
779 dopingan [D : he eh] itu ga pernah sih, biasa-biasa aja. [D : ohh ohh iya] paling kalo
780 namanya manusia ya pasti aja.. mesin aja bisa rusak hehehe [D : hmm.. hmm..] pas gini
781 kondisi ga gini.. ya lemes lah [D : hmm.. hmm.. hmm..] tapi harus dipaksain juga harus
782 kerja hehe 01:07:58-3
783 D: 01:07:58-6 hmm.. iya kalo disitu ndak.. ndak tedun, ndak ikut tedun banjar itu seperti
784 apa sanksinya biasanya? 01:08:05-6
785 Y: 01:08:06-1 Ndak sih ada sanksi, cuman kita aja yang malu jadinya [D : iya iya iya]
786 kan di masyarakat ndak gini [D : iya hmm.. hmm..] ndak sih ada.. orang tyang kalo ayah
787 tu kan beli [D : iya iya] udah bayar, tapi sekarang suka rela aja [D : hmm..] tapi kita
788 ndak enak sama masyarakat disana, apalagi.. apa pendatang gitu lah dibilang.. kita
789 jarang dirumah kan [D : iya iya] gitu makanya tyang.. kalo mertua tyang dulu ndak
790 pernah.. mebraya gitu [D : ohh] ndak pernah emang.. semenjak tyang disana baru
01:08:38-3
791 D: 01:08:38-6 iya.. kenapa awalnya semenjak ibu mula itu lah ikut mebraya nike?
01:08:43-2
792 Y: 01:08:44-9 gimana ya.. kalo udah disuruh.. namanya juga banjar tu kan ndak enak
793 kita ndak ikut [gitu [D : hmm.. hmm.. hmm..] tyang makanya ngayah gitu disuruh, "oh
794 orang ngayah ini" kalo mertua tyang kan ndak dulu.. ndak mau.. [D : hmm..] bukan
795 ndak mau.. mungkin karena kurang komunikasi mungkin, kalo ibunya ndak mau nanya
797 disana gimana adatnya disana itu [D : hmm.. hmm..] ngga sihh.. mertua tyang ngga ada
798 yang tau disana hehehe [D:hmm.. hehe] di kampung.. suami tyang ndak ada yang tau
799 [D : hmm..] makanya tyang, "yang mana suaminya bu Yani?" gituin dah hehehe.
01:09:24-3
800 D: 01:09:24-1 hmm hehehe kalo.. kalo suami mangkin gimana? 01:09:27-9
801 Y: 01:09:28-3 udah... [D : udah] kalo tyang kan udah tak ajar-ajarin gini [D : hmm..]
802 kan dulu masih ee.. uwaknya itu, yang cowok aja [D : iya iya] ya paling itu aja yang
803 tedun tu kan [D : hmm] "dah.. ganti iwenya jangan kasi iwenya tedun, kita sekarang
804 yang gini" gitu.. "nanti kalo udah ndak ada siapa yang suruh" tak gituin dah [D : hmm..
805 hmm..] kalo dulu pertama surh-suruh ngayah tu ndak.. malu katanya [D : hmm] orang
806 memang ndka pernah kan [D : hmm.] ngga.. ngga salah.. ngga nyalahin juga [D : iya]
807 ga bisa bergaul seperti itu.. orang diem disini aja, kalo kita kan udah di.. dari rumah [D
808 : iya] orang udah biasa [D : iya] seperti itu gitu.. 01:10:08-0
809 D: 01:10:08-0 Apalagi dulu besarnya di Bongkasa nike nggih iya.. 01:10:10-7
810 Y: 01:10:10-1 he eh.. di rumah ibunya, trus sekolah disini, trus kerja di Lombok kan
811 ndak ada yang tau di rumah desa [D : hmm] tapi kalo sekarang udah biasa [D : iya]
812 udha.. udah lah tau orang-orang disana hehe 01:10:22-7
813 D: 01:10:22-9 Awalnya siapa nike yang memutuskan untu yuk ee.. mulai dah dari
814 sekarang tedun banjar, ikut menyama braya gitu? 01:10:30-3
815 Y: 01:10:30-5 ngga sih ada yang memutuskan begitu, cuman kan dituntut oleh banjar
816 [D: hmm..] kita, "oh disana ngga pernah gini" disuruh dah orang ngayah gini, kita lah
817 yang sadar [D : iya] dengan itu gitu. [D : hmm] tyang ngayah dah setiap kalo udah ada..
818 kalo disana ada odalan tu ngayah dah [D : hmm] memang sepuluh harian lah [D : hmm..
819 hmm..] ngayah.. kalo dulu tyang kan masih mertua yang cowok tu [D : he eh] ndak
820 ngambil kerjaan gini.. cuman ee.. ngajak anak aja kan [D : iya iya] cuma paling bantu-
821 bantu aja, ndak lah berperan utama gitu [D : iya] kan masih bisa ditinggal [D :iya] kalo

822 tyang ngayah itu diem dah di kampung.. [D : hmm] gitu [D : hhmm.. hmm..] bapaknya
823 bisa ngajag dari sana [D: hmm] kerja..[D: kerja? iya] itu lah awal-awalnya. 01:11:19-5
824 D: 01:11:20-4 Berarti sekarang untuk misalnya perawatan ibu atau apa, bu Yani aja dah
825 dengan suami ya yang [Y: iya] banyak memutuskan kenten nggih? 01:11:28-2
826 Y: 01:11:28-0 iyaa..[D: iya] tyang aja dahyang gini [D: he eh] berdua hehe 01:11:32-8
827 D: 01:11:33-0 hehehe.. waktu ini tu apa namanya.. pertimbangan ndak mau amputasi
828 nike yang akhirnya.. maksudnya ga ke Sanglah lah takut.. takut diamputasi [Y : iya] ya?
829 itu.. ee.. apa memang ikut aja keputusan suami atau kalo bu.. bu Yani gimana
830 ngeliatnya? 01:11:52-6
831 Y: 01:11:51-6 ikut.. ya tyang sih rasa memang seperti itu ndak mau [D : hmm.. hmm..]
832 gini dia, yaudah kalo ndak gini itu dah kasian kan udah tua [D : iya] nanti kalo
833 diamputasi emangnya sembuh gitu [D : hmm] kan ndak tau kita gitu [D : iya iya]
834 makanya nah lebih baik ndak dah gitu. 01:12:08-6
835 D: 01:12:09-0 Kalo hal-hal yang kayak gitu pernah ngga dicoba komunikasikan ke
836 adiknya? 01:12:12-9
837 Y: 01:12:13-6 endak.. ndak.. ndak pernah [D : hmm] memang susah ajak.. karena
838 gimana ya.. ga bisa diajak konsul gitu hehehe (D tertawa) komunikasinya susah [D :
839 hmm] kalo itu berdua sodara.. [D : iya] tyang aja ga ngerti juga hehehe.. sodara ndak
840 kayak kita kan.. sama sodara [D : iya] care lah gitu [D : iya iya] kalo disitu ndak.. [D :
841 hmm] ndak tau mungkin karena apa tu ndak ngerti dah tyang juga ndak ngerti [D :
842 hmm.. hmm.. hmm..] karena itu dah.. marah-marah aja, kalo udah gini kakaknya juga
843 sering marah-marah gitu sama kakaknya ada.. dibilang kakaknya terlalu gini, terlalu
844 gitu.. gitu [D : hmm.. hmm..] makanya udha malesa dah, gausah dah.. kasian juga kan..
845 tyang kasian sama suami soalnya nanti biar ga kepikiran [D : iya iya] udah beban kita..
846 kita yang juga akhirnya ngambil kan, ndak usah dah gitu. 01:13:07-4
847 D: 01:13:07-9 Kalo responnya suami gimana? 01:13:09-3
848 Y: 01:13:10-5 iya sih ehehehe kalo udah.. makanya kalo gini tyang dah, "kasi tau nae
849 gini gini gini" susah dia.."males mau ngomong" gitu dah dia gitu. 01:13:21-0
850 D: 01:13:20-2 ohh.. jad lebih banyak diem aja? 01:13:23-3
851 Y: 01:13:23-5 he eh..males dia ngomong, ntar dia dah yang gini, kalo gimana.. misalnya
852 kalo sakit ya tengokin ne kesana biar kita kan berusaha biar dia bersodara tu bagus kan
853 gitu [D: hmm..] itu sih keinginan kita kan [D: hmm] itu.. susah..mau sih akhirnya gitu
854 [D: hmm] cuman agak gini harus terus pelan-pelan [D: hmm hmm] ngasi tau gitu
01:13:47-1
855 D: 01:13:47-2 iya.. kalo sama adiknya yang perempuan? [Y : biasa] biasa, kalo nike
856 biasa ya? 01:13:54-4
857 Y: 01:13:53-9 he eh.. biasa kalo ada apa.. kalo memang ngasi tau mau dia. 01:13:56-9
858 D: 01:13:57-0 hmm.. hmm.. sekarang kan sudah berkeluarga ya? [Y: he eh] sering
859 masih kerumah nike? 01:14:02-6
860 Y: 01:14:04-5 ee.. gini kalo gimana dia dateng gitu [D : hmm..] kalo ndak sih.. kan
861 sibuk juga [D : he eh] disana [D : iya iya] punya anak dia kan.. tyang ndak pernah gini,
862 mau.. ibunya sakit tu kesini gini iya.. [D : iya] kesadarannya dia aja [D : hmm hmm
863 hmm] mau sih kadang-kadang kalo gimana.. mau datang. 01:14:24-4
864 D: 01:14:24-8 hmm.. nggih (Y tertawa) hehehe kalo.. kalo tadi kan ibu bilang ya kenapa
865 penting keluarga merawat mertua karena nike kewajiban [Y : iya] gitu ya [Y : he eh]
866 kenapa ibu ngeliatnya itu kewajiban gitu? 01:14:40-2
867 Y: 01:14:41-4 ya bukannya kewajiban.. kalo itu? hehehe 01:14:43-1
868 D: 01:14:43-4 iya iya.. kenapa ibu bisa punya.. a-- tertanam nike ya [Y : ohh] di didiri
869 ibu gimana awalnya? 01:14:49-0
870 Y: 01:14:48-7 ya emang.. ndak sih memang udah.. tyang pikir itu udah memang
871 kewajiban kita [D : hmm.. hmm..] kita kan harus gimana.. balas budi sama orangtua [D
872 : hmm.. hmm..] gimana caranya kalo ngga dirawat [D : iya] seperti itu dah [D : iya] kalo
873 tyang.. [D : balas budi ya?] he eh.. gimana pikiran.. kita kalo gimana ya orangtua sakit
874 kan ngga senang ya.. [D : hmm.. hmm..] makanya kan memang kewajiban kita memang
875 [D : hmm] harus ngerawatnya gitu. 01:15:25-1

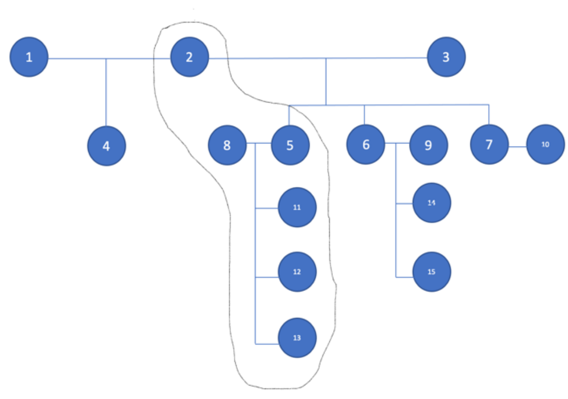
876 D: 01:15:26-2Ada yang pernah mungkin bu Yani jadikan contoh gitu,sehingga akhirnya
877 nilai-nilai bhw merawat orangtua itu kewajiban gitu, menjadi sabar 01:15:37-3
878 Y: 01:15:36-9 ndak sih.. [D : ndak?] cuman kan kesadaran kita aja. 01:15:41-6
879 D: 01:15:41-6 kesadaran (Y tertawa) hehehe mungkin ada dulu liat siapa gitu dari
880 keluarga disini memang yang punya apa ya ini yang sama gitu, pengalaman yang sama?
881 ndak? [Y: ndak sih hehehe] memang kesadaran bahwa itu ini ya, kewajiban ya.. kalo
882 dari odahnya sendiri pernah ga dia cerita harapannya gitu? pengennya gimana dirawat
883 sama anak, cucu? pernah ga gitu? 01:16:11-3
884 Y: 01:16:11-0 ya kalo harapan odahnya tu sih biar ya dirawat sama.. kan semua
885 orangtua berharap biar dirawat sama anak-anaknya hehehe (D tertawa) semua anak-
886 anaknya sih [D : iya iya] harapannya, cuman kan ya kan ndak semua anak mau ngerawat
887 [D : hmm.. hmm.] orangtua gitu yaa.. "iya siapa yang mau gini" tak gituin aja sih [D :
888 hmm] jangan terlalu berpikir seperti itu, itu kan sudah memang karma kita gitu hehehe 01:16:36-3
889 D: 01:16:36-3 hmm.. hehehhe trus pernah ga punya harapan tertentu yang odahnya
890 cerita tapi masih belum ya merasa belum ee.. kesampean atau gimana? 01:16:47-2
891 Y: 01:16:47-6 ya kalo harapannya itu kan biar anak-anaknya rukun semua [D : ohh]
892 gitu, kalo harapannya odahnya [D : hmm.. hmm.. hmm..] itu aja sih ndak ada [D : ndak..
893 ndak ada yang lain ya] anak-anaknya rukun semua, biar ngga apa.. saling [D : hmm]
894 selisih lah gitu [D : hmm.. hmm. hmm. iya] itu aja ndak ada lagi. 01:17:08-6
895 D: 01:17:09-6 Kalo ibu sebagai menantu gitu, sudah.. bu Yani.. sudah merasa sejauh
896 mana bisa memenuhi harapannya odah gitu ya? 01:17:17-0
897 Y: 01:17:18-4 Belum sih bisa hehehe [D : hehehe kenapa? kenapa bu Yani?] apa yang
898 dia--tyang belum bisa memenuhi apa-apa, cuman bisa itu aj--ngerawat itu aja [D : he
899 eh hmm] ngajak seperti itu aja sih ndak.ndak bisa memberi apa-apa hehehe 01:17:34-5
900 D: 01:17:34-5 hehehe.. apa yang bu A-- ee.. yang yang bu.. bu Yani maksud gitu, masih
901 belum bisa.. 01:17:39-8
902 Y: 01:17:40-5 Ngga bisa ngasi apa-apa hehehe (D tertawa) aduhh apa yang dikasi ndak
903 ya.. belum lah kita bisa memenuhi semua kan [D : hmm.. hmm.. hmm..] apa
904 keinginannya gitu kan. Kalo kita ndak tau juga [D: hmm.. hmm.. hmm.. iya] ndak tau
905 juga kalo dari odahnya senengnya apa ndak itu kan [D: hmm.. ohh] ndak tau.. [D : oh
906 iya, oh dia] kiat, ya kita berusaha lah yang.. terbaik untuk beliau gitu [D: he eh] itu aja
907 sih ndak01:18:11-1
908 D: 01:18:11-4 iya.. beliau pernah ngga cerita ee.. misalnya ee.. kayak orang-orang
909 lansia kan suka mepangenan [Y : he eh] atau apa ya tentang anak-anaknya, tentang ee..
910 apa ya kondisinya beliau gitu.. 01:18:25-3
911 Y: 01:18:25-5 iya itu dah.. ngell-- ngeluh itu anak-anaknya ya ndak.. ndak sinkron lah
912 gitu kan biasa.. 01:18:33-2
913 D: 01:18:32-9 oh yang.. yang tadi bu.. bu Yani cerita ya? 01:18:35-9
914 Y: 01:18:35-9 he eh.. itudah.. gitu aja, ndak ada lagi.. kan namanya juga orangtua.. biasa
915 seperti itu kan, kepikiran anak-anaknya. 01:18:44-9
916 D: 01:18:45-7 hmm.. kalo dari bu Yani apa yang udah diupayakan gitu, untuk
917 membantu ya itu ya.. beliau punya harapan anaknya ee.. ini apa namanya.. ee.. rukun-
918 rukun atau tu dari.. bu Yani pernah ga? 01:18:58-6
919 Y: 01:18:58-0 kalo.... tyang sih berupaya untuk ya mengalah aja [D : hmm] biar semua
920 jad bak gitu hehehe (D tertawa) ga mau.. artinya kalo anak-anaknya bertengkar kan
921 orangtua jadi kepikiran [D : hmm...] jadi stres gitu ya, diupayakanlah biar kita ngalah,
922 ya biar gimana.. kita berusaha lah menjalani yang tebaik gitu aja [D : hmm.. hmm..]
923 ndak ada lagi hehehe. 01:19:23-9
924 D: 01:19:24-6 Pernah beliau apa namanya kayak.. ee.. misalnya ibu ngajak periksa ke
925 dokter atau ke mantri nike ee.. apa yang.. pernah ga beliau cerita apa yang dirasakan
926 gitu, gimana reaksinya? 01:19:37-3
927 Y: 01:19:37-9 ohh ndak.. kalo abis disuntik tu paling udah agak ringanan gitu [D : ohh
928 hmm] udah agak.. udah bisa jalan [D : iya] kan agak ringan [D : iya] sakitnya tu udah
929 lebih berkurang kan jadi.. lebih baik, lebih ceria lah [D : iya] jadinya gitu. 01:19:55-9

930 D: 01:19:56-6 Kira-kira beliau puas ngga sama ini apa.. ee.. ya anak-anaknya terutama
931 suaminya bu Yani sama bu Yani ya [Y : he eh] sama cucunya, ngerawat beliau atau
932 gimana reaksinya? 01:20:06-9
933 Y: 01:20:07-3 Reaksinya sih kalo udah namanya orangtua tu pingin di perhatiin terus
934 gitu [D : ohh iya] hehehe [D : gimana?] ya seneng sih kalo dia diperhatin tu ndak sih
935 pernah ngeluh [D : hmm] gini gitu tu ndak.. udah gin-- gini apa.. anak-anaknya tu dah
936 kalo udah.. udah ngga sakit dia, seneng dah dia gitu [D : iya] gitu aja ndak ada gitu
937 hehe. 01:20:36-8
938 D: 01:20:37-4 Bisa cerita satu pengalaman yang berkesan gitu bersama ibu mertua? 01:20:41-0
939 Y: 01:20:44-3 Apa yang berkesan heheheh (D tertawa) ndak sih ada [D : ndak ada?]
940 belum ada hehehe (D tertawa) belum ada soalnya hehehe aduhh.. 01:20:54-4
941 D: 01:20:55-6 Belumm.. belum pernah ada? [Y : he eh.. belum sih] hehehe siap ayang
942 paling deket sama beliau sekarang ini? 01:21:01-1
943 Y: 01:21:01-9 Sama odahnya? [D : he eh] tyang sama cucu-cucunya iya.. itu aja.. orang
944 sama tyang aja setiap hari [D : iya hehehhe] hehehehe apa-apa tu paling beraninya minta
945 sama tyang gitu [D : ohh] iya.. mau apa gitu, sama tyang dah dia minta gitu 01:21:21-2
946 D: 01:21:21-8 minta.. ee.. barang-barang itu untuk keperluan sehari-hari? 01:21:24-6
947 Y: 01:21:24-9 iya.. he eh.. minta obat apa itu [D : iya] iya.. 01:21:28-7
948 D: 01:21:30-9 Nah terakhir ini kalo ibu.. bu Yani sendiri gitu ya.. harapanannya nanti
949 kalo udah seumuran odah gitu ya.. yang merawat siapa? 01:21:38-4
950 Y: 01:21:40-0 nah tyang ndak ada gni.. ya siapa je nanti yang gini.. yang anak-anak
951 mau sadar hehehe 01:21:46-0
952 D: 01:21:46-8 oh hehehe yang anak-anak mau sadar? 01:21:47-9
953 Y: 01:21:48-1 he eh.. anak-anak mau sadar yaa.. orang tyang kan ndak punya anak laki-
954 laki [D : hmm] pasrah aja, siapa je nanti yang mau gitu, ndak sih tyang berharap anak
955 ini, anak itu ndak.. [D : iya] he eh.. ya biar semua lah anak-anak mau [D : hmm.. hmm..]
956 biar bisa dia ada kesadaran untuk itu [D : iya] itu aja sih, ndak ada tyang mau bebankan
957 anak ini itu ndak sih.. si ini, si itu ndak. [D : hmm] ya biar dia bersama-sama lah [D :
958 iya] untuk ngerawat nanti [D : iya] kesadarannya dia gitu aja. 01:22:22-3
959 D: 01:22:23-0 Kalo tadi bu kebetulan ceri-- bilang tidak punya anak laki-laki gitu ya [Y
960 : iya] ini gapapa ya bu saya tanya [Y : gapapa] kalo untuk bu Yani sendiri gimana
961 melihatnya? [Y : Maksudnya?] ibu ga punya anak laki-laki ya, untuk ibu sendiri
962 bagaimana ibu menerimanya? 01:22:39-3
963 Y: 01:22:39-8 ya pasrah aja gimana.. hehehe [D : kenapa adiknya? hehe] namanya
964 anak.. kepingn sih punya.. cuman ga dikasi [D : iya] mau gimana lagi hehehe.. ndak sih
965 ada gini.. ya biasa-biasa aja lah.. kita harus menerima semua. 01:22:57-8
966 D: 01:22:58-8 Kalo dari keluarga? [Y : Dari keluarga?hehehe] hehehe gimana
967 melihatnya? apa menerimanya gitu ya.. kalo ibu kan menerima, pasrah, jalanin
968 memang.. su-- sudah itu yang dari Tuhan gitu ya kalo.. kalo 01:23:13-2
969 Y: 01:23:13-3 Kalo tyang ndak sih ada yang bilang apa-apa.. [D : hmm.. hmm..] ndak
970 gini apa.. biar.. ndak sih ada yang komen apa-apa gitu [D : hmm.. hmm..] "ya gimana
971 orang udah gitu ye jalannya" gitu sih semua keluarga yang deket-deket, yang baik-baik
972 gitu. [D: hmm..] ndak ada gini.. 01:23:34-1
973 D: 01:23:34-2 iya.. kalo odahnya? 01:23:35-7
974 Y: 01:23:36-7 Kalo odahnya.. gimana ya hehehe (D tertawa) dulu sih ada.. gimana..
975 agak sedih, "ngapain itu yang diiniin, biarin dah semua udah ini udah jalan Tuhan, mau
976 gimana lagi" gitu sih.. ngga sih.. ndak ada. 01:23:54-2
977 D: 01:23:54-5 Kalo dulu sempet tapi sekarang sudah [Y : he eh] iya.. 01:23:57-9
978 Y: 01:23:58-5 waktu.. waktu lahir ini kan.. [D : he eh] di harapkan cowook hehehe,
979 ndak mau cowok.. "ya ndak papa" kalo ini bapaknya tu ndak sih [D : ohh] gini.. pasrah
980 aja.. ngapain orang itu udah anugerah, kita harus syukurin mungkin ada rahasia apa
981 dibalik itu, kita kan ndak tau [D : hmm] kita hanya manusia gitu sih bapaknya.. 01:24:18-5
982 D: 01:24:19-0 hmm.. hmm.. gimana caranya waktu itu menyadarkan ee.. odahnya yang

983 untuk bisa menerima? 01:24:24-9
984 Y: 01:24:26-1 oh itu bapaknya, tyang ndak tau hehehe 01:24:28-6
985 D: 01:24:28-0 ohh hehehe oh tu bapak [Y : he eh] suami yang bicara? 01:24:31-6
986 Y: 01:24:31-6 iya.. ndak sih gini.. itu kenapa ga gini.. orang cewek-cowok kan sama..
987 kan belum tentu juga anak cowok yang gini nanti kan hehehe [D : he eh he eh] ya kalo
988 memangnya.. kalo udah punya anak cowok.. kita udah pasti bahagia kan belum tentu
989 [D : iya iyaa] ini.. "kayak ibu aja ini udah punya anak cowok, emangnya bahagia? kan
990 belum tentu" digituin, "masih juga nangis" digituin ibunya hehehehe 01:24:58-3
991 D: 01:24:58-1 hehehe.. dibalikin lagi. 01:25:01-1
992 Y: 01:25:01-3 he eh hehehe.. aduhh.. kalo tyang sih biasa-biasa aja [D : hmm] ya
993 gimana maunya.. kan keinginan kita mas-- sih ada.. cuman ya itu dah.. namanya gini
994 kan.. anugerah [D : iya] kita harus terima aja hehehe 01:25:20-0
995 D: 01:25:20-1 iya diatas yang menentukan nggih. 01:25:21-7
996 Y: 01:25:22-3 Kita kan hanya bisa berusaha hehehe 01:25:24-3
997 D: 01:25:24-1 hehehehe nggih.. iya bu.. bu Yani ada yang pengen disampaikan?
998 sebelum tyang tutup wawancaranya? 01:25:32-9
999 Y: 01:25:33-3 Apa ya.. ndak sih [D : bener?] ndak bener.. ndak ada hehehe 01:25:37-2
1000 D: 01:25:37-8 Lebih plong atau jadi lebih banyak pikiran setelah diwawancara? hehehe 01:25:42-0
1001 Y: 01:25:42-3 Ndak.. tyang ya nggak pernah beban.. beban beban begitu [D: iya]
1002 kepikiran, untuk apa kita nyakitin diri sendiri kan [D : hmm.. hmm..] kalo tyang
1003 walaupun ya kadangkala seperti itu ngga pernah terpikir [D : hmm] ngga pikiran seperti
1004 itu tyang [D: hmm] kalo dulu sih iya.. ada.. kalo dad ipar ngomong gini, gitu kita
1005 kepikiran kan.. [D: hmm] sakit lah.. "untuk apa kita trus sakit" tyang kan sakit aja dulu
1006 [D : hmm] wakut, "oh kenapa kita harus berpikir seperti itu ini.. omongan orang ini kan
1007 biasa.. lebih baik kita ya.. cuek aja dah, jangan mikir omongan orang, yang penting kita
1008 berjalan [D: hmm..hmm..hmm] sesuai yang terbaik aja" gitu.. ndak pernah. 01:26:27-6
1009 D: 01:26:27-8 sakitnya dulu sakit apa biasanya bu? 01:26:29-7
1010 Y: 01:26:30-2 Tyang udah.. usus buntu [D : ohh] operasi angkat pYanidara [D : ohh]
1011 itu dah kan.. memang sakit aja tyang dulu waktu baru anak.. punya anak satu tu kan..
1012 biasa baru ya mertua gini-gitu ipar [D : iya] orang kita ndak biasa kan denger omongan
1013 gini-gitu kan kepikiran [D : hmm..] makanya.. ada temen ngasi tau, "oh ngapain gini
1014 menyiksa diri sendiri, mikir yang gini keluarga emang gitu kok kita berkeluarga" iya
1015 bener juga sih hehehe [D : hmm.. hmm..] semua penyakit dari pikiran ya. 01:27:06-6
1016 D: 01:27:06-7 iya iya.. dari proses itu lah ya.. apa namanya.. ee.. pernah mengalami
1017 sakit tertentu atau apa [Y : he eh] sampe sekarang itu ee.. apa ini apa dampaknya ke
1018 kehidupan ibu ya.. memberikan perubahan gitu ke.. pribadiibu lah gitu? 01:27:24-2
1019 Y: 01:27:24-4 Pribadi tyang untuk.. ya.. yang penting kita cuek.. cueknya dalam artian..
1020 ndak cuek kita memikirkan diri sendiri aja gitu [D : hmm] dah.. cuek kita yaa.. apa yang
1021 kita bisa kerjakan, kerjakan.. apa yang bisa kita bantu, bantu itu aja.. ndak.. biar ndak
1022 jadi beban.. [D : hmm] untuk kita, "ohh ee.. kalo biasanya keluarga itu kan.. ini berdua,
1023 oh ada ini kita harus bagi dua" ga mau nanti kita, "oh dia ga mau" gini kan.. umpamanya
1024 seperti itu kan kepikiran kita.. tyang ndak.. bayar ya sudah bayar aja nanti.. nanti anu.
1025 Tuhan yang lebih tau dari kita.. itu aja tyang berpikir.. (D tertawa) ndak pernah hehehe 01:28:11-1
1026 D: 01:28:12-5Jadi perubahannya ketika ada temen yang ngasi tau ibu ya? 01:28:16-7
1027 Y: 01:28:17-2 Iya.. itu dah biar ngga kepikiran ya juga sih.. semua penyakit dari pikiran
1028 hehe. 01:28:22-7
1029 D: 01:28:23-3 Itu kapan bu? itu berubahnya? 01:28:25-7
1030 Y: 01:28:25-1 ohh udah dulu itu.. udah.. tyang operasi usus buntu anak tyang yang
1031 pertama baru umur dua tahun [D : ohh udah lama ya] he eh.. baru dua tahun trus.. ee...
1032 gini apa.. PAMnya itu, anak tyang baru berapa ya.. 01:28:46-5
1033 D: 01:28:50-4 sudah dua anak waktu tu? 01:28:51-5
1034 Y: 01:28:51-7 Ndak.. baru satu [D : baru satu?] itu dah dua kali tyang operasi.. waktu
1035 bom Bali.. 01:28:58-1

1036 D: 01:28:58-3 ohh duaribu du-empat nike? [Y:he eh] 2003, 2004 lah 2004. 01:29:05-2
1037 Y: 01:29:04-2 he eh itu dah tyang gini.. operasi.. 01:29:06-6
1038 D: 01:29:07-1 eh 2002, 2004 kan tsunami ya.. 2002 ya.. 01:29:10-7
1039 Y: 01:29:10-7 2002 tu? [D : he eh] he eh tu dah.. trus operasi pYanidara tyang. [D:
1040 hm..hmm..] karena PAM [D : iya] itu karena sakit, ya trus gitu dah.. sinus tyang dulu
01:29:23-3
1041 D: 01:29:23-9 hmm.. oh iya itu stres tu kalo sinus itu heheheh 01:29:26-7
1042 Y: 01:29:25-8 itu dah sinus aduh banyak.. ah akhirnya [D : iya] ya untuk apa kita gini
1043 kan gitu.. udah biasa.. kalo bu Dyah kan ndak ngajak ipar ya? 01:29:36-2
1044 D: 01:29:37-2 Pernah.. disitu.. pas sama ibu kan sempet.. he eh 01:29:40-8
1045 Y: 01:29:41-7 tapi kan ngga pernah gini.. gimana rasanya? hehehe 01:29:44-2
1046 D: 01:29:43-5 tapi ya.. sama sih, cuman ya tyang itu dah juga, saya mikir sama dah
1047 sama ibu (Y tertawa) maksudnya ya.. yang penting bisa kita jalanin, jalanin.. kalo ndak
1048 ya marah, sakit hati pernah tapi.. kenapa itu di.. 01:29:59-7
1049 Y: 01:29:59-9 he eh.. [D : he eh] seperti itu dah. 01:30:01-6
1050 D: 01:30:01-6 yang penting saya, suami, anak-anak bahagia dan ini tyang mikir gitu
1051 hehehe 01:30:07-4
1052 Y: 01:30:06-7 he eh.. iya seperti itu dah kalo kita sama ipar gitu kan biasa [D : iya] kalo
1053 kita ndak cepet sadar itu kan terus berlarut jadinya [D : he eh] makanya tyang ndak
1054 pernah mikir-mikir yang kayak gitu. 01:30:19-5
1055 D: 01:30:19-6 he eh.. apalagi tyang kan ipar perempuan yang banyakan hehehe lebih
1056 ini lah ya [Y : iya] tapi tyang mikir, "ah udah lah" gitu 01:30:27-8
1057 Y: 01:30:27-8 kalo sama ipar ini ndak pernah? 01:30:29-1
1058 D: 01:30:29-5 ee.. pernah.. [Y : istrinya..] pernah.. pernah satu.. satu rumah gitu, cuman
1059 ya ee.. dulu ini juga sempet kayak ibu tu.. pisah aja dapurnya biar ndak ini.. ndak apa..
1060 karena kan memang ee.. ya kalo mau ini.. masih saya sama ibu yang banyakan masak
1061 [Y: he eh] dia kan udah misalnya beli-beli diluar, anaknya udah dititipin di mbok mang..
1062 [Y: he eh] di BTN [Y : he eh] gitu mereka masing-masing beli kan tapi kan namanya
1063 mertua kan.. pengennya bareng nae.. gitu lo [D : iya] ya namanya mertua, "bareng nae,
1064 bangun nah masih semengan, ini ini" gitu-gitu. 01:31:06-0
1065 Y: 01:31:05-4 iya he eh.. biar sama-sama [D : he eh] kan semua orangtua [D : iya]
1066 seperti itu. 01:31:09-6
1067 D: 01:31:09-9 Cuman saya bilang, "ngapain pisah dapur jek misi ribet biin ini ini" gitu
1068 lo.. udah lah gitu.. nyen.. nyen bise masak, itu yang masak.. kalo ndak beli jek'e apa
1069 gitu.. saya mikirnya hehehe 01:31:23-5
1070 Y: 01:31:24-3 apa aja gitu [D : iya] kalo dikampung kan jadi satu masih. [D : he eh]
1071 kalo ini.. ya masak biasa.. disediain aja, kalo mau makan ya sudah, kalo ndak yasudah
1072 [D : he eh] gitu.. kalo sama ipar kan biasa [D : iya] hehehehe.. [D : iya gitu] hahh itu
1073 lah pengalaman.. kita baru berumahtangga baru hehhee 01:31:43-8
1074 D: 01:31:43-9 he eh.. hehehehe... iya sampe kadang kenapa? 01:31:48-6
1075 Y: 01:31:46-7 haduh.. kadang... penuh dengan lika liku hehehehe 01:31:51-8
1076 D: 01:31:51-9 iya hehehehe.. iya tapi kesini-kesini juga ya.. 01:31:56-2
(Y berbicara dengan orang lain)
Y : 01:32:24-6 kan tau ini? kakak tyang 01:32:26-2
D : 01:32:26-5 ohh.. tapi belum.. eh pernah ga ketemu ya? 01:32:28-9
K : 01:32:29-3 pernah [D : pernah? hehehe] ee.. nomer duanya, ni tiga. 01:32:33-4
D : 01:32:36-8 Bli Putu nya nomor satu? 01:32:37-7
Y : 01:32:38-0 iya... 01:32:38-1
K : 01:32:39-2 Seangkatan sama bli Gede 01:32:40-2
D : 01:32:40-6 oh iyaiya.. 01:32:41-7
K : 01:32:42-0 he eh.. sekelas lagi hehehe

An example of family summary



Family 1

Note

1	:	Husband 1	6	:	Son 3	11	:	Granddaughter 1
2	:	Grandmother	7	:	Daughter	12	:	Granddaughter 2
3	:	Husband 2	8	:	Daughter-in-law Son 2	13	:	Granddaughter 3
4	:	Son 1	9	:	Daughter-in-law Son 3	14	:	Grandson 1
5	:	Son 2	10	:	Son-in-law	15	:	Granddaughter 4

2, 5, 8, 11, 12, dan 13 Living in three generation household
4 and 5 conflict with 2

Narrative	Themes
Life	Poverty Hard life Persistence
Family Relationship	
Value	Daughter over daughter in-law Grandson over granddaughter
Quality	Conflict
Illness and Caregiving	
Value	Reciprocity Autonomy Disruption of everyday life
Housing	Balinese traditional housing
Illness	Ulcus
Treatment	Traditional medicine
Family support	Information Household chores Meal Self-care Emotional Financial (Buying medicine) Decision making
Family caregivers	Son Daughter in-law Self-treatment
Grandchildren support	Household chores Grandmother's home industry Look after for newborn sister Meal Self-care
Stress and burnout	Grandmother: everyday life disruption Son deals with conflict and multiple care recipients Daughter in-law manages social roles and domestic roles Granddaughters manage school, household chores, and home industry
National health coverage	Minimum utilisation

Transcribing agreement

Multigenerational caregiving for older people in Bali

CONFIDENTIALITY AGREEMENT

I am I Gede Damar Saputra agree to keep confidential all information concerning the project Multigenerational caregiving for older people in Bali.

I will not retain or copy any information involving the project.

Signature: ______________________ Date: February 14th, 2021

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Multigenerational caregiving for older people in Bali

TRANSCRIBER'S CONFIDENTIALITY AGREEMENT

I am **I Gede Damar Saputra** agree to transcribe the recordings provided to me.

I agree to keep confidential all the information provided to me.

I will not make any copies of the transcripts or keep any record of them, other than those required for the project.

Signature: ______________________ **Date:** January 31st, 2020

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Appendix D. Data Analysis

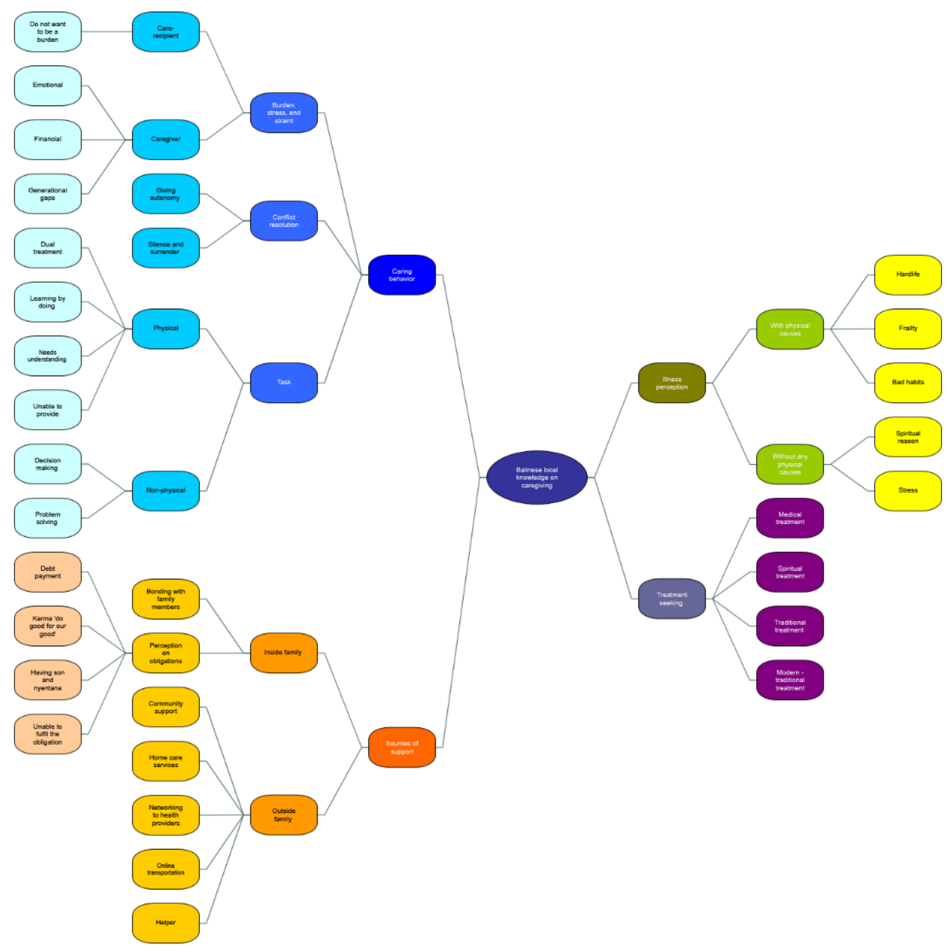
Analysis flow

Policy study

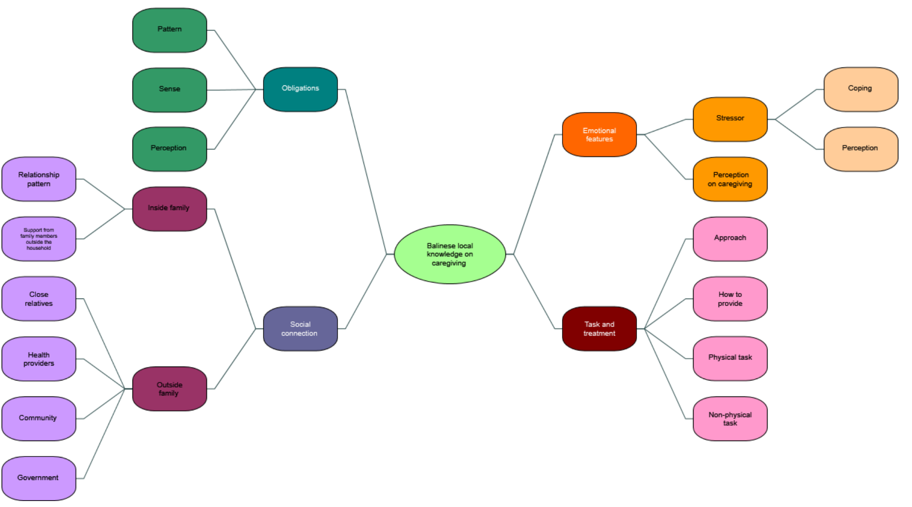
1. Managing data
    a. Retrieving regional ageing policies from the government website.
    b. Saving in one folder by region and published date.
2. Analysing data
    a. Coding policy contents.
    b. Doing CDA per contents.

Interview study

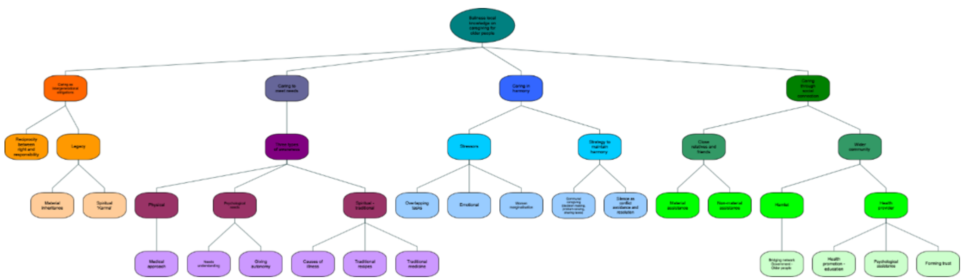
1. Managing data
    a. Transcribing and writing interviews summary for each participant.
    b. Preparing family summary and genogram.
    c. Familiarisation with the data.
    d. Combining across-case and within-case approach in analysing the data to see the commonalities and the variation of families' experiences. Across-case comparison was used to find out the forms of local knowledge that common in all of the interview accounts (Study 2), whereas used individual analysis to understand how local knowledge shapes personal stories on multigenerational caregiving (Study 3).
2. Analysing data
    a. Thematic analysis
        1. Doing an iterative process of comparison called the hermeneutic spiral (Ayres, 2000; Ayres et al., 2003).
        2. Analysing interview transcripts moves back and forth between individual elements of the text and the whole text. Here, open coding across participants was done.



3. The process was followed by across case comparison. Here, Braun and Clarke's (2006) thematic analysis was applied, in which classifies initial coding into themes through iterative comparison within individual interviews, across generations within the family, and across all individual interviews.



Themes and sub-themes were reviewed, and followed by themes naming.



Four general themes, afterwards called forms of local knowledge were identified.

Forms of local knowledge	Definition	Example of behaviour
Caring as intergenerational obligations	Includes three forms of caring; as an obligation and giving back from children to parents, part of karma (a result of our past and causes of our future), responsibility beyond here and now, and family legacy, in which having a son and grandson is pivotal for the families for the sustainability of family ties and caregiving for the next generation.	1. Look after for parents to show someone gratitude for everything that parents have provided during their childhood. 2. Provide care because mother' karma attaches to children' karma. 3. Do good for our good. 4. Rely on the son for care and expecting grandson to continue the family legacy.
Caring in harmony	Living in harmony is vital for the families, in which it is a source of support for families in providing physical as well as emotional care for the older people. Living in harmony includes the member of household and family members who do not live under the same roof (e.g., children, children-in-law, grandchildren of the older people). To avoid conflict and maintain older people' well-being, both generations show a similar coping mechanism, which is silence.	1. Family members inside and outside household become sources of support. 2. Avoid mother-in-law when she gets bossy and demanding. 3. Conflict with brother solves by the time, do not have to argue.
Caring to meet needs	A set of physical tasks that family provide including how to offer and dual treatment.	1. Needs understanding in providing care. 2. Use traditional recipes that shared across generation. 3. Traditional – spiritual approach as crucial as the medical approach, whether to combine or interchange.
Caring through social connection	Balinese is a communal society; hence support network becomes a source of support in family caregiving. The support network contains a broader spectrum from close relatives and friends, community, until the governmental level. For families, support network provides supports that reduce the experience of burden.	1. Close relatives and friends assist families with emotional, financial, and shared tasks support. 2. Hamlets and primary health services hand in hand in providing information about social security scheme and

	health provision that can be utilised in family caregiving. 3. Bonding with the health personnel (e.g., doctor and nurses) is an essential part of older people' care.

b. Narrative analysis
   1. Within-case analysis was conducted, in which using the family as the unit analysis to understand how local knowledge interconnects and resemble in the personal' narratives of multigenerational caregiving.
   2. Narrative analysis to the extracts from 1 example of fit-comfortably family and 3 examples of unliveable narratives.

Family 2 - Grandfather			
Themes	**Positioning**	**Characters**	**Positioned**
Shifting roles in the late life How others provide care for him	Someone who deserve care	Children Doctor	Everybody has an obligation to look after him
To show that: Everybody looks after him Special treatment from health personnel On the other hand, he does not want to be a family burden	Someone who received care Deserve care Does not want to be a family burden	Doctor Daughter-in-law	Reliable providers
Duties of each child and teamwork	Looked after by all children	Children	Gender-based tasks Boys vs girls Most and less reliable Children comparison
Children teamwork in financing health Children teamwork in taking care his emotional state	Looked after by children Easy going and less worry in the late life	Children	Teamwork Reliable
Standard of children' obligation Should follow father-in-law' needs and value	Someone who deserve care	Son Daughter-in-law	Disobedient family value
Children' teamwork	Received care Deserve care	Sons Daughter Daughters-in-law	Good management makes less burden and strains
Family 9 – Daughter-in-law			
Themes	**Positioning**	**Characters**	**Positioned**
To show Her relationship with mother-in-law How she is inspired by her mother-in-law She is different to other daughters-in-law	Obedient to mother-in-law Close to mother-in-law Virtuous daughter-in-law	Mother-in-law Other daughters-in-law	Nurturing, caring, organise, motivating, should be followed Distance to mother-in-law, could not get any benefit from their relationship with mother-in-law
Showing the challenges in providing care Sister-in-law intervention	Victim Defended by mother-in-law Virtuous daughter-in-law	Sister-in-law	Cynical Never satisfied with her provision Bossy Abandoned their mom

Showing her experiences in providing care Showing the complicated family Comparing	Nurturing Virtuous daughter-in-law Someone who understands her mother-in-law Virtuous daughter-in-law Criticised brothers and sisters-in-law Accepting the situation	Brother-in-law Father-in-law Mother-in-law Brothers and sisters-in-law	Neglectful Close to her, loves her Motivating person Demanding yet neglectful
Comparison between daughters-in-law	Criticised other daughters-in-law Virtuous daughter-in-law	Other daughters-in-law	Neglectful
The changes before and after marriage	Prioritising family Detach from youthful life Thanking mother-in-law Resilient person	Mother-in-law Brothers and sisters-in-law	Difficult yet motivating/inspiring Annoying
Overwhelmed by caregiving without support from other family members	Resilient Motivated by mother-in-law	Sisters-in-law	Bossy Did not contribute much in providing care
Decision making and disagreement in the family	Avoid conflict	Brothers and sisters-in-law Mother-in-law	Failed in providing care Does not want to burden her youngest son
To show the better me	A better person Virtuous daughter-in-law	Moher-in-law	Motivating Always defends her
Alone in providing care, financially as well	Willing to learn Was not supported by sister-in-law, even though they are doctors	Sisters-in-law	Conflictual Selfish Do not do much
Show women empowerment	From marginalised to empowered	Parents-in-law Sibling	Marginalise women

Family 3 – Daughter-in-law

Themes	Positioning	Characters	Positioned
Showing difficult life, poverty	Dislike by mother-in-law Emotionally abused Marginalised Living in poverty Responsible mother	Mother-in-law Sister-in-law Son	Never appreciated her Sources of strength
Difficult life	Supported by son Tackle husband responsibility as a breadwinner Try to fulfil the obligation even though how hard it is	Son Husband Mother-in-law	Supporting Dependent Dislike her yet very demanding
Stressful life	Strained by life demand	Son and friends Husband Mother-in-law	Supporting Dominant yet dependent Dislike her yet demanding
Dreaming of a better life	Hardiness is my destiny Maintain other emotional state Be patient Full of dedication, even though seem hard to fulfil the obligation. Do it alone without decent supports from other family members in doing household chores	Son Mother-in-law Husband	Supporting only emotionally Demanding Dominant, demanding, dependent Unreliable family members
Financial burden	Understood by father-in-law	Father-in-law	Understanding
The different between before and after mother-in-law frailty	Marginalised Dislike Got abuse Chaos family	Mother-in-law Sister-in-law	Loose bonding, conflictual Abusive
Conflict and envy in the family	No support from sibling	Brother-in-law	Neglectful son Sibling rivalry

Future	Do good for her good Care about public image Prioritising son' future Still handle family expenditure alone	Son	Prioritising himself and public image
Family 1 – Granddaughter			
Themes	**Positioning**	**Characters**	**Positioned**
To show family conflict	Want to know and get involve but is positioned as a kid in the family. She is forbidden to know the family matters	Grandmother Father Uncle	Got depressed by conflict with sons Avoid conflict Demanding and greedy
To show her concern	Want to prove something to the family Perseverance toward good future Concern to her family	Family	All family members position her as a kid
To show her duties vs unmet needs	Overwhelmed by household chores Sacrifice her teenage year Have only few friends because of overwhelmed by family duties Good liar to get permission	Mother Grandmother	Need her help with the household chores
Grandma' needs	Empathy to grandma' needs Empathy to dad' needs Annoyed by family conflict Virtuous daughter	Grandma Dad Uncle	Someone who has needs and she should fulfil her family dreams and needs Demanding and conflictual
To show her feeling about being woman in the family and culture in Bali	Overwhelmed by gender stereotype/ role Questioning	Women in the family Dad	Do most of the household chores Gets privileges as a man in the family and because he has done his duties as a breadwinner
Comparison between aunt and mom	Giving her opinion about virtuous and imperfect daughter-in-law toward having offspring	Mom Aunt	Unable to fulfil cultural expectation Virtuous person
Family expectation on having male offspring	Marginalised Questioning: girls and boys are precious and equal. Want to prove it to the family	Grandma Dad	Sad because do not have grandson Worry about son' future Overwhelmed by family conflict and cultural expectation

c. Discourse analysis

1. Open coding based on four discourses (decline, successful ageing, family obligations, public responsibility). Here extracts were screening.
2. Focus on the decline and successful ageing discourses.
3. Doing the positioning analysis to the extracts.

Theme	Subtheme	Participants	Extracts	Analysis
Family 1				
Decline		Grandma	Setelah itu **saya sakit keras, ga bisa membuat dagangan banyak-banyak**. Saya kira, orang mengira saya yang meninggal duluan dari bapaknya made disini. Tahunya beliau yang meninggal duluan. **Setelah itu lama juga saya libur sama Ayuk ini, "apa ya yang bisa dikerjainn yuk, biar jadi aja makan, kalau gini mengandalkan gajinya Made ga cukup untuk makan semua" gitu saya, "mau yuk belajar ke pasar?" saya gituin. Mau dia belajar ke pasar, bisa dia buat, "Cukup biar dapetnya jangan nyari untung biar kita kaya, biar jadi makan aja syukur"**. Setelah itu, mau dia ke pasar, lagi saya mula buat jajan, lagi orang tiba-tiba dateng nyari jajan gitu. Gitu sejarah saya, dari dulu, ini dah dari semenjak saya sakit, ada cucu, ga bisa buat jajan banyak. Gitu…gitu terus orang minta, saya yang ga bisa meladeni gitu.	Contradiction
	Hard life	Grandma	Gitu perjuangan saya biar bisa punya tempat tinggal keinginannya saya untuk anak. Bagaimana pagi hingga malem kerja saya berdua, **kepayahan ketika itu saya makanya saya begini sekarang**. Begitu saya dulu. Sekarang bikin segini aja jam setengah tiga tu udah harus bangun.	Constraint: hard life
Successful ageing	Achievement and autonomy	Grandma	Sekarang kalau nyaman saya hidup, saya disini, ini kan **hasil jerih ayah saya yang saya tinggalin disini**. **Nyaman tidak akan minta siapa-siapa, tapi saya minta ke anak aja, ga liat disana-sini lagi saya. Kalau masih di desa ga, mau gini liat yang lain dulu karena saya bersaudara banyak bapak saya itu**. Saya cuma berdua aja sama ibu saya aja. Ga bisa jauh lebih nyaman lagi saya sekarang, mumpung seperti itu…artinya perjuangan saya yang saya tempatin.	Contradiction
	Reciprocity Power relation	Grandma	Keinginan saya itu ya saya, biar bisa aja saya ikut bantu Ayu, **selama saya hidup biar bisa saya bantu- b[illegible]ar di dapur saya bantuin. Biar masih saya bisa gini, bantuin dia, saya dibantu, saya bantuin dia, nunjukkin pekerjaan ibaratnya.** Kalau tidak orangtua nunjukkin orang umur segitu belum terampil ambil kerjaan. Begitu keinginan saya.	Contradiction
Family obligations		Son	Ndak ada sebenarnya…biasa-biasa aja setelah dijalankan nggih…artinya memberatkan mungkin gini ya karena itu dah cobaan udah dari dulu…dulu gini gini dalam artian…**biasa aja gitu ndak dipake beban ndak…ndak tau istri saya sama yang lain ngga tau juga. Yen tyang biase-biase gen, nah kemu atehang…kemu atehang…sing ade pis, "nah jek anggon gen malu, apa je ade to gen" keto tyang memang sih ee…tyang sebenarne menahan-nahan juga kalo ndak…seperti bilang tyang tadi kalo tyang marah dengan ibu tu ya biasa aja…pang ten biin ye anggone kenten artinya seara umum, beban untuk merawat tu ndak ada.**	Contradiction Fracture; financial constraint
			Disamping itu kewajiban juga kan…mungkin ada rasa ucapan istilahnya terimakasih kita tidak secara langsung kepada orangtua. Kewajiban dan mungkin, dan itu harus dilakukan sebenarnya walaupun care iwe tyang sing ngelah nak cenik kan mungkin ye merasa…ada yang memerhatikan kan… padahal pedalem tyang keto lo nah liu nak yen cerita nike, termasuk ibu…ibu yang merawat saya di rumah kampung itu	Keywords: Duties/responsibility Gives back

d. SEM

1. Doing additional analysis on the point of fracture on public provision in Indonesia.
2. Combining all the finding into SEM

An example of translation and back translation

Translation extracts in article 4

No	Extracts
1	It's my daughter-in-law who always goes to the *banjar* to join an exercise. I never join, I can't do exercise, I am old already. I just stay at home, never go anywhere. At home, I make offerings from young coconut leaves (*busung*). When I have the strength, I will finish making the offerings. When I don't feel so well, I will just have a rest, I do nothing. What else can I do? I have no strength. Sometimes I have an appetite, other times I don't.
2	For example, when my mom falls down, sometimes my younger or older sibling scolds her as if she were a child who is physically strong. It wouldn't be a problem if it were a child, but this is an older person, with stress issues, and whose stress level is high. To be further scolded, she will feel even more down. I don't scold her like that. I'll be sure to make her feel happy first, and then I will advise her not to do that anymore, that if she continues to be disobedient, to keep wanting to walk over here and there, in case she falls, she can break her legs and she won't be able to have a surgery and recover because she is already old.
3	I am senile and considered not normal, my hearing is not normal. When I ask about something, I won't hear the answer so that I have to ask twice. That's why my husband gets mad at me, and I get annoyed with being scolded, moreover if he also scorns me. If I could get a divorce, I would, so I don't have to see my husband anymore. I want to fight but I can't.
4	"Kak, you are old already, don't think too hard," is my doctor's advice for me. So now, I work in the rice field only to break a sweat. In no longer than one hour, I will already be sweating, and then I will go straight home and have a shower. Going to the rice field is only to restore my energy, even if I lose. In fact, I lose a lot.
5	When there is an activity, I just stay at the *banjar*, I don't join in the leisure walk activity. Everyone already knows about my condition. In fact, I am told to just stay. "Just stay here, Odah, don't come with us." As my doctor told me, the importance of going to the *banjar* is to get some refreshing time, to get a chance to talk with friends. I am told not to force myself if I can't do it, like a while ago when I got sick. "You may go to the *banjar*, Odah, but don't join in the exercise, just watch it," the doctor told me. I was recommended to do all kinds of things by the doctor. I will take a walk if I can, but if I can't I will just stay at home, I think that's better. If I force myself and then I fall down, who will help me?
6	After that I got seriously ill, I could not make things to sell in large amounts. I thought, people thought I would pass away first before Made's father here. It turned out that he passed away first. After that, for quite some time I did nothing with Ayuk. "What do you think we can do, Yuk, so that we can eat? If we only depend on Made's salary like this, there won't be enough for everyone to eat," I told her. "Do you want to learn working at the market?" I asked her. She was willing to learn to work at the market, she was able to do it. "It is not our goal to make profits so that we become rich, but just to be able to put food on the table is something we are already grateful for."
7	What I wish for is that I am able to help Ayu for as long as I live, to be able to help even if just in the kitchen. Just so that I can still help her. I have been supported, so I want to help her, to show my contributions. Older people need to show how work is done, as people her age are not skilled enough to do some work. So that's my wish.
8	After picking unhulled rice from the ground, he… what is it called – what do you call *nyuwun*… [D: *Nyuwun*.) *Nyunggi,* he carries the grains of rice on his head (*nyunggi*), can you imagine, from Penarungan carrying one basket like that. [D: On foot?] Yes, on foot, he only arrives home in the evening, sometimes with her older sister. He is too tired physically from carrying such a heavy weight every day and walking long distances, so I guess that maybe he won't be able to walk when he gets old. It seems that his bones will no longer be strong due to fatigue, I suppose so.
9	My cardiologist said, "I bet you used to be a vendor, right?" he said to me. "How do you know, Doctor?" "Most of the people who were vendors in the past, their blood sugar went up, because they liked to snack, they snacked right from the morning." Whatever I wanted to eat, I would buy it. Many people were selling food and I had money.
10	That's why I always pray, I can't risk getting fat, because I don't want to be like my parent-in-law who can't walk. If possible, I want to be able to do everything by myself. To continue to be able-bodied and, if possible, to not get sick, that's all. But because of staying up late until 12 midnight my husband has started to become worried because it's not good for health. That's all.
11	She still makes interventions, and does not position herself as an older person who is ill.

	She does not understand the current situation, she still makes interventions. So, I, as a person whom you can say both old and young, in those two positions, want to make changes especially in the social domain. For example, when we have a ceremony, we should just do it in principle, let us practice our religion in principle, as we often listen to discourses on Hindu teachings (*dharma wacana*), read books – in short, the principal things. But since she is keen on preparing offerings, she feels that she must do this hobby. She would prepare one kind of offerings and the other as well. She is indeed the one who does it all, but us the family becomes burdened, too. Unlike them, I am ready to lose. I am ready to lose. For example, for matters in the kitchen, whatever things my daughter-in-law gives me, I accept it.
12	They count as obligations, and not as chores. Obligations are things we must carry out, so I don't think too much about them, like, "Oh, why are our parents this way?" I don't think that way. Those are the obligations of a stay-at-home mother… such as looking after our elderly, taking care of my three children, those are my obligations. Even though I feel tired and although those obligations do not earn me money, those are my home obligations, the obligations of a housewife, whereas my house chores are standard things…
13	When Nini (Grandma) was ill, my tasks doubled… I took care of the baby… I took care of my child, while taking care of Nini, too… Even though it was my father who focused on Nini because I focused on the children, still I did both things at the same time… I looked after my children while also looking after Nini… After looking after my children, when my wife is having her day off… I look after Nini. I feel sorry for my father that he looks after Nini by himself…
14	When I go to the hospital, they just drop me there from home. Everyone is working and busy. The important thing is that I have people to take care of me. Everyone at the hospital would ask me, "Don't you have anyone to accompany you here?" When I am done with the doctor's visit, I will be picked up. I have been given a list of my family's telephone numbers. The information staff at the hospital would help me contact my family. They would call them one by one, and the one who answers first will pick me up. If no one picks me up, I will order an online motorcycle taxi (*ojek*). That way, I do not cause much trouble to my children-in-law.
15	Yes, my son works out of town and got married there. If he leaves his job, it will cause some big trouble. He can get fired.
16	He also has his own family, has responsibilities, I feel sorry for him… not to mention he lives out of our home village, poor boy… That is why I never demand him to do anything, telling him, "This is what you must do, De." Never…
17	Actually, we are all there to take care of my elder sister. As for my wife, she does not get along well with my elder sister. So, she chose not to get involved.
18	There's no one to keep me company. If I asked my daughter-in law to keep me company, where would we get money to buy rice? Her husband (my son) is unable to work. Even though my grandson is employed, it's not like he gets the money right after he finishes his work. If we relied on that, what would we use to buy our meals with? That is why I am not hospitalized. As for my grandson, his salary is not even enough for his needs. His salary is used up for his own needs already, such as for buying a motorbike, a handphone, and cigarettes. I can't say anything about it.
19	She was really just hoping that I would give birth to a son. When she found out that it was a girl, she cried… "So, this is what my fate has come to," she said as she cried. "Why are you crying? Later when you pass away surely you won't be neglected by our family," I responded. She was probably worried because there is no one at home, there is not a son, and my younger sibling also does not care much about home.
20	My sister-in-law can't ride a motorcycle, my other sister-in-law is busy in the market. All my brothers-in-law work, so does my husband. When everyone works, no one takes care of the house and my parents-in-law. So, whether or not I had the courage to, I had to leave my job. I used to work on a golf course and accompanied my husband while he was on duty in Klungkung.
21	The good thing about BPJS is that it is like a saving, so that we do not make the payment all at once, and do not get shocked by the amount.
22	Sometimes we manage to get the syringe, but not the needle. Eventually we have to buy it ourselves, that's how the game goes. Now BPJS is not like what it used to be, they have a lot to cover now, so there are drugs that we have to buy ourselves. I usually buy medicines at a pharmacy nearby, but the last time it was out of stock. I had to buy it elsewhere and finally got it.

	So, it's not completely wrong that people protest that BPJS contributions increase, while the pharmacy service is lacking, we have to bear the cost of medicines ourselves. Where is the extra money that we pay gone to, we wonder?
23	My mother was already declared fit to go home. I was hoping at that time that my mother would be treated for a few more days in the hospital until her wound healed. But the doctor said she was fit to go home and her wound could be treated at home. For the homecare, because it was not covered by BPJS, I tried my best to cover the cost jointly with my siblings. I hope that there will be health personnel from the government who cover patients like my mother. I ask the government for help and that they really pay attention to this matter.
24	There is none in the Tabanan area, only in Badung. The elderly gets clothes, food, and house repairs.
25	Actually, KBS… the KBS drivers, the KBS nurses… they should stand by on site… if something happens to the members of the local community in the village, it must be handled quickly. At that time, I waited 20 minutes. I was shaking, I went there to look for them twice at that time, my father panicked at that time. “What should we do?” he asked... “What’s taking them so long?” he kept asking. Nini was already out of breath. I went looking for them again, and then they came. You can see some comments on Facebook, there are pros and cons, about KBS… Someone once commented, “Those KBS driver, all they do is just sleep.”
26	I thought if outside Badung the person accompanying the patient would not receive it. But they said the accompanying person would receive it… but it is still being applied for by my first child. We were told to apply for it even though I didn't want to. We should focus on Ninik’s condition first. So that people won’t think we are waiting for money. So that they won’t think we need it so badly. But because they said it is our right, it has to be taken, that’s what the *Klian Dinas* (Head of Banjar) told us.
27	According to the doctor, it's the mind that causes us to get sick. The strongest cause is the mind, it makes illnesses come fast. “Sometimes, Kak (Grandpa), if you think too hard about something, and you keep thinking about it, you will be stressed,” the doctor said. “Kak, because you’re old, you’ll get 3S.” “What is it, Doc?” “Stress, Stroke, *Setra* (cemetery).” That sounds true for me.
28	Everyone wants to be healthy, but when I asked the doctor about my illness, he just said, “You are old.” That's how he always answered.
29	Smoking was the cause. Since getting that heart attack, I have quit smoking. I was hospitalized in the ICU for three days. I was unconscious at that time. I used to be delinquent. First, I smoked, and then I drank too much coffee, gambled, and did cockfighting. I did cockfighting everywhere. After getting sick, I stopped cockfighting, quit smoking, and went out less. In the past, before I got sick, in the morning I would do cockfighting, and at night I would gamble.

Back translation extracts article 4

Nomor	Kutipan
1	Menantu perempuan saya yang selalu pergi ke *banjar* untuk ikut olahraga. Saya tidak pernah ikut, saya tidak bisa berolahraga, saya sudah tua. Saya hanya diam di rumah, tidak pernah kemana-mana. Di rumah, saya membuat sesaji dari daun kelapa muda (*busung*). Ketika saya merasa kuat, saya akan menyelesaikan sesaji yang saya buat. Ketika saya merasa tidak enak badan, saya hanya akan beristirahat, saya tidak melakukan apa-apa. Apa lagi yang bisa saya lakukan? Saya tidak kuat lagi. Kadang saya punya nafsu makan, kadang tidak.
2	Misalnya, ketika Ibu saya jatuh, terkadang adik saya atau kakak saya memarahinya seolah-olah dia adalah anak kecil yang kuat secara fisik. Mungkin tidak masalah kalau misalnya dia adalah seorang anak kecil, tetapi dia adalah orang yang lebih tua, dengan masalah stres, dan yang tingkat stresnya tinggi. Kalau dimarahi lagi, dia akan merasa lebih sedih. Saya tidak memarahinya seperti itu. Saya akan pastikan untuk membuatnya merasa bahagia terlebih dahulu, dan kemudian saya akan menasihatinya untuk tidak melakukan itu lagi, bahwa jika Ibu terus tidak mengikuti nasihat, terus ingin berjalan ke sana-sini, jika dia jatuh, kakinya bisa patah dan dia tidak akan bisa menjalani operasi dan pulih karena dia sudah tua.
3	Saya pikun dan dianggap tidak normal, pendengaran saya tidak normal. Ketika saya bertanya tentang sesuatu, saya tidak akan mendengar jawabannya sehingga saya harus bertanya dua kali. Makanya suami saya marah-marah, dan saya kesal dimarahi, apalagi kalau dia juga mencemooh saya. Jika saya bisa bercerai, saya akan cerai, jadi saya tidak perlu melihat suami saya lagi. Saya ingin melawan tapi saya tidak bisa.

4	"Kak, pekak sudah tua, jangan berpikir terlalu keras," begitu nasihat dokter untuk saya. Jadi sekarang, saya kerja di sawah hanya untuk cari keringat. Tidak lebih dari satu jam, saya sudah berkeringat, dan kemudian saya akan langsung pulang dan mandi. Pergi ke sawah hanya untuk memulihkan tenaga, meski rugi. Nyatanya saya rugi banyak.
5	Jika ada kegiatan, saya hanya diam di *banjar*, saya tidak ikut kegiatan jalan santai. Semua orang sudah tahu tentang kondisi saya. Bahkan, saya disuruh diam saja. "Diam saja di sini, Odah, jangan ikut dengan kami." Seperti yang dikatakan dokter saya, pentingnya pergi ke *banjar* adalah untuk mendapatkan waktu penyegaran, untuk mendapatkan kesempatan untuk berbicara dengan teman-teman. Saya diberitahu untuk tidak memaksakan diri jika saya tidak bisa melakukannya, seperti beberapa waktu yang lalu ketika saya sakit. "Odah bisa pergi ke *banjar*, tapi jangan ikut olahraga, Odah nonton saja," kata dokter kepada saya. Saya disarankan untuk melakukan segala macam hal oleh dokter. Saya akan jalan-jalan jika saya bisa, tetapi jika saya tidak bisa, saya akan tinggal di rumah saja, saya pikir itu lebih baik. Jika saya memaksakan diri dan kemudian saya jatuh, siapa yang akan membantu saya?
6	Setelah itu saya sakit parah, saya tidak bisa membuat barang untuk dijual dalam jumlah besar. Saya pikir, orang mengira saya akan meninggal duluan sebelum ayah Made di sini. Ternyata dia meninggal lebih dulu. Setelah itu, untuk beberapa waktu saya tidak melakukan apa-apa dengan Ayuk. "Menurutmu apa yang bisa kita lakukan, Yuk, agar kita bisa makan? Kalau kita hanya mengandalkan gaji Made seperti ini, tidak akan cukup untuk makan semua," kata saya kepadanya. "Apakah kamu mau belajar kerja di pasar?" Saya bertanya kepadanya. Dia mau belajar kerja di pasar, dan dia bisa melakukannya. "Tujuan kami bukan mencari untung supaya bisa kaya, ada makanan saja kami sudah bersyukur."
7	Yang saya harapkan adalah saya bisa membantu Ayu selama saya hidup, bisa membantu meski hanya di dapur. Hanya agar saya masih bisa membantunya. Saya telah dibantu selama ini, jadi saya ingin membantunya, untuk menunjukkan kontribusi saya. Orang yang lebih tua perlu menunjukkan bagaimana suatu pekerjaan dilakukan, karena orang seusia Ayu tidak cukup terampil untuk melakukan beberapa pekerjaan. Jadi itu keinginan saya.
8	Setelah mengambil gabah dari tanah, he… apa namanya ya – apa namanya *nyuwun*... [D: *Nyuwun*.) *Nyunggi,* dia membawa gabah di kepalanya (*nyunggi*), bisa dibayangkan, dari Penarungan membawa satu keranjang seperti itu. [D: Berjalan kaki?] Ya, dengan berjalan kaki, dia sampai di rumah pada malam hari, terkadang dengan kakak perempuannya. Dia terlalu lelah secara fisik karena membawa beban yang begitu berat setiap hari dan berjalan jauh, jadi saya kira mungkin dia tidak akan bisa berjalan ketika dia tua. Sepertinya tulangnya tidak akan kuat lagi karena kelelahan, saya rasa begitu.
9	Ahli jantung saya berkata, "Saya yakin Anda pernah menjadi pedagang, kan?" katanya kepada saya. "Bagaimana Anda tahu, Dokter?" "Kebanyakan orang yang dulunya adalah pedagang, gula darahnya naik, karena suka jajan, jajan dari pagi." Apa pun yang ingin saya makan, saya beli. Banyak orang yang menjual makanan dan saya punya uang.
10	Makanya saya selalu berdoa, saya tidak bisa ambil risiko gemuk, karena saya tidak mau seperti mertua saya yang tidak bisa jalan. Jika memungkinkan, saya ingin bisa melakukan semuanya sendiri. Untuk terus sehat dan, jika memungkinkan, tidak sakit, itu saja. Tapi karena begadang sampai jam 12 malam suami saya sudah mulai khawatir karena tidak baik untuk kesehatan. Itu saja.
11	Dia masih ikut campur tangan, dan tidak memposisikan dirinya sebagai orang tua yang sakit. Dia tidak mengerti situasi saat ini, dia masih melakukan intervensi. Jadi, saya sebagai orang yang bisa dibilang tua dan muda, di dua posisi itu, ingin melakukan perubahan terutama di ranah sosial. Misalnya, ketika kita mengadakan upacara, kita harus melakukannya secara prinsip, mari kita menjalankan agama kita secara prinsip, karena kita sering mendengarkan ceramah tentang ajaran Hindu (*dharma wacana*), membaca buku – singkatnya, hal-hal prinsip. Tapi karena dia rajin menyiapkan sesaji, dia merasa harus melakukan hobi ini. Dia akan menyiapkan satu jenis sesaji dan yang lainnya juga. Dia memang yang melakukan itu semua, tapi kami sekeluarga juga jadi terbebani. Tidak seperti mereka, saya siap kehilangan. Saya siap kehilangan. Misalnya untuk urusan dapur, apa pun yang diberikan menantu saya, saya terima.
12	Hal-hal itu dianggap sebagai kewajiban, dan bukan sebagai tugas. Kewajiban adalah hal yang harus kita laksanakan, jadi saya tidak terlalu memikirkannya, seperti, "Oh, kenapa orang tua kita begini?" Saya tidak berpikir seperti itu. Itu kewajiban ibu rumah tangga… seperti menjaga orang tua kami, merawat ketiga anak saya, itu kewajiban saya. Meskipun saya merasa lelah

	dan meskipun kewajiban itu tidak menghasilkan uang bagi saya, itu adalah kewajiban rumah saya, kewajiban ibu rumah tangga, sedangkan pekerjaan rumah saya adalah hal standar…
13	Ketika Nini (Nenek) sakit, tugas saya berlipat ganda… Saya mengurus bayi… Saya mengurus anak saya, sambil mengurus Nini juga… Meskipun ayah saya yang fokus pada Nini karena saya fokus pada anak-anak, tetap saja saya melakukan keduanya sekaligus… Saya mengurus anak-anak saya sambil juga merawat Nini… Setelah mengurus anak-anak saya, ketika istri saya sedang libur… Saya mengurus Nini. Saya merasa kasihan pada ayah saya karena dia merawat Nini sendiri ...
14	Ketika saya pergi ke rumah sakit, mereka hanya menurunkan saya di sana dari rumah. Semuanya bekerja dan punya kesibukan. Yang penting saya punya orang yang menjaga saya. Semua orang di rumah sakit akan bertanya kepada saya, "Tidakkah ada orang yang menemani Anda di sini?" Ketika saya selesai di dokter, saya akan dijemput. Saya telah diberi daftar nomor telepon keluarga saya. Staf informasi di rumah sakit akan membantu saya menghubungi keluarga saya. Mereka akan menghubungi keluarga saya satu per satu, dan orang yang menjawab pertama akan menjemput saya. Jika tidak ada yang menjemput saya, saya akan memesan ojek online. Dengan begitu, saya tidak terlalu merepotkan menantu saya.
15	Ya, anak saya bekerja di luar kota dan menikah di sana. Jika dia meninggalkan pekerjaannya, akan ada beberapa persoalan besar. Dia bisa dipecat.
16	Dia juga punya keluarga sendiri, punya tanggung jawab, saya kasihan padanya… apalagi dia tinggal di luar kampung halaman kami, anak malang… Itu sebabnya saya tidak pernah memintanya melakukan apa pun, saya tidak pernah mengatakan kepadanya, "Inilah yang harus kamu lakukan, De." Tidak pernah…
17	Sebenarnya, kita semua ada untuk menjaga kakak perempuan saya. Sedangkan istri saya, dia tidak rukun dengan kakak perempuan saya. Jadi, dia memilih untuk tidak terlibat.
18	Tidak ada yang menemani saya. Jika saya meminta menantu perempuan saya untuk menemani saya, dari mana kami mendapatkan uang untuk membeli beras? Suaminya (anak saya) tidak bisa bekerja. Meskipun cucu saya bekerja, dia tidak dapat uang langsung setelah dia menyelesaikan pekerjaannya. Jika kami mengandalkan itu, apa yang bisa kami pakai untuk beli makan? Itu sebabnya saya tidak dirawat inap. Sedangkan cucu laki-laki saya, gajinya bahkan tidak cukup untuk kebutuhannya. Gajinya sudah habis untuk kebutuhan sendiri, seperti untuk membeli motor, hp, dan rokok. Saya tidak bisa mengatakan apa-apa tentang itu.
19	Dia benar-benar hanya berharap bahwa saya akan melahirkan seorang putra. Ketika dia mengetahui bahwa bayi saya perempuan, dia menangis… "Jadi beginilah nasibku," katanya sambil menangis. "Kenapa menangis? Nanti saat meninggal pasti tidak akan ditelantarkan oleh keluarga kita," saya jawab begitu. Dia mungkin khawatir karena tidak ada orang di rumah, tidak ada anak laki-laki, dan adik saya juga tidak terlalu peduli dengan rumah.
20	Ipar perempuan saya tidak bisa naik motor, ipar saya yang lain sibuk di pasar. Semua ipar laki-laki saya bekerja, begitu juga suami saya. Ketika semua orang bekerja, tidak ada yang mengurus rumah dan mertua saya. Jadi, entah saya punya keberanian atau tidak, saya harus meninggalkan pekerjaan saya. Saya dulu bekerja di lapangan golf dan menemani suami saya saat dia bertugas di Klungkung.
21	Bagusnya BPJS itu seperti menabung, jadi kita tidak melakukan pembayaran sekaligus, dan tidak kaget dengan jumlahnya.
22	Terkadang kami berhasil mendapatkan alat suntik, tetapi tidak dengan jarumnya. Akhirnya kami harus beli sendiri, begitulah permainannya. Sekarang BPJS tidak seperti dulu, sekarang banyak yang harus ditanggung, jadi ada obat yang harus kita beli sendiri. Saya biasanya membeli obat-obatan di apotek terdekat, tetapi terakhir kali stoknya habis. Saya harus membelinya di tempat lain dan akhirnya mendapatkannya. Jadi, tidak sepenuhnya salah bahwa masyarakat memprotes kenaikan iuran BPJS, sedangkan pelayanan obatnya kurang, biaya obat harus ditanggung sendiri. Ke mana uang ekstra yang kami bayar, kami bertanya-tanya?
23	Ibu saya sudah dinyatakan sehat dan boleh pulang. Saya berharap saat itu ibu saya akan dirawat beberapa hari lagi di rumah sakit sampai lukanya sembuh. Tapi dokter bilang Ibu sudah boleh pulang dan lukanya bisa dirawat di rumah. Untuk perawatan rumah, karena tidak ditanggung BPJS, saya berusaha semaksimal mungkin untuk menanggung biayanya bersama-sama dengan saudara-saudara saya.

	Saya berharap ada tenaga kesehatan dari pemerintah yang mengcover pasien seperti ibu saya. Saya meminta bantuan pemerintah dan supaya mereka benar-benar memperhatikan masalah ini.
24	Di daerah Tabanan tidak ada, hanya di Badung. Para lansia mendapatkan pakaian, makanan, dan perbaikan rumah.
25	Sebenarnya KBS…pengemudi KBS, perawat KBS…harusnya stand by di lokasi…kalau terjadi apa-apa dengan warga desa, hal itu harus segera ditangani. Saat itu, saya menunggu 20 menit. Saya gemetar, saya pergi ke sana untuk mencari mereka dua kali saat itu, ayah saya panik saat itu. "Apa yang harus kita lakukan?" Dia bertanya... "Kenapa mereka begitu lama?" dia terus bertanya. Nini sudah kehabisan napas. Saya pergi mencari mereka lagi, dan kemudian mereka tiba. Anda dapat melihat beberapa komentar di Facebook, ada pro dan kontra, tentang KBS… Seseorang pernah berkomentar, "Sopir-sopir KBS itu, kerjaannya hanya tidur."
26	Saya pikir jika di luar Badung orang yang menemani pasien tidak akan dapat hal itu. Tapi mereka bilang orang yang menemani akan dapat… tapi masih diajukan oleh anak pertama saya. Kami disuruh mengajukan permohonan meskipun saya tidak mau. Kami harus fokus pada kondisi Ninik dulu. Agar orang tidak mengira kami sedang menunggu uang. Supaya mereka tidak berpikir bahwa kami sangat membutuhkannya. Tapi karena mereka bilang itu hak kami, itu harus diambil, itulah yang dikatakan Klian Dinas kepada kami.
27	Menurut dokter, pikiranlah yang menyebabkan kita sakit. Penyebab terkuat adalah pikiran, itu membuat penyakit datang dengan cepat. "Kak, Kadang-kadang jika Kak berpikir terlalu keras tentang sesuatu, dan Kak terus memikirkannya, Kak akan stres," kata dokter. "Karena Kak sudah tua, Kak akan dapat 3S." "Apa itu, Dok?" "Stres, Stroke, *Setra* (kuburan)." Bagi saya, ada benarnya juga.
28	Semua orang ingin sehat, tetapi ketika saya bertanya kepada dokter tentang penyakit saya, dia hanya berkata, "Anda sudah tua." Dia selalu jawab begitu.
29	Merokok adalah penyebabnya. Sejak terkena serangan jantung itu, saya berhenti merokok. Saya dirawat di ICU selama tiga hari. Saya tidak sadarkan diri saat itu. Saya dulunya nakal. Pertama, saya merokok, dan kemudian saya minum kopi terlalu banyak, berjudi, dan melakukan sabung ayam. Saya melakukan sabung ayam di mana-mana. Setelah sakit, saya berhenti sabung ayam, berhenti merokok, dan jarang keluar rumah. Dulu, sebelum saya sakit, pagi saya akan melakukan sabung ayam, dan pada malam hari saya akan berjudi.

Translator agreement

Multigenerational caregiving for older people in Bali

TRANSLATOR'S CONFIDENTIALITY AGREEMENT

I NI LUH WINDIARI (Full Name - printed) agree to do translation and back translation of the interview extracts provided to me.

I agree to keep confidential all the information provided to me.

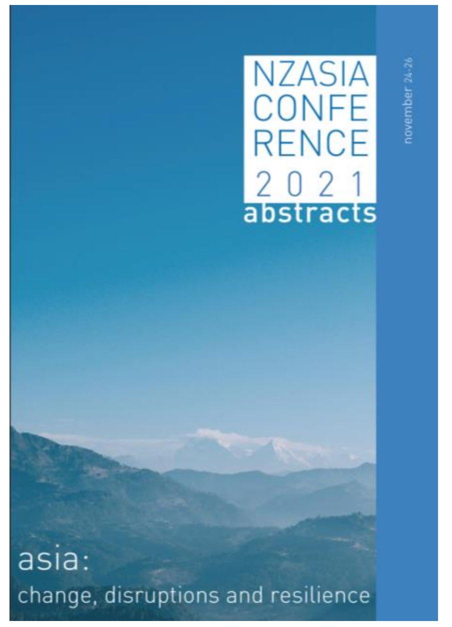
I will not make any copies of the transcripts or interview extracts or keep any record of them, other than those required for the project.

Signature: [signature] **Date:** 20 JUNE 2021

Page **1** of **1**

Appendix E. Publications and DRC 16

NZ Asia Conference



Jordan King (Panel Chair)

Discussion Panel: 'State of Asia Research'

Kerry Ann Lee

Creative Methodologies for Care and Resilience within Asian Aotearoa Arts

Made Diah Lestari

Balinese Family Caregiving Model: The Challenges and Opportunities

Ye Liu

Extended Temporariness and Uncertain Permanence: An Analysis of Chinese Working Holiday Makers' "Triple Rootlessness"

Link to Video Multigenerational Caregiving in Bali

https://drive.google.com/file/d/1g2bDeKe0Xl7GVp5hFHJFZRXFiG7Vb8XM/view?usp=sharing

Link to Video Intergenerational Relationships during Pandemic

https://drive.google.com/file/d/1xIcIiBYxI6IWVSYqckYSTIdwdI3ATiyQ/view?usp=sharing

Ageing & Society (2021), 1–21
doi:10.1017/S0144686X20001907

ARTICLE

Constructions of older people's identities in Indonesian regional ageing policies: the impacts on micro and macro experiences of ageing

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(Accepted 8 December 2020)

Abstract
As Indonesia experiences rapid growth of the ageing population, the government's attention has turned to the wellbeing of older people. This study aims to review critically the construction of older people's identity and care within regional ageing policies in Indonesia. Working from a critical gerontology perspective, a critical discourse analysis of 16 regional ageing policies identified two constructions, labelled 'material' and 'cultural' ageing, which were used to position older people. The analysis showed that 'material ageing' positions older people at the intersection of 'decline' and 'successful ageing' discourses, while 'cultural ageing' positions older people's welfare at the intersection of 'public responsibility' and 'family obligation' discourses. These discursive constructions in the policy documents have both micro (interpersonal) and macro (structural) constructive effects. At the micro-level, the regional ageing policies stand at a crossroad between empowering and marginalising older people and their families. While the dominant discourse of 'successful ageing' encourages older people to be healthy, it marginalises those who do not, or cannot, meet its criteria, undermining a rehabilitative approach as a policy priority. In addition, the rights of the family are overlooked, despite being a pivotal element of cultural ageing. At the macro level, a moral dilemma appears in defining the public and private domains of older people's welfare. Eligibility requirements for state assistance (due to budgetary constraints) ensure that elder care is often relegated to the private sphere, without support. Recommendations for policy improvement are discussed, including the recognition of families' rights and the importance of local cultural practices in providing care for older people.

Keywords: ageing policy; critical discourse analysis; critical gerontology; older people's identity; older people's care

Introduction

The proportion of older people in Indonesia reached 7.6 per cent in 2010, and this figure is projected to increase to approximately 25 per cent by 2050 (Adioetomo and Mujahid, 2014; Adioetomo *et al.*, 2018). This upward trend has been influenced by

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JOURNAL OF INTERGENERATIONAL RELATIONSHIPS
https://doi.org/10.1080/15350770.2022.2059606

The Role of Local Knowledge in Multigenerational Caregiving for Older People

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ABSTRACT

Little is known about how local knowledge informs the way that families provide care for older people beyond the role played by the cultural values of obligation and reciprocity. Better understanding of the role of local knowledge in caregiving practices can contribute to the improvement of support for family caregiving in particular contexts. Addressing this knowledge gap, this study identifies forms of local knowledge that play a role in the way care is provided for older family members in multigenerational Balinese households. Narrative interviews were conducted with 49 members of 11 multigenerational households in Bali. Using thematic analysis, four important forms of local knowledge were identified: (i) caring as intergenerational obligation; (ii) caring to meet needs; (iii) caring in harmony; and (iv) caring through social connections. These local findings contribute to the global discussion on family relationships, the role of social networks, and medical practices on aging and policy.

KEYWORDS

Aging; local knowledge; multigenerational caregiving

Introduction

Research on culture and family caregiving has highlighted the role of cultural values of obligation and reciprocity (Cruz, 2017; Epps, 2014), but has overlooked the role of local knowledge in the way that families provide care for older people. This research aims to remedy the research gap. We examine the ways in which Balinese multigenerational households provide care for older people in terms of local knowledge.

Local knowledge and family caregiving

Local knowledge is the way of knowing and understanding the world that people develop over time in response to local culture and context. It arises as a result of living in a particular social-cultural context in which local customs and practices supplement global knowledge (Harvath et al., 1994; Smith, 2010) and is embedded in community practices, institutions, and relationships (Smith, 2010). This study sees local knowledge as rooted in culture and

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