WORKING PAPER

# CULTURAL PERCEPTIONS OF COMMUNITY LEADERSHIP AND PARTICIPATION IN HEALTH IMPROVEMENT EFFORTS IN INDONESIA

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# Cross Cultural Perceptions of Community Leadership and Participation in Health Improvement Efforts in Indonesia

## Abstract

This paper presents findings from a set of studies conducted in early 2003 by the STARH (Sustaining Technical Achievements in Reproduction Health) program in Indonesia. Using a combination of 20 focus groups and interviews with 1680 community members in 10 communities representing major ethnic groups in Java and Sumatra, these studies explored perceptions of community leadership and community participation in health improvement. Community members see health improvement as an obvious arena for the exercise of leadership and are more likely to participate in community-wide health improvement activities, if activities are championed by leaders with characteristics defined locally as desirable. Yet, a literature review showed little if any attention in leadership theory and research to leadership within a health improvement context. Reviewing the Indonesian data from a transformational leadership theory perspective shows how the Indonesia data conform to theoretical frameworks, with variations consistent with local cultural context. A "culturally adjusted" leadership rating scale is developed and used to show how the presence of culturally appropriate leadership in a community is predictive of community participation in local health improvement efforts. Implications for how to mobilize communities to action on local health issues through health communication programs are discussed.

## INTRODUCTION

Constructing interventions and effectively motivating individuals to engage in sustained healthy behavior relies on an understanding of the social and cultural factors that affect involvement with and response to health promotion efforts. In collectivist societies, community processes and structures, including leadership, may be among the most important of these factors (Figueroa et al., 2002). Literature on leadership theory abounds, concerning such topics as power, persuasion, influence, leader-follower dynamics, universal traits and styles, cultural contexts, and collective efficacy and action. However, most of this work is oriented toward organizational/industrial management, performance motivation, and/or increasing productivity. We have been surprised to find little --if any--leadership theory and research specifically applied to the domain of health promotion and improvement.

This paper uses contemporary leadership theory and research to analyze the role of local leaders in community mobilization for health purposes and illustrates the merits of operationalizing 'leadership' in the design and evaluation of health communication programs. Our jumping off point is a recent set of studies in Indonesia for the STARH (Sustaining Technical Achievements in Reproductive Health) Program, which indicated that community members saw health improvement as an obvious arena for the exercise of community leadership.

These studies were designed before either of the authors was familiar with the leadership literature, so this paper is a retrospective look at existing data through the newly discovered (for us) lens of leadership theory. First, we review the literature, focusing on the newer charismatic/transformational leadership theory, and devoting particular attention to the issues of cross-cultural variation, working self-concept, and social bases of power. Next, we describe the context and methods used in the Indonesian studies and report what members of 10 culturally diverse communities in Indonesia told us about the salient attributes of leaders and leadership processes. We then relate those finding to the concepts of follower's self-identity and leader's power bases. Finally, we describe the construction of a culturally adjusted leadership rating scale and use survey data from the STARH project to analyze the effects of leadership perceptions on community member willingness to participate in local health improvement programs. We conclude with a discussion of how leadership and followership processes might be tapped to improve community participation in health promotion programs.

## OVERVIEW OF PAST AND PRESENT APPROACHES TO THE STUDY OF LEADERSHIP

Leadership is "the process of social influence in which one person is able to enlist the aid and support of others in the accomplishment of a common task" (Chemers, 2000, p. 27). Historically, there have been four main theoretical approaches to the study of leadership: trait theory, behavioral/cognitive theory, situational/contingency theory, and charismatic/ transformational theory, roughly in chronological order of appearance.

***Trait theories*** focus on enduring personal characteristics and attributes (e.g., intelligence, desire to lead, self-confidence, energy, knowledge, ambition, and honesty) that set leaders apart from others (Stogdill, 1948; Mann, 1959; Dorfman, 2003).

***Behavioral/cognitive theories*** focus on behavioral styles or patterns of leadership and suggest that leader style (e.g., autocratic, democratic, laissez faire) is the key determinant of leadership success. In the evolution of leadership studies, these theories shifted the focus from "what leaders are to what leaders do" (Tirmizi, 2002, p. 270).

***Situational/Contingency theories*** focus on the contexts in which leadership is exercised and how context varies. "No leadership traits, behaviors or styles automatically constitute leadership," and effectiveness often depends upon the degree to which the situation gives the leader control and influence (Tirmizi, 2002, p. 269).

***Charismatic/transformational leadership theory*** has emerged from the three earlier streams of theory and, for the past two decades, has been the focus of much of the leadership research. Compared to earlier perspectives, charismatic/transformational leadership theory focuses more on both leaders and followers, and attempts to "explain why the followers of some leaders are willing to exert exceptional effort and make personal sacrifices to accomplish the group objective or mission" (Tirmizi, 2002, p. 270). As opposed to 'transactional leadership'—predicated on the exchange of rewards for compliance—followers of charismatic/transformational leaders are motivated to do more than is expected due to their admiration for, trust of, and loyalty to the leaders (Bass, 1985; Tirmizi, 2002). Because of their unique relationship with followers, charismatic/transformational leaders have been identified as powerful agents of social change (Fiol, Harris & House, 1999).

The framework originally used to guide the research reported here, the Rockefeller Foundation's Integrated Model of Communication for Social Change (Figueroa et al., 2002), identified leadership as an important catalyst of community dialogue and collective action, but does not elaborate on leadership processes or test the impact of leadership on social change, hence, our interest in leadership theories.

## Cross cultural variation in leadership

Leadership is a universal phenomenon, but the way it is actualized is culture specific. For example, the Globe Leadership and Organizational Behavior Effectiveness (GLOBE) project (Den Hartog et al., 1999; House et al., 1999) used data from over 60 countries (including Indonesia) to examine the inter-relationships between societal culture, organizational culture and practices, and organizational leadership. The GLOBE study identified six dimensions of transformational leadership (Charismatic/Value Based, Team-Oriented, Self–protective, Participative, Humane, and Autonomous) (Den Hartog, 1999; Dorfman & Howell 1997), but found variance across countries in the mean factor score for each of the six universal dimensions. Table 1 summarizes the factor means, ranges, and standard deviations for the six leadership factors for all 60 GLOBE countries. Mean factor scores for Indonesia alone (which reflect the relative importance of each factor in Indonesia compared to the total sample) are also provided to illustrate how a given country may differ in the weight attributed to various factors. Indonesia scores above the mean on all factors, except Participative, on which it was lower.[1]

**Table 1. Mean Factor Scores, Ranges, and Standard Deviations for Six Leadership Factors in the GLOBE Sample and Indonesia**

| Leadership factor | Overall Mean | Min | Max | sd | Indonesian mean |
|---|---|---|---|---|---|
| Charismatic/value based | 5.83 | 4.51 | 6.46 | .33 | 6.15 |
| Team oriented | 5.76 | 4.74 | 6.21 | .26 | 5.92 |
| Self-protective | 3.45 | 2.54 | 4.55 | .41 | 4.13 |
| Participative | 5.35 | 4.50 | 6.09 | .41 | 4.61 |
| Humane | 4.87 | 3.82 | 5.61 | .38 | 5.43 |
| Autonomous | 3.86 | 2.27 | 4.65 | .45 | 4.19 |

Source: Den Hartog (1999)

Note: Descriptive statistics are based on the aggregated data from 60 countries. N = 60.

Ensari and Murphy examined cross-cultural variations in leadership perceptions and attribution of charisma to the leader to try to understand how culture may affect leadership in individualistic compared to collectivistic cultures (Ensari & Murphy, 2003). They concluded that, in a collectivistic society, culture has a stronger effect on perceptions of leaderships and information processing of leader behaviors (Ensari & Murphy, 2003). Thus, when examining and discussing health program design and outcomes at the community level in a collectivistic society such as Indonesia, cultural perceptions and values are significant concepts that must be identified and acknowledged, although—as the GLOBE study showed—the dynamics may differ in various locales, even those in close proximity to one another.

## Leadership and follower self-identity

To complete the picture of leadership processes, one must also consider followers. Leadership theory and research is often remiss by not focusing more on "how followers create meaning from leadership acts and how this meaning helps followers to self-regulate in specific contexts" (Lord & Brown, 2004, p. xi).

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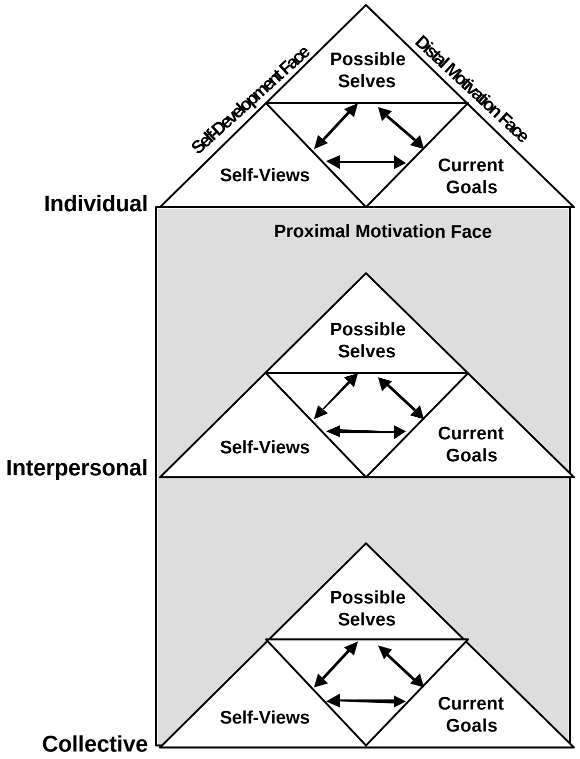
[1] In Indonesia, leadership and decision-making tend to be hierarchical, not horizontally participatory.

The concept of "follower" contains the important notion of "working self-concept" (WSC) (Markus and Wurf, 1987), which reflects the notion that the self is "not a unitary whole by rather a confederation of selves that varies in their activation across times and contexts" (Lord & Brown, 2004, p. 17). Although an in-depth discussion of the features of WSC is beyond the scope of this paper, a brief summary would highlight the fact that working self concept includes one's current identity, short term practical goals, and longer term aspirations, which form a self-regulatory system (Lord & Brown, 2004, p. 18). WSC guides self—and social perceptions and behavior, according to the level at which the follower defines her/himself in any given situation: *individual, relational* or *collective* (Lord & Brown, 2004; Lord, Brown, & Freiberg, 1999; see Figure 1), resulting in different sets of considerations depending on culture and context. Whether operating primarily at an individual, relational, or collective level, self-identity is at the core of the leader-follower dynamic because it helps define what followers want their leaders to be. In the context of the present study—a collectivist society like Indonesia—of particular interest is how social values are reflected in the characteristics of admired and effective leaders.

**Figure 1: Model of Working Self Concept (WSC) at Alternative Identity Levels**


Self-Development Face
Distal Motivation Face
Possible Selves
Self-Views
Current Goals
Individual
Proximal Motivation Face
Possible Selves
Self-Views
Current Goals
Interpersonal
Possible Selves
Self-Views
Current Goals
Collective

Source: Lord, Brown & Freiberg, 1999

***Individual Self-Identity*** arises from dimensions or attributes that are personally important and differentiate oneself from others (Lord & Brown, 2004). Leadership practices that focus on individual-level identities would be effective where individual aspects of identity are salient, but less effective when relational or collective identities are salient.

***Relational-level Self-Identity*** derives from perceptions of how others perceive us and is often defined by helping, caring, or otherwise close relationships with others (Lord & Brown, 2004). Leadership targeting this level is often based on role relations between leaders and followers and implies similarity in terms of attitudes and values, and "creates an ego-enhancing basis for subordinates to identify with leaders" (Lord & Brown, 2004, p. 57).

***Collective-Level Identity*** is typically based on organizational culture or on collective norms (Lord & Brown, 2004). Leadership practices that foster group-level identities should be particularly effective when social norms rather than individual attitudes are major determinants of behaviors (Ybarra & Trafimow, 1998). When collective identities predominate, leaders tend to be evaluated in terms of their fit with specific group prototypes rather than with a general leadership stereotype (Lord & Brown, 2004). Charismatic leaders tend to make more references to collective history and the collective identities of their followers (Lord & Brown, 2004; Shamir et al., 1994).

When designing health improvement programs at the community level, it may be helpful to distinguish which level(s) of identity are most salient in a given location, because leaders would be more effective when they synchronize their efforts with the identity level of followers. Programs can be tailored to maximize appropriate leader-follower dynamics.

## Leadership and sources of social power

The design of health programs can benefit from a focus on leadership if it can help those programs achieve desired outcomes. The practical question then is, what makes leaders more successful and how can this be tailored to the cultural context and needs of followers? In short, how can leaders more effectively mobilize followers?

Rifkin's study of the attitudes about community participation in community health programs in Southeast Asia (Rifkin, 1983), spawned a series of questions which are akin to the questions asked in this paper. Having attempted to "establish some of the potentials and problems of community participation" in health programs in this region, Rifkin was left asking:

> "What does the community want from a community health program? How do professionals communicate their objectives to community people? Is the field of healthcare a field in which community participation is particularly difficult to obtain? Are there certain types of activities, methodologies and/or teaching and communication skills which help community people to overcome their reluctance to enter as a full partner in community health?" (Rifkin, 1983, p. 1494).

Besides cross-cultural variation and follower self-identity then, a third aspect of transformational leadership that is particularly pertinent for understanding the influence process is the leader's base of social power. French and Raven (1959) were the first to propose a leader power base typology, namely reward, coercive, legitimate, referent, and expert power. Their typology continues to be used, with modifications (Hinkin and Schriesheim, 1989; Barbuto, 2000).

Reward power is the ability to administer things desired or to remove undesirable things. Leaders have gained reward power once targets believe leaders can control rewards. (Hinkin & Schriesheim, 1989; Barbuto, 2000). For example, administrative leaders in Indonesian communities control overall allocation of development funds, as do to a lesser extent the informal financial leaders at the local level. Coercive power is the ability to administer punishments, including various forms of social sanctions. If followers believe leaders can punish them in the ways described, then leaders have coercive power, regardless of whether leaders in fact have such ability (Hinkin & Schriesheim, 1989; Barbuto, 2000). Legitimate power is the ability to elicit feelings of obligation and responsibility from others consistent with existing social or administrative hierarchies. This base of power has also been described as position power and structural power (Hinkin & Schriesheim, 1989; Barbuto, 2000). Referent power plays on social values, and the need for acceptance or belonging to the group. If followers emulate their leaders, feel admiration toward them, or harbor a strong desire for acceptance from them, then leaders have gained referent power (Hinkin & Schriesheim, 1989; Barbuto, 2000). An individual may seek this acceptance from a leader, social group, or organization. This base of social power might apply to the informal religious and traditional leadership in Indonesian communities. Finally, Expert power refers to the leader having unique expertise or qualifications for asserting claims or making requests, and usually depends on the leader having special access to information or knowledge.

Barbuto (2000) describes the way that these sources of power are actualized by leaders in their interactions with followers as “influence triggers.” The likelihood of an influence trigger resulting in follower compliance (e.g. member participation in a community health program) will depend on how it is grounded in power structures and on the compatibility of the influence trigger with the followers’ motivations and constraints (Barbuto, 2000). In other words, a successful influence trigger is one that resonates with the followers’ WSC and the leader’s sources of social power, described above.

In Indonesia, formal leaders (governmental and administrative) and informal leaders (financial, religious, traditional, local professional) categories identified via the STARH study can be found in Barbuto’s version of French and Raven’s work, indicating that it may be a useful tool for local community health program planners and managers. Having a working knowledge of these general leader-follower dynamics (i.e. self-identity theory and leader’s bases of social power) is advantageous for planners of health improvement initiatives. It will help them achieve better outcomes due to the culturally appropriate incorporation of local leadership into the overall health program design and delivery. The following application of this approach to the STARH program in Indonesia indicates its applicability.

## LEADERSHIP AND HEALTH IMPROVEMENT AT THE COMMUNITY LEVEL IN INDONESIA

The Indonesian STARH (Sustaining Technical Achievements in Reproductive Health Program) study results indicate that local leadership can be an integral element for success of a community health initiative.

### Sustaining Technical Achievements in Reproductive Health (STARH)

In this section, we first describe the STARH program, and our study methods and sources of data. Then, we review findings from 10 districts in Indonesia to determine typical leadership characteristics and roles (as perceived by community members) that may foster community participation in dialogue and collective action. We relate these findings to the leadership theories described above. Finally, we test some models of leader influence on participation for evidence that positive leadership dynamics increase community member motivation to play an active role in local health improvement.

The STARH Program began in 2000 as a response to the Asian economic crisis, which threatened to undermine 30 years of successful family planning and reproductive health efforts in Indonesia. STARH's mandate was to help build the quality of reproductive health services at the local level and generate demand for those services by forging partnerships between communities and local service facilities and staff. This approach was dubbed Community Driven Quality Improvement (CDQI). Besides working closely with health care providers on service delivery issues, STARH's strategy required motivating communities to take initiative, as well. Few models or precedents for this existed.

One of the few available approaches was the Integrated Model of Communication for Social Change (CFSC) (Figueroa et al., 2001), which describes a community dialogue process resulting in plans for collective action. One of the elements identified in the CFSC model that contributes to successful community dialogue and collective action is the identification and involvement of leaders within the community. The CFSC model defines leadership in terms of six dimensions: extent of leadership, equity and diversity, flexibility, competence in encouraging and securing dialogue and action, vision and innovation, and trustworthiness and popularity. Yet, program planners in STARH realized that they knew little of the leadership dynamics in Indonesian communities, and whether or not the CFSC dimensions of leadership were operative in Indonesia. A set of qualitative and quantitative studies was designed to fill this gap.

## Methods

Building on the Integrated Model of Communication for Social Change (Figueroa et al., 2001), 20 focus groups (10 composed of men, 10 of women) were conducted in July-August 2002 to explore definitions of community, ideal characteristics of leaders, roles of various types of leaders, and the dynamics of leader-member relationships. Focus group locations were chosen to reflect STARH's programmatic constituencies in 10 districts from eight provinces in Java and Sumatra, the most populous of Indonesia's principal islands. Communities tend to be religiously homogeneous: Java is predominantly Muslim, while Sumatra is more mixed, with major Christian ethnic groups in northern areas of that island. Types of communities ranged from peri-urban locations (e.g., Malang in East Java, known for tea plantations and hill resort tourism) to relatively isolated rural locations (e.g., Bangka, off the southeast coast of Sumatra, known for tin mining).

Based on the qualitative findings, a survey instrument was developed and used to conduct interviews with 1680 randomly selected community members in the same 10 districts represented by the focus groups. Respondents were selected through multistage random sampling from communities in the catchment areas of community health centers where STARH was active in service quality improvement efforts. The surveys were conducted in January-February 2003 and were designed to quantify family planning and reproductive health attitudes and behaviors, exposure to early stages of a media campaign promoting close relationships between community members and service providers, perceptions of ideal and actual community leaders, membership in community action groups, and intended participation in upcoming community-based health improvement efforts.

Measurement of leadership perceptions. In the community survey, community members were asked to rate on a 10-point scale the importance of 14 leadership attributes. Mean ratings were computed for each study location. The top seven of these (concern for others, willingness to share resources and benefits, understanding of local culture, understanding of the needs of the local community, well-educated, ability to obtain external resources, and ability to appeal to higher authorities for support) were used for subsequent analysis. Community members were also asked to consider a current community leader who they thought was effective and then to rate that leader, using a 10-point scale, on each of the seven most important criteria.

A perceived leadership scale was then constructed by multiplying the current leader rating for each attribute by the importance of that attribute, then summing across the seven products to create a standardized "culturally adjusted" leadership scale (Chronbach's alpha=.88).

Measurement of participation & involvement. In an effort to examine the relationship between leadership and followership, a number of measures from the community survey were used. Respondents were asked a series of questions about community activities related to improving health. Among these questions were:

1. Have there been any community meetings about health and family planning in the past year?
2. Did you participate in any of those meetings?
3. Are there any groups in the community actively working on health improvement issues?
4. If there were community efforts to improve the quality of health, would you be willing to physically participate?
5. If there were community efforts to improve the quality of health, would you be willing to contribute resources to those efforts?
6. To what extent should the community itself be responsible for solving its health problems?
7. To what extent do you believe that the community can solve its health problems (collective efficacy)?

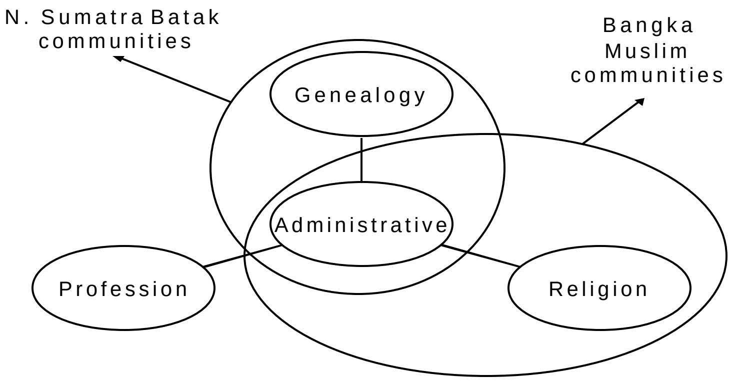
The first five of these items (community meetings, participation in those meetings, presence of active health-related groups, willingness to participate, willingness to contribute) were dichotomous, coded 0 (no) or 1 (yes). The last two items (community responsibility, and collective efficacy) used 10-point scales. Community responsibility was measured by asking respondents, "To what extent does the community as a whole bear responsibility for solving health problems?" Collective efficacy was measured using three 10-point agree-disagree attitude questions that factored together: (1) People in my community tend to neglect the quality of health services, (2) There are parties that won't be able to work together to solve health problems, and (3) Problems of health service quality are too complex to be solved by the community. A standardized additive index was created using these three collective efficacy items (Chronbach's alpha=.64).

Intention to participate and intention to contribute were subsequently used as dichotomous outcome variables in oneway ANOVAs and ordinary least squares regressions examining the effect of specific leadership characteristics and other control variables on intention to participate in health improvement efforts.

## Results of the Community Focus Group Study

In this study, community was subjectively defined. Community boundaries in Indonesia are sometimes established along the lines of religious groupings, other times according to formal administrative divisions or ethnic relations (see Figure 2). For example, in predominantly Christian Batak ethnic areas of north central Sumatra, communities tend to be organized around family and clan, with cultural leaders often assuming administrative functions, as well. In comparison, the predominantly Muslim areas of Bangka in southeastern Sumatra tend to define communities around mosques, and religious leaders are likely to have local administrative roles. Similarly, in many parts of predominantly Muslim Java, religious study groups (*kelompok pengajian*) are common community venues for discussion of local problems and activities and tend to define community boundaries.

**Figure 2: Christian Batak and Muslim Bangka Community Definitions**



Source: STARH/ACNielsen Qualitative Community Study, 2003

Indonesia has a strong tradition of community mobilization and collective action, which most commonly take the form of (1) *arisan*, a form of community fund, often managed by a religious organization, (2) *serikat tolong menolong*, a form of mutual welfare organization involving and serving economically disadvantaged groups, or (3) *gotong royong*, an occasional community event in which everyone pitches in to do something for mutual benefit (e.g. digging a well or eradicating mosquitoes).

Leadership was defined in all communities as deriving from one or more sources of authority; financial/business, religious, *adat* (cultural traditions), or professional—but the emphasis and importance of each source of authority varied from community to community. Successful leaders were almost universally characterized as vigorous or energetic, economically independent (i.e., not deeply in debt or financially beholden to others), charismatic, and with ties to the local community (i.e., involved in social functions). Other attributes included sociability, broadmindedness, approachability, credibility, and flexibility.

In all focus groups, respondents were guided to further define specific characteristics associated with effective local leaders. Both formal and informal leaders were considered, the criterion for effective leadership being someone who was able to motivate others in the community to work together for mutual benefit. Formal leaders are those who have a politically or legally defined administrative role, while informal leaders are those with important social roles. Types of informal leaders included (1) traditional (*adat*) leaders associated with the pre-independence practice of ethnic rituals, transmission of values, and conflict resolution; (2) religious leaders; and (3) financial leaders, who are successful local businessmen. These categories sometimes overlap (especially *adat* and religious), but the importance of *adat* leaders has eroded somewhat over time, with formal government leaders assuming responsibility for many civic functions. Financial leaders (a source of loans and support for community events) tended to be less important in the districts in Java, where a tradition of village cooperatives and community banks is strong.

People tended to feel strongly that community leaders should have roots in the community, a reaction against a modern political system in which formal leaders are sometimes appointed from outside the community. Formal leaders are most likely to have access to and control over government development funds, yet may have limited legitimacy if they are not from the community. In such a case, they may form alliances with informal traditional leaders who lend legitimacy in exchange for more say in the resource allocation process. In the absence of strong formal administrative leadership, often religious or *adat* leaders step in to become key community mobilizers.

From the focus groups, the 14 most salient characteristics of effective leaders were shortlisted: (1) has concern for others, (2) is willing to share resources and benefits, (3) understands local community needs, (4) understands local culture, (5) is well educated, (6) can identify and obtain outside resources, (7) can appeal to a higher authority for support, (8) is the same religion as the majority of community members, (9) has lived in the community more than five years, (10) is rich, (11) is male, (12) is a current government official, (13) is a retired government official, (14) and has supernatural abilities.

Even though we were retrofitting the results of the Indonesian study to available theory, we were pleased to note parallels between the leadership characteristics identified in the focus groups and the sources of power identified by Barbuto (2000) and others (see Table 2). Of the 14 elicited Indonesian characteristics, the greatest number (5) relate to referent power, which is derived from group cohesion and shared values, followed by legitimate power, which is derived from the leader's position in a structural hierarchy and the followers' sense of obligation within that social structure. It should be no surprise that these characteristics are paramount in Indonesia, a highly collectivist and hierarchically-minded society, in which one's links to the community and shared values, beliefs, and concerns are expected of everyone, including leaders. Furthermore, being tied into external power structures to which one can appeal for support, including having current or former links with government, and being male in a male-dominated society, are assets for leaders there.

**Table 2: Parallels between Social Bases of Power Theory[1] and Valued Characteristics of Leaders in Indonesia**

| Source of leader power | Valued leader characteristics in Indonesia |
|---|---|
| **Referent power**<br>(Based on group cohesion, belonging, social values) | Has concern for others<br>Understands local culture<br>Understands local needs<br>Has lived in the community more than 5 years<br>Is the same religion as majority of community |
| **Legitimate power**<br>(Based on position, hierarchy, followers' sense of obligation) | Can appeal to a higher authority for support<br>Is a current government official<br>Is a former government official<br>Is male |
| **Reward power**<br>(Based on ability to confer benefits and resources) | Is willing to share resources and benefits<br>Can identify and obtain outside resources<br>Is rich |
| **Expert power**<br>(Based on unique expertise or qualifications) | Is well-educated<br>Has supernatural abilities |
| **Coercive power**<br>(Based on ability to punish) | -- |

[1] From Barbuto (2000) and Hinkin & Schriesheim (1989)

Source: JHUCCP/AC Nielsen Focus Group Study (2003)

Next in order of emphasis is reward power, based on the ability of a leader to confer benefits and resources. Related to the hierarchical organization of Indonesian society are ingrown systems of patronage, within which those with access to resources are expected to share them. Expert power, too, is a source of authority in Indonesia, were leaders are expected to be educated enough to understand issues the community faces. Mystical or supernatural "expertise," in which many traditional as well as modern Indonesians still believe, is also a valued characteristic of a leader, although to a much lesser extent than are other attributes.

The only source of power not clearly represented in the characteristics mentioned in the focus groups is coercive power. Since the fall of Suharto in 1998, the influence and power of coercive state military and police institutions has declined noticeably, to be replaced by the social pressures inherent in referent and legitimate power bases. Not that coercion has vanished in an increasingly democratic Indonesia, but it has clearly become a less important source of power than it used to be not long ago.

## Results of the Community Survey

Following the community focus group study, a survey questionnaire was developed. Items included measures of the importance of the previously identified leadership characteristics and the degree to which current community leaders matched those characteristics from the perspective of community members. Table 3 shows the mean importance ratings for leader characteristics across all study sites.

**Table 3: Mean importance ratings of leader attributes (range=0-10)**

| Leader characteristic | Mean importance rating | s.d. |
|---|---|---|
| Has concern for others | 8.9 | 1.17 |
| Is willing to share resources & benefits | 8.6 | 1.26 |
| Understands needs of local community | 8.6 | 1.32 |
| Understands local culture | 8.5 | 1.36 |
| Is well educated | 8.5 | 1.46 |
| Can obtain outside resources | 8.3 | 1.36 |
| Can appeal to higher authority for support | 8.2 | 1.49 |
| Is the same religion as majority of community | 7.3 | 2.73 |
| Has lived in community more than five years | 7.2 | 2.24 |
| Is rich | 6.7 | 2.48 |
| Is male | 6.3 | 2.79 |
| Is a current government official | 5.8 | 2.70 |
| Is a retired government official | 5.2 | 2.71 |
| Has supernatural abilities | 3.8 | 3.02 |

Source: JHUCCP/AC Nielsen Community Survey, 2003 (n=1826)

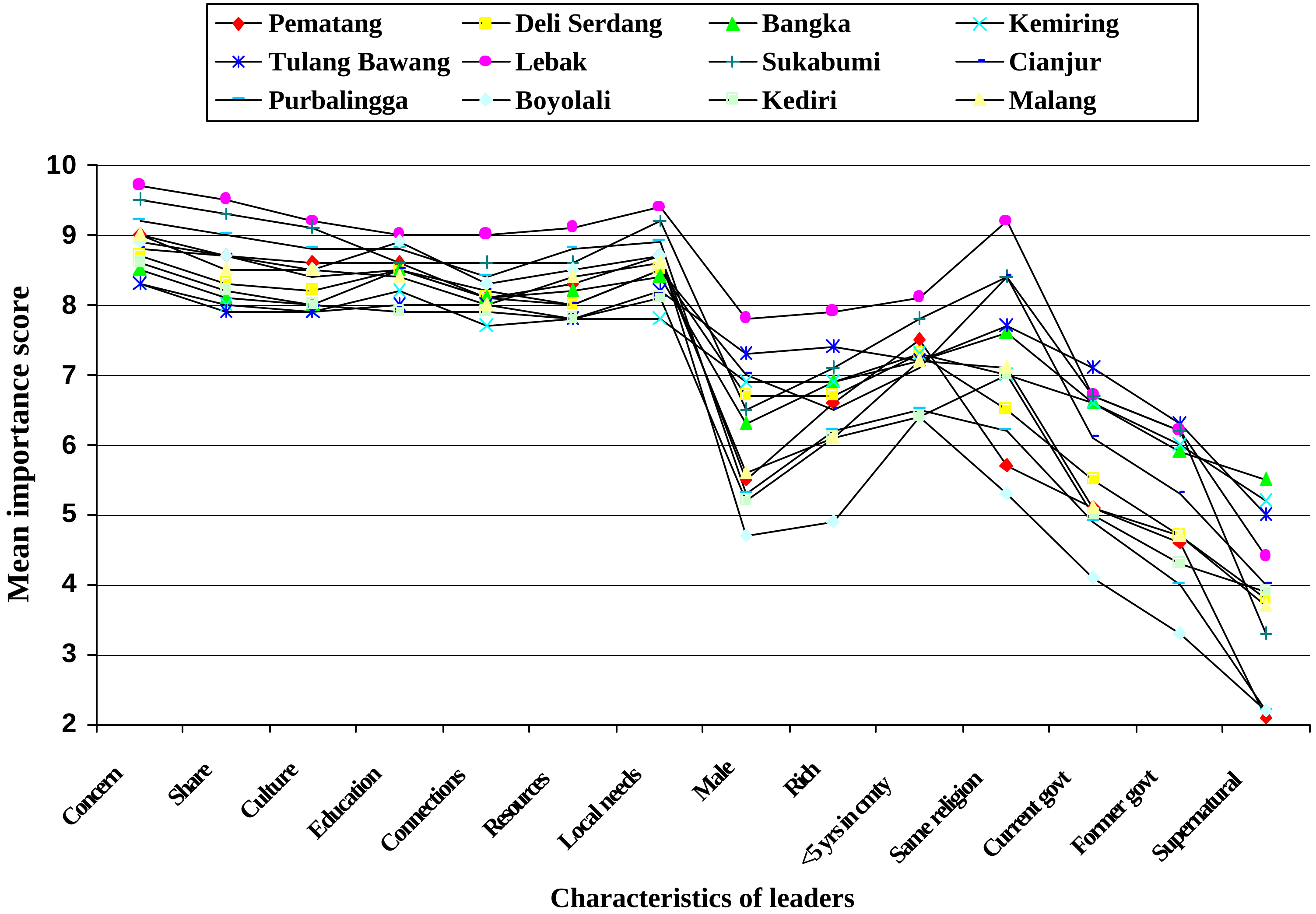
Concern for others received the highest overall importance rating, followed closely by willingness to share resources and program benefits, understanding of local needs and local culture, education, and access to resources and support from beyond the community. Less important characteristics included religion, longer term residence in the community, current or past position in the government, and supernatural ability (especially in Java, belief in the spiritual potency of traditional healers, religious mystics, artists, and adherents of certain disciplined practices is still strong).

How did the importance of leadership characteristics vary from community to community? Figure 3 shows the mean importance score for each of the leader characteristics by study location. Within a district, importance scores did not differ dramatically across the first seven characteristics (approximate difference between highest and lowest score for any one district was no more than a full point on a scale of 0-10). The range in importance scores was much greater (e.g., more than five full points in the case of Pematang) for the next set of seven characteristics.

Across districts there was considerable agreement on the importance of the first seven characteristics, but much less agreement on the importance ratings for the next set of seven characteristics. For example, respondents in all areas tended to give lower importance scores to education (among the top seven characteristics) and to supernatural abilities (among the bottom seven characteristics), but respondents in Sukabumi gave one of the highest ratings to Concern for Others and one of the lowest for Education. Also, respondents in some districts were more likely to give consistently higher (e.g., Lebak) or consistently lower (e.g., Komering) importance ratings.

Clearly, there is a marked degree of consistency and agreement across locations, especially for the top seven most important leadership characteristics, although the emphasis varies somewhat. For subsequent analyses, only these top seven were examined.

**Figure 3: Mean importance rating of leadership characteristics by district**



Source: STARH Community Survey, 2002, n=1826

## Effects of Leadership on Participation

We next turned our attention to the question of whether or not leadership characteristics were related to community participation. As noted in the Methods section, ratings of current leaders were averaged and used in a oneway analysis of variance to determine if specific leadership characteristics were associated with follower intentions to participate if the community initiated health improvement activities. Table 4 shows that higher ratings of community leaders on each of the seven top leadership characteristics, with the exception of leader education, were associated with intention to participate. Note that these characteristics are the ones related to the sources of power most important to Indonesians: referent, legitimate, and reward power.

**Table 4: Mean rating of Current Leaders on Seven Most Important Attributes by Intention to Participate in Health Improvement Efforts of the Community**

| | Intend to participate | | |
|---|---|---|---|
| **Leader attribute** | **No (n=438)** | **Yes (n=1388)** | **F** |
| Has concern for others | 7.1 | 7.5 | 26.37** |
| Is willing to share resources & benefits | 6.8 | 7.2 | 37.78** |
| Understands local culture | 6.9 | 7.3 | 28.64** |
| Is well educated | 6.6 | 6.5 | 0.29 |
| Can appeal to higher authority for support | 6.6 | 6.9 | 12.82* |
| Can obtain outside resources | 6.7 | 6.9 | 12.98* |
| Understands needs of local community | 6.9 | 7.3 | 23.68* |

Source: JHUCCP/AC Nielsen Community Survey, 2003, *p<.001**p<.0001

## Models of Leadership and Participation

Finally, we tested the extent to which overall ratings of current leaders was predictive of follower participation, controlling for a variety of other factors, using ordinary least squares regression. Ratings of current leaders were calculated, as in the Methods section, to take into account the relative importance of leadership characteristics. Ratings of current leaders on each of the top seven attributes were multiplied by the importance rating of each attribute, then standardized and summed to create a culturally weighted leadership rating scale.

Table 5 shows that culturally appropriate leadership at the community level is positively associated with community member willingness to participate in local health improvement efforts, even when controlling for a variety of other predisposing variables. Two models were tested, one for intention to physically participate and one for intention to contribute resources to local health improvement efforts. Control variables in both models included sex, level of education, household income, and district of residence. Other variables that were conceptually likely to influence involvement included: exposure to any radio messages about family planning services in the past 6 months (dichotomous), if there had been any community meetings about health or family planning in the past year (dichotomous), the extent to which the community as a whole should be responsible for solving its own health problems (range 0-10), the existence of any groups in the community actively working on health issues (dichotomous), and the perceived collective efficacy scale. The predictor variable of interest was the culturally adjusted current community leadership scale.

**Table 5: Beta Coefficients for Models of Community Member Intention to Participate in and Contribute to Local Health Improvement Efforts**

| Control and predictor variables | Model 1: Intention to physically participate | | Model 2: Intention to contribute resources | |
|---|---|---|---|---|
| | beta | p | beta | p |
| Sex of respondent (male=1, female=2) | -.091 | .0001 | .00001 | ns |
| Level of education | .059 | .015 | .161 | .0001 |
| Income | .014 | ns | -.065 | .010 |
| District | -.051 | .039 | .005 | ns |
| Exposure to radio messages about FP services in past six months | -.026 | ns | -.006 | ns |
| Ever had community discussion about health & FP | .047 | .043 | .089 | .0001 |
| Believes community should be responsible for its own health improvement | -.027 | ns | .007 | ns |
| Groups exist in community that work on health issues | .024 | ns | -.042 | ns |
| Current community leadership scale | .173 | .0001 | .100 | .0001 |
| Level of collective efficacy | .055 | .019 | .083 | .0001 |
| Model statistics | | | | |
| Number of respondents | 1826 | | 1826 | |
| F-value | 10.15 | | 12.76 | |
| p-value | .0001 | | .0001 | |
| Adjusted model R-squared | .048 | | .060 | |

Source: JHUCCP/AC Nielsen Community Survey, 2003

Leadership was a significant predictor of intention to both physically participate and to contribute resources. Leadership was the strongest predictor of physical participation and the second strongest predictor of resource contribution (after level of education). Education, group meetings, and perceived collective efficacy were significant predictors of both types of participation, while sex and district were predictors of physical participation and income was a predictor of resource contribution.

These findings suggest that the presence of a leader whose characteristics resonate with the social conventions and cultural values of the community can be a force for mobilizing collective action around health improvement. The fact that the measure of leadership used in this study was weighted to account for local variations in leadership preferences, lends support for this interpretation.

## DISCUSSION & CONCLUSIONS

Indonesia, having a symbolically rich and colorful leadership history, was a fitting venue to investigate some of these leader-follower dynamics. We were pleased to note how perceived characteristics of leaders and leadership processes in Indonesia reflect common frameworks in the leadership literature, even though the study was not designed with these frameworks in mind. For example, although there were differences between locations in the importance of specific leadership characteristics, there was considerable agreement on the most important attributes in ways that plausibly conform to the collectivist cultural values and bases of social power in Indonesian society.

As noted earlier, we found little or no attention in the literature to studies of leadership in the domain of health improvement programs. Yet, there is an abundance leadership research that could be pragmatically applied for social change around health issues. The present study points to a potential growth area for health communication research. As a first step in this direction, the STARH results from Indonesia provide a closer look at 'the leader' as an important intercultural instrument to include in the development and delivery of community health initiatives in developing countries. We see this study as a catalyst for future health-related leadership research and contributions to existing health and intercultural communication scholarship as well as to community health program planning.

Not only does this does this paper provide the chance to contribute to additional perspective to health communication and leadership theory, but it may ultimately provide a base of evidence and guideline for international health agencies wanting to involve local indigenous leaders in new programs. Fiol, Harris and House (1999) and others have already called for the use of charismatic/transformational leadership as an effective strategy for generating social change. Because the Integrated Model of Communication for Social Change is a point of reference for the Indonesian STARH project, this focus on community health-related leadership research may lay some groundwork for further investigation into the fostering of collective action for health improvement.

This study also underscores why community health program planners should have an appreciation of cultural variability in leadership processes. Through an understanding of the basic concepts and dimensions of leader-follower dynamics, such as WSC theory and social bases of power, health communication program planners can use leadership as an important and effective design element. Our overview of general leadership theory and research indicates how a leadership framework can be helpful during the formative research and design stages of a health program that endeavors to leverage local leadership.

For example, program planners may want to identify locally important attributes of leaders and use that information to recruit mobilizers to assist with the program. Project communication materials could be developed that reflect the local cultural sensitivities of followers. Leaders/mobilizers could be coached to conform to culturally appropriate leader-follower dynamics. And leadership could be included as a component in program models and as a variable in evaluation designs. Finally, fostering effective leader-follower relationships may help improve program sustainability by building the capacity of community members to engage with and participate in health improvement.

Finally, this study has taken a first step in developing survey tools and culturally appropriate measures of leadership by showing how a leadership scale can have predictive value, at least in the area of community mobilization and participation. This effort continues in two new projects currently being developed in Egypt and Jordan.

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