Older People and COVID-19 in Indonesia

Osuke Komazawa Ni Wayan Suriastini Ika Yulia Wijayanti Maliki Dinar Dana Kharisma







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Ministry of National Development Planning/National Development Planning Agency (Bappenas), Republic of Indonesia Jalan Taman Suropati No. 2 Jakarta Pusat 10310 Indonesia

SurveyMETER Jl. Jenengan Raya No. 109, Maguwoharjo, Depok, Sleman, D.I. Yogyakarta 55282 Indonesia

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The tables and figure are from the phone survey conducted in July 2020.

Foreword

Human beings have never been free of infectious disease. Countless such diseases have brought serious challenges, some of which have been catastrophic. We have overcome such crises by exerting our wisdom, solidarity, and resilience. To combat the coronavirus disease (COVID-19) pandemic, we need to examine its effects empirically. However, the health protocol to prevent the transmission of COVID-19 strongly encourages us to maintain social distance and avoid face-to-face meetings. Under these conditions, how can we collect information about the impact of the pandemic on various groups in society?

Social distancing makes surveys on people's daily lives very challenging, but such surveys are increasingly necessary as COVID-19 is creating a massive impact on people's lives throughout the world. The 'Older People and COVID-19 in Indonesia: A SILANI follow-up survey' employed the phone survey method and is a good example of a feasible method that can be implemented in the era of social distancing. We were able to maintain social distancing throughout the procedures required to implement this survey – from the preparations to the interviews and data processing. All meetings amongst team members, as well as interviews with respondents, were conducted remotely. Phone surveys have limitations as to the extent of data collection (e.g. the duration of interviews is limited to about 30 minutes because people do not like to spend long on the phone), and in-person interviews can collect more extensive data. However, even phone surveys can collect very valuable information which can contribute to effective policymaking. At this point, let me express my gratitude to the members of this project team for proposing the idea of conducting a phone survey during the pandemic.

This phone survey focuses on the impact of COVID-19 on older people. As many other reports have confirmed, COVID-19 disproportionately affects older people and those with chronic health conditions. Human beings have never before had the current population structure, which has a vast number of older people. In the case of Japan, the 2015 census showed that the proportion of people aged 75 years or older is as high as 12.7%, whereas it was only 1.3% in the 1920 census. According to the United States Centers for Disease Control and Prevention, the chance of mortality of people aged 75–84 years is 220 times that of people aged 18–29 years and as high as 630 times for people aged 85 years and above. While population ageing reflects the success of human development, COVID-19 touches a sore spot in contemporary society. As responsible cosmopolitans, contemporary humans are required to participate in global collaboration and pool our knowledge and wisdom to mitigate and overcome the impacts of COVID-19.

Indonesia is the country most affected by COVID-19 amongst the Association of Southeast Asian Nations (ASEAN) Member States, in terms of the number of confirmed cases and deaths. As stated in this report, Indonesia's older population has much higher COVID-19 fatality rates than younger generations. This trend is common all over the world. Although the Government of Indonesia has made the utmost effort to slow down or stop the spread of this epidemic in the country, including large-scale social restrictions or Pembatasan Sosial Berskala Besar (PSBB), the battle against this disease is not straightforward. At the time of writing, the confirmed cases are still steadily increasing, even accelerating, and PSBB is still in effect. The persistent epidemic in the country, and the pandemic in the global sense, have pushed Indonesia into recession for the first time since the 1998 Asian financial crisis. COVID-19 is seriously affecting people's health status, social interactions, and economic activities – particularly underprivileged people, including many older people. The government is under pressure to respond swiftly to this crisis, so precise information on the actual daily lives of various groups of people is desperately needed. This survey was proposed by the Indonesian Ministry of National Development Planning (Bappenas). Considering the urgent need and critical importance, the Economic Research Institute for ASEAN and East Asia (ERIA) was pleased to collaborate with Bappenas on this survey.

This survey succeeded in revealing the actual lives of older people during the COVID-19 epidemic in Indonesia. More than half of the respondents reported decreased incomes and almost half of them reported that they had reduced the quality of the food they consumed during the pandemic. Such severe hardship runs the risk of undermining the health status of older people. However, this survey confirmed that government services have expanded to cover the higher number of people needing support during the epidemic, and the mutual support in families and communities has played a significant role in mitigating the impact of COVID-19. Such solidarity – often cited as the tradition of *gotong royong* – will bring great strength to the Indonesian people in this battle with the infectious disease, and can be shared with other countries as a good practice during the pandemic.

Finally, we would like to express our sincere appreciation to all the respondents and the people who supported them. As stated above, this survey was conducted by employing the phone survey method, so the kind support of their family members was indispensable. Indeed, in many cases, we called the contact telephone numbers of family members. In other cases, the selected respondents were incapable of answering the interview due to impaired cognitive function or other reasons, and families were requested to answer the questions as proxies. It seems to me that without a deep understanding of the importance of this survey, the respondents and families would not have remained on the phone throughout the interview. Our sincere thanks thus go to the respondents and their families for their patience, to Bappenas for the firm leadership of our colleagues, and to SurveyMETER for its dedicated work. The second report of this survey will be published in 2021, using the data from the second-round survey to compare the first and second surveys. As the President of ERIA, based in Jakarta, I am extremely happy to continue the collaboration with Indonesia, and I sincerely hope that the outcome of such cooperation will inform the government's policymaking to benefit the Indonesian people.

2. Nishimu Ja

Professor Hidetoshi Nishimura President, Economic Research Institute for ASEAN and East Asia

Preface

The number of people diagnosed with COVID-19 (coronavirus disease) around the world now exceeds 60 million, and about 1.5 million people have died.¹ Indonesia had reported more than 500,000 cases and about 17,000 deaths as of 30 November 2020. The case fatality rate in the old-age group or those 60 years old and above is higher compared to the younger adult group, which accounts for 38.5%.²

Riskesdas (*Riset Kesehatan Dasar*: Basic Health Research) Data of 2018 reports that older people are more likely to suffer from non-communicable diseases, such as heart disease, diabetes mellitus, stroke, hypertension, and arthritis, than younger generations. Many studies found that hypertension, diabetes, and cardiovascular diseases are the most prevalent comorbidity amongst the death cases from COVID-19. Amongst the confirmed cases of COVID-19 in Indonesia, hypertension accounted for 50.5%, diabetes 34.5%, and cardiovascular disease 19.9%.³ This is why older people are considered the most affected group during this pandemic.⁴

This phone survey of older people and COVID-19 in Indonesia, therefore, aims to (i) measure the general knowledge of older people regarding COVID-19 and their sources of information; (ii) compare the welfare of older people before and during the COVID-19 pandemic; (iii) understand the difficulties they face during the pandemic; (iv) monitor the assistance they receive during the pandemic; and (v) identify the most suitable policies on their health and welfare.

¹ https://covid19.who.int

² https://Covid19.go.id.

³ ibid

⁴ http://www.padk.kemkes.go.id/article/read/2020/04/23/21/hindari-lansia-dari-Covid-19.html.

This study was initiated by the Bappenas (*Badan Perencanaan Pembangunan Nasional*: National Development Planning Agency) and sponsored by the Economic Research Institute for ASEAN and East Asia (ERIA). The data collection, including technical support, instrument design, and basic analysis, was conducted by SurveyMETER. This report was compiled based on the analysis of the data collected from the first round of the survey in July 2020.

The first round of phone survey was implemented in July 2020 and the second will be conducted in November 2020. We randomly selected the respondents from the older people registered in SILANI (Information System of Older People) which is implemented in three provinces of Indonesia: *Daerah Istimewa* Yogyakarta (DIY), Bali, and *Daerah Khusus Ibukota* (DKI) Jakarta. In these three provinces, seven districts or cities were selected as project areas: Sleman District, Bantul District, Yogyakarta City, Denpasar City, Gianyar District, West Jakarta City, and South Jakarta City. From each of these seven districts/cities, one village or *kelurahan* was selected. As a result, the project area of SILANI consisted of seven villages/*kelurahan*.⁵ The total number of respondents is 3,500, and this was divided proportionately amongst the villages according to the population of older people who have phone numbers in each village. The sampling was made randomly within each village.

SurveyMETER wishes to thank Bappenas and ERIA for the support provided – from the preparation to data collection until data analysis. We hope that the result of this phone survey will be good inputs for the government and the policymakers in their efforts to improve the welfare of the community, particularly of the older people.

> Ni Wayan Sriastini Executive Director, SurveyMETER

⁵To protect the research subject, names of research villages remain undisclosed. *Kelurahan* is an administrative subdivision like *desa* or village in urban communities.

List of Project Members

Bappenas (National Development Planning Agency Team)

Maliki: Director for Poverty Alleviation and Community Empowerment

Dinar Dana Kharisma: Senior Policy Planner, Directorate of Poverty Alleviation and Community Empowerment

SurveyMETER Team

Ni Wayan Suriastini (Team Leader): Executive Director Endra Dwi Mulyanto (Assistance Team Leader): Researcher Danang Prasetya: Programmer Ika Yulia Wijayanti: Researcher/Analyst Naryanta: Researcher/Field Supervisor

Economic Research Institute for ASEAN and East Asia (ERIA) Team

Osuke Komazawa: Special Advisor on Healthcare and Long-Term Care Policy **Sota Machida**: Senior Policy Officer, Healthcare and Long-Term Care Policy

The support team is listed in the appendix.

Table of Contents

List of Figures and Tables	xi
List of Abbreviations	xiv
Executive Summary	XV
CHAPTER 1. Background and Objectives	1
1. Introduction	1
2. Objectives	3
3. Methodology	3
4. Completion Rate and Proxy	4
5. Deceased Respondents	6
CHAPTER 2 Characteristics of Respondents	8
CHAPTER 3 Economic and Social Protection	12
1.Income	12
2. Assistance	24

CHAPTER 4 Health	
1. Physical Health	0
2. Mental Health	
3. Health Services	
CHAPTER 5 Interaction and Social Support	
1. Social Interaction	0
2. Social Support	
CHAPTER 6 Conclusions and Recommendations	
1. Conclusions	0
2. Recommendations	
References	
Appendix: Support Team	0

List of Figures and Tables

Figures

1.1 Study Sample	4
Tables	
1.1 Completion Rate	5
1.2 Reasons for Proxy	6
1.3 Deceased Respondents from amongst the Original Sample	7
2.1 Characteristics of Completed Respondents	8
2.2 Distribution of Respondents, by Age Group	10
2.3 Distribution of Respondents, by Sex	11
3.1 Income Changes of Older People During the Pandemic	13
3.2 Source of Income of Respondents Before the Pandemic	15
3.3 Number of Sources of Income Before the Pandemic	17
3.4 Distribution of Income Source of Respondents Who Had Only One Source Before the Pandemic	19
3.5 Impact of Income Changes on Food Consumption	21

3.6 Coping Strategy Against Income Decrease During the Pandemic	23
3.7 Types of Assistance Received by Respondents During the Pandemic	26
3.8 Number of Assistance Types Received by Respondents During the Pandemic	28
3.9 Percentage of Respondents Who Received Assistance During the Pandemic from Individuals and/or Groups Living in the Same Village/ Dusun/RW/Banjar	29
3.10 Types of Assistance Received by Respondents Whose Income Decreased During the Pandemic	30
3.11 Number of Types of Assistance Received by Respondents Whose Income Decreased During the Pandemic	32
3.12 Percentage of Respondents Whose Income Decreased and Who Received Assistance from Individuals and/or Groups Living in the Same Village/ <i>Dusun/Rukun Warga/Banjar D</i> uring the Pandemic	33
3.13 Percentage of Respondents Who Received Assistance Before and During the Pandemic	35
3.14 PKH Assistance Before and During the Pandemic	37
3.15 Non-cash Food Assistance Before and During the Pandemic	39
4.1 Respondents Who Reported their Health Conditions Deteriorated During the Pandemic	42
4.2 Respondents Who Had Difficulty in Activities of Daily Living (at the Time of the Interview)	43
4.3 Respondents Who Had Difficulty in Instrumental Activities of Daily Living (IADL) (at the Time of the Interview)	44

4.4 Comorbidity Score Change from Before the Pandemic	46
4.5 Morbidity Rates of Six Chronic Conditions Before and During the Pandemic	47
4.6 Practices to Maintain Physical Health During the Pandemic	48
4.7 Change of Depression Scores from the Pre-pandemic Period	52
4.8 Respondents Suffering from Abuse	53
4.9 Practices to Maintain Mental Health During the Pandemic	54
4.10 Respondents Who Had Difficulty Accessing Health Facilities During the Pandemic	57
4.11 Reason for Difficulty Accessing Health Facilities During the Pandemic	59
4.12 Respondents Who Delayed Consultation in Health Facilities During the Pandemic	60
4.13 Shortage of Routine Medicine During the Pandemic	61
4.14 Reasons for Shortage of Routine Medicine During the Pandemic	63
5.1 Social Relations with Relatives/Friends/Neighbours During the Pandemic	65
5.2 Participation in Community Activities During the Pandemic	67
5.3 Support for Family and Community During the Pandemic	69
5.4 Public and Social Support Received by Respondents through Home Visit or Telecommunication	71
5.5 Support from Family and Community During the Pandemic	73

xiii

List of Abbreviations

ADL	activities of daily living
ATM	anjungan tunai mandiri (automated teller machine)
Bappenas	Badan Perencanaan Pembangunan (Nasional National
	Development Planning Agency)
BLT	Bantuan Langsung Tunai (Unconditional Cash Transfer
	Programme)
BPJS	Badan Penyelenggara Jaminan Sosial (Healthcare and
	Social Security Agency)
BPNT	Bantuan Pangan Non Tunai (Non-cash Food Assistance)
BST	Bantuan Sosial Tunai (Unconditional Cash Transfer
	Programme)
COVID-19	Coronavirus disease 2019
DIY	Daerah Istimewa Yogyakarta (Special Region of
	Yogyakarta)
DKI Jakarta	Daerah Khusus Ibukota Jakarta (Special Capital
	Region)
GDS	Geriatric Depression Scale
IADL	instrumental activities of daily living
РКН	Program Keluarga Harapan (Family Hope Programme)
Sembako	Sembilan Bahan Pokok (Nine Basic Needs
	Commodities)
Stranas	Strategi Nasional (National Strategy)
SMS	short message service
SILANI	Sistem Informasi Lanjut Usia (Information System of Older
	People)

Executive Summary

Indonesia has confirmed hundreds of thousands of COVID-19 cases, together with thousands of death cases. The case fatality rate of COVID-19 amongst older people is quite high: about 15% as of 9 September 2020 (*Gugus Tugas Percepatan Penanganan* COVID-19, n.d.-a). The COVID-19 pandemic has several impacts on the economic, health, and social conditions of older people. This phone survey was conducted to identify such conditions during and/or after the COVID-19 pandemic.

This study was initiated by Bappenas and sponsored by the Economic Research Institute for ASEAN and East Asia (ERIA). SurveyMETER was responsible for data collection and basic analysis. The respondents were 3,500 older people aged 60 years and above and randomly selected from the target population of the project areas of SILANI (*Sistem Informasi Lanjut Usia*: Information System of Older People). SILANI covers three provinces in Indonesia: *Daerah Istimewa* Yogyakarta (DIY), Bali, and *Daerah Khusus Ibukota* (DKI) Jakarta. SILANI covered seven districts/cities (Sleman District, Bantul District, Yogyakarta City, Denpasar City, Gianyar District, West Jakarta City, and South Jakarta City), and one village/*kelurahan*¹ per each district/city was selected as a project area of SILANI. The first round of data collection of this phone survey was carried out in July 2020 and the second round will be conducted in November 2020. In the first round, we found 70 respondents had passed away. The total completed interview was 3,430. The findings from the first-round survey are discussed below.

¹To protect the research subjects, names of research villages/kelurahan remain undisclosed. *Kelurahan* is associated with urban areas, while village or *desa* is to rural areas. *Kelurahan* is the smallest government unit at the similar level as village, with some limited authority delegated by *kecamatan* (subdistrict). It has no authority to make policies, manage its own financial resources, and elect leader like *desa* (Law No. 23 of 2014).

The Economic Condition of Older People

Older people experience a decline in economic conditions. This affects the quality of their food. This is overcome by dipping into savings, looking for new jobs, and seeking assistance. During the pandemic, older people received more assistance than before the pandemic.

- The main source of income of older people is work or job (36%) and children who are non-household members (30%). One out of two older people experienced a decline in income during the COVID-19 pandemic. The income of the respondents who generated income from work and the respondents depending on the income of children who do not live together was significantly more likely to decrease than that of their counterparts.
- 2. Amongst the respondents who reported their income decreased, for almost half the frequency did not decrease, nor did the amount and quality of food consumption, but for about 42% of them the quality of meals fell.
- 3. More than half of the respondents said they had not done anything to overcome the decline in income. Some respondents asked for help from richer families or communities, dipped into savings, and looked for new jobs.
- 4. About three out of four respondents received at least one type of assistance during the pandemic. Non-cash food assistance (*sembako*) dominated the type of assistance. Four out of five respondents whose income decreased received at least one type of assistance during the pandemic.
- 5. About 7% of the respondents were beneficiaries of the PKH (*Program Keluarga Harapan*: Family Hope Programme/Conditional Cash Transfer Programme) during the pandemic. About 70% of them received from the PKH during the pandemic only, whilst the rest (30%) received assistance from before the pandemic. Around 51% of respondents were recipients of the *Sembako* programme during the pandemic only, and 5% received the *Bantuan Pangan Non Tunai* (BPNT), which is equivalent to *sembako*, from before the pandemic.

Health Condition of Older People

The physical and mental health of some older people during the COVID-19 pandemic has deteriorated. Several respondents have problems in getting health services and have run out of medicine. Older people carried out various activities to maintain physical and mental health during the pandemic.

- 1. One out of six respondents stated that their physical health has decreased during the pandemic. Eight percent also have problems doing activities of daily living (ADL), such as dressing, bathing, or feeding. A total of 9% of the respondents stated that they have experienced problems with instrumental activities of daily living (IADL) such as shopping or using an ATM (*anjungan tunai mandiri* or automated teller machine) without assistance.
- 2. The need for health services during the pandemic is quite high but some face problems in accessing health services. One out of nine respondents who needed to go for consultation at health facilities stated they have difficulty in accessing health services. Amongst the respondents who answered that they have difficulty in accessing health services, 45% cited that they felt worried or scared to go to a health facility, whilst about 28% said that health facilities were closed or did not provide services for older patients.
- 3. About 12% of respondents who need routine medicine stated that they had run out of medicine because they did not have money to buy medicine (45%).
- 4. Almost all respondents stated that they adopted the practices to maintain physical health (99%) and mental health (98%). More than 50% stated that they maintain physical health by sunbathing, adopting an active lifestyle at home and/or outside the home, and exercising outdoors. Meanwhile, more than 60% of respondents stated that they maintain mental health by praying.

Social Support for Respondents

Social interaction is undermined by the COVID-19 pandemic because of social restrictions to prevent the spread of the disease. This study found, however, that many respondents still contributed to community service.

- During the pandemic, only 5% of respondents stated that they have never communicated with relatives, friends, and neighbours either in person or through telecommunication, whereas about 75% of respondents stated that they keep social relations via telephone, short message service (SMS), or social networking service like WhatsApp during the pandemic. About 60% of the respondents suspended their participation in community activities which took place outside their houses after the onset of the pandemic, while about one third of respondents still participated.
- 2. During the COVID-19 pandemic, around 43% of respondents contributed to their families and communities. The commonest contribution was caring for children under 5 years old (20%), followed by donation of *sembako* (19%).
- 3. A total of 8% of respondents stated that during the pandemic they received visits or calls made by *Posyandu*² cadres, social cadres, and/or health workers. The commonest form of assistance received by the respondents was information about COVID-19 (45% of the respondents who received public and social support), followed by other health information (32% of same respondents as above). Regarding the support from family and community, i.e. neighbours, friends, village/kelurahan, rukun warga³ staff, etc., the commonest form of support was 'keeping socially connected through home visits, phone calls, SMSs, or WhatsApp messages' (74%), followed by 'help in keeping the house and surroundings clean' (67%).

² Posyandu (Pos Pelayanan Terpadu: Integrated Service Post) is a community-based health service for promotive and preventive effort purpose. It is carried out by communities; non-governmental, private, and social organisations, as well as in collaboration with several sectors. *Posyandu's* cadres are responsible for managing regular activities. In Indonesia, there are two types of *Posyandu*, namely, *Posyandu Balita* for children under 5 years and *Posyandu Lansia* for older people (Minister of Health Regulation No. 67 of 2015).

³ *Rukun warga* or government-fostered community institution under a village/*kelurahan* facilitates participation in planning, implementation, and supervision of development, as well as improvement of village community services. This institution is not a division of government administration. There are several *rukun warga* in a village or *kelurahan*.

CHAPTER 1 Background and Objectives

1.Introduction

The World Health Organization declared on 11 March 2020 the Coronavirus disease (COVID-19) as a pandemic. Tens of millions of people in the world had been confirmed infected with COVID-19, and more than a million died. In Indonesia, the earliest cases were confirmed on 2 March 2020. To date, hundreds of thousands of cases have been confirmed as SARS-CoV-2 positive, and more than 10,000 fatalities have been reported. The number of confirmed cases has been steadily increasing since the first case was identified in early March 2020.



COVID-19 has impacted all aspects of life. SARS-CoV-2 infects all age groups, but older people are most affected in terms of hospitalisation and mortality.

In Indonesia, the case fatality rate of older people or those aged 60 and above was 13.9% as of 9 November 2020,

whilst that of 19–30 years old was 0.47% (*Gugus Tugas Percepatan Penanganan* COVID-19, n.d.-a). Per the website of the Centers for Disease Control and Prevention of the United States (US), people with underlying medical conditions – such as cancer, chronic obstructive pulmonary disease, obesity, serious heart disease, type 2 diabetes, etc. – have an increased risk of COVID-19 (Centers for Disease Control and Prevention, 2020). The result of *Riskesdas* (*Riset Kesehatan Dasar*: Basic Health Research) suggests that more than 20% of Indonesian older adults are hypertensive, more than 15% have diabetes mellitus, about 5% have heart disease, about 15% have elevated creatinine

level which suggests chronic kidney disease, and about 4% have a chronic obstructive pulmonary disease (Ministry of Health, 2019).

Daerah Khusus Ibukota (DKI) (Special Capital Region) Jakarta is one of the provinces with a large number of population aged 60 years old or above, whilst Bali and Daerah Istimewa Yogyakarta (DIY) (Special Region of Yogyakarta) are amongst the provinces with the largest proportion of older people in Indonesia. We can conclude that the three provinces have been most affected by COVID-19 considering the high risk of fatalities and hospitalisation of older people. The Large-Scale Social Restrictions (*Pembatasan Sosial Berskala Besar* or PSBB), which Government Regulation Number 21 of 2020 and Minister of Health Regulation Number 9 of 2020 introduced, was enforced in DKI Jakarta. The PSBB requires people of targeted areas to adjust their lives to several social restriction measures, such as school closure, working from home, limitation of religious activities, and other activities in public facilities. The PSBB was not introduced in Bali and DIY, despite COVID-19 affecting older people's lives in many aspects like health, economy, and social inclusion.

As of 9 November 2020, 112,743 COVID-19 positive cases have been confirmed in DKI Jakarta (25.6% of nationally accumulated number); 12,293 (2.8%) cases in Bali; and 4,269 (1.0%) in DIY (*Gugus Tugas Percepatan Penanganan* COVID-19, n.d.-b). These numbers amount to 1,110 confirmed cases per 100,000 people in Jakarta, 296 in Bali, and 116 in DIY, if calculated with the data of SUPAS (*Survei Penduduk Antar Sensus*: Inter-census population survey) 2015 (BPS, 2015). Though the proportions of confirmed cases per population are comparatively low in Bali and DIY, the percentage of older people in the two provinces is high, i.e. 13.55% in DIY and 10.40% in Bali (BPS, 2015). We can say that these three provinces are vulnerable to the COVID-19 pandemic.

Taking this concern, we planned to conduct two rounds of telephone surveys to observe the conditions of older people during and/or after the COVID-19 pandemic in DIY, Bali, and DKI Jakarta. The first round of telephone surveys was conducted in July 2020 and the second round will be in November 2020.

Ethical approval for this study was obtained from Atma Jaya Catholic University.

2. Objectives

The objectives of this telephone survey study are as follows:

- 1. To measure the common knowledge of older people about COVID-19 and identify their source of the information;
- 2. To compare the welfare of older people before, during, and/or after the COVID-19 pandemic;
- 3. To understand the difficulties they face during this pandemic;
- 4. To monitor the assistance older people receive during the COVID-19 pandemic; and
- 5. To identify the most suitable policies on the health and welfare of older people.

3. Methodology

We conducted the first round of data collection in July 2020 using a quantitative approach with longitudinal research design. The sample size was 3,500. The number of respondents was assigned proportionally to the population of older people at each village/kelurahan which is included in SILANI (*Sistem Informasi Lanjut Usia:* Information System of Older People) project areas. Simple random sampling was done in each village/kelurahan.

SILANI, a project initiated by the *Badan Perencanaan Pembangunan Nasional* (Bappenas) or National Development Planning Agency, was designed to promote collaboration amongst multi-stakeholders to develop the integrated database on older persons, on both demand and supply sides, and to establish an integrated system to facilitate active ageing and long-term care.

SILANI's project sites comprise seven villages/kelurahan. One village/kelurahan was selected from each of the following seven districts or cities: Sleman District, Bantul District, Yogyakarta City, Denpasar City, Gianyar District, West Jakarta City, and South Jakarta City. All project sites of SILANI are located in any of the following three provinces in Indonesia: DIY, Bali, and DKI Jakarta. The respondents of this phone survey were limited to older people whose households have a landline or cell phone, according to the results of the SILANI survey. In the first round of the survey, 'during the pandemic' refers to the period starting March 2020 (when the first case of COVID-19 in Indonesia was identified and WHO announced the pandemic status) until the time of the interview (July 2020). Therefore, 'before the pandemic' (or 'pre-pandemic') refers to the period before March 2020.

4. Completion Rate and Proxy

We defined 'completed' respondents as either of the following cases: (i) those who went through all the items in the questionnaire, whether they still live in the study areas or they have moved temporarily or travelled; or (ii) those who had died. Out of a total of 3,500 respondents of the original target sample, 2,574 (73.5%) respondents completed the interviews whilst 70 (2%) respondents died between the SILANI baseline survey and this phone survey. The original sample respondents who died were not replaced by the reserve sample.

To fulfil the target sample size of 3,500, we replaced the original respondents who could not complete the interviews (856 respondents) with a reserve sample (Figure 1.1). The reasons for replacement are described in Table 1.1.



Figure 1.1: Study Sample

Table	1.1	Completion	Rate
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Information	N	%
1. Original Sample		
Completed		
Completed interview	2,574	73.50
Deceased	70	2.00
Not Completed		
Refused	45	1.30
Temporarily live in another place, do not have new contact	12	0.30
Moved out, do not have new contact information	23	0.70
Cannot be reached		
Phone not active	209	6.00
No response	476	13.60
Rescheduled, until the time was over	91	2.60
Total	3,500	100.00
2. Reserve Sample		
Completed		
Completed interview	856	55.20
Deceased	23	1.50
Not Completed		
Refused	11	0.70
Temporarily live in another place, no new contact	12	0.80
Moved out, no new contact information	1	0.10
Cannot be reached		
Phone not active	259	16.70
No response	343	22.10
Rescheduled, until the time was over	46	3.00
Total	1,551	100.00

Our team contacted 1,551 older persons from the reserve sample to meet the needs of 856 substitution respondents. A reserve respondent who died was replaced by another candidate. Eventually, to complete the 3,500 respondents, we contacted 5,051 older persons, i.e. 3,500 original sample respondents and 1,551 replacement candidates from the reserve sample.

In this study, a proxy was allowed if the respondents could not answer the questions for several reasons; a different questionnaire was used for proxies. As a result, proxies answered for 504 respondents (14.4% of the total sample). The reason for the four proxy cases was COVID-19. The most common reasons for proxy cases are hearing loss (364 respondents) and communication problems (275 respondents) (Table 1.2).

Reason	N = 504 (Multiple answers allowed)	
	n	%
Sick because of COVID-19	4	0.50
Sick not because of COVID-19	85	11.20
Hearing disorder	364	48.00
Communication disorder	275	36.30
Cognitive	30	4.00
Total	758	100.00

Table 1.2 Reasons for Proxy

5. Deceased Respondents

The telephone survey found 70 respondents had died. One respondent from the 70–79 age group died from COVID-19. About two out of five deceased respondents died before 2 March 2020, the beginning of the COVID-19 pandemic (Table 1.3).

Table 1.3 Deceased Respondents from amongst the Original Sample

Characteristics	Died from COVID-19	Died During the Pandemic, Not from COVID-19	Died Before the COVID-19 Pandemic	N
Total	1.40	58.60	40.0	70
Sex				
Male	0.00	51.40	48.60	35
Female	2.90	65.70	31.40	35
Age				
60–69 years	0.00	70.00	30.00	30
70–79 years	5.30	47.40	47.40	19
80 years and older	0.00	52.40	47.60	21

CHAPTER 2 Characteristics of Respondents

The respondents of this study are the older people registered as participants of the SILANI Project (*Sistem Informasi Lanjut Usia*: Information System of Older People), the first survey of which was conducted from October 2019 to February 2020. The total number of respondents for this study was 3,500. Seventy respondents of the original sample had died, and 3,430 respondents completed the interview. One of the death cases was confirmed as death from COVID-19.

Table 2.1 shows the demographic characteristics of the respondents in this study.

Characteristics	%	N
Total	100	3,430
Sex		
Male	46.44	1,593
Female	53.56	1,837
Age		
60–69 years	65.04	2,231
70–79 years	26.41	906
80 years and older	8.54	293
Living location		
Urban	92.45	3,171
Rural	7.55	259

Table 2.1 Characteristics of Completed Respondents^a

Characteristics	%	N
Province		
Bali	22.77	781
DIY	25.60	878
DKI Jakarta	51.63	1,771

^a Completed respondents refer to (i) those who went through all the items in the questionnaire, whether they still live in the study areas or they have moved temporarily or travelled; or (ii) those who had died.

Table 2.1 shows that female respondents accounted for 54% of all respondents. The sampling was made proportionately with the registered population in SILANI, which included all older people residing in the project villages/*kelurahan*. Since we did not conduct weighted sampling, the demographic characteristics of the respondents of this phone survey reflected that of the whole older population of study areas. Thus, the 60–69 age group has the highest percentage amongst the three age groups, and the percentage of the respondents in DKI Jakarta is the highest amongst the three study provinces.

As for living location which refers to urban and rural areas, we used the classification provided by BPS (*Badan Pusat Statistik*: Statistics Indonesia).¹ The majority of the respondents lived in urban areas (92%) and only 8% of them were in rural areas.

The respondents in this study were categorised into three groups: the young-old group (60–69 years), the middle-old group (70–79 years), and the oldest-old group (80 years and older). Table 2.2 shows the distribution of respondents by age group. It also reflects the trend of distribution of the whole population by age group in Indonesia. According to Statistics of Old Age Population 2019, the proportion of the young-old group (aged 60–69 years) comprises 63.82%; the middle-old group (aged 70–79 years), 27.68%; and the oldest-old group (80 years and older), 8.50% (*Badan Pusat Statistik*, 2019).

¹ The BPS classification is based on population density, percentage of farm households, and some urban facilities such as highway, formal education facilities, public health facilities, etc. (*Peraturan Kepala Badan Pusat Statistik* Nomor 37 Tahun 2010 *Tentang Klasifikasi Perkotaan dan perdesaan di Indonesia*/Regulation of the Head of the Central Statistics Agency Number 37 of 2010 Concerning Classification of Urban and Rural Areas in Indonesia, 2010).

		Age		N
Characteristics	60–69 Years	70–79 Years	80 Years and Older	
Total	65.04	26.41	8.54	3,430
Sex				
Male	65.22	27.43	7.34	1,593
Female	64.89	25.53	9.58	1,837
Living location				
Urban	66.29	25.86	7.85	3,171
Rural	49.81	33.20	16.99	259
Province				
Bali	57.11	31.75	11.14	781
Daerah Istimewa Yogyakarta	63.55	24.60	11.85	878
DKI Jakarta	69.28	24.96	5.76	1771

Table 2.2 Distribution of Respondents, by Age Group

The percentage of female respondents from the oldest group is higher than their male counterparts. The percentage of the middle- and oldest-old groups living in rural areas is higher than those in urban areas. The middle-old group is found the highest in Bali; the percentage of the oldest-old group in Bali and DIY is remarkably higher than that of DKI Jakarta.

Table 2.3 shows that the percentage of female respondents is higher than male respondents. This portion applies to all age groups, yet the highest female percentage is found in the oldest group, which is approximately 60%.

Characteristics	S	ex	N
Characteristics	Male	Female	
Total	46.44	53.56	3,430
Sex			
Male	46.57	53.43	2,231
Female	48.23	51.77	906
Living location	39.93	60.07	293
Urban			
Rural	46.67	53.33	3,171
Province	43.63	56.37	259
Bali	48.02	51.98	781
Daerah Istimewa Yogyakarta	45.56	54.44	878
DKI Jakarta	46.19	53.81	1,771

Table 2.3 Distribution of Respondents, by Sex

CHAPTER 3 Economic and Social Protection

1.Income

The COVID-19 pandemic has slowed down economic activities all over the world. This is an inevitable consequence of the lockdown policy which was implemented to prevent the community transmission of the virus. Job and income losses had severely impacted the economic condition of most people, including older people, directly or indirectly.

As a developing country whose informal sector comprises a high proportion, Indonesia is faced with the serious impact of COVID-19 on its economy. According to the World Bank, the domination of the informal sector may amplify the impact of COVID-19. Informality is associated with underdevelopment in a wide range of areas, such as widespread poverty, lack of access to financial systems, deficient public health and medical resources, and a weak social safety net (World Bank, 2020b). Indeed, the impact of COVID-19 on the labour market had started in late March 2020. Based on the World Bank panel phone monitoring survey, nearly a quarter of respondents had stopped working and two-thirds of the survey respondents who were still working experienced reduced income (World Bank, 2020a).

Older people might also experience the impact of the pandemic on their income. Some of them live with a caregiver, household member, or non-household member who cares for and always helps older people in urgent conditions, whether the caregiver is paid or not. This study revealed that older people and their caregivers have been affected in terms of income due to the COVID-19 pandemic.

	Respo	ndent's Inco	me	Careg	<mark>iver's Incom</mark> e	
Characteristics	Decreased	The Same/ Increased	N	Decreased	The Same/ Increased	N
Total	53.7	46.30	3,430	61.32	38.68	2,960
Sex						
Male	55.68	44.32	1,593	57.98	42.02	1,385
Female	51.99	48.01	1,837	64.25	35.75	1,575
Age						
60–69 years	58.09	41.91	2,231	61.06	38.94	1,872
70–79 years	47.57	52.43	906	61.32	38.68	817
80 years and older	39.25	60.75	293	63.10	36.90	271
Living location						
Urban	52.54	47.46	3,171	59.67	40.33	2,705
Rural	67.95	32.05	259	78.82	21.18	255
Province						
Bali	59.15	40.85	781	74.86	25.14	716
DIY	42.03	57.97	878	52.04	47.96	638
DKI Jakarta	57.09	42.91	1,771	58.97	41.03	1,606

Table 3.1 Income Changes of Older People During the Pandemic



1 out of 2 respondents experienced a decrease in income Table 3.1 shows that more than half of the respondents (54%, 95%CI [Confidence Interval] 52.0%–55.4%) and their caregivers (61%, 95%CI 59.6%–63.1%) experienced a decrease in income. The male respondents whose income decreased were significantly more than the females (p<0.05 ¹). We found a significant difference in income decreases amongst the three age groups (p<0.001). The 60–69 group reported the highest income decrease (58%, 95%CI 55.9%–60.3%). We found no significant difference

in the percentage of caregivers' income decrease amongst the age groups of respondents.

¹All p-values were calculated from chi-squared test in this report, unless otherwise stated.

The respondents and their caregivers who experienced an income decrease in rural areas were significantly more than in urban areas (p<0.001 for both). DIY had remarkably fewer respondents who were affected by income decrease amongst the three provinces in this study. Caregivers in Bali were the most affected by the decline in income.

Older people are usually not considered members of the productive age group. Since many people, including older people, are still not covered by the pension or old-age insurance system in Indonesia, many older adults are still working to generate income. Meanwhile, some older people depend on their assets and/or family members to meet their needs. Some of the sources of income of older people reported in this study are summarised in Table 3.2.



More than 36% of the respondents are still working to generate income to meet their needs. The employed male respondents were significantly more than their female counterparts (p<0.001). On the contrary, the female respondents whose income was from their children, whether living with them or not, were significantly more than their male counterparts (p<0.001).

The 60–69 group had the highest percentage of employed respondents amongst the three age groups; the oldest group was the lowest. Contrary to this, the oldest group had the highest percentage of respondents who had income from a household member; the youngest group had the lowest percentage.

Respondents engaged in subsistence farming, including livestock, in rural areas were significantly more than their urban counterparts (p<0.001). On the other hand, the urban respondents who depend on their children who are non-household members were significantly more than their rural counterparts (p<0.05). These results imply that rural older people are more independent than urban older people in terms of subsistence living.

				Source	ef Income			z
Characteristics	Work	Rent/ Sharecrop- ping	Savings	Insur- ance	Children (Non-household Member)*	Family/ Relative (Non-house- hold Member)	Neighbours/ Friends**	
All respondents	36.12	1.78	0.70	0.12	29.56	2.71	0.29	3,430
Sex								
Male	44.95	2.20	0.94	0.19	23.48	2.57	0.19	1,593
Female	28.47	1.42	0.49	0.05	34.84	2.83	0.38	1,837
Age								
60-69 years	43.57	1.70	0.67	0.18	27.88	2.29	0.18	2,231
70–79 years	25.39	1.88	0.66	0.00	32.23	3.53	0.44	906
80 years and older	12.63	2.05	1.02	0.00	34.13	3.41	0.68	293
Living location								
Urban	36.36	1.83	0.73	0.13	30.05	2.78	0.32	3,171
Rural	33.20	1.16	0.39	0.00	23.55	1.93	0.00	259
Province								
Bali	35.08	1.79	0.38	0.13	21.25	2.43	0.13	781
Daerah Istimewa Yogya- karta	41.12	1.71	0.8	0.00	12.64	2.96	0.23	878
DKI Jakarta	34.11	1.81	0.79	0.17	41.61	2.71	0.40	1,771
Respondents' income								
Decreased	54.23	1.95	0.65	0.16	33.01	3.04	0.54	1,842
Same/Increased	15.11	1.57	0.76	0.06	25.57	2.33	0.00	1,588

Table 3.2 Source of Income of Respondents Before the Pandemic

Note: * Biological, adopted, or stepchildren; **Non-family/relatives

			Sour	ce of Income			z
Characteristics	Pension (%)	Govt Social Protection	Private Social Protection	Subsistence Farm- ing/Livestock	Spouse (Non-house- hold Member)	Household Member	
All respondents	18.37	1.43	0.26	3.62	0.15	18.48	3,430
Sex							
Male	21.72	0.88	0.25	4.90	0.19	12.81	1,593
Female	15.46	1.91	0.27	2.50	0.11	23.41	1,837
Age							
60-69 years	16.94	0.72	0.13	3.27	0.18	16.05	2,231
70–79 years	21.63	1.99	0.44	4.75	00.0	21.30	906
80 years and older	19.11	5.12	0.68	2.73	0.34	28.33	293
Living location							
Urban	18.89	1.48	0.28	1.36	0.16	19.17	3,171
Rural	11.97	0.77	0.00	31.27	00.0	10.04	259
Province							
Bali	15.36	0.26	0.00	13.32	00.00	19.59	781
Daerah Istimewa Yog- yakarta	30.18	2.28	0.00	1.82	0.34	15.83	878
DKI Jakarta	13.83	1.52	0.51	0.23	0.11	19.31	1,771
Respondents' income							
Decreased	4.61	1.03	0.27	4.89	0.16	12.38	1,842
Same/Increased	34.32	1.89	0.25	2.14	0.13	25.57	1,588

Table 3.2 (Continued)

16

As for pension coverage, the respondents in DIY had a significantly higher coverage rate than other provinces. This result could be related to the lowest percentage of DIY respondents who depend on their non-household-member children compared with those in the other two provinces, as well as the lowest percentage of respondents who suffered from income decrease in DIY, as described in Table 3.1.

In terms of the employment of respondents, the employed respondents were significantly more likely to experience a decrease in income than their counterparts (p<0.001). The respondents whose income depended on their non-household-member children were also more likely to experience a decrease in income (p<0.001), while the income of the respondents who depended on pension were significantly less likely to decrease than non-pensioners (p<0.001).

Characteristics	Income from	Nur Nor	nber of I 1-househ	ncome f old Mem	rom Iber	N
	Household Member	1	2	3	4	
Total	18.48	68.98	11.52	0.99	0.03	3,430
Sex						
Male	12.81	73.38	12.43	1.32	0.06	1,593
Female	23.41	65.16	10.72	0.71	0.00	1,837
Age						
60–69 years	16.05	71.36	11.47	1.08	0.04	2,231
70–79 years	21.30	65.45	12.25	0.99	0.00	906
80 years and older	28.33	61.77	9.56	0.34	0.00	293
Living location						
Urban	19.17	68.34	11.48	0.98	0.03	3,171
Rural	10.04	76.83	11.97	1.16	0.00	259
Province						
Bali	19.59	71.32	8.45	0.64	0.00	781
Daerah Istimewa Yogyakarta	15.83	74.72	9.00	0.46	0.00	878
DKI Jakarta	19.31	65.10	14.12	1.41	0.06	1,771

Table 3.3 Number of Sources of Income Before the Pandemic

Characteristics	Income from	Nur Nor	N			
	Household Member	1	2	3	4	
Respondents' income						
Decreased	12.38	72.20	13.95	1.41	0.05	1,842
Same/Increased	25.57	65.24	8.69	0.50	0.00	1,588
Caregivers' income						
Respondents who had caregivers	19.56	67.60	11.72	1.08	0.03	2,960
Decreased	20.44	67.33	11.29	0.94	0.00	1,815
Same/Increased	18.17	68.03	12.40	1.31	0.09	1,145

Table 3.3 shows that 69% of the respondents had only one source of income from a non-household member before the pandemic, whilst about 19% of them received income from a household member. Twelve percent of respondents had two sources of income from a non-household member. Less than 1% of the rest had three or four sources of income from a non-household member.

The female respondents are significantly more likely to receive income only from a household member than their male counterparts (p<0.001). Interestingly, the result of this study indicates that the respondents who had no income other than from a household member before the pandemic were significantly less likely to experience a decrease in income during the pandemic (p<0.001). The most affected group by decreased income was those whose only income comes from non-household members.

Table 3.4 shows the sources of income of respondents who had only one income source from a non-household member before the pandemic. Work (41%, 95%CI: 40.0%-42.9%) was the most common source of income. Female respondents were more likely to depend on their children who are non-household members than male counterparts (p<0.001). Amongst those whose only income source is a pension, the respondents residing in urban areas are more likely to depend on a pension than their counterparts in rural areas (p<0.01). DIY had the highest percentage of respondents whose only income source is pension amongst the three provinces in this study.
lable 3.4 Distributio	on of Inco	ome source	ot kespo	ondents W	/ho Had Unly U	ne source bet	ore the Pand	emic
			Source of	Income fror	n Non-household M	ember		z
Characteristics	Work	Rent/ Share- cropping	Savings	Insurance	Children (Non-household Member)*	Family/Relative (Non-household Member)	Neighbours/ Friends**	
All respondents who had only one income source	40.96	1.14	0.42	0.04	30.81	2.07	0.08	2,366
Sex								
Male	48.76	1.54	0.43	0.09	20.36	1.88	0.17	1,169
Female	33.33	0.75	0.42	0.00	41.02	2.26	0.00	1,197
Age								
60-69 years	48.87	0.88	0.38	0.06	27.32	1.63	0.06	1,592
70–79 years	27.82	1.18	0.34	0.00	36.42	2.70	0.17	593
80 years and older	14.36	3.31	1.10	0.00	43.09	3.87	0.00	181
Living location								
Urban	41.58	1.15	0.46	0.05	31.24	2.03	0.09	2,167
Rural	34.17	1.01	00.0	0.00	26.13	2.51	0.00	199
Province								
Bali	42.01	1.08	0.18	0.18	24.78	1.80	0.18	557
Daerah Istimewa Yogyakarta	46.19	0.61	0.91	0.00	11.89	2.13	0.00	656
DKI Jakarta	37.47	1.47	0.26	0.00	44.49	2.17	0.09	1,153
Respondents' income								
Decreased	59.32	1.20	0.23	0.08	31.73	1.95	0.15	1,330
Same/Increased	17.37	1.06	0.68	0.00	29.63	2.22	0.00	1,036
Caregivers' income								
Respondents who had care- givers	40.98	1.15	0.25	0.05	32.43	2.00	0.05	2,001
Decreased	42.72	1.06	0.25	0.08	36.66	2.21	0.08	1,222
Same/Increased	38.25	1.28	0.26	0.00	25.8	1.67	0.00	779

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Note: * Biological, adopted, or stepchildren; **Non-family/relatives.

		Table 3.	4 (Continued)			
		Source of In	come from Non-hous	ehold Member		z
Characteristics	Pension	Government Social Protection	Social Protection Private	Subsistence Farming/ Live- stock	Spouse (Non-household Member)	
All respondents who had only one income source	19.86	1.06	0.13	3.30	0.13	2,366
Sex						
Male	21.73	0.51	0.09	4.28	0.17	1,169
Female	18.05	1.59	0.17	2.34	0.08	1,197
Age						
60-69 years	17.65	0.38	0.06	2.58	0.13	1,592
70–79 years	24.79	1.69	0.00	4.89	0.00	593
80 years and older	23.20	4.97	1.10	4.42	0.55	181
Living location						
Urban	20.63	1.15	0.14	1.34	0.14	2,167
Rural	11.56	0.00	0.00	24.62	0.00	199
Province						
Bali	17.59	0.00	0.00	12.21	0.00	557
Daerah Istimewa Yogyakarta	34.15	2.29	0.00	1.37	0.46	656
DKI Jakarta	12.84	0.87	0.26	0.09	0.00	1,153
Respondents' income						
Decreased	0.75	0.30	0.08	4.14	0.08	1,330
Same/Increased	44.40	2.03	0.19	2.22	0.19	1,036
Caregivers' income						
Respondents who had caregivers	17.99	1.20	0.15	3.65	0.10	2,001
Decreased	10.56	1.39	0.08	4.83	0.08	1,222
Same/Increased	29.65	0.90	0.26	1.80	0.13	779

Amongst those who had only one income source before the pandemic and experienced income decrease during the pandemic, the employed respondents accounted for the highest percentage (59%, 95%CI: 56.7%–62.0%), followed by those whose only income source was their non-household-member children (32%, 95%CI: 29.2%–34.2%). Pensioners topped the list (44%, 95%CI: 41.4%-47.4%) of respondents who had only one income source before the pandemic and experienced an increase or no change of income during the pandemic. They were followed by respondents whose only income source was their non-household-member children (30%, 95%CI: 26.8%–32.4%).

Characteristics	Reduce the Frequency/ Amount of Meals (%)	Reduce the Quality of Meals	Used Some/ All Savings to Afford Daily Meals	No Change	N*
All respondents whose income de- crease	17.21	41.91	2.33	47.94	1,842*
Sex					
Male	17.25	41.49	1.92	48.70	887
Female	17.17	42.30	2.72	47.23	955
Age					
60–69 years	17.28	43.36	2.47	46.84	1,296
70–79 years	17.40	37.59	1.62	51.51	431
80 years and older	15.65	41.74	3.48	46.96	115
Living location					
Urban	17.77	42.02	2.46	47.54	1,666
Rural	11.93	40.91	1.14	51.70	176
Province					
Bali	20.56	37.88	1.30	45.67	462
Daerah Istimewa Yogyakarta	8.94	31.98	4.88	58.54	369
DKI Jakarta	18.69	47.38	1.88	45.10	1,011

Table 3.5 Impact of Income Changes on Food Consumption

Characteristics	Reduce the Frequency/ Amount of Meals (%)	Reduce the Quality of Meals	Used Some/ All Savings to Afford Daily Meals	No Change	N*
Caregivers' income					
Respondents who had caregivers	17.24	42.98	2.09	47.04	1,624
Decreased	18.67	44.81	1.99	44.07	1,205
Same/Increased	13.13	37.71	2.39	55.61	419

Notes: *N Respondents who experienced a decrease in income. Respondents were allowed multiple answers.



This study suggests that the decreases in income might deteriorate the quality of life of older people. As described in Table 3.5, about half of the respondents whose income decreased stated that income decrease indeed impacted their food consumption.

About 42% (95%CI: 39.7%–44.2%) of respondents whose income decreased during the pandemic reported that they reduced the quality of their meals as their income decreased, whilst 17% (95%CI: 15.5%–18.9%) reported that they reduced the frequency and/or amount of meals due to income decrease. In DIY, the respondents who reduced the frequency and/or amount of meals were significantly low (9%, 95%CI: 6.03%–11.9%) compared to those in the other two provinces.

About 2% of respondents whose income decreased spent their savings to meet their daily food needs. The percentage of DIY respondents who reduced the frequency of meals was the lowest amongst the provinces; the percentage of those who used savings to meet their daily food needs was also the highest in DIY.

The caregivers' income affected the food consumption of the respondents. Regardless of the change in the respondents' income during the pandemic, the respondents whose caregivers' income increased or did not change during the pandemic were significantly less likely to be affected in the quality of their food consumption (p<0.001). No difference was found in the effect of income decrease on food consumption between respondents from the urban and rural areas.

)	5	5)			
Characteristics	Sought a New Job %	Took Loan	Used Savings	Pawned Assets	Sold Assets	Asked for Assis- tance**	Extended Working Hours	Reduced Ex- penditures	None	*N
All respondents whose income decreased	7.60	7.00	7.71	0.60	2.71	17.81	1.41	1.79	58.41	1,842
Sex										
Male	9.24	7.22	7.55	0.68	2.59	17.93	1.69	1.80	57.05	887
Female	6.07	6.81	7.85	0.52	2.83	17.70	1.15	1.78	59.69	955
Age										
60-69 years	8.02	7.02	8.56	0.77	2.85	16.98	1.70	1.77	57.41	1,296
70–79 years	6.26	7.66	5.80	0.23	2.78	20.88	0.93	1.86	59.40	431
80 years and older	7.83	4.35	5.22	0.00	0.87	15.65	0.00	1.74	66.09	115
Living location										
Urban	7.08	7.20	8.28	0.66	2.82	18.61	1.38	1.80	57.62	1,666
Rural	12.50	5.11	2.27	0.00	1.70	10.23	1.70	1.70	65.91	176
Province										
Bali	9.31	11.04	4.98	0.00	1.95	14.72	1.30	1.30	60.17	462
Daerah Istimewa Yogya- karta	10.03	5.42	10.30	1.08	2.98	26.83	1.08	0.54	47.43	369
DKI Jakarta	5.93	5.74	8.01	0.69	2.97	15.92	1.58	2.47	61.62	1,011
Caregivers' income										
Respondents who had caregivers	7.70	7.08	7.45	0.37	2.65	16.63	1.48	1.60	59.85	1,624
Decreased	7.88	7.39	7.97	0.50	2.90	16.43	1.49	1.24	59.50	1,205
Same/Increased	7.16	6.21	5.97	0.00	1.91	17.18	1.43	2.63	60.86	419
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Table 3.6 Coping Strategy Against Income Decrease During the Pandemic

Notes: *N Respondents who experienced income decrease, ** Assistance from family and/or community with better economic conditions, or companies.

The respondents were allowed multiple answers.

Income decrease is the most critical economic challenge that must be solved immediately to prevent a negative impact on the quality of life. Even though the majority of the respondents whose income decreased during the pandemic reported they did not take any specific measures to cope with income decrease (58%, 95%CI: 56.2%-60.7%), many reported that they made some efforts to improve their economic condition.

One effort of respondents whose income decreased was to ask for assistance from family members, the community, or companies with better economic conditions (18%, 95%CI: 16.1%–19.6%). The respondents of urban residents were more likely to use this strategy than their rural counterparts (p<0.01). On the contrary, the rural respondents were more likely to seek new jobs as a coping strategy against income decrease than their urban counterparts (p<0.05).

The respondents in DIY whose income decreased were the least likely to take no action to cope with such a decrease. The percentage of the respondents who took a loan as a coping strategy in Bali was the highest.

2. Assistance

Social protection mechanisms from the central government, as well as assistance from the community, are an essential support for older people during this hard time. Low-income households and older people are vulnerable groups and need social protection (World Bank, 2020b). Since the pandemic has made older people more vulnerable, they need support, either in cash or in kind, to maintain their quality of life.

As a response to the impact of the pandemic on livelihood, the government improves social assistance and expands its coverage to older people (World Bank, 2020a). One of the government programmes that have been implemented for a long time since before the pandemic is the PKH (*Programme Keluarga Harapan*: Family Hope Programme, or Conditional Cash Transfer Programme). Older people who are 70 years old or above are one of the beneficiaries' groups of this programme. In response to the pandemic, the government decided to increase the frequency of cash transfers under this programme from every 3 months to monthly, until December 2020. Also, the government has approved more older people as beneficiaries of this programme.

The government has another programme of social protection as an effort to mitigate the negative impact of the COVID-19 pandemic. It is enacted by the Regulation of the Ministry of Social Affairs number 54/HUK/2020 regarding the Implementation of Assistance Programme in the Form of Cash as well as Non-cash Food Assistance. This is also known as the *Sembako* (*Sembilan Bahan Pokok*: Nine Basic Needs Commodities) programme. This programme has been operating in some areas of western Java such as Jakarta, Bogor, Tangerang, and Bekasi (Jabodetabek).

The government has also expanded social protection during this pandemic by allowing the village fund (*dana desa*) to be used as cash transfer and in-kind assistance. This policy adjustment was enacted in the Regulation of the Ministry of Village, Development, and Transmigration number 11 of 2019 and number 6 of 2020 regarding the Priority of Usage of Village Fund for 2020. The beneficiaries of the village fund are the villagers who are registered in the *rukun tetangga* and the *rukun warga* and those who are not receiving benefits from the PKH, pre-employment, and the BPNT (in-kind assistance) programmes.

Other than the government programmes mentioned, Indonesians also have a mutual assistance system amongst community members, which is one of the forms of social capital in the community. As Indonesians have strong empathy and a spirit of cooperation, they are willing to help each other in the face of hardship. They collect funds or goods from community members to distribute to vulnerable groups, including older people. This kind of support and assistance help the community ease the burden caused by the pandemic.

2.1. Assistance for All Respondents during the Pandemic

Table 3.7 shows the types of assistance the respondents received. More than half received non-cash food assistance (*sembako*) since March 2020 (57%, 95%CI: 55.1%– 58.4%). However, urban respondents were more likely to receive *sembako* than their rural counterparts (p<0.001). This is understandable as people in rural areas usually have better food security than those in urban areas because they were significantly more likely to be engaged in subsistence farming, including livestock farming, than their urban counterparts (Table 3.2). On the contrary, the rural respondents are significantly more likely to receive BLT or BST (unconditional cash transfer) than their urban counterparts (p<0.001).

Table 3.7	Types	of Assistance	Received	by Respond	lents During the	Pandemic
	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•••••••••				

		Туре	of Assistance		N
Characteristics	PKH for Old- er People (%)	BLT (Cash Transfer)*	Sembako/ Non-cash Food Assistance from Government	Assistance from the Commu- nity/ Private/ NGO	
All respondents	6.73	10.38	56.79	37.76	3,430
Sex					
Male	6.34	10.48	57.38	37.23	1,593
Female	7.08	10.29	56.29	38.21	1,837
Age					
60–69 years	5.02	10.58	59.97	37.02	2,231
70–79 years	8.50	9.93	53.09	38.52	906
80 years and older	14.33	10.24	44.03	40.96	293
Living location					
Urban	7.10	8.80	58.37	37.72	3,171
Rural	2.32	29.73	37.45	38.22	259
Province					
Bali	1.41	12.29	32.78	45.97	781
Daerah Istimewa Yogyakarta	11.39	19.25	21.30	41.80	878
DKI Jakarta	6.78	5.14	84.98	32.13	1,771
Respondents' in- come					
Decreased	6.30	12.00	62.27	38.44	1,842
Same/Increased	7.24	8.50	50.44	36.96	1,588
Caregivers' income					
Respondents who had caregivers	6.59	11.88	63.36	38.85	2,960
Decreased	5.89	12.61	61.33	38.84	1,815
Same/Increased	8.59	9.79	69.21	38.90	1,145

NGO = non-governmental organisation.

Notes: * BLT (*Bantuan Langsung Tunai*) or BST (*Bantuan Sosial Tunai*) of central government/ local government/village. Both BLT and BST mean unconditional cash transfer. The respondents were allowed multiple answers.



The percentage of respondents who received *sembako* was remarkably high in DKI Jakarta (85%, 95%CI: 83.3%–86.6%). This result reflects the government's policy that the *Sembako* programme is one of the most important programmes to mitigate the impact of COVID-19 in DKI Jakarta. As for the PKH and BLT or BST programmes, the percentage of respondents who benefited from these programmes was highest in DIY amongst the three provinces.

The oldest group (aged 80 years and older) had the highest percentage as beneficiaries of the PKH programme whilst the youngest group (60–69 years old) had the highest percentage of *Sembako* beneficiaries.

Respondents whose income decreased were more likely to receive assistance from BLT (p<0.01) and *Sembako* (p<0.001) than their counterparts. Meanwhile, respondents living with caregivers whose income decreased were more likely to receive BLT assistance than their counterparts.

Table 3.8 shows that about a quarter of the respondents did not receive any type of assistance stated in Table 3.7 at all during the pandemic (24%, 95%CI: 22.6%–25.4%). In DIY, the percentage of respondents who did not receive assistance is the highest amongst other provinces (41%, 95%CI: 37.6%–44.2%), whereas the percentage was much lower in DKI Jakarta (11%, 95%CI: 9.29%–12.2%).

The percentage of respondents who received only one type of assistance was 46% (95%CI: 44.5%–47.8%) of the total respondents. The results indicated that respondents whose income decreased were more likely to receive at least one type of assistance (p<0.001), whilst caregivers' income did not significantly affect the number of types of assistance that the respondents received during the pandemic.

	Nu	umber of Ty	pes of Assi	stance		N
Characteristics	Not Received at All	1	2	3	4	
All respondents	24.02	46.15	24.75	4.29	0.79	3.430
Sex						
Male	22.41	48.96	23.92	4.21	0.50	1,593
Female	25.42	43.71	25.48	4.35	1.03	1,837
Age						
60–69 years	21.34	49.53	24.83	3.81	0.49	2,231
70–79 years	27.81	41.72	24.28	4.97	1.21	906
80 years and older	32.76	34.13	25.60	5.80	1.71	293
Living location						
Urban	23.81	46.14	25.17	4.04	0.85	3,171
Rural	26.64	46.33	19.69	7.34	0.00	259
Province						
Bali	35.21	40.72	20.49	3.59	0.00	781
Daerah Istimewa Yogyakarta	40.89	33.37	18.56	5.47	1.71	878
DKI Jakarta	10.73	54.88	29.70	4.01	0.68	1,771
Respondents' in- come						
Decreased	19.33	48.59	26.44	5.05	0.60	1,842
Same/Increased	29.47	43.32	22.80	3.40	1.01	1,588
Caregivers' income						
Respondents who had caregivers	22.03	47.23	25.34	4.53	0.88	2,960
Decreased	20.94	47.82	25.51	4.85	0.88	1,815
Same/Increased	23.76	46.29	25.07	4.02	0.87	1,145

Table 3.8 Number of Assistance Types Received by Respondents During the Pandemic

The assistance, either in cash or in kind, provided to older people by individuals and/ or groups living in the same *desa* (village)/*dusun/rukun warga/banja*r (in Bali) has been common during this pandemic. Table 3.9 shows that more than half of the respondents received assistance from the community (54.7%, 95%CI: 53.0%–56.4%). In Bali and DKI Jakarta, the percentage of respondents receiving assistance from the community was around 60%, whilst the percentage in DIY was the lowest (42%, 95%CI: 39.2%–45.7%). Respondents whose income decreased or whose caregivers' income decreased were more likely to receive assistance from individuals and/or groups living in the same village than their counterparts (p<0.05 and p<0.001).

Table 3.9 Percentage of Respondents Who Received Assistance During the Pandemic from Individuals and/or Groups Living in the Same Village/Dusun/ Rukun Warga/Banjar

Characteristics	Recipients (%)	N
All respondents	54.69	3,430
Sex		
Male	55.30	1,593
Female	54.16	1,837
Age		
60–69 years	55.54	2,231
70–79 years	53.97	906
80 years and older	50.51	293
Living location		
Urban	55.09	3,171
Rural	49.81	259
Province		
Bali	61.46	781
Daerah Istimewa Yogyakarta	42.48	878
DKI Jakarta	57.76	1,771
Respondents' income		
Decreased	56.46	1,842
Same/Increased	52.64	1,588
Caregivers' income		
Respondents who had caregivers	55.71	2,960
Decreased	58.35	1,815
Same/Increased	51.53	1,145

2.2. Assistance for the Respondents Whose Income Decreased during the Pandemic

The living conditions, productivity, and health risks of older persons whose income decreased due to the economic downturn caused by COVID-19 were more affected than those of the other groups whose income did not decrease. Table 3.10 focuses on this group and shows the types of assistance they have received since March 2020. These groups should be prioritised to receive assistance to cope with the hardship due to the pandemic.

Table 3.10 shows that more than half of the respondents whose income decreased were recipients of the *Sembako* programme (62.2%, 95%CI: 60.0%–64.5%). The group whose income decreased and who benefited from the *Sembako* programme in DKI Jakarta was the highest (89%, 95%CI: 86.8%–90.7) compared with the other provinces (p<0.001).

Amongst the respondents whose income decreased, the beneficiaries of PKH and BLT were much fewer than *Sembako* programme beneficiaries. PKH beneficiaries were only 6.3% (95%CI: 5.25%–7.53%) whilst BLT beneficiaries totalled 12% (95%CI: 10.6%–13.6%).

About 38% (95%CI: 36.2%–40.7%) of respondents whose income decreased received assistance from organisations or individuals that were not based in the same village. No significant differences were found amongst the characteristics of respondents.

Table 3.10 Types of Assistance Received by Respondents Whose Income Decreased During the Pandemic

		Types of A	ssistance		
Characteristics	PKH for Older People (%)	BLT (Cash Transfer)*	Sembako/ Non-cash Food Assistance from Government	Assistance from the Private Sector**	N***
All respondents whose income de- creased	6.30	12.00	62.27	38.44	1,842

		Types of A	ssistance		
Characteristics	PKH for Older People (%)	BLT (Cash Transfer)*	Sembako/ Non-cash Food Assistance from Government	Assistance from the Private Sector**	N***
Sex					
Male	5.41	12.40	62.68	39.46	887
Female	7.12	11.62	61.88	37.49	955
Age					
60–69 years	5.09	12.27	64.04	38.19	1,296
70–79 years	8.12	11.37	59.40	39.44	431
80 years and older	13.04	11.30	53.04	37.39	115
Living location					
Urban	6.78	9.60	65.01	38.78	1,666
Rural	1.70	34.66	36.36	35.23	176
Province					
Bali	1.30	16.45	31.17	44.59	462
Daerah Istimewa Yogyakarta	11.38	26.02	28.73	46.61	369
DKI Jakarta	6.73	4.85	88.72	32.64	1,011
Caregivers' income					
Respondents who had caregiver	6.59	11.88	63.36	38.85	1,624
Decreased	5.89	12.61	61.33	38.84	1,205
Same/Increased	8.59	9.79	69.21	38.90	419

Notes:

* BLT (Bantuan Langsung Tunai) or BST (Bantuan Sosial Tunai) of central government/local government/village. Both BLT and BST mean unconditional cash transfer

** Non-governmental organisations (NGOs)/companies/institutions/community, family members/individuals who were not living in same the village.

*** N Respondents experienced income decrease.

The respondents were allowed multiple answers.

Table 3.11 Number of Types of Assistance Received by Respondents Whose Income Decreased During the Pandemic

	Nur	nber of Ty	pes of Ass	sistance		N
Characteristics	Not Received at All	1	2	3	4	
Respondents whose income decreased	19.33	48.59	26.44	5.05	0.60	1,842
Sex						
Male	16.80	52.09	25.93	4.74	0.45	887
Female	21.68	45.34	26.91	5.34	0.73	955
Age						
60–69 years	17.44	50.93	26.62	4.63	0.39	1,296
70–79 years	21.58	46.17	25.75	5.34	1.16	431
80 years and older	32.17	31.30	26.96	8.70	0.87	115
Living location						
Urban	18.55	48.74	27.37	4.68	0.66	1,666
Rural	26.70	47.16	17.61	8.52	0.00	176
Province						
Bali	34.63	41.99	18.61	4.76	0.00	462
Daerah Istimewa Yogyakarta	31.44	35.23	24.39	7.05	1.90	369
DKI Jakarta	7.91	56.48	30.76	4.45	0.40	1,011
Caregivers' income						
Respondents who had caregivers	18.10	49.69	26.29	5.23	0.68	1,624
Decreased	18.67	50.12	25.73	4.81	0.66	1,205
Same/Increased	16.47	48.45	27.92	6.44	0.72	419

Note: * N Respondents experienced income decrease.



4 in 5 respondents whose income decreased received at least 1 type of assistance

Table 3.11 shows the number of types of assistance received by the respondents whose income decreased during the pandemic. The percentage of those whose income decreased and did not receive any kind of assistance comprises about 19% (95%CI: 17.5%–21.1%). It means about four in five respondents whose income decreased received at least one type of assistance.

The analyses combining the data shown in Tables 3.7 and 3.11 enable the comparative study between the respondents whose income decreased and those that did

not. The urban respondents whose income decreased were significantly less likely to miss receiving assistance than urban respondents whose income did not decrease (p<0.001); in rural areas, such difference could not be found. Likewise, a significant difference between those whose income decreased and their counterparts could not be detected in Bali although such differences are significant in DIY and DKI Jakarta (P<0.001 for both).

Table 3.12 Percentage of Respondents Whose Income Decreased and Who Received Assistance from Individuals and/or Groups Living in the Same Village/Dusun/Rukun Warga/Banjar during the Pandemic

Characteristics	Percentage	N
Respondents whose income de- creased	56.46	1,842
Sex		
Male	56.82	887
Female	56.13	955
Age		
60–69 years	57.79	1,296
70–79 years	53.83	431
80 years and older	51.30	115
Living location		
Urban	57.32	1,666
Rural	48.30	176

Characteristics	Percentage	N
Province		
Bali	57.79	462
Daerah Istimewa Yogyakarta	47.43	369
DKI Jakarta	59.15	1,011
Caregivers' income		
Respondents who had caregivers	57.08	1,624
Decreased	58.01	1,205
Same/Increased	54.42	419

Note: * N Respondents experienced income decrease.

Table 3.12 shows the percentage of respondents whose income decreased and received assistance either in cash or in kind from individuals and/or groups living in the same village, *rukun warga, or dusun/banjar* (in Bali).

The respondents whose income decreased and who lived in rural areas were significantly less likely to receive this kind of assistance than their counterparts (p<0.05). Those who resided in DIY were significantly less likely to receive this kind of assistance (p<0.001). Only 47% of them received assistance from individuals and/or groups living in the same village/dusun/rukun warga/banjar.

2.3. Comparison of Assistance Before and During the Pandemic

The Government of Indonesia provides several social welfare and assistance programmes to vulnerable groups, including older people. In the SILANI baseline survey, we asked the respondents if they were the beneficiaries of social welfare and assistance programmes, such as JKN-KIS (*Jaminan Kesehatan Nasional – Kartu Indonesia Sehat*: Social Security Health Insurance Program – Indonesia Health Card); KKS (*Kartu Keluarga Sejahtera*: Social Protection Card); BPNT (*Bantuan Pangan Non Tunai*: Non-cash Food Assistance); PKH for older people, unconditional allowance for older people, unconditional allowance for people with disabilities, other assistance from local governments, other assistance from the central government; RTLH (*Rumah Tidak Layak Huni*: renovation support programme for the uninhabitable house); and others. In this study, we treated the SILANI baseline data as the assistance received by the respondents before the pandemic. As a response to the crisis caused by the pandemic, the government introduced additional social protection programmes. PKH assistance, which has existed since before the pandemic, has been expanded to more beneficiaries. Also, the government and other parties have provided other assistance programmes to mitigate the impact of the pandemic. The questionnaire of this phone survey was designed to identify the assistance received by the respondents. Only the following five items were included in the questionnaire to find out the types of assistance the respondents received: (i) PKH for older people; (ii) BLT or BST; (iii) *sembako*; (iv) assistance from entities other than community institutions, including individuals and families of other households; and (v) assistance from community institutions.

We observed the respondents who participated in both the SILANI baseline survey and this phone survey. Then we compared the data of this phone survey (during the pandemic) and the SILANI baseline survey (before the pandemic). Table 3.13 shows the percentage of the respondents who received assistance before and during the pandemic. Because of the inconsistent questionnaire between the baseline survey and this phone survey, only two types of assistance could be compared, namely, PKH assistance and non-cash food assistance. Non-cash food assistance in the SILANI baseline survey was identified as BPNT whilst in the SILANI phone survey, it was *Sembako* assistance. The comparative analyses of these two items are reported in the following sections.

Type of Assistance	Before Pandemic	During Pandemic	N
Jaminan Kesehatan Nasional – Kar- tu Indonesia Sehat	65.48	NA	3,430
Kartu Keluarga Sejahtera	5.51	NA	
Bantuan Pangan Non Tunai or Sembako	6.97	56.79	
Program Keluarga Harapan for older people	3.15	6.73	

Table 3.13 Percentage of Respondents Who Received Assistance Before and During the Pandemic

Type of Assistance	Before Pandemic	During Pandemic	N
Allowance for older people	0.73	NA	
Allowance for people with disabil- ities	0.06	NA	
Other assistance from local govern- ment	0.96	NA	
Other assistance from the central government	0.20	NA	
Rumah Tidak Layak Huni	0.64	NA	
Others	0.99	NA	
Bantuan Langsung Tunai or Bantu- an Sosial Tunai	NA	10.38	
Assistance from community groups, private organisations, NGOs, companies, individuals, schools, or families who do not live in the household	NA	37.76	

NGO = non-governmental organisation.

2.3.1. PKH assistance comparison before and during the pandemic

The PKH is one of the social protection programmes in the form of conditional cash transfer which the government has been implementing long before the pandemic. Some adjustments have been made to the programme since the COVID-19 pandemic broke out, such as the expansion of the beneficiaries and the increased frequency of cash transfers.

We conducted a longitudinal analysis using the data from the SILANI baseline survey, which was implemented in late 2019, to identify the PKH beneficiaries before the pandemic and then compared it with the SILANI phone survey data. The change of PKH beneficiaries is presented in Table 3.14.

Table 3.14 PKH Assistance Before and During the Pandemic

Characteristics	Received PKH Before and During the Pandemic	Received PKH During the Pan- demic Only	Received PKH Before the Pandemic Only	Never Re- ceived PKH Assistance	N
All respondents	2.19	4.55	0.96	92.3	3,430
Sex					
Male	1.76	4.58	1.19	92.47	1,593
Female	2.56	4.52	0.76	92.16	1,837
Age					
60–69 years	0.85	4.17	0.9	94.08	2,231
70–79 years	3.31	5.19	0.99	90.51	906
80 years and older	8.87	5.46	1.37	84.3	293
Living location					
Urban	2.37	4.73	0.95	91.96	3171
Rural	0	2.32	1.16	96.53	259
Province					
Bali	0	1.41	0.38	98.21	781
DIY	6.04	5.35	1.82	86.79	878
DKI Jakarta	1.24	5.53	0.79	92.43	1,771
Respondents' in- come					
Decrease	1.63	4.67	1.14	92.56	1,842
Same/increase	2.83	4.41	0.76	92	1,588
Caregivers' income					
Respondents who had caregivers	2.33	4.9	0.95	91.82	2,960
Decrease	2.31	4.74	0.83	92.12	1,815
Same/increase	2.36	5.15	1.14	91.35	1,145

PKH = *Program Keluarga Harapan:* Family Hope Programme/Conditional Cash Transfer Programme.

Table 3.14 shows that most respondents had never received PKH assistance both before and during the pandemic (92%, 95%CI: 91.3%–93.2%). The percentage of respondents who received PKH assistance both before and during the pandemic was 2.2% (95%CI: 1.74%–2.75%), whilst 4.6% of respondents received PKH assistance only during the pandemic (95%CI: 3.89%–5.31%). We can interpret this to mean that significantly more respondents received PKH assistance during the pandemic than before the pandemic (p<0.001, McNemar's chi-squared test).

2.3.2. Non-cash food assistance before and during the pandemic

Since long before the pandemic, the government has been providing non-cash food assistance. The questionnaire of the SILANI baseline survey included a question on BPNT assistance. In response to the pandemic, the government expanded the beneficiaries of non-cash food assistance through the *Sembako* programme. Table 3.15 shows the percentage of the beneficiaries of non-cash food assistance programmes before and/or during the pandemic.

More than half of the total respondents received non-cash food assistance before and/ or during the pandemic (58.3%, 95%CI: 56.6%–60.0%). Compared with the percentage of the beneficiaries before the pandemic (7.0%, 95%CI: 6.15%–7.88%), the percentage jumped up to 56.8% (95%CI: 55.0%–58.4%). This means that most of the respondents received this assistance as a response to the pandemic.

Before the pandemic, the respondents aged 60–69 were significantly less likely to receive this assistance than the older age groups (p<0.001). During the pandemic, these younger respondents were more likely to receive *sembako* (p<0.001) although the number of beneficiaries also considerably increased during the pandemic even amongst the oldest group. Respondents living in Bali were significantly less likely to receive BPNT (p<0.001), whilst during the pandemic, respondents in DIY were significantly less likely to receive *sembako* (p<0.001).

Table 3.15 Non-cash Food Assistance Before and During the Pandemic

Characteristics	Received Before and During the Pandemic	Received During the Pan- demic Only	Received Before the Pandemic Only	Never Re- ceived	N
All respondents	5.45	51.34	1.52	41.69	3,430
Sex					
Male	4.27	53.11	1.51	41.12	1,593
Female	6.48	49.81	1.52	42.19	1,837
Age					
60–69 years	5.24	54.73	0.9	39.13	2,231
70–79 years	5.3	47.79	1.99	44.92	906
80 years and older	7.51	36.52	4.78	51.19	293
Living location					
Urban	5.74	52.63	1.51	40.11	3,171
Rural	1.93	35.52	1.54	61	259
Province					
Bali	1.02	31.75	0.77	66.45	781
DIY	5.47	15.83	5.13	73.58	878
DKI Jakarta	7.4	77.58	0.06	14.96	1,771
Respondents' in- come					
Decrease	6.57	55.7	1.36	36.37	1,842
Same/increase	4.16	46.28	1.7	47.86	1,588
Caregivers' income					
Respondents who had caregivers	5.84	53.01	1.52	39.63	2,960
Decrease	6.34	52.62	1.6	39.45	1,815
Same/increase	5.07	53.62	1.4	39.91	1.145

CHAPTER 4 Health

The According to Law no. 36 of 2009 on Health, health is the physical, mental, and social condition that supports people's productive life in the social and economic aspects. All people, including older people, have the same right to access safe, high-quality, and affordable health services. High-quality health services will improve one's health status in terms of physical, mental, spiritual, and social aspects.

One of Indonesia's development goals, as stated in the 2020–2024 National Medium-Term Development Plan, is to develop high-quality and competitive human resources supported by healthy, intelligent, innovative, skilled, and strong human resources. All Indonesians, including older people, have the same right to take a part in the development process and reach this goal.

In response to population ageing, the government has developed a special strategy as manifested in *Strategi Nasional* (Stranas) *Kelanjutusiaan* ('the Concept of National Strategy on Ageing). This document was drafted by Bappenas; to date, it is to be signed by the President as a presidential decree. However, through several forums and interviews, Bappenas has shared the concepts of this policy document with stakeholders. The vision of Stranas *Kelanjutusiaan* is to create societies that ensure the independent, prosperous, and dignified lives of Indonesian older people. Some clauses of this policy draft focus on the well-being of older people, such as livelihood, physical and mental health, social support, etc. (Rendon and Olufemi, n.d.).

The SILANI questionnaire was developed to assess the needs of older people and to support the implementation of Stranas *Kelanjutusiaan*. Since this phone study is

based on SILANI, the basic concept used is quite similar, with some adjustments to COVID-19 pandemic conditions. In this study, health status was measured based on the statements of respondents or proxies. Some questions aiming for the comparison between before and during the pandemic were also adopted in this phone survey.

The questionnaire also included a question on the care need of the respondents for activities of daily living (ADL), such as bathing, toileting, eating, or dressing, and another question about instrumental activities of daily living (IADL), such as shopping or using an automated teller machine (ATM). Respondents were asked if they had



1 amongst 6 respondents stated that their physical health had deteriorated and 1 amongst 8 respondents had an increased depression score

been diagnosed by health professionals for several ill conditions, i.e. high blood pressure, heart disease, diabetes, lung disease, kidney disease, and stroke. The morbidity was compared between before and during the COVID-19 pandemic.

Mental health, specifically depression states, was assessed using the selected five items of the Geriatric Depression Scale (GDS). Then, the depression score derived from this study was compared with the score of the SILANI baseline survey to enable longitudinal analysis. The questionnaire

included a question on physical and/or verbal abuse which the respondents have encountered during the COVID-19 pandemic.

1. Physical Health

Table 4.1 shows the percentage of respondents who answered that their health conditions have deteriorated during the COVID-19 pandemic compared with before the pandemic. Around 16% (95%CI: 14.9%–17.4%) of the total respondents reported that their health condition deteriorated. In terms of the relationship between age and the deterioration of health condition, the older respondents were more likely to answer that their health condition deteriorated during the pandemic (p<0.05, Wilcoxon rank-sum test). Another interesting fact is that the rural respondents were more likely to report that their physical health condition deteriorated than their urban counterparts (P<0.05). No significant difference was found amongst the three study provinces: Bali, DIY, and DKI Jakarta.

Table 4.1 Respondents	Who Reported	their Health	Condition	Deteriorated
	During the	Pandemic		

Characteristics	Percentage	N
All respondents	16.12	3,430
Sex		
Male	16.20	1,593
Female	16.06	1,837
Age		
60–69 years	14.88	2,231
70–79 years	17.88	906
80 years and older	20.14	293
Living location		
Urban	15.70	3,171
Rural	21.24	259
Province		
Bali	16.26	781
Daerah Istimewa Yogyakarta	15.49	878
DKI Jakarta	16.37	1,771
Respondents' income		
Decreased	20.20	1,842
Same/Increased	11.40	1,588
Caregivers' income		
Respondents who had caregivers	16.99	2,960
Decreased	18.29	1,815
Same/Increased	14.93	1,145

The respondents whose income decreased were significantly more likely to report their health condition deteriorated than those whose income did not decrease (p<0.001). The results indicate that the caregivers' income also affected the self-reported deterioration of the health status of respondents. Those whose caregivers' income decreased were more likely to report that their health conditions deteriorated than their counterparts (p<0.05).

Table 4.2 shows the percentage of respondents who answered that they need support for ADL such as bathing, toileting, eating, or dressing at the time of the interview. The result shows around 8.2% (95%CI: 7.28%–9.14%) answered they needed support. The female respondents were more likely to need support than male respondents (p<0.001). The older respondents were more likely to answer that they need support for ADL (p<0.001, Wilcoxon rank-sum test).

The respondents in urban areas were more likely to answer that they needed support for ADL than those in rural areas even though the statistical difference is marginal (p=0.07). No significant difference was found amongst the three provinces involved in this study. The respondents whose income decreased were significantly less likely to answer that they need ADL support than those whose income did not decrease (p<0.001). Caregivers' income was not significantly related to the care need of the respondents.

Characteristics	Need Support for ADL		
Characteristics	Percentage	N	
All respondents	8.16	3,430	
Sex			
Male	6.47	1,593	
Female	9.64	1,837	
Age			
60–69 years	4.53	2,231	
70–79 years	9.82	906	
80 years and older	30.72	293	
Living location			
Urban	8.42	3,171	
Rural	5.02	259	
Province			
Bali	8.19	781	
Daerah Istimewa Yogyakarta	9.11	878	
DKI Jakarta	7.68	1,771	

Table 4.2 Respondents Who Had Difficulty in Activities of Daily Living (at the Time of the Interview)

Characteristics	Need Support for ADL		
	Percentage	N	
Respondents' income			
Decreased	6.41	1,842	
Same/Increased	10.20	1,588	
Caregivers' income			
Respondents who had caregivers	8.82	2,960	
Decreased	9.09	1,815	
Same/Increased	8.38	1,145	

Note: *Daily activities such as bathing, toileting, eating, or dressing.

Table 4.3 shows the percentage of the respondents who answered 'no' to the question, 'Can you go shopping by yourself or can you use an ATM by yourself?'. This question was asked to indicate the IADL. About 9.9% (95%CI: 8.97%–11.0%) of all respondents answered that their IADL was impaired. Female respondents were significantly more likely to have impaired IADL than male respondents (p<0.001). Older respondents were significantly more likely to have impaired IADL that maile respondents (p<0.001, Wilcoxon rank-sum test).

No significant difference was detected between urban and rural respondents, as well as amongst the three provinces in this study. The respondents whose income decreased were significantly less likely to have impaired IADL than those whose income did not decrease (P<0.001). The respondents whose caregivers' income decreased were more likely to have impaired IADL than their counterparts (p<0.05).

Table 4.3 Respondents Who Had Difficulty inInstrumental Activities of Daily Living (IADL) (at the Time of the Interview)

Characteristics	Do Not Carry pendo	Do Not Carry Out IADL Inde- pendently*		
	Percentage	N		
All respondents	9.94	3,430		
Sex				
Male	7.97	1,593		
Female	11.65	1,837		

Characteristics	Do Not Carry Out IADL Inde- pendently*		
	Percentage	N	
Age			
60–69 years	4.75	2,231	
70–79 years	13.80	906	
80 years and older	37.54	293	
Living location			
Urban	9.97	3,171	
Rural	9.65	259	
Province			
Bali	10.63	781	
Daerah Istimewa Yogyakarta	10.25	878	
DKI Jakarta	9.49	1,771	
Respondents' income			
Decreased	8.14	1,842	
Same/Increased	12.03	1,588	
Caregivers' income			
Respondents who had caregivers	11.01	2,960	
Decreased	11.96	1,815	
Same/Increased	9.52	1,145	

Note: * It means could not shop/use an ATM by themselves.

We defined 'comorbidity score' in this study as the number of respondents' chronic conditions that had been diagnosed by health professionals. We asked them about six chronic conditions: high blood pressure, heart disease, diabetes, lung disease, kidney disease, and stroke. Table 4.4 shows the change of the comorbidity scores from before the pandemic to the time of the interview. About 1.6% (95%CI: 1.2%–2.1%) of the respondents had increased comorbidity scores compared to the pre-pandemic period. However, more respondents' comorbidity scores decreased, and their percentage was about 17% (95%CI: 15.6%–18.1%).

Table 4.4 Comorbidity Score Change from Before the Pandemic

Characteristics	Increased (%)	Decreased (%)	No Change (%)	N
All respondents who answered all morbidity questions	1.60	16.80	81.60	3,424
Sex				
Male	1.30	17.10	81.70	1,592
Female	1.90	16.50	81.60	1,832
Age				
60–69 years	1.80	16.70	81.50	2,231
70–79 years	1.30	16.00	82.60	904
80 years and older	1.00	19.40	79.60	289
Living location				
Urban	1.60	16.70	81.70	3,165
Rural	1.20	17.80	81.10	259
Province				
Bali	1.00	11.60	87.70	781
Daerah Istimewa Yogya- karta	2.30	15.00	82.70	873
DKI Jakarta	1.70	19.90	78.40	1,770
Respondents' income				
Decreased	1.60	16.10	82.20	1,840
Same/Increased	1.60	17.50	80.90	1,584
Caregivers' income				
Respondents who had caregivers	1.50	17.00	81.50	2,954
Decreased	1.20	16.80	82.00	1,810
Same/Increased	2.00	17.30	80.70	1,144

Can this result suggest that the chronic conditions of older people had improved during the pandemic? We would like to suggest another potential reason for this result. For example, limited access to proper health services during the pandemic hindered older people from knowing their real health condition. In this study, the percentage of respondents who had postponed going to health facilities during the pandemic reached 17%. Even looking at the change of morbidity rates of each of the six items, a significant decrease in morbidity rates was detected for all six chronic conditions (Table 4.5).

No significant difference was detected in the percentage of the respondents whose comorbidity scores decreased amongst the three provinces in this study. The income of respondents did not affect the comorbidity scores significantly nor did the caregivers' income.

Table 4.5 Morbidity Rates	of Six Chronic Cor	nditions Betore and	During the
	Pandemic		

Type of Chronic Conditions	Before COVID-19 Pandemic (%)	After COVID-19	N*
High blood pressure	36.33	26.93	
Heart disease	8.53	6.66	
Diabetes	12.79	11.21	2 4 2 4
Lung disease	4.32	2.34	3,424
Kidney disease	2.22	1.14	
Stroke	4.50	3.07	

Note: *N is respondents who answered all morbidity questions.

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Characteristics	Follow the Pro- tocol to Prevent COVID-19* (%)	Exercise Outdoors	Exercise Indoors	Eat Balanced Nutrition	Reduce Smoking	Limit Time to Read the News on COVID-19	Do Breathing Exercise, Relaxation, Yoga	Read Book/ Holy Book	Watch TV/ YouTube	z
All respondents	34.05	53.12	17.96	15.28	0.90	0.12	1.43	3.03	19.18	3,430
Sex										
Male	35.34	60.89	16.26	14.94	1.88	0.19	1.82	2.70	17.89	1,593
Female	32.93	46.38	19.43	15.57	0.05	0.05	1.09	3.32	20.30	1,837
Age										
60-69 years	38.01	57.60	18.33	15.42	0.76	0.13	1.52	2.87	18.96	2,231
70–79 years	30.79	49.89	17.77	15.67	1.32	0.11	1.21	3.09	20.75	906
80 years and older	13.99	29.01	15.70	12.97	0.68	0.00	1.37	4.10	16.04	293
Living location										
Urban	33.68	55.06	17.57	15.74	0.98	0.13	1.45	3.06	19.80	3,171
Rural	38.61	29.34	22.78	9.65	00.0	0.00	1.16	2.70	11.58	259
Province										
Bali	26.38	43.02	22.28	8.58	00.0	0.00	1.92	1.28	8.45	781
DIY	15.03	59.34	11.16	6.61	0.11	0.00	0.80	5.01	26.08	878
DKI Jakarta	46.87	54.49	19.42	22.53	1.69	0.23	1.52	2.82	20.50	1,771
Respondents' Income										
Decrease	36.81	53.09	17.26	14.98	1.36	0.16	1.41	2.82	17.59	1,842
Same/increase	30.86	53.15	18.77	15.62	0.38	0.06	1.45	3.27	21.03	1,588
Caregivers' income										
Respondents who had care- givers	34.73	51.15	18.18	15.74	0.91	0.14	1.52	2.91	16.89	2,960
Decrease	35.65	50.36	17.41	16.36	0.99	0.17	1.10	2.42	16.03	1,815
Same/increase	33.28	52.40	19.39	14.76	0.79	0.09	2.18	3.67	18.25	1,145

Table 1.6 Practices to Maintain Physical Health During the Pandemic

Notes: * Stay at home, wear masks, etc. The respondents were allowed multiple answers.

Characteristics	Listen to Music (%)	Sing/ Play Musical Instrument	Express Uncomfort- able Feeling and Thoughts to Others	Keep an Active Life- style in Daily Lives*	Sunbathe	Sleep Regularly/ Sufficiently	Take Vitamins/ Supplements/ Spices/Herbs	None	Other	z
All respondents	1.92	0.5	2.1	56.27	55.69	15.51	0.87	1.08	0.9	3,430
Sex										
Male	2.45	0.75	1.57	51.1	50.97	15.82	0.69	0.88	1.07	1,593
Female	1.47	0.27	2.56	60.75	59.77	15.24	1.03	1.25	0.76	1,837
Age										
60-69 years	1.93	0.67	2.2	58.14	55.4	15.37	0.9	0.4	0.81	2,231
70–79 years	1.88	0.22	2.32	55.19	57.28	15.78	0.88	1.32	1.21	906
80 years and older	2.05	0	0.68	45.39	52.9	15.7	0.68	5.46	0.68	293
Living location										
Urban	1.86	0.5	2.18	54.71	57.43	16.62	0.85	1.14	0.95	3,171
Rural	2.7	0.39	1.16	75.29	34.36	1.93	1.16	0.39	0.39	259
Province										
Bali	2.3	0.26	0.51	60.56	33.93	6.91	1.02	2.05	0.51	781
DIY	3.19	0.8	1.25	62.98	48.86	3.87	0	1.71	0	878
DKI Jakarta	1.13	0.45	3.22	51.04	68.66	25.07	1.24	0.34	1.52	1,771
Respondents' Income										
Decrease	1.95	0.6	2.39	56.13	55.7	16.4	0.92	0.76	0.81	1,842
Same/increase	1.89	0.38	1.76	56.42	55.67	14.48	0.82	1.45	1.01	1,588
Caregivers' income										
Respondents who had caregivers	1.82	0.54	2.2	54.49	58.24	16.82	0.88	1.15	0.95	2,960
Decrease	1.82	0.5	1.93	54.77	58.07	16.75	0.83	0.99	0.66	1,815
Same/increase	1.83	0.61	2.62	54.06	58.52	16.94	0.96	1.4	1.4	1,145

Table 4.6 (Continued)

Health 49

Note: * Sweep and mop the floor, clean the house, go to the rice field, etc.

The campaign to combat the COVID-19 pandemic urges people, including older people, to change behaviour into a more hygienic one to prevent transmission. Older people are encouraged to adapt to the 'new normal' habits like complying with health protocols. This requires support from all parties, especially from their families.

Table 4.6 shows the practices of the respondents to maintain their physical health during the pandemic. Almost all respondents stated that they do some practices to maintain their physical health. Only 1.1% (95%CI: 0.77%–1.50%) of the respondents answered that they did not carry out any practices to maintain physical health during the pandemic. More than half of the respondents kept an active lifestyle in their daily lives, sunbathed, and performed outdoor exercises. Thirty-four percent (95%CI: 32.5%–35.6%) of respondents stated they followed the COVID-19 prevention protocol.

The male respondents were significantly more likely to practice outdoor sports activities than females (p<0.001). The female respondents were significantly more likely to be engaged in home chores actively than male respondents (p<0.001). This data suggests that older people continue to carry out routine activities that promote their active lifestyle even during the pandemic.

The older respondents were significantly less likely to follow the protocol to prevent COVID-19 transmission (p<0.001, Wilcoxon rank-sum test). Looking at the differences between those in the rural and urban areas, urban respondents were significantly more likely to exercise outdoors and sunbathe (p<0.001 for both), whilst rural respondents were more likely to have an active lifestyle in their daily lives (P<0.001).

Amongst the three provinces, the respondents in DKI Jakarta were significantly more likely to practice the prevention protocol of COVID-19 and to take balanced nutrition, whilst the Bali respondents were significantly more likely to answer they did not watch TV or YouTube to maintain their physical health during the pandemic.

The Ministry of Health, in its guidelines to maintain the health of older people during the pandemic, encourages people to sleep sufficiently and regularly, and eat balanced nutrition. About 15% of the respondents stated that they practiced these recommendations, but significant inter-provincial differences were found. The respondents in DKI Jakarta were significantly more likely to practice these two recommendations regarding sleep and nutrition.

2. Mental Health

The depressive status of the respondents was assessed using the Geriatric Depression Scale (GDS). The GDS has three versions: the full GDS which has 30 items, and the short forms of 15 items and 5 items. Previous studies in Indonesia mostly used the 15-item GDS (Pramesona and Taneepanichskul, 2018; Wada et al., 2005; Widiatie et al., 2018).

Since this study adopted the phone-survey method to avoid the risk of virus transmission through face-to-face interviews, the time per interview was limited. The study team agreed to use the five-item GDS because this is the most effective way to collect the information related to the depressive status of respondents within the short time available. Though it is the shortest version, the 5-item GDS has been validated as effective as the 15-item GDS to screen depression (Hoyl et al., 1999; Rinaldi et al., 2003). As for the Indonesian version of GDS questions, we referred to the Petunjuk Teknis Istrumen Pengkajian Paripurna Pasien Geriatri (Technical Instructions for Plenary Assessment of Geriatric Patients) provided by the Ministry of Health (2017). This document provides the Indonesian translation of each question of the 15-item GDS questionnaire. We picked up five questions equivalent to the five-item GDS from the Indonesian version of the 15-item GDS.

The five-item GDS encompasses the following factors which are related to depressive status: (i) satisfaction, (ii) boredom, (iii) helplessness, (iv) reluctance to go out of the house, and (v) worthlessness. We defined the depression score in SILANI study as the sum of all items. In this first round telephone survey, however, we excluded the variable {iv} stated above because this question may confuse and tend to create ambiguity in answers during the pandemic when older people are encouraged to stay at home. Table 4.7 shows the change of 4-item depression score which was modified in this survey from the pre-pandemic period to the time of the interview.

The result shows that about 25% (95%CI: 23.0%–26.2%) of the respondents' depression scores increased compared to the pre-pandemic period. No significant difference was found between male and female respondents in terms of the change of depression scores.

Table 4.7 Change of Modified (4-item) Depression Scores from the Pre-pandemic Period

Characteristics	Increased (%)	No Change (%)	N
All respondents who answered the five-item GDS questions both in the SILANI baseline and phone survey by themselves	24.56	51.90	2,867
Sex			
Male	24.30	53.76	1,358
Female	24.78	50.23	1,509
Age			
60–69 years	25.43	52.09	2,029
70–79 years	23.83	50.92	705
80 years and older	15.04	54.14	133
Living location			
Urban	24.45	51.93	2,671
Rural	26.02	51.53	196
Province			
Bali	33.15	50.54	558
Daerah Istimewa Yogyakarta	17.44	63.49	734
DKI Jakarta	24.83	46.98	1,575
Respondents' income			
Decreased	27.88	47.41	1,582
Same/Increased	20.47	57.43	1,285
Caregivers' income			
Respondents who had caregivers	25.35	50.78	2,426
Decreased	27.96	47.36	1,459
Same/Increased	21.41	55.95	967

Oldest-old group of respondents was less likely to increase their modified depression scores during the pandemic compared with before the pandemic (p<0.01). The depressive status of respondents in Bali was significantly more likely to increase their modified depression scores (p<0.001) whilst that of the respondents in DIY was significantly less likely to increase modified depression scores (p<0.001). Respondents whose income decreased or those whose caregivers' income decreased were

significantly more likely to report increased 4-item depression scores during the pandemic (p<0.001).

The Badan Pusat Statistik (BPS) of Indonesia reported the increasing trend of violence against women and abuse of older people during the COVID-19 pandemic (BPS, 2020). Table 4.8 shows that about 1% (95%CI: 0.66%–1.4%) of the respondents self-reported physical and/or verbal abuse during the pandemic. No significant trend of abuse amongst older people by age was detected, nor was there a difference between urban and rural areas. In DIY, no respondents reported abuse during the pandemic.

Characteristics	Percentage	N
All respondents	0.96	3,430
Sex		
Male	1.00	1,593
Female	0.93	1,837
Age		
60–69 years	1.08	2,231
70–79 years	0.88	906
80 years and older	0.34	293
Living location		
Urban	1.01	3,171
Rural	0.39	259
Province		
Bali	0.38	781
Daerah Istimewa Yogyakarta	0.00	878
DKI Jakarta	1.69	1,771
Respondents' income		
Decreased	1.25	1,842
Same/Increased	0.63	1,588
Caregivers' income		
Respondents who had caregivers	0.98	2,960
Decreased	0.83	1,815
Same/Increased	1.22	1,145

Table 4.8 Respondents Suffering from Abuse

	Table 4.9 I	Practic	es to N	Jainta	in Mental	Health du	ring the Pa	Indemic (Part 1)		
Characteristics	Follow the Protocol to Prevent COVID-19* (%)	Pray	Exercise Out- doors	Exer- cise In- doors	Do Breathing Exercise, Relaxation, Yoga	Take Balanced Nutrition	Keep an Ac- tive Lifestyle Indoors**	Communi- cate with Friends and Family	Accept Changes	Express Feeling to Others	z
All respondents	17.55	66.85	21.95	6.85	1.25	5.51	34.29	28.66	3.56	4.46	3,430
Sex											
Male	19.02	65.41	26.49	7.78	1.63	5.15	28.44	27.81	4.08	3.89	1,593
Female	16.28	68.10	18.02	6.04	0.93	5.82	39.36	29.40	3.10	4.95	1,837
Age											
60-69 years	19.00	68.67	23.35	7.17	1.43	5.87	35.86	30.79	3.90	4.44	2,231
70–79 years	17.22	64.79	21.96	6.07	1.10	4.86	33.44	25.83	3.20	4.30	906
80 years and older	7.51	59.39	11.26	6.83	0.34	4.78	24.91	21.16	2.05	5.12	293
Living location											
Urban	16.08	66.79	21.79	6.31	1.14	5.55	33.05	29.99	3.69	4.54	3,171
Rural	35.52	67.57	23.94	13.51	2.70	5.02	49.42	12.36	1.93	3.47	259
Province											
Bali	24.33	65.17	29.32	9.86	2.82	3.33	40.72	11.65	1.02	2.30	781
DIY	12.64	72.67	18.91	2.73	0.91	3.87	29.73	18.79	0.34	3.53	878
DKI Jakarta	17.00	64.71	20.21	7.57	0.73	7.28	33.71	41.05	6.27	5.87	1,771
Respondents' Income											
Decrease	19.65	66.99	23.83	7.33	1.09	5.48	35.78	29.75	3.69	4.78	1,842
Same/increase	15.11	66.69	19.77	6.30	1.45	5.54	32.56	27.39	3.40	4.09	1,588
Caregivers' income											
Respondents who had care- givers	17.64	65.54	22.53	7.09	1.22	5.64	36.42	30.41	3.61	4.56	2,960
Decrease	18.68	64.90	23.58	7.38	1.27	6.28	37.08	30.80	3.80	4.90	1,815
Same/increase	15.98	66.55	20.87	6.64	1.14	4.63	35.37	29.78	3.32	4.02	1,145
•	-										

54

Notes: * Stay at home, wear masks, etc. ** Sweep and mop the floor, clean the house, go to the rice field, etc. The respondents were allowed multiple answers.
				ומטות	4.7 /COILU	(nanii						
Characteristics	Limit Time to Read News about COVID-19 (%)	Read Book/ Holy Book	Listen to Music, Watch TV/ YouTube, Listen to Preachers	Care for Plants	Maintain En- vironmental Cleanliness	Spend More Time for Hobby	Keep an Ac- tive Lifestyle Outdoors ***	Sunbathe	Walk Out- doors	Others	None	z
All respondents	2.39	27.00	13.03	10.96	6.33	9.48	0.52	0.47	0.15	0.47	2.01	3,430
Sex												
Male	1.95	24.80	13.56	9.60	4.96	11.68	0.88	0.38	0.19	0.38	1.63	1,593
Female	2.78	28.91	12.57	12.14	7.51	7.57	0.22	0.54	0.11	0.54	2.34	1,837
Age												
60-69 years	2.42	27.75	13.49	11.47	6.81	10.04	0.63	0.67	0.04	0.54	1.08	2,231
70-79 years	2.43	26.60	12.47	10.82	6.07	9.27	0.33	0.11	0.22	0.33	2.98	906
80 years and older	2.05	22.53	11.26	7.51	3.41	5.80	0.34	00.0	0.68	0.34	6.14	293
Living location												
Urban	2.40	28.86	13.72	11.16	6.18	9.87	0.57	0.50	0.16	0.50	2.11	3,171
Rural	2.32	4.25	4.63	8.49	8.11	4.63	0.00	00.0	0.0	0.00	0.77	259
Province												
Bali	1.92	5.76	7.68	7.68	6.02	10.12	0.64	0.13	0.38	0.51	3.33	781
DIY	2.05	40.89	7.97	16.17	5.35	6.04	0.00	00.0	0.00	0.34	1.82	878
DKI Jakarta	2.77	29.47	17.90	9.82	6.95	10.90	0.73	0.85	0.11	0.51	1.52	1,771
Respondents' Income												
Decrease	2.17	24.65	13.52	8.31	6.73	9.17	0.81	0.49	0.05	0.33	2.06	1,842
Same/increase	2.64	29.72	12.47	14.04	5.86	9.82	0.19	0.44	0.25	0.63	1.95	1,588
Caregivers' income												
Respondents who had caregivers	2.30	23.75	12.57	10.91	6.11	9.97	0.61	0.44	0.17	0.51	2.23	2,960
Decrease	1.93	19.78	12.18	9.20	5.79	10.41	0.66	0.44	0.17	0.39	2.48	1,815
Same/increase	2.88	30.04	13.19	13.62	6.64	9.26	0.52	0.44	0.17	0.70	1.83	1,145
Note: *** Go to fields, g	ardens, etc.											

Table 4.9 (Continued)

Maintaining mental health during the pandemic is challenging because everybody is encouraged to limit in-person contacts to prevent virus transmission and to adopt the 'new normal' behaviours. Table 4.9 shows the practices reported by the respondents to maintain their mental health. Praying was the commonest practice. About 67% (95%CI: 65.2%–68.4%) stated that they pray to maintain their mental health. This was followed by 'keeping an active lifestyle in the house', 'communicating with friends and family/ relatives, and 'reading books or the Holy Book'. Only around 2.0% (95%CI: 1.58%– 2.55%) of the respondents stated that they did not practice anything to maintain mental health during this pandemic.

The older respondents were significantly less likely to practice the activities to maintain mental health (p<0.001, Wilcoxon rank-sum test) and so do the respondents in Bali. Significantly more urban respondents read books or the Holy Book than rural respondents (p<0.001). Significantly more respondents in DKI Jakarta listen to music or watch TV whilst those in Bali were significantly more likely to do breathing exercises, relaxation, yoga, or meditation even though the practising rate was not so high (2.8%, 95%CI: 1.82%–4.30%).

3. Health Services

Since the COVID-19 pandemic began, people have been strongly encouraged to stay at home, but it may have limited their chances to access health services. Older people tend to have more chronic conditions, and lesser chances for healthcare consultation could undermine their health status. Table 4.10 shows the percentage of respondents who had difficulty accessing health facilities. About 11% (95%CI: 9.77%–12.9%) who needed to go to health facilities at the time of the interview found difficulty in doing so.

The age of respondents was not significantly related to the difficulty in accessing health facilities. Urban respondents were significantly more likely to report that they had difficulty than rural respondents (p<0.01). Likewise, the respondents in DKI Jakarta were significantly more likely to have difficulty in accessing health facilities than those from the other two provinces. Respondents whose income decreased were more likely to have difficulty of access (p<0.01), whilst no significant difference was detected between the respondents whose caregivers' income decreased or did not decrease.

Table 4.10 Respondents Who Had Difficulty Accessing Health Facilities During the Pandemic

Characteristics	Percentage	N*
Respondents who reported that they needed con- sultation with health facilities	11.12	1,924
Sex		
Male	9.84	874
Female	12.19	1,050
Age		
60–69 years	10.57	1,268
70–79 years	13.26	513
80 years and older	8.39	143
Living location		
Urban	11.86	1,746
Rural	3.93	178
Province		
Bali	6.72	357
DIY	2.16	464
DKI Jakarta	16.32	1,103
Respondents income		
Decrease	13.01	1,022
Same/increase	8.98	902
Caregivers' income		
Respondents who had caregivers	12.14	1,680
Decrease	13.06	1,018
Same/increase	10.73	662

Note: * N is applied to the respondents who needed to go to health facilities.

Since the COVID-19 pandemic began, people have been strongly encouraged to stay at home, but it may have limited their chances to access health services. Older people tend to have more chronic conditions, and lesser chances for healthcare consultation could undermine their health status. Table 4.10 shows the percentage of respondents who had difficulty accessing health facilities. About 11% (95%CI: 9.77%–12.9%) who needed to go to health facilities at the time of the interview found difficulty in doing so. The age of respondents was not significantly related to the difficulty in accessing health facilities. Urban respondents were significantly more likely to report that they had difficulty than rural respondents (p<0.01). Likewise, the respondents in DKI Jakarta were significantly more likely to have difficulty in accessing health facilities than those from the other two provinces. Respondents whose income decreased were more likely to have difficulty of access (p<0.01), whilst no significant difference was detected between the respondents whose caregivers' income decreased or did not decrease.

The answers of the respondents to the question of why they had difficulty in accessing healthcare facilities are summarised in Table 4.11. About half (45%, 95%CI: 38.6%–52.2%) answered that they were scared of being infected with COVID-19. About a quarter (28%, 95%CI: 21.8%–34.2%) stated that the health facilities were closed or services for older people were unavailable. Other reasons were 'can't afford healthcare services' (8.4%, 95%CI: 5.2%–13.2%), 'no one to accompany me to health facilities' (4.7%, 95%CI: 2.4%–8.7%), 'BPJS was not available' (4.7%, 95%CI: 2.4%–8.7%), etc.

Though the number of rural respondents who reported difficulty accessing healthcare was small, the result showed that rural respondents were significantly more likely to have a financial restriction as a cause of this difficulty than urban respondents (p<0.05, Fisher's exact test). Five respondents whose income decreased reported that they had problems accessing health facilities because they were not members of the BPJS, whilst no respondents whose income did not decrease selected this answer.

	Others N*	1.87 214		4.65 86	0.00 128		2.99 134	0.00 68	0.00 12		1.45 207	14.29 7		4.17 24	0.00 10	1.67 180		1.50 133	2.47 81		1.96 204	1.50 133	, , ,
mic	Limited Capacity of Pa- tients	1.40		2.33	0.78		0.75	1.47	8.33		1.45	0.00		0.00	20.00	0.56		2.26	00.0		1.47	1.50	1 11
Pande	Long Queue	3.74		2.33	4.69		3.73	4.41	0.00		3.86	0.00		4.17	20.00	2.78		5.26	1.23		3.43	3.01	4 23
ing the	BPJS Not Available	4.67		8.14	2.34		3.73	7.35	0.00		4.83	0.00		0.00	20.00	4.44		3.76	6.17		4.90	3.76	7.04
es Dur	Wor- ried/ Scared	45.33		39.53	49.22		44.78	44.12	58.33		46.86	0.00		45.83	10.00	47.22		41.35	51.85		46.08	45.11	47.89
alth Faciliti	Discrimination against Older People	3.74		4.65	3.13		3.73	2.94	8.33		3.86	00:0		4.17	20.00	2.78		4.51	2.47		2.45	2.26	2.82
sing Hea	Staff Busy re COVID-19	4.21		2.33	5.47		3.73	4.41	8.33		4.35	0.00		0.00	0.00	5.00		3.76	4.94		3.92	3.76	4.23
y Acces	No One to Ac- company Older Person	4.67		4.65	4.69		4.48	5.88	0.00		4.83	0.00		0.00	0.00	5.56		6.02	2.47		4.41	3.76	5.63
ifficult	Do Not Have Money for Trans- port	0.93		1.16	0.78		1.49	0.00	0.00		0.48	14.29		4.17	0.00	0.56		0.75	1.23		0.49	0.75	0.00
for D	Do Not Have Money for Ser- vices	8.41		6.98	9.38		8.96	8.82	0.00		7.25	42.86		25.00	0.00	6.67		9.02	7.41		8.82	10.53	5.63
Reasor	Do Not Have BPJS	2.34		2.33	2.34		1.49	4.41	00.0		1.45	28.57		8.33	0.00	1.67		3.76	0.00		2.45	3.01	1.41
Table 4.11 I	Facilities Closed/Older Patients Not Accepted (%)	27.57		25.58	28.91		28.36	27.94	16.67		28.50	0.00		16.67	10.00	30.00		27.82	27.16		27.94	27.82	28.17
	Characteristics	All respondents	Sex	Male	Female	Age	60-69 years	70–79 years	80 years and older	Living location	Urban	Rural	Province	Bali	DIY	DKI Jakarta	Respondents' Income	Decrease	Same/increase	Caregivers' income	Respondents who had caregivers	Decrease	Same/increase

Note: * N is applied to the respondents who have difficulty in accessing health services.

Following the government's recommendation (Ministry of Health, 2020), about 29% (95%CI: 27.2%–31.2%) of the respondents who needed consultation in health facilities postponed consultation to avoid COVID-19 exposure (Table 4.12). Female respondents were significantly more likely to postpone their consultation in health facilities than males (p<0.001).

The respondents in DKI Jakarta were significantly more likely to postpone their consultation in medical facilities than those from the other two provinces (p<0.001). That choice was also more likely taken by the respondents whose income decreased (p<0.01), whilst caregivers' income did not affect the delay of their consultation in health facilities significantly.

<u> </u>		
Characteristics	Percentage	N*
Respondents who needed consultation in health facilities	29.20	2.048
Sex		
Male	24.87	929
Female	32.80	1,119
Age		
60–69 years	29.67	1,318
70–79 years	28.92	567
80 years and older	26.38	163
Living location		
Urban	29.74	1,883
Rural	23.03	165
Province		
Bali	17.78	388
DIY	17.46	544
DKI Jakarta	38.89	1,116
Respondents income		
Decrease	31.76	1,058
Same/increase	26.46	990
Caregivers' income		
Respondents who had caregivers	30.75	1,795
Decrease	30.71	1,091
Same/increase	30.82	704

Table 4.12 Respondents Who Delayed Consultation in Health Facilities During the Pandemic

The government had issued a recommendation to postpone routine health checks to prevent older people from being exposed to COVID-19. It also highlighted that an adequate supply of routine medications should be ensured to maintain older people's well-being even during the pandemic (Ministry of Health, 2020). Table 4.13 shows that about 12% (95%CI: 10.2%–13.3%) of the respondents experienced a shortage of routine medicine during the pandemic.

There is no significant difference in the proportion of male and female respondents. The respondents in urban areas were significantly more likely to have a shortage of routine medicine than those in rural areas (p<0.001). The respondents in DKI Jakarta were significantly more likely to have a shortage of medicine than those in the other two provinces (p<0.001). Those whose income decreased were significantly more likely to experience a shortage of medicine than their counterparts (p<0.001). No significant difference is evident in the percentage between the respondents whose caregivers' income decreased and those whose caregivers' income did not decrease.

Characteristics	Percentage	N*
Respondents who need routine medicine	11.69	1,711
Sex		
Male	12.03	748
Female	11.42	963
Age		
60–69 years	12.13	1.088
70–79 years	11.31	504
80 years and older	9.24	119
Living location		
Urban	12.36	1,570
Rural	4.26	141
Province		
Bali	3.73	322
DIY	2.34	385
DKI Jakarta	17.83	1,004
Respondents income		
Decrease	14.60	897
Same/increase	8.48	814

Table 4.13 Shortage of Routine Medicine During the Pandemic

Characteristics	Percentage	N*
Caregivers' income		
Respondents who had caregivers	12.65	1,478
Decrease	13.36	891
Same/increase	11.58	587

About half (46%, 95%CI: 38.5%–52.7%) of the respondents who experienced a shortage of routine medicine during the pandemic stated they did not have money to buy medicine (Table 4.14). The next commonest reason (16%, 95%CI: 11.4%–22.0%) was the closure or absence of services for older people at health facilities or pharmacies, followed by 'no one takes them to buy medicines at health facilities/pharmacies' (14%, 95%CI: 9.24%–19.2%), and 'no stock of medicine in health facilities' (13%, 95%CI: 8.40%–18.1%).

Because of the small number of respondents who reported a shortage of medicine, a significant difference was not detected for almost all combinations between the characters of respondents and the items included in the questionnaire as the reasons for medicine shortage. However, the following factors may have significant relations.

The respondents in DIY were significantly more likely to state that the lack of someone to accompany them to health facilities or pharmacies was the reason for the shortage of routine medicine than other provinces (p<0.05, Fisher's exact test). The majority of respondents in Bali said they do not have money to buy medicines. Those whose income decreased were more likely to state that lack of money to purchase medicine caused the shortage of routine medicine than their counterparts though the statistical significance was marginal (p<0.05). Such a significant difference was found even between the respondents whose caregivers' income decreased and their counterparts. The statistical difference in this comparison was also marginal (p<0.05).

Table 4.14 Reasons for Shortage of Routine Medicine During the Pandemic

				,								
Characteristics	Facilities, Phar- macies Closed/ Not Serving Older People	Do Not Have BPJS	Do Not Have Money for Medicine	Do Not Have Money for Transport	No One to Accompany Older Person	Staff Busy re COVID-19	Discrimination against Older People	No Stock	Worried/ Scared	Forgot/ Late/ No time	Other	ž
All respondents	16.00	2.00	45.50	1.00	13.50	1.00	2.00	12.50	6.50	9.00	2.50	200
Sex												
Male	16.67	2.22	48.89	1.11	8.89	2.22	1.11	14.44	5.56	8.89	2.22	90
Female	15.45	1.82	42.73	0.91	17.27	00.0	2.73	10.91	7.27	60.6	2.73	110
Age												
60-69 years	15.91	1.52	46.97	0.76	11.36	0.76	2.27	12.88	7.58	9.09	2.27	132
70–79 years	15.79	3.51	43.86	0.00	17.54	1.75	1.75	12.28	5.26	8.77	3.51	57
80 years and older	18.18	0.00	36.36	9.09	18.18	00.0	0.00	9.09	0.00	9.09	0.00	11
Living location												
Urban	16.49	2.06	45.36	0.52	13.40	1.03	2.06	12.89	6.70	9.28	2.06	194
Rural	0.00	0.00	50.00	16.67	16.67	00.0	0.00	0.00	0.00	0.00	16.67	¢
Province												
Bali	8.33	0.00	50.00	8.33	16.67	00.0	0.00	0.00	0.00	0.00	16.67	12
DIY	11.11	11.11	44.44	11.11	44.44	00.0	0.00	0.00	0.00	11.11	00.0	6
DKI Jakarta	16.76	1.68	45.25	0.00	11.73	1.12	2.23	13.97	7.26	9.50	1.68	179
Respondents' Income												
Decrease	13.74	3.05	51.15	0.76	11.45	0.76	2.29	13.74	6.11	6.11	2.29	131
Same/increase	20.29	0.00	34.78	1.45	17.39	1.45	1.45	10.14	7.25	14.49	2.90	69
Caregivers' income												
Respondents who had caregivers	16.04	2.14	46.52	1.07	12.83	1.07	1.60	12.83	5.88	8.56	2.67	187
Decrease	12.61	3.36	52.94	0.00	14.29	0.84	1.68	12.61	5.88	5.88	1.68	119
Same/increase	22.06	0.00	35.29	2.94	10.29	1.47	1.47	13.24	5.88	13.24	4.41	68

Note: *N is applied to the respondents who experienced a shortage of needed medicine.

CHAPTER 5 Interaction and Social Support



Social interaction is a dynamic social relationship between one individual and another, between one group and another, and between groups and individuals (Soekanto, 1995).



To stop the transmission of COVID-19, the government encourages people to stay at home and keep physical distancing. It has also quarantined confirmed and closecontact cases, imposed the *Pembatasan Sosial Berskala Besar* (PSBB) or Large-Scale Social Restrictions, etc. Such recommendations and obligations are applied to

all, including older people. In these circumstances, in-person interaction can be very limited, and indirect interaction using telecommunication tools is an essential means to keep social connectedness. Older people, however, are believed to have a big disadvantage in using communication media.

Social interaction in this study was measured through three indicators: (i) how older people establish social relations with relatives, friends, and/or neighbours during the COVID-19 pandemic, either in-person or indirect interaction; (ii) participation in activities outside the house during the pandemic, such as *arisan*¹, meetings amongst

¹Arisan is a regular meeting aimed at collecting a certain amount of money from a group of people as the main activity. At each meeting, a lottery is held to determine one or several members who are entitled to receive an amount of money or goods equivalent to the total money collected from all members. Thus, a round of regular meetings will be completed until all members have received their share.

older people, and others; and (3) contribution and support to family and communities during the pandemic. The results of the three indicators are presented in Tables 5.1 to 5.3.

Table 5.1 shows the answers of respondents to the question, 'how do you keep social connectedness and interaction with relatives, friends, or neighbours during the COVID-19 pandemic?'. Only 4.9% (95%CI: 4.24%–5.72%) reported that they had never interacted. The most common way of social interaction was 'meeting in person' (82%, 95%CI: 80.7%–83.3%), followed by phone calls (53%, 95%CI: 51.6%–54.9%).

	Social Relat	ions with Rela uring the COV	ntives/Friends/ /ID-19 Pandem	Neighbours ic	Ν
Characteristics	Meeting in Person	Phone Calls	Texting (SMS/ WhatsApp, etc)	Never In- teracted	
All respondents	82.07	53.27	21.66	4-93	3,430
Sex					
Male	85.12	53.17	23.48	3.20	1,593
Female	79.42	53.35	20.09	6.42	1,837
Age					
60–69 years	83.28	59.35	25.82	2.73	2,231
70–79 years	80.68	46.47	15.23	7.73	906
80 years and older	77.13	27.99	9.90	12.97	293
Living location					
Urban	82.34	55.44	23.21	4.57	3,171
Rural	78.76	26.64	2.70	9.27	259
Province					
Bali	72.98	30.86	6.27	12.8	781
Daerah Istimewa Yog- yakarta	85.88	53.76	29.95	4.21	878
DKI Jakarta	84.19	62.90	24.34	1.81	1,771
Respondents' income					
Decreased	83.66	52.01	19.11	4.51	1,842
Same/Increased	80.23	54.72	24.62	5.42	1,588

Table 5.1 Social Relations with Relatives/Friends/Neighbours During the Pandemic

Characteristics	Social Relat dr Meeting in Person	ions with Rela uring the COV Phone Calls	tives/Friends/ /ID-19 Pandem Texting (SMS/ WhatsApp, etc)	Neighbours ic Never In- teracted	Ν
Caregivers' income					
Respondents who had caregivers	82.20	53.24	19.83	5.51	2,960
Decreased	82.15	48.43	16.03	6.28	1,815
Same/Increased	82.27	60.87	25.85	4.28	1,145

Note: Respondents were allowed multiple answers.

Male respondents were significantly more likely to meet relatives, friends, or neighbours in person than female respondents (p<0.001), whilst female respondents were more likely to report that they had never had any social interaction during the pandemic (p<0.001). The older respondents were more likely to answer that they had never interacted during the pandemic (p<0.001, Wilcoxon rank-sum test), so were rural respondents than urban counterparts.

Amongst the three provinces in this study, the respondents in Bali were significantly less likely to meet in person with relatives, friends, or neighbours than those from the other two provinces. The respondents in Bali were significantly more likely to state that they had not interacted at all during the pandemic. Those whose income decreased were significantly more likely to have in-person meetings for social interaction than those whose income did not decrease (p<0.05). Those who had decreased income were significantly less likely to send SMS or WhatsApp messages for social interaction (p<0.001). The respondents whose caregivers' income decreased were significantly less likely to send SMS or Up<0.001) or they sent SMS or WhatsApp messages (p<0.001) for social interaction during the pandemic. They were significantly more likely to state that they made a phone call (p<0.001) or they sent SMS or WhatsApp messages (p<0.001) for social interaction during the pandemic. They were significantly more likely to state that they had not interacted socially (p<0.05).

Table 5.2 shows the result of the question, 'during the COVID-19 pandemic, do you still participate in the activities out of your house, such as arisan, gatherings of older people, in a mosque, temple, or church, etc?'. About 59% (95%CI: 57.2%–60.5%) answered that they never participated in such activities during the pandemic, whilst only 6.2% (95%CI: 5.41%–7.05%) said they had not participated in such activities

since even before the pandemic. Female respondents were significantly more likely to answer that they never participated during the pandemic than male participants (p<0.001).

	Participation suc	in Communit h as Arisan, F	y Activities Duri Religious Activit	ng the Pandemic, ies, etc.	
Characteristics	Always/ Often	Some- times	Never	Had Not Par- ticipated since Before the Pan- demic	N
All respondents	18.60	16.33	58.89	6.18	3,430
Sex					
Male	27.31	18.90	49.15	4.65	1,593
Female	11.05	14.10	67.34	7.51	1,837
Age					
60–69 years	20.71	18.83	57.96	2.51	2,231
70–79 years	16.11	13.36	61.15	9.38	906
80 years and older	10.24	6.48	59.04	24.23	293
Living location					
Urban	19.65	16.24	58.06	6.05	3,171
Rural	5.79	17.37	69.11	7.72	259
Province					
Bali	6.15	18.95	66.58	8.32	781
Daerah Istimewa Yogyakarta	24.03	14.81	55.35	5.81	878
DKI Jakarta	21.40	15.92	57.26	5.42	1,771
Respondents' income					
Decreased	18.51	19.00	58.03	4.45	1,842
Same/Increased	18.70	13.22	59.89	8.19	1,588
Caregivers' income					
Respondents who had caregivers	19.05	16.79	57.09	7.06	2,960
Decrease	16.64	17.74	58.18	7.44	1,815
Same/increase	22.88	15.28	55.37	6.46	1,145

Table 5.2 Support for Family and Community During the Pandemic

By age group, if the respondents who had not participated in community activities even before the pandemic were excluded from the analysis, the older respondents were significantly more likely to state that they did not participate in activities outside their house during the pandemic (p<0.001, Wilcoxon rank-sum test). Rural respondents were significantly more likely to answer that they never participated in the activities outside their house than urban respondents (p<0.001).

The respondents in Bali were significantly more likely to report that they never participated in community activities outside their house during the pandemic than the other two provinces. Excluding those who had not participated in community activities even before the pandemic, the respondents whose income did not decrease during the pandemic were more likely to report that they never participated in community activities during the pandemic than their counterparts (p<0.01).

Table 5.3 shows the answers of respondents to the question, 'what do you do to support your family and the community during the pandemic?'. About 57% (95%CI: 55.0%–58.3%) answered, 'do nothing'. Amongst the four specific alternatives to the answers to this question, most respondents selected 'take care of children under 5 years' (20%, 95%CI:19.1%–21.8%).

Female respondents were significantly more likely to take care of children under 5 years than male respondents (p<0.01). Male respondents were significantly more likely to participate in community activities such as distributing flyers containing information on the prevention of COVID-19 transmission (p<0.001) and providing *sembako*, masks, etc. for neighbours or the community (p<0.001).

Older respondents were less likely to be involved in supporting the family and the community (p<0.001, Wilcoxon rank-sum test). Urban respondents were significantly more likely to be engaged in supporting the family and the community than rural respondents (p<0.001). For example, about 21% (95%CI: 20.0%–22.9%) of urban respondents took care of children under 5 years old compared to only 8.9% (95%CI: 4.71%–11.0%) of rural respondents.

In Bali, about 70% (95%CI: 66.9%–73.5%) of the respondents reported that they did not do anything to support the family and the community; about half (95%CI: 47.4%– 52.1%) of those in DKI Jakarta reported similarly.

The respondents whose income did not decrease during the pandemic were significantly more likely to donate *sembako*, masks, etc. to the communities than their counterparts (p<0.05), so were those whose caregivers' income did not decrease (p<0.001).

	Support for	Families and (Communities dur demic	ring the COVII	D-19 Pande	micPan-	
Characteristics	Take Care of Children under 5 Years	Provide Daily Needs to Neigh- bour/ Com- munity *	Distribute Flyers with Information on COVID-19 Prevention	Support for Delivery of Sembako, Masks, etc.	Do Nothing	Other	N
All respondents	20.44	18.54	6.09	5.95	56.65	0.82	3,430
Sex							
Male	18.14	18.02	7.97	8.54	55.74	1.19	1,593
Female	22.43	19.00	4.46	3.70	57.43	0.49	1,837
Age							
60–69 years	23.22	20.71	7.04	7.71	50.96	0.90	2,231
70–79 years	16.56	16.00	5.30	3.09	63.47	0.88	906
80 years and older	11.26	9.90	1.37	1.37	78.84	0.00	293
Living location							
Urban	21.38	19.65	6.31	6.31	54.46	0.85	3,171
Rural	8.88	5.02	3.47	1.54	83.40	0.39	259
Province							
Bali	19.85	8.07	4.10	1.41	70.29	0.64	781
Daerah Istimewa Yog- yakarta	11.85	23.12	10.48	5.81	58.43	0.34	878
DKI Jakarta	24.96	20.89	4.80	8.02	49.75	1.13	1,771
Respondents' income							
Decreased	21.06	17.05	5.92	6.30	56.57	0.92	1,842
Same/Increased	19.71	20.28	6.30	5.54	56.74	0.69	1,588
Caregivers' income							
Respondents who had caregivers	20.98	17.80	4.97	5.47	57.30	0.81	2,960
Decrease	21.43	14.10	4.74	4.85	60.06	0.83	1,815
Same/increase	20.26	23.67	5.33	6.46	52.93	0.79	1,145

Table 5.3 Support for Family and Community During the Pandemic

Note: * Sembako, mask, money, etc.

The respondents were allowed multiple answers

2. Social Support

Social support refers to forms of assistance, appreciation, enthusiasm, or acceptance from people who have close social relationships, such as parents, siblings, children, friends, relatives, or other people. It can be in the form of information, certain behaviours, or material that can make the individual who receives help feel loved, cared for, and valued (Riadi, 2017).

For older people in general, social support is extremely important to maintain their independent lives because physical function deteriorates as people get older. The state of their mental health can also change. Social support from family and surrounding communities can make them feel valued, loved, and respected, which will finally contribute to increased self-confidence.

In this study, social support is measured in two ways: (i) assistance from $Posyandu^2$ cadres, health workers, and social cadres through a home visit or phone call; and (ii) assistance from family, neighbours, friends, village staff, rukun warga³, rukun tetangga⁴, or non-governmental organisations (NGOs) during the COVID-19 pandemic.

Regarding (i), 268 respondents (7.8%, 95%CI: 6.96%-8.79%) reported that they received home visits or communication (phone calls, messages through WhatsApp, or SMS) by Posyandu cadres, healthcare workers, or social cadres during the pandemic. The univariate analysis showed no significant relationship between the percentage of the respondents who received a home visit or contact and some characteristics of the respondents, namely, sex, age, and income. Rural respondents (p<0.01) and those in DKI Jakarta (p<0.01) were significantly more likely to receive home visits, phone calls, or messages through WhatsApp or SMS (p<0.001 for both).

² Posyandu (Pos Pelayanan Terpadu: Integrated Service Post) is a community-based service promoting ² Posyandu (Pos Pelayanan Terpadu: Integrated Service Post) is a community-based service promoting health and disease prevention. It can be conducted by the community, non-governmental organisations, private, social organisations, as well as in collaboration with several sectors. Posyandu's cadres are responsible for managing regular activities. Indonesia has two types of Posyandu: Posyandu Balita for children under 5 years old and Posyandu Lansia for older people (Minister of Health Regulation No. 67 of 2015) ³ This facilitates community participation in planning, implementation, and supervision of development, as well as improvement of village community services. This institution is not a division of government administration. There are several rukun warga in a village/kelurahan.
⁴ The role of this institution is like the rukun warga with a smaller territory. Commonly, each rukun warga consists of 3 to 10 rukun tetangga, while each rukun tetangga consists of 10–50 households.

			Home Visit	t or Tele	communica	ation				
			Support for Familie	s and Commu	nities during the C	OVID-19 PandemicPanden	nic			
Characteristics	Provide Face Masks	Provide Sembako	Provide Counselling on COVID-19	Provide Food	Asking about Conditions	Provide Healthcare Counselling besides COVID-19	Check Mosqui- to Larvae	Health Check	Other	z
Respondents who received public and social support	23.13	7.46	45.15	1.87	23.51	32.46	13.81	7.46	3.73	268
Sex										
Male	25.42	7.63	46.61	0.85	26.27	34.75	11.86	4.24	4.24	118
Female	21.33	7.33	44.00	2.67	21.33	30.67	15.33	10.00	3.33	150
Age										
60-69 years	24.35	6.22	44.56	1.55	21.24	32.64	16.58	5.70	4.15	193
70–79 years	17.31	11.54	48.08	3.85	32.69	34.62	7.69	11.54	0.00	52
80 years and older	26.09	8.70	43.48	0.00	21.74	26.09	4.35	13.04	8.70	23
Living location										
Urban	18.80	7.26	41.88	1.71	25.21	35.47	15.81	8.55	4.27	234
Rural	52.94	8.82	67.65	2.94	11.76	11.76	0.00	00.0	0.00	34
Province										
Bali	31.25	4.69	51.56	3.13	26.56	17.19	6.25	10.94	1.56	64
Daerah Istimewa Yogyakarta	14.29	4.76	52.38	0.00	11.90	33.33	2.38	7.14	4.76	42
DKI Jakarta	22.22	9.26	40.74	1.85	25.31	38.27	19.75	6.17	4.32	162
Respondents' income										
Decreased	27.56	8.97	50.00	1.92	24.36	35.26	13.46	6.41	1.92	156
Same/Increased	16.96	5.36	38.39	1.79	22.32	28.57	14.29	8.93	6.25	112
Caregivers' income										
Respondents who had caregivers	23.95	7.56	44.54	2.10	24.37	32.35	12.18	7.56	3.78	238
Decrease	30.46	9.93	48.34	1.32	21.19	29.80	9.93	9.93	1.99	151
Same/increase	12.64	3.45	37.93	3.45	29.89	36.78	16.09	3.45	6.90	87

Table 5.4 Public and Social Support Received by Respondents through

71

Table 5.4 shows the specific types of public and social support provided by *Posyandu* cadres, healthcare personnel, and social cadres through a home visit or telecommunication like a phone call, SMS, or WhatsApp message. About half (45%, 95%CI: 39.1%-51.3%) of the 268 respondents who received such support types listed in the questionnaire answered they had received counselling services on COVID-19. Rural respondents were more likely to receive face masks (p<0.001) as well as counselling services on COVID-19 (p<0.01) than urban respondents. Mosquito larvae checks and health checks were received only by urban respondents.

No significant difference was found amongst the three provinces in terms of the percentage of respondents who received face masks and counselling services on COVID-19 as public and social support. In Bali and DIY, only a few respondents received *sembako* and mosquito larvae checks from *Posyandu* cadres, healthcare personnel, or social cadres.

The respondents whose income decreased were more likely to receive face masks (p=0.060) and counselling services on COVID-19 (p=0.079) as public or social support although the statistical difference was marginal. Likewise, the respondents whose caregivers' income decreased were significantly more likely to receive face masks from public or social support personnel (p<0.01).

Table 5.5 shows the types of support that the respondents received from families, neighbours, friends, village officials, *rukun warga, rukun tetangga*, NGOs through home visits or telecommunication tools, like a phone call, WhatsApp messages, and SMS. About 7.1% (95%CI: 6.23%–7.98%) reported that, during the pandemic, they had never received such support as listed in the questionnaire: help in preparing meals; help in buying daily needs; help in keeping the house and surroundings clean; keeping socially connected through home visits or telecommunication tools such as phone call, WhatsApp, or SMS; and help in mitigating mental and emotional problems as well as coping with stress. The rural respondents (p<0.001) and those in Bali (p<0.001) were significantly more likely to answer that they had not received any of the types of support listed in the questionnaire.

Table 5.5 Support from Family and Community During the Pandemic

	Support from Family, Neighbour, Friend, Village Official, Rukun Warga, Rukun Tetangga, or NGO during the COVID-19 Pandemic					
Characteristics	Help in Preparing Meals	Help in Buy- ing Daily Needs	Help in Keeping the House and Surroundings Clean	Keep Socially Connected through In-Person Visit, Phone, WhatsApp Messages, or SMS	Help in Mitigating Mental Problem and Coping with Stress	N
All respondents	18.13	23.12	67.32	73-73	30.41	3,430
Sex						
Male	17.20	19.71	67.98	72.19	26.93	1,593
Female	18.94	26.08	66.74	75.07	33.42	1,837
Age						
60–69 years	14.43	19.32	68.27	75.17	30.70	2,231
70–79 years	22.41	26.60	65.45	72.30	29.14	906
80 years and older	33.11	41.30	65.87	67.24	32.08	293
Living location						
Urban	18.57	23.15	69.06	75.43	30.78	3,171
Rural	12.74	22.78	45.95	52.90	25.87	259
Province						
Bali	18.18	26.76	52.75	65.43	28.81	781
Daerah Istimewa Yog- yakarta	14.92	22.10	75.17	65.60	27.68	878
DKI Jakarta	19.71	22.02	69.85	81.42	32.47	1,771
Respondents' income						
Decreased	18.19	22.64	69.22	73.51	32.30	1,842
Same/Increased	18.07	23.68	65.11	73.99	28.21	1,588
Caregivers' income						
Respondents who had caregivers	19.49	24.43	67.03	76.39	32.20	2,960
Decrease	20.11	25.12	67.82	75.32	33.11	1,815
Same/increase	18.52	23.32	65.76	78.08	30.74	1,145

NGO = non-governmental organisation. Note: The respondents were allowed multiple answers.

Amongst the answers to the five questionnaire items, the most selected (74%, 95%CI: 72.2%–75.2%) was 'home visit and contact through a phone call, WhatsApp, and SMS to ask the condition of older persons and keep social connectedness'. Female respondents were significantly more likely to receive support to shop for daily needs and mental support. The older respondents were more likely to receive support in preparing meals, shopping for daily needs (p<0.001, Wilcoxon rank-sum test), whilst the younger respondents were more likely to have contact from families and communities (p<0.01, Wilcoxon rank-sum test).

Significantly more urban respondents reported that they were supported in preparing meals (p<0.05), cleaning the house (p<0.001), and being contacted through home visits, phone calls, WhatsApp, or SMS to maintain social connectedness than their rural counterparts (p<0.001).

The respondents in DIY were significantly more likely to receive support for cleaning their house and its surroundings than those from the other two provinces. Those in DKI Jakarta were significantly more likely to receive home visits or telecommunication messages to confirm their condition and promote social connectedness. The respondents whose income decreased were significantly more likely to receive support for cleaning their house (p<0.05) and mitigating mental and emotional problems (p<0.05).

CHAPTER 6

Conclusions and Recommendations

1. Conclusions

Indonesia is one of the ASEAN Member States most affected by COVID-19 in terms of the numbers of confirmed cases and fatalities. Data from around the world shows that older people are most affected by COVID-19 in terms of mortality and seriousness of symptoms, but the impact of COVID-19 on older people is not limited to direct effect of this infectious disease. The COVID-19 pandemic requires the authorities to impose social restriction measures to prevent the spread, which is called *Pembatasan Sosial Berskala Besar* or PSBB (Large-Scale Social Restriction) in Indonesia. Social restriction measures can undermine the economic conditions, overall well-being, social connectedness of people, particularly underprivileged people – many older people are categorised as such. An urgent response by the government is required to support the people whose daily lives are desperately affected by this pandemic, and the real situations of their lives need to be revealed for effective and efficient action. However, due to the health protocol to prevent COVID-19 transmission, such as keeping social distancing or avoiding close contact, surveys requiring in-person interviews have been strongly discouraged during this pandemic.

This study used a telephone survey method, so it succeeded in avoiding close contact with the respondents while collecting the data. The sampling has the limitation that older people whose households did not have a telephone contact number were excluded. In some of seven villages/kelurahan taken as SILANI project sites, which are also the study sites of this survey, more than 30% of the households with older people did not have telephone contact numbers, in most cases more than half. The readers of this report, therefore, are urged to be careful about the interpretation of the results of this study.

Another limitation is that the sample of this study is not nationally representative. The target provinces and districts/cities were selected purposively when SILANI was established in 2019. We believe the study sites are representative of Indonesia to some extent, i.e. Jakarta represents a megacity, Yogyakarta is an example of a middlesized city, and rural area with high proportions of older people and Bali are examples of non-Muslim culture with high proportions of older people. The readers, however, should be aware that these study sites were not selected randomly.

In spite of these limitations, we still believe this study provides very important and valuable information about the impact of COVID-19 on older people. No other studies have been conducted in Indonesia in terms of the comprehensiveness of the contents of questionnaires, and no other studies have succeeded in approaching the real lives of older people during this pandemic. The following are some major findings of this study that may help policymaking to mitigate the impact of the pandemic.

1.1 Economic condition of older people

The study found more than half of the respondents experienced a decrease in income during the COVID-19 pandemic. The result shows that the pandemic most affected the income of the respondents who earned income from work and whose income depended on children who do not live together, while pensioners were less likely affected. Amongst the respondents whose income decreased, about 42% of them reported that the quality of their food became lower.

Amongst the respondents whose income decreased, more than half reported they had not taken any actions to overcome the decline in income, while about 18% asked for help from families and/or communities who had better economic conditions.

Support programmes by the government play important roles in daily subsistence of the respondents. In DKI Jakarta, about 85% of all respondents received *sembako* as one of the public services to underprivileged people, and most of them received *sembako* during the pandemic only. About 6.7% of respondents were the beneficiaries of PKH during the pandemic, and compared with before the pandemic, significantly more respondents received PKH during the pandemic. It is notable that the nongovernmental assistance is not ignorable. About 38% of respondents reported that they received assistance from community groups, private sector, school, or family members who do not live together.

1.2 Health condition of older people

The questionnaire of this study was designed to assess the needs of older people, as set out in *Strategi Nasional* (Stranas) *Kelanjutusiaan*. It includes the questions on self-assessed health, ADL, IADL, comorbidities, access to healthcare facilities, etc.

About 16% of respondents stated that their physical health had deteriorated. Only 1.6% of respondents reported that the number of diseases diagnosed by health professionals increased, but this result should be carefully interpreted because the difficulty in the access to health facilities during the pandemic may have affected the result. As for mental health, the result suggests that about one out of four respondents experienced a worsening of depression, but the oldest-old people were less likely to become more depressed.

Almost all respondents adopted practices to maintain physical health (99%) and mental health (98%). The practices engaged in by more than half of respondents to maintain physical health were sunbathing, adopting an active lifestyle, and exercising outdoors. Two out of three respondents reported that they prayed to maintain mental health.

Amongst the respondents who needed consultations with health facilities, about 11% of them had difficulty accessing healthcare facilities, the most common reason for it being fear of contracting COVID-19 at health facilities (45%). About 12% of respondents who needed routine medicine reported that they had run out of medicine during the pandemic, the most common reason being lack of money to buy medicine (45%).

1.3 Social support for older people

Social interaction is threatened by the COVID-19 pandemic. People are encouraged to stay at home and to communicate using telecommunication tools to maintain social connectedness without physical contact. But older people are believed to be at a great disadvantage when it comes to using communication tools and are likely therefore to be at risk of social isolation.

The results of the study show that, during the pandemic, only about 5% of respondents never communicated with relatives, friends, or neighbours either in person or through telecommunication. The most common way of social interaction was in-person communication (82%). One out of three respondents still participated in community activities outside their houses, whereas about 60% of respondents reported that they had suspended participating in community activities since the start of the pandemic. Even during the pandemic, around 43% of respondents still supported their families and communities. The most common form of support they provided was caring for children under 5 years old (20%), followed by *sembako* (19%).

In terms of social support, about 8% of respondents received some sort of support from *Posyandu* cadres, social cadres, and/or healthcare personnel through home visits or telecommunication. The most common form of support was the provision of information about COVID-19 (45% of respondents who received public and social support). Regarding the support from family and community, more than 90% of respondents reported that they received it. The most common types of such support were in-person visits and/or other forms of communications, such as phone calls, SMSs, or WhatsApp messages to keep socially connected (74%), followed by help in keeping the house and surroundings clean (67%).

2. Recommendations

Economic and social support for older people should be maintained and continued even after the pandemic. It is crucial to minimise the negative impact of falls in income and social restrictions on the welfare of older people – such as decreased food quality, more limited access to healthcare facilities, and their greater social isolation.

As mandated in the Guidelines for Older People Health Services in the COVID-19 Pandemic Era (Ministry of Health, 2020), the main priority is the prevention of COVID-19 amongst older people through effective and persistent efforts and collaboration with the government and the community, including family. However, the mitigation of the impact of economic distress and social isolation is also crucially important. The quick development of a comprehensive support system for older people is strongly encouraged. Such efforts would surely contribute to the accomplishment of the goals stated in the Concept of National Strategy on Ageing, which is to ensure independent, prosperous, and dignified lives of older people.

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Appendix: Support Team

Table A. List of Data Collection Team Members

No.	Name	Position		
1.	Shifa Fauzia	PIP		
2.	Triono Agus Santoso	PIP		
3.	Laura Novianti	PIP		
4.	Sunar Indriati	Supporting Training		
5.	Upit Sarimanah	Enumerator		
6.	Nugroho Dwi Saputro	Enumerator		
7.	Lina Ratnasari	Enumerator		
8.	Panuju Dwianto	Enumerator		
9.	Akhmad Kurniawan	Enumerator		
10.	Bangkit Abul Yatama	Enumerator		
11.	Farid Ma'Ruf	Enumerator		
12.	Agung Tri Prabowo	Enumerator		
13.	Deni Septia Agus Riswanto	Enumerator		
14.	Karina Rani Wijayanti	Enumerator		
15.	Hasan Rifai	Enumerator		
16.	Diftya Twas Galih Atyasa	Enumerator		
17.	Oki Petrus Laoh	Enumerator		
18.	Pradika Gautama	Enumerator		
19.	Afiani Puspita Sari	Enumerator		
20.	Anis Masruroh	Enumerator		
21.	Karlin Maulinda	Enumerator		
22.	Fajar Kumala	Enumerator		
23.	Ardika Senja Abadi	Enumerator		
24.	Hafidz Abdul Aziz	Enumerator		