Chapter 1

Background and Objectives

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CHAPTER 1

Background and Objectives

1. Background

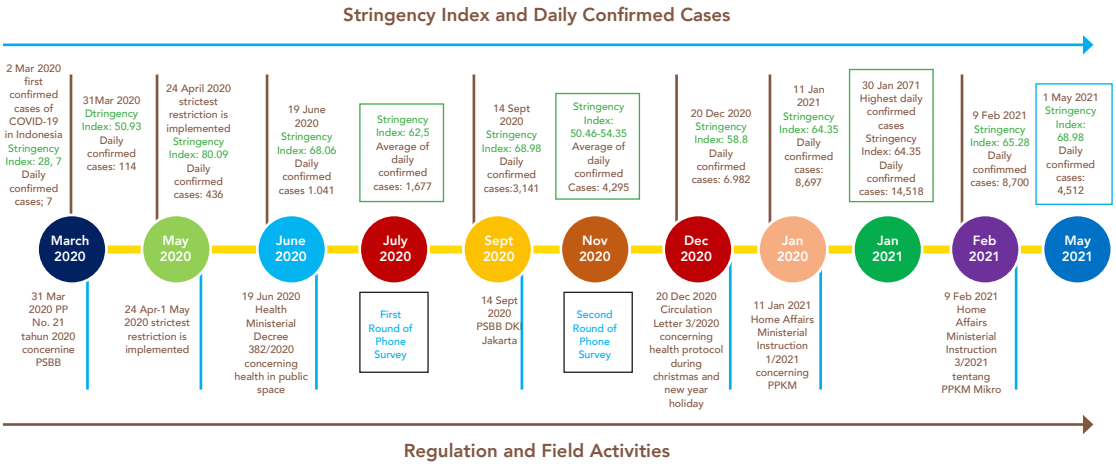
Since the first case of COVID-19 was identified on 2 Mach 2020, Indonesia has reported the escalation in daily confirmed cases. The government has made various efforts to control the COVID-19 pandemic, including imposing restrictions on social activities. Activity restrictions during the pandemic even plunged Indonesia into an economic crisis. Social restrictions cannot be carried out in the long term because of the high costs needed. Therefore, along with the length of the pandemic period, the government changes and adjusts policies to the new normal conditions to restore economic and social activities. These various adjustments continuously change regulation-related activities and their impacts. However, in general, restrictions on social activities tended to be relaxed amidst increasing daily cases, at least until early 2021.

Figure 1.1 shows the number of daily confirmed cases of COVID-19 in Indonesia[1] and the Stringency Index,[2] which indicates how strict social closures and restrictions were implemented at several milestones from the beginning of the pandemic to May 2021. The higher the Stringency Index number, the higher intensity of the restrictions implemented (Hale et al., 2021). Thus, Figure 1.1 shows that Indonesia has never actually implemented a full restriction (lockdown) because the strictest restriction ever applied was only 80.09.

[1] The number of daily confirmed cases of COVID-19 was obtained from the *Satuan Tugas Penanganan* COVID-19 dan *Komite Penanganan* COVID-19 dan Pemulihan Ekonomi Nasional's official site, https://covid19.go.id/peta-sebaran-covid19

[2] The Stringency Index is measured by some experts from Oxford University using The Oxford COVID-19 Government Response Tracker (OxCGRT). This index captures governement policies related to closure and containment, and health and economic policies for more than 180 countries including Indonesia. The indicators used include school closures, travel bans, etc. (Hale et al., 2021).

Figure 1.1: Restriction Policies, Daily Confirmed Cases of COVID-19, and Field Study Activities



Sources:
Stringency Index: https://ourworldindata.org/grapher/covid-stringency-index?tab=chart&country=~IDN
Daily confirmed cases: https://covid19.go.id/

When the first case of COVID-19 was confirmed on 2 March 2020, Indonesia had not yet officially imposed restrictions, as indicated by the Stringency Index, which reached only 28.7. However, the Large-Scale Social Restrictions were implemented only on 31 March 2020, per Government Regulation No. 21 of 2020. At that time, the Stringency Index had increased to 50.93. The peak of social restrictions in Indonesia occurred from 24 April 2020 to 1 May 2020 or after Eid al-Fitr, with a Stringency Index of 80.09. During this period, the number of confirmed cases was relatively stable.

To recover the economy, the government began implementing a relaxation restrictions policy for community activities on 19 June 2020, r egulated by Minister of Health Decree No. 382 of 2020 concerning health protocols in public places. The Stringency Index reflected the relaxation, which decreased to 68.06 despite the increasing daily cases of COVID-19. Social restrictions continued to loosen until the end of 2020, as indicated by the downward trend in the Stringency Index, including in the two rounds of phone surveys conducted in July and November 2020.

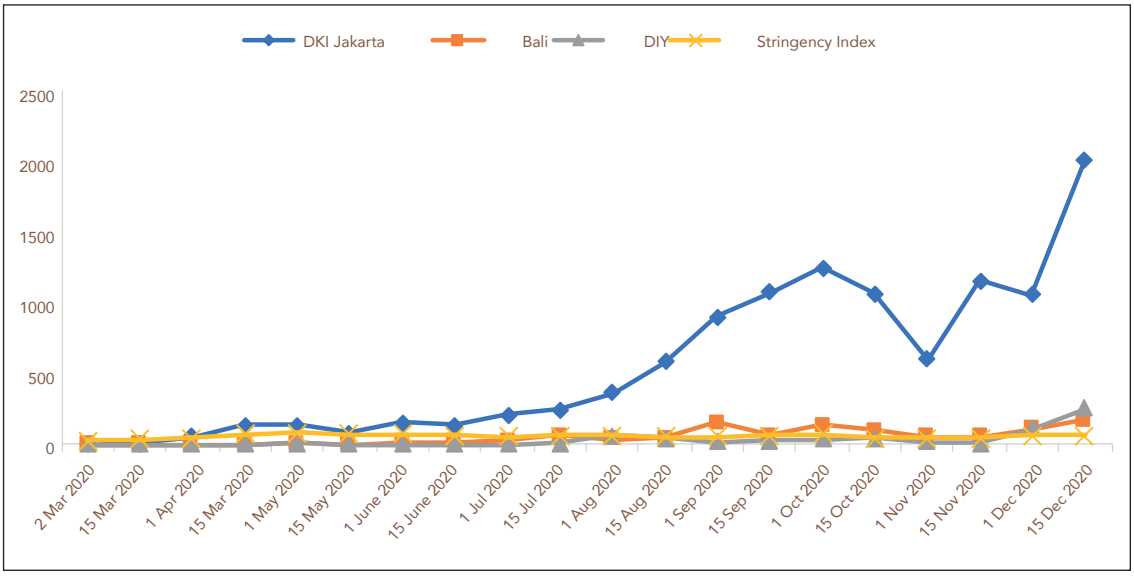
Efforts to increase social restrictions carried out after several previous efforts, such as the DKI Jakarta Large-Scale Social Restrictions in September 2020 and Circular Letter No. 3 of 2020 on health protocols during the Christmas and New Year holidays, were not sufficient to control the increase in daily cases of COVID-19. Therefore, on 11 January 2021, the government implemented the

PPKM (Pemberlakuan Pembatasan Kegiatan Masyarakat: Implementation of Community Activity Restrictions) to anticipate the impact of the Christmas and New Year holidays. At that time, the Stringency Index increased to 64.35 from the previous 58.8, with the daily number of confirmed COVID-19 cases reaching 8,692.

However, the year-end holiday still had a big effect, as indicated by the highest daily number of cases reaching 14,518 on 30 January 2021. The number of daily cases had doubled in about 1 month, from 20 December 2020, which only reached 6,982. After extending the implementation of PPKM until 8 February 2020, the government changed the restriction strategy by implementing the PPKM on a microscale from 9 February 2020 to 31 May 2020, as regulated by the Minister of Home Affairs Instructions No. 3 and No. 4 of 2020.

Figure 1.2 shows the escalating trend of COVID-19 daily confirmed cases from March 2020 to November 2020 in three provinces. Even if Indonesia's COVID-19 cases escalated, the Stringency Index indicated a slightly decreasing trend. Indeed, Stringency Index data at the provincial level is not available. The Stringency Index data in Figure 1.2 refers to the response level of the strictest sub-region (Hale et al., 2021). The strictest restriction has been imposed in DKI Jakarta to lower the Stringency Index in other provinces. Relaxation in activity restrictions resulted in Indonesians having more social activities than in the early part of the pandemic.

Figure 1.2. COVID-19 Daily Confirmed cases and Stringency Index



Sources:

Stringency Index: https://ourworldindata.org/grapher/covid-stringency-index?tab=chart&country=~IDN

Daily confirmed cases: https://covid19.go.id/

Changes in policies to control the COVID-19 pandemic and real societal conditions can change the impact of the pandemic on older people. Based on the results of the first round of phone surveys conducted in July 2020, older people experienced various impacts on health, economic, and social aspects (Study Team 2021a).

Based on these concerns, we conducted the second round of phone surveys, 'Older People and COVID-19 in Indonesia', in November 2020. This follow-up survey intended to identify the development of conditions older people over the COVID-19 pandemic period and compare the changes with the first round of surveys.

1.1.Objectives

The objectives of the second round of phone surveys are as follows:

1. To compare the welfare of older people before and during the COVID-19 pandemic between July 2020 and November 2020;
2. To compare the difficulties they faced between July 2020 and November 2020;
3. To understand the changes in social assistance received by older people as a response to COVID-19 in July 2020 and November 2020; and
4. To identify the most suitable policies in mitigating the impacts of the pandemic on older people based on the change of situation during the pandemic

2. Methodology

We conducted the second round of data collection in November 2020 using a quantitative approach with the longitudinal research design. We re-interviewed respondents from the first survey round. We targeted 3,430 respondents who completed the interview in the first round. As described in the first round, those respondents were assigned proportionally to the population of older people at each village/*kelurahan*,[3] which is included in the project areas of SILANI (*Sistem Informasi Lanjut Usia*: Information System of Older People). In each village/***kelurahan***, older people whose households have a landline or cell phone, according to the SILANI survey results, were selected by simple random sampling.

[3] *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*** (sub-district). It has no authority to make policies, manage its own financial resources, and elect leaders like the ***desa*** (Law No. 23 of 2014).

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

SILANI's pilot 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 SILANI project sites were located in any of the following three provinces of Indonesia: DIY, Bali, and DKI Jakarta.

The second round used the same instrument as the first round, with a slightly modified timeline. In the first round, we asked about the respondents' condition during March–July 2020 (identified as the beginning of the pandemic in the first round of survey report). Then, we asked about the respondents' condition in July–November 2020. We also simply wrote July 2020 phone survey and November 2020 phone survey in our analysis to refer to these two periods when respondents were interviewed, unless there is additional information.

3. Completion Rate and Proxy

'Completed' respondents are (i) those who go through all the items in the second round of the survey, whether they still live in the study areas or temporarily moved/travelled; or (ii) those who completed the interview in the July 2020 phone survey but died by the November 2020 phone survey. Out of 3,430 respondents originally targeted, only 3,125 (91.1%) completed the interviews, while 70 (2.0%) respondents died between July 2020 and November 2020.

Table 1.1: Completion Rate

Information	N	%
Completed		
Completed Interview	3,125	91.11
Deceased	70	2.04
Not completed		
Refused	112	3.27
Partly completed	9	0.26
Cannot be reached		
Phone active, yet no response	65	1.90
Phone not active	47	1.37
Rescheduled until time was over	2	0.06
Total	**3,430**	**100**

We could not replace the remaining respondents in the July 2020 phone survey to provide longitudinal data. About 3.3% of respondents from the July 2020 phone survey refused to be re-interviewed, while 0.3% of respondents partly completed the interview. Our team could not contact and interview 3.4% of the respondents even if the phone interviews were rescheduled and the survey period extended due to telephone connection problems.

Complete information on the completion rate of the second round of telephone surveys is presented in Table 1.1. Eventually, the completion rate of the second round was 91.11%. This rate is higher than other longitudinal surveys, such as the Indonesia Family Life Survey/IFLS (86.9% for individual respondents who were completely interviewed), and most longitudinal surveys in the US and Europe (Strauss et al., 2016). Since the attrition is random, indicated by a similar completion rate across respondent characteristics such as sex, age, living location, and province, attrition bias is not a concern when interpreting changes between the two survey rounds. The details about respondent characteristics are described in Chapter 2. As for the analyses in Chapters 3 to 5, we selected the same respondents from the first survey round so that we have 3,125 individual panel data from both rounds to be analysed.

Table 1.2 Reasons for Proxy

Reason	N = 631 (Multiple answers allowed)	
	n	%
Sick because of COVID-19	2	0.21
Sick not because of COVID-19	126	13.24
Hearing disorder	396	41.60
Communication disorder	266	27.94
Cognitive	127	13.34
Other	35	3.68
Total	**952**	**100**

This study allowed proxies if the respondents could not answer the questions for several reasons; proxies answered a different questionnaire. As a result, a total of 631 respondents (20.2% of the total sample) answered the questions by proxy. As presented in Table 1.2, the reason for the two proxy cases was COVID-19. The most common reasons for the remaining proxy cases are hearing loss (364 respondents) and communication problems (275 respondents).

4. Deceased Respondents

During the November 2020 phone survey, we found 70 respondents died after the July 2020 phone survey. Nonetheless, COVID-19 was not the cause of death. Most deceased respondents were 60–69 years old (40 respondents), followed by respondents aged 70–79 years old and 80 years old and older (Table 1.3).

Table 1.3: Deceased Respondents

Characteristics	N	%
Total	**70**	**100**
Sex		
Male	35	50
Female	35	50
Age		
60–69 years	40	57.14
70–79 years	19	27.14
80 years and older	11	15.71