Older People and COVID-19 in Indonesia

(2022 Edition)

Ni Wayan Suriastini
Endra Dwi Mulyanto
Ika Yulia Wijayanti
Osuke Komazawa
Takuma Kato
Maliki
Dinar Dana Kharisma

ERIA
Kementerian PPN/ Bappenas
SurveyMETER

Older People and COVID-19 in Indonesia (2022 edition)

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Sentral Senayan II 6th Floor

Jalan Asia Afrika no.8, Gelora Bung Karno

Senayan, Jakarta Pusat 12710

Indonesia

Ministry of National Development Planning/National Development

Planning Agency, Republic of Indonesia (Bappenas)

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 figures are from the first and second rounds of phone surveys.

Foreword

In the first report of 'Older People and COVID-19 in Indonesia', I wrote that human beings have overcome countless infectious diseases with wisdom, solidarity, and resilience. The COVID-19 pandemic, however, is still having a major impact all over the world even though more than 2 years have passed since the outbreak. In their efforts to overcome the pandemic, many countries are still combating the mutation of the virus through a wide range of measures, such as expanding vaccination coverage. Indonesia is one of the ASEAN Member States most affected by COVID-19 in terms of the numbers of confirmed cases and fatalities. ERIA research reported that COVID-19 in Indonesia infected more than 6.0 million people and caused over 150,000 deaths (as of 30 June 2022). Of all age groups, older people are most affected by COVID-19 in terms of serious symptoms and mortality.

The worst health impacts since World War II the Indonesian economy has experienced has given rise to a recession. Indonesia reported three consecutive quarters of negative growth, of 1.74%, 2.41%, and 4.19%, quarter-on-quarter, respectively, from the fourth quarter of 2019 until the second quarter of 2020 (CEIC, 2021). Meanwhile, the Indonesian the government has been engaged in trying to improve economic growth with a view to achieving an upturn. The latest CEIC reports show that Indonesia's GDP expanded by 5.01%, year-on-year, in March 2022. Moreover, Indonesia's total exports in April 2022 reportedly reached an all-time high of about US$27.3 billion, an estimated increase of over 45% compared with the previous year. These successes are the fruits of the government's effort and its effective economic policies.

But we must also consider the situation from a micro perspective. The COVID-19 has affected vulnerable people, such as the elderly, in particular. The Indonesian Government did not overlook the impact on those people and collaborated with us to clarify their challenges. Our first survey showed that the impact of COVID-19 on older people is not limited to the direct effects of the disease, but that it also includes the effect on their social and economic situation. The second survey of 'Older People and COVID-19 in Indonesia' was conducted in November 2020 to visualise the impact on the lives of older people. I am pleased to be able to publish this report as it shows that we are now gradually emerging from the worst of the pandemic.

I believe that this series of research has great academic and practical significance in that it shows the situation in the early stages of the pandemic, which will guide future policy to deal with possible public health emergencies.

The follow-up survey revealed changes in the condition of older people about 5 months after the first survey, which was conducted in July 2020. Over the course of 5 months, the COVID-19 situation in Indonesia had improved, and social activities gradually resumed accordingly. The survey, however, revealed that the situation of aged people had not necessarily improved. Around 40% of respondents saw their incomes decline, and 25% of them did nothing to overcome declining income problems. Although these tendencies had improved compared to the first round, cash assistance was still preferred to and had more beneficiaries than non-cash assistance. Moreover, the respondents who reported that their physical health had deteriorated increased compared to those in July 2020. In November 2020, about 21.41% of respondents said their health had deteriorated, compared with only 15.52% in July 2020. These two surveys revealed the necessity of easy and safe access to health facilities during a pandemic. Furthermore, some respondents still had difficulties gaining access to health facilities and medicine due to their economic situation. Meanwhile, mental health conditions over the same period – more older people chose in-person meetings to maintain social connectedness than before.

To mitigate the impact of COVID-19, it is necessary to understand what the actual impacts are. The first-round study provides valuable information about the impact of COVID-19 on older people in terms of their economic situation, health, and social interaction. Many older people saw a decline in their income and a deterioration in their physical and mental health, and changed their social interaction patterns. On the basis of various kinds of information including this survey, the government of Indonesia has tried to strike a balance between the economy and health during these 2 years. The policies concerning older people were also changed several times based on the infection situation. In this context, this follow-up survey was needed to provide an update on the COVID-19 impact on the condition of older people during the pandemic.

This survey was proposed by the Indonesian Ministry of National Development Planning (BAPPENAS). Considering the urgent need for and critical importance of such a survey, the Economic Research Institute for ASEAN and East Asia (ERIA) was honoured to collaborate with BAPPENAS on it, and we are pleased that our surveys contributed to supporting their economic and healthcare strategy. As Dr Pungky Sumad, Deputy for Population and Manpower, mentioned, the Indonesian government will continue to work to 'improve older people's livelihoods, including their health, economic conditions, and access to social protection during emergencies' for a better future society.

Beginning with this series of research, ERIA commits itself to assisting Indonesian policy making in the healthcare fields for the future as well.

Finally, we would like to express our sincere appreciation to our older respondents, who generously agreed to participate in this survey. We also appreciate the family members of older people for their kind support in making the phone survey a success. In the phone survey interviews, they were a big help for our team as they explained the survey's objectives and connect us with older people respondents in their families. As some of the selected respondents were incapable of responding to the interview questions because of their impaired cognitive function or for other reasons, their family members were requested to answer the questions as proxies.

Our sincere gratitude goes to BAPPENAS for the firm leadership of our colleagues and to SurveyMETER for its dedicated work. Conducting a survey during the pandemic was difficult employing usual methods as face-to-face meetings had to be avoided as much as possible. But this phone survey became a good example of a feasible method to be used during a pandemic.

Using the data from the second-round survey and comparing it with the first survey gives us a more insightful analysis enabling us to understand the change of older people over time and inputs to the adaptive policies. 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.

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

Foreword

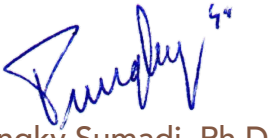
Indonesia's population is ageing at a rapid pace. According to the *Badan Pusat Statistik* (Statistics Indonesia), the number of Indonesia's older people (aged 60 and above) reached 29.3 million in 2021, representing a growth of 3.2% over a decade. Now is a strategic time, therefore, for Indonesia to give more attention to and create a more robust policy for the older population. BAPPENAS has started the initiative by developing a pilot of Older People Information and Service System or SILANI, covering about 15,000 older people in three provinces, including the Capital Region of Jakarta, the Special Region of Yogyakarta, and Bali. The last two regions have shown the most rapid growth of older people compared to other Indonesian provinces.

The COVID-19 pandemic has created a more vital urgency for the Indonesian government to move forward with better ageing policies. Older people have been disproportionally affected by the pandemic, calling for action. ERIA came to support BAPPENAS, as the national development planning institution, to better understand how the COVID-19 pandemic has made the older population more vulnerable. The SILANI pilot has provided a unique opportunity to develop a two-waves phone survey to help understand the impact of the pandemic on older people.

The first survey wave was conducted in July 2020 and showed that older Indonesian people suffered the multidimensional impacts of income, physical health, and mental health deterioration due to the pandemic. The second round conducted in the next 2 months clarified that there had been some further negative impacts. However, the survey also found a slight improvement associated with the relaxation of the physical distancing and lockdown enforcement. This finding implies that the pandemic created anxiety due to its health impacts on older people, and the enforcement of physical distancing significantly affected their well-being. These findings will be significant to support policymaking on ageing issues.

This study is in line with several government initiatives. The President of the Republic of Indonesia recently signed the Presidential Regulation of 88/2021 concerning the National Strategy of Aging. The President has also declared the goal of reaching 0% extreme poverty by 2024. Both initiatives mandate the government to improve older people's livelihoods, including their health, economic conditions, and access to social protection during emergencies.

Finally, we would like to thank ERIA for supporting the study and SurveyMETER for executing the survey. The report has been helpful for us, and we genuinely hope that this research product will be equally valuable and inspirational for other parties, especially in formulating affirmative action policies for older people. We are open to input and suggestions for improving this study. Thank you very much.



Pungky Sumadi, Ph.D.
Deputy for Population and Manpower
BAPPENAS

Preface

Indonesia reported an escalation in COVID-19 daily confirmed cases from the early period of the pandemic on 2 March 2020 to the end of 2020. On the other hand, social activity restrictions tended to be relaxed to drive economic recovery. The change of conditions over time in the prolonged pandemic most probably changed the impact of the pandemic on older people.

In our previous study – 'Older People and COVID-19 in Indonesia' first-round phone survey – we found that older people are one of the vulnerable groups in this pandemic. The high fatality rates amongst older people in Indonesia are closely related to their comorbidity. Unfortunately, despite the need for health consultation and routine medicine, older people face difficulties accessing health services and experience a shortage of routine medicines they need during the pandemic. In response to the impacts of the pandemic on the economic crisis and social activity restrictions, some older people received assistance in the form of cash, in-kind, and other social support.

We conducted a follow-up survey, the second round of phone surveys, to observe the current condition of the respondents. The second survey was conducted in November 2020. Using the same instrument as the first survey round conducted in July 2020, we aimed to identify the change in the impacts of the pandemic on respondents. For this reason, we re-interviewed the respondents from the first survey round. We asked about some conditions they experienced after the first interview.

This study was initiated by Bappenas (Badan Perencanaan Pembangunan Nasional: National Development Planning Agency) and sponsored by the Economic Research Institute for ASEAN and East Asia (ERIA). Data collection, including technical support, instrument design, and basic analysis, was conducted by SurveyMETER. This report was compiled based on panel data analysis of both the first and second survey rounds. Our findings show that there were changes in several impacts felt by respondents. Since the impacts on older people are dynamic over time, support to help them cope must be responsive. As the pandemic is not over yet, a follow-up to this survey will be good.

SurveyMETER wishes to thank Bappenas and ERIA for the support provided. 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 and prosperity of the community, particularly of the older people.

Yogyakarta, 2021
Ni Wayan Sriastini
Executive Director, SurveyMETER

List of Project Members

Bappenas (Ministry of National Development Planning/ National Development Planning Agency) Team

Maliki : Director of Poverty Alleviation and Community Empowerment
Dinar Dana Kharisma: Senior Policy Planner, Coordinator for Social Assistance

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 (moved to National Institute of Infectious Diseases on 1 August 2021)
Takuma Kato: Director for Healthcare and Long-Term Care Policy
Sota Machida: Senior Policy Officer (moved to Japan External Trade Organization on 31 August 2021)
Asuka Nagatani: Senior Policy Officer

The members of the support team are listed in the appendix.

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List of Abbreviations

ATM	*anjungan tunai mandiri* (automated teller machine)
Bappenas	*Badan Perencanaan Pembangunan Nasional* (National Development Planning Agency)
BLT	*Bantuan Langsung Tunai*
BPJS	*Badan Penyelenggara Jaminan Sosial*
BPS	*Badan Pusat Statistik* (Statistics Indonesia)
BST	*Bantuan Sosial Tunai* (unconditional cash transfer)
COVID-19	Coronavirus disease 2019
DIY	Daerah Istimewa Yogyakarta
DKI Jakarta	Daerah Khusus Ibukota Jakarta
GDS	Geriatric Depression Scale
IADL	instrumental activities of daily living
NGO	non-governmental organisation
PKH	*Program Keluarga Harapan*
Posyandu	*Pusat Pelayanan Terpadu* (Integrated Service Post)
Sembako	*Sembilan Bahan Pokok* (Non-cash food assistance)
SMS	short message service
SILANI	*Sistem Informasi Lanjut Usia* (Information System of Older People)

Executive Summary

The ongoing pandemic still negatively impacts older people disproportionately. Based on the findings from the first round of phone survey on 'Older People and COVID-19 in Indonesia' conducted in July 2020, older people experienced significant negative impacts, particularly on health, economic, and social aspects.

The relaxation of government restrictions on social activities, along with the duration of the pandemic, brings hope for economic recovery and better access to public facilities and outdoor activities, which were very limited during the early stage of the pandemic and had negatively impacted older people's health.

To determine the current situation of older people during this prolonged pandemic, we conducted the second round of phone surveys on older people and COVID-19 in Indonesia in November 2020. Through this follow-up phone survey, we intended to observe the change in older people's condition and the impacts they felt compared to the first round of phone surveys in July 2020. Therefore, we used the same instrument as the first round, with slight modifications related to the timeline.

We re-interviewed the first round of respondents to generate longitudinal data. As explained in the first round, the respondents were selected from the SILANI (Sistem Informasi Lanjut Usia: Information System of Older People) pilot project conducted in 2019.

This survey targeted 3,430 respondents who completed the interviews in the first round in July 2020. However, 70 respondents passed away after the first round. Some respondents did not complete the interview, refused, or were not reached by phone calls. Overall, the completion rate of the second survey round is 91.11%. This rate is relatively high compared to other longitudinal surveys. In total, 3,125 respondents completed the interviews. Since the attrition is random across the respondent characteristic, attrition bias is not a concern when interpreting changes between the two survey rounds. In this report, we selected the same respondents from the first survey round to present a comparative analysis with the second survey round.

This study was initiated by Bappenas and sponsored by the Economic Research Institute for ASEAN and East Asia (ERIA), while SurveyMETER collected the data collection and conducted the basic analysis. The findings from the survey's first and second rounds are discussed below.

The Economic Condition of Older People

The number of older people whose income decreased in November 2020 was less than in July 2020. The impact of reduced income on food consumption also changed. More older people adopted some strategies to overcome income decline. Fewer older people received social assistance in November 2020.

1) The percentage of older people with decreased income fell from 54.18% in July 2020 to 38.75% in November 2020.
2) Older people who stated that declining income did not affect food consumption increased from 47.78% to 50.04%. Accordingly, respondents who consumed lower food quality decreased from 42% to 37.99%. Meanwhile, those with less frequency or quantity of food increased from 16.77% to 18.08%.
3) More than half of older people said they did nothing to overcome the decline in income in July 2020. Hereafter, in November 2020, only about a quarter of those whose income decreased answered that they did nothing. The percentage of older people who asked for help from richer families decreased from 18.19% to only 9%. On the contrary, those who answered that they reduced spending as their strategy increased drastically from only 1.89% in July 2020 to 57.31% in November 2020.
4) Older people who received at least one type of assistance decreased from 76.42% in July 2020 to 70.08% in November 2020. Beneficiaries of all kinds of assistance declined, except BLT or BST beneficiaries which increased from 10.94% to 11.52%. Older people whose income decreased were less likely to lose their assistance.
5) Around 9.22% of older people living in PKH (*Program Keluarga Harapan* or Family Hope Program/Conditional Cash Transfer Program) families receive PKH transfer at least once before the pandemic (SILANI baseline) in July 2020 or in November 2020. Most PKH families (3.10% of total respondents) received the PKH assistance continuously in two rounds of phone surveys during the pandemic. In this study, non-cash food assistance before the pandemic refers to BPNT (B*antuan Pangan Non Tunai*). During the pandemic, it refers to any kind of nine basic food commodities (*Sembilan Bahan Pokok*, sembako) assistance provided either by the central or local government. Approximately 61.06% of respondents received non-cash food assistance at least once amongst the three survey rounds. Most of them (42.21% of the total respondents) received it continuously in the two rounds of phone surveys during the pandemic.

Health Condition of Older People

Better access to health services in November 2020 than in July 2020 resulted in more physical health problems being identified. Meanwhile, older people's mental health conditions slightly improved. Nevertheless, several respondents still had difficulties accessing health services and had a shortage of medicines. In addition, older people changed their preference for activities to maintain physical and mental health as restrictions were relaxed.

1) Based on self-assessment, respondents who stated in November 2020 that their physical health had deteriorated comprised 21.41%. The number increased from 15.52% in July 2020. Likewise, respondents who needed support for instrumental activities of daily living (IADL) such as shopping or using an ATM (Anjungan Tunai Mandiri or automated teller machine) increased from 9.22% in July 2020 to 10.78% in November 2020.

2) More older people had increasing comorbidity scores from July 2020 (1.64%) to November 2020 (15.58%). On the other hand, respondents with decreasing scores also slightly lessened from 16.70% to 9.51%. This is most probably caused by better access to health facilities due to the relaxation of activity restrictions. Thus, more chronic conditions were properly diagnosed.

3) Older people whose depression scores increased from before the pandemic (SILANI baseline) to July 2020 reached 23.96%, while those from July 2020 to November 2020 reached 10.88%. Similarly, older people with decreasing scores declined from 23.60% to 22.02%.

4) The decreasing percentage of older people who had difficulties accessing health services indicated better access. In July 2020, it accounted for 11.27%. Hereafter, it only reached 9.36%. Those who delayed visiting health facilities also fell from 28.82% to 21%.

5) The reasons of respondents who still have difficulties accessing health services changed. In November 2020, the most common reasons were (i) did not have money to pay for health services and (ii) long queues. These findings are different from the July 2020 survey, where the dominant reason was worry and closed health facilities. The percentage of respondents who experienced a shortage of medicines and their reason for not having money to buy medicines did not change significantly.

6) Preference in activities to maintain older people's physical and mental health changed. Compliance with health protocols to maintain physical health decreased drastically from 33.92% in July 2020 to only 20.38% in November 2020, as fewer respondents chose this option. Conversely, more older people decided to take vitamins, supplements, spices, or herbs (from 0.93% to 26.59%) and do outdoor exercises (from 53.95% to 57.44%) to maintain their physical health. As for maintaining mental health, in November 2020, more older people chose to listen to music, watch YouTube, or listen to preachers (from 12.99% to 39.84%) and engage in outdoor activities. In contrast, fewer older people chose to pray, read books, including holy books (from 67.33% to 37.63%), and adopt an active lifestyle inside the house.

Social Support for Respondents

Older people who maintain social interaction through personal meetings increased in November 2020 compared to July 2020. On the other hand, fewer older people contributed to their communities. The number of public and social support increased; nonetheless, the types of support they received were lesser.

1) Older people who communicate with relatives, friends, and neighbours through personal meetings or telecommunications increased from 95.26% in July 2020 to 97.79% in November 2020.

2) More older people participated in activities outside the house such as *arisan*[1]; gatherings of older people; and activities in mosques, temples, churches, etc. They increased from 35.15% in July 2020 to 49.22% in November 2020.

3) The number of older people who contributed to their families, relatives, and community increased from 43.20% in July 2020 to 58.08% in November 2020. However, the forms of contributions they made were lesser, as indicated by the decreasing percentage of beneficiaries.

[1] *Arisan* 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 entitled to receive an amount of money or goods equivalent to the total money collected from all members. Thus, a round of these regular meetings will be completed when all members have received their share.

4) The total number of respondents who received support from *Posyandu*[2] cadres, social cadres, and/or health workers doubled from 254 respondents in July 2020 to 593 in November 2020.

5) Trends in the form of social support received by older people from July 2020 to November 2020 varied. Beneficiaries of COVID-19 counselling decreased from 45.28% to 21.25%. Likewise, those who received other health counselling decreased from 30.71% to only 12.32%. Conversely, beneficiaries of mosquito larvae checks increased from 14.57% in July 2020 to 50.59% in November 2020. An increasing percentage of beneficiaries received health checks, which increased from 7.48% to 25.80%.

6) All types of social support provided by family, neighbours, friends, village officials, *rukun warga*[3], *rukun tetangga*[4], or non-governmental organisations (NGOs) decreased from July 2020 to November 2020. The decrease is shown by the decline in the percentage of its beneficiaries. Some types of social support that significantly decreased were help in buying for daily needs (from 23.17% to 20.38%), help in keeping the house and surroundings clean (from 67.52% to 42.05%), and mitigating mental problems and coping with stress (from 30.56% to 26.69%). Change in the eligible beneficiaries and delay in distribution might affect the trend.

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

[3] This facilitates community participation in planning, implementation, supervision of development, and 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* comprises 3 to 10 *rukun tetangga*, while each *rukun tetangga* consists of 10–50 households.

CHAPTER 1

Background and Objectives

1. Background

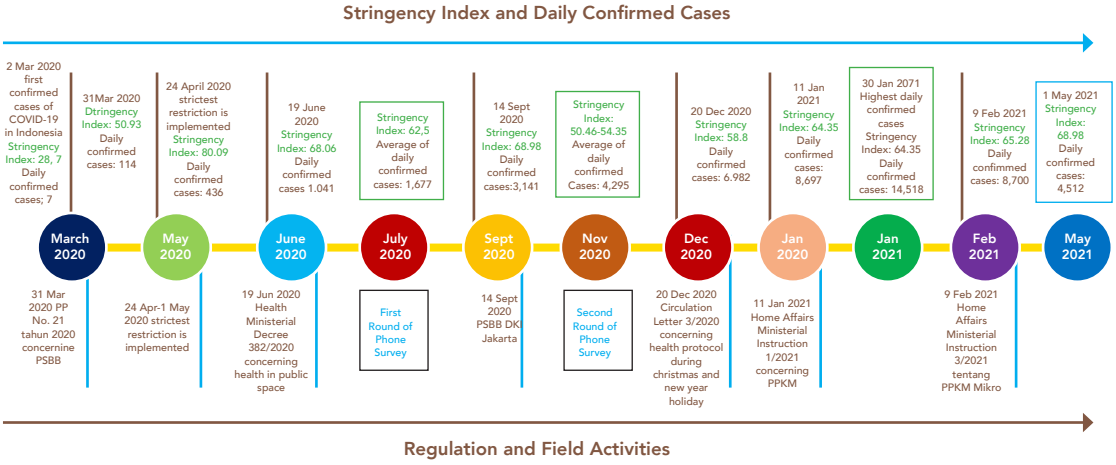
Since the first case of COVID-19 was identified on 2 Mach 2020, Indonesia has reported the escalation in daily confirmed cases. The government has made various efforts to control the COVID-19 pandemic, including imposing restrictions on social activities. Activity restrictions during the pandemic even 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.

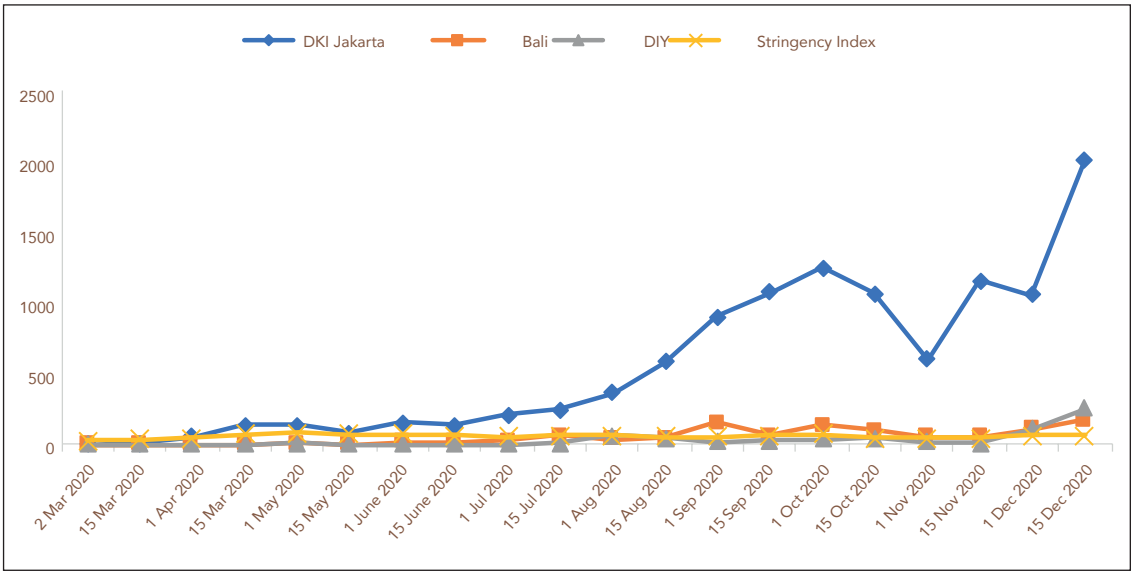
Efforts to increase social restrictions carried out after several previous efforts, such as the DKI Jakarta Large-Scale Social Restrictions in September 2020 and Circular Letter No. 3 of 2020 on health protocols during the Christmas and New Year holidays, were not sufficient to control the increase in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

CHAPTER 2

Characteristics of Respondents

Regardless of the difference in the number of respondents who completed the interview in both survey rounds, the distribution of respondent characteristics between the two rounds did not change (Table 2.1).

Table 2.1: Characteristics of Completed Respondents[a]

Characteristics	July 2020		November 2020	
	N	%	N	%
Total	**3,430**	**100**	**3,125**	**100**
Sex				
Male	1,593	46.44	1,449	46.37
Female	1,837	53.56	1,676	53.63
Age				
60–69 years	2,231	65.04	2,036	65.15
70–79 years	906	26.41	822	26.30
80 years and older	293	8.54	267	8.54
Living location				
Urban	3,171	92.45	2,873	91.94
Rural	259	7.55	252	8.06
Province				
Bali	781	22.77	701	22.43
DIY	878	25.6	847	27.10
DKI Jakarta	1,771	51.63	1,577	50.46

[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 died.

In the November 2020 phone survey, the percentage of female respondents (53.63%) was higher than the male respondents (46.37%). Since we did not conduct the sampling weights, the distribution of respondents' characteristics in these phone surveys represented the entire population of older people in the study area. The percentage of the 60–69 age group is the highest amongst the other three age groups, and the percentage of respondents in DKI Jakarta is the highest amongst the other three provinces.

As for the living location, we used the classification provided by the BPS (*Badan Pusat Statistik*/ Statistics Indonesia).[1] The majority of respondents (92.45%) live in urban areas, and only 7.55% live in rural areas.

Table 2.2: Distribution of Respondents, by Age Group

Characteristics	Age			N
	60–69 Years	70–79 Years	80 Years and Older	
Total	**100**	**100**	**100**	**3,125**
Sex				
Male	66.05	26.71	7.25	1,449
Female	64.38	25.95	9.67	1,676
Living location				
Urban	66.45	25.72	7.83	2,873
Rural	50.40	32.94	16.67	252
Province				
Bali	56.92	31.81	11.27	701
DIY	63.40	24.79	11.81	847
DKI Jakarta	69.75	24.67	5.58	1,577

[1] Classified by the Statistics Indonesia (BPS) based on population density, percentage of farm households, and several urban facilities such as formal education facilities, public health facilities, etc. (Peraturan Kepala Badan Pusat Statistik *Nomor 37 Tahun 2010 Tentang Klasifikasi Perkotaan dan Perdesaan di Indonesia*, 2010/ Regulation of the Head of BPS-Statistics Indonesia Number 37 of 2010 Concerning the Classification of Urban and Rural Areas in Indonesia, 2010).

The respondents are 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 and the entire population by age group in Indonesia. According to the Statistics of Older People 2019, the proportion of the young-old group (60–69 years) is 63.82%, the middle-old group is 27.68%, and the oldest-old (80 years and above) is 8.5% (BPS-Statistic Indonesia, 2019).

The percentage of females in the oldest-old group is higher than their male counterparts. The percentage of older people 70–79 years and 80 years and older in rural areas is higher than those in urban areas. Bali has the highest number of older people aged 70–79, those aged 60-69 years are in DKI Jakarta, and those aged 80 years and above are in DIY. The percentage of female respondents in rural areas and DIY is the highest (Table 2.3).

Table 2.3: Distribution of Respondents, by Sex

Characteristics	Sex		N
	Male	Female	
Total	**100**	**100**	**3,125**
Age			
60–69 years	47.00	53.00	2,036
70–79 years	47.08	52.92	822
80 years and older	39.33	60.67	267
Living location			
Urban	46.64	53.36	2,873
Rural	43.25	56.75	252
Province			
Bali	47.79	52.21	701
DIY	45.81	54.19	847
DKI Jakarta	46.04	53.96	1,577

The number of respondents with caregivers increased from July 2020 (2,960 respondents) to November 2020 (2,983 respondents). However, the distribution of each characteristic did not change much except for the provincial characteristics. In July 2020, the number of respondents with caregivers in Bali is the second-highest after DKI Jakarta. However, in November 2020, the number of respondents in Bali who had a caregiver was the least.

Table 2.4: Characteristics of Respondents Who Have Caregivers

Characteristics	July 2020		November 2020	
	N	%	N	%
Total	**2,960**	**100**	**2,983**	**100**
Sex				
Male	1,385	46.79	1,389	46.56
Female	1,575	53.21	1,594	53.44
Age				
60–69 years	1,872	63.24	1,930	64.7
70–79 years	817	27.6	792	26.55
80 years and older	271	9.16	261	8.75
Living location				
Urban	2,705	91.39	2,739	91.82
Rural	255	8.61	244	8.18
Province				
Bali	716	24.19	674	22.59
DIY	638	21.55	806	27.02
DKI Jakarta	1,606	54.26	1,503	50.39

CHAPTER 3

Economic and Social Protection

1. Income

The COVID-19 pandemic has been raging until early 2021. It is uncertain when this condition, with a prolonged negative impact on the economy, will end. Indonesia has plunged into a recession because of the slowdown in economic activity in 2020. Even though the economy had begun to recover at the end of 2020, such recovery is partial in several sectors (World Bank, 2020). Some sectors relying on direct interaction with customers have not fully recovered.

1.1. Sources of older people's income

The respondents of this phone survey earn their income from various sources (Table 3.1). The July 2020 respondents were asked about their income source before the COVID-19 pandemic. The November 2020 respondents were asked about their income source during the early stage of the COVID-19 pandemic, around March–July 2020.

Table 3.1 shows a decreasing trend in the percentage of some sources. The July 2020 phone survey revealed that respondents whose income source was working were the most affected by the economic slowdown because of a decrease in income (Study Team, 2021b). This was also confirmed by comparing the July 2020 and November 2020 phone surveys. In the July 2020 phone survey, which referred to the pre-pandemic period, respondents who earned income from work reached 36.74% (95% CI: 35.04%–38.45%). However, in the November 2020 survey, which referred to the early stage of the pandemic period, only 30.40% earned their income from work (95% CI: 28.79%–32.05%).

The income source of non-household member children has a high proportion and decreased in percentage from the pre-pandemic to the early period of the pandemic. However, the percentage decrease was not significant. Another source of income, which significantly decreased, was pension ($p<0.01$, McNemar chi-squared test).[1] Respondents earning income from pension decreased by more than 1% point

[1] McNemar chi-squared test is used to test the significance of differences between the two survey rounds for variables with binary data.

from the pre-pandemic period (18.05%, 95% CI: 16.71%–19.44%) than those in the early stage of the pandemic (16.66%, 95% CI: 15.57%–18.22%). All characteristics in both rounds of survey have similar trends, where respondents living in DIY who earn their income from pension have the highest percentage than other provinces ($p<0.001$, Pearson chi-squared test).[2]

Respondents who earned their income from insurance and non-household member spouses also decreased in percentage even though the change was insignificant. Another income source with a decreasing rate is the work of the respondents, non-household children, or non-household spouses. Since non-household children or spouses most probably made their income from work, this finding indicates a weak labour market during the pandemic.

According to the World Bank's panel survey, about 25% of respondents lost their job in May 2020 (World Bank, 2020). More than 13 million people in Indonesia, or approximately 10.55% of the total population aged 15 years and older who still worked in February 2020, were 60 years and older (BPS-Statistics Indonesia, 2020). Such a feeble labour market due to the economic crisis will seriously threaten the older people group as its proportion to the working population is high. Moreover, older workers who lose their jobs tend to have longer unemployment than younger ones. If the older workers are re-hired, the possibility of salary reduction is bigger than younger workers (Zhe et al., 2020).

On the other hand, some income sources had an increasing trend from the pre-pandemic to the early pandemic (Table 3.2). Respondents relying on household members for their daily needs increased more than 7% points from the pre-pandemic (18.25%, 95% CI: 16.90%–19.4%) to the early pandemic (25.70%, 95% CI: 24.17%–27.27%) period.

The trend on almost all characteristics in both rounds is similar, except for the living location. Overall, this indicates that older people without an income apart from household members and who need help in meeting their daily needs increased in the early pandemic than those before the pandemic. Older people's dependence on their families increased during the pandemic because of the older people's limited work opportunities and the lack of pension coverage in Indonesia (Handayani, 2020).

[2] Pearson chi-squared test is used to analyse the significance of association bertween variable and characteristics of respondents

Table 3.1: Source of Respondents' Income, with Decreasing Trend

Characteristics	Source of Income										N
	Work		Children (Non-household Member)		Pension		Insurance		Spouse (Non-household Member)		
	PP[a]	EP[b]	PP	EP	PP	EP	PP	EP	PP	EP	
All respondents	**36.74**	**30.4**	**29.02**	**27.42**	**18.05**	**16.86**	**0.13**	**0.10**	**0.16**	**0.06**	**3,125**
Sex											
Male	45.89	37.47	22.84	23.33	20.98	19.88	0.21	0.14	0.21	0	1,449
Female	28.82	24.28	34.37	30.97	15.51	14.26	0.06	0.06	0.12	0.12	1,676
Age											
60–69 years	43.96	37.82	27.36	26.47	16.90	15.28	0.20	0.10	0.20	0.05	2,036
70–79 years	26.40	19.46	31.51	29.20	21.05	20.32	0	0.12	0	0.12	822
80 years and older	13.48	7.49	34.08	29.21	17.60	18.35	0	0	0.37	0	267
Living Location											
Urban	37.00	30.60	29.55	28.89	18.62	17.19	0.14	0.10	0.17	0.07	2,873
Rural	33.73	28.17	23.02	10.71	11.51	13.10	0	0	0	0	252
Province											
Bali	34.95	28.67	20.26	17.40	14.41	14.41	0.14	0.14	0	0.14	701
DIY	41.91	35.66	12.51	18.89	29.75	27.74	0	0.12	0.35	0.12	847
DKI Jakarta	34.75	28.34	41.79	36.46	13.38	12.11	0.19	0.06	0.13	0	1,577

[a]PP = pre-pandemic

[b]EP = early period of pandemic

Notes: Respondents were allowed multiple answers.

Table 3.2: Source of Respondents' Income, with Increasing Trend

Characteristics	Source of Income								N
	Household Member		Government Social Protection		Family/Relative (Non-household Member)		Rent/ Sharecropping		
	PP[a]	EP[b]	PP	EP	PP	EP	PP	EP	
All respondents	**18.24**	**25.70**	**1.54**	**5.60**	**2.75**	**3.30**	**1.76**	**3.04**	**3,125**
Sex									
Male	12.56	18.15	0.90	5.80	2.62	3.04	2.21	3.38	1,449
Female	23.15	32.22	2.09	5.43	2.86	3.52	1.37	2.74	1,676
Age									
60–69 years	15.77	22.20	0.79	5.65	2.26	3.34	1.82	2.75	2,036
70–79 years	21.05	29.68	2.19	5.72	3.77	3.28	1.58	3.41	822
80 years and older	28.46	40.07	5.24	4.87	3.37	3.00	1.87	4.12	267
Living Location									
Urban	18.90	24.57	1.60	5.67	2.85	3.41	1.81	3.13	2,873
Rural	10.71	38.49	0.79	4.76	1.59	1.98	1.19	1.98	252
Province									
Bali	20.11	34.09	0.29	2.14	2.28	4.71	1.57	3.42	701
DIY	15.47	19.36	2.36	3.31	3.07	1.77	1.77	4.72	847
DKI Jakarta	18.90	25.36	1.65	8.37	2.79	3.49	1.84	1.97	1,577

[a]PP = pre-pandemic

[b]EP = early period of pandemic

Notes: Respondents were allowed multiple answers.

(Table 3.2: Continued)

Characteristics	Source of Income										N
	Saving		Subsistence Farming/ Livestock		Neighbours/ Friends		Private Social Protection		Other		
	PP[a]	EP[b]	PP	EP	PP	EP	PP	EP	PP	EP	
All respondents	**0.74**	**1.34**	**3.84**	**3.87**	**0.26**	**0.67**	**0.29**	**0.42**	**0**	**0.03**	**3,125**
Sex											
Male	0.97	1.79	5.11	6.07	0.07	0.62	0.28	0.55	0	0	1,449
Female	0.54	0.95	2.74	1.97	0.42	0.72	0.30	0.30	0	0.06	1676
Age											
60–69 years	0.69	1.67	3.49	3.49	0.15	0.64	0.15	0.34	0	1	2,036
70–79 years	0.73	0.85	4.99	5.11	0.36	0.61	0.49	0.61	0	0	822
80 years and older	1.12	0.37	3.00	3.00	0.75	1.12	0.75	0.37	0	0.37	267
Living Location											
Urban	0.77	1.39	1.43	2.16	0.28	0.63	0.31	0.38	0	0.03	2,873
Rural	0.40	0.79	31.35	23.41	0	1.19	0	0.79	0	0	252
Province											
Bali	0.43	1.71	14.41	11.41	0	0.86	0	0.57	0	0	701
DIY	0.83	1.65	1.89	4.25	0.24	0.35	0	0.24	0	0.12	847
DKI Jakarta	0.82	1.01	0.19	0.32	0.38	0.76	0.57	0.44	0	0	1,577

[a]PP = pre-pandemic

[b]EP = early period of pandemic

Notes: Respondents were allowed multiple answers.

Before the pandemic, the percentage of respondents living in urban areas who depended on household members for their daily needs was higher than those in rural areas ($p<0.01$, Pearson chi-squared test). In contrast, respondents living in rural areas had a higher percentage in the early stage of the pandemic ($p<0.001$, Pearson chi-squared test). Moreover, even urban and rural respondents who depend on their income on household members significantly increased from before the pandemic to the early pandemic ($p<0.001$, McNemar chi-squared test). The increasing percentage for rural respondents was higher (27.78% points) than urban respondents (5.67% points). It means that the pandemic affects rural respondents more than urban respondents.

Social security from the government as a source of respondents' income during the early pandemic (5.60%, 95% CI: 4.82%–4.46%) drastically increased than before the pandemic (1.54%, 95% CI: 1.13%–2.03%). Indeed, the government's social security increased in the early pandemic compared to those before the pandemic to respond to the economic crisis caused by activity restriction. There was a change in the trend of government social security beneficiaries, where no significant difference existed between male and female respondents in the early period of the pandemic. Nonetheless, more female respondents received social security from the government before the pandemic ($p<0.01$, Pearson chi-squared test). The opposite condition is found in the province's characteristics. In the early months of the pandemic, DKI Jakarta had the highest percentage of social security beneficiaries from the government compared to other provinces ($p<0.001$, Pearson chi-squared test). However, there was no significant difference in percentage before the pandemic.

Even though the percentage is low, both rent and profit-sharing and savings increased significantly to almost twice from the pre-pandemic to the early period of the pandemic ($p<0.01$ for both, McNemar chi-squared test). Respondents who earned their income from rent and profit-sharing before the pandemic comprised 1.76% (95% CI: 1.33%–2.28%), while in the pandemic's early months, they reached 3.04% (95% CI: 2.47%–3.70%). Before the pandemic, 0.74% of respondents (95% CI: 0.05%–1.10%) earned their source of income from savings. Subsequently, that percentage increased to 1.34% (95% CI: 0.10%–1.81%) in the early period of the pandemic.

The percentage of other income sources – income from family or relatives, subsistence farming, and private social protection – increased but not significantly. Most income sources that significantly increased cannot be categorised as productive sources; they seemed to be a response to meeting the needs of the elderly in the early period of the pandemic, who were most likely to be affected by changes in income.

Tables 3.1 and 3.2 show the multiple responses of older people, indicating that some respondents have more than one income source (Table 3.3).

In the two survey rounds, the number of sources of respondents' income from non-household members significantly changed ($p<0.05$, Wilcoxon signed-rank test).[3] The percentage of respondents with only one source of income from a non-household member in the early months of the pandemic (58.05%, 95% CI: 56.29%–59.78%) decreased by around 11% points compared to those before the pandemic (69.38%, 95% CI: 67.73%–70.90%). Meanwhile, respondents who had two, three, and four sources of income from non-household members in the early part of the pandemic increased by about 1%–3% points.

Table 3.3: Number of Sources of Income

Characteristics	Income from Household Member (%)		Number of Income Sources from Non-household Member (%)								N
			1		2		3		4		
	PP[a]	EP[b]	PP	EP	PP	EP	PP	EP	PP	EP	
All respondents	**18.24**	**25.70**	**69.38**	**58.05**	**11.30**	**13.92**	**1.06**	**2.14**	**0.03**	**0.19**	**3,125**
Sex											
Male	12.56	18.15	74.12	64.73	11.87	14.42	1.38	2.35	0.07	0.35	1,449
Female	23.15	32.22	65.27	52.27	10.80	13.48	0.78	1.97	0	0.06	1,676
Age											
60–69 years	15.77	22.20	71.81	60.71	11.20	14.64	1.18	2.21	0.05	0.25	2,036
70–79 years	21.05	29.68	65.82	54.26	12.17	13.87	0.97	2.07	0	0.12	822
80 years and older	28.46	40.07	61.80	49.44	9.36	8.61	0.37	1.87	0	0	267
Living Location											
Urban	18.90	24.57	68.78	59.31	11.24	14.10	1.04	1.91	0.03	0.10	2,873
Rural	10.71	38.49	76.19	43.65	11.90	11.90	1.19	4.76	0	1.19	252
Province											
Bali	20.11	34.09	71.75	50.64	7.42	11.7	0.71	2.85	0	0.71	701
DIY	15.47	19.36	74.85	64.23	9.21	14.52	0.47	1.89	0	0	847
DKI Jakarta	18.90	25.36	65.38	58.02	14.14	14.58	1.52	1.97	0.06	0.06	1,577

[a]PP = pre-pandemic
[b]EP = early period of pandemic

Notes: Respondents were allowed multiple answers.

[3] Wilcoxon signed-rank test is used to test the significance of the difference between two rounds of survey with ordinal data.

Female respondents experienced a significant change in the number of income sources ($p<0.05$, Wilcoxon signed-rank test). The percentage of female respondents with only one source of income from non-household members in the early period of the pandemic (52.27%, 95% CI: 49.84%–54.68%) decreased by about 13% points compared to those before the pandemic (65.27%, 95% CI: 62.94%–67.55%). Meanwhile, female respondents who had two or three income sources in the early stage of the pandemic increased by around 1%–3% points.

Based on the age group, respondents aged 70–79 years and 80 years and older experienced a significant change in the number of income sources from non-household members ($p<0.05$ for each, Wilcoxon signed-rank test). Respondents in the 70–79 age group who only had one source of income in the early months of the pandemic (54.26%, 95% CI: 50.78%–57.70%) decreased by 12% points compared to those before the pandemic (65.82%, 95% CI: 62.46%–69.06%). Those aged 80 years and older who only had one source of income in the early part of the pandemic (49.44%, 95% CI: 43.29%–55.60%) decreased by 12% points compared to those before the pandemic (61.80%, 95% CI: 55.68%–67.65%). Respondents from both age groups who had two, three, or four income sources in the early months of the pandemic increased by about 0.12%–2% points than those before the pandemic.

The number of income sources of respondents living in rural areas also significantly changed ($p<0.01$, Wilcoxon signed-rank test). Rural respondents who had only one source of income from non-household members in the early pandemic period decreased (43.65%, 95% CI: 37.43%–50.02%) by around 32% points compared to those before the pandemic (76.19%, 95% CI: 70.44%–81.31%). Otherwise, respondents who had three sources of income increased by almost 4% points, and those with four sources of income increased by more than 1% point.

Amongst the three provinces, only respondents in DKI Jakarta experienced a significant change in the source of income ($p<0.01$, Wilcoxon signed-rank test). Respondents who only had one source of income in the early months of the pandemic (58.02%, 95% CI: 55.54%–60.47%) decreased by about 7% points than those before the pandemic (65.38%, 95% CI: 62.97%–67.73%). On the contrary, respondents who had two or three sources of income increased by about 0.5% points, respectively.

1.2 Change in older people's income

The survey results show that older people's income declined in November 2020. Nevertheless, the percentage of respondents with decreasing income fell by 15% points than in July 2020 ($p<0.001$, McNemar chi-squared test). The percentage of respondents whose income decreased in November 2020 (38.75%, 95% CI: 37.04%–40.49%) was lower than July 2020 (54.18%, 95% CI: 52.41%–55.93%). This result indicates that the economy was recovering slowly in November 2020 than

in July 2020 and the early pandemic. World Bank's December 2020 Indonesian Economics Prospects concluded that the Indonesian economy is gradually recovering following the partial reopening of the domestic and global economies after being severely affected by the COVID-19 pandemic in the second quarter (World Bank, 2020)"BPS-Statistics Indonesia data confirmed that implicit growth of GDP in the fourth quarter (1.31%) is greater than in the second (-1.87%) and third quarter (0.54%) of 2020 (BPS-Statistics Indonesia, n.d.).

Table 3.4: Income Changes of Older People

Characteristics	July 2020			November 2020		
	Decreased (%)	The Same/ Increased (%)	N	Decreased (%)	The Same/ Increased (%)	N
All respondents	**54.18**	**45.82**	**3,125**	**38.75**	**61.25**	**3,125**
Sex						
Male	56.18	43.82	1,449	41.20	58.80	1,449
Female	52.45	47.55	1,676	36.63	63.37	1676
Age						
60–69 years	58.69	41.31	2,036	43.37	56.63	2,036
70–79 years	48.05	51.95	822	32.97	67.03	822
80 years and older	38.58	61.42	267	21.35	78.65	267
Living Location						
Urban	53.01	46.99	2,873	39.23	60.77	2,873
Rural	67.46	32.54	252	33.33	66.67	252
Province						
Bali	58.92	41.08	701	37.95	62.05	701
DIY	42.74	57.26	847	31.88	68.12	847
DKI Jakarta	58.21	41.79	1,577	42.80	57.20	1,577

Table 3.4 shows older people's income in both rounds of phone surveys. Significantly, more male respondents experienced decreased income in November 2020 than female respondents ($p<0.01$, Pearson chi-squared test). The trend is similar to those in July 2020, whereas those aged 60–69 years who reported a decrease in income have the highest percentage than the other age groups in both survey rounds.

Although the percentage of respondents whose income decreased significantly declined in all living locations ($p<0.001$, McNemar chi-squared test for both) in

November 2020, there was no significant difference in percentage between the groups living in rural and urban areas. This result is different from July 2020: the respondents whose income decreased in rural areas were significantly higher than those in urban areas ($p<0.001$, Pearson chi-squared test).

In November 2020, the percentage of respondents whose income decreased in DKI Jakarta was the highest amongst all three provinces (42.80%, 95% CI: 40.34%–45.29%). Again, there was a change from the July 2020 results, where most respondents whose income decreased were living in Bali (58.92%, 95% CI: 55.17%–62.59%). Meanwhile, those living in DIY remained the fewest in both survey rounds.

1.3 Change in caregiver's income

The number of respondents who had a caregiver in November 2020 was more than in July 2020 (Table 2.4). In July 2020, 2,960 respondents (about 86%) had a caregiver. Meanwhile, in November 2020, respondents who had a caregiver totalled 2,983, or about 95%. Regardless of the number of caregivers, the percentage of caregivers with decreased income changed (Table 3.5).

Table 3.5. Income Changes of Caregivers

Characteristics	July 2020			November 2020		
	Decreased (%)	The Same/ Increased (%)	N	Decreased (%)	The Same/ Increased (%)	N
Respondents who had caregiver	**61.55**	**38.45**	**2,692**	**48.47**	**51.53**	**2,983**
Sex						
Male	58.33	41.67	1,255	47.95	52.05	1,389
Female	64.37	35.63	1,437	48.93	51.07	1,594
Age						
60–69 years	61.61	38.39	1,706	46.99	53.01	1,930
70–79 years	60.86	39.14	741	53.03	46.97	792
80 years and older	63.27	36.73	245	45.59	54.41	261
Living Location						
Urban	59.74	40.26	2,444	46.26	53.74	2,739
Rural	79.44	20.56	248	73.36	26.64	244
Province						
Bali	74.88	25.12	645	66.77	33.23	674
DIY	52.36	47.64	615	39.08	60.92	806
DKI Jakarta	59.50	40.50	1,432	45.31	54.69	1,503

The trend in caregivers' income from July 2020 to November 2020 is similar to the respondents' income. Some caregivers experienced a decline in income in November 2020 (48.47%, 95% CI: 46.67%–50.28%), although the percentage to total caregivers fell by around 13% points compared to July 2020 (61.55%, 95% CI: 59.68%–63.39%).

In November 2020, caregivers of respondents aged 70–79 years whose income decreased were significantly the highest ($p<0.01$, Pearson chi-squared test). This condition changed from July 2020, when no significant difference was seen between the percentage of caregivers whose income decreased in all three age groups.

In the two survey rounds, the percentage of caregivers whose income decreased and living in rural areas was higher than those in urban areas ($p<0.01$ for each, Pearson chi-squared test). Based on the province, the percentage of caregivers with decreased income in Bali was the highest, whereas DIY was the lowest ($p<0,001$, Pearson chi-squared test).

1.4 Impact of income changes on food consumption

The decrease in income experienced by some respondents in November 2020 can potentially reduce older people's quality of life. The impact of decreased income on the respondents' food consumption is shown in Table 3.6.

The number of respondents whose income decreased was smaller. Regardless of the difference in total respondents whose income decreased, the percentage of respondents who felt various impacts caused by the lesser income also changed.

The most impact felt by respondents was reducing the food quality. It means they consumed cheaper food with worse quality than before their income decreased. The percentage of respondents who experienced this impact declined in November 2020. Respondents who reported reducing their food quality in November 2020 (37.99%, 95% CI: 35.24%–40.79%) decreased by approximately 4% points compared to July 2020 (42%, 95% CI: 39.63%–44.39%).

The lowest percentage of respondents who reported reduced food quality based on age category changed from July to November 2020. In July 2020, it came from those aged 70–79 years group ($p<0.05$, Pearson chi-squared test), while in November 2020, it came from the 80 years and older age group ($p<0.05$, Pearson chi-squared test). Respondents with lower food quality due to income decrease in July 2020 reached 41.75% (95% CI: 32.10%–51.88%); subsequently, in November 2020, the percentage reached only 24.56% (95% CI: 14.17%–37.76%).

Table 3.6: Impact of Income Changes on Food Consumption

Characteristics	Impact on Food Consumption (%)										N	
	Reduce the Frequency/ Amount of Meals		Reduce the Quality of Meals		Use Some/All Savings to Afford Daily Meals		Other		No Change			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov
Respondents whose income decreased	**16.77**	**18.08**	**42.00**	**37.99**	**2.42**	**2.89**	**0**	**0.17**	**47.78**	**50.04**	**1,693**	**1,211**
Sex												
Male	17.20	17.92	41.28	39.53	1.97	2.51	0	0.34	48.53	48.41	814	597
Female	16.38	18.24	42.66	36.48	2.84	3.26	0	0	47.10	51.63	879	614
Age												
60–69 years	16.82	18.23	43.68	39.64	2.59	2.94	0	0.11	46.44	49.04	1,195	883
70–79 years	17.47	19.93	36.96	35.42	1.77	2.95	0	0.37	51.65	49.08	395	271
80 years and older	13.59	7.02	41.75	24.56	2.91	1.75	0	0	48.54	70.18	103	57
Living Location												
Urban	17.27	17.21	42.09	37.62	2.56	3.02	0	0.18	47.41	50.58	1,523	1,127
Rural	12.35	29.76	41.18	42.86	1.18	1.19	0	0	51.18	42.86	170	84
Province												
Bali	20.58	19.92	38.01	49.25	1.45	4.89	0	0	45.28	40.23	413	266
DIY	8.84	14.81	31.77	24.07	4.97	3.33	0	0.37	58.56	62.96	362	270
DKI Jakarta	18.19	18.67	47.82	39.11	1.85	1.93	0	0.15	44.66	48.74	918	675

Notes: Respondents were allowed multiple answers.

The change in trend between the two rounds of phone surveys also applied in the living location. The percentage of respondents in rural areas with reduced food quality was higher than in urban areas in November 2020. Meanwhile, in July 2020, respondents in urban areas were more likely to reduce their food quality.

The next impact felt by respondents is the reduction in the frequency of meals. Respondents felt this impact increased from July 2020 to November 2020. In November 2020, the percentage of respondents who reduced the frequency of their meals (18.08%, 95% CI: 15.95%–20.37%) increased by more than 1% point compared to July 2020 (16.77%, 95% CI: 15.02%–18.64%). However, respondents aged 80 years and older who reduced the frequency of meals in November 2020 (7.02%, 95% CI: 1.94%–17.00%) decreased by 7% points from July 2020 (13.59%, 95% CI: 7.63%–21.75%).

Conversely, the percentage of respondents living in rural areas who reduced the frequency or quantity of their meals in November 2020 increased. The percentage of respondents with reduced frequency of meals rose from 12.35% (95% CI: 7.81%-18.26%) in July 2020 to 29.76%(95%CI: 20.27%-40.73%) in November 2020.

Respondents who did not feel the impact of decreased income comprised the largest percentage, and increased from July to November 2020. In November 2020, respondents who did not feel any impact increased by about 2% points (50.04%, 95% CI: 47.19%–52.89%) from those in July 2020 (47.7%, 95% CI: 45.38%–50.20%).

Along with this negative impact, respondents made various efforts to overcome their decreased income. Respondents carried out several strategies to overcome decreased income from July 2020 to November 2020.

In July 2020, more than half of the respondents stated that they did nothing to overcome the income decline (58.12%, 95% CI: 55.73%–60.48%). However, in November 2020, respondents who chose not to do anything reduced by about half (24.69%, 95% CI: 22.28%–27.22%). This indicates that, in November 2020, most respondents were more aware of doing something to overcome the fall in their income. They had more flexible access to activities than during the early months of the pandemic when the restrictions were very tight.

Almost all strategies have a diminishing trend, except for reduced spending. In July 2020, respondents who chose that strategy comprised only 1.89% (95% CI: 1.30%–2.66%). Nonetheless, in November 2020, more than half of the respondents were trying to reduce spending (57.31%, 95% CI: 54.56%–60.11%). In November 2020, respondents had started to adjust their spending patterns with decreased income conditions compared to the early period of the pandemic. Respondents living in the rural areas were more likely to reduce spending in November 2020 than those in urban areas ($p<0.001$, Pearson chi-squared test). Based on the

province, respondents in Bali ($p<0.01$, Pearson chi-squared test) made the most efforts to reduce their expenditure, while respondents from DKI Jakarta were the least ($p<0,001$, Pearson chi-squared test).

One strategy that drastically decreased is asking for help from family members, communities, or companies with better economic conditions. Respondents who chose this strategy in November 2020 (9%, 95% CI: 7.45%–10.75%) were approximately half compared to those in July 2020 (18.19%, 95% CI: 16.38%–20.11%). In addition, in November 2020, no respondents aged 80 years or older chose this strategy.

The percentage of respondents who used their savings in November 2020 also decreased by almost half (3.06%, 95% CI: 2.16%–4.19) compared to those in July 2020 (7%, 95% CI: 6.18%–8.73%). In July 2020, respondents in DIY who used their savings had the highest percentage ($p<0,05$, Pearson chi-squared test), while in November 2020, respondents in Bali reached the highest ($p<0,001$, Pearson chi-squared test). This condition indicated that older people's savings are limited and cannot be an alternative solution in the long term.

2. Assistance

The COVID-19 pandemic triggered an economic crisis that increased poverty. Unemployment and decreasing income during the pandemic worsened the poverty level and pushed more people to fall into poverty. According to the BPS-Statistics Indonesia, the percentage of poor people in September 2020 was 10.19%, an increase of 0.41% points against March 2020 and 0.97% points against September 2019 (BPS-Statistics Indonesia, 2021). As a response to the pandemic's impact on poverty, the Indonesian government issued a fiscal stimulus package in the form of expanded social assistance and increased benefit levels. Based on a simulation exercise by the Ministry of National Development Planning (Bappenas), without any special interventions, the national poverty rate will be around 11.12%, which implies a potential increase in the number of poor people of 5.2 million (Aulia and Maliki, 2021).

In line with the Bappenas simulation, the World Bank's simulation shows that government social assistance could significantly mitigate this impact. However, initial delays and difficulties in reaching some affected groups have likely reduced the impact of the social assistance package.

Thus, coverage, adequacy, and responsiveness of the social assistance package should be continuously monitored and improved to protect the poor and other vulnerable groups (World Bank, 2020).

Table 3.7: Coping Strategy Against Income Decrease during the Pandemic

Characteristics	Strategy Against Income Decrease (%)								N	
	Reduce Spending		Do Nothing		Ask for Assistance from Richer Family/ Relatives		Use Savings			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov
Respondents whose income decreased	**1.89**	**57.31**	**58.12**	**24.69**	**18.19**	**9.00**	**7.38**	**3.06**	**1,693**	**1,211**
Sex										
Male	1.97	55.95	57.13	22.61	18.55	10.05	7.00	2.68	814	597
Female	1.82	58.63	59.04	26.71	17.86	7.98	7.74	3.42	879	614
Age										
60–69 years	1.84	59.68	57.15	21.97	17.32	9.17	8.03	3.06	1,195	883
70–79 years	2.03	50.55	58.48	31.37	21.77	10.33	5.82	2.58	395	271
80 years and older	1.94	52.63	67.96	35.09	14.56	0	5.83	5.26	103	57
Living Location										
Urban	1.90	55.90	57.26	25.55	19.11	9.23	7.94	3.19	1,523	1,127
Rural	1.76	76.19	65.88	13.10	10.00	5.95	2.35	1.19	170	84
Province										
Bali	1.45	66.54	59.81	19.17	14.53	10.15	4.84	7.14	413	266
DIY	0.55	60.37	46.69	20.00	27.07	8.15	10.5	4.07	362	270
DKI Jakarta	2.61	52.44	61.87	28.74	16.34	8.89	7.30	1.04	918	675

Notes: Respondents were allowed multiple answers.

Table 3.7: Continued

Characteristics	Strategy Against Income Decrease (%)										N	
	Look for a New Job		Take Loan		Pawn Assets		Sell Assets		Extend Working Hours			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov
Respondents whose income decreased	**7.74**	**7.60**	**6.91**	**5.28**	**0.59**	**0.41**	**2.89**	**2.06**	**1.48**	**0.41**	**1,693**	**1,211**
Sex												
Male	9.21	9.38	7.00	5.86	0.61	0.34	2.70	1.17	1.72	0.84	814	597
Female	6.37	5.86	6.83	4.72	0.57	0.49	3.07	2.93	1.25	0	879	614
Age												
60–69 years	8.28	8.38	7.11	5.89	0.75	0.45	3.01	2.04	1.76	0.45	1,195	883
70–79 years	6.08	5.54	7.34	3.32	0.25	0.37	3.04	2.21	1.01	0.37	395	271
80 years and older	7.77	5.26	2.91	5.26	0	0	0.97	1.75	0	0	103	57
Living Location												
Urban	7.22	7.72	7.09	4.61	0.66	0.44	3.02	2.04	1.44	0.44	1,523	1,127
Rural	12.35	5.95	5.29	14.29	0	0	1.76	2.38	1.76	0	170	84
Province												
Bali	9.20	4.14	11.38	11.65	0	0.75	2.18	1.88	1.45	0	413	266
DIY	10.22	9.63	5.52	4.44	1.10	0	3.04	4.81	1.10	0	362	270
DKI Jakarta	6.10	8.15	5.45	3.11	0.65	0.44	3.16	1.04	1.63	0.74	918	675

Notes: Respondents were allowed multiple answers.

The Indonesian government expanded social assistance in several forms (Aulia and Maliki, 2021). Several social assistance programs were provided for targeted groups based on the Integrated Social Welfare Database (*Data Terpadu Kesejahteraan Sosial*, DTKS). Such programs are the Family Hope Program (*Program Keluarga Harapan*, PKH), *Sembako* program and other food assistance, unconditional cash transfer (BLT and BST), and electricity subsidies. In addition, another unconditional cash transfer or in-kind assistance was provided by the village fund (*dana desa*) to those not registered in the DTKS.

Besides the government programs mentioned, Indonesians also have a mutual assistance system amongst community members, a form of social capital in the community. Community members collect funds or goods from amongst themselves to distribute to vulnerable groups, including older people. This kind of support and assistance help the community ease the burden caused by the pandemic.

The finding of the July 2020 phone survey analysis showed that some older people whose income decreased did not receive any social assistance. Still, some whose income remained stable or increased received assistance. Therefore, the November 2020 follow-up phone survey aimed to monitor the aid respondents received after the July 2020 interview.

2.1. Assistance for all respondents during the pandemic

Some respondents received assistance from the government and other parties in both survey rounds (Table 3.8). Respondents were asked about the four types of assistance. Out of the four types, three beneficiaries decreased from July 2020 to November 2020. Meanwhile, the beneficiaries of the BLT (*Bantuan Langsung Tunai*) or the BST (*Bantuan Sosial Tunai*), both unconditional cash transfer programs, did not significantly increase from July 2020 to November 2020.

The three types of assistance that have fewer beneficiaries from July 2020 to November 2020 were (i) the PKH for older people ($p<0.05$, McNemar chi-squared test); (ii) non-cash food assistance ($p<0.001$, McNemar chi-squared test); and (iii) assistance from the community, the private sector, and the NGOs ($p<0.001$, McNemar chi-squared test).

Since the beneficiary of PKH is at the household level, PKH beneficiaries here means older people living with PKH families. Older people living with PKH families in November 2020 (6.34%, 95% CI: 5.51%–7.25%) decreased by 1% point compared to July 2020 (7.10%, 95% CI: 6.23%–8.06%). Older people living with PKH families in July 2020 and November 2020 are similar in several characteristics, except for the respondents' income. In the PKH scheme, older people are not mandatory beneficiaries. A poor household can be a PKH beneficiary if it has children or pregnant women, while older people and household members with

Table 3.8: Types of Assistance Received by Respondents during the Pandemic

Characteristics	Type of Assistance (%)								N	
	PKH for Older People		BLT/BST (Unconditional Cash Transfer)		Non-cash Food Assistance from Central or Local Government		Assistance from the Community/ Private/NGOs			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov		
All Respondents	**7.10**	**6.34**	**10.94**	**11.52**	**56.48**	**50.53**	**38.08**	**27.97**	**3,125**	
Sex										
Male	6.83	6.07	10.97	11.53	57.21	51.28	37.54	27.74	1,449	
Female	7.34	6.56	10.92	11.52	55.85	49.88	38.54	28.16	1,676	
Age										
60–69 years	5.21	4.27	11.00	11.79	59.63	54.52	37.43	26.52	2,036	
70–79 years	9.25	8.52	10.71	10.71	53.04	46.23	38.69	30.66	822	
80 years and older	14.98	15.36	11.24	11.99	43.07	33.33	41.20	30.71	267	
Living Location										
Urban	7.52	6.72	9.29	9.82	58.27	52.77	38.04	28.40	2,873	
Rural	2.38	1.98	29.76	30.95	36.11	25.00	38.49	23.02	252	
Province										
Bali	1.57	1.14	13.12	15.69	32.81	18.69	46.79	31.24	701	
DIY	11.45	9.09	19.24	20.43	21.37	14.99	41.20	19.72	847	
DKI Jakarta	7.23	7.17	5.52	4.88	85.86	83.77	32.53	30.94	1,577	
Income									**Jul**	**Nov**
Decrease	6.56	6.69	12.64	11.89	62.08	58.38	38.69	30.55	1,693	1,211
Same/Increase	7.75	6.11	8.94	11.29	49.86	45.56	37.36	26.33	1,432	1,914

NGO = non-governmental organisation.

Notes: Respondents were allowed multiple answers.

a disability are the additional components. When the children have graduated from school, and there is no pregnant woman, the poor household is not eligible anymore for PKH assistance. The decreasing trend of older people who received a PKH in November 2020 was most probably caused by decreasing mandatory beneficiaries in older people's households since, in that period, the Indonesian government did not reduce the PKH beneficiaries at the aggregate level. Delay in distribution might also be another reason of respondents who answered they did not receive the assistance.

Respondents who received non-cash food assistance in the form of nine basic food commodities (*Sembilan Bahan Pokok, sembako*) provided by the central or local government in November 2020 (50.53%, 95% CI: 48.76%–52.29%) decreased

by almost 6% points than those in July 2020 (56.48%, 95% CI: 54.72%–58.22%). The trend of the beneficiaries in all respondent characteristics is similar between July 2020 and November 2020. A significant reduction in non-cash food assistance, along with a slight increase in the BLT or the BST, indicates that cash assistance is preferable to in-kind or non-cash assistance during a prolonged pandemic. Indeed, cash assistance is more effective in driving the economy (Ministry of Social Affairs-Kementerian Sosial RI, 2021; Zuraya, 2020).

A declining percentage is also found in the beneficiaries of assistance from community groups, the private sector, and NGOs. Respondents who received assistance from the community, the private sector, and the NGOs in November 2020 (27.97%, 95% CI: 26.40%–19.58%) decreased by about 10% points than those in July 2020 (38.08%, 95% CI: 36.37%–39.81%). Beneficiaries of this assistance living DKI Jakarta did not significantly change between the two survey rounds, while those in the other two provinces decreased from July 2020 to November 2020. This type of assistance is voluntary and spontaneous in emergency response during the pandemic, so it is very likely unsustainable.

Table 3.9 shows the reduced assistance received by respondents in November 2020. The number of assistance respondents received significantly changed from July 2020 to November 2020 ($p<0.001$, Wilcoxon signed-rank test). The percentage of respondents who received only one type of assistance and those who did not receive any assistance increased in November 2020. Otherwise, the percentage of respondents who received more than one type of assistance decreased in November 2020.

Those who did not receive any assistance in November 2020 (29.92%, 95% CI: 28.32%–31.56%) increased by about 6% points than in July 2020 (23.68%, 95% CI: 22.30%–25.21%). Meanwhile, respondents who received only one type of assistance in November 2020 (47.33%, 95% CI: 45.56%–49.10%) increased by about 1% point than those in July 2020 (46.08%, 95% CI: 44.32%–47.85%). The beneficiaries of two types of assistance in November 2020 decreased by more than 5% points from July 2020. In contrast, those who received more than three types of assistance decreased by almost half from 4.52% (95% CI: 3.36%–5.53%) to 2.88% (95% CI: 1.74%–3.42%).

The decreasing trend of assistance received by respondents in November 2020 came from non-cash food assistance financed by the village fund (*dana desa*) and other voluntary emergency response programs provided by NGOs in the early period of the pandemic.

In the early period of the pandemic, many people provided cash and in-kind assistance to their neighbours or communities affected by the pandemic, including

Table 3.9: Number of Assistance Types Received by Respondents during the Pandemic

Characteristics	Number of Types of Assistance (%)										N	
	Not Received at All		1		2		3		4			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov		
All Respondents	**23.68**	**29.92**	**46.08**	**47.33**	**24.96**	**19.55**	**4.51**	**2.88**	**0.77**	**0.32**	**3,125**	
Sex												
Male	22.02	28.71	48.72	49.00	24.43	19.53	4.35	2.48	0.48	0.28	1,449	
Female	25.12	30.97	43.79	45.88	25.42	19.57	4.65	3.22	1.01	0.36	1,676	
Age												
60–69 years	20.97	27.70	49.61	50.15	25.05	19.70	3.93	2.26	0.44	0.20	2,036	
70–79 years	27.25	32.36	41.61	43.80	24.57	19.71	5.35	3.65	1.22	0.49	822	
80 years and older	33.33	39.33	32.96	36.70	25.47	17.98	6.37	5.24	1.87	0.75	267	
Living Location												
Urban	23.36	29.10	46.12	47.69	25.41	19.94	4.28	2.96	0.84	0.31	2,873	
Rural	27.38	39.29	45.63	43.25	19.84	15.08	7.14	1.98	0	0.4	252	
Province												
Bali	34.09	47.08	41.37	40.66	20.68	10.84	3.85	1.28	0	0.14	701	
DIY	41.20	53.72	32.94	31.40	18.77	12.04	5.55	2.60	1.53	0.24	847	
DKI Jakarta	9.64	9.51	55.23	58.85	30.18	27.46	4.25	3.74	0.70	0.44	1,577	
Income											**Jul**	**Nov**
Decrease	18.90	22.30	48.67	52.11	26.58	21.72	5.26	3.55	0.59	0.33	1,693	1,211
Same/Increase	29.33	34.74	43.02	44.31	23.04	18.18	3.63	2.46	0.98	0.31	1,432	1,914

older people. This is shown by the July 2020 phone survey result, where more than half of the respondents (54.98%, 95% CI: 53.21–56.73%) received assistance from individuals and/or groups living in the same village, *dusun*, *rukun warga*, or *banjar* (in Bali). Next, in the November 2020 phone survey, the respondents who received this type of assistance significantly decreased ($p<0.001$, McNemar chi-squared test) by approximately 38% points (16.77%, 95% CI: 15.45%–18.12%).

There is a significant difference in the percentage of beneficiaries between the provinces in July 2020 ($p<0.001$, Pearson chi-squared test). The largest percentage of those who received this assistance were Bali, DKI Jakarta, while DIY had the smallest percentage. However, in November 2020, respondents in DKI Jakarta received the most assistance, while beneficiaries of this assistance in DIY remained the least ($p<0.001$, Pearson chi-squared test).

Table 3.10: Percentage of Respondents Who Receive Assistance during the Pandemic from Individuals and/or Groups Living in the Same Village, *Dusun, Rukun Warga,* or *Banjar*

Characteristics	July 2020 Beneficiaries (%)	November 2020 Beneficiaries (%)	N	
All respondents	**54.98**	**16.77**	**3,125**	
Sex				
Male	55.76	16.56	1,449	
Female	54.30	16.95	1,676	
Age				
60–69 years	55.80	16.16	2,036	
70–79 years	54.14	18.13	822	
80 years and older	51.31	17.23	267	
Living Location				
Urban	55.41	17.02	2,873	
Rural	45.63	13.89	252	
Province				
Bali	61.34	15.69	701	
DIY	42.15	9.80	847	
DKI Jakarta	59.04	20.99	1,577	
Income			**Jul**	**Nov**
Decrease	56.76	17.59	1,693	1,211
Same/Increase	52.86	16.25	1,432	1,914

2.2. Assistance for respondents whose income decreased during the pandemic

Respondents whose income decreased declined from July 2020 to November 2020 (Table 3.1). However, despite the difference in the numbers, the percentage of respondents whose income decreased and received some assistance also decreased. Out of four assistance shown in Table 3.11, the percentage of beneficiaries of three assistance decreased in November 2020. Only a percentage of PKH beneficiaries whose income decreased slightly rose.

The beneficiaries of assistance from the community, the private sector, and NGOs have the largest decrease in percentage. Beneficiaries of this assistance in November 2020 (30.55%, 95% CI: 27.97%–33.23%) declined by around 8% points compared to those in July 2020 (38.69%, 95% CI: 36.36%–41.06%). This is quite reasonable considering that this type of assistance was voluntary and initiated as a form of solidarity.

Table 3.11: Types of Assistance Received by Respondents Whose Income Decreased

Characteristics	Type of Assistance (%)								N	
	PKH for Older People		BLT/BST (Unconditional Cash Transfer)		Non-cash Food Assistance from Central or Local Government		Assistance from the Community/ Private/NGOs			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov
Respondents whose income decreased	**6.56**	**6.69**	**12.64**	**11.89**	**62.08**	**58.38**	**38.69**	**30.55**	**1,693**	**1,211**
Sex										
Male	5.65	6.87	12.78	13.07	63.02	57.79	39.80	31.32	814	597
Female	7.39	6.51	12.51	10.75	61.21	58.96	37.66	29.80	879	614
Age										
60–69 years	5.19	4.98	12.80	12.46	63.68	59.34	38.49	28.43	1,195	883
70–79 years	8.86	11.07	12.15	9.59	60.00	56.09	39.49	35.79	395	271
80 years and older	13.59	12.28	12.62	14.04	51.46	54.39	37.86	38.60	103	57
Living Location										
Urban	7.09	7.01	10.18	10.03	65.07	60.51	39.07	31.06	1,523	1,127
Rural	1.76	2.38	34.71	36.90	35.29	29.76	35.29	23.81	170	84
Province										
Bali	1.45	0.75	17.68	16.92	30.75	20.68	45.28	34.96	413	266
DIY	11.33	9.63	25.69	23.33	28.45	19.63	46.41	24.44	362	270
DKI Jakarta	6.97	7.85	5.23	5.33	89.43	88.74	32.68	31.26	918	675

NGO = non-governmental organisation, PKH = *Program Keluarga Harapan:* Family Hope Program/Conditional Cash Transfer programme.

Notes: The respondents were allowed multiple answers.

Thus, this assistance was rampant in the early part of the pandemic as an emergency response to affected groups and those who could not adapt to the pandemic conditions. However, over the prolonged pandemic, the initiative to raise assistance from communities or agencies diminished, as well as the resources used for assistance.

Non-cash food assistance, which has the largest percentage of beneficiaries, also decreased by almost 4% points in November (58.38%, 95% CI: 55.55%–61.75%) compared to July 2020 (62.08%, 95% CI: 59.72%–64.40%). Likewise, the BLT or BST beneficiaries decreased by 1% point in November 2020 (11.89%, 95% CI: 10.12%–13.85%) than July 2020 (12.64%, 95% CI: 11.09%%–13.85%). Many local governments also provided BLT/BST and assistance as the emergency response for the pandemic to help those not covered by assistance from the central government. However, as the pandemic prolonged, assistance from the local government and the village fund decreased, usually due to the limited fiscal capacity of the regions.

Older people living in PKH families slightly rose by 0.13% points in November 2020 than those in July 2020. It indicates that the expansion of PKH assistance during the pandemic reached the elderly with declining incomes accurately.

Respondents whose income decreased also experienced a declining trend of assistance in November 2020 (Table 3.12). The percentage of respondents whose income decreased and did not receive any assistance in November 2020 (22.30%, 95% CI: 19.98%–24.75%) rose by about 3% points compared to July 2020 (18.90%, 95% CI: 17.06%–20.85%). The increase is lower than the percentage of all respondents who did not receive assistance (Table 3.9), which increased by about 6% points.

In contrast, the percentage of respondents whose income decreased and received only one type of assistance in November 2020 (52.11%, 95% CI: 49.25%–54.95%) rose about 3% points compared to July 2020 (48.67%, 95% CI: 46.26%–51.08%). Meanwhile, the increasing percentage in all respondents was only 1% point (Table 3.9). It means the probability of respondents whose income decreased to receive one type of assistance was higher than all respondents.

The decreasing percentage of respondents whose income declined and received more than one type of assistance (6.83% points) is also lower than the percentage of all respondents, which reached 7.49% points (Table 3.9). Thus, it indicates that although the assistance received by respondents tended to fall in November 2020, respondents whose incomes decreased were less likely to lose their assistance.

Table 3.12: Number of Types of Assistance Received by Respondents Whose Income Decreased

Characteristics	Number of Types of Assistance (%)										N	
	Not Received at All		1		2		3		4			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov
Respondents whose income decreased	**18.90**	**22.30**	**48.67**	**52.11**	**26.58**	**21.72**	**5.26**	**3.55**	**0.59**	**0.33**	**1,693**	**1,211**
Sex												
Male	16.09	21.27	52.09	52.6	26.66	22.28	4.79	3.52	0.37	0.34	814	597
Female	21.50	23.29	45.51	51.63	26.51	21.17	5.69	3.58	0.80	0.33	879	614
Age												
60–69 years	17.15	22.31	50.96	53.34	26.78	21.29	4.77	2.94	0.33	0.11	1,195	883
70–79 years	20.51	22.88	46.58	48.71	26.08	22.14	5.57	5.54	1.27	0.74	395	271
80 years and older	33.01	19.30	30.10	49.12	26.21	26.32	9.71	3.51	0.97	1.75	103	57
Living Location												
Urban	17.99	21.92	48.85	51.91	27.58	22.18	4.92	3.64	0.66	0.35	1,523	1,127
Rural	27.06	27.38	47.06	54.76	17.65	15.48	8.24	2.38	0	0	170	84
Province												
Bali	33.66	40.23	42.62	47.74	18.64	10.53	5.08	1.50	0	0	413	266
DIY	31.77	45.56	35.08	36.30	24.31	14.07	7.18	3.70	1.66	0.37	362	270
DKI Jakarta	7.19	5.93	56.75	60.15	31.05	29.19	4.58	4.30	0.44	0.44	918	675

Ideally, older people whose income decreased should receive social assistance. Nonetheless, some obstacles, such as a limited government budget and lack of updated data, hindered the social assistance programs to optimally reach all older people in need (Handayani, 2020).

More than half of respondents whose income decreased (56.76%, 95% CI: 54.36%–59.14%) received assistance from individuals and/or groups living in the same village, *dusun, rukun warga,* or *banjar* in July 2020. However, in November 2020, the number of respondents who received this assistance dropped by around 39% points (17.59%, 95% CI: 15.48%–19.85%). Comparing the percentage of beneficiaries of assistance to all respondents in Table 3.10, which decreased by 38% points, the decline in respondents whose income decreased and received this assistance is slightly higher. It means that respondents whose income decreased were more likely to lose assistance from individuals or groups who live in the same village, *dusun, rukun warga,* or *banjar* in November 2020. However, the 1% point difference may also be influenced by a decrease in income that people who live in the same village, *dusun, rukun warga,* or *banjar* can potentially experience.

Table 3.13: Percentage of Respondents Whose Income Decreased and Received Assistance from Individuals and/or Groups Living in the Same *Village, Dusun, Rukun Warga,* or *Banjar*

Characteristics	July 2020		November 2020	
	%	N	%	N
Respondents whose income decreased	**56.76**	**1,693**	**17.59**	**1,211**
Sex				
Male	57.13	814	18.76	597
Female	56.43	879	16.45	614
Age				
60–69 years	57.74	1,195	16.53	883
70–79 years	54.43	395	20.66	271
80 years and older	54.37	103	19.30	57
Living Location				
Urban	57.65	1,523	17.66	1,127
Rural	47.06	170	16.67	84
Province				
Bali	57.14	413	14.66	266
DIY	47.24	362	14.81	270
DKI Jakarta	60.35	918	19.85	675

2.3. Comparison of assistance before and during the pandemic

The questions about assistance asked of respondents in the November 2020 phone survey questionnaire were similar to the July 2020 phone survey, with different time references. The previous sections discussed the beneficiaries in July 2020 and November 2020. However, since two types of assistance existed before the pandemic and were asked at the SILANI baseline survey – PKH assistance and non-cash food assistance – the next sections will compare the beneficiaries of these two kinds of assistance in the three survey periods.

2.3.1 PKH assistance before and during the pandemic

The beneficiaries of PKH assistance significantly changed from before the pandemic to July 2020 ($p<0.001$, McNemar chi-squared test) and from July 2020 to November 2020 ($p <0.05$, McNemar chi-squared test). Table 3.14 shows that most respondents never received PKH assistance before or during the pandemic (90.78%, 95% CI: 89.71%–91.77%). It means that only around 9.22% of the respondents received PKH assistance in at least one survey period. Determining the target and submitting the beneficiaries' data into the DTKS *(Data Terpadu Kesejahteraan Sosial:* Unified Database for Social Protection) delayed the distribution of PKH assistance to older people (Handayani, 2020). Therefore, to mitigate the economic impact on vulnerable communities, especially older people, during the pandemic, the government needs to adjust the mechanism.

Most respondents who received PKH assistance continuously in two rounds of phone surveys during the pandemic (3.10%, 95% CI: 2.52%–3.78%) did not receive it before the pandemic. Meanwhile, around 2.75% of respondents (95% CI: 2.21%–3.39%) reported receiving PKH assistance in one of the two rounds during the pandemic. Approximately 2.05% of respondents (95% CI: 1.58%–2.61%) received PKH assistance continuously in the three survey rounds, i.e. before the pandemic and two rounds during the pandemic.

Respondents living in urban areas were more likely to receive PKH assistance. Amongst the three sample provinces, the highest percentage of respondents who received the PKH assistance was in DIY, except those who received it in one or two rounds during the pandemic, which most respondents in DKI Jakarta received. On the other hand, respondents in Bali have the lowest percentage. Neither respondents in rural areas nor Bali received PKH assistance continuously in three or two periods (once before and once during the pandemic).

Table 3.14: PKH Assistance Before and During the Pandemic

Characteristics	PKH Assistance (%)						N
	Received Before and During the Pandemic	Received Before the Pandemic and 1 Round During the Pandemic (2 rounds)	Received During the Pandemic (2 rounds)	Received During the Pandemic (1 round)	Received Before the Pandemic (1 round)	Never Received	
All respondents	**2.05**	**0.38**	**3.10**	**2.75**	**0.93**	**90.78**	**3,125**
Sex							
Male	1.66	0.35	3.04	3.17	1.17	90.61	1,449
Female	2.39	0.42	3.16	2.39	0.72	90.93	1,676
Age							
60–69 years	0.69	0.25	2.5	2.85	0.88	92.83	2,036
70–79 years	3.28	0.49	4.14	2.43	0.97	88.69	822
80 years and older	8.61	1.12	4.49	3.00	1.12	81.65	267
Living Location							
Urban	2.23	0.42	3.27	2.82	0.90	90.36	2,873
Rural	0	0	1.19	1.98	1.19	95.63	252
Province							
Bali	0	0	0.71	1.28	0.43	97.57	701
DIY	5.08	1.06	3.31	2.72	1.65	86.19	847
DKI Jakarta	1.33	0.19	4.06	3.42	0.76	90.23	1,577

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

2.3.2 Non-cash food assistance before and during the pandemic

Non-cash food assistance refers to BPNT (*Bantuan Pangan Non Tunai*) for the baseline SILANI survey. In both rounds of phone surveys during the pandemic, it refers to any kind of nine basic food commodities (*Sembilan Bahan Pokok, sembako*) assistance provided either by the central or local government.

Respondents who never received non-cash food assistance before or during the pandemic reached 38.94% (95% CI: 37.23%–40.67%). This means that most respondents (approximately 61.06%) received non-cash food assistance at least once out of three survey rounds before and during the pandemic. However, recipients of non-cash food assistance before the pandemic until two survey rounds during the pandemic experienced a significant change ($p<0.001$ change from pre-pandemic to July 2020 and $p<0.05$ from July 2020 to November 2020, McNemar chi-squared test).

Most beneficiaries continuously received non-cash food assistance in both survey rounds during the pandemic (42.21%, 95% CI: 40.47%–43.96%). However, only 11.52% of respondents (95% CI: 10.42%–12.69%) received this assistance in one round only during the pandemic. Meanwhile, around 5.15% of respondents received non-cash food assistance continuously in three rounds before and during the pandemic.

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

Characteristics	Non-cash Food Assistance						N
	Received Before and During the Pandemic	Received Before the Pandemic and 1 Round During the Pandemic (2 rounds)	Received During the Pandemic (2 rounds)	Received During the Pandemic (1 round)	Received Before the Pandemic (1 round)	Never Received	
All respondents	**5.15**	**0.77**	**42.21**	**11.52**	**1.41**	**38.94**	**3,125**
Sex							
Male	3.52	0.97	44.51	11.59	1.45	37.96	1,449
Female	6.56	0.60	40.21	11.46	1.37	39.80	1,676
Age							
60–69 years	4.86	0.74	46.71	10.27	0.74	36.69	2,036
70–79 years	5.47	0.49	36.98	13.87	2.07	41.12	822
80 years and older	6.37	1.87	23.97	13.86	4.49	49.44	267
Living Location							
Urban	5.46	0.77	44.34	10.65	1.43	37.35	2,873
Rural	1.59	0.79	17.86	21.43	1.19	57.14	252
Province							
Bali	0.86	0.43	14.27	20.83	0.71	62.91	701
DIY	4.01	2.01	8.74	8.85	4.60	71.78	847
DKI Jakarta	7.67	0.25	72.61	8.81	0	10.65	1,577

More female respondents received non-cash food assistance continuously in the three survey rounds. In comparison, male respondents were more likely to receive this assistance in one or two survey rounds before and during the pandemic. Respondents aged 60–69 years who received food assistance continuously in two survey rounds during the pandemic had the highest percentage. Amongst the three sample provinces, most respondents who received non-cash food assistance continuously in two rounds during the pandemic were from DKI Jakarta. This is in line with the government's non-cash food assistance program during the pandemic in DKI Jakarta and several places around it.

CHAPTER 4

Health

The November 2020 phone survey applied the same instrument as the July 2020 phone survey. Therefore, some indicators and measurements used in this report's analysis have the same standard as the July 2020 phone survey report. For example, this study measured indicators related to physical health such as Instrumental Activities of Daily Living/IADL and morbidity score. In addition, mental health was measured by the modified four-item Geriatric Depression Scale (GDS) (Study Team, 2021c).

As explained in the July 2020 phone survey report, questions used to identify the respondents' mental health condition refer to the five-item GDS. However, one variable related to reluctance to go out of the home might confuse and create ambiguity in answers during the pandemic when older people were encouraged to stay at home. Therefore, we excluded this variable from the analysis. In our analysis, we summed up four variables and identified the score change between each survey round.

1.Physical Health

Table 4.1 shows that in November 2020, more respondents significantly reported that their physical health deteriorated compared to those in July 2020 ($p<0.01$, McNemar chi-squared test). In November 2020, about 21.41% of respondents (95% CI: 19.9%–22.8%) said their health deteriorated, while only 15.52% (95% CI: 14.2%–16.8%) reported the same issue in July 2020. In addition, older respondents were more likely to say that their physical health deteriorated ($p<0.05$, Wilcoxon rank-sum test).

More respondents living in urban areas reported that their physical health deteriorated in November 2020 than in July 2020 ($p<0.01$, McNemar chi-squared test). Significantly more respondents living in DKI Jakarta and Bali reported in November 2020 that their physical health deteriorated compared to those in July 2020 ($p<0.01$, McNemar chi-squared test). Also, those whose income decreased were more likely to report that their physical health deteriorated than their counterparts ($p<0.001$, Pearson chi-squared test).

The other findings show no significant differences between respondents aged 80 years old who reported their physical health deteriorated in the two survey rounds.

The fact that more respondents stated their health condition decreased might be related to better access to health services in November 2020 than those in July 2020, so they obtained more accurate information about their health conditions.

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

Characteristics	Health Conditions Deteriorated (%)		N	
	July 2020 (%)	November 2020 (%)		
All respondents	**15.52**	**21.41**	**3,125**	
Sex				
Male	15.46	21.05	1,449	
Female	15.57	21.72	1,676	
Age				
60–69 years	14.49	20.24	2,036	
70–79 years	16.91	23.11	822	
80 years and older	19.10	25.09	267	
Living Location				
Urban	15.04	21.30	2,873	
Rural	21.03	22.62	252	
Province				
Bali	15.69	21.11	701	
DIY	14.99	18.54	847	
DKI Jakarta	15.73	23.08	1,577	
Income			**Jul**	**Nov**
Decrease	19.91	28.24	1,693	1,211
Same/Increase	10.34	17.08	1,432	1,914

NGO = non-governmental organisation.

Notes: Respondents were allowed multiple answers.

Table 4.2 shows the percentage of respondents who answered 'no' to: 'Can you go shopping or use an ATM by yourself?' This question means the respondent cannot independently shop or use an ATM at the time of the interview, indicating the instrumental activities of daily life (IADL). The result shows that those with impaired IADL were significantly higher in November 2020 than July 2020 ($p<0.01$, McNemar chi-squared test). About 10.78% of respondents (95% CI: 9.7%–11.9%) answered that they had impaired IADL in November 2020 compared to only 9.22% (95% CI: 8.2%–10.3%) in July 2020.

Female respondents were significantly more likely to report that they need support for IADL compared to their male counterparts in both rounds of the survey ($p<0.001$, Pearson chi-squared test). Similarly, older respondents were significantly more likely to state impaired IADL ($p<0.001$, Wilcoxon rank-sum test). In November 2020, respondents living in rural areas were significantly more likely to answer that they have impaired IADL than their counterparts in urban areas ($p<0.001$, Pearson chi-squared test). Meanwhile, there was no significant difference in July 2020. On the other hand, respondents living in rural areas in November 2020 were significantly more likely to report impaired IADL than those in July 2020 ($p<0.001$, McNemar chi-squared test). Several factors such as technology adoption, availability of health devices, and access to health services are the main causes of their serious IADL problem in rural areas.

Respondents living in Bali were significantly more likely to have impaired IADL in November 2020 than those in July 2020 ($p<0.001$, McNemar chi-squared test). There is no significant difference between respondents living in DIY and DKI Jakarta in both survey rounds. Respondents whose income did not decrease significantly were more likely to report having IADL problems than those with declining income in both survey rounds ($p <0.001$, Pearson chi-squared test).

Table 4.2: Respondents Who Had Difficulty in Instrumental Activities of Daily Living (IADL)

Characteristics	Need Support for IADL* (%)		N
	July 2020 (%)	November 2020 (%)	
All respondents	**9.22**	**10.78**	**3,125**
Sex			
Male	6.97	7.38	1,449
Female	11.16	13.72	1,676
Age			
60–69 years	4.08	5.01	2,036
70–79 years	12.90	15.45	822
80 years and older	37.08	40.45	267
Living Location			
Urban	9.12	9.75	2,873
Rural	10.32	22.62	252
Province			

Characteristics	Need Support for IADL* (%)		N	
	July 2020 (%)	November 2020 (%)		
Bali	9.99	15.69		701
DIY	9.92	9.45		847
DKI Jakarta	8.50	9.32		1,577
Income			**July**	**Nov**
Decrease	7.50	8.34	1,693	1,211
Same/Increase	11.24	12.33	1,432	1,914

* means they could not shop/use an ATM by themselves.

This study also used the comorbidity score as an indicator of physical health. The 'comorbidity score' refers to the number of respondents' chronic conditions that health professionals have diagnosed. We asked them about six chronic conditions: high blood pressure, heart disease, diabetes, lung disease, kidney disease, and stroke. As for the analysis, the score change in July 2020 represents the change in the comorbidity score between the pre-pandemic period and the July 2020 phone survey, both of which were asked during the first interview. Meanwhile, the score change in November 2020 represents the change in the comorbidity score from July 2020 to November 2020. Thus, the comorbidity scores either increased, decreased, or did not change.

Table 4.3 shows that the respondents' comorbidity scores significantly changed in July 2020 and November 2020 ($p<0.001$, Wilcoxon signed-rank test). For example, the percentage of respondents whose comorbidity scores increased in November 2020 was about 15.58% (95% CI: 14.32%–16.90%) while, it was only 1.64% (95% CI: 1.22%–2.15%) in July 2020. Conversely, about 16.70% of the respondents (95% CI: 15.41%–18.06%) had decreased comorbidity scores in July 2020, while the percentage in November 2020 was only 9.51% (95% CI: 8.50%–10.59%).

Respondents living in rural areas experienced a significant change in comorbidity scores in July 2020 ($p<0.001$, Wilcoxon signed-rank test), while no significant change was found in November 2020. The percentage of respondents living in rural areas whose comorbidity score increased was 13.89% (95% CI: 9.87%–18.78%) in November 2020; in July 2020, it was only 1.19% (95% CI: 0.25%–3.44%).

Respondents living in Bali experienced a significant change of comorbidity scores in July 2020 ($p<0.001$, Wilcoxon signed-rank test), while no significant change was found in November 2020. The percentage of respondents living in Bali whose comorbidity scores increased was 12.91% (95% CI: 10.51%–15.63%) in November 2020, while it was only 0.72% (95% CI: 0.23%–1.67%) in July 2020. Respondents

with decreased comorbidity scores comprised 11.62% (95% CI: 9.34%–14.24%) in July 2020, but only 10.19% of respondents (95% CI: 8.04 %–12.67%) in November 2020.

At this point, in our opinion, the cause of the increasing comorbidity score in November 2020 cannot be interpreted as more cases of chronic conditions or more older people suffering from the disease. Another possibility is the relaxation of restrictions that resulted in better access to health facilities in November 2020. Fewer older people delayed medical check-ups, and more comorbidity cases could be diagnosed than those in July 2020. No significant correlations between age group or gender characteristics existed with the changes in comorbidity scores.

Morbidity rates are measured based on the respondents' six chronic conditions, i.e. hypertension, heart disease, diabetes, lung disease, kidney disease, and stroke, as diagnosed by a health professional. Table 4.4 shows significant changes in morbidity rates of almost all chronic conditions except stroke.

Table 4.3: Comorbidity Score Change

Characteristics	Comorbidity Score (%)						N
	Increased		Decreased		No Change		
	C Jul	C Nov	C Jul	C Nov	C Jul	C Nov	
Respondents who answered all morbidity questions	**1.64**	**15.58**	**16.70**	**9.51**	**81.66**	**74.91**	**3,113**
Sex							
Male	1.32	14.96	16.97	9.90	81.72	75.14	1,444
Female	1.92	16.12	16.48	9.17	81.61	74.72	1,669
Age							
60–69 years	1.87	15.09	16.71	9.63	81.43	75.28	2,035
70–79 years	1.22	16.63	16.01	9.66	82.76	73.72	818
80 years and older	1.15	16.15	18.85	8.08	80.00	75.77	260
Living Location							
Urban	1.68	15.73	16.64	9.58	81.68	74.69	2,861
Rural	1.19	13.89	17.46	8.73	81.35	77.38	252
Province							
Bali	0.72	12.91	11.62	10.19	87.66	76.90	697
DIY	2.26	14.49	14.73	10.81	83.02	74.70	842
DKI Jakarta	1.72	17.34	20.01	8.51	78.27	74.14	1,574

Characteristics	Comorbidity Score (%)						N	
	Increased		Decreased		No Change			
	C Jul	C Nov	C Jul	C Nov	C Jul	C Nov		
Income							**Jul**	**Nov**
Decrease	1.66	17.04	16.10	8.77	82.24	74.19	1,689	1,209
Same/Increase	1.62	14.65	17.42	9.98	80.97	75.37	1,424	1,904

Notes: C Jul = Change in score from before pandemic to July 2020 (both asked in July 2020).
C Nov = Change in score from July 2020 to November 2020.

Morbidity rates for hypertension, diabetes, and kidney disease significantly decreased from before the pandemic to July 2020 ($p<0.001$, McNemar chi-squared test). However, subsequently, these rates increased significantly from July 2020 to November 2020 ($p<0.001$, McNemar chi-squared test). In contrast, morbidity rates for heart and lung diseases significantly decreased in July 2020 ($p<0.001$, McNemar chi-squared test). Nevertheless, they did not change substantially in November 2020. This finding indicates that older people did not get a proper medical diagnosis during the pandemic. Indeed, some respondents faced difficulties with accessing or postponed visiting health facilities caused by social activity restrictions and changes in their condition affected by the COVID-19 pandemic. We will explore the detail in the following section.

Various efforts to restrain the spread of COVID-19 were being implemented until the November 2020 phone survey. Amongst these efforts is social activity restrictions, even though these are more likely to be relaxed and comply with health protocols in public places.

Table 4.4: Morbidity Rates of Six Chronic Conditions Before and During Pandemic

Type of Chronic Condition	Before COVID-19 Pandemic (%)	July 2020 (%)	November 2020 (%)	N*
High blood pressure	36.49	27.05	31.55	3,113
Heart disease	8.42	6.59	7.48	3,113
Diabetes	12.17	10.60	11.05	3,113
Lung disease	4.08	2.18	2.67	3,113
Kidney disease	1.99	0.96	1.38	3,113
Stroke	4.53	3.02	3.28	3,113

Note: *N refers to respondents who answered all morbidity questions.

Aside from the government effort, society, including older people, must maintain their physical health during the pandemic. However, as the pandemic continues, the strategies of older people also change. Table 4.5 shows the strategies that increased or were chosen by more respondents in November 2020 than July 2020.

Almost half of the respondents reported that they maintained their physical health by exercising outside their homes. In November 2020, the percentage of people who exercised outside their homes increased than in July 2020 ($p<0.01$, McNemar chi-squared test). In the July 2020 phone survey, around 53.9% of respondents (95% CI: 52.18%–55.71%) chose outdoor exercises. In November 2020, the percentage increased to 57.44% (95% CI: 55.68%–59.18%).

In addition, respondents who consumed vitamins, supplements, traditional medicine, and herbs increased in November 2020 than in July 2020 ($p<0.001$, McNemar chi-squared test). Respondents who chose this practice increased from July 2020, at only 0.93% (95% CI: 0.62%–1.33%), to November 2020, which reached 26.59% (95% CI: 25.05%–28.18%). Respondents who did breathing exercises, relaxation, and yoga also significantly increased ($p<0.01$, McNemar chi-squared test). Approximately 1.41% respondents (95% CI: 1.02%–1.88%) chose this health practice in July 2020; in November 2020, it increased to 2.24% (95% CI: 1.41%–2.82%).

Respondents who chose 'others' effort significantly increased in November 2020 ($p<0.01$, McNemar chi-squared test). Most respondents who chose 'other' practices stated that they maintained their physical health by their dietary pattern, drinking lots of water, and always thinking positively. Meanwhile, the number of respondents who chose not to make any effort to maintain their physical health did not significantly increase in the two survey rounds.

Table 4.5: Practices to Maintain Physical Health, with Increasing Trends

Characteristics	Practices to Maintain Physical Health (%)														N	
	Exercise Outdoors		Take Vitamins/ Supplements/ Spices/Herbs		Have Balanced Nutrition		Limit Time to Read the News on COVID-19		Do Breathing Exercises, Relaxation, Yoga		Other		None			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov		
All respondents	**53.95**	**57.44**	**0.93**	**26.59**	**14.50**	**15.58**	**0.13**	**0.22**	**1.41**	**2.24**	**0.90**	**1.79**	**0.86**	**1.31**	**3,125**	
Sex																
Male	62.04	66.05	0.69	24.57	14.15	14.01	0.21	0.28	1.79	3.04	1.10	2.21	0.55	1.17	1,449	
Female	46.96	50.00	1.13	28.34	14.80	16.95	0.06	0.18	1.07	1.55	0.72	1.43	1.13	1.43	1,676	
Age																
60–69 years	58.74	62.08	0.98	27.60	14.54	15.32	0.15	0.20	1.52	2.36	0.83	1.77	0.15	0.88	2,036	
70–79 years	50.36	52.92	0.85	24.70	15.09	15.45	0.12	0.36	1.22	2.19	1.09	2.07	1.09	1.09	822	
80 years and older	28.46	35.96	0.75	24.72	12.36	17.98	0	0	1.12	1.50	0.75	1.12	5.62	5.24	267	
Living Location																
Urban	56.11	56.77	0.90	26.73	14.97	15.18	0.14	0.24	1.46	2.26	0.94	1.88	0.90	1.39	2,873	
Rural	29.37	65.08	1.19	25.00	9.13	20.24	0	0	0.79	1.98	0.40	0.79	0.40	0.40	252	
Province																
Bali	43.37	49.64	1.14	21.83	8.42	22.40	0	0.43	1.85	3.42	0.57	1.57	1.57	0.86	701	
DIY	59.86	57.73	0	26.92	6.73	15.23	0	0	0.83	1.65	0	1.77	1.53	1.42	847	
DKI Jakarta	55.49	60.75	1.33	28.54	21.37	12.75	0.25	0.25	1.52	2.03	1.52	1.90	0.19	1.46	1,577	
Income															**Jul**	**Nov**
Decrease	54.11	60.20	1.00	26.51	14.06	12.39	0.18	0.33	1.30	2.06	0.83	1.40	0.65	0.99	1,693	1,211
Same/Increase	53.77	55.69	0.84	26.65	15.01	17.61	0.07	0.16	1.54	2.35	0.98	2.04	1.12	1.52	1,432	1,914

Note: Respondents were allowed multiple answers.

Table 4.6: Practices to Maintain Physical Health, with a Declining Trend

Characteristics	Practices to Maintain Physical Health (%)										N	
	Keep an Active Living Style Inside/ Outside the Home		Sunbathe		Follow the Protocol to Prevent COVID-19		Watch TV/ YouTube		Exercise Indoors			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov		
All respondents	**56.86**	**47.97**	**55.58**	**49.54**	**33.92**	**20.83**	**18.98**	**9.50**	**17.34**	**15.71**	**3,125**	
Sex												
Male	51.76	44.72	50.93	46.17	35.61	20.91	17.67	9.94	15.25	14.56	1,449	
Female	61.28	50.78	59.61	52.45	32.46	20.76	20.11	9.13	19.15	16.71	1,676	
Age												
60–69 years	58.79	50.00	55.30	48.58	37.62	22.45	18.86	9.18	17.73	15.72	2,036	
70–79 years	55.47	45.74	56.93	52.68	31.14	20.32	20.44	10.95	16.79	16.67	822	
80 years and older	46.44	39.33	53.56	47.19	14.23	10.11	15.36	7.49	16.10	12.73	267	
Living Location												
Urban	55.31	46.54	57.40	48.28	33.45	21.51	19.63	7.55	16.88	16.67	2,873	
Rural	74.60	64.29	34.92	63.89	39.29	13.10	11.51	31.75	22.62	4.76	252	
Province												
Bali	62.34	56.49	33.52	41.08	26.68	12.41	8.42	15.26	21.83	12.13	701	
DIY	63.52	56.55	49.00	37.43	15.11	15.35	26.33	6.97	11.10	13.11	847	
DKI Jakarta	50.86	39.57	68.93	59.80	47.24	27.52	19.72	8.31	18.71	18.71	1,577	
Income											**Jul**	**Nov**
Decrease	56.35	48.97	55.88	50.70	36.68	24.77	16.95	9.58	16.42	14.37	1,693	1,211
Same/Increase	57.47	47.34	55.24	48.80	30.66	18.34	21.37	9.46	18.44	16.56	1,432	1,914

(Table 4.6: Continued)

Characteristics	Practices to Maintain Physical Health (%)												N	
	Sleep Regularly/ Sufficiently		Read Book/Holy Book		Express Uncomfortable Feelings and Thoughts to Other		Listen to Music		Reduce Smoking		Sing/play Musical Instrument			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov		
All respondents	**14.69**	**13.12**	**3.10**	**1.89**	**1.95**	**1.02**	**1.89**	**1.82**	**0.86**	**0.80**	**0.54**	**0.42**	**3,125**	
Sex														
Male	14.70	14.29	2.69	1.86	1.52	0.83	2.35	2.90	1.79	1.73	0.83	0.62	1,449	
Female	14.68	12.11	3.46	1.91	2.33	1.19	1.49	0.89	0.06	0	0.3	0.24	1,676	
Age														
60–69 years	14.54	12.13	3.00	2.11	2.06	1.23	1.96	2.06	0.74	0.98	0.74	0.49	2,036	
70–79 years	15.33	14.96	2.92	1.22	2.19	0.36	1.58	1.58	1.34	0.61	0.24	0.12	822	
80 years and older	13.86	14.98	4.49	2.25	0.37	1.50	2.25	0.75	0.37	0	0	0.75	267	
Living Location														
Urban	15.84	11.14	3.13	1.88	2.02	1.04	1.81	1.78	0.94	0.84	0.56	0.38	2,873	
Rural	1.59	35.71	2.78	1.98	1.19	0.79	2.78	2.38	0	0.40	0.40	0.38	252	
Province														
Bali	6.13	26.82	1.43	1.00	0.57	0.57	2.00	2.28	0	1.00	0.29	0.86	701	
DIY	3.78	5.55	5.08	2.13	1.06	1.06	3.19	1.06	0.12	0.71	0.83	0.24	847	
DKI Jakarta	24.35	11.10	2.79	2.16	3.04	1.20	1.14	2.03	1.65	0.76	0.51	0.32	1,577	
Income													**Jul**	**Nov**
Decrease	15.71	12.88	2.89	1.73	2.19	1.32	1.89	1.98	1.24	1.49	0.65	0.66	1,693	1,211
Same/Increase	13.48	13.27	3.35	1.99	1.68	0.84	1.89	1.72	0.42	0.37	0.42	0.26	1,432	1,914

Note: Respondents were allowed multiple answers.

Some practices that respondents implemented to maintain their physical health showed a downward trend or were chosen by fewer respondents in November 2020 than in July 2020 (Table 4.6).

In July 2020, more than half of the respondents adopted an active lifestyle inside or outside the home and sunbathed. However, the percentage of respondents who adopted this practice decreased significantly in November 2020 ($p<0.001$ for both, McNemar chi-squared test). Respondents who practiced an active lifestyle declined from July 2020, at 56.87% (95% CI: 55.10%–58.61%), to November 2020, which reached only 47.97% (95% CI: 46.20%–49.74). Likewise, respondents who sunbathed decreased from 55.58% (95% CI: 53.82%–57.34%) to 49.54% (95% CI: 47.77%–51.30%).

Another fact revealed in November 2020 is that fewer respondents complied with health protocols to prevent COVID-19 than those in July 2020 ($p<0.001$, McNemar chi-squared test). This study shows that older respondents were less likely to follow health protocols to prevent COVID-19 ($p <0.001$, Wilcoxon rank sum-test). In November 2020, significantly more respondents living in urban areas followed protocols to prevent COVID-19 than those in rural areas ($p <0.01$, Pearson chi-squared test). More respondents stated that they chose to exercise at home ($p <0.001$, Pearson chi-squared test).

Respondents who maintained physical health by watching TV and/or Youtube decreased by almost half from July 2020, at 18.89% (95% CI: 17.61%–30.79%), to November 2020, which reached only 9.50% (95 % CI: 8.50%–10.59%). The relaxation in community activities' restrictions decreased the number of respondents who adopted strategies involving activities at home and increased outdoor activities.

2.Mental Health

As explained in the July 2020 phone survey report, this study used the five-item GDS to collect information on depression status in a short time via a phone survey (Study Team 2021c). The 5-item GDS version was validated as effective as the 15-item GDS to screen depression (Hoyl et al., 1999; Rinaldi et al., 2003). As for the Bahasa 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 (Ministry of Health-*Kementerian Kesehatan* RI, 2017).

The five-item GDS encompasses the following factors related to depressive status: (i) satisfaction, (ii) boredom, (iii) helplessness, (iv) reluctance to go out of the house, and (v) worthlessness. However, in line with the previous July 2020 phone survey, we excluded variable (iv) because this question might confuse and create ambiguity in answers during the pandemic when older people were

encouraged to stay at home. Therefore, the score of depression is the sum of the modified four-item GDS.

We analysed the change in depression scores from the pre-pandemic period (SILANI baseline interview) to the July 2020 phone survey and from the July 2020 phone survey to the November 2020 phone survey. Table 4.7 shows the change in the modified four-item depression score. The result indicates that fewer respondents experienced increasing depression scores in November 2020, comprising only 10.88% (95% CI: 9.7%–12.2%) than those in July 2020, which reached 23.97% (95% CI: 22.3%–25.7%).

Respondents' depression scores differed significantly in the three provinces except for those living in Bali in November 2020 ($p<0.001$ for each, Pearson chi-squared test). Respondents in DIY have the least percentage of those who experienced changes in depression scores than the other two provinces in both survey rounds. Meanwhile, respondents in Bali reported the highest percentage of those whose depression scores changed.

A significant difference in respondents' depression scores is found in all respondents' income characteristics in both survey rounds ($p<0.001$, Pearson chi-squared test). Respondents whose income decreased were more likely to experience changes – either increasing or decreasing – in their depression scores than their counterparts.

Table 4.7: Change in Depression Scores

Characteristics	Change of Depression Scores (%)						N
	Increased		Decreased		No Change		
	C Jul	C Nov	C Jul	C Nov	C Jul	C Nov	
Respondents who answered the five-item GDS questions in SILANI baseline and phone survey by themselves	**23.97**	**10.88**	**23.60**	**22.02**	**52.43**	**67.10**	**2,407**
Sex							
Male	23.94	10.98	22.30	21.78	53.76	67.24	1,157
Female	24.00	10.80	24.80	22.24	51.20	66.96	1,250
Age							
60–69 years	24.74	10.83	22.63	22.81	52.62	66.36	1,754
70–79 years	23.06	9.86	25.53	20.60	51.41	69.54	568

Characteristics	Change of Depression Scores (%)						N	
	Increased		Decreased		No Change			
	C Jul	C Nov	C Jul	C Nov	C Jul	C Nov		
80 years and older	14.12	18.82	30.59	15.29	55.29	65.88		85
Living Location								
Urban	24.03	10.97	23.63	22.08	52.33	66.95		2,251
Rural	23.08	9.62	23.08	21.15	53.85	69.23		156
Province								
Bali	31.26	12.89	16.23	23.87	52.51	63.25		419
DIY	17.63	8.30	19.11	14.67	63.26	77.04		675
DKI Jakarta	24.90	11.58	28.26	25.21	46.84	63.21		1,313
Income							**Jul**	**Nov**
Decrease	27.21	12.88	24.54	27.03	48.25	60.08	1,345	947
Same/Increase	19.87	9.59	22.41	18.77	57.72	71.64	1,062	1,460

Notes: C Jul = Change in score from before pandemic to July 2020 (both asked in July 2020).
C Nov = Change in score from July 2020 to November 2020.

Table 4.8 shows the proportion of physical and verbal cases experienced by the respondents during the pandemic and reported in both survey rounds. In November 2020, more respondents reported becoming victims of violence ($p<0.05$, McNemar chi-squared test). Physical or verbal violence reported by respondents in November 2020 reached 1.6% (95% CI: 1.2%–2.1%), while those in July 2020 only comprised 0.9% (95% CI: 0.6%–1.3%).

Respondents in urban areas were significantly more likely to report physical and/or verbal abuse in November 2020 than in July 2020 ($p<0.05$, McNemar chi-squared test). In contrast, there is no significant difference for respondents living in rural areas. The percentage of physical and/or verbal abuse reported by the respondents in DIY significantly increased in November 2020 compared to July 2020, when no respondents reported physical and/or verbal abuse.

Table 4.8: Respondents Suffering from Abuse

Characteristics	Respondents Suffering from Abuse (%)		N	
	July 2020	November 2020		
All respondents	**0.90**	**1.60**		**3,125**
Sex				
Male	0.83	1.24		1,449
Female	0.95	1.91		1,676
Age				
60–69 years	1.03	1.62		2,036
70–79 years	0.85	1.82		822
80 years and older	0.00	0.75		267
Living Location				
Urban	0.94	1.60		2,873
Rural	0.40	1.19		252
Province				
Bali	0.43	0.86		701
DIY	0.00	0.94		847
DKI Jakarta	1.59	2.28		1,577
Income			**Jul**	**Nov**
Decrease	1.18	1.57	1,693	1,211
Same/Increase	0.56	1.62	1,432	1,914

Maintaining health during this COVID-19 pandemic refers to physical and mental health so that older people can still prosper, be happy, and be healthy. It is a challenge since we have to adopt the 'new normal' habits during this pandemic.

In the July 2020 phone survey, almost all respondents made several efforts to maintain mental health during the pandemic (Study Team 2021c). However, the respondents' preferences changed with the length of the pandemic period. As a result, fewer respondents chose some efforts in the November 2020 phone survey (Table 4.9).

In July 2020, around 67.33% of respondents stated that they maintain mental health by praying (95% CI: 65.6%–69.0%); however, this number decreased in November 2020 to only 37.6 (95% CI: 35.9%–39.3%). Thus, this option significantly declined from July 2020 to November 2020($p<0.001$, McNemar chi-squared test).

Respondents who adopted an active lifestyle at home decreased from 34.62% (95% CI: 32.95%–36.32%) in July 2020 to almost half, 18.62% (95% CI: 17.27%–20.03%), in November 2020. Respondents in rural areas were significantly more likely to choose an active lifestyle at home than their counterparts in July 2020 and November 2020 ($p<0.001$, Pearson chi-squared test). Meanwhile, respondents in urban areas were significantly more likely to read more books, including the Holy Book, than their counterparts ($p<0.001$, Pearson chi-squared test).

Compliance with health protocols was significantly less preferred in November 2020 than in July 2020 ($p<0.001$, McNemar chi-squared test). In July 2020, respondents who complied with health protocols reached 17.28% (95% CI: 15.96%–18.65%), while it was 7.65% (95% CI: 6.74%–8.64%) in November 2020. Older respondents were significantly less likely to follow health protocols in preventing COVID-19 in July 2020 and in November 2020 ($p<0.001$, Wilcoxon rank sum-test).

The increasing percentage of respondents who used several strategies to maintain mental health during the pandemic illustrates changes in respondents' preferences. For example, in November 2020, around 39.84% of respondents (95% CI: 38.1%–41.6%) stated that they maintained mental health by listening to music, watching TV/YouTube, or listening to preachers. In contrast, only 12.99% of respondents (95% CI: 11.83%–14.22%) preferred these in July 2020. This means more respondents who chose these efforts significantly increased from July 2020 to November 2020 ($p<0.001$, McNemar chi-squared test).

Significantly more respondents chose several outdoor activities in November 2020 than in July 2020. Amongst these activities are walking outdoors, adopting an active lifestyle outside the house, and sunbathing ($p<0.001$, McNemar chi-squared test).

In July 2020, only 0.13% of respondents (95% CI: 0.03%–0.33%) chose walking outdoors to maintain mental health. In November 2020, this increased to 18.91% of respondents (95%) CI: 17.55%–20.33%). On the other hand, respondents who adopted an active lifestyle outside the house, such as going to rice fields, gardens, etc., increased quite dramatically from 0.58% (95% CI: 0.34 %–0.91%) in July 2020 to 14.14% (95% CI: 12.94%–15.41%) in November 2020. Similarly, respondents who sunbathed to maintain mental health increased from 0.51% (95% CI: 0.29%–0.83%) in July 2020 to 12.58% (95% CI: 11.43%–13.79%) in November 2020.

The increasing trend of outdoor activities to maintain mental health in November 2020 is in line with the restriction relaxation policy on community activities amidst the rising number of confirmed COVID-19 cases.

Table 4.9: Practices to Maintain Mental Health, with a Declining Trend

Characteristics	Practices to Maintain Mental Health												N	
	Pray		Keep an Active Lifestyle Indoors		Read Book/Holy Book		Exercise Outdoors		Follow the Protocol to Prevent COVID-19		Care for Plants			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov		
All respondents	**67.33**	**37.63**	**34.62**	**18.62**	**27.10**	**18.62**	**22.27**	**20.32**	**17.28**	**7.65**	**11.26**	**11.10**	**3,125**	
Sex														
Male	65.84	36.09	28.64	14.70	24.78	17.53	26.71	26.09	18.50	8.76	10.01	10.42	1,449	
Female	68.62	38.96	39.80	22.02	29.12	19.57	18.44	15.33	16.23	6.68	12.35	11.69	1,676	
Age														
60–69 years	69.06	38.90	36.39	19.16	27.75	19.60	23.97	22.79	18.66	8.40	11.59	12.48	2,036	
70–79 years	65.57	37.71	33.09	18.98	26.76	17.76	21.78	17.03	17.03	7.18	11.56	9.73	822	
80 years and older	59.55	27.72	25.84	13.48	23.22	13.86	10.86	11.61	7.49	3.37	7.87	4.87	267	
Living Location														
Urban	67.32	38.71	33.38	17.09	29.13	19.74	22.10	19.77	15.70	7.52	11.49	10.72	2,873	
Rural	67.46	25.40	48.81	36.11	3.97	5.95	24.21	26.59	35.32	9.13	8.73	15.48	252	
Province														
Bali	65.05	36.80	41.80	25.11	5.42	5.56	29.39	21.26	24.54	8.27	8.13	11.55	701	
DIY	73.20	42.50	30.11	15.47	40.97	23.38	19.36	14.05	12.40	7.79	16.53	15.35	847	
DKI Jakarta	65.19	35.38	33.86	17.44	29.30	21.88	20.67	23.27	16.68	7.29	9.83	8.62	1,577	
Income													**Jul**	**Nov**
Decrease	67.69	34.35	35.62	19.16	24.93	16.52	23.63	22.63	19.02	7.68	8.62	10.65	1,693	1,211
Same/Increase	66.90	39.71	33.45	18.29	29.68	19.96	20.67	18.86	15.22	7.63	14.39	11.39	1,432	1,914

(Table 4.9: Continued)

Characteristics	Practices to Maintain Mental Health												N	
	Spend More Time for Hobbies		Exercise Indoors		Maintain Environmental Cleanliness		Eat Balanced Nutrition		Limit Time to Read News about COVID-19		None			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov		
All respondents	**9.34**	**5.57**	**6.62**	**4.67**	**6.30**	**5.60**	**5.34**	**3.17**	**2.40**	**0.96**	**1.79**	**1.57**	**3,125**	
Sex														
Male	11.80	8.90	7.45	4.49	4.90	5.66	4.83	2.97	1.86	0.97	1.52	1.52	1,449	
Female	7.22	2.68	5.91	4.83	7.52	5.55	5.79	3.34	2.86	0.95	2.03	1.61	1,676	
Age														
60–69 years	10.02	5.89	7.12	4.86	6.78	5.94	5.70	3.19	2.41	1.18	0.74	1.08	2,036	
70–79 years	8.76	5.60	5.11	4.74	5.96	4.99	5.11	3.16	2.43	0.61	2.92	1.58	822	
80 years and older	5.99	3.00	7.49	3.00	3.75	4.87	3.37	3.00	2.25	0.37	6.37	5.24	267	
Living Location														
Urban	9.75	5.64	6.09	4.77	6.16	4.80	5.36	3.10	2.40	0.90	1.84	1.71	2,873	
Rural	4.76	4.76	12.70	3.57	7.94	14.68	5.16	3.97	2.38	1.59	1.19	0	252	
Province														
Bali	10.13	4.42	9.70	4.71	5.85	9.99	3.28	4.28	1.85	0.71	3.14	1.14	701	
DIY	6.14	6.61	2.72	3.90	5.55	5.08	4.01	2.01	2.13	0.59	1.77	1.77	847	
DKI Jakarta	10.72	5.52	7.36	5.07	6.91	3.93	6.98	3.30	2.79	1.27	1.20	1.65	1,577	
Income													**Jul**	**Nov**
Decrease	8.98	5.20	7.15	4.71	6.50	6.19	5.26	2.56	2.13	1.16	1.89	1.49	1,693	1,211
Same/Increase	9.78	5.80	6.01	4.65	6.08	5.22	5.45	3.55	2.72	0.84	1.68	1.62	1,432	1,914

Note: Respondents were allowed multiple answers.

Table 4.10: Practices to Maintain Mental Health, with an Increasing Trend

Characteristics	Practices to Maintain Mental Health										N	
	Listen to Music, Watch TV/YouTube, Listen to Preachers		Communicate with Friends and Family		Walk Outdoors		Keep an Active Lifestyle Outdoors		Sunbathe			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov		
All respondents	**12.99**	**39.84**	**28.32**	**35.14**	**0.13**	**18.91**	**0.58**	**14.14**	**0.51**	**12.58**	**3,125**	
Sex												
Male	13.39	38.85	27.74	33.54	0.21	20.70	0.97	15.53	0.41	12.63	1,449	
Female	12.65	40.69	28.82	36.52	0.06	17.36	0.24	12.95	0.60	12.53	1,676	
Age												
60–69 years	13.56	40.13	30.55	34.77	0	19.06	0.69	14.98	0.74	12.13	2,036	
70–79 years	12.04	40.27	25.67	35.28	0.24	19.10	0.36	13.26	0.12	13.38	822	
80 years and older	11.61	36.33	19.48	37.45	0.75	17.23	0.37	10.49	0	13.48	267	
Living Location												
Urban	13.75	39.23	29.73	33.73	0.14	17.26	0.63	11.28	0.56	11.17	2,873	
Rural	4.37	46.83	12.3	51.19	0	37.70	0	46.83	0	28.57	252	
Province												
Bali	7.56	37.66	11.55	39.23	0.29	23.11	0.71	24.25	0.14	14.98	701	
DIY	7.91	38.72	18.89	29.16	0	20.54	0	15.82	0	6.49	847	
DKI Jakarta	18.14	41.41	40.84	36.53	0.13	16.17	0.82	8.75	0.95	14.77	1,577	
Income											**Jul**	**Nov**
Decrease	13.76	40.21	29.36	40.13	0.06	20.15	0.89	15.03	0.53	13.38	1,693	1,211
Same/Increase	12.08	39.60	27.09	31.97	0.21	18.13	0.21	13.58	0.49	12.07	1,432	1,914

(Table 4.10: Continued)

Characteristics	Practices to Maintain Mental Health								N	
	Express Feeling to Others		Accept Changes		Do Breathing Exercises, Relaxation, Yoga		Other			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov		
All respondents	**4.45**	**5.70**	**3.55**	**4.45**	**1.25**	**1.98**	**0.48**	**1.79**	**3,125**	
Sex										
Male	4.00	5.80	4.28	4.49	1.73	2.90	0.41	1.66	1,449	
Female	4.83	5.61	2.92	4.42	0.84	1.19	0.54	1.91	1,676	
Age										
60–69 years	4.42	5.80	3.88	4.76	1.42	2.06	0.54	1.92	2,036	
70–79 years	4.38	6.20	3.28	4.50	1.09	2.19	0.36	1.58	822	
80 years and older	4.87	3.37	1.87	1.87	0.37	0.75	0.37	1.50	267	
Living Location										
Urban	4.52	6.09	3.69	4.77	1.15	1.84	0.52	1.88	2,873	
Rural	3.57	1.19	1.98	0.79	2.38	3.57	0	0.79	252	
Province										
Bali	2.57	1.43	1.00	2.28	2.71	5.14	0.57	0.57	701	
DIY	3.54	4.72	0.35	1.89	0.83	0.94	0.24	2.24	847	
DKI Jakarta	5.77	8.12	6.40	6.79	0.82	1.14	0.57	2.09	1,577	
Income									**Jul**	**Nov**
Decrease	4.73	7.35	3.72	4.62	1.06	1.82	0.30	1.90	1,693	1.211
Same/Increase	4.12	4.65	3.35	4.34	1.47	2.09	0.70	1.72	1,432	1.914

Note: Respondents were allowed multiple answers.

3. Health Services

The government still recommends limiting visits to health facilities other than for emergencies. Based on the July 2020 survey report, people are also worried about going to health facilities for fear of being infected by COVID-19 (Study Team 2021c). On the other hand, some older people need regular visits to health facilities because they have chronic diseases requiring regular check-ups and treatment. Therefore, activity restrictions during the pandemic might have affected older people's access to health services.

Table 4.11: Respondents Who Have Difficulty Accessing Health Facilities during the Pandemic

Characteristics	July 2020			November 2020		
	Who Have Difficulty Accessing Health (%)	Who Have Difficulty Accessing Health (N)*	Who Need Health Services at Health Facilities (N)	Who Have Difficulty Accessing Health (%)	Who Have Difficulty Accessing Health (N)*	Who Need Health Services at Health Facilities (N)
Respondents	**11.27**	**196**	**1,739**	**9.63**	**221**	**2,295**
Sex						
Male	9.64	76	788	9.93	103	1,037
Female	12.62	120	951	9.38	118	1,258
Age						
60–69 years	10.69	123	1,151	9.65	142	1,472
70–79 years	13.67	63	461	9.76	62	635
80 years and older	7.87	10	127	9.04	17	188
Living Location						
Urban	12.08	189	1,564	10.24	217	2,119
Rural	4.00	7	175	2.27	4	176
Province						
Bali	7.08	23	325	4.51	22	488
DIY	2.25	10	444	7.38	44	596
DKI Jakarta	16.80	163	970	12.80	155	1,211
Income						
Decreased	13.01	122	938	10.18	91	894
Same/ Increased	9.24	74	801	9.28	130	1,401

Notes: * The dominators of these indicators are calculated based on numbers of "Respondents who need health services at health facilities"

The number of respondents who need to visit health facilities increased from July 2020 to November 2020. Regardless of the difference in the number of respondents who need health services, the percentage of respondents who have difficulty accessing health facilities in November 2020 (9.63%, 95% CI: 8.45 %–10.91%) was lower than those in July 2020 (11.27%, 95% CI: 9.82%–12.85%). Respondents in urban areas were more likely to have difficulty accessing health facilities than their counterparts in both survey rounds ($p<0.01$ for each, Pearson chi-squared test).

Amongst the three sample provinces, DKI Jakarta had the highest percentage of respondents who had difficulty accessing health facilities in both survey rounds ($p<0.001$ for each, Pearson chi-squared test). In contrast, the province with the least respondents experiencing challenges in accessing health facilities was DIY for the July 2020 telephone survey, then replaced by Bali in the November 2020 telephone survey ($p<0.001$ each, Pearson chi-squared test)

Respondents expressed various reasons for difficulty accessing health facilities. (Table 4.12). In July 2020, the most common reason reported by respondents was the worry or fear of being infected with COVID-19, which reached 44.39% (95% CI: 37.7%–51.1%). However, the percentage was lower in November 2020 (25.3%, 95% CI: 19.7%–31.6). Respondents in urban areas were more likely to answer that they were afraid or worried than those in rural areas in July 2020 ($p<0.05$, Pearson chi-squared test). Respondents in DIY tended to answer less fear or worried ($p<0.05$, Pearson chi-squared test) in the July 2020 phone survey, while there was no significant difference in the November 2020 survey.

Table 4.12: Reason for Difficulty Accessing Health Facilities, with a Declining Trend

Characteristics	Reason for Difficulty in Accessing Health Facilities						N	
	Worried/Scared		Facilities Closed/ Older Patients Not Accepted		No One to Accompany Older Person			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov
Respondents with difficulty in accessing health facilities	**44.39**	**25.34**	**27.55**	**9.95**	**5.10**	**4.98**	**196**	**221**
Sex								
Male	36.84	21.36	25.00	11.65	5.26	1.94	76	103
Female	49.17	28.81	29.17	8.47	5.00	7.63	120	118
Age								
60–69 years	43.90	26.06	29.27	9.15	4.88	3.52	123	142
70–79 years	44.44	24.19	25.40	11.29	6.35	6.45	63	62

Characteristics	Reason for Difficulty in Accessing Health Facilities						N	
	Worried/Scared		Facilities Closed/ Older Patients Not Accepted		No One to Accompany Older Person			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov
80 years and older	50.00	23.53	20.00	11.76	0	11.76	10	17
Living Location								
Urban	46.03	25.35	28.57	10.14	5.29	4.61	189	217
Rural	0	25.00	0	0	0	25.00	7	4
Province								
Bali	43.48	9.09	17.39	4.55	0	4.55	23	22
DIY	10.00	29.55	10.00	6.82	0	2.27	10	44
DKI Jakarta	46.63	26.45	30.06	11.61	6.13	5.81	163	155
Income								
Decreased	40.98	23.08	27.87	9.89	6.56	6.59	122	91
Same/Increased	50.00	26.92	27.03	10.00	2.70	3.85	74	130

Notes: The respondents were allowed multiple answers.

Respondents who stated that the reason for the difficulty accessing health facilities was that the facilities were closed or did not accept the elderly also decreased by almost a third from July 2020, which reached 27.77% (95% CI: 24.42%–34.37%) to November 2020, which reached only 9.95% (95% CI: 6.34%–14.68%).

The reasons for problems in accessing health services expressed by respondents in November 2020 tend to be different in July 2020, indicated by the decreasing percentage for several reasons (Table 4.12). On the other hand, other reasons increased in the percentage or were chosen by more respondents in November 2020.

Amongst the reasons stated by respondents and experiencing a large percentage increase is that they do not have money to pay for health services. Respondents reporting these reasons increased from 8.16% (95% CI: 4.9%–12.6%) in July 2020 to 20.81% (95% CI: 15.7%–26.8%) in November 2020. Respondents in rural areas were more likely to answer 'no money to pay for health services' than in urban areas in July 2020 ($p<0.01$, Pearson chi-squared test); nonetheless, no significant difference was found in November 2020.

Long queues are also why older people have difficulty accessing health services, with a higher percentage in November 2020 or almost six times than July 2020.

Table 4.13: Reason for Difficulty Accessing Health Facilities, with an Increasing Trend

Characteristics	Reason for Difficulty in Accessing Health Facilities										N	
	Do Not Have Money for Services		Long Queue		BPJS Not Available		Staff Busy re COVID-19		Limited Capacity of Patients			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov
Respondents with difficulty in accessing health facilities	**8.16**	**20.81**	**3.06**	**18.10**	**5.10**	**7.69**	**4.59**	**4.98**	**1.53**	**4.52**	**196**	**221**
Sex												
Male	7.89	20.39	1.32	18.45	9.21	8.74	2.63	6.80	2.63	1.94	76	103
Female	8.33	21.19	4.17	17.80	2.50	6.78	5.83	3.39	0.83	6.78	120	118
Age												
60–69 years	8.13	21.13	3.25	18.31	4.07	9.15	4.07	4.93	0.81	4.23	123	142
70–79 years	9.52	24.19	3.17	16.13	7.94	6.45	4.76	4.84	1.59	6.45	63	62
80 years and older	0	5.88	0	23.53	0	0	10.00	5.88	10.00	0	10	17
Living Location												
Urban	6.88	20.74	3.17	17.97	5.29	7.83	4.76	4.61	1.59	4.61	189	217
Rural	42.86	25	0	25.00	0	0	0	25.00	0	0	7	4
Province												
Bali	26.09	36.36	4.35	22.73	0	9.09	0	9.09	0	4.55	23	22
DIY	0	2.27	20.00	25.00	20.00	13.64	0	0	20.00	11.36	10	44
DKI Jakarta	6.13	23.87	1.84	15.48	4.91	5.81	5.52	5.81	0.61	2.58	163	155
Income												
Decreased	9.02	21.98	4.10	17.58	4.10	6.59	4.10	4.40	2.46	5.49	122	91
Same/Increased	6.76	20.00	1.35	18.46	6.76	8.46	5.41	5.38	0	3.85	74	130

(Table 4.13: Continued)

Characteristics	Reason for Difficulty in Accessing Health Facilities								N	
	Do Not Have BPJS		Discrimination against Older People		Do Not Have Money for Transport		Others			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov
Respondents with difficulty in accessing health facilities	**2.55**	**3.62**	**3.57**	**3.62**	**1.02**	**3.17**	**2.04**	**9.50**	**196**	**221**
Sex										
Male	2.63	3.88	3.95	2.91	1.32	1.94	5.26	12.62	76	103
Female	2.50	3.39	3.33	4.24	0.83	4.24	0	6.78	120	118
Age										
60–69 years	1.63	2.11	3.25	4.23	1.63	2.11	3.25	9.86	123	142
70–79 years	4.76	6.45	3.17	0	0	4.84	0	11.29	63	62
80 years and older	0	5.88	10	11.76	0	5.88	0	0	10	17
Living Location										
Urban	1.59	3.69	3.70	3.69	0.53	2.76	1.59	9.68	189	217
Rural	28.57	0	0	0	14.29	25.00	14.29	0	7	4
Province										
Bali	8.70	4.55	4.35	4.55	4.35	4.55	4.35	4.55	23	22
DIY	0	4.55	20.00	0	0	0	0	9.09	10	44
DKI Jakarta	1.84	3.23	2.45	4.52	0.61	3.87	1.84	10.32	163	155
Income										
Decreased	4.10	4.40	4.10	3.30	0.82	3.30	1.64	8.79	122	91
Same/Increased	0	3.08	2.70	3.85	1.35	3.08	2.70	10.00	74	130

BPJS = Badan Penyelenggara Jaminan Sosial.

Note: Respondents were allowed multiple answers.

The percentage of respondents who stated this was 3.06% (95% CI: 0.03%–7.11%) in July 2020 and increased to 18.10% (95% CI: 11.49%–27.3%) in November 2020. Respondents in DIY were more likely to answer long queues as a problem of access ($p<0.01$, Pearson chi-squared test).

The number of respondents who needed consultation at a health facility increased from July 2020 to November 2020. Yet, the percentage of respondents who postponed consultations in November 2020 is lower than those in July 2020.

Female respondents were more likely to delay their consultation than their male counterparts in both rounds of phone surveys ($p<0.001$ for July 2020 and $p<0.1$ for November 2020, Pearson chi-squared test). In addition, respondents in urban areas were more likely to delay their consultation than those in rural areas in November 2020 ($p<0.5$, Pearson chi-squared test). In contrast, no significant difference was found in July 2020.

Respondents in DKI Jakarta were most likely to delay consultation than other provinces in both survey rounds ($p<0.001$ for each, Pearson chi-squared test). Meanwhile, DIY had the lowest percentage of respondents delaying consultation in July 2020, while it was Bali in November 2020 ($p<0.001$ for each, Pearson chi-squared test).

Table 4.14: Respondents Who Delayed Consultation in Health Facilities during the Pandemic

Characteristics	July 2020			November 2020		
	Who Delayed Consultation at Health Facilities (%)	Who Delayed Consultation at Health Facilities (N)*	Respondents Who Planned Consultation at Health Facilities (N)	Who Delayed Consultation at Health Facilities (%)	Who Delayed Consultation at Health Facilities (N)*	Respondents Who Planned Consultation at Health Facilities (N)
Respondents	**28.82**	**538**	**1,867**	**21.00**	**482**	**2,295**
Sex						
Male	24.35	205	842	18.13	188	1,037
Female	32.49	333	1025	23.37	294	1,258
Age						
60–69 years	29.06	351	1,208	21.74	320	1,472
70–79 years	29.32	151	515	20.63	131	635
80 years and older	25.00	36.00	144	16.49	31	188

Characteristics	July 2020			November 2020		
	Who Delayed Consultation at Health Facilities (%)	Who Delayed Consultation at Health Facilities (N)*	Respondents Who Planned Consultation at Health Facilities (N)	Who Delayed Consultation at Health Facilities (%)	Who Delayed Consultation at Health Facilities (N)*	Respondents Who Planned Consultation at Health Facilities (N)
Living Location						
Urban	29.21	498	1,705	21.52	456	2,119
Rural	24.69	40	162	14.77	26	176
Province						
Bali	18.66	67	359	13.93	68	488
DIY	17.08	89	521	15.94	95	596
DKI Jakarta	38.70	382	987	26.34	319	1,211
Income						
Decreased	31.35	306	976	22.48	201	894
Same/ Increased	26.04	232	891	20.06	281	1,401

Notes: * The dominators of these indicators are calculated based on numbers of "Respondents Who Planned Consultation at Health Facilities"

Respondents whose income decreased in July 2020 were more likely to delay consultation than those whose income did not decline; no significant difference was found in November 2020.

The number of respondents who need routine medicine increased in November 2020 compared to July 2020 (Table 4.15). Likewise, the percentage of respondents who experienced a shortage of medicines increased from 11.66% (95% CI: 10.10%–13.37%) in July 2020 to 12.98% (95% CI: 11.37%–14.73%) in November 2020.

In July 2020, respondents in urban areas were more likely to experience a shortage of routine medicines than those in rural areas ($p<0.01$, Pearson chi-squared test). No significant difference was found in November 2020.

Respondents in DKI Jakarta were most likely to have a shortage of routine medicines than those in other provinces in both survey rounds ($p<0.001$ for each, Pearson chi-squared test). Meanwhile, DIY was the province with the lowest percentage of respondents experiencing a shortage of medicines in July 2020, while it was Bali in November 2020 ($p<0.001$ for DIY and $p<0.01$ for Bali, Pearson chi-squared test).

Respondents whose income decreased were more likely to experience a shortage of medicines than those whose income did not fall in both survey rounds ($p<0.001$ for July 2020 and $p<0.01$ for November 2020, Pearson chi-squared test).

Table 4.15: Shortage of Routine Medicines during the Pandemic

Characteristics	July 2020			November 2020		
	Respondents Who faced a Shortage of Medicines (%)	Respondents Who faced a Shortage of Medicines (N)*	Respondents Who Need Routine Medicine (N)	Respondents Who faced a Shortage of Medicines (%)	Respondents Who faced a Shortage of Medicines (N)*	Respondents Who Need Routine Medicine (N)
Respondents	**11.66**	**179**	**1,535**	**12.98**	**208**	**1,602**
Sex						
Male	12.01	79	658	12.87	91	707
Female	11.40	100	877	13.07	117	895
Age						
60–69 years	12.05	118	979	12.55	129	1,028
70–79 years	12.00	54	450	14.07	64	455
80 years and older	6.60	7	106	12.61	15	119
Living Location						
Urban	12.37	173	1,398	13.13	193	1,470
Rural	4.38	6	137	11.36	15	132
Province						
Bali	3.82	11	288	8.65	27	312
DIY	2.43	9	370	8.99	34	378
DKI Jakarta	18.13	159	877	16.12	147	912
Income						
Decreased	14.37	117	814	16.05	95	592
Same/ Increased	8.60	62	721	11.19	113	1,010

Notes: * The dominators of these indicators are calculated based on numbers of "Respondents Who Need Routine Medicine?

The most common reason respondents experienced a shortage of medicines in both survey rounds was the lack of money to buy the medicines. In July 2020, the percentage of respondents who reported not having money to buy drugs reached 43.58% (95% CI: 36.2%–51.2%). In November 2020, this percentage increased, although not significantly enough, to 46.15% (95% CI: 39.2%–53.2%). In November 2020, DIY had the lowest percentage of respondents stating this reason compared to other provinces ($p<0.05$, Pearson chi-squared test). However, in July 2020, no significant difference was found.

Table 4.16: Reasons for Shortage of Routine Medicines during the Pandemic, with an Increasing Trend

Characteristics	Reasons for Shortage of Routine Medicines (%)										N	
	Do Not Have Money for Medicines		Forgot/Late/ No time		No Stock		Worried/Scared		Do Not Have Money for Transport			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov
Respondents with shortage of medicine	**43.58**	**46.15**	**8.38**	**22.60**	**13.97**	**18.75**	**6.70**	**8.65**	**1.12**	**4.81**	**179**	**208**
Sex												
Male	46.84	49.45	8.86	21.98	16.46	23.08	5.06	6.59	1.27	2.20	79	91
Female	41.00	43.59	8.00	23.08	12.00	15.38	8.00	10.26	1.00	6.84	100	117
Age												
60–69 years	44.92	50.39	8.47	20.16	14.41	15.50	7.63	9.30	0.85	4.65	118	129
70–79 years	40.74	40.63	5.00	25.00	12.96	25.00	5.56	9.38	0	4.69	54	64
80 years and older	42.86	33.33	0	33.33	14.29	20.00	0	0	14.29	6.67	7	15
Living Location												
Urban	43.35	44.56	8.67	23.32	14.45	19.69	6.94	8.81	0.58	4.15	173	193
Rural	50.00	66.67	0	13.33	0	6.67	0	6.67	16.67	13.33	6	15
Province												
Bali	45.45	62.96	0	18.52	0	7.41	0	11.11	9.09	7.41	11	27
DIY	44.44	26.47	11.11	35.29	0	14.71	0	5.88	11.11	2.94	9	34
DKI Jakarta	43.40	47.62	8.81	20.41	15.72	21.77	7.55	8.84	0	4.76	159	147
Income												
Decreased	47.86	54.74	5.98	13.68	15.38	14.74	5.98	9.47	0.85	8.42	117	95
Same/Increased	35.48	38.94	12.9	30.09	11.29	22.12	8.06	8.65	1.61	1.77	62	113

Note: Respondents were allowed multiple answers.

Table 4.17: Reasons for Shortage of Routine Medicines during the Pandemic, with a Declining Trend

Characteristics	Reasons for Shortage of Routine Medicines (%)												N	
	Facilities, Pharmacies Closed/Not Serving Older People		No One to Accompany Older Person		Discrimination against Older People		Do Not Have BPJS		Staff Busy re COVID-19		Others			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov
Respondents with shortage of medicine	**17.32**	**4.81**	**13.97**	**5.29**	**2.23**	**0.48**	**1.68**	**0.48**	**0.56**	**0.48**	**2.79**	**0.48**	**179**	**208**
Sex														
Male	18.99	4.40	8.86	4.40	1.27	0	1.27	1.10	1.27	0	2.53	0	79	91
Female	16.00	5.13	18.00	5.98	3.00	0.85	2.00	0	0	0.85	3.00	0.85	100	117
Age														
60–69 years	17.80	4.65	11.86	3.88	2.54	0.78	1.69	0.78	0	0.78	2.54	0	118	129
70–79 years	16.67	4.69	18.52	7.81	1.85	0	1.85	0	1.85	0	3.70	1.56	54	64
80 years and older	14.29	6.67	14.29	6.67	0	0	0	0	0	0	0	0	7	15
Living Location														
Urban	17.92	4.66	13.87	5.70	2.31	0.52	1.73	0.52	0.58	0.52	2.31	0.52	173	193
Rural	0	6.67	16.67	0	0	0	0	0	0	0	16.67	0	6	15
Province														
Bali	9.09	3.70	18.18	0	0	0	0	0	0	0	18.18	0	11	27
DIY	11.11	5.88	44.44	11.76	0	0	11.11	0	0	0	0	0	9	34
DKI Jakarta	18.24	4.76	11.95	4.76	2.52	0.68	1.26	0.68	0.63	0.68	1.89	0.68	159	147
Income														
Decreased	14.53	7.37	12.82	4.21	2.56	0	2.56	1.05	0.85	1.05	2.56	1.05	117	95
Same/Increased	22.58	2.65	16.13	6.19	1.61	0.88	0	0	0	0	3.23	0	62	113

Note: Respondents were allowed multiple answers.

Respondents whose income declined significantly more likely experienced a shortage of medicines due to lack of money to buy medicines than those whose income did not decrease in November 2020 ($p<0.05$, Pearson chi-squared test). However, no significant difference was found in July 2020.

Forgetting, being late, or not having the time to buy medicines ($p<0.001$, McNemar chi-squared test) and not having money for transportation ($p<0.05$, McNemar chi-squared test) are other reasons widely reported by respondents and increased significantly from July 2020 to November 2020. Around 8.38% of respondents (95% CI: 4.77%–13.44%) stated they lacked routine medication because they forgot, were late, or did not have time to buy medicines in July 2020. Then, the percentage increased to 22.60% (95% CI: 17.10%–28.89%) in November 2020. Respondents who stated that they did not have money for transportation costs increased from 1.12% (95% CI: 0.13%–3.98%) in July 2020 to nearly 4.81% (95% CI: 2.33%–8.66%) in November 2020.

Regarding the reasons for medicine shortages, health facilities/pharmacies were closed or did not serve the older people ($p<0.01$, McNemar chi-squared test) and no one took them to the pharmacy or health facility ($p<0.05$, McNemar chi-squared test) decreased significantly in November 2020 than in July 2020.

The percentage of respondents who stated that health facilities were closed in November 2020 decreased to only 4.81% (95% CI: 2.33%–8.66%) compared to July 2020, which reached 17.32% (95% CI: 12.08%–23.67%). Meanwhile, respondents who stated that there was a shortage of routine medicines because no one took them to the pharmacy or health facilities decreased from 13.97% (95% CI: 9.25%–19.92%) to only 5.29% (95% CI: 2.67%–9.26%) in November 2020.

CHAPTER 5

Interaction and Social Support

Older people are prone to experiencing social isolation and loneliness that will affect their morbidity and mortality (Mays et al., 2020). Thus, efforts have been made for older people to get involved regularly in activities or interactions in the community to maintain their physical and mental health. However, during this pandemic, activities to maintain social interaction cannot be conducted as in normal times.

The effectiveness of social restrictions during the pandemic should be evaluated, considering the increasing trend of COVID-19 cases. Social restrictions are implemented to restrain the number of COVID-19 cases, especially in the high-risk group, including older people. However, this policy also creates pros and cons.

On one side, social interaction patterns are changed so that older people are safe. Nonetheless, older people might be socially isolated. The risk can be reduced by providing a safe and effective social support mechanism.

1.Social Interaction

Social activity restrictions during the pandemic are a way of restraining the spread of COVID-19. On the other hand, social activity restrictions have many consequences, such as economic slowdown which affects social well-being and disrupts social interaction. Even though social activity restrictions tend to be relaxed, as shown in Figure 1.1, older people are a vulnerable group. Thus, they must still limit their social interaction.

Communication and social media are expected to accommodate social interaction with such social restrictions during the pandemic. However, not everyone, including older people, is quite familiar and quickly adapts to communicate through online media. Moreover, older people's digital literacy in Indonesia and globally is low. Only around 16.2% of older people aged 60–64 years and 8.5% of older people aged 65 years or older use the internet (APJII, 2018). Therefore, it will be problematic to implement social distancing while keeping social connectedness in the community.

This chapter discusses older people's social interaction patterns during the pandemic. Implementation of social distancing creates potential social isolation in the older people community. Social interaction in this study is measured using

three indicators: (i) how older people maintain their social relationship with relatives, friends, and/or neighbours during the COVID-19 pandemic, whether in person or indirect interaction; (ii) participation in outdoor activities during the pandemic, such as arisan,[1] older people's gathering; and (iii) contribution and support for family and community during the pandemic. Tables 5.1 to 5.3 present all three indicators.

Table 5.1 shows the platforms that respondents used to communicate with relatives, friends, and/or neighbours during the COVID-19 pandemic. In both rounds of the phone survey, there is a significant change in older people's preference for some platforms used to interact with each other.

Respondents who claimed they did not interact were significantly less in November 2020 than in July 2020 ($p<0.001$, McNemar chi-squared test). In July 2020, respondents who stated that they did not interact were around 4.74% (95% CI: 4.02%–5.54%), whereas, in November 2020, the percentage was only 2.21% (95% CI: 1.72%–2.79%). Older respondents were less likely to interact than younger respondents in both rounds ($p<0,001$, Wilcoxon rank-sum test). Thus, we can conclude that respondents interacted more in November 2020 (97.79%) than in July 2020 (95.26%).

Respondents in both survey rounds who are still socially interacting chose to meet in person. In November 2020, when social restrictions were more relaxed than in July 2020, significantly more respondents stated that they chose to meet their relatives, friends, and/or neighbours in person to maintain social connectedness ($p<0.001$, McNemar chi-square).

Approximately 82.69% of respondents chose to meet in person to maintain social connectedness in July 2020 (95% CI: 83.31%–83.1%). In November 2020, that percentage increased by around 8.00% and 90.98% (95% CI: 89.92%–91.96%). Thus, there is no significant difference in almost all characteristics between the two survey rounds except for the respondents' income.

In July 2020, respondents with decreased income were significantly more likely to meet in person with their relatives, friends, and/or neighbours than their counterparts ($p<0.05$, Pearson chi-squared test). However, in November 2020, there was no significant difference between those two income categories.

[1] *Arisan* 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 numbers entitled to receive an amount of money or goods equivalent to the total money collected from all members. Thus, a round of these regular meetings will be completed until all members have received their share.

Table 5.1: Social Relationship with Relatives, Friends, and/or Neighbours during the Pandemic

Characteristics	Social Relationship with Relatives, Friends, and/or Neighbours										N	
	Meeting in Person		Phone Call		Message (SMS, WhatsApp, etc.)		Others		Never Interact			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov		
All respondents	**82.69**	**90.98**	**52.80**	**52.51**	**22.02**	**23.49**	**0**	**0.86**	**4.74**	**2.21**	**3,125**	
Sex												
Male	85.51	92.68	53.00	52.66	24.02	26.02	0	1.04	3.04	1.86	1,449	
Female	80.25	89.50	52.63	52.39	20.29	21.30	0	0.72	6.21	2.51	1,676	
Age												
60–69 years	83.89	91.65	59.04	57.81	26.28	29.22	0	1.03	2.60	1.38	2,036	
70–79 years	81.27	90.15	45.62	45.62	15.45	15.21	0	0.61	7.54	2.68	822	
80 years and older	77.90	88.39	27.34	33.33	9.74	5.24	0	0.37	9.13	7.12	267	
Living Location												
Urban	82.94	91.09	55.13	54.51	23.70	24.89	0	0.94	4.35	1.81	2,873	
Rural	79.76	89.68	26.19	29.76	2.78	7.54	0	0.00	9.13	6.75	252	
Province												
Bali	74.18	88.59	30.39	31.95	6.28	9.42	0	0.00	12.41	4.85	701	
DIY	86.07	94.45	53.36	57.62	29.87	35.06	0	3.07	4.01	1.30	847	
DKI Jakarta	84.65	90.17	62.46	58.91	24.79	23.53	0	0.06	1.71	1.52	1,577	
Income											**Jul**	**Nov**
Decrease	84.11	91.66	51.57	50.37	19.37	19.82	0	0.33	4.43	1.65	1,693	1,211
Same/Increase	81.01	90.54	54.26	53.87	25.14	25.81	0	1.20	5.10	2.56	1,432	1,914

Note: Respondents were allowed multiple answers.

Respondents who used SMS (short message service) or WhatsApp were also significantly higher in November 2020 than in July 2020 ($p<0.05$, McNemar chi-squared test). Around 22.02% of respondents (95% CI: 20.57%–23.51%) in July 2020 chose SMS or WhatsApp to interact socially compared to 23.49% in November (95% CI: 22.01%–25.10%).

Respondents who used SMS or WhatsApp significantly increased in the 60–69 years age group ($p<0.01$, McNemar chi-squared test). On the other hand, respondents aged 80 years and above significantly did not use much SMS or WhatsApp in November 2020 than in July 2020 ($p<0.05$, McNemar chi-squared test). Respondents living in rural areas, Bali, and DIY significantly increased using SMS or WhatsApp ($p<0.01$ for each, McNemar chi-squared test).

Both survey rounds showed no significant changes in respondents who socially interacted with relatives, friends, and/or neighbours using the phone. However, between July 2020 and November 2020, there were significant changes in respondents in DIY and DKI Jakarta who used the phone for social interaction.

Respondents in DIY who interacted with relatives, friends, and/or neighbours using the phone were significantly higher in November 2020 than in July 2020 ($p<0.05$, McNemar chi-squared test). On the other hand, those in DKI Jakarta reported significantly less in November 2020 ($p<0.05$, McNemar chi-squared test).

Table 5.2: Participation in Community Activities during the Pandemic

Characteristics	Participation in Community Activities such as Arisan, Religious Activities, etc. (%)								N
	Always/ Often		Sometimes		Never		Not Participated even Before the Pandemic		
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	
All respondents	**18.72**	**31.20**	**16.42**	**18.02**	**59.14**	**44.38**	**5.73**	**6.40**	**3,125**
Sex									
Male	27.74	40.92	18.36	19.81	49.97	34.78	3.93	4.49	1,449
Female	10.92	22.79	14.74	16.47	67.06	52.68	7.28	8.05	1,676
Age									
60–69 years	20.92	35.76	19.16	20.19	57.86	41.90	2.06	2.16	2,036
70–79 years	16.06	24.70	12.90	16.18	61.92	49.51	9.12	9.61	822
80 years and above	10.11	16.48	6.37	7.12	60.30	47.57	23.22	28.84	267

Characteristics	Participation in Community Activities such as Arisan, Religious Activities, etc. (%)								N	
	Always/ Often		Sometimes		Never		Not Participated even Before the Pandemic			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov		
Living Location										
Urban	19.87	32.65	16.36	17.86	58.27	43.47	5.50	6.02		2,873
Rural	5.56	14.68	17.06	19.84	69.05	54.76	8.33	10.71		252
Province										
Bali	5.99	13.84	18.54	22.68	67.76	55.21	7.70	8.27		701
DIY	24.32	47.11	15.23	13.70	55.14	32.82	5.31	6.38		847
DKI Jakarta	21.37	30.37	16.11	18.26	57.45	45.78	5.07	5.58		1,577
Income									**Jul**	**Nov**
Decrease	18.55	29.73	18.90	21.14	58.48	44.59	4.08	4.54	1,693	1,211
Same/Increase	18.92	32.13	13.48	16.04	59.92	44.25	7.68	7.58	1,432	1,914

Note: Respondents were allowed multiple answers.

In November 2020, restricting outdoor activities – such as *arisan*; older people's gatherings; religious activities inside mosques, temples, churches; and others – was suggested to control the spread of COVID-19. However, social activity restrictions were not as rigid as at the beginning of the pandemic or in July 2020. Table 5.2 shows that community compliance to restricted outdoor activities decreased.

This analysis excluded respondents who did not participate in outdoor activities since pre-pandemic. For the rest of the respondents, more stated that they participated in outdoor activities in November than in July 2020. ($p<0.001$, McNemar chi-squared test). The participation intensity of respondents in outdoor activities also increased in November 2020 ($p<0.001$, Wilcoxon signed-rank).

Around 59.14% of respondents (95 CI: 57.39%–60.87%) stated they never participated in outdoor activities in July 2020. However, that percentage declined in November 2020 to 44.38% (95 CI: 42.63%–46.15%). In other words, respondents who participated in activities outside their house increased from 35.15% in July 2020 to 49.22% in November 2020.

The trend of each respondent's characteristics between both survey rounds is similar, except for the respondents' income. For example, in July 2020, respondents whose income did not decrease stated that they are less likely to participate in community activities than those whose income declined ($p<0.01$,

Pearson chi-squared test). However, in November 2020, respondents whose income decreased stated that they were less likely to participate in activities outside their house during the pandemic ($p<0.01$, Pearson chi-squared test).

Tables 5.1 and 5.2 show that, in November 2020, people were more likely to conduct social interaction than in July 2020. Respondents were significantly more likely to meet in person, communicate via WhatsApp and SMS, and participate in outdoor activities. Thus, restrictions and social distancing were more effective only at the beginning of the pandemic. However, these are not the only way to flatten the curve of COVID-19 cases. Restrictions and social distancing might not be economically and socially feasible to be imposed for a long time. Nevertheless, social distancing plays a greater role in delaying the sharp increase in cases, giving the community time to strengthen its healthcare capacity, and preparing a more comprehensive mitigation scheme when the restrictions are lifted (Matrajt and Leung, 2020).

Table 5.3 shows respondents' answers to the question 'What did you do to help your family and community during this pandemic?' In November 2020, almost all responses showed a significant decline compared to July 2020 ($p<0.01$ for taking care of children under 5 years old and $p<0.001$ for other options, McNemar chi-squared test), except providing daily necessities for neighbours or the community, such as the nine basic commodities, masks, and money.

Respondents who provided daily needs to their neighbours or the community decreased by only 1% point from July 2020 (18.34%, 95 CI: 19.99%–19.74%) to November 2020 (17.54%, 95 CI: 16.22%–18.91%). However, there were significant changes in several characteristics of the respondents who chose this kind of support. Respondents in rural areas ($p<0.001$, McNemar chi-squared test) and in Bali ($p<0.01$, McNemar chi-squared test) significantly chose this contribution in November 2020. On the other hand, those in DKI Jakarta who chose this contribution decreased in November 2020 ($p<0.001$, McNemar chi-squared test).

More than half of the respondents said they did not do anything for their neighbours or the community in July 2020 (56.80%, 95 CI: 55.04%–58.55%). Moreover, that percentage declined in November 2020 to 41.92% (95 CI: 40.18%–43.67%). In July 2020, respondents in DKI Jakarta were the last to do something ($p<0.001$, Pearson chi-squared test); however, in November 2020, the respondents living in DIY were the last to 'not do anything' ($p<.01$, Pearson chi-squared test).

Table 5.3: Support for Family and Community during the Pandemic

Characteristics	Support for family and community (%)												N	
	Take Care of Child under 5 Years old		Provide Daily Needs		Distribute Flyers on How to Avoid COVID-19		Distribute non cash food assistance, Masks, etc.		Others		Do not Do Anything			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov		
All respondents	**20.13**	**17.22**	**18.34**	**17.54**	**6.21**	**0.80**	**6.27**	**4.26**	**0.83**	**1.47**	**56.80**	**41.92**	**3,125**	
Sex														
Male	17.53	16.56	17.74	17.53	8.01	0.97	8.83	6.63	1.24	2.28	56.04	38.10	1,449	
Female	22.37	17.78	18.85	17.54	4.65	0.66	4.06	2.21	0.48	0.78	57.46	45.23	1,676	
Age														
60–69 years	22.79	19.70	20.83	19.30	7.32	1.08	8.20	5.60	0.93	1.62	50.69	34.97	2,036	
70–79 years	16.91	14.23	15.09	16.55	5.11	0.36	3.16	2.31	0.85	1.46	64.11	48.91	822	
80 years and above	9.74	7.49	9.36	7.12	1.12	0.00	1.12	0.00	0.00	0.37	80.90	73.41	267	
Living Location														
Urban	21.09	17.33	19.53	17.72	6.44	0.87	6.68	4.42	0.87	1.53	54.47	40.06	2,873	
Rural	9.13	15.87	4.76	15.48	3.57	0.00	1.59	2.38	0.40	0.79	83.33	63.10	252	
Province														
Bali	19.54	21.26	7.42	11.70	4.14	0.29	1.57	1.85	0.57	0.57	71.04	57.20	701	
DIY	12.28	14.99	22.43	25.62	10.74	1.06	5.90	5.43	0.35	2.13	58.56	37.43	847	
DKI Jakarta	24.60	16.61	20.99	15.79	4.69	0.89	8.56	4.69	1.20	1.52	49.52	37.54	1,577	
Income													**Jul**	**Nov**
Decrease	20.85	19.32	17.01	16.02	5.91	0.74	6.62	4.54	0.95	0.83	56.65	56.73	1,693	1,211
Same/Increase	19.27	15.88	19.90	18.50	6.56	0.84	5.87	4.08	0.70	0.84	56.98	56.84	1,432	1,914

Note: Respondents were allowed multiple answers.

Out of several forms of support provided by respondents, the most common was taking care of children under 5 years old. In July 2020, around 20.13% of respondents (95 CI: 18.73%–21.58%) helped to take care of children younger than 5 years. However, in November 2020, the percentage declined to 17.22% (95 CI: 15.91%–18.58%). Respondents in DKI Jakarta provided this support the most in July 2020 ($p<0.001$, Pearson chi-squared test), while those in Bali chose this option the most in November 2020. ($p<0.01$, Pearson chi-squared test).

Respondents who chose to distribute non-cash food assistance, masks, etc. also decreased by 2% points in November 2020 (4.26%, 95 CI: 3.57%–5.02%) than in July 2020 (6.27%, 95 CI: 4.45%–7.18%). A significant decrease was evident in November 2020 from respondents aged 60–69 years ($p<0.01$, McNemar chi-squared test), those living in urban areas, and in DKI Jakarta ($p<0.001$ for both, McNemar chi-squared test). This significant decline was probably linked to the analysis result in Table 3.8 in which non-cash food assistance also decreased significantly in November 2020.

Respondents who helped distribute pamphlets on COVID-19 prevention in July 2020 were around 6.21% (95 CI: 5.39%–7.11%), while in November 2020, the percentage fell to 0.80% (95 CI: 0.52%–1.18%). In November 2020, when the pandemic persisted for almost 9 months, sharing information on COVID-19 prevention was not as massive as during the early onset of the pandemic.

2. Social Support

In this study, social support is measured by (i) support from *Posyandu* cadres,[2] health workers, social cadres through a home visit or phone call to older people; and (ii) support from family, neighbours, friends, village staff, and r*ukun warga, rukun tetangga*, or NGOs during the COVID-19 pandemic.

In November 2020, around 593 respondents claimed they received home visits or calls (phone, WhatsApp, or SMS) from *Posyandu* cadres, health workers, or social cadres. That number more than doubled compared to July 2020, which totalled only 254 respondents. Some options decreased in the percentage of beneficiaries from July 2020 to November 2020.

Beneficiaries increased in November 2020 in the following types of support: face masks, mosquito larvae checks, and health checks. The greatest increase was on checking dengue mosquitos, rising by about 36% points from July 2020

[2] *Posyandu* (Pos Pelayanan Terpadu: Integrated Service Post) is community-based service promoting health and disease prevention. It can be conducted by the community, non-governmental organizations, private, social organizations, 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 tahun 2015).

(14.57%, 95 CI: 10.47%–19.51%) to November 2020 (50.59%, 95 CI: 46.49%–54.69%). Indonesia is a region with a tropical climate; thus, infectious diseases with mosquitos as the vector is a threat, especially during the rainy season. The second survey round was conducted in November, which is a rainy season; thus, checking mosquito larvae increased.

Health check support also increased by around 19% points in November 2020 (25.80%, 95 CI: 22.32%–29.52%) compared to July 2020 (7.48%, 95 CI: 4.56%–11.53%). This increase showed a good response to the need for health services of older people. As previously reported, this need was quite high during the pandemic. However, some older people experienced difficulties accessing health care (Table 4.11). Home visits, phone calls, or other communication media, such as WhatsApp and SMS, that *Posyandu* cadres, health workers, or social cadres provided will help older people needing health services.

As the duration of the pandemic extends, the implementation of health protocols adds to older people's list of needs, including masks. Based on this consideration, masks have become one of the most common non-cash support. Provision of masks to respondents increased in November 2020 (27.82%, 95 CI: 24.25%–31.62%) compared to July 2020 (23.62%, 95 CI: 18.65%–29.33%), indicating responses from *Posyandu* cadres, health workers, and social cadres. However, we should recognise that providing masks and other protective kits without increasing the awareness amongst older people and their families would not lead to optimum benefits to reduce the spread of COVID-19.

On the other hand, public and social support decreased. Table 5.5 shows that respondents who received COVID-19 and other health counselling services decreased from July 2020 to November 2020. Beneficiaries of COVID-19 counselling decreased from 45.28% (95% CI: 39.04%–51.62%) in July 2020 to 21.25% (95% CI: 10.02%–24.76%) in November 2020. On the other hand, those receiving other health counselling services decreased from 30.71% (95% CI: 25.09%–36.78%) in July 2020 to less than half, 12.31% (95% CI: 9.77%–15.22%), in November 2020.

Asking about the condition of older people slightly decreased in percentage because the pandemic has been ongoing for a while. It is assumed that people already know what to do and have adapted to the new normal. However, we need to be aware that the pandemic is not over, and we cannot start neglecting health protocols. *Posyandu* and social cadres and health workers should ensure older people's awareness in adhering to health protocols.

Another support that decreased even though it has more beneficiaries was non-cash food assistance and food preparation. The decrease in non-cash food assistance beneficiaries was relatively high from 7.48% (95% CI: 4.56%–11.43%) in July 2020 to 2.53% (95% CI: 1.42%–4.14%) in November 2020.

Table 5.4: Public and Social Support from Posyandu Cadres, Health Workers, and Social Cadres, with Increasing Trend

Characteristics	Support from Posyandu Cadres, Health Workers, or Social Cadres								N	
	Check on Mosquito Larvae		Health Check		Provide Face Masks		Others			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov
Respondents who receive public and social support	**14.57**	**50.59**	**7.48**	**25.80**	**23.62**	**27.82**	**3.94**	**4.05**	**254**	**593**
Sex										
Male	12.50	52.33	4.46	25.67	25.89	26.00	4.46	3.00	112	300
Female	16.20	48.81	9.86	25.94	21.83	29.69	3.52	5.12	142	293
Age										
60–69 years	17.58	52.37	6.04	24.19	24.73	29.43	4.40	4.74	182	401
70–79 years	8.16	50.00	10.20	26.43	18.37	25.00	0	2.86	49	140
80 years and above	4.35	38.46	13.04	36.54	26.09	23.08	8.70	1.92	23	52
Living Location										
Urban	16.67	54.39	8.56	23.55	18.92	27.48	4.50	4.11	222	535
Rural	0	15.52	0	46.55	56.25	31.03	0	3.45	32	58
Province										
Bali	6.78	37.91	11.86	38.56	32.20	15.69	1.69	1.96	59	153
DIY	2.38	23.81	7.14	38.10	14.29	5.95	4.76	13.10	42	84
DKI Jakarta	20.92	62.36	5.88	17.42	22.88	38.20	4.58	2.81	153	356
Income									**Jul**	**Nov**
Decrease	14.38	46.00	6.16	28.00	28.77	26.00	2.05	3.00	146	200
Same/Increase	14.81	52.93	9.26	24.68	16.67	28.75	6.48	4.58	108	393

Note: Respondents were allowed multiple answers.

Table 5.5: Public and Social Support from Posyandu Cadres, Health Workers, and Social Cadres, with Decreasing Trend

Characteristics	Support from Posyandu Cadres, Health Workers, or Social Cadres										N	
	Provide Counselling on COVID-19		Provide Other Health Counselling		Ask About Condition		Provide Non-cash food assistance		Provide Food			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov
Respondents who receive public and social supports	**45.28**	**21.25**	**30.71**	**12.31**	**23.23**	**20.91**	**7.48**	**2.53**	**1.97**	**1.52**	**254**	**593**
Sex												
Male	47.32	22.33	33.04	10.67	25.89	21.67	7.14	2.00	0.89	2.00	112	300
Female	43.66	20.14	28.87	13.99	21.13	20.14	7.75	3.07	2.82	1.02	142	293
Age												
60–69 years	44.51	21.95	30.22	12.72	20.88	19.45	6.04	2.00	1.65	1.50	182	401
70–79 years	48.98	19.29	34.69	11.43	32.65	25.00	12.24	5.00	4.08	1.43	49	140
80 years and above	43.48	21.15	26.09	11.54	21.74	21.15	8.70	0	0	1.92	23	52
Living Location												
Urban	41.89	17.01	34.23	11.59	24.77	19.44	7.21	2.62	1.80	1.68	222	535
Rural	68.75	60.34	6.25	18.97	12.50	34.48	9.38	1.72	3.13	0	32	58
Province												
Bali	50.85	30.07	15.25	16.99	27.12	20.26	5.08	3.27	3.39	0.65	59	153
DIY	52.38	19.05	33.33	14.29	11.90	28.57	4.76	0	0	2.38	42	84
DKI Jakarta	41.18	17.98	35.95	9.83	24.84	19.38	9.15	2.81	1.96	1.69	153	356
Income											**Jul**	**Nov**
Decrease	50.00	23.50	32.88	10.00	23.97	28.00	8.90	3.50	2.05	2.50	146	200
Same/Increase	38.89	20.10	27.78	13.49	22.22	17.30	5.56	2.04	1.85	1.02	108	393

Note: Respondents were allowed multiple answers.

This is understandable considering that this kind of support is regarded as emergency assistance during the early days of the pandemic to ensure that older people would not have difficulty purchasing daily needs or preparing food. The declining trend of this support went hand in hand with the decline of non-cash food assistance (Table 3.8).

Table 5.6 shows the types of support received by respondents from family, neighbours, friends, village officials, *rukun warga, rukun tetangga,* or NGOs. Of the five types of support respondents received, all declined in November 2020, although not all significantly decreased.

Support to take care of environment cleanliness was also significantly less received ($p<0.01$, McNemar chi-squared test). Those who received such assistance in July 2020 comprised 67.52% (95% CI: 65.84%–69.16%), while it was about 42.05% (95% CI: 40.31%–43.80%) in November. The decline was shown on all respondent's characteristics, except those living in rural areas, which increased though not significant.

Beneficiaries of support regarding mental health and handling stress decreased from 30.56% (95 CI: 28.85%–32.21%) in July 2020 to only 26.69% (95 CI: 25.14%–28.18%) in November 2020. The highest decline happened in November 2020 with the female recipients ($p<0.01$, McNemar chi-squared test), respondents aged 60–69 years ($p<0.01$, McNemar chi-squared test), urban respondents ($p<0.01$, McNemar chi-squared test), and those living in DIY (0.001, McNemar chi-squared test).

Recipients who received support in buying daily needs also declined significantly ($p<0.01$, McNemar chi-squared test) from 23.17% (95% CI: 21.70%-24.69%) in July 2020 to only 20.38% (95% CI: 18.31%-21.84%) in November 2020. The most significant decline happened amongst female respondents, urban respondents, and those living in DIY.

Support in providing food and maintaining social connectedness through visits, phone calls, WhatsApp, and SMS were the two types of support that did not significantly change between the two rounds of phone surveys although these changed significantly in some provinces. Respondents who received assistance in preparing food in DIY declined significantly ($p<0.05$, McNemar chi-squared test) in November 2020 (9.80%, 95 CI: 7.88%–12.00%) than in July 2020 (14.52%, 95 CI: 12.22%–17.08%).

Table 5.6: Support from Family and Community during the Pandemic

Characteristics	Support from Family, Neighbours, Friends, Village Officials, Rukun Warga, Rukun Tetangga, or NGOs										N	
	Keep Social Connectedness		Help in Keeping the House and Surroundings Clean		Help in Mitigating Mental Problems and Coping with Stress		Help in Buying Daily Needs		Assist in Preparing Food			
	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov	Jul	Nov		
All respondents	**73.06**	**72.54**	**67.52**	**42.05**	**30.56**	**26.69**	**23.17**	**20.38**	**17.92**	**17.50**	**3,125**	
Sex												
Male	71.43	70.12	68.46	42.44	26.71	25.40	19.25	17.32	16.70	15.73	1,449	
Female	74.46	74.64	66.71	41.71	33.89	27.80	26.55	23.03	18.97	19.03	1,676	
Age												
60–69 years	74.75	73.08	68.52	41.99	30.84	26.47	19.25	17.29	14.05	14.64	2,036	
70–79 years	71.05	28.47	65.45	41.24	29.20	27.13	26.76	23.60	22.26	20.32	822	
80 years and above	66.29	72.28	66.29	44.94	32.58	26.97	41.95	34.08	34.08	30.71	267	
Living Location												
Urban	74.77	74.59	69.40	41.11	30.87	26.52	23.15	20.68	18.38	18.00	2,873	
Rural	53.57	49.21	46.03	52.78	26.98	28.57	23.41	17.06	12.70	11.90	252	
Province												
Bali	64.34	64.91	52.92	45.51	28.96	32.67	26.96	26.68	17.69	19.40	701	
DIY	65.05	72.49	74.97	34.00	27.51	13.81	22.20	11.33	14.52	9.80	847	
DKI Jakarta	81.23	75.97	70.01	44.83	32.91	30.94	22.00	22.45	19.85	20.80	1,577	
Income											**Jul**	**Nov**
Decrease	73.24	70.27	69.76	45.83	32.60	28.90	22.68	19.98	18.13	16.76	1,693	1,211
Same/Increase	72.84	73.98	64.87	39.66	28.14	25.29	23.74	20.64	17.67	17.97	1,432	1,914

Note: Respondents were allowed multiple answers.

Support in maintaining social connectedness in DKI Jakarta also declined significantly ($p<0.01$, McNemar chi-squared test) in November 2020 (75.97%, 95 CI: 73.78%–78.06%) compared to July 2020 (81.23%, 95 CI: 79.21%–83.13%). However, this type of assistance increased significantly in DIY ($p<0.01$, McNemar chi-squared test) in November 2020 (72.49%, 95 CI: 69.35%–75.47%) than in July 2020 (65.05%, 95 CI: 61.74%–68.27%). The types of support presented in Table 5.6 were voluntarily provided by relatives, neighbours, friends, etc.

As another voluntary support, we cannot ensure its sustainability. The declining trend in these types of support is more likely caused by the assumption that, along with the length of the pandemic, people have been able to adapt towards new normal conditions so that the enthusiasm to provide voluntary support to others decreases.

CHAPTER 6

Conclusions and Recommendations

1. Conclusions

It has been more than a year since the COVID-19 pandemic started, and there is no certainty when it will be overcome completely. With the escalation of confirmed cases and fatality rates, Indonesia has become the most afflicted country in Southeast Asia. COVID-19 has disproportionally affected older people worldwide in terms of health, economic, and social aspects. The July 2020 phone survey report provided evidence of these impacts, such as limited access to health services, shortage of medicines, declining income, reduced quality of food consumption, the risk of social isolation, etc.

The second round of phone surveys on 'Older People and COVID-19 in Indonesia' conducted in November 2020 aimed to determine the current conditions of older people and compare them with the findings of the July 2020 phone survey. For this purpose, we re-interviewed respondents from July 2020. We used the phone survey method to avoid close contact with the respondents while collecting data. Both the phone interview and the sample selection brought some limitations to this study.

As described in the July 2020 survey report (Study Team, 2021a), the sample of this study is not nationally represented. The target provinces and districts/cities were purposively selected when SILANI was established in 2019. Also, phone interviews excluded some SILANI respondents who did not have a landline or mobile phone. Thus, we are urging readers to be careful about the interpretation of the results of this study.

Despite these limitations, we still believe this study provides vital and valuable information on the impact of COVID-19 on older people. Besides the comprehensiveness of the questionnaires that made it possible to reflect the actual lives of older people during this pandemic, the longitudinal approach in this study successfully identified the change of older people's conditions over time. We hope that the findings of this longitudinal study will help in policymaking and improve the strategies to mitigate the impact of the pandemic.

1.1. Economic condition of older people

Some older people lost their productive source of income and even experienced income decline in the ninth month. As a result, their food consumption was affected in terms of quality and quantity. The strategies adopted by some older people to overcome economic problems changed as the pandemic period extended. In general, in-kind assistance changed to cash assistance.

- In November 2020, fewer respondents experienced a decline in income as restrictions on economic activities were relaxed. Likewise, respondents whose income decreased experienced a reduction in their food quality. Nonetheless, more respondents reduced the frequency or amount of their meals.
- Regardless of the change in the number of respondents whose income decreased, a lower percentage of respondents did nothing to overcome this condition in November 2020 than those in July 2020. The highest preference of most respondents who tried to overcome income reduction in July 2020 asked for help from families and/or communities that had better economic conditions. Hereafter, in November 2020, they preferred to reduce their expenditure.
- Most older people living in PKH families and non-cash food assistance beneficiaries received these continuously in July 2020 and November 2020.

1.2. Health condition of older people

Better access to health services leads to proper diagnoses so that more older people who have physical health problems were identified. Meanwhile, older people's mental health slightly improved. However, several respondents still had problems accessing healthcare facilities and ran out of medicines. In addition, older people changed their preference for activities to maintain physical and mental health as the pandemic lasted longer.

- More older people stated that their physical health deteriorated. More need support for instrumental activities of daily living (IADL) than those in the early part of the pandemic. Likewise, more respondents had increasing comorbidity scores. We cannot just conclude that more respondents were ill. Rather, this has to be correlated with proper diagnoses and easier access to health services due to the relaxation of restrictions.
- Older people's mental health slightly improved. As the pandemic persisted, older people became more adaptable to changing conditions.

- Relaxation of social restrictions made access to health services better so that lesser old people had difficulties accessing and delayed visiting health facilities. Nonetheless, some of them still had difficulties accessing health facilities caused by the lack of money to pay health service costs and long queues. In addition, some respondents had a shortage of medicines since they had no money to buy the medicines.
- Almost all respondents preferred to maintain physical and mental health by increasing outdoor activities. Besides outdoor exercises, they took vitamins, supplements, spices, or herbs to maintain physical health. Meanwhile, they preferred listening to music, watching TV/YouTube, or listening to preachers besides praying. Unfortunately, fewer older people adhered to health protocols.

1.3. Social support for older people

The risk of social isolation decreases with the length of the COVID-19 pandemic. The percentage of beneficiaries of social support decreased.

- In November 2020, more respondents socially interacted with relatives, friends, and/or neighbours through in-person meetings than those in July 2020.
- The number of respondents who contributed to the community increased; however, the type of social support declined.
- The total beneficiaries of social and public support from Posyandu cadres, healthcare workers, and/or social cadres more than doubled from July 2020 to November 2020.
- The trend of the forms of social support received by the older people from Posyandu cadres, health workers, and/or social cadres changed. The percentage of beneficiaries of COVID-19 and other health counselling decreased, while the percentage of beneficiaries of mosquito larvae checks and health checks increased.
- All types of support received by respondents from families, neighbours, friends, village officials, rukun warga, or rukun tetangga, etc. in November 2020 decreased than those in July 2020.

2. Recommendations

The world has been in a pandemic for a long time, and it has not shown any signs of abating. Thus, an effective mitigation strategy is still needed to minimise the

negative impact of the pandemic on older people. Nevertheless, many efforts have been made to respond to the condition.

Based on several significant findings in this study, we formulate the following recommendations to mitigate the impact of the pandemic on older people.

Health:

- Provide dedicated care and waiting rooms/areas for older people in health facilities to minimise long queues and crowds with other patients;
- Expand online registration services in health facilities to simplify the procedures and shorten queueing time for older people or family members who assist older people in accessing healthcare;
- Improve home care services from health workers, *Posyandu* cadres, healthcare personnel, and/or social cadres to reach older people who have difficulty visiting health facilities;
- Provide transportation support from the community and families for older people who need access to health services;
- Provide medicine delivery services to older people to anticipate the shortage of medicines by involving *Posyandu* cadres, healthcare personnel, and/or social cadres;
- Ensure the increase of *BPJS Kesehatan* coverage for older people regularly to achieve universal health coverage;
- Provide alternative health service cost subsidies to older people who do not have *BPJS Kesehatan* or other health insurance and those who need those subsidies.

Economic and Social Protection:

- Update data on social assistance beneficiaries with a responsive mechanism to the increasing number of older people who need social assistance during the pandemic, including the possibility to accommodating community participation in reporting older people who need it;
- Increase social assistance coverage for older people, especially for those who experienced a decrease in income;
- Monitor and evaluate the sustainability of social assistance so that older people who need it still receive such assistance continuously, at least during

the pandemic or until the economic crisis is resolved;

- Involve older people who can work in productive economic recovery programs organised by the government or the private sector to help them overcome crises and maintain independence.

Social support:

- Provide proper information of the detail for social support to older people and their families.
- Increase the awareness of older people and their families on health compliance protocols through various effective communication by involving health workers, *Posyandu* cadres, healthcare personnel, and/or social cadres in their community;
- Monitor the condition of older people regularly to ensure their physical and mental needs are sufficient and assess the need for social support programs according to current conditions. This can be done by involving families, *Posyandu* cadres, healthcare personnel, and/or social cadres, and community institutions in their community.

Overall, such strategies to mitigate the crisis caused by COVID-19, which also affected older people, need collaboration between stakeholders – the government, community, and family. A comprehensive support system must ensure that older people are safe through this pandemic and achieve better resilience and well-being. Digital technology can facilitate older people's needs with available services. Therefore, community-based integrated older people care assisted with digital technology is a priority strategy. In Indonesia, Bappenas, with development partners, has initiated a pilot of integrated older people care in some SILANI locations in the Yogyakarta Special Region and Bali. The pilot empowers and integrates older people care programs and providers at the village level to provide more comprehensive care to older people in need. Integrated care is also equipped with SILANI digital platforms that allow digital connection between older people and case managers, which is appropriate in a pandemic setting by potentially accelerating service provision and reducing infection risk

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Appendixes

Appendix 1: Characteristics of Older People Households

Household Characteristics	Jul-20	
	N	%
Total	**3125**	**100**
Building area per HH member		
Less than 8 m^2	458	14.66
8 m^2 and over	2,667	85.34
Floor		
Marble/granite	17	0.54
Ceramic	2,621	83.87
Parquet/Vynil/Carpet	3	0.1
Tile	220	7.04
Wood/Board	11	0.35
Cement/Brick	230	7.36
Bamboo	2	0.06
Soil	21	0.67
Wall		
Brick	3023	96.74
Plastered woven bamboo	9	0.29
Wood	69	2.21
Woven bamboo	14	0.45
Bamboo	1	0.03
Others	9	0.29
Toilet Facility		
No facility	48	1.54
Water sealed with septic tank	2805	89.76
Water sealed without septic tank	228	7.3
Pit latrine with slab	13	0.42
Pit latrine without slab	31	0.99

Household Characteristics	Jul-20	
	N	%
Source of Drinking Water		
Branded bottled water	497	15.9
Refilled bottled water	506	16.19
Tap water	874	27.97
Pump	528	16.9
Protected well	660	21.12
Unprotected well	21	0.67
Protected spring	33	1.06
Unprotected spring	5	0.16
Surface water (river/lake)	1	0.03
Home Cooking Energy		
Electricity	6	0.19
LPG 5.5 kg/blue gas	52	1.66
LPG 12 kg	463	14.82
LPG 3 kg	2423	77.54
Piped gas	2	0.06
Kerosene	24	0.77
Wood	136	4.35
Others	3	0.1
No home cooking	16	0.51
Weekly animal protein/dairy consumption		
More than once daily	195	6.24
Once daily	367	11.74
3 - 6 times	510	16.32
1 - 2 times weekly	1,402	44.86
More than 3 times monthly	538	17.22
Never	113	3.62
Frequency of daily meal		
3 times or more daily	2,099	67.17
2 times daily	1010	32.32
Once daily	15	0.48
3-4 times weekly	1	0.03

Household Characteristics	Jul-20	
	N	%
Buy new clothes annually		
Less than 1 set annually	296	9.47
One set annually	1448	46.34
More than 1 set annually	931	29.79
Never	450	14.4
Affordability to pay treatment cost at puskesmas/polyclinic		
Yes	3,079	98.53
No	46	1.47
Head of HH is a farmer with 0.5 ha land or another worker with monthly income less than 600,000 rupiah		
Yes	1,800	57.6
No	1,325	42.4
Head of HH highest education		
No school	779	24.93
Elementary school	1,007	32.22
Junior high school	392	12.54
Senior high school	634	20.29
Academy/Diploma	119	3.81
University	194	6.21
Have asset worth 500,000 rupiah for each		
No asset	359	11.49
1-2 assets	1,490	47.68
3-4 assets	835	26.72
5-6 assets	391	12.51
7-8 assets	50	1.6

Appendix 2: Support Team
Phone Survey Older People and COVID-19 in Indonesia

NO.	NAME	POSITION
1.	Santi Wulandari	PIP
2.	Laura Novianti	PIP
3.	Tri Welas Asih	PIP
4.	Faroh Dina	PIP
5.	Ayudya Prima Safirawati	PIP
6.	Sunar Indriati	Supporting Training
7.	Alfi Nurjanah	Enumerator
8.	Darmadi	Enumerator
9.	Desi Ayu Prabawati	Enumerator
10.	Dhika Pratama Arizona	Enumerator
11.	Ega Wisnu Selia	Enumerator
12.	Emha Dzia'ul Haq	Enumerator
13.	Fajar Kumala	Enumerator
14.	Hafidz Abdul Aziz	Enumerator
15.	Hari Hadiyatullah	Enumerator
16.	Hasan Rifai	Enumerator
17.	Hendra Priyantoro	Enumerator
18.	Ika Bhineka Lestari Pertiwi	Enumerator
19.	Imam Ahmad	Enumerator
20.	Karina Rani Wijayanti	Enumerator
21.	Khoirul Mustangin	Enumerator
22.	Mega Sugesti	Enumerator
23.	Muh. Satryawansyah	Enumerator
24.	Nugroho Dwi Prastyo	Enumerator
25.	Putut Krisna Aji	Enumerator
26.	Rohmah Ahdiyati	Enumerator
27.	Sabriena Yully Puspita	Enumerator
28.	M Arif Darmawan	Enumerator
29.	Sutianik Romadhoni	Enumerator
30.	Tommy Setiawan	Enumerator
31.	Wulan Praptiwi	Enumerator
32.	Agung Tri Prabowo	Enumerator
33.	Firda Amalia Sekarningrum	Enumerator
34.	Suprafti	Enumerator
35.	Zainal Abidin	Enumerator
36.	Rissa Nurashri Habibu	Enumerator