2021

VOLUNTARY NATIONAL REVIEW (VNR)

ON THE IMPLEMENTATION OF THE 2030 SDGS IN THE IMPACTS OF COVID-19 PANDEMIC IN INDONESIA

THE INCLUSION OF OLDER PERSONS

COMPREHENSIVE REPORT BY

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Acknowledgement

This report has been prepared as a part of the 2021 VNR on the progress and achievement of the nine SDGs Goals, Goal 1, 2, 8, 10, 12, 13, 16 and Goal 17. We thank Bappenas and SDGs Secretariat, in particular Dr. Subandi Sardjoko, Deputy for Human Development and Culture and Ibu Ms. Woro Srihastuti Sulistyaningrum S.T., MIDS, Director for Family, Women, Children, Youth and Sports who put high concern on the inclusion of older persons in the SDGs Goals. It is highly important and timely as Indonesia is on the threshold of aging society which will bring social, health, economic, and political effects on people's lives, not only on the older persons, but also the family and the government. Inputs and advices from colleagues at the Ministry of Health Sub Directorate of Healthy Aging, and from the Ministry of Social Affairs Directorate of Rehabilitation on Aging issues, enrich this report.

We also grateful to friends at the BPS Statistics Indonesia related to access of relevant data and consultation about the reliability and validity of statistics. Especially we are grateful to Ms. Sri Soelistyowati M.A., former Deputy Chief Statistician for National Account and Statistical Analysis; Dr. Ali Said, M.A., Director of Analysis and Statistical Development. Special thanks go to Dr. Windhiharso P.A. Putranto, Deputy Director for Indicator Statistics and team for their invaluable inputs regarding data on the impact of COVID-19 on older persons. Million thanks go to Mr. Gantjang Amanullah M.A., Former Director of Welfare Statistics at BPS, for fruitful discussions on SDGs Indicators.

This study is not possible without the support and advice from UNDP, UNCR, UNFPA (Indonesia country office), with special thanks to Ms. Anjali Sen, the UNFPA Indonesia representative. Many thanks go to Pak Richard, Dikot, Bu Imma and Jumita, four your invaluable inputs, your leadership and advice and facilitation are well appreciated. From Knowledge Hub KRI, thanks to Prof. Budi Utomo, for your leadership and coordination, and to Bu Nohan, Bu Restu, thanks a million for facilitating this work.

Many thanks are to friends from Lembaga Demografi Faculty of Economics and Business Universitas Indonesia for discussions related to SDGs' targets and indicators; to my partner who worked on the inclusion on aging issues, Ms. Elda Luciana Pardede M.Sc., Ph.D. candidate of Department of Demography, Faculty of Spatial Sciences University of Groningen, and Faizal Moeis, research assistant who is very smart in developing poverty rates for older persons and deprivation of basic services. Your helps are most appreciated.

Sri Moertiningsih Adioetomo
Jakarta, 6 June 2021

List of Abbreviations

Abbreviations	Indonesian Language	English
ADL	*Aktivitas Hidup Sehari-hari*	Activity Daily Living
BPNT	*Bantuan Pangan Non Tunai*	Non-Food Cash Assistance
BPJS	*Badan Penyelenggara Jaminan Sosial*	Social Security Administrative Body
BPS	*Badan Pusat Statistik*	National Statistics Office
BRS	*Berita Resmi Statistik*	Official Statitic News
BUMDES	*Badan Usaha Milik Desa*	Village-Owned Enterprise
BUMN	*Badan Usaha Milik Negara*	State-Owned Enterprise
COVID-19	*Penyakit disebabkan Virus Corona*	Coronavirus Disease 2019
DTKS	*Data Terpadu Kesejahteraan Sosial*	Integrated Social Welfare Database
FLW	*Kehilangan dan Kemubaziran Makanan*	Food Loss and Waste
GBV	*Kekerasan Berbasis Gender*	Gender-Based Violence
GDP	*Produk Domestik Bruto*	Gross Domestic Product
GERMAS	*Gerakan Masyarakat Hidup Sehat*	Healthy Living Society Movement
HALE	*Angka Harapan Hidup Sehat*	Health Adjusted Life Expectancy
HH	*Rumah Tangga*	Household
IADL	*Aktivitas Hidup Sehari-hari yang Instrumental*	Instrumental Activity Daily Living
ICT	*Teknologi, Informasi, dan Komunikasi*	Information, Communication, and Technology
IMR	*Angka Kematian Bayi*	Infant Mortality Rate
IPK	*Ikatan Psikolog Klinis*	Indonesian Clinical Psychologists Association
IUGR	*Pertumbuhan Janin yang Terhambat*	Intrauterine Growth Retardation
IT	*Teknologi Informasi*	information Technology
JAMKESDA	*Jaminan Kesehatan Daerah*	Local Social Insurance
JKN	*Jaminan Kesehatan Nasional*	National Social Insurance
KAP	*Pengetahuan, Sikap dan Praktik*	Knowledge Attitude and Practice
KKS	*Kartu Keluarga Sejahtera*	Family Welfare Card
KPM	*Keluarga Penerima Manfaat*	Family Beneficiaries of Social Assistance
KPPPA	*Kementerian Pemberdayaan dan Perlindungan Perempuan dan Anak*	Ministry of Empowerment and Protection of Women and Children
KPS	*Kartu Perlindungan Sosial*	Social Protection Card
KTP	*Kartu Tanda Penduduk*	Identity Card
KUBE/KUB	*Kelompok Usaha Bersama*	Local Joint Venture Group
KUR	*Kredit Usaha Rakyat*	People's Business Credit
LNPRT	*Lembaga Non-Profit yang Melayani Rumah Tangga*	Non-Profit Institution Providing Services for the Households
MMR	*Rasio Kematian Ibu (Karena Kehamilan)*	Maternal Mortality Ratio
MOHA	*Kementerian Kesehatan Republik Indonesia*	Ministry of Health
MSMEs	*Usaha Mikro, Kecil, dan Menengah*	Micro, Small, and Medium Enterprises

NCDs	*Penyakit Tidak Menular*	Non-Communicable Disease
NEET	*Tidak bekerja, tidak bersekolah atau mengikuti pelatihan dan tidak mencari pekerjaan*	Not in Employment, Education or Training
PBI	*Penerima Bantuan Iuran*	Beneficiaries of Social Insurance with Membership Paid by the Government
PERPU	*Peraturan Pemerintah Pengganti Undang-Undang*	Government Regulation in Lieu of Law
PHK	*Pemutusan Hubungan Kerja*	Employment Termination/Discharge
PIP	*Program Indonesia Pintar*	Smart Indonesia Program
PISA	*Program Penilaian Pelajar Internasional*	Program for International Student Assessment
PKH	*Program Keluarga Harapan*	Family Hope Program-Conditional Cash Assistance
PoU	*Prevalensi Kekurangan Gizi*	Prevalence of Undernourishment
Posyandu	*Pos Pelayanan Kesehatan Terpadu*	Integrated Health Posts
PPA-PKH	*Program Nasional Pengurangan Pekerja Anak dalam Rangka Mendukung Program Keluarga Harapan*	National Program for Reducing Child Labor to Support Family Hope Program
ProKes	*Protokol Kesehatan*	Health Protocols
PSBB	*Pembatasan Sosial Berskala Besar*	Large-Scale Social Distancing
Puskesmas	*Pusat Kesehatan Masyarakat*	Community Health Center
PUSTU	*Puskesmas Pembantu*	Auxiliary Primary Health Center
Raskin	*Beras untuk Rumah Tangga Miskin*	Rice Subsidy for the Poor
Rastra	*Beras Sejahtera*	Rice for the Poor
RKP	*Rencana Kerja Pemerintah*	Government Annual Workplan
RPJMD	*Rencana Pembangunan Daerah Jangka Menengah*	Medium-Term Regional Development Plan
RPJMN	*Rencana Pembangunan Jangka Menengah Nasional*	Medium-Term National Development Plan
Riskesdas	*Riset Kesehatan Dasar*	Basic Health Research
Sakernas	*Survey Angkatan Kerja Nasional*	National Labor Force Survey
SD	*Sekolah Dasar*	Primary School
SDGs	*Target Pembangunan Berkelanjuran (TPB)*	Sustainable Development Goals
SDS	*Online Survei Sosial Demografi Dampak COVID-19*	Social and Demographic Survey on the Impact of COVID-19
SJSN	*Sistem Jaminan Sosial National*	National Social Security System
SKTM	*Surat Keterangan Tidak Mampu*	Statement of Poverty Letter
SMIs	*Industri Skala Kecil dan Mikro*	Small and Micro Industries
SUPAS	*Survei Penduduk Antar Sensus*	Intercensal Population Survey
Susenas	*Survei Sosial Ekonomi Nasional*	National Socioeconomic Survey
TB	*Tuberkulosis*	Tuberculosis
TPT	*Tingkat Pengangguran Terbuka*	Open Unemployment Rate
UN	*Persatuan Bangsa-Bangsa (PBB)*	United Nations

UNDP	*Badan Program Pembangunan Perserikatan Bangsa-Bangsa*	United Natios Development
UNFPA	*Lembaga PBB untuk Dana Kependudukan*	United Nations Population Funds
UNICEF	*Dana Darurat Anak Internasional Perserikatan Bangsa-Bangsa*	United Nations Children's Fund
WASH	*Air, Sanitasi dan Higiene*	Water, Sanitation, and Hygiene
WB	*Bank Dunia*	World Bank
WHO	*Organisasi Kesehatan Dunia*	World Health Organization
Y-o-Y	*Perbandingan dari Tahun ke Tahun*	Year-on-Year

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EXECUTIVE SUMMARY

THE IMPACTS OF COVID-19 ON OLDER PERSONS AND THE ACHIEVEMENT OF THE 2030 SDGS AGENDA

Indonesia is doing better in mitigating the impact of COVID-19 than the neighboring countries (Hill, 2021). Nevertheless, the economic shutdown and mobility restriction have resulted in GDP contraction up to -5.31 percent during the second quarter of 2020 (y-o-y). Since then, it is slowly rebound, indicated by the reduction of the contraction to -3.49 percent during the third quarter and to -2.19 percent during the fourth quarter of 2020. The first quarter of 2021 shows that the contraction has become smaller to only -0.74 percent. However, this economic condition is not enough to lift the purchasing power of the people that the COVID-19 has hard hit. The -0.74 percent of economic contraction was contributed mostly by the contraction of household consumption by -1.22 (BPS, 5 May 2021). The COVID-19 has severe impacts on people's lives, especially on older persons who were already poor before the pandemic, as well as those who were vulnerable that could worryingly be plunged back into poverty.

The poverty rate among older persons is higher than the national average (Goal 1.2). Intervention to ease older persons' financial burden through social protection (Goal 1.3) and expanding employment for those who still want and can work (Goal 8.5) may reduce the poverty rate of older persons, which in turn can help to accelerate national poverty reduction (Goal 1.2). However, the COVID-19 has put the national poverty rate back to the level of 2017 (10.12 percent). At that time, the GDP growth was 5.07 percent, while now the GDP growth is still -0.74 percent in the first quarter of 2021. Thus, the current situation is much worse than that before the pandemic.

The effects of COVID-19 on older persons are carried through the nine goals of the 2030 SDGs agenda. Poverty and vulnerability increase food insecurity (Goal 2.1), which was apparent before the pandemic (Patunru & Amanta, 2021), in particular among older persons. Thus, there is a strong need to expand the coverage of social assistance in terms of food subsidy and prolong the duration of the social assistance (Goal 1.3). At the same time, the targeting system on the distribution of social assistance should be reviewed.

Access to and affordability of health services and care have been disrupted, which increases the unmet need for health services and care among older persons (Goal 3.8). The health system has also been disrupted due to the mobilization of health workers and the closing of many primary health care centers and clinics (Witoelar & Ryanti, 2021). On the demand side of the health system, older persons are advised to stay home to avoid getting an infection by the deadly virus. As Indonesia is reaching toward population aging, the increase in the size of the older population is accompanied by an increasing prevalence of non-communicable diseases (Ministry of Health, Agency of Research and Development, 2019). The COVID-19 has hampered routine checkups, treatment, obtaining medicine re-prescription and rehabilitation services. This situation has worsened the conditions of older persons suffering from NCDs. In addition, the uncertainties about the end of the pandemic have also disrupted the mental health of those with NCDs. These add the burden to provide health care support for older persons with NCDs

The effect of the disruption in the health system may take a long time to recover. To overcome the disruption, the government should prioritize the activation of primary health care and other clinic services to make health services closer to the patients in need. For older persons who have difficulties in accessing health services, home care may be a good alternative. One of the most critical issues is to find ways to include patients with NCDs, particularly those who need long-term care, in the entire health system, including referral and rehabilitation system (Goal 3).

Aside from NCDs, the massive education and information about the COVID-19 might also threaten older persons' mental health (Bessel & Bexley, 2021; Witoelar & Ryanti, 2021). The family of the older persons and the government should be cautious regarding untold fear or hidden effects due to the pandemics. The feelings of fear, anxiety and loneliness due to quarantine or isolation can lead to stress and depression among older persons. The duration of depression is difficult to determine, but it may take longer to recover in a pandemic situation. This situation may add another burden to the family, whether in terms of costs or time caring for the patients. For the government, the financial costs of health may increase. It is suggested that health care and services should also be included in the existing health system.

Regarding social health insurance, income and job loss among workers due to COVID-19 tend to lead to the discontinuation of JKN membership (Witoelar & Ryanti, 2021). If their family members paid older persons' membership before the pandemic, the job loss of family members might discontinue older persons' membership. This discontinuation contributes to the increase in unmet need for health services among older persons. It is hoped that the government increases the coverage of BPJS PBI and reallocates the budget if there is an indication of mistargeting (Goal 1.3). It is safe to conclude that the COVID-19 tends to delay the achievement of the entire Goal 3.

Violence against older persons might also have increased. Income and job losses among older and younger people can affect the safety of senior persons. Even before the pandemic, older persons have experienced theft, theft with assaults, and sexual assaults (BPS, Stastitik Penduduk Lansia 2020). Unfortunately, data on the impact of COVID-19 on violence or abuse against older persons are rare. Data collected by the KOMNAS Perempuan (2021) reveal that violence increases among couples since the relationship become more tensed than before the pandemic, perhaps due to decline income, job loss, or dispute about child care. These issues may also lead to violence against older people if the couples live in households with older persons as their members (Goal 16.2).

On the other hand, the availability and accessibility of the internet have prevented the massive layoff of workers due to the strategy of working from home (Manning, 2021). Nevertheless, the unemployment rate among older persons has increased, especially among those who work in service and social service sectors that are hardly hit (BPS, Beritas Resmi Statitik on Employment, 5 November 2021; BPS Online Survey Social and Demographic Impact of COVID-19) (Goal 8). Those who are hard hit by the pandemic are those with income up to 3 million Rupiah a month. Many poor people have also experienced a decrease in income. Still, they are challenged with the increase in food prices due to the disruption of production, supply chain, and distribution (delaying the achievement of Goal 2 and Goal 8). Financial stimulus and social assistance have to be expanded and prolonged (Goal 1.3).

Furthermore, access to mobile phones and the internet facilitates older persons to communicate with their families, relatives, and friends. This access reduces the feeling of loneliness due to isolation or

quarantine. However, older persons' access to the internet is only 11 percent, clustered among the higher educated, living in urban areas, and the wealthiest household expenditure category (Goal 17.8). Therefore, an intervention to increase IT literacy among older persons is a must. Increasing IT literacy among older persons can be done through the help of younger family or community members. For older persons who are still potentially economically active, having access to and using the internet facilitates them to obtain small credit for SMEs. Poor households with internet access can use KPS and KKS to get BPNT and PKH social assistance. Thus, the government has to expand internet access, especially in the areas of *TIGA T*, the frontier, outermost, and least developed regions. Infrastructure to increase the availability and accessibility of electricity and internet is highly needed (Goal 8.3 and Goal 8.5).

As for Goal 12 and Goal 13, we recommend to include human perspectives in the targets and indicators. Population growth, people's behavior, and climate change are highly intertwined, as people are the agents as well as the objects within the entire system of climate. It is also recommended to treat COVID-19 as a natural disaster, beside a health crisis, as mandated by the Government through Presidential Decree no 7 of 2020 (then revised with the Decree no 9 of 2020). In coping with the disaster, adaptation and mitigation has to be done to inhibit the spread of the COVID-19 and its effects on people's lives.

We conclude that the impacts of COVID-19 on older persons will delay the achievement of seven out of the nine goals presented in the coming VNR. Appropriate policies, strategies, and intervention focusing on mitigating the impact of the pandemic on older persons will help to accelerate poverty reduction at the national level.

1

THE REPORT

THE INCLUSION OF OLDER PERSONS IN THE 2021 VOLUNTARY NATIONAL REVIEW (VNR) REPORT

INTRODUCTION

1.1 INDONESIAN ECONOMY AND THE COVID-19

Indonesia has submitted the Voluntary National Review (VNR) 2017 and VNR 2019 to the International High-Level Political Forum (HLPF). This year the government intends to present the third 2021 VNR Report in July 2021 at the same forum. The forthcoming 2021 VNR will be affected by the severe impact of the COVID19 pandemic on achieving the Sustainable Development Goals (SDGs) in Indonesia. In particular, to the nine goals that will be presented in the 2021 VNR that are: Goal 1: No Poverty; Goal 2: Zero Hunger; Goal 3: Good Health and Well-being; Goal 8: Decent Work and Economic Growth; Goal 10: Reduced Inequality; Goal 12: Responsible Consumption and Production; Goal 13: Climate Action; Goal 16: Peace, Justice, and Strong Institutions; and Goal 17: Partnerships for the Goals.

During the last decades, Indonesia has made significant progress in maintaining economic growth at the level of 5 percent until 2019. At the same time, the poverty rate has declined from 13.3 percent in 2010 to 9.22 percent in September 2019. By 2020, the coverage of social health insurance which started in 2014, has reached 70.30 percent of the total population (BPS, Statistik Kesejahteraan Rakyat 2020). In minimizing the impact of COVID-19, Indonesia is doing better than the neighboring countries. Nevertheless, the economic shutdown and mobility restriction have resulted in the contraction of economic growth by -5.32 percent during the second quarter of 2020, to -4.39 percent during the third quarter, and -2.19 during the fourth quarter of 2020. The recent development has shown that the economic condition has started to bounce back slowly, with the contraction being minimized to -0.74 percent during the first quarter of 2021. This condition is promising for Indonesia, although the disruption of people's lives due to the coronavirus still prevails. This has created concern that it would have a long-lasting impact.

Early in 2020, the government quickly responded to the pandemic by launching instruments to inhibit the further spread of the COVID-19 and its impact on the people's lives, which regrettably jeopardizing the efforts to achieve the 17 SDGs goals. Since the philosophy of the SDGs is 'NO ONE LEFT BEHIND,' it is essential to also include the older persons' issues in each of the Goals and their detailed Targets, which were not accommodated in the VNR 2017 and VNR 2019.

This report, therefore, focuses on Indonesian older persons, their size, growth, distribution and their social, economic, and health conditions related to each of the nine goals previously mentioned. It is then followed by the social, economic, and health impact of the COVID-19 on older persons related to each of the nine goals and how it will disrupt the efforts to achieve the 2030 SDGs and Targets.

1.2 THE REASONS TO INCLUDE OLDER PERSONS IN 2030 SDGS AND TARGETS

Indonesia is on the threshold of an aging population. The recent 2020 Census has recorded 26.84 million of the older population age 60 years and older or 9.75 percent of the 270.2 million total population. It was projected that the number of older persons would increase to 42.8 million in 2030, which is the SDGs year, then to reach 63.3 million in 2045, the golden year of Indonesia. The share of older people was estimated to increase from 14.6 percent in 2030 to 19.9 percent in 2045. The social-political, health, and economic impacts of the massive population aging have to be anticipated from now on since the current situation of Indonesian older persons is not so rosy. Therefore, the appropriate intervention to maintain the quality of life of Indonesian older persons has to start from now on. One of the steps that can be taken is by including the potentials and challenges faced to achieve each of the nine goals concerning the issues on older persons presented in the coming 2021 VNR. Interventions and efforts to achieve the 2030 SDGs have to take into account the issues of older people.

Concerning the nine Goals of the 2021 VNR, it can be summarized that the poverty rate of older persons in 2019 (Goal 1.1) is higher than that of the national rate (11.2 percent compared to 9.22 percent). The coverage of social protection of older persons is low (Goal 1.3), but older persons households' access to basic services (Goal 1.4): electricity, safe water, and sanitation is better than that of the younger population. However, some portions of older persons are still challenged with deprivation of those basic services. As for Goal 2: No Hunger, it is difficult to estimate the prevalence of undernourishment among older persons due to technical problems in estimating the prevalence. For Goal 3: Health, the prevalence of older persons suffering from infectious diseases, in this case, Tuberculosis, is higher than that of the younger people. The percentage of older persons with unmet need for health services is high. In addition, older persons are usually accompanied by a high prevalence of non-communicable diseases.

Related to Goal 8: Productivity and Decent Work, many older persons are still working, particularly those of the young old. The average monthly income of older persons is very low, indicating that their work tends to be indecent. Older women and the oldest age group of the elderly are highly likely to depend on the transfer from children or other household members to cover daily expenses, indicating the lack of social protection. Goal 10: Inequality and Social Protection is highly related to Goal 1 previously described.

The targets and indicators of Goal 12 and Goal 13 are lacking in human perspectives, and therefore it is difficult to assess how older persons are being affected. One of the issues in which taking into account age differentials and thus older persons might be essential is food loss and food waste. It is

also difficult to assess how older persons have been impacted or have been the cause of climate change. It is, therefore, suggested to include older persons in these Goals by reviewing targets and indicators to include the human perspective.

The COVID-19 has caused massive disruption in the lives of older persons. Poverty and deprivation are upsurged. Income and job loss due to the pandemic have a tendency in increasing violent and assault against older persons if they live with family whose income decreases or job loss (Goal 16). Luckily, access and use of the internet (Goal 17) by older people prevent them from loneliness due to isolation or quarantine because of COVID-19. Communication with families, children and friends who live away from home are possible with the availability of mobile phone.

1.3 THE STRUCTURE OF THE REPORT

Following the introduction in Chapter 1, Chapter 2 deals with the method or approach to the study, desk reviews of existing national and international documents, reports, and studies about the impacts of COVID-19 on older persons. Consultative meetings with Bappenas related to the development of VNR and consultations with experts and officials related to the data development are reported. In Chapter 3, the situation analysis of the Indonesian older persons is reported (Section 3.1) and followed by the issues and challenges regarding older persons in achieving each of the nine goals (Section 3.11) that should be included in the 2021 VNR.

The first section of Chapter 4 (Section 4.1) reports the social, health, and economic impacts of COVID-19 on older persons. This section is followed by the second section of Chapter 4 (Section 4.4) on how the COVID-19 might delay the achievements of the nine goals focusing on the issues of older persons. Chapter 5 discusses challenges, and Chapter 6 presented the way forward in achieving the 2030 SDGs agenda when older persons are included.

2 APPROACH TO THE WORK

The aim of this work is Participatory and Inclusive Development of the 2021Voluntary National Review on the implementation of the 2030 Agenda in light of the impacts of the COVID-19 pandemic in the Republic of Indonesia. Thus, in developing the outputs, several steps have been undertaken: (1) A series of consultative meetings with Bappenas in particular with the consultants who develop the 2021 VNR for each of the goals; (2) Desk review on existing materials, official documents, publications, regulations and laws, survey findings related to older persons and COVID-19; (3) Review of existing data; if not available, data processing has to be done, in particular using the 2019 Susenas data, and in collaboration with BPS to rerun the BPS online survey on Social and Demographic Impact of COVID-19 to get the pictures on how the COVID-19 impacts older persons.

2.1 CONSULTATIVE MEETINGS WITH 2021 VNR CONSULTANTS FROM BAPPENAS

A series of consultative meetings have been conducted with the aim is to provide relevant inputs about the situation of Indonesian older persons to be included in each of the nine SDGs Goals. The first one was conducted to discuss the zero draft of Goal 3 of the VNR with Bappenas on Wednesday, 24 March 2021, at 09.00-12.00 Western Indonesia Time (Waktu Indonesia Barat, WIB). The agenda was to discuss the aspects of good health and well-being. The issues to be included in the 2021 VNR were the older persons' prevalence of TB, the prevalence of unmet need for health services, and the prevalence Non-Communicable Diseases (NCDs). It was followed by reviewing the zero draft of Goal 17 of the VNR on Thursday, from 08.00 WIB until the end. The agenda was to provide relevant inputs to be included regarding this goal, which were the older persons' access and use of the internet. The use of the internet facilitates older persons in maintaining communication with their family and friends and accessing the information on health services, financial transfers, or social

assistance. The concern was that the IT literate among older persons was clustered only among those with high education, living in urban areas, and among the wealthiest household expenditure category.

The subsequent discussion concerned the zero draft of Goal 16 of the 2021 VNR with Bappenas, which took place on Wednesday, 31 March 2021, from 13.00 to 15.00 WIB. Goal 16 is about Peace, Justice, and Strong Institutions. The issues that were relevant to older persons were Target 16.1 and 16.2 about Violence. Violence against older persons to be included were theft, theft with assault, and sexual assault.

The next one discussed the zero draft of Goal 2 of the VNR, Zero Hunger, with Bappenas. The lack of data hampered the inclusion of older persons' food security. Estimating the prevalence of undernourishment (PoU) among older persons is posed with a technical problem. Since the issue of food insecurity among older persons is critical, it was suggested that the SDGs Secretariat or Badan Pusat Statistik (BPS) would help provide the estimate of PoU among older persons. This meeting was held on Thursday, 1 April 2021, from 13.30 until 15.00 WIB.

On Monday, 12 April 2021, from 09.00 until 11.00 WIB, a meeting to review the zero draft of Goal 10 if the VNR was conducted with Bappenas. This goal is about Inequality and Social Protection, similar to Goal 1: Poverty and Social Protection. However, the analysis of Goal 10 achievements focused on the differentials between older persons and the national rates. Among older persons themselves, inequality persists between urban and rural residence, among age groups, and between genders.

Lastly, on June 7, the final draft of 2021 VNR was ready to review. We are happy that our inputs on important issues on older people's lives have been accommodated in the final draft, except issue on the prevalence of NCDs among older people.

2.1.1 The results of the meetings

Upon reviewing the second draft, that is draft one of the 2021 VNR (the revision of the zero draft), it was found that: (1) Older persons' poverty rates and social protection have been accommodated in draft 1 of Goal 1 of the VNR 2021; (2) Older persons' employment conditions have been accommodated in the draft 1 of Goal 8 of the 2021 VNR; (3) The issues of older persons and violence against older persons have been accommodated in draft 1 of Goal 16 of the VNR 2021; (4) The issues of older persons and their use of the internet have been accommodated in draft 1 of Goal 17 of the VNR 2021.

Later, these inclusions were elaborated in the final draft of the VNR 2021. In this final draft of VNR 2021, older persons issues that are included in Goal 1 are: Poverty Rate among older persons, Financial source to meet daily expenses, social protection and access to basic services; Goal 3: increases in the prevalence of unmet need for health services due to the impact of COVID-19; Goal 8. Older persons and work, informal and indecent work; Goal 16: Violence against older persons before and during the pandemic; Goal 17 older persons access and use of internet. Regretfully, the issue of Non-communicable Diseases among older persons is left behind. This is highly important to discuss, therefore, we suggest to include the prevalence of NCDs in the 2021 VNR.

2.2 DESK REVIEW OF EXISTING DOCUMENTS AND MATERIALS RELATED TO SDGs

Desk review of some documents and materials has been conducted to provide materials to produce this report. We have reviewed the publication of the VNR of 2017 and VNR 2019, SDGs Road Map 2020, and Meta Data 2020. We have also reviewed BPS publications that are relevant. The goal is to provide information regarding older persons' social, economic, and health situations in Indonesia in 2020 and before, if necessary. The

other source of data is the online surveys conducted by BPS on the social and demographic impacts of COVID-19.

Other reports and publications of other surveys related to the impacts of COVID-19 have also been reviewed. The first one is the survey report on older people and COVID-19 in Indonesia by ERIA, Bappenas, and Survey Meters (see Komazawa, et. al., 2021). The second one is the quantitative analysis of the Susenas 2019 combined with qualitative survey on household impacts of the COVID-19 by UNICEF et al. (2021).

A review of rules and regulations launched by Indonesian Governments has also been conducted, mainly related to the mitigation of the impact of COVID-19. Aside from this, we have also reviewed the government's documents, such as the Bappenas Rencana Kerja Pemerintah (RPK) 2021. We also reviewed other national and international publications related to older persons and COVID-19.

2.3 REVIEW OF DATA AND METHODS

To develop the report, we have used the existing publications from BPS based on Susenas 2015-2020, Sakernas 2015-2019, Supas 2015, including Statistics Indonesia, Berita Resmi Statistik on Poverty, Economic Growth and Employment 2020 and 2021. We have also used the publications of the Ministry of Health surveys, which are Riskesdas 2003, 2007, 2013, and 2018.

Aside from BPS and the Ministry of Health publications, we are also using the raw data if the information is not available in the publication. A research assistant from the Faculty of Economics and Business University of Indonesia conducted data processing of 2015-2019 Susenas. The staff of BPS also worked on data processing with a focus on older persons. These activities have included discussion regarding data quality, methodology of data collection, robustness, and the limitations of the study.

3

NO ONE LEFT BEHIND:

THE INCLUSION OF OLDER PERSONS IN SDGS 2030

3.1 THE CURRENT AND FUTURE SIZE OF OLDER PERSONS IN INDONESIA, 2015-2045

The success of Indonesian Government in managing population growth in line with social and economic development since early 1970s have resulted in an increase in life expectancy at birth from 45 years in 1971 to 71.3 years in 2019[1]. This increases the number of older people age 60 years and over in Indonesia which reached 26.2 million, recorded by 2020 Population Census[2]. It was projected that in 2030 the number of older persons will reach 42.8 million with higher number of older females (22.5 million) than the older males (20.3 million) (Figure 3.1) (see also Annex 1).

With the increasing size of older population, Indonesia is moving toward an aging society with the share of older persons 9.78 percent to total population in 2020. This was projected to increase to 14.6 percent in 2030 and increase again to 19.9 percent in 2045, when Indonesia enters the era of golden period, 100 years since the Independence (Figure 3.2).

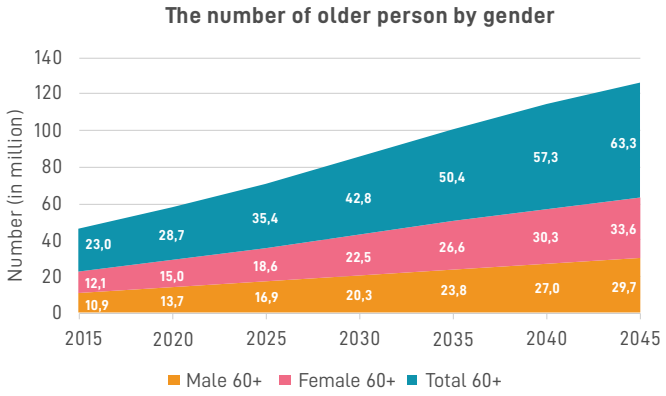


Figure 3.1 The past, current and estimated numbers of older persons 60 years and older by gender, 2015-2045

Source: Bappenas, BPS, and UNFPA (2018), Indonesia Population Projection 2015-2045.

[1] WHO Global Health Estimates 2019. Geneva: World Health Organization, 2020. https://www.who.int/data/global-health-estimates

[2] This is lower than estimated by Susenas 2020, that is 26.82 (BPS (2020), Statistik Penduduk Lansia 2020) and Population Projection 2015-2045 (see Figure 3.1).

This is a celebration, a reflection that older persons now are healthier, have better education and knowledge, and enjoy living with smaller families than the earlier generations. However, this celebration is also accompanied by challenges. Naturally older persons experience declining functional capacity: physical capacity, cognitive/memory/concentration, and emotional capacity. In addition, older persons are prone to suffer from non-communicable diseases: high blood pressure, heart disease, diabetes, obesities, that may be carried on since when they were younger. This declining functional capacity tends to result in the decline of capacity to earn income while at the same time health expenditure increases. This combination cause for concern among policy makers about how to maintain the quality of life of older persons and whether social protection is the best strategy.

Unlike developed countries, Indonesia still enjoys a large number of people at the working age. But the speed of growth of the number of older persons due to the fast increase in life expectancy may result in the decline in the support ratio, which is the ratio of the number of persons at the working age (who are potential) to (support) one older person. In the long run, the condition is alarming because while the support ratio was 12 in 2015, it has declined to only 10 by 2020. It was projected to decline further to seven workers to one elderly person by 2030, and then five workers to one older person in 2045 only (Figure 3.2 see also Annex 2 for the calculation). While older persons' needs for social, economic and health supports increase, the support ratio decreases. This condition should be anticipated from now on to overcome this future problem. The increasingly large number of older persons will absorb resources for social protection, which is mostly derived from the tax accumulated by the working age population. Therefore, it is important for policy makers not only to maintain the quality of life of older persons, but also to promote healthy and productive aging.

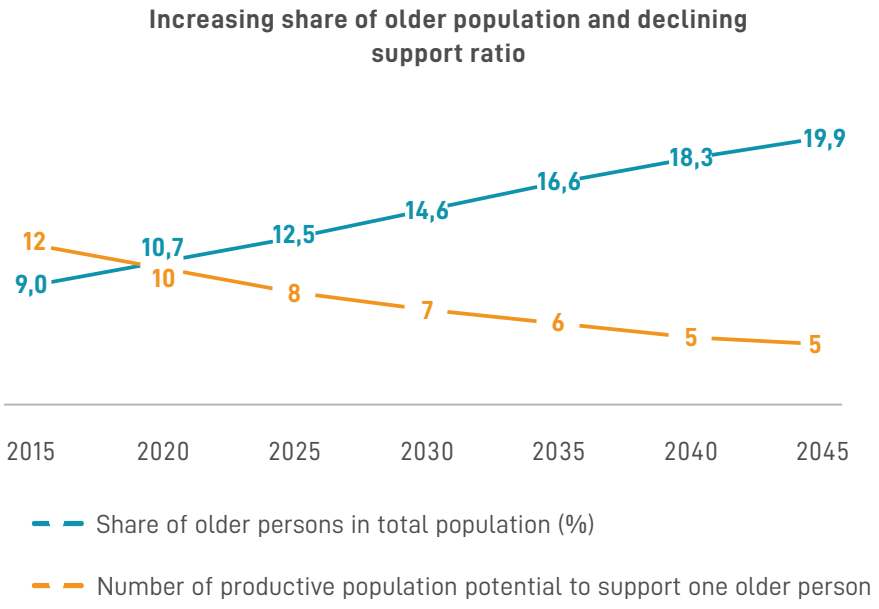


Figure 3.2 The percentage of older persons to total population and the number of productive population potential to support one older person (Support Ratio), 2015-2045

Source: Bappenas, BPS, and UNFPA (2018), Indonesia Population Projection 2015-2045.

3.2 LIFE EXPECTANCY AND HEALTH ADJUSTED LIFE EXPECTANCY (HALE)

While waiting for the detailed results of 2020 Population Census, this document makes use of the SUSENAS dataset collected in March 2020. This survey recorded that among the 26.82 million of older persons in 2020, 47.7 percent were males and 52.3 percent were females. The sex ratio was higher for older females due to longer life expectancy of females than that of males. It was expected that older women would live for 19.1 more years from 2019, longer than for older men which was 16.7 more years. However, living longer does not always mean healthier. In 2019, although Health Adjusted Life Expectancy (HALE)[3] at birth for females (63.8 years) was still higher than that for males (61.9 years), females experienced longer healthy life lost (9.5 years) than males (7.5 years) (Annex 3). This means that while females tend to live longer, they tend to be not as healthy as males. WHO estimated that during 2000-2019 Indonesians experienced increase in HALE at birth by 3.5 years for men and 4.2 years for women[4].

3.3 DISTRIBUTION OF OLDER PERSONS BY AGE, GENDER AND PLACE OF RESIDENCE

The Indonesian older persons were dominated by the young old age 60-69 years that covers 64.3 percent, while those age 70-79 years and 80 years and older were 27.2 percent and 8.5 percent, respectively (Figure 3.3). About 53 percent of the older persons lived in urban areas and the rest lived in rural areas. After ten years in 2030, the young old will become 70-79 years, and the space will be replaced by the now 50-59 years which is also a large number but is expected to have better education (see Figure 3.5).

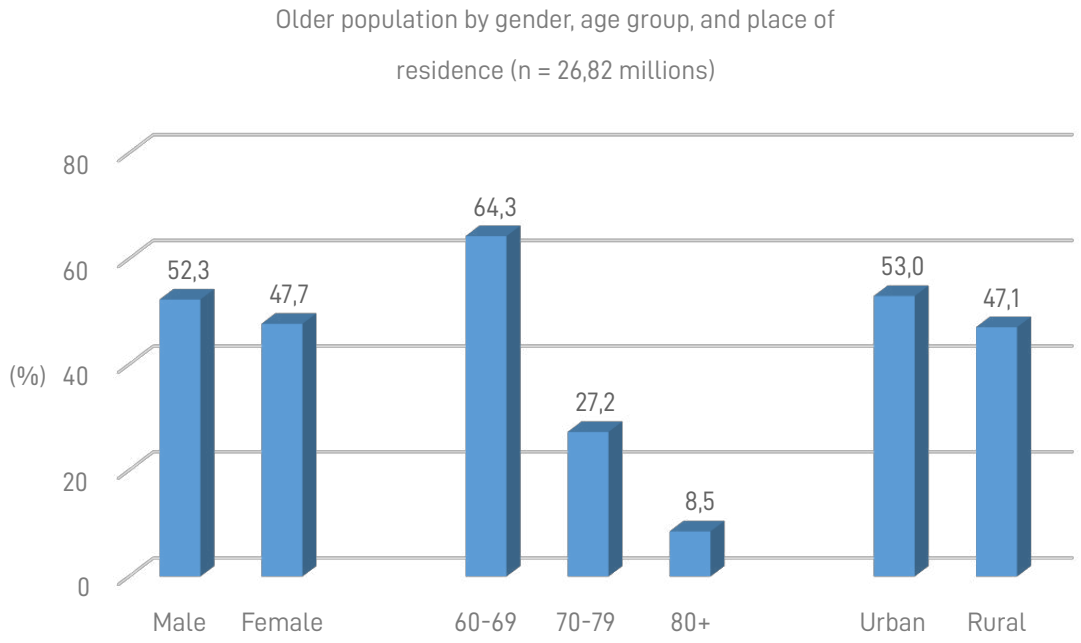


Figure 3.3 The distribution of older persons by gender, age group, and place of residence, 2020

Source: BPS (2020), Statistik Penduduk Lanjut Usia 2020.

[3] Health-adjusted life expectancy (HALE) is the average number of years that a person is expected to live in good health by taking into account years lived in less than full health due to disease or injury.

[4] WHO (2020), WHO Global Health Estimates 2019. Geneva: World Health Organization,2020. http://www.who.int/data/global-health-estimates

3.4 REGIONAL VARIATIONS OF POPULATION AGING

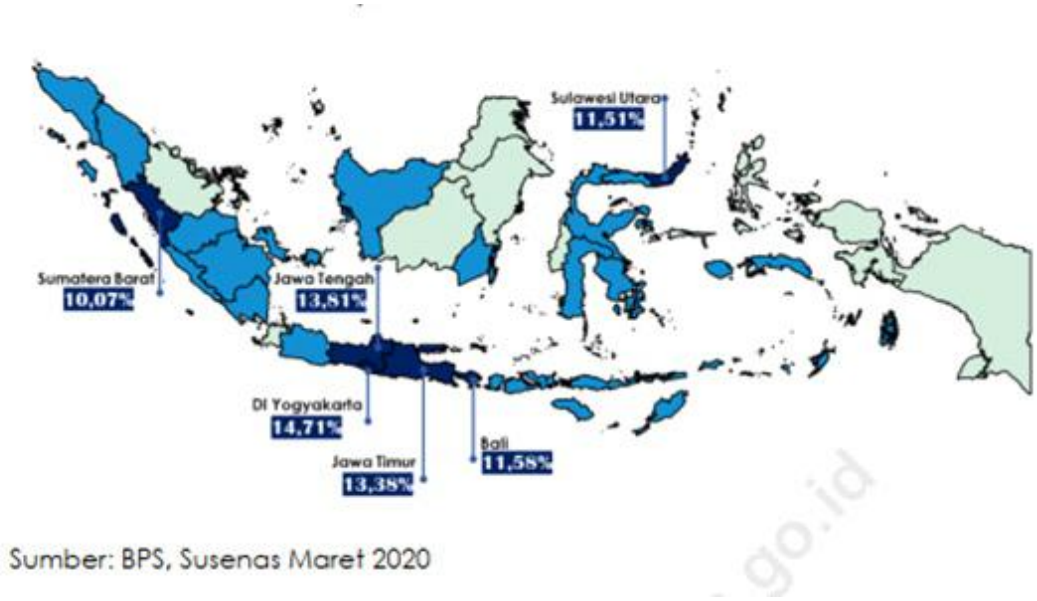


Figure 3.4 The level of population aging by province in Indonesia,

Source: Copied from BPS (2020), Statistik Penduduk Lanjut Usia 2020.

The rate of aging is not the same across the provinces. It depends on the government's success in population control through fertility reduction in the past. Provinces that are already reaching population aging by 2020 are Yogyakarta (14.7 percent), Central Java (13.8 percent), Bali (11.6 percent), and North Sulawesi (11.5 percent) (Figure 3.4).

3.5 THE SOCIAL CHARACTERISTICS OF INDONESIA'S OLDER PERSON

3.5.1 Education of older persons

The older persons nowadays were born many years before the launching of the 1973 Presidential Decree to establish primary school at least one elementary school (SD) for each village. Therefore, it is not surprising that the majority of older persons have low education with mean years of schooling of only 5 years. About 78 percent of them only finished primary school or even lower. Some have no schooling at all. Figure 3.5 shows that the oldest old have the lowest level of education, followed by the middle old (age 70-79), and then by the young old (60-69 years) with the highest level of education. This indicates 'cohort effect', showing improvement in education achievement, although still very minimal. Nevertheless, there is a hope that the future older persons will have better education.

The gender bias in education in the past was carried over until the girls and boys became old in 2020. Consequently, the older men were better educated than the older women. As for the place of residence, those who lived in rural areas were less educated than those who lived in urban areas. This shows that education development during that time (they were born between 1940-1960) was focused more in urban rather than rural areas.

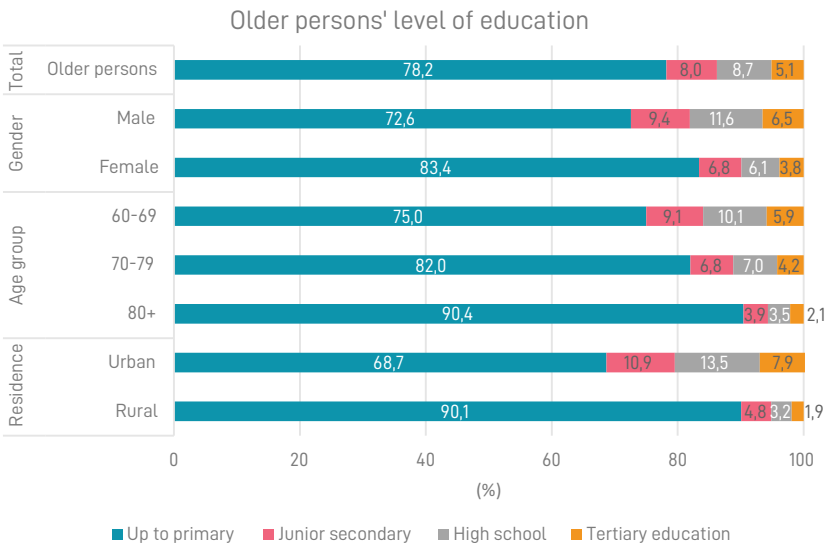


Figure 3.5 The distribution of older persons by the level of education, gender, age group, and place of residence, 2020

Source: BPS (2020), Statistik Penduduk Lanjut Usia 2020

3.5.2 Marital status and older persons as head of household

It is important to know older persons' marital status because it is related with their living arrangement. Information regarding with whom older persons live can indicate the presence of potential caregivers in the house. Figure 3.6 shows that 61 percent of older persons were married while 35.7 percent were widows or widowers, but these percentages were disproportionately distributed between genders. About 81 percent of older men were still married at the time of the survey while this number was only 42 percent for older women. This is consistent with the much lower percentage of older men (15.7 percent) who were widowers compared to 54 percent of older women who were widows. It seems to be a common perception that after their wives die, older men tend to remarry, while this is not the case for older women. This situation bears different social and economic consequences among older men and older women. Regarding area of residence, there was no striking difference about marital status between those living in urban as compared to those living in rural areas.

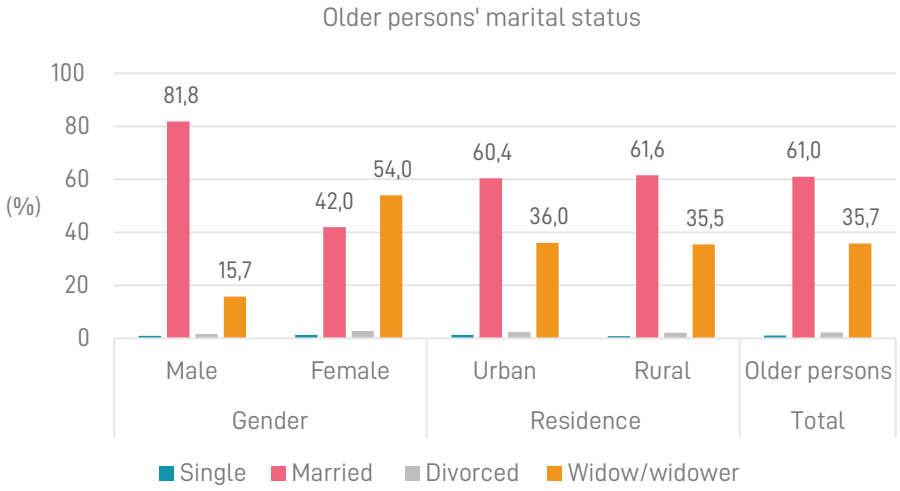


Figure 3.6 The percentage of older persons by marital status, gender, and place of residence, 2020

Source: BPS (2020), Statistik Penduduk Lanjut Usia 2020.

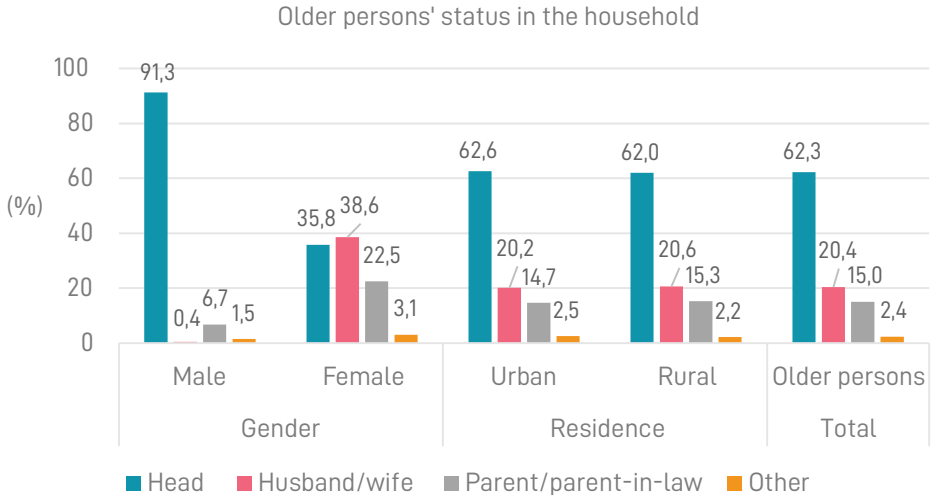


Figure 3.7 The percentage of older persons by their status in the household, gender, and place of residence, 2020

Source: BPS (2020), Statistik Penduduk Lanjut Usia 2020.

Marital status also related with the status in the household. Figure 3.7 shows that among the 26.8 million older persons, 62.3 percent of them were the household heads, 20.4 percent were the wives or husbands of the household heads, and 15 percent were the parents or parent-in-laws. By gender, however, almost all of male older persons (91%) were the heads of the households and 6.7 percent were the fathers or fathers-in-law of the heads of the households. It may indicate that most of the 60+ males might still be in charge of the management of the household. The question is whether they had enough resources to take responsibility of the welfare of their household members. As for the older women, there seems to be equal distribution between the status as the head (35.8 percent), as the wife of the head of the household (38.6 percent) and as the mothers or mother in-laws of the head of the household (22 percent). The pattern for older women is interesting because 36 percent of them, those who were the heads of household, were presumably widows. The higher percentage of older women as mother/mothers-in-law (22.2 percentage) compared to those of the older men (6.73 percentage) may indicate that older women enjoy to live with family and show the potential of the availability of caregivers. On the other hand, it poses question that whether the older women who were in charge as the heads of the households have sufficient resources to cover the household expenses.

3.5.3 Older persons and living arrangement

Aside from marital status and status in the household, knowledge about older persons' living arrangement can also show whether there are potential caregivers at home. Figure 3.8 shows that more than one-third of older persons lived with their children and grandchildren. This is promising in terms of availability of potential caregivers.

Analysis derived from IFLS 2014 show that caregivers for older persons tended to be daughters (62 %), granddaughters (14%), or daughters-in-law (5.7%) and other female family members living in the same household[5]. Unfortunately, female caregivers' welfare is often neglected. An ample of evidence show that caregivers had to quit their jobs to provide care

[5] Author's calculation from IFLS 2014 raw data

for the mothers or in-laws, so compensation for them should be considered. Furthermore, female labor force participation has always been lower (by half) than that of male. So, when non-working women doing caregiving, they do not have pensions nor saving to cover their expenses when they become old.

In this sense, the fact that about 40 percent of older persons lived three generations under one roof should be appreciated and maintained because the presence of other adult members who live in the same household is potential to help covering daily expenses incurred by older persons. Another 28 percent of older persons lived with their nuclear family members (spouse and children) which sounds ideal. However, they might be the young old who were still independent to do all the activity daily living (ADL) and did not need other persons as caregivers.

Another 21 percent of older persons lived only with their spouses. This is worrying if both husband and wife are older persons, who are more likely to suffer non-communicable diseases. In case of emergency such as a fall or a stroke, an older spouse is less likely than a younger spouse to respond immediately. They most likely need another person to help. It is strongly suggested to policy makers and stakeholders to develop an online system (such as 911 call in the US) to connect the older couples' house with the ambulance, nurses, or emergency unit for immediate response.

This worrying situation is also happened with older persons living alone as one out of ten of them lived alone. Who will take care of their welfare? Who provide the food, wash clothes or take them to the hospital when they are sick? Who will bear the costs of caring for the older persons? These questions are applied more to older women as 14 percent of them lived alone while only 5 percent of older men lived alone. This is consistent with the facts that older women were more likely to be widows (in addition to having the responsibility as the head of the household) than older men to be widowers. Further examination is needed about how these older women living alone fulfil their daily needs for food and health care. Do they have social protection? On the other hand, older females were more likely to live three generations under one roof than the older males. So, the availability of potential caregiver exists.

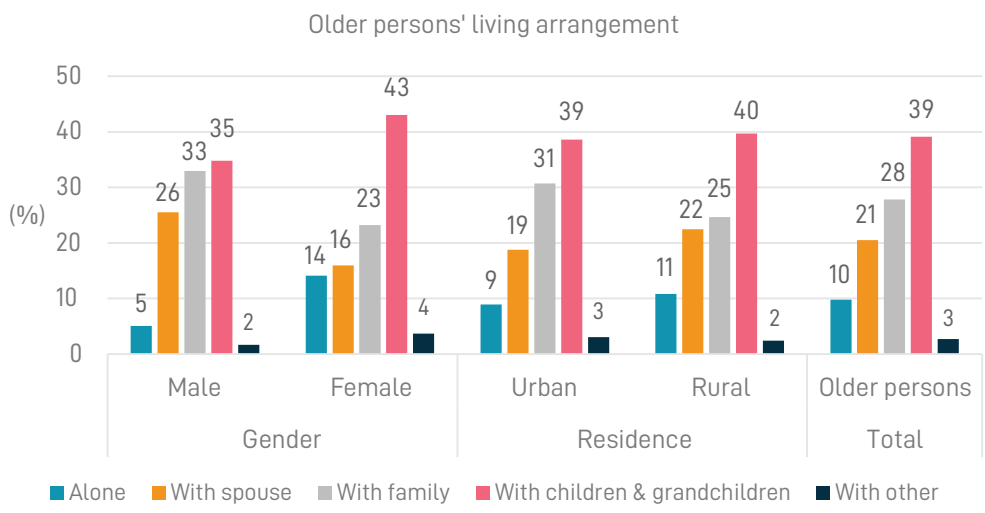


Figure 3.8 The percentage of older persons by living arrangement, gender, and place of residence, 2020

Source: BPS (2020), Statistik Penduduk Lanjut Usia 2020

Overall, the household structure in Indonesia is changing towards a small and nuclear family and out migration of female household members to other locations has become much more common. These conditions reduce the number of potential caregivers in the older persons' households.

3.5.4 Information Technology (IT) literacy, access and use of internet

COVID-19 has sped up the digitalization of communication that has been penetrating the world including Indonesia that started many years ago. The COVID-19 pushes people toward using gadgets/computers and internet to facilitate them in obtaining information about the supplies of goods (food, medicine) and services (health care). The expansion of digital marketing and online shopping has begun to form a new behavior. Older people, who are mostly forced to be isolated, are also pushed to use internet to communicate with their families, friends, and community and to access information regarding health services, supply of medicine, or cash transfer through internet. The possibility to communicate online may help the older persons not to feel lonely and thus prevent them from depression.

However, the access and use of internet among older persons are still limited. Figure 3.9 shows that overall, only 11.44 percent of older persons used or had access to internet, which is very low compared to 47.69 percent of the national level in 2019. Although half of the older persons used mobile phones (45 percent), but not all of the mobile phones have internet access.

The older persons who lived in urban areas were more likely to use the internet (18 percent) than those in rural areas (4 percent). Gender divide was also apparent, with 14.35 percent of older males compared to only 8.79 percent of older females had access to internet. Cohort effect was shown by the declining percentages of those who used internet by older persons' age group. The highest was of the young old (60-69) (14.75 percent), followed by of those age 70-79 (6.49 percent), and then the oldest old age 80+ (2.25 percent).

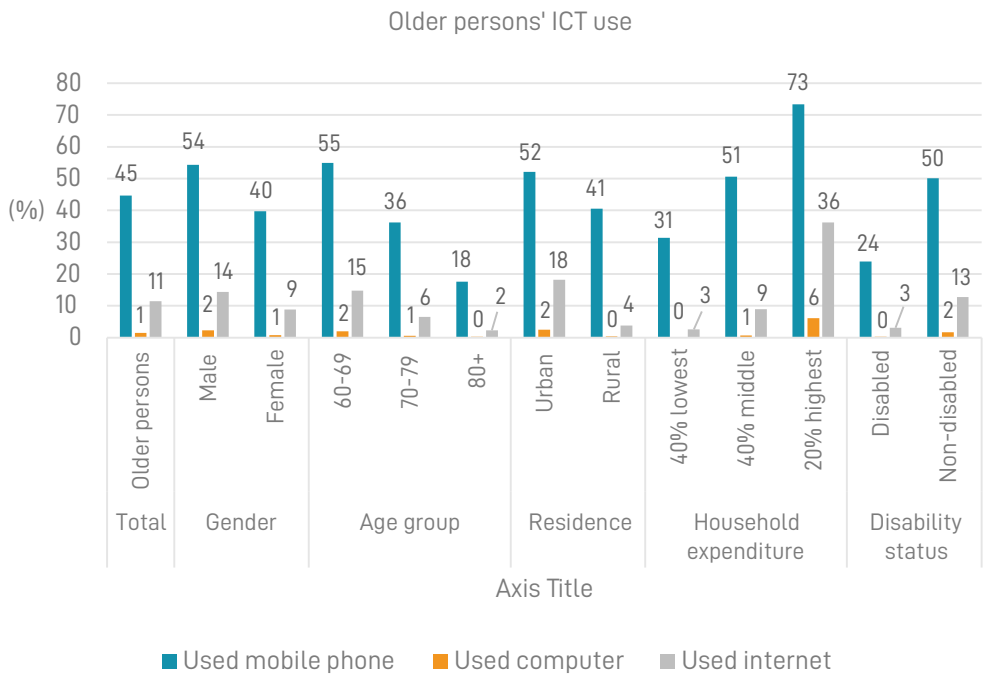


Figure 3.9 The percentage of older persons who had access and used information and communication technology (ICT) by gender, age group, place of residence, household expenditure category, and disability status, 2020

Source: BPS (2020), Statistik Penduduk Lanjut Usia 2020

Not surprisingly, the use of internet was clustered around the richest (20 percent upper HH expenditure) that is 36.17 percent, as compared to only 9 percent and 3 percent of those who were in the category middle and poorest HH expenditure, respectively. The use of internet among older persons with disability, is very low that is 3 percent compared to 13 percent of older persons not disabled.

Thus, digital divide is not only apparent between the older and younger population, but also among the older persons themselves, due to the differences in social and economic status and gender. Thus, there is an urgent need for the government to expand the internet coverage of older persons, especially for those who live in rural areas, female older persons, and those who come from lower socio-economic status. Firstly, the government is strongly advised to expand the infrastructure so that internet become available, close and less costly (to ensure access). At the same time, it is vital as well to increase IT literacy among older persons. The easiest way is through intergenerational relationship or through accompaniment by others who are more IT literate.

This is because the digital and innovative economy are booming. E-commerce is rising very fast. Online marketing and shopping, e-bank money transfer, has become a new life style, especially due to the pandemic COVID-19. New information on health and medical technology is rapidly changing. Access to this information can improve elderly welfare.

3.6 ECONOMIC CONDITION OF OLDER PERSONS

3.6.1 Poverty rates of older persons

As shown in Figure 3.10, the poverty rates of older persons have always been higher than the national poverty rates. When the government was able to reduce national poverty rate into single digit in 2019[6], which was 9.4 percent, the poverty rate of older persons remained double digits, which was 11.1 percent. Looking at the trend, the poverty rates of the older persons declined from 14.1 percent in 2015 to 11.1 percent in 2019, which were consistently above the poverty rates of the younger persons and the whole population. The consistent pattern of decline for the older persons and the whole population suggests that the trend of poverty decline of older persons was the result of the government's effort to accelerate poverty reduction for the whole population. It is not yet seen that the poverty reduction among the older persons was due to a special program or intervention targeted especially on older persons. Because the poverty rates of older persons were always higher than the national rates, it is logical that a special program and intervention focusing on older persons, either by economic empowerment such as through the SMEs, or to expand social protection, may help acceleration of the poverty rate reduction of the whole population.

Furthermore, Figure 3.11 shows that as age increases, poverty rate also increases. The rates of those age 80 years and older have been almost doubled the rates of the young old 60-69 years. The poverty rates of the young old were similar to those of the national rates. The high poverty rates among those age 70 and older might be due to income loss and lacking in social protection. Therefore, intervention targeting to the older old (70+) will have better leverage in helping the effort to reduce overall poverty toward 2030. Expansion of social protection and increasing the number of PBI beneficiaries are among the suggested interventions.

[6] Raw data of 2020 Susenas was not yet available at the time when this was developed.

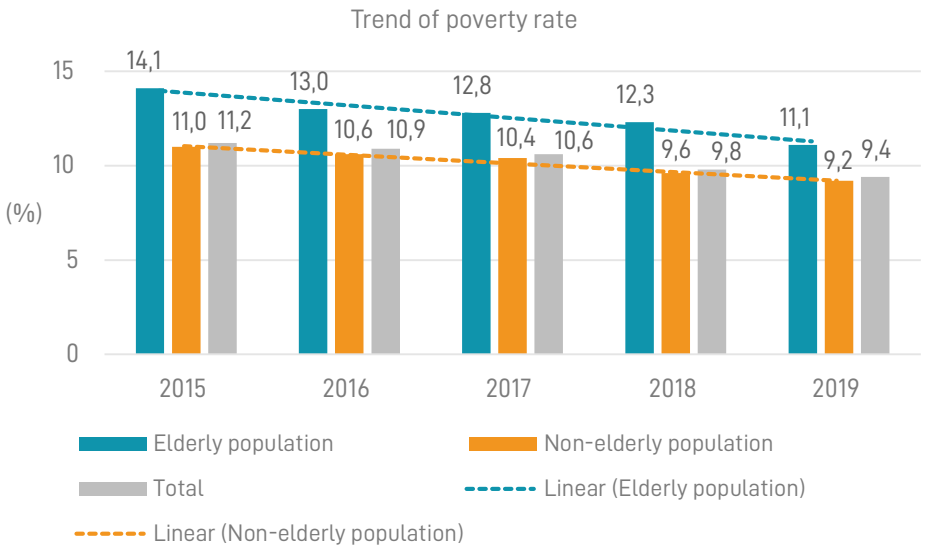


Figure 3.10 The trend of poverty rates for elderly, non-elderly, and total population, 2015-2019

Source: Susenas 2015-2019, author's calculation.

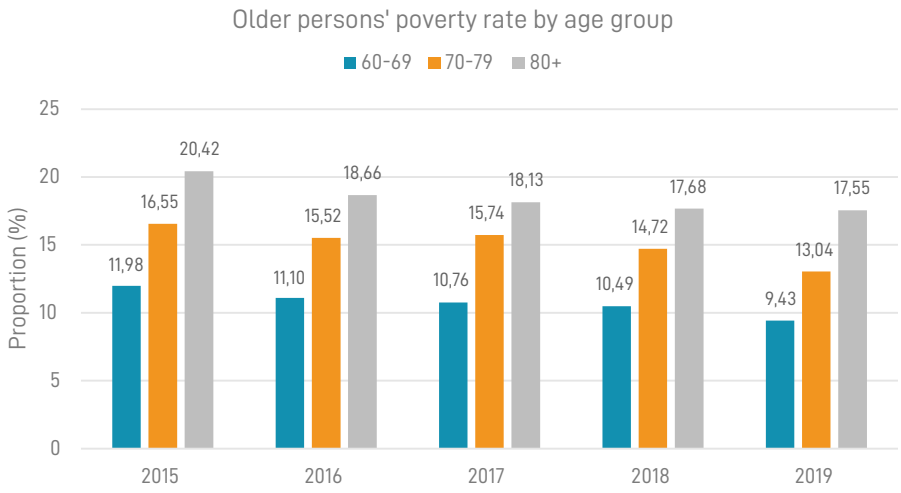


Figure 3.11 The trend of poverty rates of older persons by age group, 2015-2019

Source: Susenas 2015-2019, author's calculation.

Another way of measuring poverty is through categorization of household expenditure, which are the poorest 40 percent lowest of household (HH) expenditure, the middle 40 percent HH expenditure, and the upper 20 percent HH expenditure. Figure 3.12 shows that 43 percent of older persons fell in the category of the poorest 40 percent. There were 37 percent of older persons in the middle 40 percent category and only 19 percent of older persons were in the 20 percent highest expenditure. This pattern shows inequality among older persons. Older females were more likely to be poor than older men, and the oldest old were the most likely to be poor. It is not surprising that the disabled older persons had a higher tendency to be poor than the non-disabled ones, indicating evidence of discrimination.

Overall, the older persons have a higher tendency to be poor than the younger ones. Therefore, it is suggested that interventions and programs to reduce poverty rate of older person can help national efforts to reduce the poverty rates. Thus, the inclusion of older persons in accelerating poverty reduction, can also help reaching the target that '**no one is left behind**'.

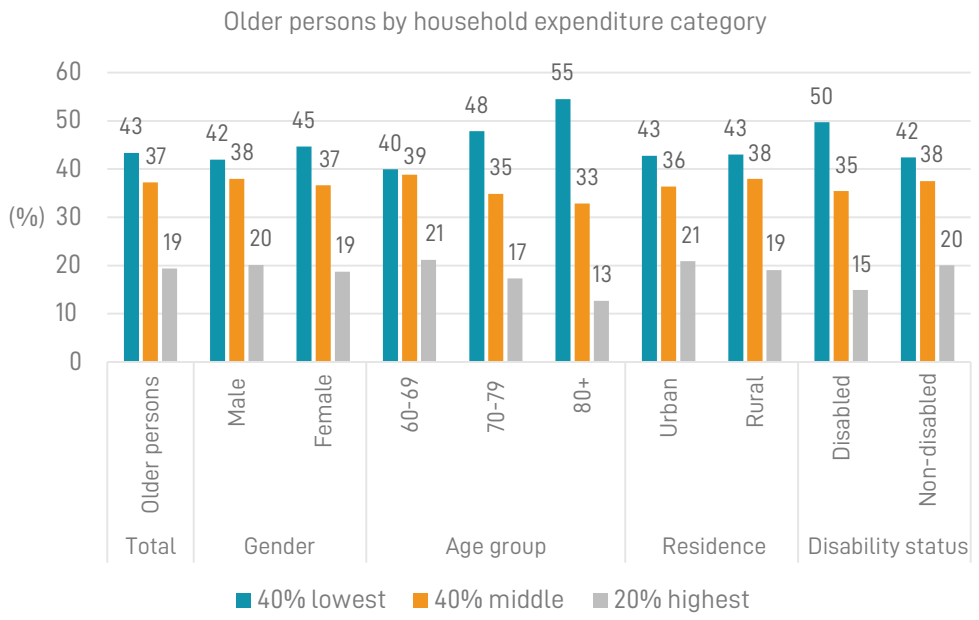


Figure 3.12 The distribution of older persons according to household expenditure category by gender, place of residence, age group, and disability status, 2020

Source: BPS (2020), Statistik Penduduk Lanjut Usia 2020.

3.6.2 Main source to cover expenses

Figure 3.13 shows that, for older persons, the main source to cover household expenses is mostly from work, whether the work is done by the older persons themselves or from another member of the household (81.8 percent for older males and 61.4 percent for older females). It is interesting to see the pattern that as age increases, more older persons need transfer (either in the form as cash or in kind) while only a small portion of them using their pensions. It is clear from this evidence that social protection for older person is highly urgent.

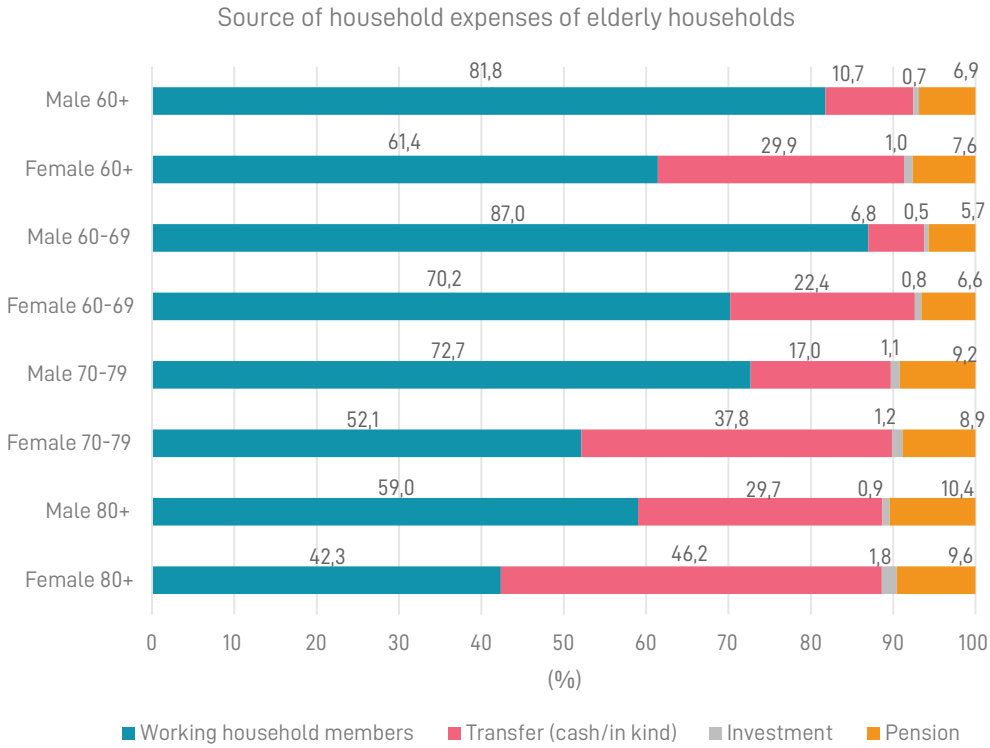


Figure 3.13 The distribution of the source of household expenses of elderly households by gender and age group of the household head, 2019

Source: Susenas 2019, author's calculation.

3.6.3 Older persons and work

3.6.3.1 The employment of older persons

Some of the issues regarding the employment of older persons are as follows. Firstly, about half of the older persons were still employed from 2015-2020 (Figure 3.14), although the proportions of older persons working were lower by age group. There was even an increase of 4.5 percentage point of the older persons working comparing the number in 2015 and 2020. Further assessment is needed to find out whether older persons working is by choice to keep themselves productive or due to necessity. If about less than one-fifth of the oldest older persons (80+) were working, it might have been due to necessity.

The second issue regarding older persons working is that about 80 to 90 percent of them were working in informal sector (Figure 3.15). The proportions of older persons working in informal sector were higher for female older persons, increased by age group, and higher for older persons living in rural areas. If working in informal sector is characterized by lacking of contract, low wage, and high uncertainty, the older persons may have higher vulnerability than the other age groups, particularly for the females, the oldest old, and those living in rural areas.

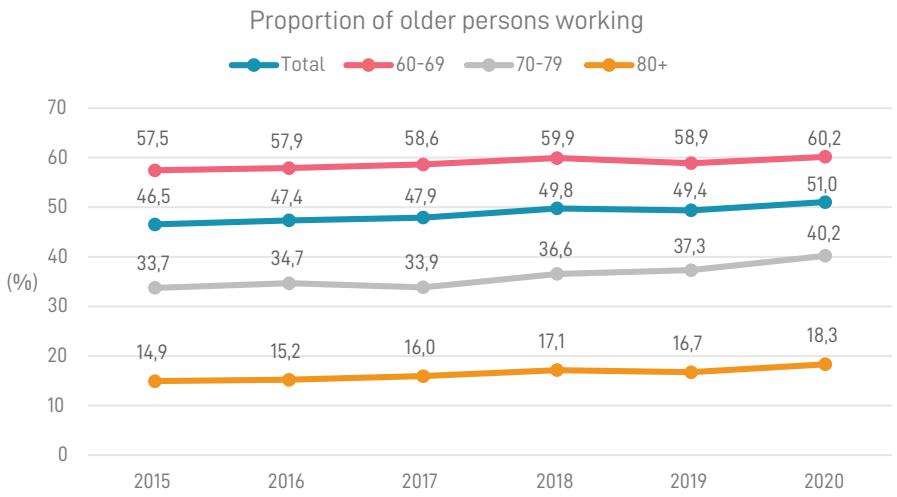


Figure 3.14 The trend of the percentage of older persons working by age group, 2015-2020

Source: BPS, Statistik Penduduk Lansia, 2015-2020

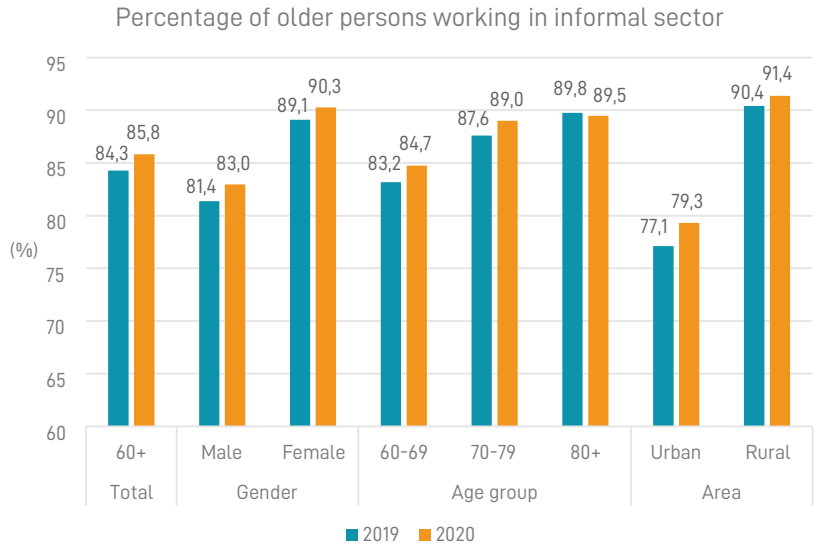


Figure 3.15. The percentage of older persons working in informal sector, 2019 and 2020

Source: Calculated from BPS (2019, 2020), Statistik Penduduk Lansia, 2019 and 2020.
Note: The definition of working in informal sector includes those who are self-employed, self-employed with non-regular or unpaid workers, freelance workers (pekerja bebas) and family or unpaid workers.

3.6.3.2. The earnings of older persons and the issue of decent work

In Figure 3.16 we can see the average earning of older persons in 2020. The average earnings were lower by age group of the older persons, lower for females compared to males, and lower for older persons living in rural than in urban areas. Regarding the issue of vulnerability, the oldest older persons may need more income due to their needs because of lower health status in average. Female older persons may also need more earnings as they tend to have fewer financial resources compared to male older persons. The issue of average earnings, however, is not straightforward for the case of older persons by area because the living cost is usually lower in rural areas than in urban areas. However, older persons in rural areas may have lower level of saving or no pension fund due to the domination of older persons working in informal sector in rural areas (see Figure 3.15).

Further assessment of older persons' earnings can be seen in Figure 3.17. The fact that about one-third of the older persons had low earnings might indicate that their work might not have been decent in terms of the payment they received. Nevertheless, the earnings need to be calculated per hour to be able to state for certain that some of the older persons' works were not decent in terms of payment.

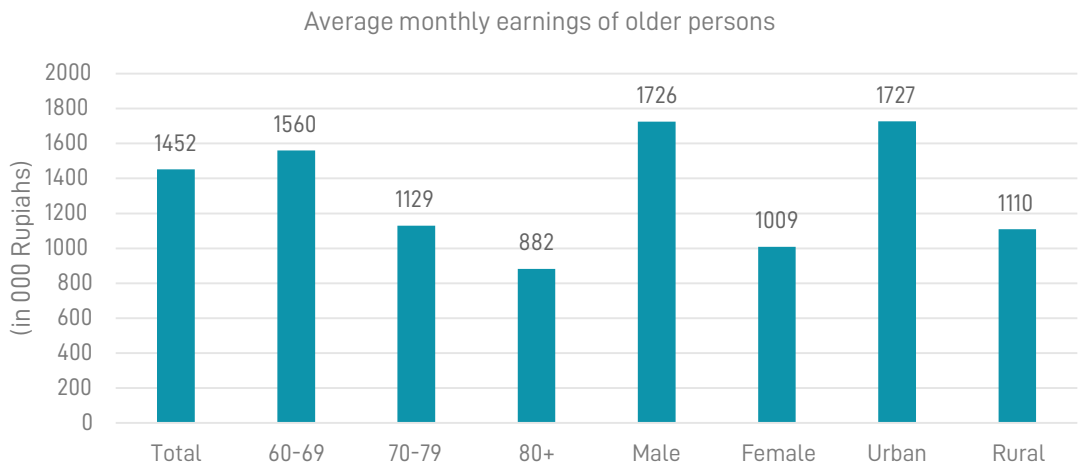


Figure 3.16 The average of monthly earnings of older persons by age group, gender, and place of residence, 2020

Source: BPS (2020), Statistik Penduduk Lanjut Usia 2020

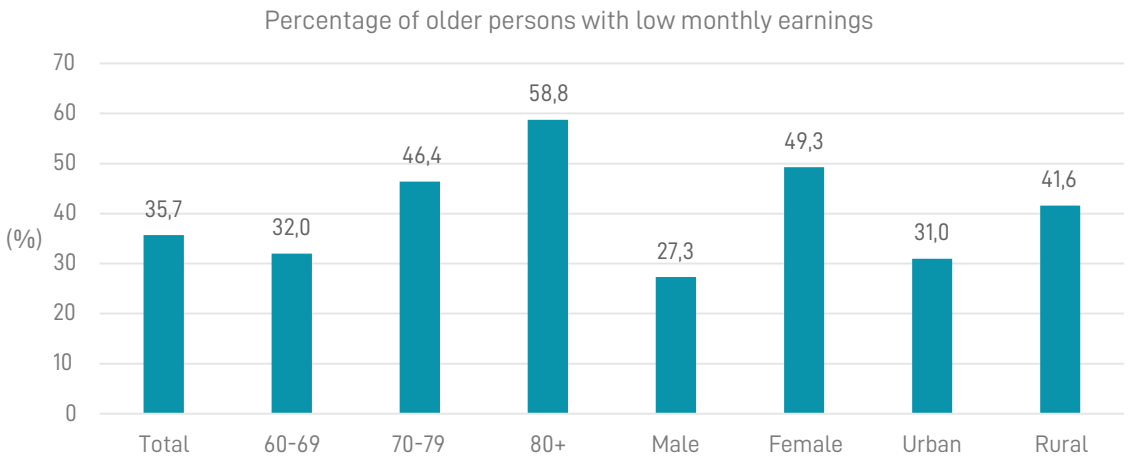


Figure 3.17 The percentage of older persons with low monthly earnings by age group, gender, and place of residence, 2020

Source: BPS (2020), Statistik Penduduk Lanjut Usia 2020. Note: Low earning is defined as lower than 2/3 of the median earnings.

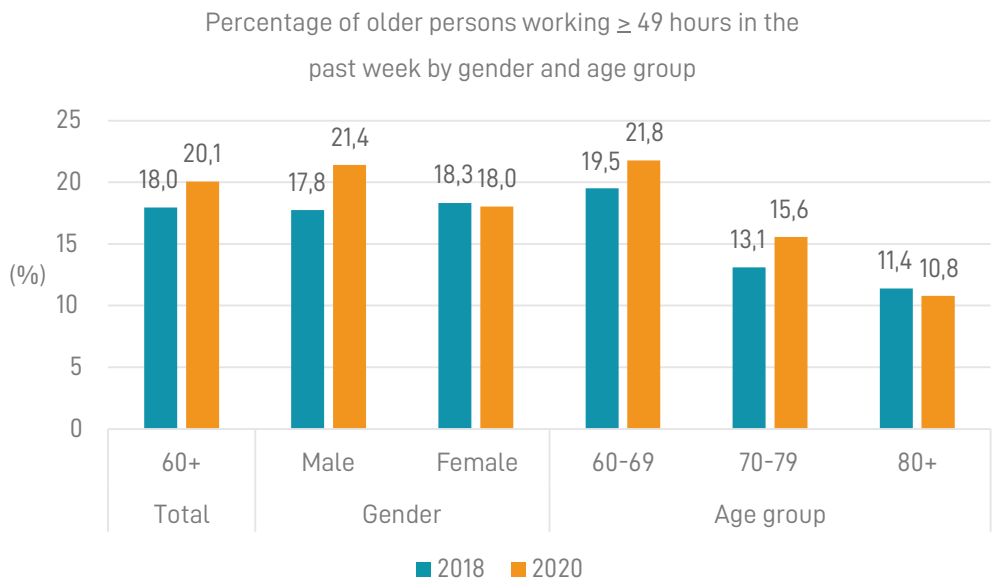


Figure 3.18 The percentage of older persons working 49 hours and longer in the past week by gender and age group, 2018 and 2020

Source: BPS (2018, 2020), Statistik Penduduk Lanjut Usia 2018 and 2020

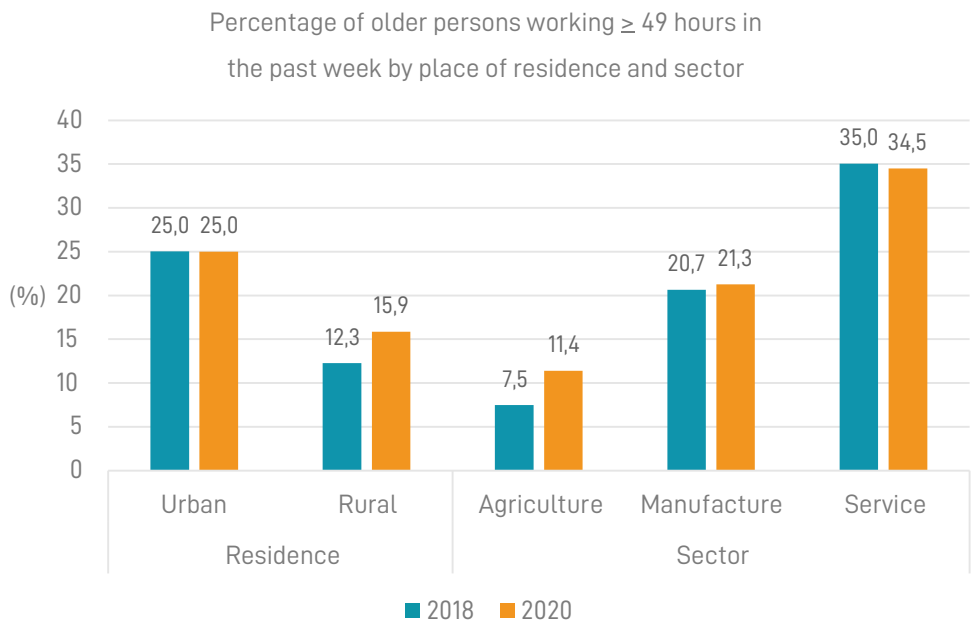


Figure 3.19 The percentage of older persons working for 49 hours and longer in the past week by place of residence and sector, 2018 and 2020

Source: BPS (2018, 2020), Statistik Penduduk Lanjut Usia 2018 and 2020

Another way to assess the level of decent work of the older persons is to supplement the earning information with working hours. Figure 3.18 shows that about one-fifth of the older persons worked 49 hours and longer in the past week. Although these numbers were lower for the oldest old (80+), 11 percent of them were still working for at least 49 hours. Presumably they worked for long hours due to necessity, particularly if the highest proportions of those who worked in long hours were in service sectors (Figure 3.19). Thus, quite a number of older persons in Indonesia seemed not to work in decent situation. The policy regarding the employment of for the older persons should address these issues.

3.6.4 Older persons' access to bank and other financial institutions

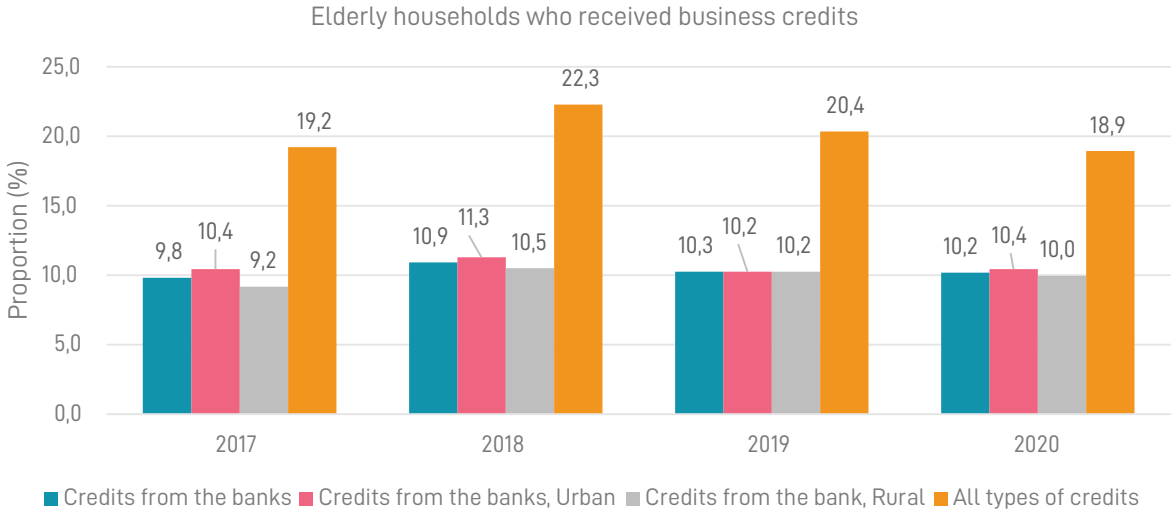


Figure 3.20 The percentage of the households headed by older persons who received business credits from a bank and all types of credits, 2017-2020

Source: Calculated from BPS, Statistik Penduduk Lansia, 2017-2020.
Note: The proportions of business credits from the bank consist of three types of business credits from the bank: people's business credit or Kredit Usaha Rakyat (KUR), commercial bank credit (non-KUR), and People's Credit Bank (Kredit Bank Perkreditan Rakyat). All types of credits include these three types and cooperative's credit (Kredit Koperasi), private credit with interest, pawn shop (pegadaian), leasing corporation, and local bodies created for social economic empowerment programs such as Kelompok Usaha Bersama (KUBE/KUB), and Badan Usaha Milik Desa (BUMDES).

Focusing on the issue of access to financial institutions, the data on the proportions of older persons who have an account in a bank or other financial institutions are not available. Instead, the data on older persons' household receiving business credits from the banks are available as can be seen in Figure 3.20. Those who received credits would have had to open a bank account. Thus, it is safe to assume that among the households headed by the elderly, about 10 percent of them have had a bank account due to their status as business credit recipients. Because the proportion of those who have a bank account may be higher than the proportion of those who receive business credits, the proportion of older persons who have bank account is perhaps much higher.

Related to the issue of micro, small, and medium enterprises (MSMEs), all the business credits received by older persons' households might have tended to finance businesses that were smaller in scales. Thus, the numbers of all of the proportions of older persons' households, around 20 percent, may indicate the involvement of older persons' households in MSMEs.

3.7 AGING AND HEALTH

3.7.1 The prevalence of Lung Tuberculosis (TB) suffered by older persons

Malaria and Tuberculosis (TB) are two among the diseases that are the focus of Goal 3.3: to end epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases, etc. While the government claimed that malaria had been under control, it was not the case with tuberculosis. The prevalence of TB increases with the increase of age, as shown in Figure 3.21. Concerning older persons, this pattern is worrying because it indicates that the vulnerability and the risk of morbidity among older persons is higher than the younger ones. In relation with COVID-19, TB is one among other underlying diseases that increases the risk of dying when infected by the Corona virus. Furthermore, TB can spread easily from infected older persons to other household members, especially in the case where housing condition is not proper. Usually this happens among poor elderly living in small shabby non-permanent house with a large number of household members.

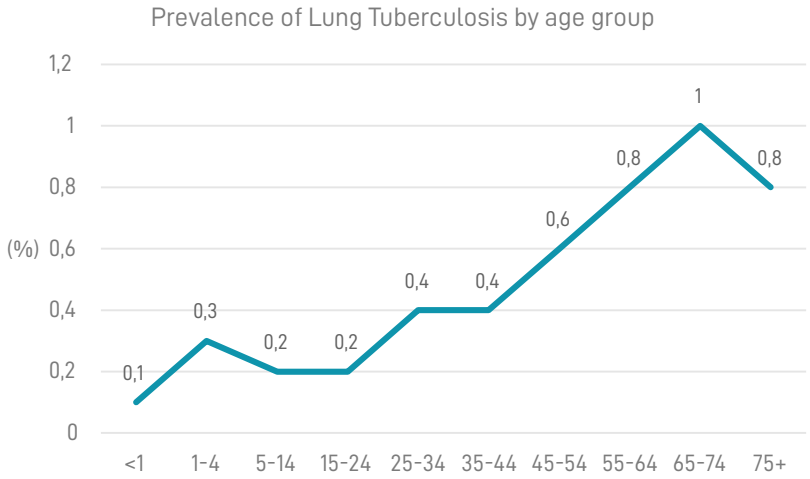


Figure 3.21 The prevalence of Lung Tuberculosis (TB) (%) based on the history of doctor's diagnosis by age, 2018

Source: Balitbangkes Kementerian Kesehatan (2019), National Report of Riskesdas 2018.

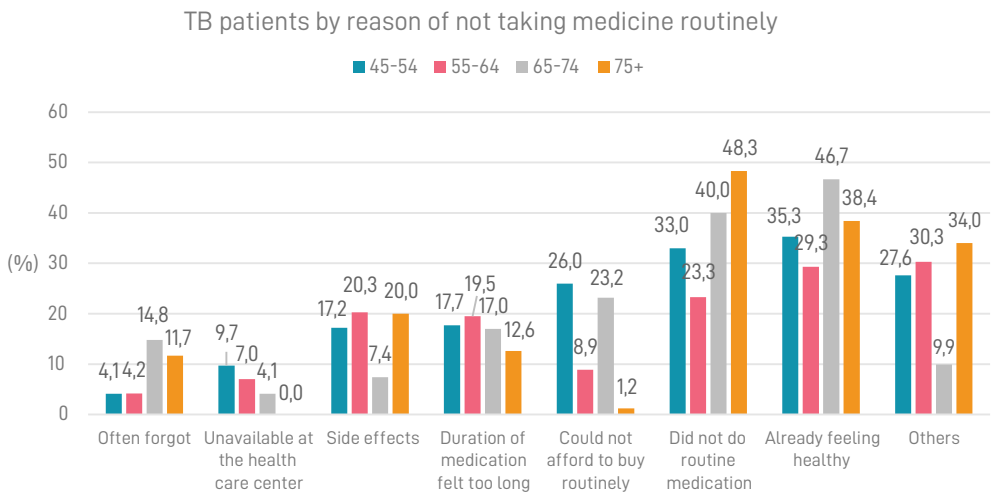


Figure 3.22 The percentage of TB patients who did not take medicine routinely by the reason for not taking medicine routinely and age group, 2018

Source: Balitbangkes Kementerian Kesehatan (2019), National Report of Riskesdas 2018.

Regardless the severity of the disease, it was found that many TB patients did not take their medicine routinely. Figure 3.22 shows the reasons for not complying to instruction to take medicine routinely. The most cited reason by older persons was that they felt healthy already and therefore they did not feel the need to take the medicine. This is worrying, since these older persons might still be the carrier of TB disease that may infect other persons living with them. The second most cited reason of not taking medicine routinely was due to not going to treatment regularly and therefore could not have the medicine. About 23 to 26 percent said they could not afford to buy the medicine. This is a surprising finding because it can be obtained by using BPJS.

3.7.2 Health complaints and morbidity rate

According to (WHO 1948)[7] 'health of a person or persons is a state of complete physical, mental and social well-being, and not merely the absence of disease. Health can be considered in terms of a person's body structure and function and the presence or absence of disease or signs (health status); their symptoms and what they can and cannot do i.e., the extent to which the condition affects the person's normal life (quality of life)'. With regard to older persons, they are

[7] WHO (1948), Measures of health status, quality of life and health care. https://www.healthknowledge.org.uk/public-health-textbook/research-methods/1c-health-care-evaluation-health-care-assessment/measures-health-status

more vulnerable in general to all kind of health hazards than the younger ones, mostly due to declining physical and mental capacity as well as increasing risk of non-communicable diseases they may carry. The health status and the quality of life of elderly people can be measured using the instruments such as functional disability, social and quality of life, and accidents (such as fall) that are common among the elderly.

In Indonesia, the health status of elderly is measured by the prevalence of health complaints included mental health and injury (e.g., fall). According to BPS (Statistik Penduduk Lanjut Usia 2020) based on the Susenas 2020, half of older persons had health complaints during the last month before the survey. However, the morbidity rate of older persons was 24.5, a measure that captures when health problems disturb daily activities and work. Observing morbidity rate during 2015-2020, there is an indication of slight improvement of the health status of older persons. Morbidity rates declined from 28.6 percent in 2015 to 24.4 percent in 2020[8]. Health status and morbidity rate are highly related to health care, which is highly linked to the health system. According to WHO, health care, or to be exact primary health care, should ensure the highest level of health and well-being, 'focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment' (2021)[9]. Health care is delivered through the services offered by health care organizations and professionals and it includes all the goods and services designed to promote health. Thus, there is a question of how these complaints are being treated. Figure 3.23 shows the answer.

3.7.3 Unmet need for health care and services

Among older persons having health complaints, about 4 percent did not do any treatment, 44 percent did self-treatment, 25 percent went to the health facilities (as outpatient), and the rest

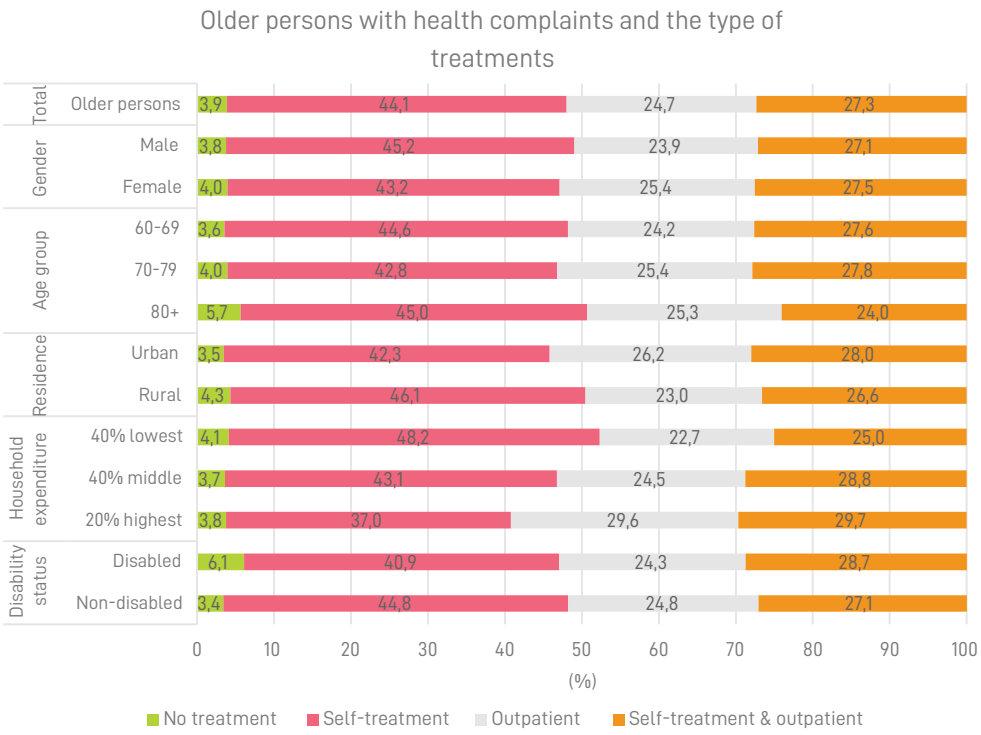


Figure 3.23 The distribution of older persons with health complaints by the type of treatments, 2020

Source: BPS (2020), Statistik Penduduk Lanjut Usia 2020.

[8] Morbidity rate is measured by percentage of population having health complaints that disturbed daily activities.
[9] WHO (2021). 'Primary health care'. 1 April 2021. https://www.who.int/news-room/fact-sheets/detail/primary-health-care Last visited 29 May 2021.

27 percent did self-treatment and became outpatients. From Figure 3.23 it is seen that the high percentage of older persons with health complaints but did not do any treatment or did self-treatment (3.8 plus 44.1 percent) indicate a high percentage of unmet need for health care. One of the reasons for not going for treatment was that the perception that the health problem needed no treatment (32.75 percent), 61.36 other did self-treatment and 2.36 percent related to cost (BPS, 2000, Statistik Penduduk Lanjut Usia 2020). Although the percentage of those who could not afford the medicine was low, it was consistent with Figure 3.23, that those who did not seek treatment came from the poorest 40 percent HH Expenditure (4.1+48.2=52.3 percent). Therefore, aside from affordability, some portions of those who were not going for treatment, may be due to low awareness in health seeking behavior, which is seen among the oldest old. Lack of accessibility such as the absence of persons available to accompany the older persons may also prevent them to go to health facilities. The solutions for this problem could be to make the services closer to older persons or to have somebody for home care.

The next issue regarding the health of older persons is where they go for health treatment as outpatients. Figure 3.24 presents the distribution of where older persons went for treatment as outpatients. Among the 52 percent of older persons who sought treatment as out patients, general practitioners of midwives were the most cited, especially for those who lived in rural areas and those from the poorest HH expenditure. Primary Health Centre or PUSTU is the next most cited by the older persons as their place of treatment as outpatients.

How do older persons finance their treatment as outpatients? Figure 3.25 shows that utilizing JKN with the contribution paid by the government (PBI) was the highest among older outpatients, particularly for those who lived in rural areas, for female outpatients, and for those from the poorest household expenditure. This figure suggests that the government's efforts to help poor people, including poor elderly, is on the right tract. Still, more work has to be done, especially to care for older persons with low health-seeking behavior. Helping them to increase awareness and willingness to seek for health treatment will increase their quality of life.

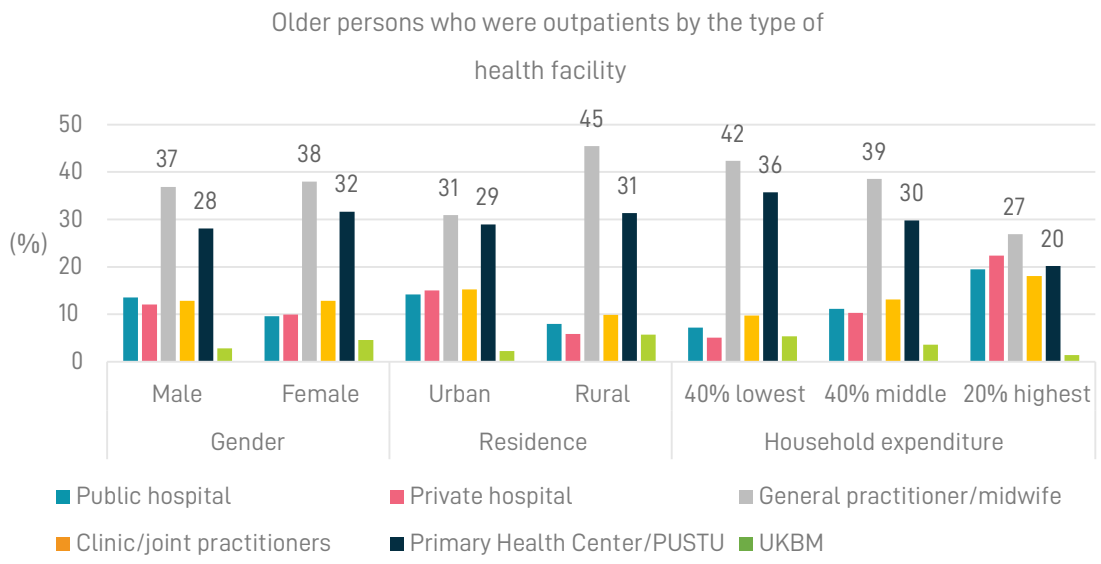


Figure 3.24 The distribution of older persons who were outpatients by the type of health facilities, place of residence, gender, and expenditure category, 2020

Source: BPS (2020), Statistik Penduduk Lanjut Usia 2020.

capacity. Thus, maintaining independence and preventing disability starts from early life and continues to adult life. The ultimate goal is to achieve healthy, independent and active aging, which is to be productive and to fully participate in economic and social activities. If the decline of functional capacity among older persons passes the disability threshold, the costs of rehabilitation and long-term care (medical care, non-medical care and caregivers' costs) to ensure their quality of life are very high. For the case of Indonesia, this will increase the family burden as well as the government in the social health insurance, particularly for the PBI ones.

Older persons are also highly susceptible from NCDs, such as high blood pressure, diabetes, heart/coronary disease, arthritis or obesities. NCDs prevention should start from early life, even during fetal growth. Intra Uterine Growth Retardation (IUGR) or slower than normal growth of fetus will hamper the brain development, increase the risk of childhood stunting and increase the risk of NCDs in later life. Rajagopalan (2003) has warned this since 2003, when he observed the high percentage of pregnant Indian women who were malnourished, a condition that was highly likely to cause IUGR (see also Achadi, 2020). In line with this, Figure 3.27 shows that the development of NCD starts from fetal life. High maternal nutrition status and prevention of low birth weight are important determinants of healthy babies. During infancy and early childhood, it is important to prevent diseases and to monitor growth rate to prevent child growth failure. During adulthood, healthy diet to prevent obesity, regular physical activity, and not smoking is the path toward healthy aging. Compliance to healthy life and behavior will maintain low risk of suffering from NCDs.

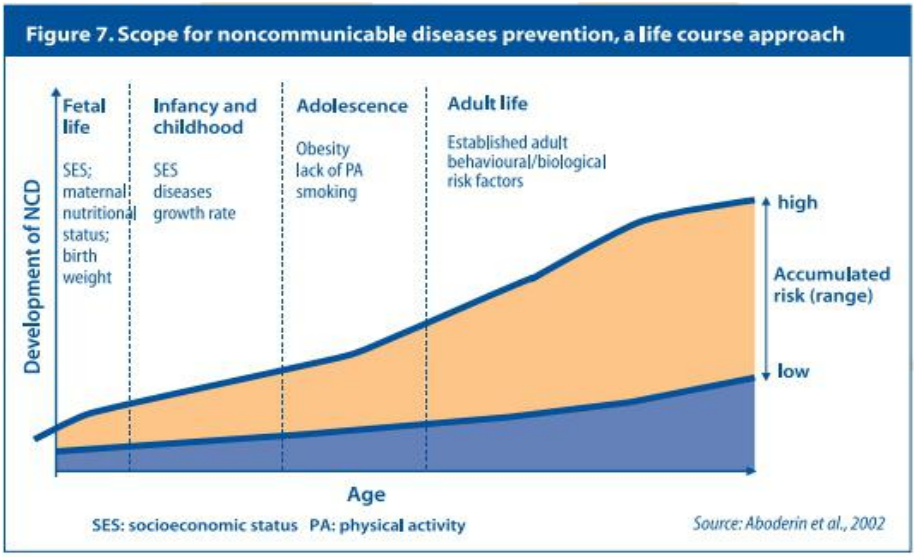


Figure 3.27 Scope for Non-Communicable Diseases prevention, a life course approach

Source: Copied from WHO (2002). Active Aging. Policy Framework.

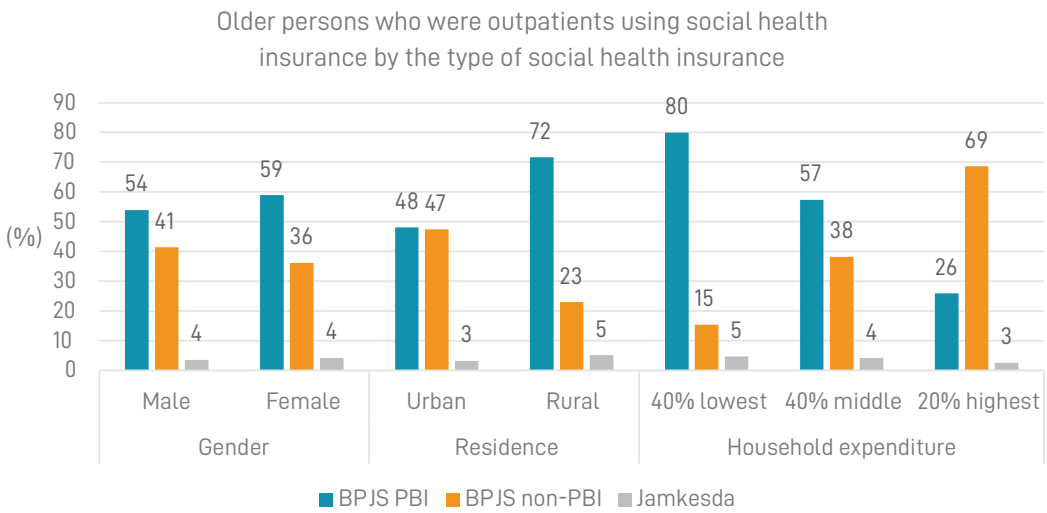


Figure 3.25 The distribution of older persons who were outpatients who utilized social health insurance (JKN) for their treatments by the type of social insurance, gender, place of residence, and household expenditure category, 2020

Source: BPS (2020), Statistik Penduduk Lanjut Usia 2020.

3.7.4 Declining functional capacity and Non-Communicable Diseases (NCDs) among older persons in Indonesia

Aside from natural declining functional capacity, the risk of non-communicable diseases (NCDs) increases as age increases. The presence of olde persons suffer from NCDs increases the burden of family who take care of them. It also increases the burden for the government to pay for rehabilitation services due to catastrophic diseases and for the long-term care for those who have difficulties in activity daily living and performing self-care. Nevertheless, NCDs among older persons can be prevented since early life and throughout the life course. WHO (2002) developed a policy framework for active aging using the life course perspective to maintain functional capacity and to prevent NCDs since early life (Figure 3.26 and 3.27).

Figure 3.26 shows that functional capacity increases at early life until adult period when it starts to decline toward the end of life. The speed of the decline depends on how a person maintains one's functional capacity. Adequate food and nutrition and appropriate behavior such as healthy life style, healthy diet, regular exercise and not smoking, can slow the speed of the decline to maintain the highest possible level of functional

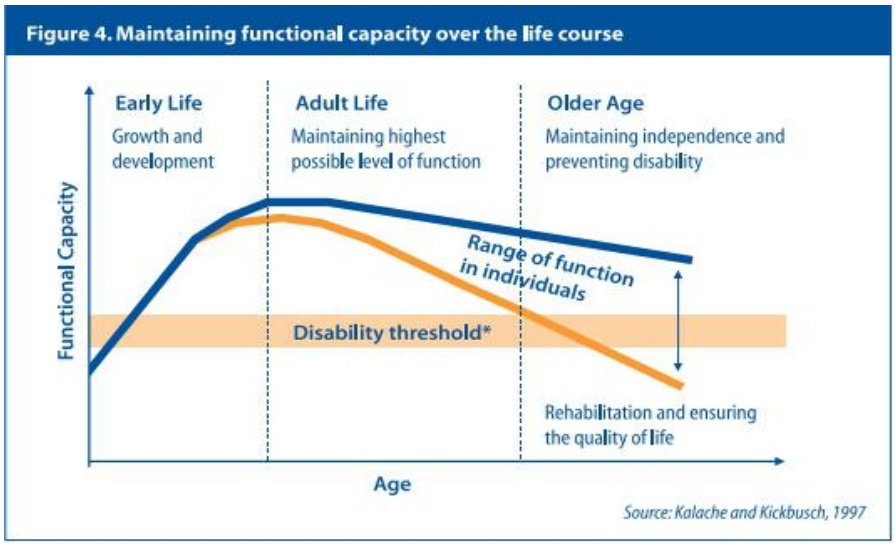


Figure 3.26 Maintaining functional capacity over the life course

Source: Copied from WHO (2002). Active Aging. Policy Framework.

Table 3.1 The percentage of older persons suffered from NCDs by the type of NCD, 2018

Prevalence of non-communicable disease (%)			
Disease type	Age group		
	55-64	64-74	75+
Hypertension	55.2	63.2	69.5
Stroke	32.4	45.3	50.2
Diabetes mellitus	15.6	15.1	13.6
Arthritis	15.5	18.6	19.0
Heart disease	3.9	4.6	4.7
Mental/emotional disorder	11.0	12.8	15.8
Depression	6.5	8.0	8.9
Cancer	4.6	3.5	3.8
Kidney failure	0.7	0.8	0.8

Source: Balitbangkes Kementerian Kesehatan (2019), National Report of Riskesdas 2018.

Using the framework in Figure 3.27, the result from Riskesdas 2018 shows that the prevalence of NCDs among older persons is quite high (Table 3.1). More than half of older persons sufferred from hypertension and the prevalence increased by age group, which was the highest prevalence among other NCDs of older persons in 2018. Stroke, which affects daily activities of the patients and most of them require long-term care, was the second highest prevalence of NCDs among older persons, which increased by age group as well. The prevalences of diabetes mellitus and arthritis were about the same, but for athritis, the prevalence was higher among older persons age 70 years and older. Suffering from arthritis hampers older persons' mobility and activities, increases dependency, and also increases the risk of falling. Housing suitable for older persons is needed to prevent them from further falling or other injury.

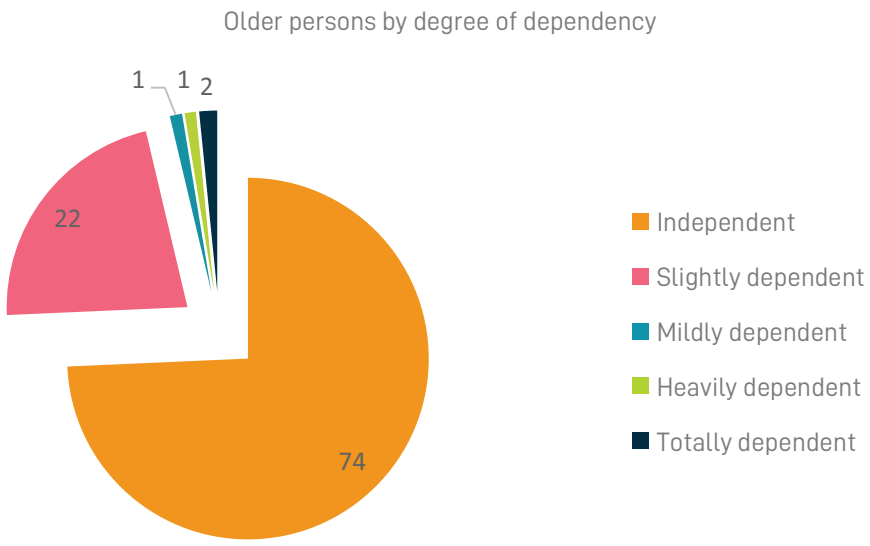


Figure 3.28 The distribution of older persons by degree of dependency, 2018

Source: Balitbangkes Kementerian Kesehatan (2019), National Report of Riskesdas 2018.

Declining functional capacity and suffering from NCDs risking the independence of older persons in doing actvity daily living (ADL) and also performing IADL (instrumental daily activities) such as cooking, house cleaning, picking up the phone, or going to do groceries. It also means higher risk of disability among older persons. If the older persons become disabled, they will need long-term care and caregivers to help them to perform ADL and IADL, or going to the health facilities and to buy medicine. Thus, the costs of long-term care in such a situation are very high.

Figure 3.28 shows that 74 percent of older persons in 2018 were still independent while 22 percent of them were slightly dependent but might have not needed other persons to assist them. About four percent of them were dependent from others. In the near future, the increasing life expectancy will result in increasing number of older persons. The rate of increase of the oldest old—who have naturally higher risk of NCDs than the others—was estimated to be the fastest. This situation should be anticipated with intervention to prevent older persons from NCDs, from disability, and from needing long-term care.

Furthermore, Figure 3.29 shows that older persons with stroke were the most likely to be dependent and need long-term care. About two-third of the older persons with stroke were slightly dependent up to totally dependent on other persons in doing their ADL, self-care, or communicating with others. Unfortunately, the prevalence of older persons with dementia or Alzheimer was not available, while these are the two diseases that mostly need long-term care.

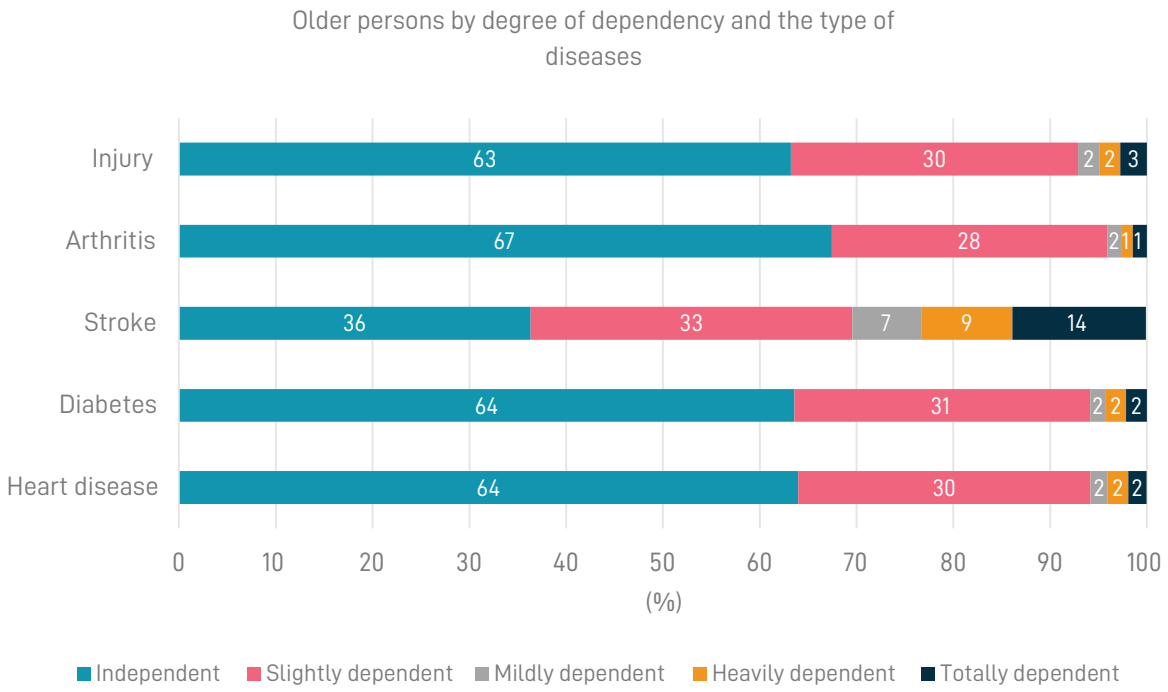


Figure 3.29 The percentage of older persons by degree of dependency and the type of diseases, 2018

Source: Balitbangkes Kementerian Kesehatan (2019), National Report of Riskesdas 2018.

3.8 VIOLENCE AND ABUSE AGAINST OLDER PERSONS

Abuse or violence against older people can be distinguished by physical, verbal, emotional, neglect or economic abuse. Poverty, neglect and poor health status among older persons are highly potentials for abuse. Physical abuse may happen when older persons are highly dependent on other persons in doing activity daily living, when neglected (living alone and poor), or when they still have to work as unpaid family workers. Economic abuse is usually related to financial abuse such as theft or misuse of parents' or older persons' pensions/savings, property or asset (such as selling the house while older persons still living at home), or inheritance. Emotional abuse may include low quality of services by caregivers.

It is important to have high concerns and taking action after such violence and abuse, aiming at maintaining quality of life through rehabilitation, consultation and therapy. However, data showing evidence of violence or abuse against older persons are minimal or absent. This section is a compilation of some available information regarding this issue and some are not statistically representative to the entire older population.

If at all available, publication concerning violence and abuse is usually focused on gender-based violence (GBV) and rarely focus on older persons.[10] One publication about violence is from Ministry of Women Empowerment, Protection for Women and Children (web SIMFONI KPPA 2021), as can be seen in Figure 3.30. This figure shows that the number of older victims was very low, while the reported cases of the younger age was very high. Based on daily observations, it may be the case that violence against older persons is highly underreported.

Figure 3.31 shows that most of the occurrence of violence took place at home. Assuming that this is the case for older persons as well, it may suggest that the violence against them tended to be done mostly by close family or caregivers. As previously mentioned, many older persons were dependent on other persons for daily activities (Figure 3.28). On the other hand, older persons living alone (14 percent of older women lived alone) may be the results of neglect, which is one type of abuse. Older women and men who are still working as unpaid family workers are also prone to be abused or to experience violence against them.

The representative data on violence and abuse against older persons are available from BPS (Statistik Penduduk Lanjut Usia 2020), although the information is not very detailed. The information is, however, can be linked with Goal 16: 16.1 Significantly reduce all forms of violence and related death rates everywhere and 16.1.3 Proportion of older persons subjected to physical, psychological or sexual violence in the previous 12 months.

Figure 3.30 The number of the victims of violence by age, 2021

Source: SIMFONI-KemenPPPA (2021) https://kekerasan.kemenpppa.go.id/ringkasan

[10] KPPPA. Simfoni 2021 https://kekerasan.kemenpppa.go.id/register/login

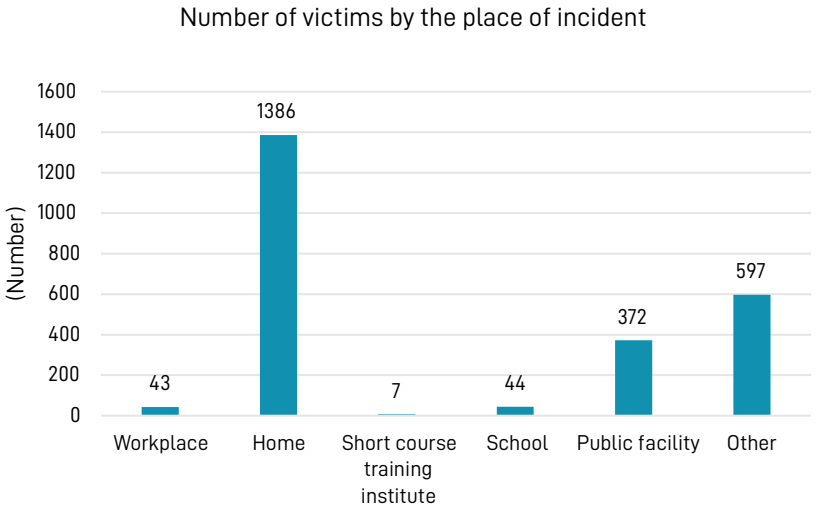


Figure 3.31 The number of the victims of violence by place of incident, 2021

Source: SIMFONI-PPA (2021). https://kekerasan.kemenpppa.go.id/ringkasan

The trend of the number of older persons who experienced crime per 100,000 can be seen in Figure 3.32. Although the trend was not consistently declining, the lowest number was in fact in 2020, where 970 of older persons per 100,000 reported to have experienced crime. If we compare these numbers with the trend of the national crime rates, the national crime rates were around 10 percent of the elderly crime rates. Because the national crime rates were based on the information from the police (reported and documented), it may be the case that many crimes experienced by the elderly were not reported. Although it may be true that some people are reluctant to report criminal acts to the police because the damage is not comparable to the trouble to report (for example, the things stolen were not that valuable), it may indicate lack of trust. Trust is particularly important for the older persons because they tend to be more vulnerable than the younger population. Another thing to note from this figure is that many of the older persons experienced crimes, which indicate that lack of safety may be a big issue for the older persons.

Among the older persons who experienced criminal acts in the past year in 2019, most of them experienced theft (Figure 3.33). Note that the numbers are not mutually exclusive because one person might have experienced more than one type of crimes. For example, among the 1,000 cases of crime experienced by older persons (60+), 895 cases were theft. Without being mutually exclusive, among the 1,000 cases of crime experienced by older persons (60+), 122 cases were other crimes.

From Figure 3.33, there seems to be no clear patterns by age group for the older persons in the case of theft, but the crime rates per 1,000 cases for the oldest older persons were the highest. It may indicate that the oldest old were the ones most vulnerable to experience crimes.

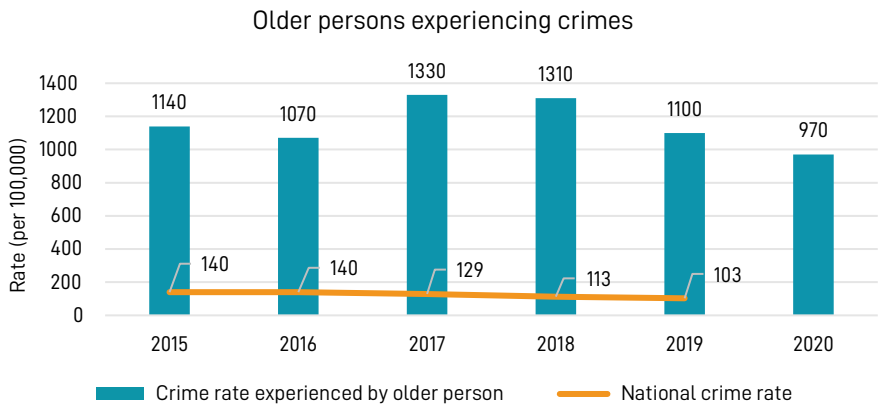


Figure 3.32 The trend of the number of older persons who experienced crimes in the past year per 100,000 older persons, 2015-2020 and the trend of national crime rates per 100,000 population, 2015-2019.

Source: The elderly crime rates were calculated from BPS, Statistik Penduduk Lanjut Usia, 2015-2020. The national crime rates were taken from BPS, Statistik Indonesia, 2017 and 2020. The national crime rates at year t were based on reported and documented crimes per 100,000 population at year t.

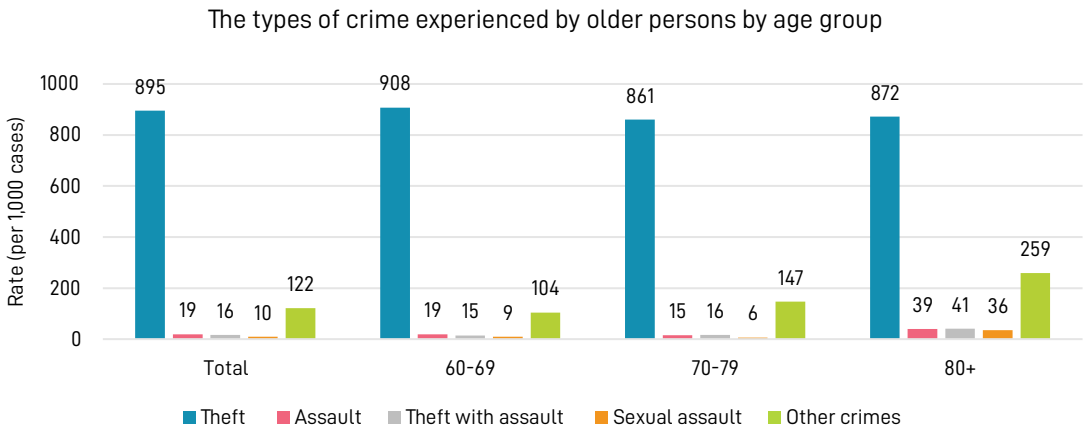


Figure 3.33 The number of older persons who experienced crimes in the past year per 1,000 cases by the type of crimes and age group, 2019

Source: The crime rates were calculated from BPS (2019), Statistik Lansia 2019.

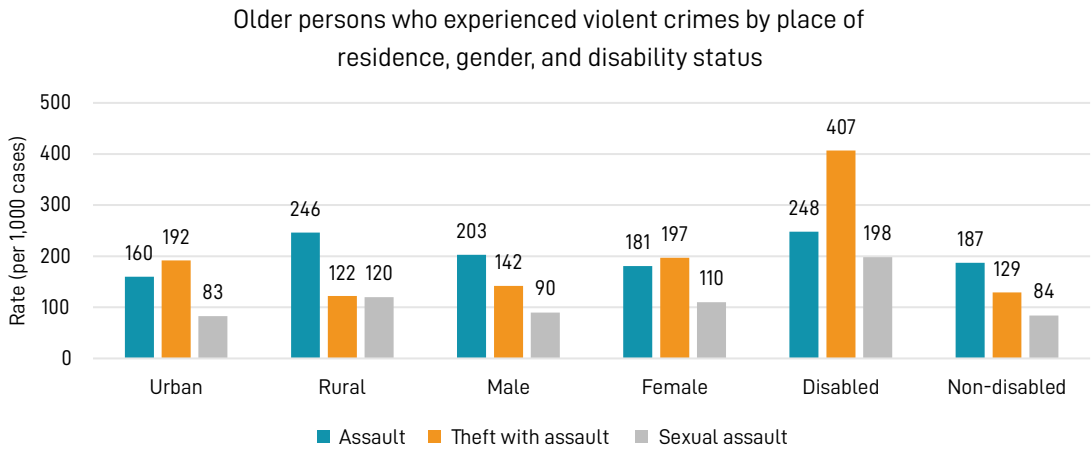


Figure 3.34 The number of older persons who experienced violent crimes in the past year per 1,000 cases by the type of crimes, place of residence, gender, and disability status, 2019

Source: The crime rates were calculated from BPS (2019), Statistik Penduduk Lanjut Usia, 2019.

We can assess further the patterns of experiencing crimes of the older persons by focusing only on violent crimes in Figure 3.34. This figure shows that the rates of violent crimes were higher in rural areas than in urban areas, except for theft with assault. The rates of theft with assault and sexual assault experienced by older females were higher than those of older males. The most worrying cases were the violent crime rates experienced by disabled older persons, which roughly twice the rates of violent crimes experienced by non-disabled older persons. The disabled older persons were thus the most vulnerable to experience crime and could have been targeted more simply of their disability status.

In sum, to ensure the safety of all citizens, we need to pay attention to reduce the violent crime rates experienced by older persons, particularly by the oldest old, and for some cases of older persons in rural areas, older females, and the disabled older persons. While the government has already been aware of the high rates of GBV and has taken action to reduce this crime, but the data of and services against violence on older persons still need to be expanded to cover cure Data on the abuse of older persons, its causes, disaggregated by the source of abuse, are highly needed, for the government to take action to minimize violence against older persons.

3.9 ACCESS TO BASIC SERVICES (GOAL 1.4)

Related to poverty, Goal 1.4 is by 2030, ensure that all men and women, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other form of property, inheritance, natural resources, appropriate new technology and financial services, including microfinance. However, in this VNR 2021, Goal 1.4 is targeted to focus on access to basic services. Access to basic services is a part of multidimensional poverty.

3.9.1 Level of electricity deprivation of elderly households

It is surprising that the level of electricity deprivation of the elderly households had been lower than that of the younger households (Figure 3.35). What is more important is that the trend is declining during 2015-2019 and that the gap between elderly households and younger households is getting smaller, declined from 0.6 to 0.3 percent. So, there is hope that electricity deprivation of the younger households is declining, and electricity deprivation is diminishing.

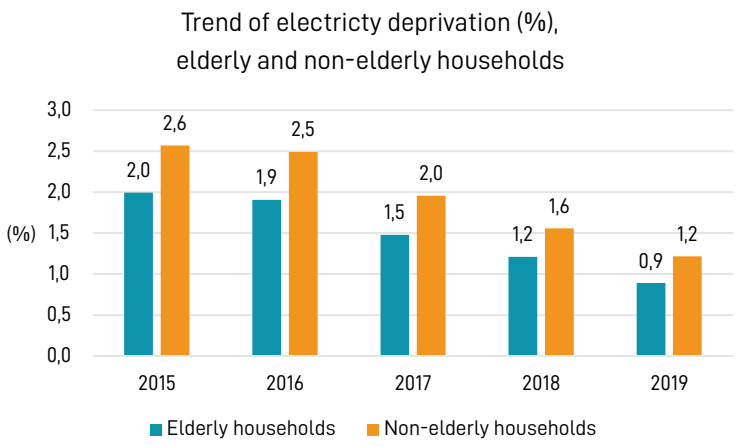


Figure 3.35 The trend of the level of electricity deprivation (%) among households headed by elderly and households headed by non-elderly, 2015-2019

Source: Susenas 2015-2019, authors' calculation.

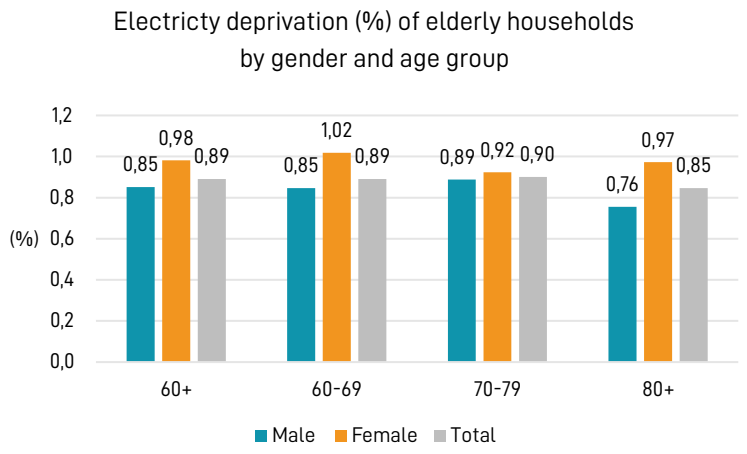


Figure 3.36 The level of electricity deprivation (%) of elderly households by gender and age group of the household head, 2019

Source: Susenas 2019, authors' calculation.

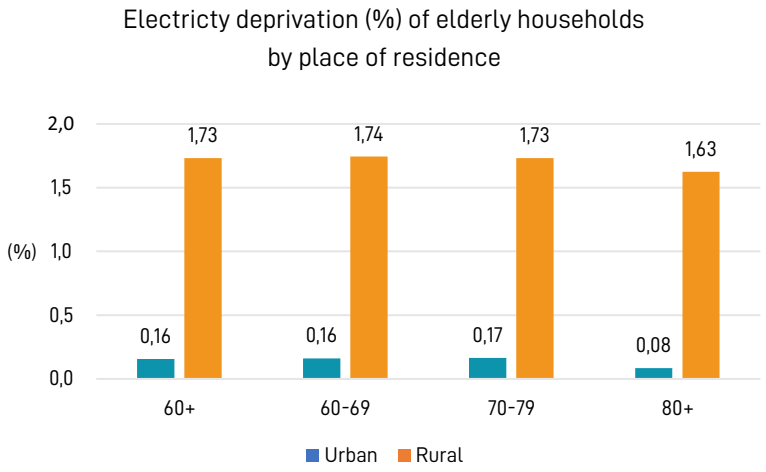


Figure 3.37 The level of electricity deprivation (%) of elderly households by age group of the household head and place of residence, 2019

Source: Susenas 2019, authors' calculation.

When comparing the level electricity deprivation between genders, it was found that the level of deprivation of the households of the elderly women was higher than that of the elderly men across the age group, although slightly (Figure 3.36). It could be a concern since access to electricity is related to economic activities, access to information on business opportunity, and on health care and services that make possible for older persons to maintain their quality of life.

The electricity deprivation among elderly households was found mostly in rural than urban areas (Figure 3.37). This means that rural elderly people have low access to internet which is useful for communication with their children or relatives, to obtain transfers, or to access social assistance such through Kartu Sejahtera Keluarga (KSK). This KSK is a card used to receive financial transfers from the government and through this card the beneficiaries can buy rice and cooking oil subsidies. In other words, some elderly in rural areas who did not have electricity are left behind in receiving social assistance their mostly need.

3.9.2 Access to improved and safe water (Indicator 1.4. and 6.1.1)

Goal 6.1 states that by 2030 achieved universal access to improved water, safe and accessible to all people. To measure the progress of this goal, indicator 6.1.1 is used, which is the percentage of households using safe drinking water. In meta data 2020, the definition of safe water (improved water) is pipe water (leding), water from protected sources, and rain water. Protected water includes pump water (sumur pompa), or borehole well (sumur bor), protected spring water or well. Households using bottled water is defined as households having access to safe water if the water for bathing and washing comes from pipe water, pump water (air pompa and sumur bor), and well.

Figure 3.38 shows that most of Indonesian households had access to improved water. The trend is increasing by only 2.2 percent during 2015-2019. When comparing elderly and younger households, the figure shows that access to safe water of elderly households was only slightly higher than that of the younger households. It may indicate that inequality of access to safe water is minimal and probably diminishing. In terms of absolute number, however, 7.46 million households in 2019 (10.7 percent out of 71.28 million households), had no access to improved water. Access to improved water is crucial and highly needed, especially for elderly households who live three generations under one roof, that may have babies and under-fives living with their grandparents. Unsafe water increases the risk of babies and under-fives to experience growth failure or stunting through infections. Intervention to solve this problem is strongly advice if the government wants to reduce the prevalence of stunting.

Among elderly household having access to safe/improved water, inequality is apparent, even if only slightly. Figure 3.39 shows that the percentage of elderly households living in rural areas that had access to improved water was lower than elderly households living in urban areas.

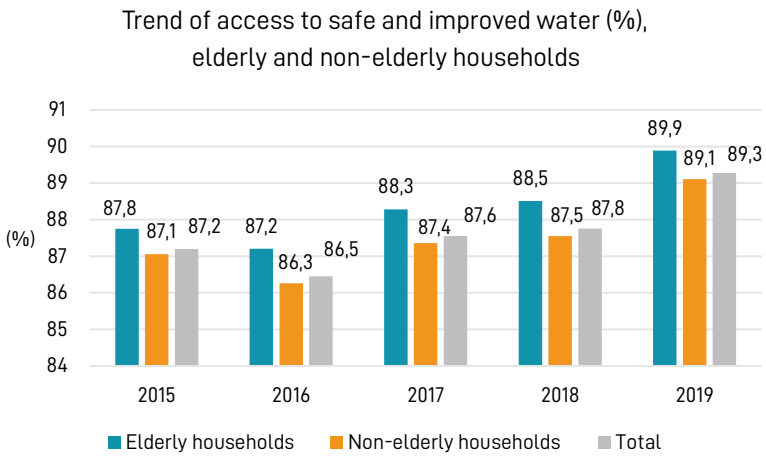


Figure 3.38 The trend of the percentage of households with access to improved and safe water among households headed by elderly and households headed by non-elderly, 2015-2019

Source: Susenas 2015-2019, authors' calculation.

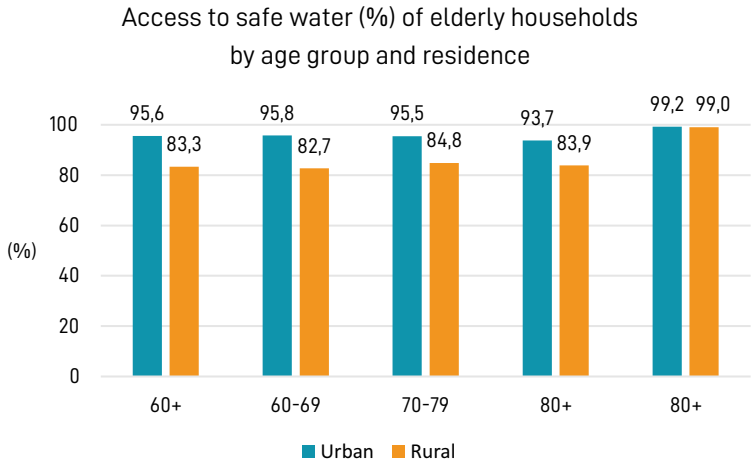


Figure 3.39 The percentage of elderly households with access to safe water by age group of the household head and place of residence, 2019

Source: Susenas 2019, authors' calculation.

Overall, elderly households had a higher percentage in accessing improved water than the younger ones, which perhaps explained by the facts that elderly households might have accumulated assets, including electricity and safe water, longer than the younger households that might be at the beginning of family and household formation. Regarding the findings by place of residence, it is obvious that elderly households living in rural areas were less likely to have access to improved water. Thus, infrastructure development of electricity and improved water should be focused on rural areas.

3.9.3 Access to proper sanitation (Indicator 1.2.2 and 6.2.1)

According to meta data, indicator 1.2.2 measures deprivation of sanitation because of poverty. The indicator 1.2.2 defines sanitation deprivation is when the households do not have access to decent lavatories (WC layak), including using the communal toilet. A decent toilet is defined as goose-neck toilet (leher angsa), and having a septic tank.

Figure 3.40 shows that the percentages of households that had access to decent sanitation had been lower than the percentages of households that had access to safe water, although during 2015-2019 it shows an increasing trend by 9.4 percent during the five-year period.

When disaggregating by age and gender among the elderly households, inequality can be seen between age groups and gender. The oldest-old households had lower percentage of those who had access to decent sanitation than the younger old households. This is consistent with the highest poverty rate of the oldest old (Figure 3.11) among the elderly. Again, elderly women households had lower likelihood to access decent sanitation than the elderly men households (Figure 3.41). Inequality of the likelihood to access to decent sanitation is also seen by the place of residence. Figure 3.42 shows that the percentage of elderly households living in urban areas having access to decent sanitation was higher than that living in rural areas.

The findings regarding access to basic facilities supports the conclusion that infrastructure and services to fulfil basic needs and reducing poverty rates among the elderly households still need much improvement. Improving access of elderly households is one among the efforts to improve the quality of life of older people while at the same time respecting their dignity. In addition, better access to basic services for elderly women households and the oldest old elderly households may help accelerating poverty reduction for all households and the whole population.

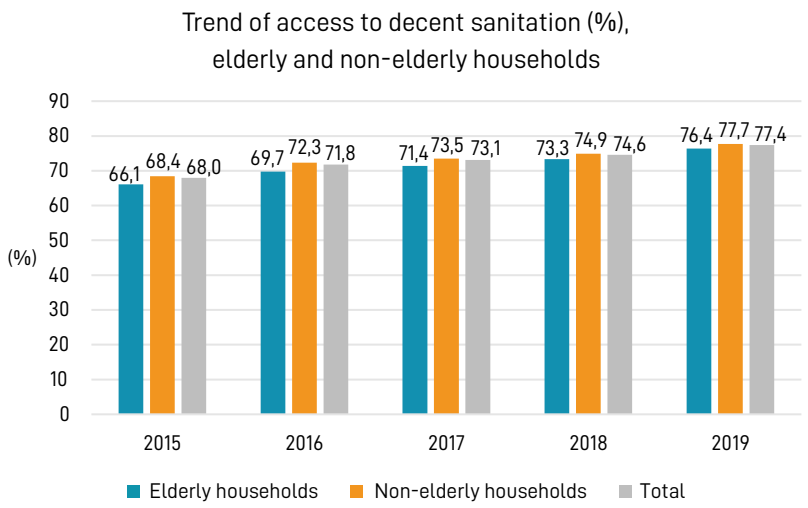


Figure 3.40 The trend of the percentage of households with access to decent sanitation among households headed by elderly and households headed by non-elderly, 2015-2019

Source: Susenas 2015-2019, authors' calculation.

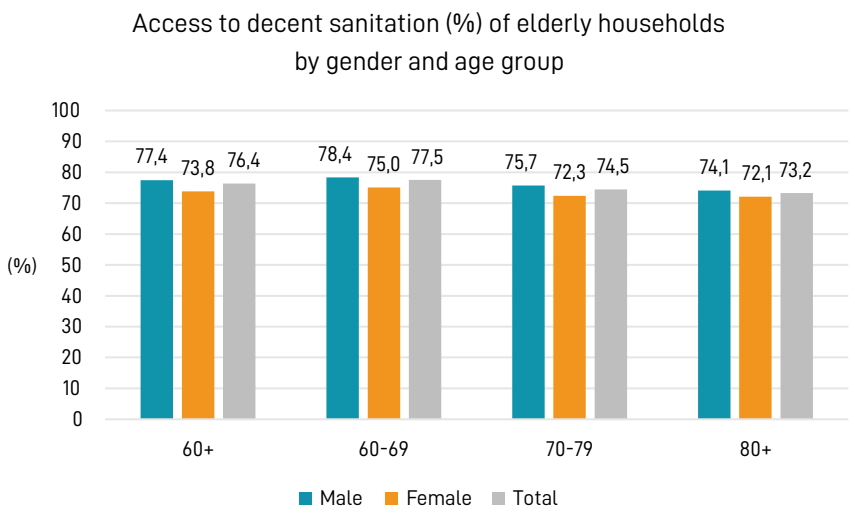


Figure 3.41 The trend of the percentage of elderly households who had access to decent sanitation by age group and gender of the household head, 2019

Source: Susenas 2019, authors' calculation.

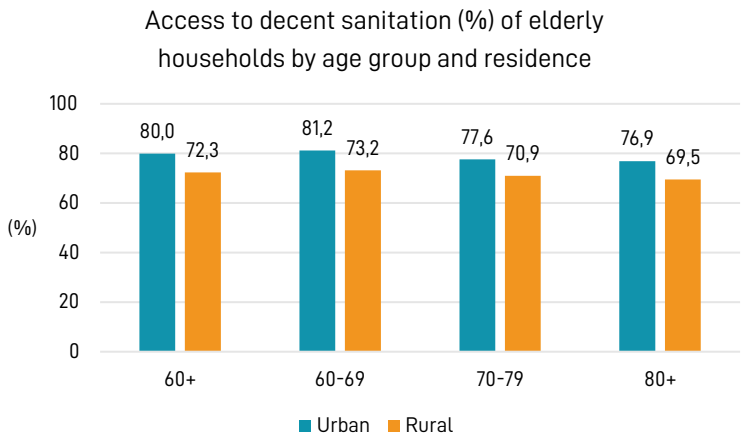


Figure 3.42 The percentage of elderly households who had access to decent sanitation by age group of the household head and place of residence, 2019

Source: Susenas 2019, authors' calculation.

3.10 SOCIAL PROTECTION

3.10.1 Social insurance

Indonesia has enacted Law number 40 of 2004 about National System of Social Insurance. This law mandates compulsory membership of social insurance with contribution. The contribution of those who cannot afford to pay, the contribution will be paid by the government. They are called the PBI *(Penerima Bantuan Iuran)* or recipients of contribution assistance. However, only in 2014 that this law was implemented through a Law number 24 of 2011 to establish insurance administrator called *Badan Penyelenggara Jaminan Sosial* (BPJS). The BPJS is divided into two categories: Health BPJS and Employment BPJS (BPJS *Ketenagakerjaan*).

Everybody has to become members of the Health BPJS or *Jaminan Kesehatan Nasional* (JKN, social health insurance). On the other hand, the BPJS *Ketenagakerjaan* focuses on employees. Their contributions are partly paid by the employers and partly paid by the employees. The beneficiaries of BPJS *Ketenagakerjaan* include the employee's immediate family members, who are registered as members.

The percentages of older persons in various schemes of social insurance can be seen in Table 3.2. The first row of this table shows that in 2020, about three quarters of the older persons were covered by social health insurance (BPJS, *Jamkesda* and private insurance), with or without contribution. It means that about a quarter of older population were not covered by health insurance, which causes for concern.

The coverage of JKN membership among older persons who lived in rural areas was much lower (68 percent) than those who lived in urban areas (79 percent). Inequality is also apparent among older persons by economic status. The highest percentage of membership was shown by older persons from the richest 20 percent household expenditure with a gap of 16 percentage point with those from the lowest expenditure category. The inequality of the membership among the older persons can be seen by gender and disability status with higher percentage for elderly males than for elderly females and higher percentage for non-disabled elderly than for disabled elderly. These inequalities show that social insurance is not yet inclusive. It may take a long time to achieve universal social insurance so that no one is left behind. However, the fact that within 6 years since the enactment of BPJS in 2014, 68 percent of membership among older persons should be appreciated. Strong efforts still have to be done to increase BPJS Health coverage to target the rest 32 percent of older persons in 2020.

Among those who covered by Health BPJS, Table 3.2 shows that almost half of the older persons were PBIs while those who were able to pay membership was only 23.16 percent. This means that the older persons should be economically empowered by increasing employment participations of the younger older persons or increasing transfers from children and relatives, so that they can afford to pay BPJS membership, and therefore easing the government's burden.

It seems that the government reached the targets of PBIs as the percentages of PBIs were higher for older persons in rural areas than in urban areas, for female older persons than male older persons, and for the disabled older persons than the non-disabled ones. However, it is worrying to see that the allocation of assistance for PBIs seems to be mistargeted. Older persons from the 40 percent middle and 20 percent richest HH Expenditure still were PBIs (43.67 percent and 23.21 percent, respectively) while only 54.94 percent of older persons of the poorest HH expenditure were PBIs. If the budget for PBIs is correctly allocated among the poorest, this will help to increase their health status, which in turn may help national efforts to reduce national poverty rate. On the other hand, the percentage of the membership of contributory

BPJS increases with the increase in economic status of the elderly. This finding shows that the target is on the right track and has to be expanded to achieve contributory membership reaching 100 percent. This should be done together with the efforts to eliminate poverty to achieve the 2030 targets.

Aside from JKN, there is also social health insurance managed by the local government called *Jaminan Kesehatan Daerah* (Jamkesda). The distribution across the characteristics of older persons was around 8-9 percent, which was quite high and should be maintained. The membership of private insurance among older persons was very low, might be due to the fact that most of private insurance companies do not accept the membership of older persons.

For employment insurance, there are social insurance of Employment BPJS, for Pensioners from Government Apparatus or State Enterprise (*Badan Usaha Milik Negara*—BUMN), ex-military corps and veterans. The social insurance covered by Employment BPJS (formerly *Jaminan Sosial Tenaga Kerja* or Jamsostek), includes Old Age Insurance (Pensions) or *Jaminan Hari Tua*, Injury (*Jaminan Kecelakaan*) and Death Insurance (*Jaminan Kematian*) and severance money if an employee is discharged from work. The distribution of beneficiaries of BPJS *Ketenenagakerjaan* (formerly Jamsostek) by various insurance schemes, place of residence, and household expenditure category can be seen in Table 3.3. This table shows that on average only 13.84 percent of the older persons had social insurance membership from the BPJS *Ketenagakerjaan.*

Disaggregated by residence and economic status, the membership of this social insurance scheme was higher among urban elderly than rural elderly, and the highest for the richest elderly workers or ex workers. This pattern holds for those who had old age, injury, and death insurance. Ownership of severance money insurance is very minimal. While the ownership of this kind of social insurance help older persons, the coverage should be expanded. Particularly in the case of severance money insurance, although it helps the workers who are discharged, its amount is usually very minimal and does not last very long, since it is paid when the employee leaves the employment. What can last for a long until the end of life is pension. In 2020, only 10.75 percent of older persons received pensions. Mostly they were the ones who lived in urban areas (15.6 percent) or in the middle and richest category of household expenses (9.95 percent and 28.36 percent, respectively).

3.10.2 Social assistance

Social protection can be divided into social insurance (with contribution) and social assistance. As a part of social assistance, BPNT is a transformation of RASTRA (rice subsidy) for those living below poverty line. BPNT started in 2017 with the goal to improve distribution mechanism and better targeting system. BPNT beneficiaries can choose the type basic food, quality, price, and place in buying the rice subsidy. To control the targeting, BPNT can only be consumed through Kartu Keluarga Sejahtera (KKS), an electronic card to exchange/ buy BPNT goods to the selected e-*warung* (e-small shops). The e-warung is selected as a part of the government efforts to empower small scale business (UMKM) through banking electronic system. This activity is also potential for the bank to accumulate assets, which in turn can drive economic activities at the grass root level.

KKS is targeted for poor people, and it is a supplement to a card named *Kartu Perlindungan Social* (KPS) or social protection card which aim to help the *Penyandang Masalah Kesejahteraan Sosial* (PMKS), which are those with social problems and not only the poor. Aside from access to BPNT, KKS and KPS are also used for saving in the form of electronic saving called e-wallet. The e-wallet is used to distribute PKH and BPNT social assistance.

Table 3.2 The percentage of older population who were covered by social or private health insurance by place of residence, household expenditure category, gender, and disability status, 2020

Percentage of older population with health insurance ownership (%)										
The type of health insurance	Older population	Residence		Household expenditure			Gender		Disability status	
		Urban	Rural	40% lowest	40% middle	20% highest	Male	Female	Disabled	Non-Disabled
SocialHealth Insurance (JKN)	73.58	78.92	67.59	68.16	73.36	83.94	74.2	73.06	71.76	73.86
BPJS PBI (non-contributory)	44.59	40.27	49.44	54.94	43.67	23.21	43.8	45.27	47.92	44.09
BPJS Non-PBI (contributory)	23.16	32.89	12.21	8.63	23.71	54.59	24.3	22.1	18.27	23.89
Jamkesda (local/regional social health insurance)	9.24	8.79	9.75	9.37	9.42	8.63	9.32	9.18	8.99	9.28
Private insurance	0.44	0.69	0.15	0.11	0.21	1.6	0.48	0.4	0.21	0.47

Source: BPS (2020), Statistik Penduduk Lanjut Usia 2020.

Table 3.3 The percentage of elderly households as the members of BPJS Ketenagakerjaan and pension by the type of insurance scheme, place of residence, and household expenditure category, 2020

Percentage of elderly households with employment social insurance ownership (%)						
The type of employment insurance & pension	Elderly households	Residence		Household expenditure		
		Urban	Rural	40% lowest	40% middle	20% highest
Employment social insurance (BPJS Ketenagakerjaan**)**						
Employment social insurance (*Jamsos*)	18.84	19.83	7.07	5.18	13.34	33.21
Old age insurance	6.58	9.48	3.2	1.94	6.27	17.01
Injury social insurance	5.78	8.32	2.9	2.28	5.83	13.12
Death insurance	6.08	8.59	3.25	1.98	5.87	15.2
Severance money (*Pesangon PHK*)	2.46	3.56	1.22	1.16	2.49	5.17
Pension (pensioners of government apparatus, state enterprises, ex-military corps and veterans)						
Pension	10.74	15.6	5.28	3.21	9.95	28.36

Source: BPS (2020), Statistik Penduduk Lanjut Usia 2020.

Table 3.4 shows the percentages of elderly household possessing KPS/KKS, received BPNT and PKH. About 13.59 percent of the elderly households possessed KPS or KKS. Around 18.99 percent and 11.3 percent owned BPNT card and PKH card, respectively. The percentage of the ownership of these cards were higher among the households in rural areas than in urban areas, and among the poorest household (40 percent lowest HH expenditure) than the richer ones. This pattern can also be seen in the distribution of BPNT and PKH as the percentages of the ownership of these cards were higher for poor elderly households than richer elderly households and those who lived in rural areas than in urban areas.

Table 3.4 The percentage of elderly households as beneficiaries of social assistance by the type of social assistance, place of residence, and economic status

Percentage of elderly households as social assistance recipients (%)						
The type of social assistance	Elderly households	Residence		Household expenditure		
		Urban	Rural	40% lowest	40% middle	20% highest
KPS/KKS (owned)	13.59	11.03	16.48	20.06	11.26	4.31
BPNT (ever received)	18.99	14.5	24.06	29.5	15.37	3.59
PKH (still received/registered as beneficiaries)	11.3	8.18	14.48	18.4	8.12	1.48

Source: BPS (2020), Statistik Penduduk Lanjut Usia 2020.

3.11 THE INCLUSION OF OLDER PERSON IN SDGS 2030[11]

'Eradicating poverty in all its form and dimensions, including extreme poverty, is the greatest global challenge and indispensable requirement for sustainable development'.

The above caption is taken from the Preamble of the United Nations Declaration 'Transforming our world: The 2030 agenda for sustainable development'. Therefore, the 17 target goals start with the eradication poverty in its form everywhere.

This section aims at including issues and challenges regarding older persons in the 2030 SDGs Agenda so that **no one is left behind**. Although, for the VNR 2021 that will be presented in the High-Level Policy Dialogues in July 2021, only nine goals are included among the 17 SDGs. These nine goals are Goal 1, 2, 3, 8, 10, 12, 13, 16, 17.

The issues and challenges this section are selected based on the comprehensive report in Section 3.1. Except when explicitly mentioned, older persons or population in this section refers to those age 60 years and older while younger population are those below 60 years. The older persons are divided into age 60-69 years (young old or youngest old), age 70-79 years (middle old) and age 80 (oldest old).

3.11.1 End poverty

GOAL 1: END OF POVERTY IN ALL ITS FORMS EVERYWHERE

Among the five targets of Goal 1, the most relevant to the issues of aging as well as according to the availability of data, are:

Target 1.2: By 2030, reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions

[11] This section is a short version of the situation analysis of older persons, in general, that is relevant to each of the nine goals that will be presented in the 2021 VNR. This section will be followed by another section, dealing in particular with the impact of COVID-19 on older persons that may affect the achievement of the 2030 SDGs agenda.

In 2019, the poverty rate of the older persons was higher than the national poverty rate as well as the poverty rate of the younger population (Susenas 2019). Among the older persons, the poverty rate increases by age group, which means that the oldest old had the highest poverty rate. The poverty rates were higher for older women than for older men and for older persons in rural areas than for older persons in urban areas.

During 2015-2019, the older persons' poverty rates show a declining trend (Susenas 2015-2019), which follows the declining trend of national poverty rates. This suggests that the improvement of welfare among older persons was mostly the results of national efforts to accelerate poverty reduction, and not because of specific programs and interventions targeting older persons in Indonesia.

Using the household expenditure category to measure the welfare of older persons (BPS, 2020, Statistik Penduduk Lansia), 43 percent of older persons fell into the 40 percent lowest household expenditure, 37 percent were in the 40 percent middle household expenditure, and only 19 percent of older persons came from the 20 percent highest household expenditures. These highlight the inequality among older persons.

The latest information, national poverty rate increased from 9.4 in 2019 to 10.19 percent in 2020 due to the impact of the COVID-19 pandemic. The COVID-19 disrupted most of the activities and livelihood of all the nations. Poor elderly suffered more and those who were vulnerable tended to fall into poverty.

Target 1.3: Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable

Social protection can be measured through social insurance social insurance.

3.11.1.1. Social insurance

By March 2020, 74 percent of older population were covered by health insurance, which consists of Social Health Insurance BPJS Health (contributory or non-contributory called PBI), Jamkesda and Private Health Insurance (with premium). Inequality in access to health insurance can be seen from the lower coverage of health insurance among older females, older disabled, older persons in the poorest category of household expenditure, and older persons in rural areas, in comparison to their counterparts.

Only one-fifth of the older persons paid their BPJS membership. This number should be increased. On the other hand, about half of the older persons covered by JKN (social health Insurance) are PBI recipient (the membership paid by the government). About half of the poorest elderly households according to household expenditure category did not receive PBI while some of the elderly households in middle or highest household expenditure category received PBI. It means that some of the PBI was not distributed on target. However, the higher percentages of older female and older disabled as recipients of PBI than their counterparts can be seen as an indication that the distribution of PBI related to gender and disability is on the right track. In addition to BPJS Health, the local government operates Jamkesda with the beneficiaries is about 10 percent across the different category of older persons.

Other social insurance schemes administered by BPJS Employment are in the form of old age insurance, injury, death, severance money. Overall, 14 percent of older persons are the beneficiaries of this insurance, dominated by the older persons in urban areas and those in the richest category of household expenditure. This is acceptable since this scheme is relate to formal employment. But for a large number of older persons, government should develop insurance scheme for those working in informal sector, particularly because

older persons were mostly working in this sector.

3.11.1.2. Social assistance

Social assistance by the government is in the form of *Program Keluarga Harapan* (PKH) or Family Hope Program targeted for families with under-five or school-age children, pregnant member, and older persons. In 2020, 11 percent household with older persons received PKH, mostly distributed to households in rural areas and those of the poorest group (Susenas 2020). The non-cash food assistance, BPNT, was distributed to 19 percent of elderly households, also dominated by rural elderly households and those who fall in the lowest category of household expenditure. These two schemes of social assistances can be consumed through ownership of Social Protection Card (KPS-*Kartu Perlindungan Sosial*) and KKS (Social Welfare Card- *Kartu Kesejahteraan Sosial*). In 2020, 13.6 percent of elderly households owned KPS/KKS.

Target 1.4: By 2030, ensure that all men and women, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology and financial services, including

In the VNR 2021, Target 1.4 is focused on basic services for elderly households, and in this section economic resources are also added.

3.11.1.3. Main sources to cover household expenses

In 2019, the main source for household expenses for household headed by older males was from work of the elderly or from the work of other household members. Other elderly households, cover their expenses through transfers, that were consistently higher for households headed by older women than by older men. However, the proportion of resources from work decreases as age increases while the resources from transfers (in cash or in kind) increases. Older women started to need transfers earlier. This indicates that social protection is highly needed by the households headed by the oldest old, particularly the oldest old women.

3.11.1.4. Access to basic services

Indicator 1.4.1: Proportion of population living in households with access to basic services

a. Electricity deprivation

Thanks to the government, that access to electricity in Indonesia is very high, with higher percentage among elderly households compared to younger people households. Still, about one percent of elderly households did not have electricity, with a higher percentage for elderly households in rural areas compared with those in urban areas. This is alarming because nowadays social assistants are distributed through e-card (e-wallet) that the beneficiaries can use to buy food and other basic needs which requires access to electricity. Thus, infrastructure for electricity should become an urgent agenda, in particular electrification of rural areas.

b. Access to safe/improved water: Target 1.4 and Indicator 6.1.1

In 2019, almost 90 percent of Indonesian households had access to improved water, with slightly higher percentage for the elderly households (Susenas 2019). During 2015-2019 access to improved water shows an increasing trend. If this trend continues, it is expected that in the next five years, deprivation of access to safe water will diminish. Still, while the access to safe water of elderly households in urban areas was almost universal, more than ten percent of elderly rural households were still deprived from access to safe water. Safe water is crucial, especially for the elderly who live with their grandchildren to prevent infection and diseases among infants and under-fives that may hamper their growth.

c. Access to sanitation: Indicator 1.2.2 and 6.2.1

For all households, access to proper sanitation was only 77 percent in 2019. Elderly women households who were lagging in access to decent sanitation and about one-fifth of the elderly households without access to decent sanitation should become the focus of intervention. Proper sanitation is highly crucial to avoid communicable diseases among older persons as well as their grandchildren. If infants and under-fives are infected with communicable diseases, their risk of growth failure may increase, which in turn increases the risk of stunting.

3.11.2 End hunger and food security

GOAL 2. END HUNGER, ACHIEVE FOOD SECURITY AND IMPROVED NUTRITION AND PROMOTE SUSTAINABLE AGRICULTURE

Target 2.1: By 2030, end hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round

As there is no available data on food security and nutrition for older persons, we suggest to create indicators to measure these for all ages, particularly for the older persons. The Prevalence of Undernourishment (PoU) can be disaggregated by age, the elderly and the younger persons.

3.11.3 Health

GOAL 3. ENSURE HEALTHY LIVES AND PROMOTE WELL BEING FOR ALL AT ALL AGES

Target 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water borne diseases and other communicable diseases

3.11.3.1 The prevalence of Tuberculosis among older persons

In 2018, the prevalence of lung TB among older persons was higher than that among younger people because the TB prevalence increases as age increases (Riskesdas 2018). One of the obstacles to reduce the TB prevalence is related to negative health behavior such as not taking medicine prescribed by doctor. One of the reasons of not taking medicine was not going to the health center, particularly among the 65 years old and older. About one-fifth of the 65-74 years old could not afford the medicine. Thus, aside from the excellent method of testing and strong medical interventions by the government, intervention to change the negative behavior is highly needed. Furthermore, as about one-third of older persons were living with children and grandchildren, these other family members could be exposed to the disease. This tends to happen among poor older persons who live in an indecent housing with inadequate sanitation. Including older persons in the national efforts to lower the national prevalence can contribute to reach the 2030 target.

Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

3.11.3.2 Health complaints and unmet need for health care

About half of the older persons reported health problems/complaints (Susenas 2020). Among the older persons with health problems, 24 percent reported that their health problems disturbed their daily activities including work, thus this is the morbidity rate among older persons in 2020.

One of the main issues regarding the treatment of the health problems is the size of unmet need of older persons for health care. The percentage of those who did not do any treatment (four percent) or conducted self-treatments (44 percent) among

the older persons who had health complaints indicates the size of this unmet need. However, the majority of reasons not to do any treatment were because the health problems that no need for treatment and cured by themselves. Only 2.4 percent did not do any treatment due to the cost, which mostly occurred among the poorest category of household expenditure.

Other issues that prevent treatment were low awareness in health-seeking behavior, particularly among the oldest old, and low accessibility of health facilities. Some older persons may need to be accompanied to go to the health facilities but could not find people for this purpose. Older persons may also have difficulties in mobility. Solution has to be sought, among others, is to make the health services closer to the older persons in need, or to provide caregivers including at home.

3.11.3.3 Places to go for those seeking treatment (as outpatients)

More than one-third of older persons tended to go to general practitioners or midwives to seek for treatment as outpatients. It is followed by visiting the Primary health center/PUSTU, which was more likely to be visited by patients in rural areas than in urban areas, by elderly female than elderly males, by the young old, and by the poorest. Only 11 percent went to public hospitals and 10.89 went to private hospital. These facts highlight the importance of first layer of primary health care, particularly for those who are more vulnerable.

3.11.3.4 Utilization of social health insurance for treatments

The majority of elderly outpatients in rural areas used BPJS PBI for treatment. Among the poorest, 80 percent used BPJS PBI for treatment. This shows that the government effort to increase health cover including for the older persons is somewhat effective. Still, strong effort is needed to achieve universal health coverage in 2030.

3.11.3.5 Non-communicable diseases (NCDs) among older persons

There are two aspects that affect the capacity of older persons to perform activity daily living (ADL) and work. Older persons naturally experience declining physical, cognitive and emotional capacities, at the same time, they are also prone to suffer from Non-Communicable Diseases (NCDs). Which mostly carried since they were young.

Related to NCDs, in 2018, the highest prevalence of the diseases suffered by older persons were high blood pressure, stroke, diabetes mellitus and arthritis (Riskesdas 2018). The 75 years old and older had the highest risk of suffering from high blood pressure, which may lead to stroke. The occurrence of stroke tends to make older persons to be totally dependent and to need long-term care. The cost of long-term care, medical, non-medical and the cost of caregiving is very high which usually become the burden of the family and the government. Prevention of NCD should starts from the earliest possible, even since in the womb of the mother (see Section 3.7.4), followed by nutritious food, healthy behavior and healthy diet, as well as regular exercise.

While the majority of older persons were independent, three percent of them were heavily and totally dependent on other persons. As the estimated number of older persons in Indonesia was 26 million (Susenas 2020), if three percent of them are dependent, then Indonesia needs 780,000 caregivers. In general, the caregivers are mostly women from nuclear family or close relatives. As the cost of caregiving is very high, efforts should be made to prevent older persons from being dependent by promoting healthy and active aging since early life. Healthy, independent, active with dignity is the ultimate goal for older persons in 2030.

3.11.4 Sustainable economic growth and employment

GOAL 8. PROMOTE SUSTAINED, INCLUSIVE AND SUSTAINABLE ECONOMIC GROWTH, FULL AND PRODUCTIVE EMPLOYMENT AND DECENT WORK FOR ALL

Target 8.5: By 2030 achieve full and productive employment and decent work for all women and men, including for young people and people with disabilities and equal pay for work of equal values

3.11.4.1 The percentage of older persons still working

One of the main issues of older persons working is whether they tend to work because of preference or a matter of survival. In 2020, half of the older persons were still working, which slightly increased from 47.37 percent in 2016 (Sakernas 2016, 2020). Furthermore, about one-fifth of the oldest old were still working. Most of older persons were working in informal sector, which is normally characterized by lack of contract, uncertainty of income, minimal social protection. Older persons may have higher vulnerability than other age groups, particularly for the females, the oldest old, and those living in rural areas. This includes 14.01 percent who worked as unpaid family members (mostly elderly women), and 10.66 percent in precarious works. This not so rosy picture of elderly employment may be due to the low education of these elderly workers.

3.11.4.2 The earnings of older persons and the issue of decent work

On average, monthly earnings of the older persons in 2020 was Rp1,452,000. It is very low to cover monthly expenditure, which increased due to the increasing cost of health care as they are aged. The average earnings were lower for the older age group of the older persons, lower for females compared to males, and lower in rural than in urban areas. Although the living cost is usually lower in rural areas, the older persons in rural areas may have lower level of savings or no pension fund due to the domination of older persons working in informal sector in rural areas.

Ideally, older persons are retired and enjoy the rest of their lives. However, in 2020, about one-fifth of the older persons worked at least 49 hours and longer in the past week and 11 percent of the oldest old worked for longer than 49 hours (BPS, 2020, Statistik Penduduk Lanjut Usia). Presumably they worked for long hours due to necessity, particularly if the highest proportions of those who worked in long hours were in service sectors.

Thus, quite a number of older persons in Indonesia seemed not to work in decent situation. The policy regarding the employment of for the older persons should address this issue. Expanding social protection is crucial to maintain their quality of life, which in turn increase their health status, easing government spending on BPJS.

3.11.4.3 Older persons' access to bank and other financial institutions

As the data on the proportions of older persons who have an account in a bank or other financial institutions are not available, we used the information on older persons' household receiving business credits from the banks (BPS 2020, Statistik Penduduk Lanjut Usia). In 2020, 10.2 percent of older persons received credit from the bank. As those who received credits would have most likely had to open a bank account, it is safe to assume that at least 10 percent among the households headed by the elderly had a bank account due to their status as business credit recipients. But as data show that 18.9 percent of elderly household had access to bank, this may indicate that about 20 percent of older persons are bank literate.

Related to the issue of MSMEs, the business credits received by older persons' households might have been used to finance businesses that were smaller in scales. Thus, the numbers of all of

the proportions of older persons' households, around 20 percent, may indicate the involvement of older persons' households in micro, small, and medium enterprises.

3.11.5 Sustainable consumption and production

GOAL 12. ENSURE SUSTAINABLE CONSUMPTION AND PRODUCTION PATTERN

Indicator 12.3.1: Reducing food loss and food waste

The current policy on food security is focused on increasing food production but lacking on food loss and food waste management. People's participation, including that of older persons in food loss and waste management is highly important. Therefore, the indicators of Goal 12 need to be more comprehensive and inclusive, by including indicators that are highly related to people's choice and decision about food consumption and waste management.

We suggest to educate, inform or advocate to the leaders and the mass to change paradigm into a new philosophy 'to consume all of the food being served' in order to reduce food waste. Elderly may play a role in this matter because a qualitative study (McAdams, Massow, & Gallant 2019) found that the elderly felt guilty if there was left over food because they were taught to consume all of the food, particularly because some of them experienced food insecurity in their past. Attitude toward food may differ among age groups. Elderly people may be more concerned about food waste reduction than the younger people. As women and elderly women are the ones who usually prepare food for the family, they may be more concerned about food waste than elderly men. Furthermore, the younger cohorts who are better off are more likely less concern about food waste reduction. Detailed study regarding attitude toward food is useful to develop intervention on food waste reduction that will help sustainable development targets by 2030.

3.11.6 Putting people's face on the policies to combat climate change and its impacts

GOAL 13. TAKE URGENT ACTION TO COMBAT CLIMATE CHANGE AND ITS IMPACT

Target 13.2: Integrate climate change measures into national policies, strategies and planning

All indicators related to Goal 13 in the Indonesian Meta Data 2020 are mostly focused on macro aspects and at the national level, whether it is about data or information, policies, and implementation. We thus suggest to integrate climate change measures within the policy, strategy, to and to include indicators of Goal 13 at national as well as local level.

Our main idea is to put people's face in Goal 13 indicators by creating indicators that are sensitive about people's characteristics. People are the economic agents while also consumers at the same time. Increasing population size resulted in growing demand for goods and services, which in turn resulted in climate change. Further, it is the people who are affected by the climate change, among others is natural disaster due to climate change. Thus, we suggest that combating climate change can focus separately on the producers and on people's behavior as consumers. In developing polices, we need to know the consumption patterns by characteristics such as age, gender, and socioeconomic status. For example, ecological foot print can be disaggregated by children, the youth, the adults, the workers, the families and the older people.

We also suggest to include COVID-19 as non-natural disaster by considering its effects vary according the characteristics of population. We highlight that COVID-19 might be one of the impacts of climate change. **We strongly suggest this pandemic should be used as a momentum to educate people regarding the negative impacts of human behavior on environment and climate change and how it might have caused the emergence of new diseases such as the COVID-19.**

The knowledge regarding how people's knowledge on and the adaptation to COVID-19 disaster varies according to their characteristics will be useful for disaster management in general. For example, older persons tend to me more knowledgeable about physical distancing policy than the younger ones, while older women tend to be more knowledgeable than older men (See Chapter 4.1). The gap of knowledge of this policy was also seen between lower educated and higher educated older men. Regarding the compliance to health protocols (Protocol Kesehatan), the percentages of those who always complied were rather high, about 60 to 90 percent. Older persons had a higher tendency to comply than the younger ones. We can see how people started to adopt the new normal behavior.

Thus, adaptation and mitigation of disasters should also be sensitive to the characteristics of the population such as age, gender, education, and socio-economic status. Furthermore, disaster and climate change might affect the vulnerable groups such as older persons, women, and children stronger than the other groups.

Therefore, we strongly advise to review the existing Goal 13 indicators and add other indicators that are sensitive to different population characteristics and develop it at regional and local level. Thus, the SDG 2030 theme 'No one left behind' would not be just a jargon.

3.11.7 Societies and institutions for sustainable development

GOAL 16. PROMOTE PEACEFUL AND INCUSIVE SOCIETIES FOR SUSTAINABLE DEVELOPMENT, PROVIDE ACCESS FOR ALL AND BUILD EFFECTIVE, ACCOUNTABLE AND INCLUSIVE INSTITUTONS AT ALL LEVELS

Target 16.1: Significantly reduce all forms of violence and related death rates everywhere.

Target 16.2: End abuse, exploitation, trafficking and all forms of violence and torture of children.

Comments: indicators 16.1 and 16.2 should add the caption 'for all ages including the older people'. This text below is concerned with violence and abuse among older persons.

Indicator 16.1.3: Proportion of older persons subjected to physical, psychological or sexual violence in the previous 12 months

Data concerning violence and abuse against older persons are rarely available. From the available data that we used we suspect the occurrence of underreporting. The first one is according to the Ministry of Women Empowerment, Protection for Women and Children (web SIMFONI KPPA 2021) which shows that compared to younger people, the number of reported cases among older people was very small. KPPPA also reported that violence was mostly done at home, by close relatives, family or caregivers. The risk of violence or abuse against older persons is higher among those who are dependent to other persons.

Upon authors' calculation, in 2020, as many as 970 older persons (per 100,000) responded to have experienced crimes (BPS 2020 Statistik Penduduk Lanjut Usia 2020). This is again suspected as underreported. This might be due to the reluctant to report because of shame (the assault is done by close family), the difficulties to access police, or in case of theft, the good stolen is invaluable. Lack of trust is also possible reason for not reporting the crime. Trust is particularly important for the older persons because they tend to be more vulnerable than the younger population. Another thing, the fact that older persons' experience theft or violence also indicate lack of safety.

For violent crimes experienced by the older persons, assault occurred more in rural areas. The reported cases of theft with assault were the highest among the elderly with disability. This indicates lacking in safety among older person

especially those with disability. Cases of sexual assault also happened among elderly in rural areas and those with disability.

Poverty, neglect and poor health status (disability and highly dependent on other persons) among older persons are highly potentials for abuse. The type of abuse against older persons are physical abuse, verbal abuse, emotional abuse, economic abuse such as property abuse and savings.

3.11.8 The means for sustainable development

GOAL 17. STRENGTHEN THE MEANS OF IMPLEMENTATION AND REVITALIZE THE GLOBAL PARTNERSHIP FOR SUSTAINABLE DEVELOPMENT

Indicator 17.8: Fully operationalize technology bank and science, technology and innovation, capacity building mechanism for least developed countries by 2017 and enhance the use of enabling technology, in particular information and communications technology

3.11.8.1 Access and use of internet

COVID 19 accelerates the era of digitalization that has been penetrates the world many years ago. People are pushed toward using gadget to facilitate them in obtaining supplies and services they need. Digital marketing and online shopping began to form new behavior. Older people are also forced to use internet for communication with their families, friends, community surrounding, and also to access information regarding health services, medicine, of cash transfer through internet. However, IT literate among older person is still limited.

In 2020, there were only 11.44 percent (Susenas 2020) of older persons used or had access to internet which was very low compared to 47.69 percent of the national level in 2019. The device to access internet was mostly by mobile phone. In 2020, about half of older people had or used a mobile phone and only 1.4 percent had used computer. The use of internet among the older persons declined by age group. The proportions of the older persons who used internet were lower for those in rural areas, for older women, and for those with lower socio-economic status. Thus, digital divide is not only apparent between the older and younger population, but also among the older persons due to the differences in social and economic status.

Thus, there is an urgent need for the government to expand the internet coverage of older persons, especially for female older persons, those in rural areas, and those from lower socio-economic status to have access to internet while at the same time to increase IT literacy among older persons. This is because of the fact that digital and innovative economy, are here. E-commerce is rising very fast. On line marketing and shopping, e bank money transfer etc. are being new life style, especially due to the pandemic COVID-19. New information on health and medical technology is rapidly changing and improved that everybody has to know, including the older persons.

4 SOCIAL, HEALTH, AND ECONOMIC IMPACTS OF COVID-19 ON ELDERLY PEOPLE

The COVID-19 has a massive impact on people's lives including those of the elderly. It is not known about the extent to which the disruption has impacted on elderly's lives. But it can be summarized that the impact can be differentiated into social, health and economic aspects on elderly's lives. This paper tries to explore the extent to which elderly people have been impacted by the COVID-19. For this purpose, we first present the bigger picture, which is the macro impact of the pandemic. It is then followed by the characteristic of the elderly population in 2020 to then show how they have been impacted by the pandemic. It is important to note that the current pandemic and its impacts on the economy and people's live are new situations and challenges faced by many nations. Therefore, the conditions regarding the availability of qualified data are dynamic and can change any time. It means that what we confirmed yesterday might be different today, tomorrow or the next day, although on the whole we are moving towards better data and information.

4.1 THE MACRO IMPACT OF COVID-19 PANDEMIC

The COVID-19 pandemic and the economic shutdown have caused massive disruptions to most of peoples' lives and are jeopardizing decades of development progress that have been achieved so far. Uncertainties are growing about when will this disruption last and what will be the best scenario to recover from the massive contraction of economics and services (World Bank Group, 2020)[13]. Nevertheless, Indonesia is one among other developing countries that shows minimal economic contraction, with -5.1 percent change of Gross Domestic Product (GDP) Growth from January 2020 and is forecasted to decline to -0.4 percent in 2021 (Word Bank Group, 2020 Table 1.1

[13] World Bank Group 2020. Flagship Report 2020. Global Economic Prospect.

Real GDP Growth). However, the Indonesia Project at the Australian National University, estimated that GDP growth is -1.5 percent, as of October 2020 (Table 4.1).

Except in comparison to China and Vietnam, Indonesia is doing better than other neighboring countries in handling the crisis and the downfall of the economy. However, the target set by Bappenas based on RKP 2021 that the economy was estimated to grow by 5.3 percent (before the pandemic), was not materialized and instead being contracted to -1.3 percent during Semester 1 2020 (Table 4.2). It was also estimated to grow by 0.4% up to 1.0 percent by July 2020. Still, recently BPS (Berita Resmi Statistik, May 5, 2021) confirmed that

the economy was contracted from -5.3 percent during the second quarter of 2020, to -3.49 percent by the third quarter, and then to -2.19 percent by the last quarter of 2020. This contraction was minimized to -0.74 percent during the first quarter of the 2021. Thus, there is a sign of recovery of the Indonesian economy in the early year of the 2021.

Again, the Rencana Kerja Pemerintah (RKP) 2021 estimated that domestic consumption was contracted by -1.5 percent (semester 1 of 2020) and it was estimated to recover to 0.6-1.5 percent in July 2020. Government consumption was contracted by 2.4 percent due to the declining expenditure for commodity and services (belanja barang dan jasa). Due to the major strategy to expand stimulus and social protection to mitigate community groups and industry that heavily impacted by the COVID-19; however, the government spending is estimated to revive to 3.2–3.7 percent in July 2020 (Table 4.2).

It is estimated that public purchasing power has declined due to income loss experienced by most of the people and increase in the price of commodity due to disruption of supplies. Social distancing and mobility limitation policies have caused the decline of domestic demand for goods and services. Still, the government consumption could be maintained as a steady growth of 3.2-3.7 percent in July 2020 was estimated.

Table 4.1. The COVID 19 crisis: Indonesia and neighbors, October 2020

Country	Covid-19 Cases	Covid-19 Fatalities	GDP Growth 2020
Indonesia	1.228	45	-1,5
China	60	3	1,8
India	5.369	82	-10,3
Thailand	53	<1	-7,1
Vietnam	12	<1	1,6
Philippines	3.198	59	-8,3
World	5.077	142	-4,4

Source: Copied from Hal Hill, 2021, Indonesia and the COVID-19 crisis: A light at the end of the tunnel. In Lewis and Witoelar, Economic dimension of COVID-19 in Indonesia: Responding to the crisis. College of Asia and the Pacific, Australian National University.

Note: COVID-19 statistics per million population, as at 15 October 2020.

This is due to the strategy to increase the government spending to provide stimulus distributed to the groups of people and the industries that have been heavily impacted by the COVID-19. The sectors with relatively stable demand were health services, information and communication sectors. The health sector experienced increasing demands for basic health supplies such as drugs, pharmaceuticals products and health supplies such as masks and sanitations. This sector was estimated to grow by 11.2 – 12.7 percent in 2020. Meanwhile, industry that experiences growth is food and beverages, groceries and daily essentials. The information and communication sector were estimated to grow by 8.3 – 9.8 percent in 2020, driven by the increasing demand for data packages to facilitate work from home and online education/school.

The RKP 2021 also estimated that the slowing down of economic growth had a severe impact on achieving the development targets. As can be seen in Table 4.3, the unemployment and poverty rates were predicted to increase and had massive impacts on people's daily lives. Initially, unemployment rate was targeted to be reduced to 4.8-5.0 from 5.3 percent in 2019, but the efforts have been hampered by many job losses during the COVID-19 in 2020. Recent findings from Sakernas show that the unemployment rate that was only 4.94 percent in February 2020 increased to 7.07 percent in August 2020, but declined to only 6.26 percent in February 2021 (BPS, Berita Resmi Statistik, 5 May 2021). The success of Indonesian government to reduce poverty rate into a single digit in 2019 (9.2 percent) was wiped out by the COVID-19 as it increased again to 10.2 percent by 2020.

Table 4.2. Gross Domestic Product (GDP) growth (percent), the demand side, 2019-2020

Uraian	2019[a]	Semester I 2020[a]	2020: Sebelum Covid-19[b]	2020: Covid-19[c]
Pertumbuhan PDB	5,0	-1,3	5,3	(0,4) - 1,0
Konsumsi Rumah Tangga dan LNPRT	5,2	-1,5	4,9	(0,6) - 1,5
Konsumsi Pemerintah	3,2	2,4	4,3	3,2 - 3,7
Investasi (PMTB)	4,4	-3,5	6,0	(2,8) - (0,5)
Ekspor Barang dan Jasa	-0,9	-5,7	3,7	(7,7) - (5,1)
Impor Barang dan Jasa	-7,7	-9,6	3,2	(12,0) - (8,6)

Source: Bappenas, 2021, Rencana Kerja Pemerintah 2021, Table 2.2 page II.15.
Note: a. BPS, 2020; b. RKP, 2020; c. Perkiraan Bappenas, Juli 2020

Table 4.3.Development targets 2020 (percent

Target Pembangunan	2019[a]	2020: Sebelum Covid-19[b]	2020: Covid-19[c]
Tingkat Pengangguran Terbuka (TPT) (%)	5,3	4,8 - 5,0	8,1 - 9,2
Tingkat Kemiskinan (%)	9,2	8,5 - 9,0	9,7 - 10,2
Rasio Gini (nilai)	0,380	0,375 - 0,380	0,379 - 0,381
IPM (nilai)	71,92	72,51	72,11 - 72,21

Source: Bappenas (2021). Rencana Kerja Pemerintah 2021. Table 2.3 page II.16
Note: a. BPS, 2019; b. Sasaran RKP, 2020; c. Perkiraan Bappenas, Juli 2020

To mitigate the impacts of COVID-19 on unemployment and poverty rates, the government increased fiscal stimulus in the form of (1) Program Keluarga Harapan (PKH, Family Hope Program), targeted to 10 million families as beneficiaries, with an increasing index by 25 percent which is being distributed monthly; (2) Program Sembako (food groceries program) was expanded to 20 million family beneficiaries or Keluarga Penerima Manfaat (KPM). Social assistant of this program became Rp200,000 monthly per KPM; (3) Cash transfer (Bantuan Sosial Tunai, BST) of Rp600.000 monthly for 9 months for 9 million beneficiaries who live outside Jakarta: Bogor, Depok, Tangerang and Bekasi (4) A Special Social Assistant in the form of Sembako packages for families being impacted by the COVID 19 who live in Jakarta, Bogor, Depok, Tangerang and Bekasi, and distributed to 1.9 million of KPMs for 9 months; (5) Electricity tariff exemption and subsidy was implemented for the 450 VA and 900 VA poor and vulnerable customers; (6) Utilization of Dana Desa (village budget) to mitigate and reduce the impact of COVID-19. All of these social assistances were hoped to halt poverty rate at around 9-10.2 percent by the end of 2020 (Bappenas, 2011)[14].

4.2. MITIGATION OF THE IMPACTS OF THE PANDEMIC BY THE GOVERNMENT AND ITS LEGAL FRAMEWORK

Following the declaration that the corona virus widely spread throughout the world named as COVID-19 and as pandemic on 11 March 2020 by WHO, the Government of Indonesia issued Presidential Decree no 12 of 2020 on 13 April 2020. This decree states a recognition that COVID-19 is a non-natural disaster caused by the COVID-19, this was preceded by Presidential Decree no 11 of 2020 the COVID-19 as Darurat Kesehatan Masyarakat (Public Health Emergency). It is therefore, the Indonesian Government sees the COVID-19 Pandemic as a disaster, a non-natural disaster.

As a disaster therefore, to cope with its impact, two important strategies/actions should be taken: adaptation and mitigation. The mitigation measures are elaborated as follows

The handling of this disaster is lead and coordinated by Gugus Tugas Percepatan Penanganan COVID-19 (A Task Force to Accelerate the Handling of the COVID-19) which was established through a Presidential Decree no 7 of 2020 (then revised with the Decree no 9 of 2020). This Task Force which directly reports to the President aims among others: (a) to increase national resilience on health, (b) to synergize efforts between ministerial/government institutions and the local government to speed up combating COVID-19. This task force is commanded by General Doni Monardo, who is also the Head of the National Disaster Management Agency Badan Nasional Penanggulangan Bencana (BNBP).

Related to the expenses that may occur to combat the spread of the virus and to cure people who are infected, and to mitigate the impact on the economy (economic slowdown), the Government enacted a powerful tool, namely PERPU no 1 of 2020, Peraturan Pemerintah Pengganti Undang-Undang.

(Government Regulation in Lieu of Law) about Kebijakan Keuangan Negara (State Financial Policy) and Stabilitas Sistem Keuangan (Financial System Stability). These regulations were issued to handle the COVID-19 pandemic and/or anticipating the threat of the COVID-19 toward national economy and/or National Financial System.

In addition, these above mitigation instruments are also equipped with national policy on Physical Distancing (Pembatasan Sosial Berskala Besar, PSBB) related to acceleration of

[14] Bappenas 2021. Rencana Kerja Pemerintah 2021.

the handling of the impact of the COVID-19. This is done through the Ministry of Health Regulation no 9 of 2020. This social distancing policy covers: (a) to ban the use of schools and workplace, (b) to limit religious activities, (c) to limit activities in public space or facilities, (d) to limit social and cultural activities, (e) to limit the use or the operation of public transportation, (f) to limit other activities particularly related to defense and security. The religious activities are limited to the ones conducted at home, attended by limited numbers of family members while keeping physical distancing. Other types of religious activities are conducted following the regulations and the decrees from official religious organizations. The limitation of activities in public space or facilities are conducted in the form of limiting the numbers of and the distance between people. The public space or facilities that are exempt from these regulations are super or minimarkets, market place, shops or places that sell medicines and medical equipment, food, beverages and groceries, essential goods, and fuel, gas, and energy. This article tries to see the impact of the Government Policy on Social Distancing, first in general, then focused on elderly's impact of the COVID-19.

4.3. THE OLDER PERSONS AND THE IMPACTS OF COVID-19 IN INDONESIA

Indonesia is on the threshold of population aging. The 2020 Population Census recorded that the number of older persons age 60 years and older was 26.2 million people or 9.70 percent of the total population. By 2021 the percentage was estimated to reach 10.7 percent, which means that Indonesia will soon be in the era of aging society. This share of older people to total population was projected to increase to reach 14.6 percent by 2030 (Bappenas, BPS, & UNFPA 2018)[15]. Indonesia has to anticipate economic, social and health consequences of an aging society.

It is by nature, that older people experience declining functional capacities: the physical, cognitive and emotional capacity. This decline of functional capacity will affect the capacity to earn income while at the same time, the cost of maintaining quality of life is increasing, especially the cost of health care. A little portion of them have difficulties in performing activity daily living (ADL) such as getting up from bed, walking to the bathroom, climbing stairs, doing selfcare, and

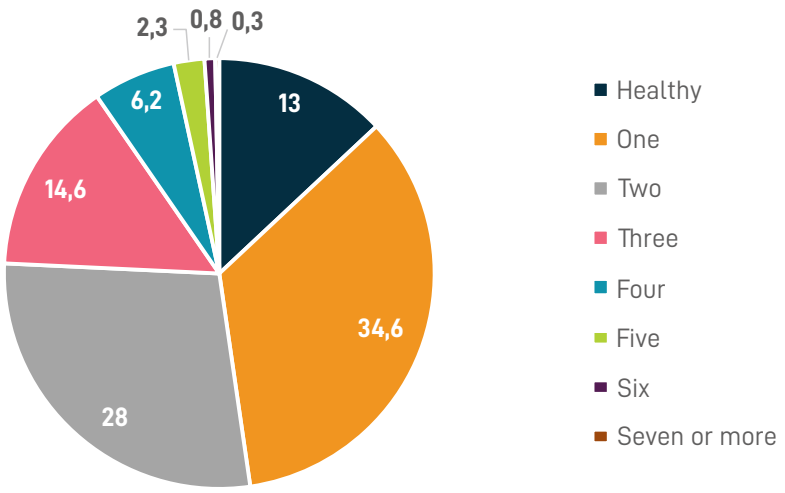


Figure 4.1. The Percentage Of Older Persons By The Number Of Diseases

Source: Elderly Health Study in Indonesia 2013 based on National Health Basic Research (Riskesdas) 2007

[15] Bappenas, BPS, UNFPA 2018. Indonesia Population Projection 2015-2045 Based on Intercensal Survey 2015

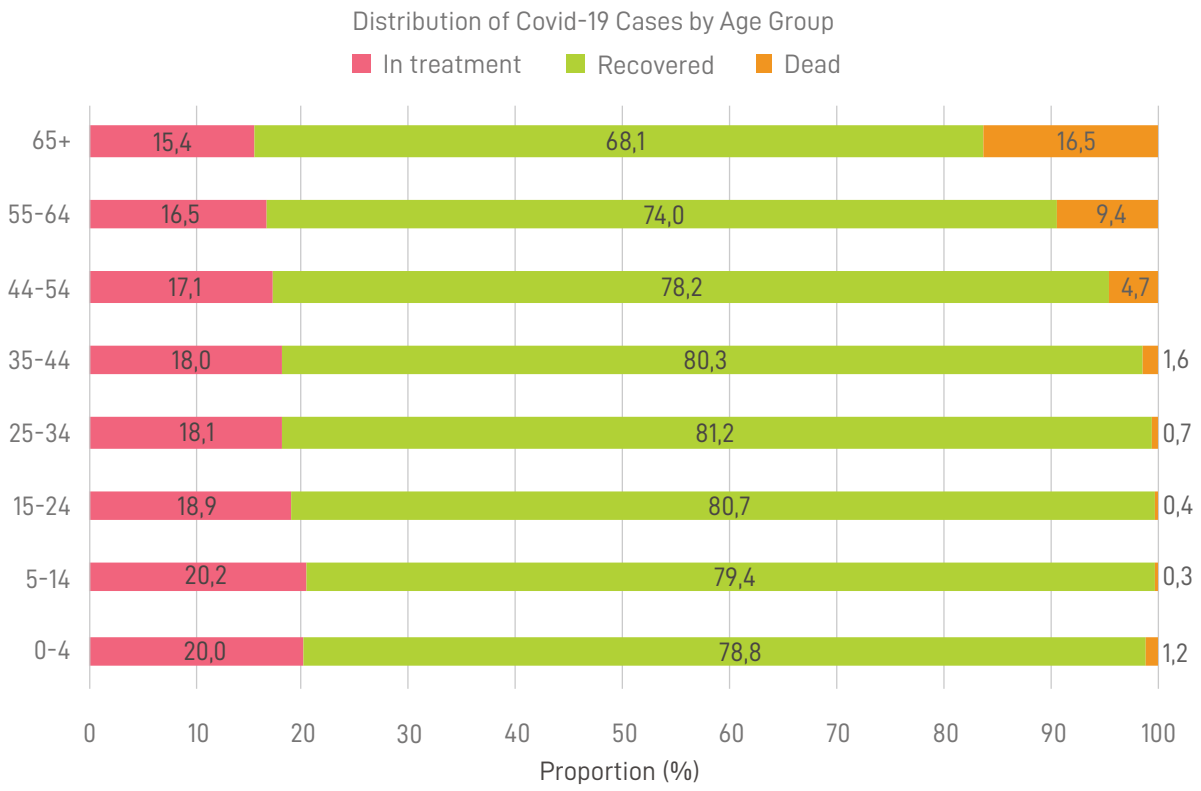


Figure 4.2. The distribution of persons with positive COVID-19 who were still in treatment (perawatan), recovered (sembuh), or dead by the age group of the patients.

Source: Ministry of Health, COVID dalam angka, Oktober 2020. Note: Condition per 19 October 2020.

therefore they need long-term care from other persons. Many of them have mild difficulties in activities called instrumental daily living (IADL) such as cooking, house cleaning, going to grocery shops or to go to the health facilities for services and treatment.

Older persons are also more susceptible to non-communicable diseases (NCD), mainly high blood pressure, heart disease, diabetes mellitus and obesity. Besides, asthma and other infectious diseases such as malaria and tuberculosis that may still being suffered. Figure 4.1 shows that only one-third of the older persons in 2007 who had one disease, while the others showed co-morbidity with two (28%), three (14%), or even four (6%) diseases at the same time. Co-morbidity is usually the underlying factors for mortality among older persons infected by the COVID-19.

Once an older person is infected, the risk of dying is higher than that for the younger ones, which is most likely due to the presence of co-morbidity. Data in Figure 4.2 seems to support this argument. The percentage of patients age 65 years and older who died due to COVID-19 infection was 16.5%. This percentage was much higher than that age 55-64 years (9.3%), and only 4.6 percent of those age 45-54 years old. This pattern is consistent with the findings by the UN (2020)[16] that states that older persons are significantly at higher risk of mortality and severe disease following COVID-19 infections. Findings from research reveal that those over 80 years died at five times the average rate. An estimated 66 percent of people age 70 years and older have at least one underlying condition, placing them at increased risk of severe impact from COVID-19.

[16] United Nations 2020. Policy Brief. The Impact of Covid 19 on Older Persons. May 2020.

4.3.1 The social impacts of Covid-19 on elderly people

Information about the physical distancing policy and its instruments have been massively communicated through media: TV, newspaper, flyers, talk shows, virtual conference, and other instruments for mass communication including the social media. The people have also been imposed to comply with Health Protocol (ProKes) (Health Ministry Regulation no 9 of 2020) and the physical distancing. These ProKEs are wearing mask, wearing gloves, using sanitizers/ disinfectants, washing hands for at least 20 seconds with soap, avoiding touching your own face, avoiding handshakes, avoiding meetings/ crowds/long queues avoiding touching things in public areas, avoiding public transportation including online taxis, keeping at least two meters distance with other people when outside the house, and telling others, particularly within one's surrounding, if one is showing any symptoms of getting infected by the COVID-19.

The results of the Social and Demographic Impact of the COVID-19[17] in Figure 4.3 shows that the level of knowledge about the policy is quite high, measured by the percentage of those who knew or knew in the details about the policy. The percentage of older persons age who knew or knew in details about the physical distancing policy was higher than that of the younger persons. The percentage of females with higher degree of knowledge about the policy was higher than that of the males (Figure 4.3). The difference between the percentage of who knew in details between older males and older females was even higher than between all males and all females, which was 27 percent. However, it needs to be noted that one-third of the respondents with lower education (up to junior high school), did not know or know very little about the policy. This may indicate that some of the respondents, particularly those with lower education, have less access to media or were ignorant about the danger of COVID-19.

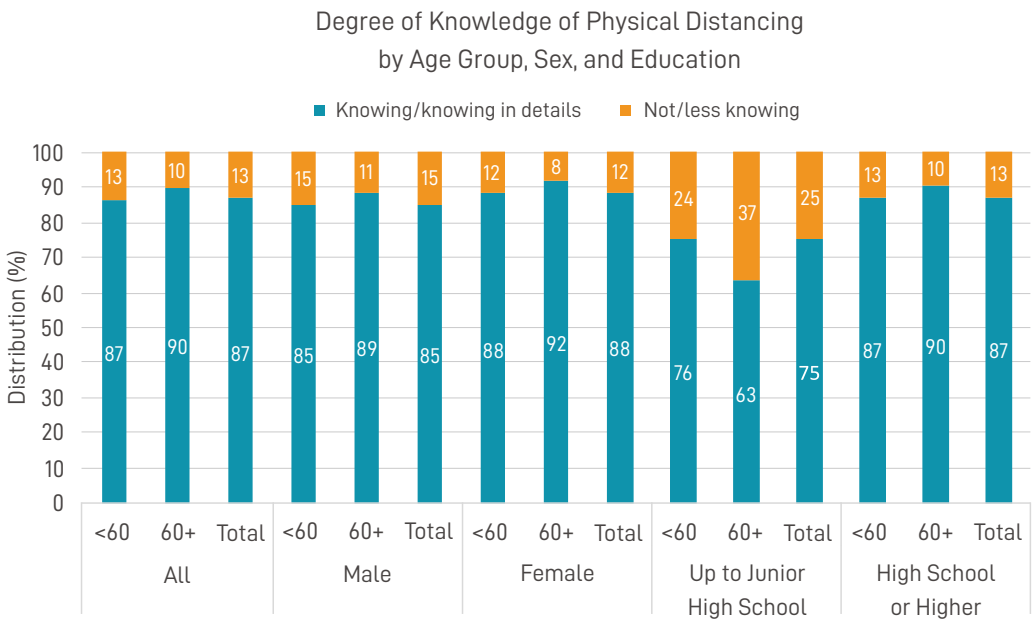


Figure 4.3 The distribution of by the Degree of Knowledge on Physical Distancing Policy by Age Group, Sexd and Education

Source: Social and Demographu Survey on The Imapct of Covid-19, 2020, author's calculation

[17] BPS 2020. Hasil Survey Sosial Demografi Dampak COVID 19. This is an online survey; thus, respondents were biased to those who were IT literate and mostly High school graduates or above. The tables here are author's calculation, that may not reflect BPS' opinion.

The high percentage of respondents with high level of knowledge about the policy could be easily understood because most of the respondents of this survey had at least finished high school. Since the survey was conducted just one month after the PSBB and other regulations were launched by the government, this shows that overall, the dissemination of the PSBB Decree to halt the spread of the COVID-19 was quite successful, at least among the respondents in this survey. This success needs to be appreciated. Still, there are rooms for improvement through strong dissemination, education and information focusing on those who are less aware, which are those who knew less or did not know about the policy. Research needs to be conducted to collect information from people who were not covered by this survey, such as those who are less or not IT literate, who are more likely coming from the lower social-economic strata.

Applying the Knowledge, Attitude and Practice (KAP) theory, it can be expected that those who knew the policy of physical distancing, tended to follow up with the new attitude to apply the ProKes heavily imposed by the government. Figure 4.4 and Figure 4.5 show this tendency. Overall, Figure 4.4 shows that respondents who knew or knew in details about the physical distancing policy, their compliance on wearing, using, or avoiding any activity to prevent being infected by the deadly virus was very high, measured by whether they always/often applied a particular ProKes. The percentages of those who said that they were very often or always wearing masks, washing hands, avoiding handshake, avoiding meeting/long queue, avoiding public transport use, were particularly high. For older persons the percentages of those who complied with all of the protocols were higher than that of the younger respondents, although the level of compliance of both of them were still above 80 percent. Regarding gender, Figure 4.5 shows that the compliance of applying ProKes was higher among women than men who knew or knew in details about the physical distancing policy.

The percentage of respondents who used sanitizer, avoided touching their faces, avoiding touching any objects in public areas, and keeping distance with others when outside of the house, still need to be increased. It may be hard to do because changes are necessary to adopt a new behavior to lower the risk of the COVID-19. In reality, one may often forget to bring or to apply sanitizer, or may not know that touching face increases the risk of being infected by the virus (especially when not wearing mask), and many may be mostly unaware that they were touching objects in public areas. Regarding touching objects in public space, people need to be told that the contamination of the COVID-19 is done through contact with droplets that can fall on any object. This may be hard to remember since people tend to be not conscious about this new behavior. Nevertheless, overall findings of this study show a sign of a new attitude complying to ProKes to avoid getting infected by the COVID-19 begins to emerge. While the perception was based on respondents' statements, we still need to observe whether these statements showing the new attitudes will lead into real new behavior.

Later in September 2020 (6 months after the outbreak), BPS conducted another online survey to collect information about respondents' behavior during the COVID-19 (not a longitudinal survey). The pattern of high compliance by the respondents still holds, that is more older respondents complied than the younger ones. The percentage of respondents applying the health protocol increased in September. The percentage of older persons who said always wearing mask was 91 percent in April, increased to 93 percent in September; those using sanitizer significantly increased from 76 to 83 percent in September; those who avoided handshakes increased from 86 to 91 percent,

those who avoided meeting with a long queue increased from 86 to 88.5 percent, and lastly those who keeping distance increased from 79 to 86 percent in September 2020[18]. These increases are achievement worth of appreciation, because this shows sign of a new normal behavior as a form of adaptation due to the COVID-19 disaster.

In addition, the findings of the September survey show that most of the respondents reported that complying to the ProKes was highly effective to prevent them from getting infected by the COVID-19. In details, wearing masks (91%), washing hands (90%), avoiding handshakes (90%), avoiding the crowds (91.5%), were considered highly effective to prevent the virus (page 8). The percentages of those saying that keeping distance and using sanitizer were lower, but still more than 85% respondents said that they were effective. The statement about effectiveness was higher among female than male respondents (page 9).

A contradictory finding from the April survey is shown in Figure 4. 6. high percentage of respondents who knew less or did not know about the physical distancing policy stated that they complied with the health protocols.

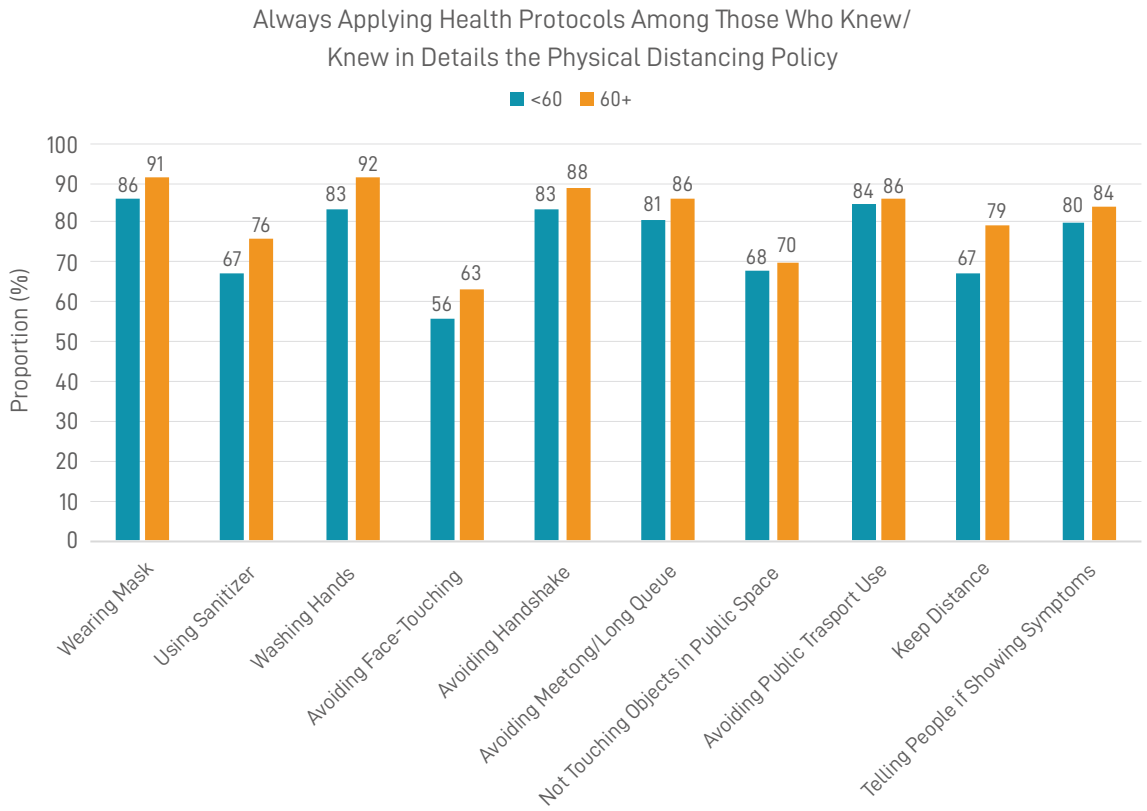


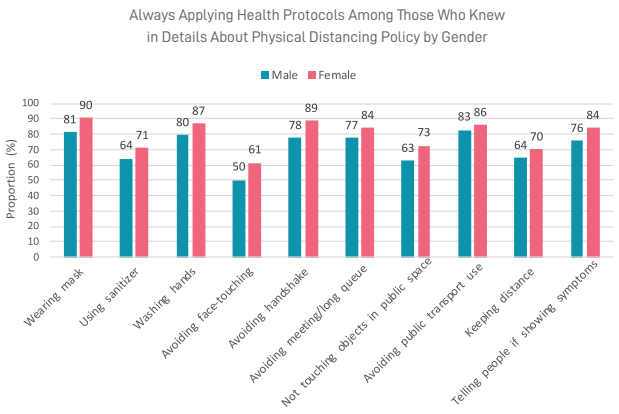
Figure 4.4 The Percentage of the Respondents Who Knew or Knew in Details About Physical Distancing Policy by Age Group and the Type of the Health Protocols They Always/Often Applied April 2020

Source: Social and Demographu Survey on The Imapct of Covid-19, 2020, author's calculation

[18] Different from Figure 4.4, the percentages of the September data described were for all respondents in this on-line survey, not only those who knew about physical distancing in details (BPS 2020. Online Survey Perilaku Masyarakat Semasa Pandemi COVID 16. September 2020, page 7).

Logically respondents who are not aware of the policy have lower tendency to apply the health protocols. Still, the percentages of those with lower degree of knowledge of physical distancing policy were lower than those with higher degree of knowledge of the policy. Perhaps people with less knowledge who complied did so because of group pressures, or from the work, neighbors, community activities such as evening prayer at the mosque of from the church. If this is the case, information about the danger of the virus has already spread throughout entire respondents, whether they are aware or unaware about the policy. They might have seen others using masks, washing their hands, and avoiding handshakes and then adopted these new behaviors.

Referring back to Figure 4.4, although the percentages of respondents who were more knowledgeable about the policy and complied to the health protocol were high, small portions of them did not comply. For example, 91 percent older respondents and 86 younger respondents said that they often or always wore mask when outside the house. The rest, about 9 percent of the seniors and 14 of the younger respondents did not or only very seldom wear it. While this April survey did not collect information about the reason of why they did not comply with the ProKes, such information can be found in BPS September 2020 survey, although both surveys are independent to each other. As can be seen, Figure 4.7 shows that the most cited reason was the absent of punishment (55%). Other reasons were that the respondents believed that there was no evidence of COVID-19 around them (39%) and that the characteristics of their work prevented them from applying the protocol (33%). The more alarming reasons were that the respondents followed others not to comply (21%), leaders did not act as role models for compliance (19%), and could not afford the high price of masks or sanitizer (23%).



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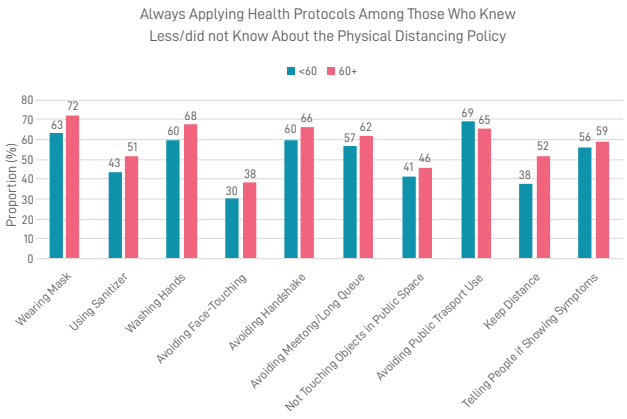


(4.6)

Figure 4.5 The Percentage of Respondents who Knew or Knew in Details About the Physical Distancing Policy by Gender and by The Type of The Health Protocols They Always/Often Applied, April 2020.

Figure 4.6 The Percentage of the Respondents Who Knew Less or did not Know About Physical Distancing Policy by Age Group and the Type of the Health Protocols They Always/Often Applied April 2020

Source: Social and Demographu Survey on The Imapct of Covid-19, 2020, author's calculation

Although, these are only applicable to the respondents, the message is clear: more information that that is easily understood is needed, while also providing solution to the new adaptive behavior such as providing free masks and sanitizers, providing space of seats at the MRT, or in other public areas.

4.3.1.1 The feeling of worry

The COVID-19 disrupted many lives, causes an untold fear and suffering to people, especially among older persons. The massive government and media information about the deadly virus increases the fear of getting infected by the virus. The survey reveals that 65 percent of the respondents said they were worried or very worried about the virus, 26 percent were quite worried, while the rest nine percent did not worry at all (Figure 4. 8). Older respondents had a lower tendency to be worried or very worried and a higher tendency to be not worried at all than the younger ones. Thus, the level of worry seems to be higher for the younger respondents. On the one side, older respondents may not know that once older people get infected by the COVID-19, the risk of dying is higher than the younger people. If this is the reason of why older persons' level of feeling worry was less than that of the younger people, advocacy or education to the older people is needed for them to understand the risk. However, this lower level of feeling worry may be also related to the higher degree of 'pasrah' or 'surrender to God's will' of older persons than that of the younger ones.

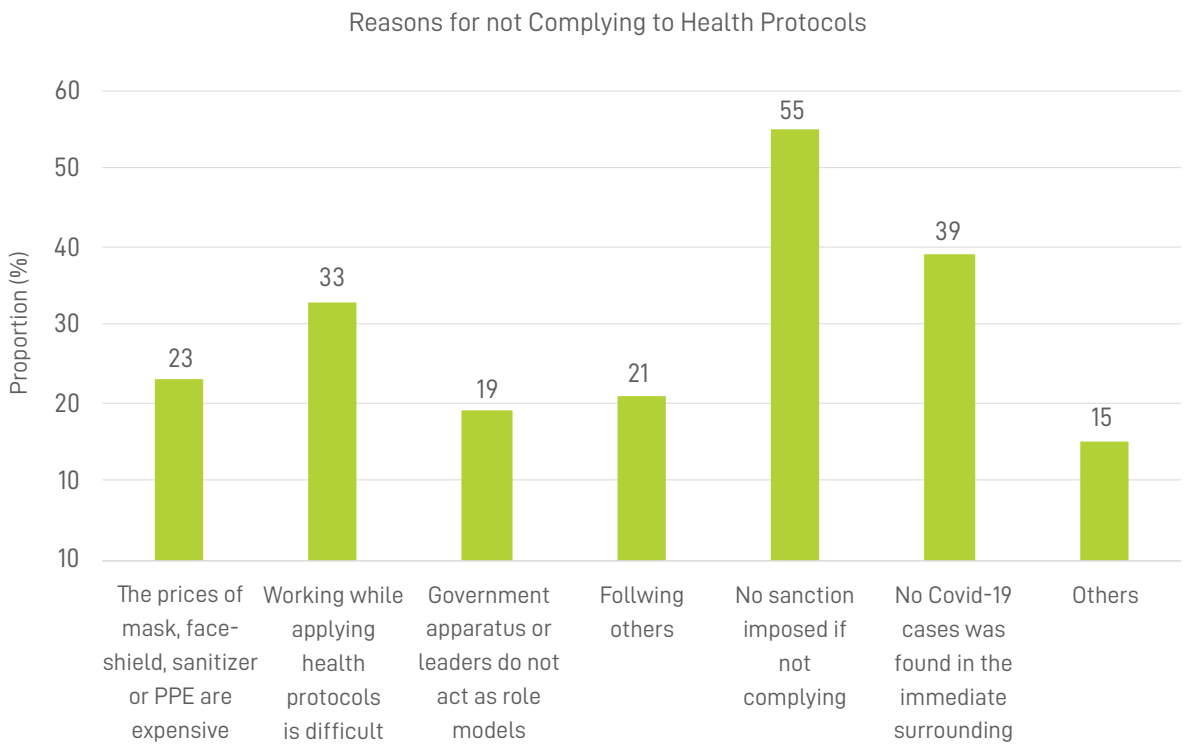


Figure 4.7 The Percentage of the Respondents Who did not comply to Health Protocols by Reasons for not Complying, September 2020

Source: Copied from Survey Perilaku Masyarakat Selama Covid-19, September 2020, page 10.
Note: PPE = Personal Protective Equipment or Alat Pelindung Diri (APD)

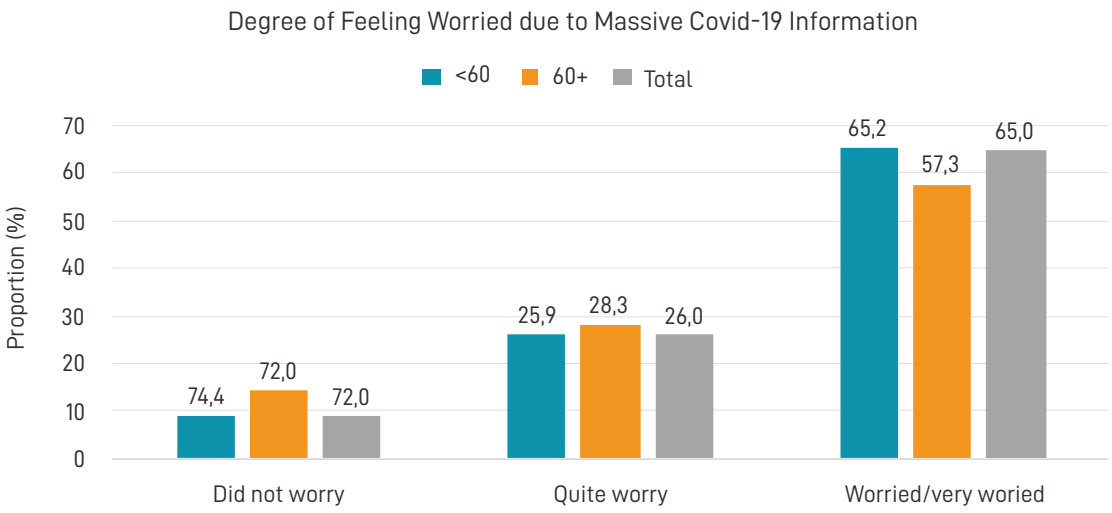


Figure 4.8 The Distribution of Respondents by The Degree of Feeling Worried About the Massive Covid-19 Information from The Media and Age Group

Source: Social and Demographu Survey on The Imapct of Covid-19, 2020, author's calculation

Concerning the compliance to the health protocol by older persons, however, Figure 4.9 shows a pattern that somewhat meets the normal expectation. The highest percentages of always applying ProKes were found among older respondents who were most worried about the condition. The highest percentage among those who were most worried was for wearing mask, while the lowest was for not touching object in public space. On the other hand, it is interesting to see that the older persons who did not worry had tended to always comply with ProKes in most cases, more than those who were quite worried. It might be related to the feeling of 'surrender' and always complying at the same time, which may indicate how some Indonesians cope with disaster, by following the rules and having a calm mind. Therefore, it might be useful to convey the message of adopting the new normal behavior and creating the atmosphere of calmness at the same time, which perhaps is already embedded in Indonesian culture. On the other hand, the compliance of those who did not worry at all is perhaps showing a sign of success in the government mitigation to curb the further spreading of the virus.

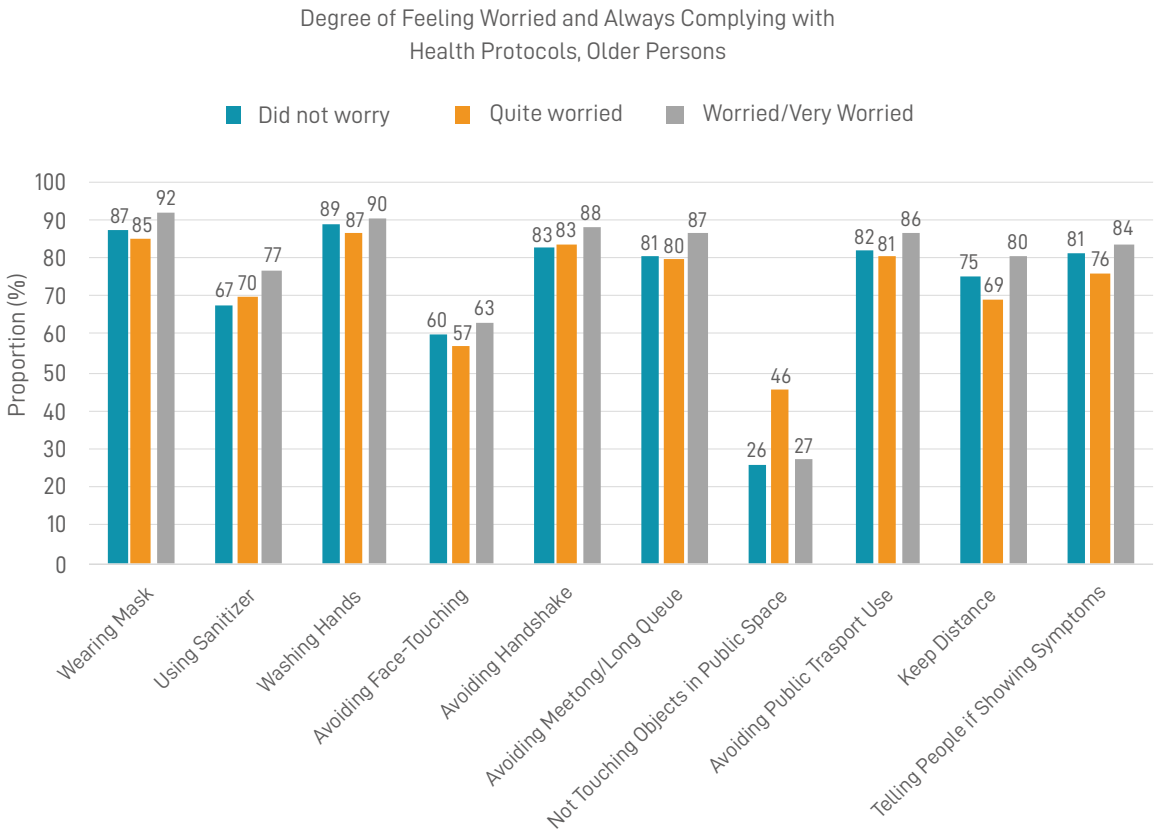


Figure 4.9 The Percentage of Older Person who often/always Complied with The Health Protocols by the Type of Protocols and The Degree of Feeling of Worried About the Covid-19

Source: Social and Demography Survey on The Imapct of Covid-19, 2020, author's calculation

4.3.1.2 Mobility Limitation

Another way of halting the spread of the virus is mobility restriction. Some of the instruments to limit mobility is by avoiding public transport use and staying at home to avoid contact with other people. The use of public transport increases the risk of older persons to be infected by the COVID-19 through other passengers. Because when travelling older persons tend to be accompanied by caregivers such as family members or other relatives, these caregivers are also prone to be infected. As shown in Figures 4.4 and 4. 5, the percentages of respondents who always avoided using public transport were about 60 to more than 80 percent.

In line with Figure 4.4 and 4.5, the respondents who often or always stayed at home to avoid in contacts with other people were slightly above 70 percent (Figure 4. 10).

However, particularly for older persons, those who often or always stayed at home tended to be with higher education. If their level of education is related to their socioeconomic status, it may indicate that the older persons who stayed at home were the ones who could afford to do so.

Aside from the fact that the sample of the online survey was purposive and biased to respondents who were IT literate, these findings may reflect the result of the government's effort to disseminate information about the alarming conditions due to COVID-19 and the government effort to mitigate the impact of the disaster by declaring physical distancing policy. In other words, information about the policy through the media seem to be highly successful referring to the results of this survey.

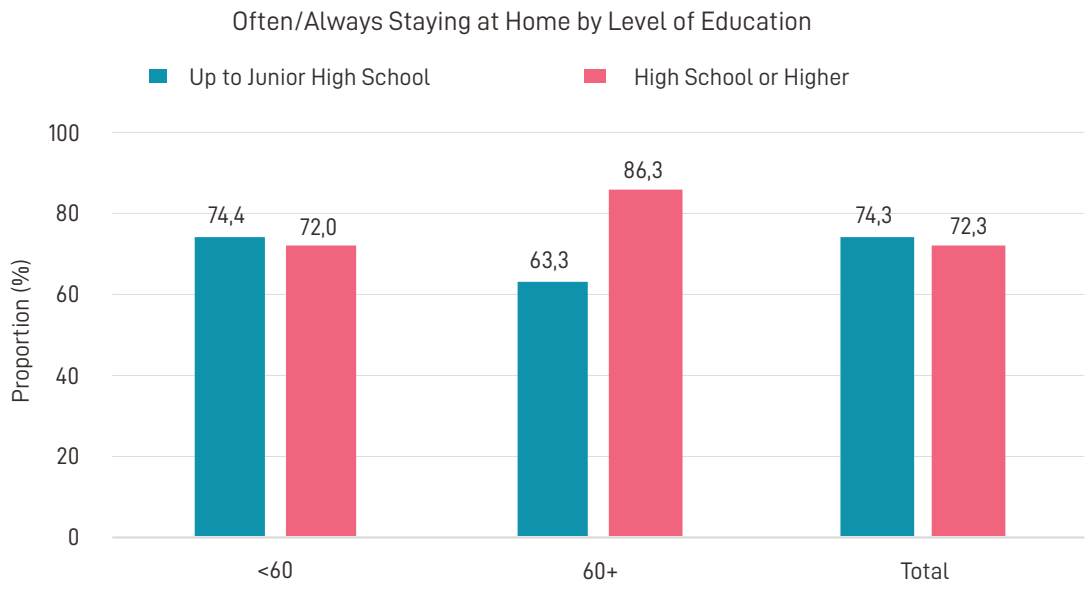


Figure 4.10 The Percentage of Respondents who often/always Stayed at Home by Age Group and Level of Education

Source: Social and Demography Survey on The Imapct of Covid-19, 2020, author's calculation.
Note: The Percentage for Older Person with up to Junior High School Education was based on Low Number of Cases.

4.3.1.3 The Impact of Covid-19 on Physical and Mental Health for Older Person

Aside from the increasing risk of mortality of older persons if they are infected, the application of ProKes and mobility limitation also severely disrupted older persons' lives including access to obtain health services and supply of medicine from clinic or primary health care. This is confirmed by findings from another on-line survey in Yogyakarta, Bali and Jakarta in July 2020 (Komazawa et al., 2021)[19]. The respondents who needed to go to the health facilities stated that they have difficulties in accessing health services. The reasons stated are as follow: (1) 45 percent said that they felt worried or scared to go to health facilities; (2) 28 percent said that the facilities were closed or did not provide services for older persons; and (3) 12 percent of respondents who needed routine medicine stated that they ran out of medicine because they did not have enough money.

Prolonged period of isolation could also have serious effects on the mental health of older persons. Isolation or being locked down at home may disrupt older persons' mental health. Feeling lonely, being secluded and kept away from children and grandchildren for a long time tend to increase stress and may cause depression, which can be fatal to older persons. Older persons who are quarantined or locked down with family members or caregivers may also face higher risk of violence, abuse and neglect (UN 2020). Nevertheless, findings from Eria, Bappenas and Survey Meter online survey in July 2020 show that 75 percent of the respondents said that they kept social relations via telephone, SMSs, or social networking service like WhatsApp during the pandemic (Komazawa et al., 2021). This number seems quite high and promising. However, those who can fill the questionnaires on an online survey are mostly IT literate (and have higher education). It also should be noted that data from 2020 Susenas reveals that only 11 percent of elderly had access and used internet (BPS 2020 Statistik Penduduk Lansia 2020). Thus, the findings of Komazawa et al. (2021) reflects only the respondents of purposive sample, but not the entire older population.

4.3.1.4 Summary: The Sign of Adaptation of The Covid-19 Health Disaster

The high percentages of respondents who always complied with the health protocols particularly among those who did not know or knew less about the physical distancing policy as well as those who did not worry about the virus but complied shows a sign of an adaptation of 'the new normal behavior'. This is the impact of strong government instructions to use health protocols. Since these findings only reflect conditions of non-representative sample of respondents who mostly were IT literate, it is important to expand the research with a sample that representative of the population.

However, the high compliance to the health protocols, the limitation of mobility and the shutdown of economic activities, resulted many disruptions on people's lives, younger as well as older respondents. The following section deals with the economic impact of COVID-19 using the SDS April 2020 by BPS.

[19] Komazawa, Osuke et al. (2021). 'Older People and COVID 19 in Indonesia'. Eria, Bappenas and Survey Meter.

4.3.2 The Economic Impacts of Covid-19 on Elderly People

4.3.2.1 Employment and Income

Figure 4. 11 shows the employment conditions from the SDS (Social and Demographic Survey on the Impact of COVID-19) April 2020. The impacts of COVID-19 on employment can be seen from the percentage of those who were temporarily dismissed or discharged, which in total was about 20 percent (= 18.3+2.5). The percentage of those temporarily dismissed or discharged may also indicate how COVID-19 impacted firms and businesses which in turn impacted the workers.

Figure 4. 11 shows the employment conditions from the SDS (Social and Demographic Survey on the Impact of COVID-19) April 2020. The impacts of COVID-19 on employment can be seen from the percentage of those who were temporarily dismissed or discharged, which in total was about 20 percent (= 18.3+2.5). The percentage of those temporarily dismissed or discharged may also indicate how COVID-19 impacted firms and businesses which in turn impacted the workers.

By gender, older females tended to be temporarily dismissed than older males while it is the other way around for the case of being discharged (Figure 4.12). However, it should be noted that the percentages discharged by gender were based on low number of cases. What needs to be assessed further is whether those who were discharged got a full compensation and had other sources of income and whether those who were temporarily dismissed still got paid. Of course, it mostly depends on whether the employers comply to the regulation and the agreement between the

Among those who were working in agriculture or manufacture, about one-fifth were temporarily dismissed (dirumahkan) (Figure 4.13). For those in service or social service sector, about a quarter were temporarily dismissed. The percentages of those who were temporarily dismissed in service or social service sector were higher for females than males. This may indicate that the effects of the pandemic are harder on these service sectors and harder on females.

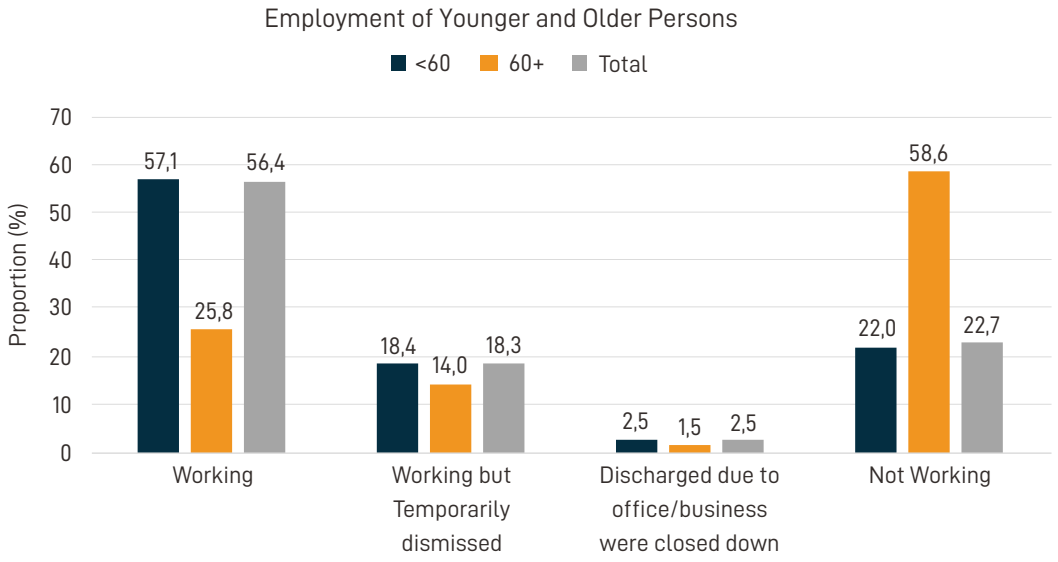


Figure 4.11 The Percentage of Respondents by Status of Employment and Age Group, April 2020

Source: Social and Demography Survey on The Imapct of Covid-19, 2020, author's calculation

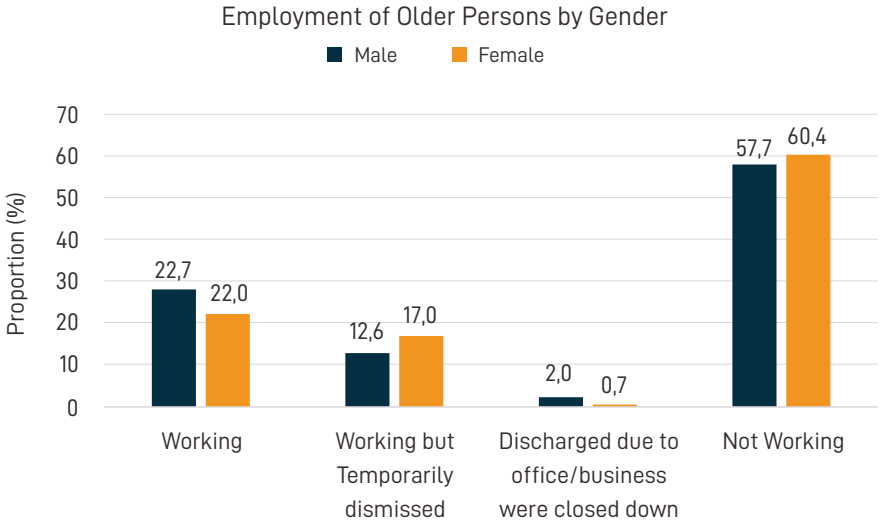


Figure 4.12 The Percentage of Older Person by Status of Employment and Gender, April 20

Source: Social and Demography Survey on The Imapct of Covid-19, 2020, author's calculation

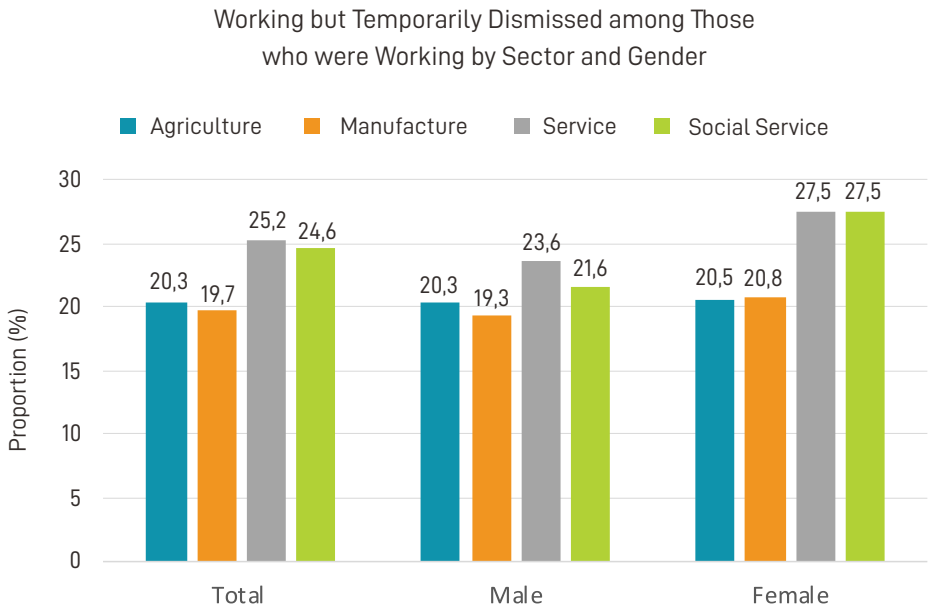


Figure 4.13 The Percentage of Working Respondents who were Temporarily Dismissed by Gender, April 20

Source: Social and Demography Survey on The Imapct of Covid-19, 2020, author's calculation

Figure 4.14 shows that while more than half of the respondents experienced stable income, 42 percent of them experienced a decline in income since the start of the pandemic. The decline in income was more likely to be experienced by the older persons than the younger ones and more likely by males than females. Interestingly, a very small portion of the respondents experienced increase in income. It may be due to the increase economic activities in digital marketing. The policies to combat COVID-19 such as physical distancing and the PSBB have perhaps increased opportunities for digital marketing that facilitated communication between producers and consumers, especially for food, groceries, and other essentials.

Furthermore, we can see the income change by sector in Figure 4.15. The decrease in income was experienced most by those with lower education in all sectors.

For those with higher education, the lowest percentages of decrease were in manufacture and social service sector. It means that the pandemic has affected sectors differently according to the level of education of the workers. According to age group, we can see in Figure 4.16 that the decrease in income was more pronounced for the older persons than the younger ones for those who worked in service and social service sectors. If the workers in service sectors who were highly impacted were in informal sectors, particularly if they were lower educated, then the impacts of COVID-19 seemed to be stronger for those who were more vulnerable groups in terms of income, even among the working ones. This can be assessed further by looking at the change in income by the size of monthly income.

Figure 4.14 The Percentage of Respondents by Age Group, Gender, and The Type of Income Change

Source: Social and Demography Survey on The Imapct of Covid-19, 2020, author's calculation
Note: The percentage of older persons who had increased income was based on a few cases.

Overall, Figure 4.17 shows that the higher the monthly income, the lower the percentage of respondents who experienced decreased income. This graph also shows that the respondents with the lowest monthly income, up to three million Rupiah, were the most likely to experience decreased income. The percentage was even higher for the older persons. Presumably, those whose income were up to 3 million a month might be those working in informal sector with uncertainty of fix income and minimal social protection.

For example, if mobility is limited and people stay at home, the demand for the street food sellers declines or diminishes. Among the younger persons with 3-4.8 million one-third of them experienced decreased income while for the case of older persons with the same level of income, more than half experienced decreased income.

Therefore, we may conclude that during the pandemic older persons were more likely to be impacted than the younger persons regarding income decline.

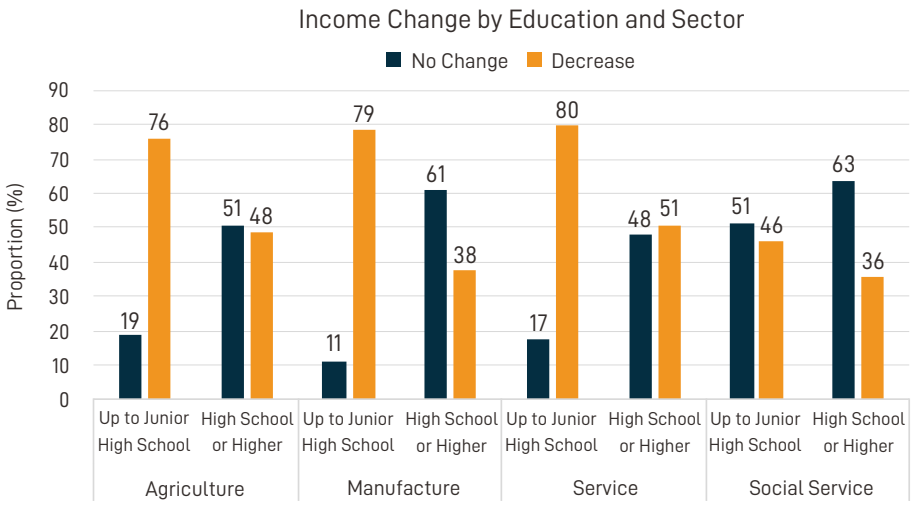


Figure 4.15 The Percentage of Respondents by The Type of Income Change, Education, and Sector

Source: Social and Demography Survey on The Imapct of Covid-19, 2020, author's calculation

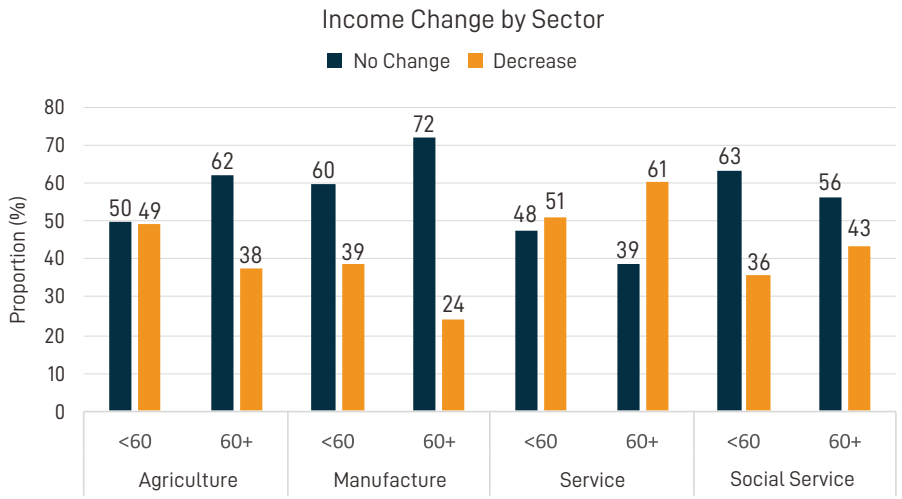


Figure 4.16 The Percentage Of Respondents By Age Group, The Type Of Income Change, And Sector

Source: Social and Demography Survey on The Imapct of Covid-19, 2020, author's calculation

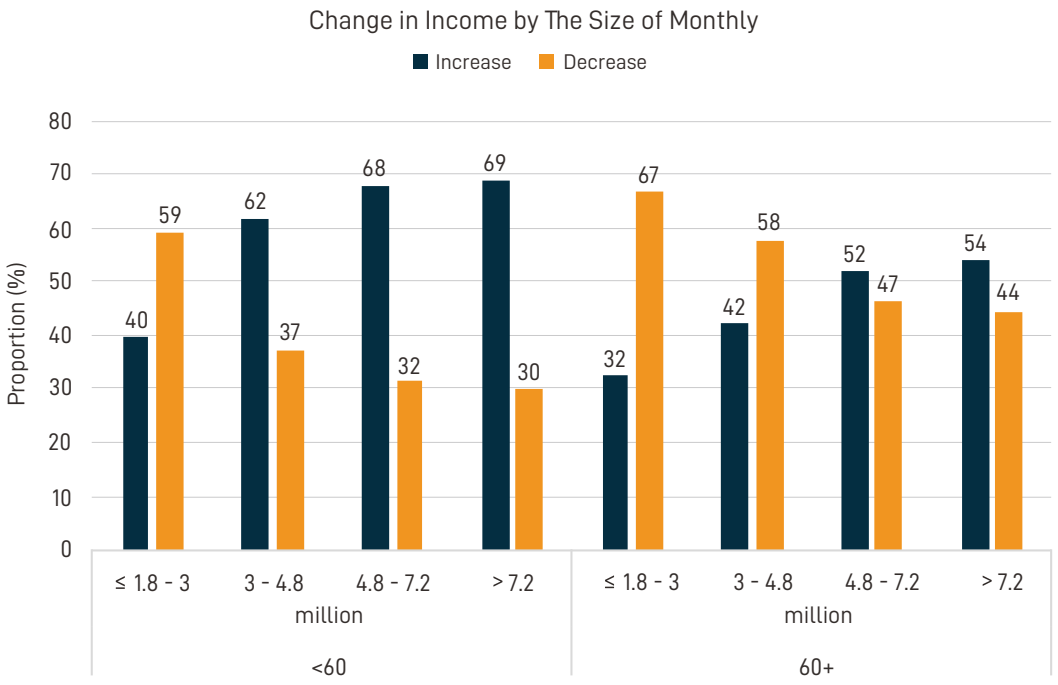


Figure 4.17 The Percentage Of Respondents According To Monthly Income (In Rupiah) By The Type Of Income Change And Age Group.

Source: Social and Demography Survey on The Imapct of Covid-19, 2020, author's calculation

4.3.2.2. Expenditure change

Other survey, which is representative at national and province level, conducted in October and November 2020 with 12,216 households as sample, found that 74 percent of the households experienced decrease in income since January 2020. Many households fell into poverty after the pandemic. Decrease in income is not the only challenge during the COVID-19. Households also have to cope with increase in expenses, mostly due to the increase in food expenses and other basic needs (UNICEF, UNDP, Prospera, and SMERU 2021)[20].

Based on SDS April 2020 by BPS, in overall, Figure 4. 18 shows that during the pandemic, 60 percent of the respondents experienced increase in expenditure, 27 percent experienced no change in expenditure, while only 12 percent experienced decline in expenditure. Therefore, during the pandemic, most people experienced increase in expenditure more than the decrease in expenditure. Females had the highest tendency to experience increase in expenditure while the highest likelihood of decrease in expenditure was among the older persons.

[20] UNICEF, UNDP, Prospera, and SMERU (2021) Analysis of the Social and Economic Impacts of COVID-19 on Households and Strategic Policy Recommendations for Indonesia, Jakarta

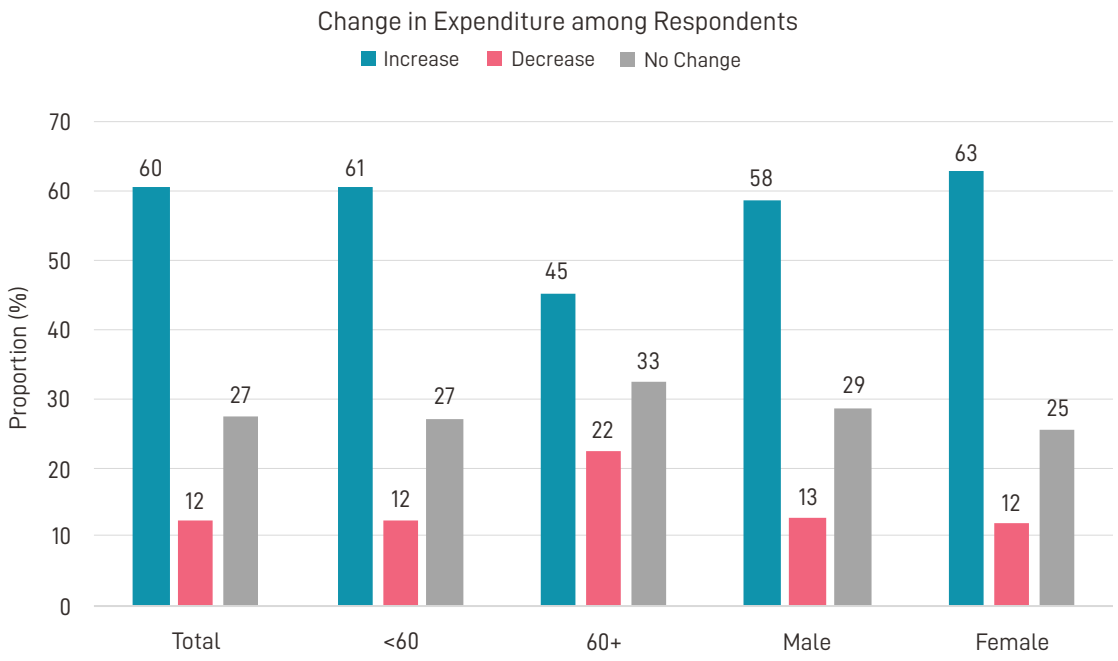
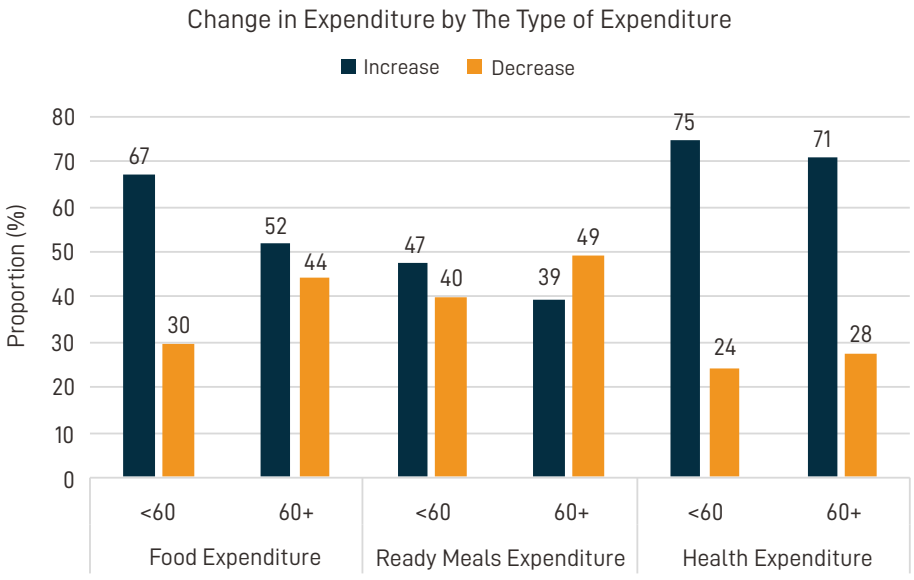


Figure 4.18 The Percentage of Respondents by The Change In Expenditure, Age Group, and Gender

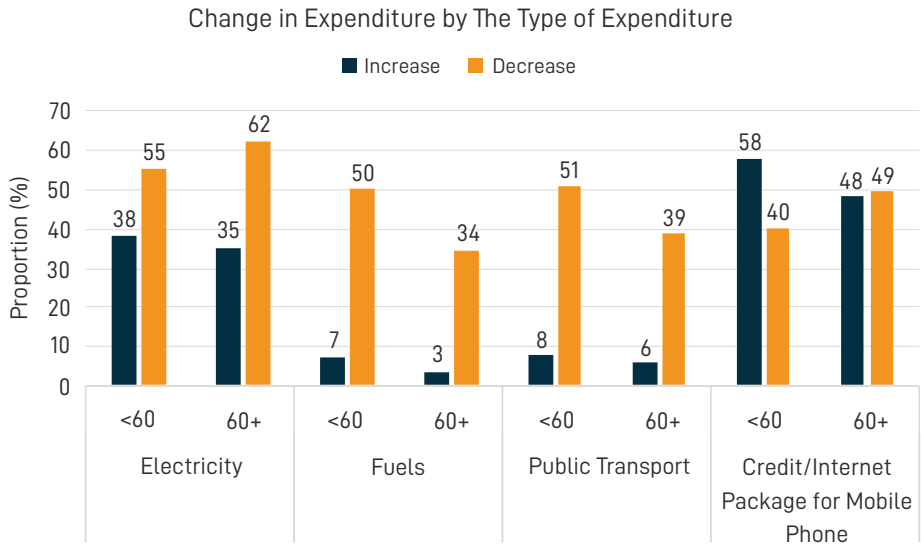
Source: Social and Demography Survey on The Imapct of Covid-19, 2020, author's calculation

From Figure 4.19a and 4.19b, we can see that mostly the younger and older persons experienced increase in expenditure for food and health expenditures. The other increase that was experienced by most was for credit (pulsa) and internet package for mobile phones.

The highest decrease experienced by the older persons was for electricity. Older persons might have cut their expenditure on electricity to compensate for food and health expenses.



(a)



(b)

Figure 4.19 The Percentage of Respondents by The Change in Expenditure and Age Group

Source: Social and Demography Survey on The Imapct of Covid-19, 2020, author's calculation

Among those who experienced decreased income, increase in health expenditure was reported by most of the respondents, which can be seen in Figure 4.20. Figure 4.21 shows that, among respondents who experienced decrease in income, there was also a decrease in expenditure, which may be due to government stimulus or impact of physical distancing. For the lowest income group of up to three million Rupiah, more than half experienced decrease in fuel, electricity, and public transport expenditures. The two richest income groups experienced the highest decrease on electricity expenditure. The decrease on electricity expenditure may be due to discounted cost of electricity during the pandemic, while the cost of fuel and transport have most likely decreased due to mobility limitation policy. On the other hand, half of the respondents who experienced a decrease in income also faced an increase in the cost of mobile credit (pulsa)/internet package. Although, the expenditure on these goods decreased might be due to self-restriction.

Regarding food expenditure, the UNICEF et al. (2021) study and the RKP 2021 documented increases in food prices due to distortion of food supply. The decrease in income accompanied by the increase in prices of food increases the risk of food insecurity among the poor. Those who are already poor may become poorer while those who are vulnerable may fall into poor category because of COVID-19. The poor who experienced decline in income but also challenged by increasing basic food expenditure should be supported by social assistants.

Further, the UNICEF 2021, reported that most of the households interviewed in October-November 2020 received at least one type of social assistants from the government, whether it was in the form of cash transfer or in kind. Half of the household respondents received cash transfer. According to this survey, 90 percent of households in the 40 percent lowest expenditure received at least one type of social assistance and 60 percent of them received in cash transfer. The ERIA survey (Komazawa et al. 2021) also reported that three-quarter of them received at least one type of assistance, dominated by non-cash food assistance. Four-fifth of those with decreased income received at least one type of assistance during the pandemic. About three-quarter of the respondents were beneficiaries of PKH. Furthermore, 70 percent of them received social assistant during the pandemic only and about 5 percent received BPNT, which is equivalent to food assistant from before the pandemic.

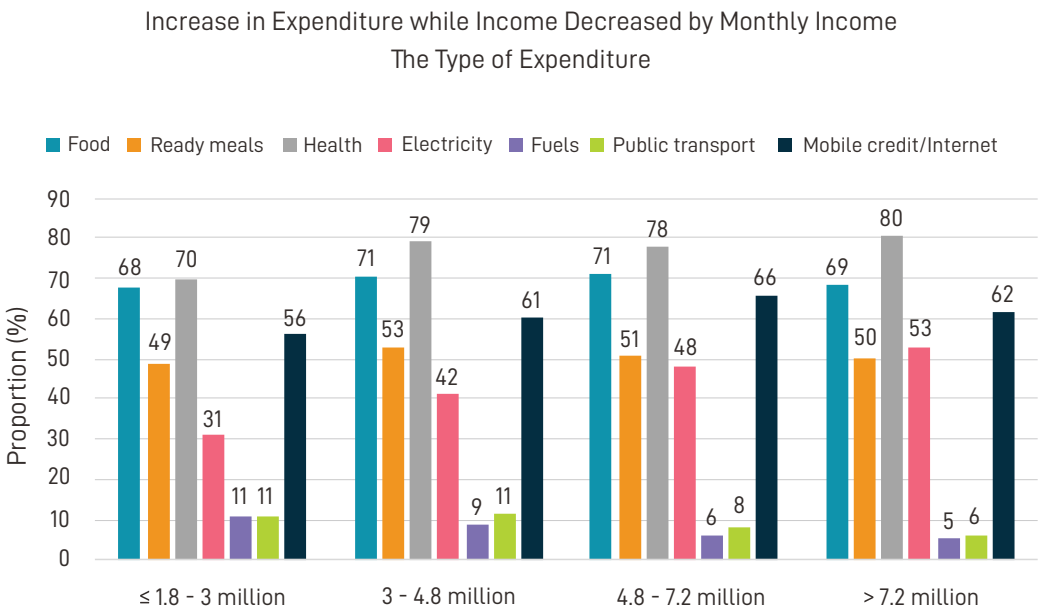


Figure 4.20 The Percentage of Respondents With Increase In Expenditure while Income Decreased by Monthly Income and The Type Of Expenditure

Source: Social and Demography Survey on The Imapct of Covid-19, 2020, author's calculation

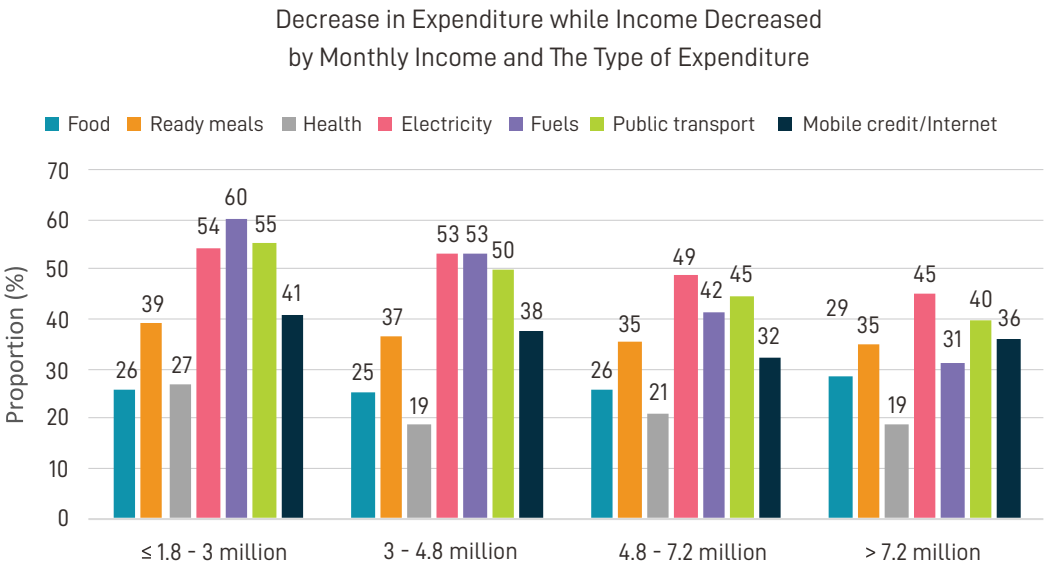


Figure 4.21 The Percentage of Respondents with Decrease In Expenditure while Income Decreased by Monthly Income and The Type of Expenditure

Source: Social and Demography Survey on The Imapct of Covid-19, 2020, author's calculation

Aside from social assistance, there can be an explanation of why respondents whose income decreased still managed to spend for food although the price increased. For the case of some older men, the main source of income was work, while elderly females and the oldest old received transfers from children or other relatives (see Figure 3.13). Such pattern is supported by findings from the survey by Komazawa et al. that the main source of income of older persons was work (36%) and children who were non-household members

(30%). About half of the respondents stated that their income declined during the pandemic. Because of the pandemic, income from work or transfers were significantly more likely to decrease than that of their counterparts. Further, this survey also reveals that many of the respondents who experienced decline in income did not do anything while others asked for help from richer families or communities, or dipped into savings (if they had savings). Their last resource was asking for social assistance from the government.

4.4. COVID-19 AND ITS EFFECTS ON SDGS ACHIEVEMENT

4.4.1. Introduction

There are mounting of evidence about the impact of COVID-19 pandemic on people's lives. The most serious one is the disruption on people's lives due to economic shut down and mobility restrictions which lead to income and job losses. Many people experienced loss or decrease in income, while at the same time also challenged with the rising prices of commodity and services due to disruption of production, supply chain and distribution. Those who were already poor before the pandemic suffered more because they had additional burden in coping with income and job losses. In addition, people who were vulnerable (who lived above the poverty line but under 1.5 times the poverty line)[21] were endangered to being plunged back into poverty.

4.4.2. Global and national economic growth and labor market condition

During the first quarter of 2021, however, BPS announced that there was a sign of economic recovery, along with the better global economic growth during January – March 2021, which was in line with the vaccination COVID-19 process in many countries. Indonesia, too, showed a slight hope in which economic contraction diminished from -5.12 percent during the second quarter of 2020 (y-o-y), to -3.49 percent in third quarter of 2020, and finally to -2.19 during the fourth quarter of 2020. The recent development recorded that the economic contraction has reduced to only -0.74 by the first quarter of 2021 (y-o-y) (BPS, Berita Resmi Statistik 5 May 2021). The contraction of household consumption is also diminishing, but still significantly contribute to the minus GDP growth by -1.22 percent by the first quarter of 2021. Household consumption was contracted by -5.52 percent during the second quarter of 2020 (y-o-y), decline to -4.05 for the third quarter, to -3.61, and reaching -2.23 during the fourth quarter of 2020 to finally reach -1.22 percent during the first quarter of 2021.

The COVID-19 pandemic also disrupted the Indonesian labor market (BPS, Berita Resmi Statistik, 5 November 2020). Findings from Sakernas 2020 August show that 29.12 million people at the working age (14.28 percent) has been impacted by the Coronavirus. This number consists of: (1) 2.56 million became unemployed; (2) 0.76 million were pushed out of the labor force; (3) 1.77 million people were temporarily not working; and (4) 24.03 million experienced shorter working hours. The total unemployment rate in August 2020 was 7.07 percent, increased by 1.84 percent point from 5.23 percent in 2019. This contributed to the increase in the national poverty rate. As it is clear that COVID-19 affected macro condition and the whole population, in the next section its impacts on older persons and the SDGs achievement focusing on this segment of population is elaborated.

[21] OECD measure.

4.4.3. The impacts of COVID-19 on older persons and SDGs achievement

The analyses in this section are based on the findings reported in the previous sections. The government's response to combat the spread of the COVID-19 was, among others, the issuance of Physical Distancing Policy and the instruments to apply health protocols. Data from an online non-representative survey called The Social and Demographic Impact of COVID-19 by BPS in April 2020, reveal that most of the respondents (80-90%) were quite knowledgeable about the policy of physical distancing. The higher degree of knowledge regarding this policy was higher among the older people than the younger ones, and among the older women than the older men (see Chapter 4.1). This was followed by the high compliance shown more among the older persons than the younger ones, indicated by the higher percentage of older persons than the younger ones in wearing mask, using sanitizer, washing hands, avoiding face touching, avoiding handshake, avoiding meeting and long que, avoiding touching object in public space, avoiding public transport use, always keeping distance, and always telling people if showing symptoms.

Among a small proportion of respondents who had lower compliance with the health protocols, more than half (55 percent) of them said that it was because there was no sanction imposed if not complying. Others said that the reason not to comply was did not find any cases in their surrounding (39 percent), difficult to apply health protocol while working (33 percent), and could not afford to buy mask, face shields, sanitizer due to expensive prices (23 percent) (BPS online survey September 2020).

Nevertheless, these findings show a new attitude, a form of adaptive behavior during the pandemic. The compliance to the health protocols rose from 80 percent in April to 90 percent in September 2020 (BPS online survey April and September 2020). This is one among the effective ways to combat the coronavirus through self-protection. However, this is not without a cost. This new behavior together with the mobility restriction and the downturn of economic activities have impacted people's lives in particular those of older persons, which in turn is hampering the efforts to achieve the SDGs in 2030.

4.4.3.1. Increase in poverty rate

GOAL 1. END OF POVERTY IN ALL ITS FORM EVERYWHERE

Changes in people's behavior and the decline in economic activities, the contraction of economics, job losses and decrease in income, decline in household consumption, while at the same time rising of commodity prices, all contribute to the increase in poverty rate. BPS confirmed that the national poverty rate has increased from 9.22 percent in September 2019 to 9.78 percent in March 2020 and increased again to 10.19 percent by September 2020, due to the coronavirus (BPS, Berita Resmi Statistik, 15 February 2021). In 2019, 25 million people living below poverty line and another 55 million people were vulnerable who were at high risk to be plunged back into poverty because of the pandemic situation. By September 2020, the number of people living under poverty line increased to 27.6 million people or an increase by 2.76 million people since September 2019.

> ***Target 1.2**: Reduce at least by half of the proportion of men, women and children of all ages living in poverty in its all dimension according to national definitions*

It is already known that poverty rate among older persons (60+) is higher than that of the national rate, that is 11 percent compared to 9.22 percent in 2019, respectively (see Chapter 3.1). Poverty rate (11.2 person) and vulnerable rate (21.3 percent) among older persons were disproportionally distributed across gender and place of residence. Higher poverty rates were found among older females and older people in rural areas than among older males and older people in urban areas (Figure 4.22). This pattern holds for older persons who were

The magnitude of the increase in poverty rate among older persons due to the pandemic is not known. But if we assume that the vulnerable older persons tend to be plunged back into category of poor (see UNICEF, et al. 2021), we can estimate the number of poor persons during the pandemic is those who already poor before the pandemic plus the new poor

Figure 4.23 shows that the estimated size of older persons living under poverty line in 2019 was 2.85 million people while the size of those vulnerable was 5.42 million. Using these figures, we can estimate that the total number of poor people (poor and the new poor) now is 8.26 million older persons. This may not be the exact number, but at least it can shed some light about the size of the problem. We should then pay attention on how to maintain older persons' quality of lives during the pandemic. The increase in poverty will increase the inability to access basic needs, health and basic services as also mandated in **Target 1.4, 2.1, 2.2,** and **3.8**.

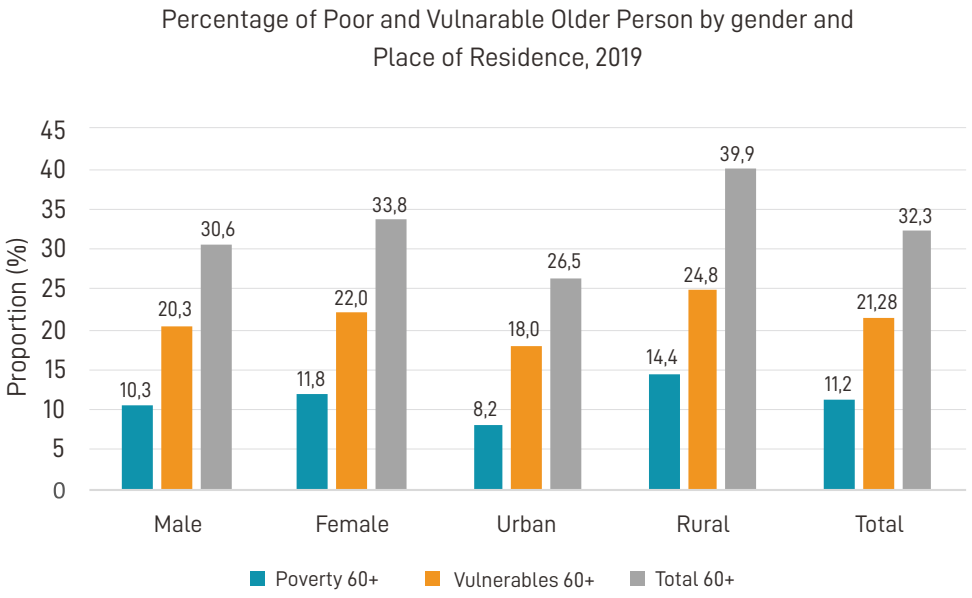


Figure 4.22 The Percentage of Older Persons Age 60 Years and Older Living Below The Poverty Line and Vulnerable by Gender and Place of Residence

Source: Susenas 2019 (own calculation)

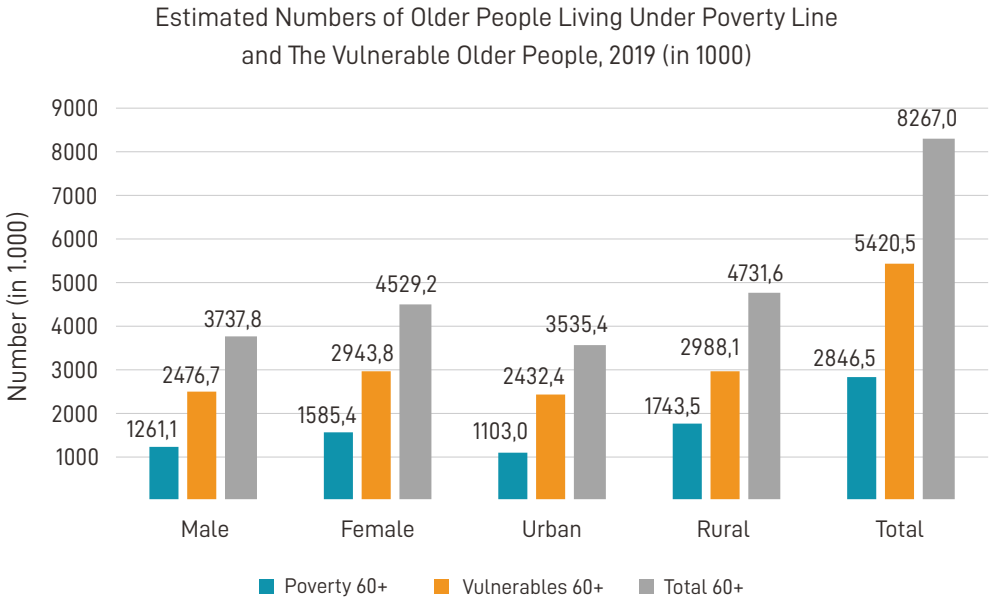


Figure 4.23 Estimated Number of Older People Living Under Poverty Line and Those Living Above Poverty Line but Under 1.5 Times of The Poverty Line (Vulnerable) by Gender And Place of Residence

Source: Susenas 2019 (own calculation)

Further impact of the COVID-19 is hampering the effort to achieve Target 1.2. It is worrying that the 2030 target to reduce at least by half the proportion of older persons living under poverty line (from 11.2 percent in 2019 to 5.6 percent in 2030) may not be achieved. This target cannot be met if appropriate intervention is not introduced, among others through the expansion of beneficiaries of social assistance, redistribution of PBI toward those who mostly are in need (40% lowest of household expenditure).

4.4.3.2. The impacts on social protection

> ***Target 1.3**: Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 substantial coverage of the poor and vulnerable*

Before the pandemic, 54 percent of older people in the category of 40 percent lowest household expenditure received PBI (social health insurance with the contribution paid by the government). Because of the increase of poverty rate, the number of PBI beneficiaries should be expanded, among others through budget reallocation and better distribution more toward the older persons who fall into category of 40 percent lowest household expenditure (see Chapter 3.1). This way, unmet need for health services among older persons can be reduced, or at least avoid not to increase during the pandemic (Target 3.8). This is one of the alternatives to increase the coverage of social protection to older persons who live under poverty line. Aside from this, there were still 26.5 percent of older persons not covered by social health insurance. Further examination on why these older people were not covered by social insurance should be conducted. One of the reasons might be that they did not have identity card (electronic KTP) as one of the requirements to obtain PBI. Targeting system should be revised according to the recent conditions.

Concern has also to be paid on the impact of COVID-19 on the discontinuation of paying JKN membership fee (5.3 million or 2.4 percent of all members), whether the membership belonged to the older persons or was paid by their children or household members. The impact on the discontinuation of membership on older persons is declining access to get routine checkups and resupply of medicine, especially for those who suffer from NCDs. Which in turn increasing unmet need.

Aside from social health insurance, before the pandemic, the government has distributed social assistance in terms of PKH, BPNT and other forms of social assistance. A combination of quantitative analysis nationally representative plus qualitative study conducted by UNICEF, et al., (2021) found that all household respondents reported being received social assistance during the pandemic, at least one scheme.

Many working-age people who used to help covering older people's expenses (in terms of direct payment or transfer) were at risk to discontinue their support too, which might have resulted in the increase of the deprivations suffered by poor older persons. The overall impact of the COVID-19 for older persons was the decreasing accessibility and affordability to obtain sufficient quantity as well as quality of food, access to health care and services, and access to basic services, which lead to the increase in multidimensional poverty).

4.4.3.3. Access to basic services

> ***Target 1.4**: Access to basic services*

Small portion of older persons experienced deprivation of access to electricity (see Chapter 3.1), but the government have exempted the cost of electricity for households with 450 VA and 900 VA subscription. It is difficult to assess whether there was an impact from the decrease or loss of income on access to decent sanitation and safe water. If any, the impact was probably on older persons' households who lived in areas where safe water had to be bought.

4.4.3.4. Employment, income, and expenditure

GOAL 8. PROMOTE SUSTAINED, INCLUSIVE AND SUSTAINABLE ECONOMI GROWTH, FULL AND PRODUCTIVE EMPLOYMENT AND DECENT WORK FOR ALL.

> ***Target 8.5**: Achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value.*

Loss of income and jobs during the pandemics are the main contributors for the increase in the poverty rates including poverty of older persons. As stated in the previous section, the BPS online survey reveals that it was the lowest income groups (with income up to 3 million rupiah monthly), older or younger persons, who were heavily impacted by the corona virus. About 67 percent of older persons with monthly income up to 3 million rupiah said that their income decreased during the pandemic. The percentage of those who experienced decrease in income declines as the monthly income increases, meaning that it was the lowest income group that tended to be the most impacted by the economic shut down and mobility restriction.

Further, from the April 2020 online survey by BPS, 25.8 percent of older respondents reported they were still working, 14.0 percent were temporarily dismissed from work, 1.5 percent were being discharged due to office/business were closed, and 58.6 percent were not working (see Figure 4. 11 in Chapter 4.1). Respondents of all ages who were temporarily dismissed from work, were most likely those working in services and social service sectors. The percentage of those dismissed was higher for women than men (see figure 13 in Chapter 4.1).

This pattern is supported by the findings from the Sakernas August 2020. As stated by Manning (2021)[22] , informal sector, tourism, labor intensive manufacturing, construction and transport were the sectors that have been hard hit by the pandemic. Aside from that, industries that were heavily dependent on international market such as tourism and labor-intensive manufacturing and non-tradeable transport and construction have also suffered badly. Nevertheless, because of the extensive use of internet to facilitate work from home and the new government program of pre-employment cards that enabled continued skill development, Indonesia has avoided the more severe labor market disruption such as experienced by other countries in the region. Therefore, despite the severity of COVID-19, the Indonesian economy and labor market are doing better than several more globally networked countries in South East Asia.

Regarding older persons' employment, findings from analysis August 2018 - August 2020 Sakernas reveal that open unemployment among older persons age 60 years increased from 0.61 percent in August 2018, to 0.68 percent in August 2019 and to 1.7 percent in August 2020. The latest (1.7%) shows the impact of COVID-19 on employment of older persons (BPS, Berita Resmi Statistik, Keadaan Ketenagakerjaan Indonesia, 5 November 2020). This may indicate that many of the older persons are still in the labor market, they wanted to work but no work because of the pandemic. As emphasized in Chapter 3.1, older persons who were still working most were probably due to necessity or survival. If they were already poor, they had to struggle on how to afford their daily expenses. This situation is worrying.

The work situation of older persons during the COVID-19 can be disaggregated into: (1) 2.92 percent were unemployed (2) 13.7 percent were those who were not in the labor market; (3) 8.08 percent were temporarily out of work; and (4) 6.99 percent experienced decrease in working hours. The August 2020 Sakernas also recorded a decrease in wage. Overall workers, their wage

[22] Manning, Chris 2021. 'The Labor Market Shock and policy responses to the coronavirus pandemic'. In Lewis and Witoelar 2021 eds. Economic dimension of COVID 19 in Indonesia. Responding to the Crisis. College of Asia and the Pacific. The Australian National University

declined by 5.20 percent that is Rp2,91 million from August 2019 Rp2,76 million in 2020 August. For older persons, the extent of the decline is not stated in the report, it only stated that by August 2020 the wage of older person is Rp2.18 million, lower by about 6 hundred rupiah compared to the national average. The wage for older men is 2,53 million rupiah and for older women is 1.30 million rupiah by August 2020. Wages for women, all ages are always lower than that of the men.

All of these situations are worrying, in particular for those who were already poor before the pandemic and the vulnerable who tend to fall back into the category of poor. This in turn hampers access to basic food, nutritious food and basic health care and services. In addition, income and job losses of younger population may induce a discontinuation of support to the older persons who are heavily dependent from transfers by their children or other relatives (see Ch 3.1). This is threatening the quality of life of older persons, especially those who were already poor before the pandemic and those who had comorbidity of NCDs. The cost of rehabilitation and curative treatment of older persons who suffer from NCD are very high (Witoelar & Riyanti 2021).

4.4.3.5 Soaring essential commodity prices and the rising of food insecurity

GOAL 2. END HUNGER, ACHIEVE FOOD SECURITY AND IMPROVED NUTRITION AND PROMOTE SUSTAINABLE SGRICULTURE

> ***Target 2.1****: By 2030, end hunger and ensure access to all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round.*

> ***Target 2.2****: By 2030, end all form of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons.*

Income and job losses threaten the accessibility and affordability of people to meet their daily needs, in particular basic food. Those who were already living under the poverty line before the pandemic suffered more from the rising of food prices. During March 2020-September 2020, commodity prices was soaring. The price of beef increased by 1.51 percent, sweetened condensed milk (susu kental manis) by 1.07 percent, cooking oil by 2.67 percent, flour by 2.76 percent, mackerel (ikan kembung) by 1.07 percent. On the other hand, some commodities experienced decline in prices such as rice (0.49 percent), chicken meat (3.5 percent), sugar (6.54 percent), chili pepper (32.37 percent), eggs (6.12 percent) (BPS, BRS 15 February 2021). Unfortunately, there is no further information on whether the decline was due to the government subsidy in mitigating the impact of the COVID-19 to maintain household consumption.

The findings from the online survey in April 2020 by BPS reveal that 41.9 percent of all respondents said that their income decreased, 57.1 percent experienced no income change, and the rest about 1 percent experienced increase in income. The percentage of income decrease was higher for older persons than the younger ones and for male respondents than the female respondents (Figure 4.14). The decrease in income was mostly experienced by respondents with low education (Figure 4.15). According to age group, the percentage of older persons who experienced decrease in income and work in agriculture and manufacture is lower than that of the younger respondents. On the other hand, the older persons who worked in service and service sector were hit harder by the COVID-19 in terms of income decrease than the younger persons working in the same sector. Older persons who most experienced decrease in income worked in service sector (61 percent) and social services (43 percent) (Figure 4.16).

Decrease in income makes it challenging for older persons to meet the need for basic food and ready meals. About 52 percent of older respondents said that their food expenditure increased while 44 percent said that their food expenditure decreased. As for expenditure on ready meals, 39 percent of older respondents said that their expenditure increased while 49 percent said it decreased (Figure 4. 19). It is not known whether this was experienced by older persons whose income decreased, increased or stable. But since 50.2 percent of older respondents said their income decreased, it can be assumed about half of older persons whose food expenditure increased came from the group of older persons who experienced decrease in income. This is worrying since this will increase food insecurity, that already prevailed before the pandemic. The pandemic increases the deprivation for basic food among older persons. Those who experienced decline in income had to compromise between quantity and quality of food. Further, older persons with decrease in income were those from the lowest group of monthly income (up to 3 million), had the lowest education, and from those who worked in service sector. Thus, the COVID-19 may alarmingly increase food insecurity **(Target 2.1).**

Another evidence of decreasing food security is shown by the findings from a combined research between quantitative and qualitative representative survey, based on Susenas 2019, conducted by UNICEF, et al., (2021)[23]. Almost one-third (30 percent) of the respondents were worried that they could not feed their families. The proportion of households facing moderate or severe food insecurity rose to 11.7 percent in 2020, it was not stated in the report but presumably it compares with before the pandemic. Income reduction and disruptions to food delivery systems were the main factors contributing to food insecurity (p. 7). Patunru and Amanta (2021)[24] supported the argument as they stated that income reduction and disruptions to food delivery systems were the main factors contributing to food insecurity.

Regarding older persons' employment, findings from analysis August 2018 - August 2020 Sakernas reveal that open unemployment among older persons age 60 years increased from 0.61 percent in August 2018, to 0.68 percent in August 2019 and to 1.7 percent in August 2020. The latest (1.7%) shows the impact of COVID-19 on employment of older persons (BPS, Berita Resmi Statistik, Keadaan Ketenagakerjaan Indonesia, 5 November 2020). This may indicate that many of the older persons are still in the labor market, they wanted to work but no work because of the pandemic. As emphasized in Chapter 3.1, older persons who were still working most were probably due to necessity or survival. If they were already poor, they had to struggle on how to afford their daily expenses. This situation is worrying.

4.4.3.6 Health issues due to COVID-19

GOAL 3. ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AGES

> ***Target 3.3**: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water borne diseases and other communicable diseases*

a. Non-Communicable Diseases among older persons

The impact of COVID-19 on older persons' health is strongly related to non-communicable diseases (NCDs), as well as infectious diseases. One of the infectious diseases that still prevails among older persons is tuberculosis (Goal 3.3). It was found that the behavior of some of older TB patients was not in compliance to the routine medical checkups, to

[23] UNICEF, UNDP, Prospera, and SMERU (2021). Analysis of the Social and Economic Impacts of COVID-19 on Households and Strategic Policy Recommendations for Indonesia, Jakarta.

[24] Patuntu, Arianto and Filippa Amanta 2021. COVID 19, food security and trade: The Case of Indonesia. In Lewis and Witoelar 2021 eds. Economic dimension of COVID 19 in Indonesia. Responding to the Crisis. College of Asia and the Pacific. The Australian National University.

getting resupply of medicine, and to routinely taking the medicine. Adverse behavior tends to hamper the efforts to minimize the prevalence of TB among older persons. This in turn increases the prevalence of unmet need for health care and services. The policy of physical distancing, mobility restriction and advice for older persons remain to stay home adding the problem and inhibiting the efforts to reduce the TB prevalence among older persons. Older persons who suffer from TB and live three generations under one roof (see Chapter 3.1) are prone to infect other household members. In particular, the older TB patients who are poor and living in indecent house with lacking ventilation have higher risk to infect other household members and thus hampering the efforts to eliminate this infectious disease.

All of these situations are worrying, in particular for those who were already poor before the pandemic and the vulnerable who tend to fall back into the category of poor. This in turn hampers access to basic food, nutritious food and basic health care and services. In addition, income and job losses of increase the prevalence of unmet need for health services and care (Chapter 3.1) (Goal 3. 8).

> ***Target 3.4**: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing*

b. Non-Communicable Diseases, drop in health insurance participation and the rising prevalence of unmet need for health care and services

Increasing poverty rates during the pandemic tends to increase the prevalence of unmet need for health services and care that was already high before the pandemic. Accessibility of medication, hospitals, clinic or general practitioners/midwives tended to decrease due to mobility restriction and advice to older persons to stay home and to avoid using public transport (see Chapter 4.1). From the supply side, closing of many health centers and mobilization of health workers to care for patients with COVID-19 have inhibited access for other patients to get proper medication. These tend to

The COVID-19 impact is more severe among people who suffer from NCDs, in particular those of the older persons. People with NCDs have to have regular checkup and take routine medicine, but as previously mentioned, access to health care was inhibited by the physical distancing and the mobility restriction policy. In addition, older people are advised not to go to the health centers due the fear of getting infected by the coronavirus

The increasing risk of unmet need for health care and services is also contributed by the drop outs of social insurance beneficiaries to pay premium. Some people are unable to continue paying the insurance premium, which in turn lowering their affordability to get access to health care and services, supply and resupply of medicine (Target Goal 1.3). This includes some of the NCDs patients, who are prone to get infected by the coronavirus while comorbidity is the most underlying cause of dying from the coronavirus. Regular checkups and routine medication are effective management for the patients to protect themselves from getting infected by the deadly virus, but adverse effect is seen due to the disruption of the routine medical checkups.

Findings from the BPS online survey in April 2020 reveal that the health expenditure increased, which was reported by 75 percent of younger respondents and 71 percent of older respondents (see Figure 4. 19a of Chapter 4.1). If those respondents were those with decrease in income, this situation poses a serious problem and needs an emergency intervention. Beside increasing prevalence of unmet need, the patients in this situation tend suffer more which can lead to stress and depression leading to death.

NCDs which used to be associated with aging population, high income, sedentary and urbanized life styles are now associated with poverty as well.

Poor individuals face higher risks of NCDs due to worse disease environment and lower access to prevention, diagnostic and care services. The COVID-19 has worsened this situation. Older people with NCDs such as hypertension, diabetes, kidney failure, heart diseases, tend to suffer more.

c. Social and physical distancing and their impacts on older persons' mental health

The massive information and education about the danger of coronavirus through various media in combination with the physical distancing may create loneliness, stress and anxiety because of isolation. In particular, people with NCDs tend to have higher prevalence of stress and anxiety. The worry about their health and the fear of getting infected by the deadly virus tend to be amplified if they are not able to access their regular NCDs' health protocol or management. Data from MOHA show that 6.8 percent of Indonesians had suffered from anxiety disorder during the pandemic. There were 14,619 people who received treatment from members of the Indonesian Clinical Psychologist Association (IPK) from March to August 2020. It was reported that the most common disorders were learning difficulties, anxiety, stress, mood disorders and depression. **(Goal 3.8).**

Findings from the BPS online survey in April 2020 reveal that 65 percent of all respondents felt very worried about the condition of the COVID-19 pandemic. However, the percentage was lower among older persons (57.3 persons) than the younger ones (65.2 percent) (Figure 4.8). Surprisingly, 14 percent of older persons stated that they did not worry at all about the pandemic. It is interesting to know further, since most of respondents in this survey finished high school and IT literate. Most of the older persons who were very worried about the situation showed high compliance to the health protocols (84-92%). Even those who said they did not worry showed high compliance with around 60-80 percent were often or always wearing mask, washing hands, avoiding handshake, avoiding meeting with crowds and long que, avoiding public transport use, keeping distance, and telling people when showing symptoms.

Still, the combination of feeing worried and high compliance to the health protocols seemed to have adverse effect on older persons' mental health. Physical distancing policy, keeping distance with family and others, avoiding mass gathering, have led to social exclusion which in turn tend to increase anxiety, worry, and the feeling of loneliness and stress that may lead to depression. Older persons with severe depression need long-term care, since the duration of the disease is unknown. The medical and the cost of care increases and the burden goes to the family and the government. Long-term care usually is done mostly by female family members such as daughters, daughters-in-law, granddaughters, and other female relatives. The quality of life of these women caregivers needs serious attention too. Many of them have to quit from work in order caring their seniors and their loved ones. Furthermore, most of these caregivers are not working before. Thus, they are most likely not to have pensions, or savings or another asset. Who will take care of them when they are old?

4.4.3.7 Sustainability in consumption and production and climate change

GOAL 12. ENSURE SUSTAINABLE CONSUMPTION AND PRODUCTION PATTERN

GOAL 13. TAKE URGENT ACTION TO COMBAT CLIMATE CHANGE AND ITS IMPACTS

Related to the recommendations stated in Chapter 3.2, we view that the indicators of these two goals are lacking in human perspective. Therefore, it is suggested to review targets and indicators of Goal 12 and Goal 13 and to design new indicators showing relationship between people's behavior, consumption and environment. The relationship between population growth, people's behavior, consumption and changes in environment is strongly intertwined.

It is also recommended that COVID-19 should be seen as a disaster, a non-natural disaster. Therefore, combating the deadly corona virus can be done through two steps, which usually applied when dealing with climate change, which is adaptation and mitigation. Findings from the BPS online survey in April and September 2020 show high compliance of respondents, in particular older persons and women, and adaptation during the pandemic (try to learn how to live under the pandemic situation – hidup berdampingan dengan coronavirus), through changes in the behavior such as wearing mask, washing hands, and so on. At the same time, the government have already developed mitigating instruments to reduce the severe impact of the COVID-19 to the large population. Among others are the issuance of PERPU March 2020, Social Distancing Policy (PSBB), financial stimulus, and increase coverage of social assistance (see Chapter 4.1)

4.4.3.8 Societies and institutions for sustainable development

GOAL 16. PROMOTE PEACEFUL AND INCLUSIVE SOCIETIES FOR SUSTIANABLE DEVELOPMENT, PROVIDE ACCESS TO JUSTICE FOR ALL AND BUILD EFFECTIVE, ACCOUNTABLE AND INCLUSIVE INSTITUTIONS AT ALL LEVELS

> ***Target 16.1**: Significantly reduce all forms of violence and related to death rates elsewhere*
>
> ***Target 16.2**: End abuse, exploitation, trafficking, and all forms of violence against and torture of*

Even before the pandemic, there were cases of older persons suffering from abuse and neglect. However, publications on this issue are very minimal except for the one reported by KPPPA (see Ch 3.1). This report claims that the prevalence of violence, in particular against older persons, is highly underreported. Meanwhile UNDP (2020) warns that COVID-19 has increased vulnerability of older people. Older people who are quarantined or locked down with family members or caregivers may also face higher risk of violence and abuse. Poor people living in indecent house with several generations and crowded houses are prone to being assaulted, experience abuse and violence, particularly the older persons.

Data derived from Susenas 2020, reveal that the type of violence against older persons are theft, theft with violence and sexual assault (BPS publication, Statistik Penduduk Lansia 2020, see Chapter 3.1). It might be because some people who experienced income and job loss saw that the only way to survive was through stealing or robbing. In this case, older persons could be targeted first. This, it is worrying that the incidence of crime against older persons could increase as an indirect effect of the COVID-19

A non-representative online survey conducted by KOMNAS PEREMPUAN (Dinamika Perubahan Rumah Tangga Selama COVID-19) reported that domestic violence against women age 31-40 years old tended to increase. The relationship with spouse is getting more tense (hubungan menjadi tegang) is stated by couples with low income - under 5 million rupiah a month. It means that economic violence tends to happen more than physical violence. Women tend to experience domestic violence more than that of the men. The predators of the violence tend to be among the household members. In addition, increase in household expenses tends to boost domestic violence in the form of physical and sexual violence. This is threatening the achievement of Goal 16.1 and 16.2

4.4.3.9 Means for sustainable development

GOAL 17 STRENGTHEN THE MEANS OF IMPLEMENTATION AND REVITALIZE THE GLOBAL PARTNESHIP FOR SUSTAINABLE DEVELOPMENT.

> ***Target 16.1**: Fully operationalize the technology bank and science, technology and innovation, capacity building mechanism for least developed countries by 2017 and enhance the use of enabling technology, in particular information and communications technology.*

a. Internet use among older persons

The penetration of information technology has been massive throughout the world including Indonesia during the last few decades. Almost everybody is now using mobile phone with or without internet. However, digital divide still exists among older persons. Susenas 2020 shows that only 11 percent of older persons used internet, although more than half of them used mobile phone. Among the 11 percent, the use of internet was clustered among those with higher education, living in urban areas, and those who were in the richest category of household expenditure (see Chapter 3.1).

Nevertheless, mobile phone and internet help to prevent older persons from being lonely and stressed. Another online survey on the impact of COVID-19 on older persons, conducted by ERIA, Bappenas and Survey Meter in November 2020, found that through the mobile phone, older persons were able to communicate with their children, families and other community members who were away from home, which in turn prevented them from feeling lonely. Those with internet in their devices tended to be able to receive transfers from their children or other family members living outside the house, in particular among older persons who were banking literate and used mobile banking.

The new mechanism of social assistance distribution, the BPNT and the small credit, is now distributed through KPS and KSS with cashless system. The government transfers the amount of the assistance into electronic cards. The beneficiaries of social assistance can buy some amount of rice or cooking oil or other essentials from the e-warung (electronic small shops at the village level) using these cards. Thus, internet can help facilitate the older persons to meet their needs, particularly the poor older persons. In particular during the pandemic

In addition to the use of internet to avoid loneliness and to receive non-cash social assistance, at macro level, labor market distortion can be minimized due to the Work from Home (WFH), a new behavior and system that heavily dependent on internet connections (Manning, 2021). Overall, the use of internet is able to reduce the adverse effect of COVID-19.

5

CHALLENGES TO MEET THE 2030 SDGs AGENDA

Indonesia is on the threshold of population aging. The 2020 census recorded 26.2 million older population age 60 years and older or 9.7 percent of the total population. It is projected that by 2030 the number of older persons will reach 42.8 million (14.6 percent) and increase to 63.3 million in 2045 (19.9 percent). An aging population is a blessing and a celebration, but at the same time also creates challenges for development. The declining functional capacity among older persons carries economic, health, and social consequences for the older persons themselves and their families, communities, and the government. Interventions to maintain and improve the whole population's quality of life and well-being should be based on a right-based approach. Therefore, the inclusion of older persons in the 2030 SDGs agenda is timely and in line with the theme of **'NO ONE LEFT BEHIND'**.

Findings from the 2019 Susenas reveal that the situation of the current older persons is worrying. . They tend to have low education and indecent work since about 80 percent of those who are working are employed in the informal sector. The poverty rate among older persons, 11.2 percent, is higher than the national rate, 9.22 percent. It means that one out of nine older persons lives under the poverty line, inhibiting access to nutritious food, health care, sanitation, and decent housing.

The COVID-19 pandemic has worsened the situation of older persons. Those who were already poor before the pandemic suffer more. Those who were vulnerable are threatened to fall back into poverty. Job loss is highly related to the decrease in income while, at the same time, the prices of the basic needs and food increase due to the disruption of production, supply chain, and distribution. Expenditure for health services also increases. Older persons are at higher risk of non-communicable diseases in comparison to younger ones. Comorbidity on older persons such as NCDs plus malaria and TB acts as one of the underlying

causes of death if they are infected by the coronavirus. The higher risk of NCDs and death faced by older persons is accompanied by the disruption on the supply side of the health system due to the mobilization of health workers to focus more on combating the pandemic. Many health centers do not have the capacity to treat older persons with NCDs or those with mental health disruption.

The COVID-19 is jeopardizing the development, so far as the national poverty rate set back to the condition in 2017. Consequently, the social and economic conditions are much worse than the 2017 condition when the GDP growth was 5.07 percent compared to minus 0.74 percent during the first quarter of 2021. It is not known when the pandemic will be over, but it will have long-lasting effects on people's lives.

It is challenging to identify the extent of the suffering due to the COVID-19 because of lacking in the availability of representative data. What is apparent is that the COVID-19 would tend to delay the achievement of the 2030 SDGs agenda. In June 2020, the World Bank Report (2020)[25] also highlighted the uncertainty of economic growth due to the pandemic. Still, it also suggests that economic recovery is related to the timing when the spread of the COVID-19 is under control. Hence, the hope is on the government's ability to increase the mass vaccination to reach herd immunity rapidly. A recent publication by The Straits Times estimates that under the current speed of vaccination, 4.7 percent of the population with two doses of vaccinations, with around 230,794 vaccination rate/doses per day, Indonesia will take 4.5 years to reach herd immunity[26]. The economic recovery is likely in line with the increase in herd immunity due to the spread of vaccination (World Bank, 2021). Aside from that, the speed of the spread of the digital economy may also help accelerate economic recovery. Nevertheless, there is no precise and exact estimate of when people's lives will be back to normal.

Still, mitigating the impacts of COVID-19 on older persons cannot be postponed. The short-term strategy should be taken to ease the challenge in meeting their daily needs, as the government has been doing now with the food assistance or Bantuan Pangan Non Tunai (BPNT). One program closely related to helping fulfill older persons' basic needs is the Asistensi Lanjut Usia Terlantar (ASLUT)[27] or the social assistance for abandoned elderly, managed by the Ministry of Social Affairs. This assistance is in the form of a cash transfer of Rp2,400,000 per year. This program is still low in coverage as in 2019, it covered only 30,000 older persons. To mitigate the impact of the COVID-19, the coverage of this program should be significantly increased. There is also a program called Asistensi Rehabilitasi Sosial (ATENSI), a form of rehabilitation services conducted within an institution, but the beneficiaries do not permanently live in the institution. The beneficiaries are given skills to increase their earning power, such as agrotourism or urban farming.

Coping with the health system disruption, some clinics and health care centers have introduced telemedicine to provide health services with less or no physical contact between the health workers and the patients. In the bigger picture, the national health system surely needs lots of improvement, not just to cope with the pandemic (Witoelar and Ryanti 2021).

It is also essential to have a visionary perspective on promoting healthy and active aging through the life cycle approach. The aim is to prepare the future older persons to be more resilient against shocks due to sickness, death of other family members,

[25] World Bank, 2020, Global Economic Prospects, June 2020. Washington, DC: World Bank. DOI: 10.1596/978-1-4648-1553-9.
[26] Strait Times May 27, 2021, based on Bloomberg data. This information is correct as of 10 PM on May 26, 2021. Herd immunity is defined as when 75% of the population is inoculated/vaccinated.
[27] BPS 2020. Statistik Penduduk Lansia 2020.

income, or job loss. The opportunity is that older persons in the future will have better education, healthier and more IT literate than the present and the previous ones. The non-poor older persons, that is, the rest 90 percent of the older population in Indonesia, are potential and able to participate in economic activities to have income from work. The task of the government is to develop guidance on what kind of work is suitable for older persons concerning the decline of their functional capacity.

6 THE WAY FORWARD

The current profile of the majority of Indonesian older persons is not promising in terms of the demographic effect of Indonesian development. They were the first and the second of the baby boom cohort because about half of them were born just after the Independence. Another half were born before the massive social and economic development during the 1970s-1980s. Malnutrition and low access to primary education inhibit many of them from enjoying full growth, living healthily, and having a better education. These situations may explain why 11 percent of older persons live in poverty. The COVID-19 even has increased their deprivation. Mitigation to cope with the impact of COVID-19 has been done by the government using massive social assistance in kind (rice, cooking oil, and other essentials). This social assistance is aimed at people impacted by the coronavirus but lacks focus on older persons. For older persons, the government manages social assistance in cash transfers, providing supplies such as mattresses, and skill development to increase their earning power.

Nevertheless, the coverage of these types of social assistance is too small compared to those in need because it is estimated that there are about 2.9 million poor older persons. Thus, within the short term, mitigating the impact of the COVID-19 is by expanding the coverage of social protection and expanding the program on skill development to increase earning power. In addition, the distribution of this assistance has to be reviewed to avoid mistargeting of the beneficiaries.

On the other hand, not all older persons are poor. About 90 percent of them are the non-poor who may be potentials to participate in the development, especially the young-old aged 60-69 years. Findings show that these young-old have a higher level of education than those of the older ages. The primary source to cover the daily expenses of the young-old is from work (see Chapter 3.1), compared to older ages who depend

more on transfer from others. These young-old older persons also tend to be healthier than the older-old as the Infant Mortality Rate has declined. If this trend continues, it is expected that older persons in the future are healthier, with higher education, more IT literate, more knowledgeable, and have higher aspirations about their well-being. Many who are now self-employed (for example through startups) before entering the older ages because of the innovation created by the digitalization in the economy, trade, and other services, will be the older persons of the future.

Based on this trend, it is expected that the quality of Indonesian future older persons will be better than the current ones. Globalization, digitalization, and technology development will create the NEW OLDs. But this process is not automatic, mainly if programs and interventions are done with a business-as-usual attitude.

In recent years, a framework of active aging has been developed by WHO (2002) using a life cycle approach (see Chapter 3.1). At an early age, an individual's functional capacity is increasing until a certain age when the functional capacity starts to decline. However, the speed of declining capacity depends on the nutrition, health care, and lifestyle of that person. Healthy behavior can prolong the onset of declining capacity. On the other hand, unhealthy behavior, alcohol, smoking, pollutions, among others, can accelerate the declining capacity in later life.

In addition, people at older ages are more prone to suffer from NCDs than younger ones. The higher risk of NCDs at later ages can be prevented since an individual is young, even since one is still in the womb. Adequacy of food and nutrition of the mother during pregnancy and sufficient iron and zinc supplements during fetal development prevent intrauterine growth retardation (Achadi, 2020). Growth failure can lead to hypertension, heart disease, diabetes, cholesterol, and obesity at a later age (Rajagopalan, 2003; see Chapter 3.1). Therefore, holistic, integrated, and comprehensive interventions starting from the womb and after birth, plus physical and emotional stimulus, healthy lifestyle, healthy diet, regular exercise, and avoiding smoking, can lead to healthy and active aging. Indirectly, this will help eliminate poverty among older persons.

Younger people who are entering their older ages in 2030 are those who were born between 1950 and 1970. Within the era of digitalization with open and abundant information, their behavior will tend to be different from the current older persons. At least the policymakers can impose healthy behavior, healthy diet, exercise, and a ban from smoking for these younger people. For the longer term, early childhood development with a life-cycle approach can be introduced to promote healthy aging for the future older persons, although this is beyond the 2030 agenda. A prominent economist and noble laureate, James Heckman (1998), said that investing in early childhood development could prevent 30 percent of GDP loss compared to not doing anything. The benefit will last until later age with healthy and active aging.

In Indonesia, the younger people who will enter the older ages were born in the early 1970s and now in their fifties. After the 2030 agenda, the millennials will enter the aging era. They will tend to have different attitudes and different styles in decision-making due to different aspirations about life. With this knowledge, we can anticipate the future direction of policies and strategies toward healthy and active aging as an agenda to end poverty among older persons.

The Pan American Health Organization and WHO (PAHO/WHO) agenda of Decade of Healthy Ageing 2020-2030[28] is in line with the 2030 SDGs agenda (The Decade of Healthy Aging 2020-2030 - PAHO/WHO). Their agenda is to promote four areas for actions in taking care of older persons within the next ten years, which are:

[28] https://www.paho.org/en/decade-healthy-aging-2020-2030 and https://www.who.int/initiatives/decade-of-healthy-ageing..

1. Action Area I: Change how we think, feel and act towards age and aging. Older persons should receive independence and autonomy, informed consent on health matters, equal recognition before the law, social security, accessibility and personal mobility, and fundamental human rights.

2. Action Area II: Ensure that communities foster the abilities of older people. Physical, social and economic environments, both rural and urban, are important determinants of healthy aging and powerful influences on the experience of aging and the opportunities that aging offers. Age-friendly environments are better places in which to grow, live, work, play, and age, which means an age-friendly community is a better place for all age groups.

3. Action Area III: Deliver person-centered integrated care and primary health services responsive to older people.

4. Action area IV: Provide access to long-term care for older people who need it. Declines in physical and mental capacities can limit older people's ability to care for themselves and to participate in society. Access to good-quality long-term care is essential to maintain functional ability, enjoy basic human rights and live with dignity. In addition, it is essential to support caregivers, so they can deliver proper care and take care of their health.

The above four action areas are highly significant to improve the quality and the well-being of older persons. Implementing these four actions will help accelerate national efforts to eliminate poverty, particularly those of older persons (Goal 1).

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ANNEXES

ANNEX 1. The Size And Share Of Older Persons In Indonesia By Age And Gender, 2015-2045

Year	2015	2020	2025	2030	2035	2040	2045
Male (x1000)							
60 - 69	7.267,2	8.993,7	10.837,4	12.654,3	14.396,8	15.694,6	16.658.6
70 - 79	2.886,5	3.803,6	4.925,9	6.163,7	7.475,1	8.776,8	10.018,2
80+	716,8	890,0	1.115,8	1,515,5	1.973,5	2.511,0	3.065,5
Male 60+	10.870,5	13.687,3	16.879,1	20.333,6	23.845,4	26.982.4	29.742,3
Female (x1000)							
60 - 69	7.428,7	9.208,3	11.300,9	13.366,6	15.208,2	16.579,7	17.582,6
70 - 79	3.610,8	4.479,0	5.579,6	6.990,6	8.635,7	10.255,5	11.701,4
80+	1.083,2	1.344,9	1.688,1	2.140,8	2.712,2	3.445,8	4.288,1
Female 60+	12.122,7	15.032,1	18.568,5	22.498,0	26.556,1	30.281,0	33.572,2
Male + Female (x1000)							
60 - 69	14.695,9	18.202,0	22.138,3	26.021,0	29.605,0	32.274,3	34.241,2
70 - 79	6.497,3	8.282,5	10.505,4	13.154,3	16.110,8	19.032,3	21.719,7
80+	1.800,0	2.234,9	2.803,9	3.656,3	4.685,7	5.956,7	7.353,6
Male + Female 60+	22.993,2	28.719,5	35.447,6	42.831,6	50.401,5	57.263,4	63,314,5
Total Population (x1000)							
Male	128.483,5	135.337,0	141.564,8	147.154,6	151.926,6	155.788,8	158.755,0
Female	127.104,5	134.266,4	140.889,7	146.961,5	152.285,3	156.716,8	160.206,0
Male + Female	255.587,9	269.603,4	282.454,5	294.116,1	304.211,9	312.505,6	318.961,0
% to total population							
%	9,0	10,7	12,5	14,6	16,6	18,3	19,9

Source: Bappenas, BPS, UNFPA (2018), Indonesia Population Projection, 2015–2045: Supas 2015.
Note: In this projection, TFR was halted at 2.1 in 2020 and assumed constant until 2045.

ANNEX 2. Support Ratio, The Estimated Number of Persons at Working Age 15-64 to Support One Older Person 65 Years And Older, 2015-2045

Support Ratio (calculated based on percentage)							
% Population 15-64	68,3	68,7	68,6	68	67,1	66,1	65,2
% Population age 65+	5,7	6,7	8,1	9,6	11,2	12,8	14,1
Support Ratio	12	10	8	7	6	5	5

Source: Bappenas, BPS, UNFPA (2018), Indonesia Population Projection, 2015–2045: Supas 2015.
Note: In this projection, TFR was halted at 2.1 in 2020 and assumed constant until 2045.

ANNEX 3. The estimates of Life Expectancy (LE) at Birth, at 60, Health-Adjusted Life Expectancy (HALE) at Birth, HALE at 60, Lost HALE at Birth, Lost HALE at 60, increase in LE at birth, increase of HALE at birth, Indonesia, 2000-2015

	LE at birth (years)			LE at 60 (years)			HALE at birth (years)			HALE at 60 (years)			Lost HALE at birth (years)			Lost HALE at birth as % of LE at birth (%LE)			HALE at birth as % of LE at birth (%LE)			HALE at 60 as % of LE at 60 (%LE)			Increase of LE at birth (years)	Increase of HALE at birth (years)
	2000	2015	2019	2000	2015	2019	2000	2015	2019	2000	2015	2019	2000	2015	2019	2000	2015	2019	2000	2015	2019	2000	2015	2019	2000-2019	2000-2019
Male	65.8	68.8	69.4	16.8	16.5	16.7	58.5	61.5	61.9	12.7	12.5	12.7	7.3	7.3	7.5	11.1%	10.6%	10.8%	89%	89%	89%	75%	76%	76%	3.6	3.5
Female	68.6	72.5	73.3	18.2	18.8	19.1	59.6	63.2	63.8	13.2	13.8	14.0	9.0	9.3	9.5	13.1%	12.8%	13.0%	87%	87%	87%	73%	74%	73%	4.7	4.2
Both sexes	67.2	70.6	71.3	17.6	17.7	17.9	59.0	62.3	62.8	13.0	13.2	13.4	8.1	8.3	8.5	12.1%	11.7%	11.9%	88%	88%	88%	74%	75%	74%	4.1	3.8

Source: WHO Global Health Estimates 2019. Geneva: World Health Organization, 2020. https://www.who.int/data/global-health-estimates Links to GHO data repository:
https://www.who.int/data/gho/data/indicators/indicator-details/GHO/gho-ghe-hale-healthy-life-expectancy-at-birth
https://www.who.int/data/gho/data/indicators/indicator-details/GHO/life-expectancy-at-birth-(years)

Note: Health-Adjusted Life Expectancy (HALE) is the average number of years that a person is expected to live in good health by taking into account years lived in less than full health due to disease or injury.

ANNEX 4. Degree of Functional Capacity of Older Persons Age 60+, Gender, Place of Residence and Type of Functional Capacity (N= 26,8 million, Male 12,7 M and Female 14,0 M)

. Age 60+ on Whether Any Difficulties In:	Yes, Totally Unable to Do	Yes, Lots of Difficulties	Yes, a Little Difficulty	No Difficulty	Total
Seeing					
Total age 60+	0.68%	4.18%	23.25%	71.88%	100.00%
Male	0.59%	3.50%	21.43%	74.47%	100.00%
Female	0.77%	4.80%	24.91%	69.52%	100.00%
Hearing					
Total age 60+	0.38%	3.64%	14.17%	81.81%	100.00%
Male	0.59%	3.50%	21.43%	74.47%	100.00%
Female	0.77%	4.80%	24.91%	69.52%	100.00%
Walking/ climbing stairs					
Total age 60+	1.75%	5.11%	15.32%	77.82%	100.00%
Male	1.40%	4.08%	12.36%	82.16%	100.00%
Female	2.06%	6.06%	18.01%	73.87%	100.00%
Using/moving hands or fingers					
Total age 60+	0.37%	1.91%	6.31%	91.41%	100.00%
Male	0.37%	1.79%	5.20%	92.64%	100.00%
Female	0.36%	2.03%	7.31%	90.29%	100.00%
Difficulties in memory/concentration					
Total age 60+	0.85%	2.95%	11.97%	84.22%	100.00%
Male	0.67%	2.36%	9.90%	87.07%	100.00%
Female	1.01%	3.49%	13.87%	81.62%	100.00%
Emotional/behavior disorder					
Total age 60+	0.29%	0.77%	3.97%	94.97%	100.00%
Male	0.25%	0.65%	3.57%	95.54%	100.00%
Female	0.33%	0.89%	4.33%	94.44%	100.00%
Speaking/communication with other					
Total age 60+	0.34%	1.69%	5.70%	92.27%	100.00%
Male	0.32%	1.48%	4.67%	93.53%	100.00%
Female	0.36%	1.88%	6.65%	91.11%	100.00%
Difficulties in selfcare					
Total age 60+	1.13%	1.64%	4.02%	93.21%	100.00%
Male	0.97%	1.38%	3.27%	94.39%	100.00%
Female	1.28%	1.89%	4.71%	92.13%	100.00%

Source: Tabulated by author from the 2020 Susenas March/KOR
Note: In this projection, TFR was halted at 2.1 in 2020 and assumed constant until 2045.