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INEQUITABLE IMPACT OF COVID-19 IN INDONESIA: EVIDENCE AND POLICY RESPONSE

POLICY REPORT
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1. INTRODUCTION

The coronavirus disease 2019 (hence COVID-19) has been exacerbating the social and economic inequality globally. Structural problems due to lack of fairness in public policy as well as persistent discrimination and marginalization continue to limit access to resources and services of certain groups based on gender, social class, ability, religion, geography or ethnicity. Health shocks force downward mobility due to unemployment, increase in dependency ratios, and higher cost of finding health treatment.[1] Poor households will remain or in a deeper state of poverty given the decline in their resilience. This means that COVID-19 will pose disproportionate risks to the most vulnerable population, particularly the poor and marginalized. Thus, policy responses should adequately take into consideration of the equity principles, particularly equal life chances and equal concerns of people's needs.[2]

[1] Bird, K. (2007). The Intergenerational Transmission of Poverty: An Overview. Working Paper 286. London: ODI. Retrieved from: https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/885.pdf

[2] Jones, H. (2009). Equity in development: Why it is important and how to achieve it. Working Paper 331. London: ODI. Retrieved from: https://www.odi.org/publications/3480-equity-development-why-it-important-and-how-achieve-it

The Government of Indonesia (GoI) has placed policy responses to support the economic downturn due to the pandemic. The packages range from incentives for the health workers, stimulus for the Micro, Small and Medium Enterprises (MSMEs), and social assistances including conditional cash transfers or Program Keluarga Harapan (PKH), ration cards or Kartu Sembako and conditional-unemployment benefit or Kartu Prakerja. Finance Minister stated that the GoI is making effort to reach out the most vulnerable and impacted group in the population, particularly women and the poorest.

Despite of the efforts that have been put by the GoI in containing both health and economic impacts of COVID-19, current policy responses have not adequately covered all groups in the population. Women and Person with Disability (PwD) in particular are still being left behind from the current policy responses since there is no specific policy that directly address the issues which have direct impacts on Women and PwD. Therefore, this report wants to address the challenges faced by the vulnerable and marginalized groups, including the poor, women, and PwD, during COVID-19 as well as policy directions that could cover these vulnerable groups better in the future.

This report finds that the Poor, Women, and PwD face greater challenges and impacts during COVID-19 compared to the other groups. The poor are still lacking in access to modern health care facility and more likely to live in unhealthy environment which make them more vulnerable to COVID-19 infection. During lockdown or social restriction phase, the women have higher burden than the men since the women could have three tasks that they should do: 1) Working on unpaid domestic work as a mother; 2) Working on paid work as an employee; and 3) Taking of children doing home-schooling during lockdown or social restriction. This is not to mention that women are overrepresented in frontline sectors that related to COVID-19, such as health and other essential services, which make them more vulnerable in contracting COVID-19. The PwDs could not get the usual treatment that they need since many health care services are prioritizing patients with COVID-19 to be treated. The challenges that they face are exacerbated by the inadequate policy responses by the GoI to cover these specific groups.

To make the policy responses more inclusive, this report proposes three steps that can be done in the future. First, the Government of Indonesia needs to establish gender and disability disaggregated database for social assistance so that policy responses could be tailored to these groups specifically. Second, the policy responses should enable alternative means for the poor, women, and PwDs impacted by the pandemic to be included in the social assistance system. Third and lastly, specific policy responses for the PwDs should be made so that they can get the treatment, care, and service they needed safely.

2. SCOPE OF THE PAPER

Our report presents a policy research that identify social and economic inequity implications of the GoI's COVID-19 pandemic policy responses. The report starts with presenting evidence on the pre-existing social inequality that potentially increases the vulnerability of marginalized population. Since COVID-19 poses both health and economic crises, we are focusing on health inequality and representation of women and people with disabilities in the labour market. Our analysis covers three main objectives:

1 Identifying the preexisting inequality and how do they pose the marginalized groups to a deeper health and economic vulnerability during the COVID-19 pandemic.

2 Analyze the adequacy of current government responses to reach the most vulnerable groups, particularly the marginalized population.

3 Alluding alternatives of additional responses to ensure the inclusion of the marginalized groups and meet the equity principles.

In our report, we focus on three groups in the population: the poor, women and People with Disability (PwD).

COVID-19 pandemic is disproportionately affecting people live in poverty. The impact will be more severe and last in the longer term for the poor because several factors that determine their vulnerability:[3] 1) *Where they live*: The majority of the poor live in rural areas with limited access to health facilities, or in urban slums with high population density and low quality of health services; 2) *Where they work*: Lockdown measures and the decline in demand will affect the loss of jobs and hence poverty. The poor are mostly engaged in low-paid, informal work or self-employment in sectors that are hit hardest by the pandemic. Non-poor workers with insecure work contract are also at risk of losing jobs and fall into poverty; 3) *High dependence on public health and education services*: Limited access to decent and affordable health care services as well as the school closures will pose severe effect for poor children in the long term. The inequality in access to internet creates disparity in access to education. School closures also reduce the nutrition intake for those relying on school feeding programs. 4) *Limited savings and other financial resources*: A coping mechanism to stay afloat during pandemic for the poor with inadequate safety nets are selling assets and reallocating expenses from human capital investment for necessities.

Global evidence shows that COVID-19 poses a different risk for men and women. The evidence of the severe impact of health crisis and economic shocks for women are well-established in the literature. Pre-existing gender inequality in the economy means that women earn less than men and have less access to productive resources that limit their ability to exercise their capabilities and participate equally with men.[4] During crisis, unpaid care work also increases with the school closures and social distancing measures as the gender norm still put care and domestic as the main responsibility for women. Lockdown measures also increase the gender-based violence which could be exacerbated by the economic pressures.[5]

COVID-19 disproportionately affects PwDs due to attitudinal, environmental, and institutional barriers.[6] Due to their existing health conditions, PwDs have higher vulnerability to get infected by the coronavirus. They need more intensive health care services than others. Overcapacity of health care facilities during the pandemic will increase the inaccessibility of health services needed by PwDs. The impact of COVID-19 on family members of PwDs will also affect PwDs in many ways. Besides the risk of being contracted by the disease, job loss of the family members, particularly the household heads, will reduce the resources for caring the PwDs. Moreover, PwDs are vulnerable in losing jobs during COVID-19. Although PwDs have low labour force participation, if they work, they tend to engage in informal employment with insecure work contract and lower access to employment insurance.

3. METHODOLOGY

Our policy research mainly uses a quantitative approach to provide evidence and draw policy options and combine it with desk research to explore relevant reports and literatures on the impact of pandemic on the marginalized population. The study analyses four population-based surveys collected by the Badan Pusat Statistik (Statistics Indonesia) and the USAID. They are National Socioeconomic Survey (Susenas) 2019, National Labour Force Surveys (Sakernas) 2018 and 2019, and Village Potentials (Podes) 2018, and Indonesia Demographic and Health Survey (DHS) 2017.[7]

3 Sanchez-Paramo (2020). COVID-19 will hit the poor hardest. Here's what we can do about it. *World Bank Blogs*. Accessed on July 1st 2020. Url: https://blogs.worldbank.org/voices/covid-19-will-hit-poor-hardest-heres-what-we-can-do-about-it
4 Baird. M., and E. Hill. (2020). COVID-19 and women's economic participation. *The Women and Work Research Group The Australian Women's Working Futures Project*. Sydney: The University of Sydney Business School. Accessed on June 20th, 2020. Url: https://www.sydney.edu.au/content/dam/corporate/documents/business-school/research/women-work-leadership/covid-19-report.pdf
5 United Nations. (2020). Policy Brief: The Impact of COVID-19 on Women, 9 April 2020. Accessed on June 1st 2020. URL:

https://asiapacific.unwomen.org/en/digital-library/publications/2020/04/policy-brief-the-impact-of-covid-19-on-women
6 United Nations Human Rights. (2020). COVID-19 and the Rights of Persons With Disabilities: Guidance. *Human Rights at the Heart of Response*. Accessed on July 25th 2020. URL: https://www.ohchr.org/Documents/Issues/Disability/COVID-19_and_The_Rights_of_Persons_with_Disabilities.pdf
7 Susenas that analysed in this report is the March round and Sakernas that analysed in this report is the August round since the samples represent down to district level.

4. CURRENT STATUS OF COVID-19 AND POLICY RESPONSES IN INDONESIA

COVID-19 has been declared by the World Health Organization (WHO) as a pandemic since March 2nd, 2020. Indonesia reported its first COVID-19 case on March 1st, 2020, in the capital city of Jakarta. Non-pharmaceutical interventions (NPIs) have been imposed to slow down the spread of the virus and to make sure that the healthcare capacity can meet the demand for treatment due to the absence of drug or vaccine to cure the disease. For instance, many cities in Indonesia, such as Jakarta, Surabaya, and Bandung, imposed a large-scale social restriction (LSSR) to prevent mass gatherings that can fasten the spread of the virus. Religious activities conducted in-person or offline were also banned, including the annual Eid Mubarak. Annual exodus during Eid Mubarak was also banned to reduce the movement of people between cities and/or provinces to slow the spread of the disease as well as to prevent the newly emerged clusters in less-developed areas, such as rural area, which have lower health care service capacity.

As of July 9th, 2020, Indonesia has confirmed 70,736 COVID-19 cases, where there are 34,668 patients still in treatment (49%), 32,651 cases recovered (46.2%), and 3,471 deaths (4.8%).[8] Majority of the confirmed cases are found in two provinces, which are East Java with 15,484 cases (21.9%) and Jakarta with 13,488 cases (19.1%). Nevertheless, there are new emerging clusters outside Java Island, such as South Sulawesi with 6,488 cases (9.2%), South Kalimantan with 3,926 cases (5.55%), and South Sumatera with 2,475 cases (3.5%). Papua as one of the less-developed provinces in Indonesia also has over two thousand confirmed cases, that is 2,101 cases (3%). This means that COVID-19 has spread in all around Indonesia and areas with lower quality and quantity of health care service capacity will be impacted the most.

[8] Gugus Tugas Percepatan Penanganan Covid-19 (Covid-19 Response National Task Force). Accessed on July 10th 2020. URL: https://covid19.go.id/peta-sebaran

5. HEALTH RISK AND INEQUITIES

Health inequities create disparities in health status between different groups of population. The inequity is rooted in the different social and economic condition in which people are born, grow, live, work, and age.[9] COVID-19 pandemic highlights the pre-existing health inequities and affects disproportionate health risk to the most vulnerable groups of population. The poor, women and PwDs are at greater risks of contracting the virus because they have limited access to good quality of health care services as well as information about the emerging diseases. Comorbidities, particularly the non-communicable diseases, also accentuate the vulnerability of contracting COVID-19.

5.1 Unequal Access to Health Care Services

The marginalized population are lacking in access to modern health care services. Studies show that the underlying causes are rooted from inaccessibility to information and services due to socioeconomic circumstances: poverty, geographical condition, living in remote or less-developed regions, and disability status. The poor, particularly women and PwDs, are less likely to receive correct information about the disease while at the same time they are more likely to be excluded from the COVID-19 test. As COVID-19 requires rigorous and advance medical treatment which more likely to be provided at hospital level, addressing the inequality in access to hospital is crucial.

The unequal distribution of health care services throughout the country is potentially magnifying the gap in health risk between Western and Eastern part of Indonesia. Modern health care facilities are more likely developed in Western part of Indonesia and mostly concentrated in Java. These facilities have better equipment and more health care workers to deal with the pandemic. For instance, Community Health Center (Puskesmas) in Java Island have a higher "readiness" index for standard precaution items, such as sterilizer, storage for infectious waste, disinfectant, and soap and running water or alcohol-based hand rub, compared to those in Eastern part of Indonesia.[10] Puskesmas in Java also have higher readiness index on diagnostic capacity than those in eastern part of Indonesia. This is not to mention that Puskesmas in urban area have a higher readiness index for items for standard precautions and diagnostics capacity than in rural area.

Abundant health care services do not necessarily translate into better health care services. On average, one health care facility serves more than 500 households in more than 61% villages across Indonesia (see Figure 1). In areas with higher population density, the condition is far worse. In Java Island, one health care facility services more than 500 households in 81.8% of the villages. In the eastern part of Indonesia, 19.7% of the villages in Papua and 27% of the villages in Maluku have similar ratio. In underdeveloped villages, front and outermost districts or 3T areas, one health care facility services more than 500 households in 25.5% of the villages.

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[9] WHO (2017). *10 facts on health inequities and their causes.* Accessed on June 22nd 2020. URL: https://www.who.int/features/factfiles/health_inequities/en/
[10] World Bank. (2018). *Is Indonesia Ready to Serve? An Analysis of Indonesia's Primary Health Care Supply-Side Readiness.* Jakarta: World Bank.

Hospitals remain inaccessible for most Indonesians. The majority of Indonesians went to primary health care facilities, both private-owned services (such as general practitioners, clinic, and midwife) and public-owned services (such as Puskesmas) to seek outpatient treatment as shown in Figure 2. More than half of people who accessed health care facility to seek outpatient treatment in the last month visited general practice/clinic/private practices (55.8%), followed by Puskesmas (34.9%). Only 14.1% of them visited hospital to seek outpatient treatment.

Inaccessibility to health care services among the poor and women continue to be persistent. Table 1 shows that only 6.6% of individuals from the poor household visited hospital for outpatient treatment

whilst only 8.3% of vulnerable[11] people and 16.4% of non-poor people visited hospital for outpatient treatment. Meanwhile, the proportion of women visited hospital is lower as compared to men. Unlike the poor and women, PwDs have a higher hospital utilization rate compared to the non-PwD counterparts which may be related to their higher needs of advance medical care. Poor women's inaccessibility to hospitals are worse, where they have a lower hospital utilization rate compared to men as shown in Table 2 (6.2% and 7%, respectively).

National health insurance (BPJS Kesehatan) improves the access to health care services for the poor, particularly poor women. Poor individuals covered by BPJS Kesehatan have a higher Puskesmas and hospital utilization rate compared to those who are not covered. Those who are not covered by BPJS Kesehatan tend to go to private primary health care facilities and less likely to visit hospital (see Table 1). Poor women have a higher proportion of Puskesmas utilization compared to poor men if they are covered by BPJS Kesehatan. Table 2 shows that, among the poor women who are the beneficiaries of subsidized fee of BPJS Kesehatan (PBI group), the utilization rate of Puskesmas is 60.4% while for poor men is 58.4%.

5.2 Inequality in the Risk of COVID-19 Infection

Social and economic inequality easing the transmission of the coronavirus. Besides the poor living conditions as well as inaccessibility to health care services, people from lower social classes have to continue to work to make their ends meet and very few are able to work from work since most of them engage in "essentials" sectors. Commuting using unreliable mass public transports will increase the risks of contracted with coronavirus.

The poor and female headed households tend to live in poor-living condition exposed to COVID-19. The result of the Index of Home Environments for protection from COVID-19 [12] constructed from Indonesia Demographic and Health Survey 2017

shows that households in lower quantile of wealth index are more likely to live in an unhealthy environment which pose a higher risk to contract Covid-19 compared to those in the higher quantile of wealth index as shown in Figure 3. Female-headed households are also more likely to have unhealthy environments than male-headed households in all quantile distribution of wealth index. Out of six indicators of the index, the availability of improved water source has the lowest percentage for all households in each wealth quantile which makes the risk to contract COVID-19 higher since the household members could not maintain their hygiene properly as shown in Table 3.

[11] Vulnerable group means that the group has expenditure per capita per month between 1 to 1.5 times of poverty line.

[12] There are six variables that composed as an index for each household: (1) has internet or phone or television or radio as source of information, (2) has two members or less per room to maintain physical distancing, (3) has toilet and does not share with other households to maintain hygiene, (4) has wall and roof of any types to maintain

hygiene, (5) improved water source, and (6) has place to wash hands and the soap is availability to maintain hygiene. See: Brown, C. S., Ravallion, M., & van de Walle, D. (2020). *Can the World's Poor Protect Themselves from the New Coronavirus?* NBER Working Paper No. 27200.

Women have a higher mobility and use of public transports. Women workers are more likely to commute daily using public transportation to go to work compared to men (see Figure 4). This is related to the gender biases in productive assets ownership, including private transportations. [13] As the social restriction eases and the economy reopens, workers are returning to work and commuting using mass public transports. In Greater Jakarta, the public transports are always packed during the peak hours with workers commute long distance and long hours. Limiting the capacity of public transports to ensure social distancing can be implemented but it is at the cost of longer hours of commuting to and back from work due to a longer queue than usual.

Comorbidities pose a different risk of COVID-19 for men and women. Global evidence shows that men are more susceptible and exposed to a higher mortality due to coronavirus. Gender differences in behaviour or cultural norms contribute to men's vulnerability to COVID-19. Men are more likely to engage in risky behaviours, such as smoking and drinking alcohol that lead to a higher risk of exposed to non-communicable diseases. The most common comorbidities found in COVID-19 patients according to the COVID-19 Response National Task Force data are hypertension (51.1% out of total cases), diabetes (34.5%), and heart disease (20.5%), and chronic obstructive pulmonary disease (10.6%). [14] Compared to men, women have a lower prevalence of cardiovascular diseases, but they have equal prevalence for diabetes and a higher prevalence of chronic pulmonary diseases (see Figure 5, 6, and 7). [15] Basic Health Survey or Riskesdas (2018) [16] recorded that North Kalimantan, Gorontalo, and

Yogyakarta have the highest prevalent of heart disease based on medical doctor diagnosis, whereas North Sulawesi, East Kalimantan, and Gorontalo have the highest hypertension prevalent cases (see Figure 8, 9, and 10).

Older people have the highest risk of dying from COVID-19. Of all deaths caused by COVID-19, only 16.9% of the cases are people age 45 years old or below according to the COVID-19 Response National Task Force data. However, the percentage is particularly high for older age-groups, i.e. 39.6% of the cases are people aged 46-59 years old and 43.5% are people aged 60 years old or older. Although older people commute less, they will still be at risk of COVID-19 from higher prevalence of non-communicable diseases and from interaction with the younger family member who are working and providing care for the elderly.

Women health workers are at the frontline to fight COVID-19 but left out from policy response. The majority of health workers are women and they are mostly nurse and the general practitioners who are at the frontline of detecting and treating COVID-19 patients. Besides facing high risk of contracting the coronavirus, health workers are often stigmatized as a "virus spreader" and rejected to return home by their neighbours and family. Some local governments, such as Jakarta, provides accommodation for the health workers to address the discrimination as well as additional compensation in workers' remuneration. The response could be extended to compensate the time loss for the family, particularly to cover cost of childcare and private transport to and back from work. [17]

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[13] Doss, C., Grown, C., and Deere, C. (2008). Gender and asset ownership: A guide to collecting individual-level data. *The World Bank Policy Research Working Paper number 4704.* Url: https://openknowledge.worldbank.org/bitstream/handle/10986/3468/WPS4704.pdf?sequence=6&isAllowed=y

[14] From 1,326 available confirmed cases.

[15] According to Institute for Health Metrics and Evaluation (IHME) Burden of Disease for Indonesia in 2017.

[16] Ministry of Health. (2018). Hasil Utama Riskesdas 2018 (*Main Findings of Basic Health Research 2018*). Retrieved from https://kesmas.kemkes.go.id/assets/upload/dir_519d41d8cd98f00/files/Hasil-riskesdas-2018_1274.pdf.

[17] Gender and Social Inclusion Prospera. (2020). Gender matters in COVID-19: Snapshot of impacts and adequacy of policy response. *Prospera Policy Brief* 8 April 2020.

6. ECONOMIC IMPACT OF COVID-19

COVID-19 creates undeniably large economic impact that can lead to the global recession and worsening of global poverty. The "nowcasting" of global poverty by the World Bank shows that COVID-19 is expected to push 40 to 60 million people into extreme poverty.[18] Lockdown or large-scale social restriction as the only way to slow the spread of the virus has a result in a slower economic growth and higher unemployment rate. ILO predicts that there will be 195 million people lost their jobs due to the pandemic. [19] Pre-existing social and economic inequalities, particularly in access to income, employment, and social protection will enhance the economic impact for the most vulnerable groups.

For Indonesia, COVID-19 is expected to flip the achievements in economic development after the 1998-2000 Asian economic crisis. Several institutions have forecasted that the Indonesian economy will be contracted by 1% (Ministry of Finance forecast),[20] or grow at slow pace: 0% (World Bank forecast),[21] to -0.3% (International Monetary Fund forecast)[22] by the end of 2020. Economic growth (year-on-year) in second quarter of 2020 has already declined by 5.32%, where transportation and storage and accommodation, food, and beverage sectors experienced the deepest decline (30.84% and 22.02%, respectively). [23] Furthermore, while the government is expected to have counter-cyclical measure during this crisis, its expenditure is also declined by 6.9% (year-on-year) in the second quarter of 2020. SMERU Research Institute (2020) shows that poverty rate in Indonesia will increase up to 12.37% depending the economic growth that will be realized in 2020.[24]

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[18] Mahler, D., Lakner, C., Aguilar, R., and Wu, H. (2020) The impact of COVID-19 (Coronavirus) on global poverty: Why Sub-Saharan Africa might be the region hardest hit. *World Bank Blogs*. Accessed on June 22nd 2020. Url: https://blogs.worldbank.org/opendata/impact-covid-19-coronavirus-global-poverty-why-sub-saharan-africa-might-be-region-hardest

[19] International Labour Organization. (2020). ILO Monitor: Covid-19 and the World of Work. Accessed on June 30th 2020. Url: https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/briefingnote/wcms_743146.pdf.

[20] Liputan6.com. (2020). Pemerintah Revisi Proyeksi Pertumbuhan ekonomi 2020 hingga Minus 1 Persen. *Liputan6.com, Jakarta,* June 23rd 2020. Available at https://www.liputan6.com/bisnis/read/4286582/pemerintah-revisi-proyeksi-pertumbuhan-ekonomi-2020-hingga-minus-1-persen. (Accessed: June 24th, 2020)

[21] World Bank. (2020). Indonesia Economic Prospects: The Long Road To Recovery. Accessed on July 21st, 2020. Url: http://documents1.worldbank.org/curated/en/804791594826869284/pdf/Indonesia-Economic-Prospects-The-Long-Road-to-Recovery.pdf

[22] International Monetary Fund. (2020). World Economic Outlook Update June 2020: A Crisis Like No Other, An Uncertain Recovery. Accessed on July 21st, 2020. Url: https://www.imf.org/en/Publications/WEO/Issues/2020/06/24/WEOUpdateJune2020

[23] BPS. (2020). Berita Resmi Statistik No. 64/08/Th. XXIII tentang Pertumbuhan Ekonomi Indonesia Triwulan II-2020. URL: https://www.bps.go.id/pressrelease/2020/08/05/1737/-ekonomi-indonesia-triwulan-ii-2020-turun-5-32-persen.html.

[24] Suryahadi, A., Izzati, R., Suryadarma, D. (2020) The Impact of COVID-19 outbreak on poverty. An estimation for Indonesia. SMERU Research Institute Working Paper, April 2020. Accessed on May 25th 2020. Url: http://smeru.or.id/en/content/impact-covid-19-outbreak-poverty-estimation-indonesia

As Indonesia is dominated by informal sector, large-scale social restriction (LSSR) has severe impact on employment. Indonesian Government estimates show that 2.8 million people had been unemployed by April 2020 due to the crisis. A joint study between Lembaga Demografi FEB-UI and LIPI (2020) suggests that unemployment rate soars up to 17%.[25] Workers in sectors that depend on "crowds" are the most vulnerable to lost their jobs since these sectors are heavily affected by social distancing. The survey shows that wholesale retail and trade and accommodation and food service activities, community services, manufacturing, and transportation, storage, and communication. As per March 2020, J-PAL COVID-19 Survey (2020) shows that around 56% of men and 57% of women had lost their jobs or no longer working.[26] The job loss occurred mostly in urban cities as compared to rural areas, and particularly large in Java. Although there are sectors that have been hit the hardest, but all sectors experienced jobs cuts, and it was affecting everyone, including the highly educated.

Four sectors in the economy which are predicted to be hit the hardest by COVID-19 in the end of 2020: (1) trade which includes wholesale and retail trade and repair of motor vehicles and motorcycles, (2) financial and insurance activities, (3) real estate activities, and (4) hospitality which includes accommodation and food service activities (Table 4). These sectors account for 34,784,864 workers or equivalent to 27.3% of total employment. These sectors also contribute to IDR 2,533,760 billion Gross Domestic Product or 24.1% of total GDP based on analysis carried out by Lembaga Demografi FEB-UI (Table 5).[27] Out of

these four sectors that are hardly hit, wholesale and retail trade and repair of motor vehicles and motorcycles and accommodation and food service activities have already account for 25.6% of employment in Indonesia. This can be translated that one out of four workers in Indonesia are vulnerable to unemployment due to COVID-19.

Women workers are disproportionately affected by COVID-19. Although men are dominating the employment in the four hardest hit sectors, women are overrepresented in type of work that are most vulnerable to the economic impact of COVID-19. Workers in informal sectors are particularly at risk of the economic shutdown as well as at risk of contracted with the disease when the economy reopens (see Table 6). There is a sizeable share of women work as self-employed and unpaid workers in the hardest hit sectors which are currently reopening. Policy response should provide support for the own-account workers to reopen their businesses without risking obtaining COVID-19.

Most women and PwD workers are vulnerable as they have insecure work contract. Most workers working in wholesale and retail trade and accommodation and food service activities sector have oral/informal work contract (26.9% for wholesale and retail trade, 26% for accommodation and food service activities) and no work contract (34% for wholesale retail and trade and 35% for accommodation and food service activities) as shown in Table 7. Workers with oral/informal or no work contract in wholesale retail and trade sectors are mostly male workers (67.3% and 66.4%, respectively), but those in accommodation and food

[25] P2 Kependudukan, Kementerian Tenaga Kerja, LD FEB UI. (2020) Survei Online: Dampak COVID-19 terhadap Tenaga Kerja di Indonesia. Url: http://lipi.go.id/siaranpress/hasil-survei-dampak-pandemi-covid-19-pada-pekerja/22011

[26] Hanna, R., and Olken, B. (2020) Survei online terkait Dampak Ekonomi dari COVID-19 di Indonesia: Hasil survei minggu ke-2. J-PAL Southeast Asia. Accessed on 25th of July 2020. URL:

https://drive.google.com/drive/u/0/folders/1dUC1DZ_c1_cFJslERp-K5nnhnCK_9qy1

[27] This calculation is based on elasticity of employment in each sector of employment.

service activities are mostly female (54.6% and 57.4%, respectively). Most workers with disability are more likely to have oral/informal or no work contract in all sectors. Three out of four workers with disability (76.1%) in wholesale retail and trade have oral/informal or no work contract; 77.2% in accommodation and food service activities; and 59.3% in real estate activities. However, only 22.7% of workers with disability in financial and insurance activities who have oral/informal or no work contract.
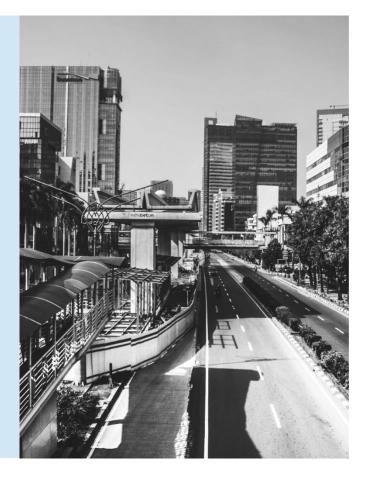
Job loss means the loss of livelihood for the family. Since Indonesia still adopts the traditional gender role where men as the breadwinner and women stay at home, the loss of employment for the household head will affect the family's welfare. From 71.4 million households, 16.5% of them are "sandwich generation" or have three generations living under one roof as shown in Table 8. Around 2.5% of the total households or equivalent to 1.7

million households have higher dependency ratio than other households where they have altogether children under age 5, primary school age 6-12 years and elderly of 60 years old and older (see Table 9).

PwDs face similar but more intense negative impact from the economic crisis. Rapid assessment by the Indonesia's Disability Person Organizations (DPO) (2020) find that PwDs, particularly those who work in informal sector, experienced income decline by 50% to 80% during the pandemic.[28] Only less than 2% of PwDs get the benefit of increase in demand for mask and other protective equipment. The largest drop in income are mostly experienced by PwDs with multiple disabilities, work in informal sector, age 60 and older, and have lower than high school education. Most of PwDs are also reported to face difficulties in buying basic needs and to repay loans and paying electricity bills.

7. SOCIAL IMPACT OF COVID-19

Lockdown measure creates additional burden for women, particularly female-headed households. School closures and lockdown measures due to COVID-19 has intensified women's domestic role and create "triple burden" for women. The pre-existing traditional gender division of labour in Indonesia put women in the disadvantageous position: they have extra responsibilities during lockdown or social restriction, such as taking care of the children to do home schooling, working to earn additional income, and doing the domestic work. Intensified care responsibilities will limit women's capacity to engage and perform work while there is a demand to accelerate income generating with the slowdown of the economy. For informal workers, additional burden of care limit their choice but to accept low-paid insecure job with poor working conditions.

28 Jaringan DPO Respon COVID-19 Inklusif. (2020). Yang bergerak dan yang terpapar di masa pandemic: Suara Disabilitas dari Indonesia. *Laporan assessment cepat dampak COVID-19 bagi penyandang disabilitas.*

School closures is potentially affecting women's economic participation. More than 27.6 million households have children at primary school age (see Table 9). With the school closures, women are usually the one who do the home schooling for children. In addition, women are the one responsible to provide care for the family, both to children and the elderly. There are nearly 23.9 million households have children under age 5, and 20 million have elderly aged 60 and older to be taken care of. With additional responsibilities for home schooling and intensified care for family members, women are at risk of leaving their jobs. This will reduce the already low and stagnant women's labour force participation rate in Indonesia.

School closures is impacting large share of female-headed households. Nearly 2.5 million households have children at primary school age, while more than 5 million households have elderly to share house as shown in Table 9. Around 300 thousand female-headed households are sandwich generation. Female household heads are usually single parents and sole earners. They are not just facing the risk of losing jobs due to economic slowdown, but they still have to provide care for their family members.

PwDs face difficulty to learn when the schools are closed. Rapid assessment by DPO (2020) finds that only 16.4% of PwDs ranged from age 10 to 59 years old are able to do online schooling, while the rest do independent learning or with their family.[29] Those with mental and sensory disability are more likely to do independent learning rather than online. Most of PwDs who do online schooling (67.9%) reported to face difficulties to follow the online teaching because some PwDs require more time adapt the online learning, have no support from the family, trouble connection, and cannot afford the internet quota.

Health and economic crisis will impact the livelihood of PwD. In 2019, there are 25.9 million Persons with Disability in Indonesia, with more than 28% of them have medium to critical disability (see Table 10). Around 18.4 million households in Indonesia have at least one PwD as their household members (see Table 11). PwD, particularly those with higher severity, are in need of intensive care and rely heavily on the assistance from the family member. They are also in need of medical care which means they would do frequent travel to health facilities, along with their caregivers. Job loss will also be impacted on PwD's livelihood as most of PwDs do not work and dependent on to other's household member income. Households with PwDs have a higher expenditure by 10.8% per month as compared to households without PwDs.[30]

Burden of care of PwD is higher for poor female-headed households. The share of poor households with at least one PwD is the highest (36%) compared to the non-poor (23.8%) and vulnerable groups (30%) as shown in Table 11. The share of female headed households that have to provide care for PwD is higher compared to male counterparts. One in two poor female-headed households have to provide care for PwD. Female headed households endured both reproductive and productive burden to provide income as well as to provide care for the family, especially member with disability. With the pandemic that pose greater risk of unemployment as well as limited access to medical care, the female headed households burden will be worsened.

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[29] Jaringan DPO Respon COVID-19 Inklusif. (2020). Yang bergerak dan yang terpapar di masa pandemic: Suara Disabilitas dari Indonesia. *Laporan assessment cepat dampak COVID-19 bagi penyandang disabilitas.*

[30] Prospera (2020) - Households with disabilities incurred 3 to 10.8% extra costs per month to reach the same standard of living as those without disability.

8. ADEQUACY OF CURRENT POLICY RESPONSES

The Indonesian Government have rolled out policy packages to response to the health and crisis during the COVID-19 pandemic. The packages focus on three areas: supporting the health sector and workers, the poor and vulnerable, and businesses. Although there is no specific policy responses for the marginalized groups, the government already provides support for the poor and vulnerable, including the micro and small enterprises, to cushion the economic impacts of COVID-19. The packages are in the form of cash transfers, such as conditional cash transfer (Program Keluarga Harapan or PKH), ration card (Kartu Sembako), and Village Fund cash transfer (Bantuan Langsung Tunai Dana Desa), and tax incentive and credit relaxation for the micro, small, and medium enterprises.[31]

For the cash transfers, the government increase the amount disbursed to the existing beneficiaries as well as making an effort to extend the support to those impacted and fall into poverty due to COVID-19.[32] For PKH, the government is expanding the beneficiaries from 9.2 to 10 million households, while for Kartu Sembako, the government increase the target from 15.2 million to reach 20 million households. In Greater Jakarta, Kartu Sembako is disbursed to 1.2 million households in Jakarta and 600 thousand households in the outers of Jakarta. For unemployment, the government initially rolled out the benefit package for those who lost their jobs due to COVID-19 through Kartu Prakerja program. Unlike unemployment benefit that provides income support for the unemployed, Kartu Prakerja is designed as cash transfer with pre-requisite. Individuals have to register, pass the tests and participate in an online training provided as a requirement to obtain the cash transfers. However, the program is currently being on hold due to issues of eligibility, disbursement, and training providers.[33]

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[31] World Bank. (2020). Social Protection and Jobs Responses to COVID-19: A Real-Time Review of Country Measures (June 12, 2020). Accessed on July 21st, 2020. URL: https://documents.worldbank.org/en/publication/documents-reports/documentdetail/590531592231143435/social-protection-and-jobs-responses-to-covid-19-a-real-time-review-of-country-measures-june-12-2020

[32] Kementerian Keuangan. (2020). Kemenkeu Tanggap COVID-10: Informasi Terkini. Accessed on 8th of July 2020. URL: https://www.kemenkeu.go.id/covid19

[33] According to Presidential Decree Number 76 Year 2020 (Peraturan Presiden Nomor 76 Tahun 2020).

Although the package is targeted to support businesses, the government is prioritizing the ultra-micro, micro and small businesses, particularly poor and vulnerable enterprises, to stay afloat during pandemic and to restart their businesses. By the end of June 2020, the government releases The National Economic Recovery Programs or Program Pemulihan Ekonomi Nasional (PEN). PEN is designed to reduce the economic impact of COVID-19 with the objective of protecting, maintaining, and increasing the capabilities of enterprises and individuals to continue their businesses during COVID-19. Under PEN, the government focuses on helping the micro, small, and medium enterprises (MSMEs) through credit relaxation and interest subsidies for enterprises that take micro and small loans through Kredit Usaha Rakyat (KUR), Ultra Micro (UMi) credit, and other micro credits and financing through formal financial services. The government is planning to provide working capital in the form of grant for poor and vulnerable micro enterprises. At the moment, the government is developing a database to determine the target and priority for micro working capital.

Despite the effort to extend the policy response to include the poor, vulnerable and those impacted by COVID-19, there has not been specific policies that targets the marginalized groups. Some of the policy packages are based on the existing programs that have not yet been inclusive. Some of the social assistance are targeted or disbursed specifically for women, such as PKH and Kartu Sembako, and PwD with the cash transfer from the Ministry of Social Affairs. However, other policy packages are designed to be gender neutral without acknowledging the pre-existing gender inequality. For example, Kartu Prakerja database does not have gender-disaggregated data.

The Indonesian Government stresses their plan to set a more inclusive policy response. In United Nations Roundtable Series of Renowned Economists held on July 1st 2020, Minister of Finance, Sri Mulyani, stated that Indonesian Government acknowledges that the pandemic is affecting grass-root people, the informal sector, the small and medium enterprises, the poor, and especially women.[34] She stated the importance to use a gender lens and focus on the poor, women, and those who were excluded from the existing policies when designing supports for "rebirthing" the economy after pandemic. Before the pandemic, a considerable number of poor households were excluded from social assistance programs. For instance, only 23.6% or 1.27 million poor households received subsidized rice programs or Beras Sejahtera (Rastra) in the past four months, 26.4% or 1.42 million poor households currently receive PKH, and only 20.8% or 1.1 million households receive non-cash food assistance or Bantuan Pangan Non-Tunai (BPNT) in 2019 (see Table 12).

Government's policy response has helped the existing beneficiaries but it needs to be extended to those who have been impacted by COVID-19. J-PAL COVID-19 survey (2020) on March 2020 showed that only 23% of men and 20% of women claimed Kartu Sembako or PKH in the last four weeks. Among those who lost their jobs, 28% of men and 23% of women are covered by BPNT/Kartu Sembako or PKH. Those who live in the cities tend to be covered as compared to rural areas. Findings from the World Bank's High Frequency Monitoring show that, as per early May 2020,[35] more than 82% of households in the lowest quintile of per-capita expenditure received any kind of social assistance and subsidies under the Government economic relief measures and social assistance. For social assistance, specifically, around 58% of respondents at the lowest quintile received any kind of social assistance programs during the pandemic. Households in the bottom 40% of consumption reported that they received at least one relief programs from the government, but only less than 30% from those who lost their jobs.

More efforts need to be done to reach the PwD in need of assistance. Rapid Assessment from DPO (2020) shows that only few PwDs received the social assistance during COVID-19 pandemic. Their survey result shows that while 35.4% of PwDs received the electricity subsidy, only 13% received PKH, 11.4% received BPNT, and 4.5% received the cash transfers. The assessment suggests that the PwDs are still under coverage in need of social assistance due to exclusion of PwDs in the database.

34 United Nations Secretary-General. (2020). Note to Correspondents. Rebirthing the Global Economy: Insights from Leading Women Thinkers on Transforming the World. Accessed onJuly 9th 2020. URL: https://www.un.org/sg/en/content/sg/note-correspondents/2020-07-

08/note-correspondents-rebirthing-the-global-economy-insights-leading-women-thinkers-transforming-the-world

35 The World Bank. (2020). Indonesia high-frequency monitoring of Covid-19 impacts, Round 1 (1-17 May 2020).

9. POLICY OPTIONS

The current policy responses have been designed at high level to cover the poor, MSMEs and businesses. During April-June 2020, the government focused on disbursing social assistance to the poor as well as rolling out the Kartu Prakerja scheme. The tax incentive and credit relaxation for enterprises have just been decided while the working capital support is currently under development. To make the responses more inclusive, particularly for the marginalized population, there are three policy options that can be done in the future.

Disaggregated data is fundamental for more inclusive policies.

The Government of Indonesia needs to establish gender and disability disaggregated database for social assistance. The existing policy responses have not yet specifically acknowledged that COVID-19 poses disproportionate impact to different groups in the population. The existing policy response are still targeting the poor who have been in the system. There has not been any clear information related on how the government will extend the beneficiaries of social assistance to the poor, women and PwDs who are not in the database. Some databases have not included gender-disaggregated data, for example, the Kartu Prakerja database that is gender blind as well as the data base for the MSMEs. Identifying PwDs are also important to understand the needs of PwDs to stay afloat during and to rebound after the pandemic. Acknowledging the different needs of different groups of population is important to effectively targeting and supporting those who are in need.

Enable different means for the poor, women and PwDs impacted from the pandemic to be included in the social assistance system.

Current policy responses, particularly social assistance, are based on the existing integrated database for social welfare programs or DTKS. The government has provided a system for self-registration (*pendaftaran mandiri*) for those who have been impacted by COVID-19. However, the current method still poses burden of proofs as the applicants have to provide approval letters from hamlet's authorities and the applications have to go to local government offices to submit their applications. For women and PwDs who have limited mobility, the long application process and burden of proofs could discourage them to register. The government could explore other means of new registration for social assistance, for example through online application, through institutions that covers remote areas such as PT Pos Indonesia (GoI's postal service), or through proactively reaching and registering the individuals impacted by deploying the social assistance support staffs (*pendamping*).
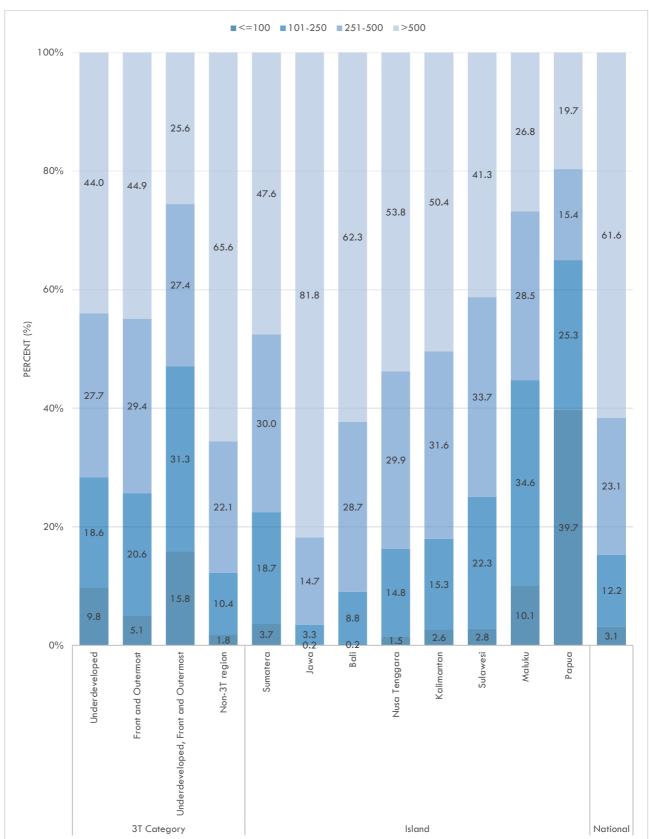
Tailor specific policies to support the PwDs.

PwDs have a higher needs of health care and assistance to implement the health protocols during the COVID-19. The government could ensure the accessibility of PwDs to health care services, for example through dedicating selected health facilities for PwDs medical care or providing home visit services. For children with disabilities, the government could consider to reopen schools for learning and therapy but with a strict health protocols.

APPENDICES

Figure 1. Distribution of Ratio of Household Served per One Health Care Facility (%)

Legend: ■ <=100 ■ 101-250 ■ 251-500 ■ >500

Category	<=100	101-250	251-500	>500
3T Category				
Underdeveloped	9.8	18.6	27.7	44.0
Front and Outermost	5.1	20.6	29.4	44.9
Underdeveloped, Front and Outermost	15.8	31.3	27.4	25.6
Non-3T region	1.8	10.4	22.1	65.6
Island				
Sumatera	3.7	18.7	30.0	47.6
Jawa	0.2	3.3	14.7	81.8
Bali	0.2	8.8	28.7	62.3
Nusa Tenggara	1.5	14.8	29.9	53.8
Kalimantan	2.6	15.3	31.6	50.4
Sulawesi	2.8	22.3	33.7	41.3
Maluku	10.1	34.6	28.5	26.8
Papua	39.7	25.3	15.4	19.7
National	3.1	12.2	23.1	61.6

Source: Podes 2018, calculated by authors.

Figure 2. Access to Health Care Facility for Outpatient Care in the Past Month (%)

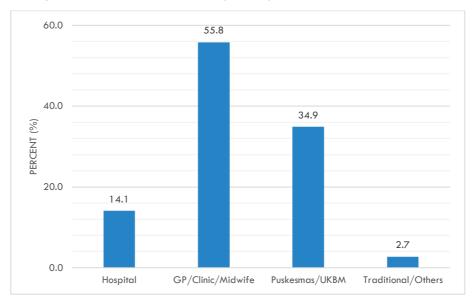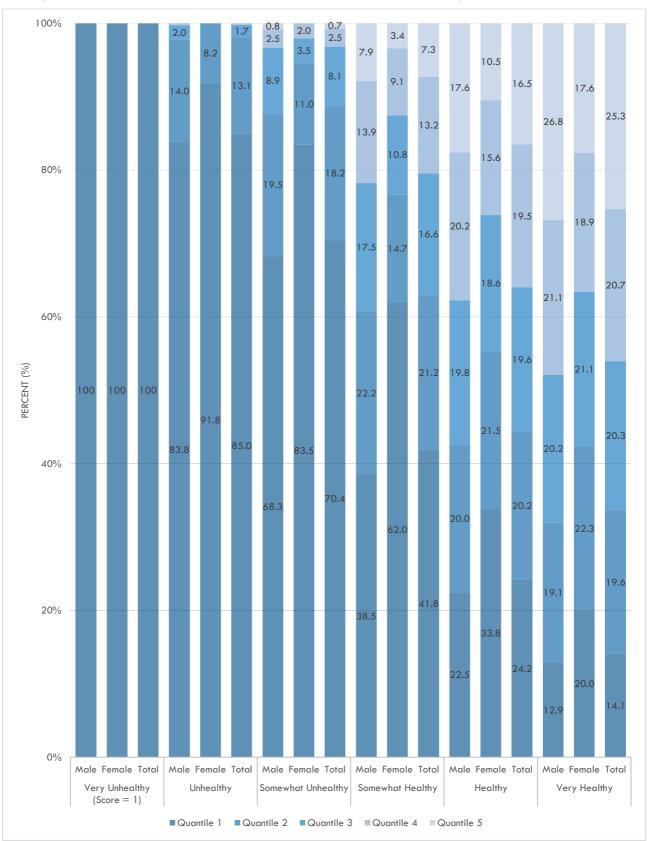Source: Susenas 2019 (March), calculated by authors.

Table 1. Access to Healthcare Facility for Outpatient by Poverty and BPJS Coverage Status (%)

	Hospital	GP/Clinic/ Midwife	Puskesmas/ UKBM	Traditional/ Others
By poverty status				
Poor	6.6	45.6	50.4	3.3
Vulnerable	8.3	52.4	43.6	2.7
Non-Poor	16.4	57.9	30.8	2.7
By poverty status and BPJS coverage				
Poor and Covered by BPJS PBI	9.0	35.6	59.5	2.9
Poor and Covered by BPJS non-PBI	17.4	47.7	37.4	3.0
Poor and Not Covered by Either BPJS	2.6	56.0	42.5	3.8
Non-Poor and Covered by BPJS	19.2	49.9	37.1	2.2
Non-Poor and Not Covered by BPJS	7.9	67.1	28.0	3.4
National	**14.1**	**55.8**	**34.9**	**2.7**

Source: Susenas 2019 (March), calculated by authors.

Table 2. Access to Healthcare Facility for Outpatient by Gender and PwD Status and Poverty and BPJS Coverage Status (%)

	Male				Female			
	Hospital	GP/Clinic/Midwife	Puskesmas/UKBM	Traditional/Others	Hospital	GP/Clinic/Midwife	Puskesmas/UKBM	Traditional/Others
By Poverty Status								
Non-Poor	16.5	59.2	29.0	2.8	16.4	56.7	32.3	2.5
Vulnerable	8.8	53.2	42.3	2.9	7.9	51.7	44.8	2.6
Poor	7.0	46.0	49.6	3.3	6.2	45.3	51.1	3.4
By Poverty and BPJS Status								
Poor and Covered by BPJS PBI	9.6	35.9	58.4	3.2	8.6	35.3	60.4	2.6
Poor and Covered by BPJS non-PBI	19.8	46.5	37.8	1.8	15.4	48.7	37.1	4.0
Poor and Not Covered by Either BPJS	2.9	55.8	42.5	3.5	2.3	56.2	42.5	4.1
Non-Poor and Covered by BPJS	19.7	51.2	35.0	2.4	18.8	48.9	38.7	2.1
Non-Poor and Not Covered by BPJS	7.9	67.7	27.2	3.5	7.9	66.6	28.8	3.3

	PwD				Non-PwD			
	Hospital	GP/Clinic/Midwife	Puskesmas/UKBM	Traditional/Others	Hospital	GP/Clinic/Midwife	Puskesmas/UKBM	Traditional/Others
By Poverty Status								
Non-Poor	25.5	50.2	31.8	4.8	14.6	59.4	30.6	2.2
Vulnerable	15.5	49.0	41.7	4.8	6.8	53.1	44.1	2.3
Poor	10.7	46.9	44.4	5.9	5.6	45.4	51.8	2.7
By Poverty and BPJS Status								
Poor and Covered by BPJS PBI	13.6	38.1	52.2	4.3	7.6	34.8	61.7	2.5
Poor and Covered by BPJS non-PBI	23.8	43.5	34.7	5.6	16.0	48.6	38.0	2.4
Poor and Not Covered by Either BPJS	3.9	61.6	33.2	8.8	2.3	55.0	44.1	2.9
Non-Poor and Covered by BPJS	28.7	42.9	37.2	3.9	17.0	51.6	37.0	1.8
Non-Poor and Not Covered by BPJS	11.8	65.0	26.8	6.6	7.3	67.5	28.2	2.9

Source: Susenas 2019 (March), calculated by authors.

Figure 3. Distribution of Index of Home Environments for Protection from COVID-19 by Gender of Head of Household
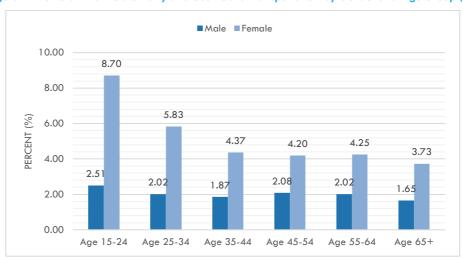

Source: Indonesia Demographic and Household Survey 2017, calculated by authors.

Table 3. Availability of Household Environment Index for Each Indicator by Household Wealth Quantile

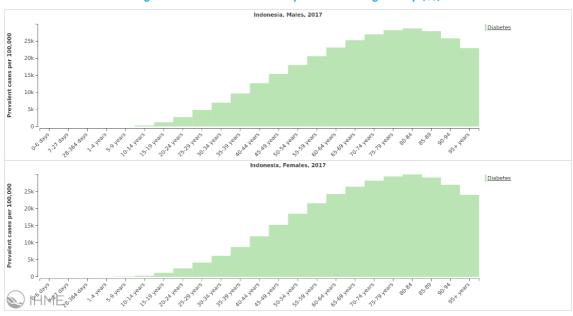| Wealth Quantile	Indicator						Average Score (Out of Six Indicators)
	[1] Communi-cation Tools	[2] Two members per room or less	[3] Toilet that does not share	[4] Roof and wall	[5] Improved Water Source	[6] Place for hand wash and soap availability	
Quantile 1	82.0%	65.4%	82.6%	100.0%	63.4%	70.0%	4.6
Quantile 2	99.4%	71.4%	90.2%	100.0%	66.7%	85.9%	5.1
Quantile 3	100.0%	73.7%	95.9%	100.0%	64.0%	92.7%	5.3
Quantile 4	100.0%	76.3%	99.2%	100.0%	63.2%	95.6%	5.3
Quantile 5	100.0%	83.7%	99.9%	99.9%	72.3%	97.7%	5.5
Total	95.9%	73.7%	93.1%	100.0%	65.8%	87.7%	5.2

Source: Indonesia Demographic and Health Survey 2017, calculated by authors.

Figure 4. Workers Who Mobile Daily and Use Public Transportation by Gender and Age Group (%)

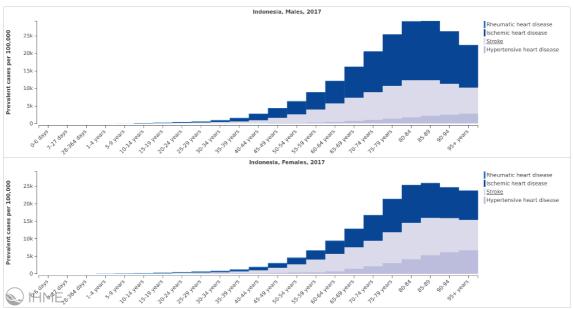Source: Sakernas 2019 (August), calculated by authors.

Figure 5. Diabetes Prevalence by Gender and Age Group (%)

Source: Institute for Health Metrics and Evaluation (IHME), 2017.
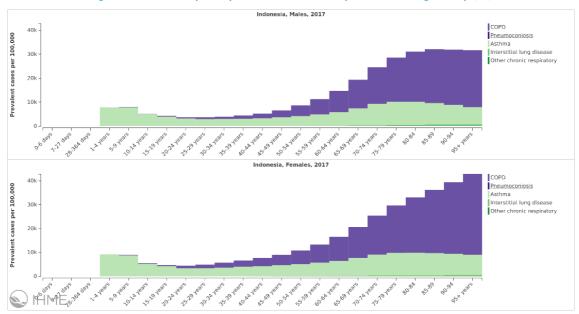Note: Disease selected is diabetes.

Figure 6. Cardiovascular Disease Prevalence by Gender and Age Group (%)

Source: Institute for Health Metrics and Evaluation (IHME), 2017.
Note: Diseases selected are rheumatic heart disease, ischemic heart disease, stroke, and hypertensive heart disease.
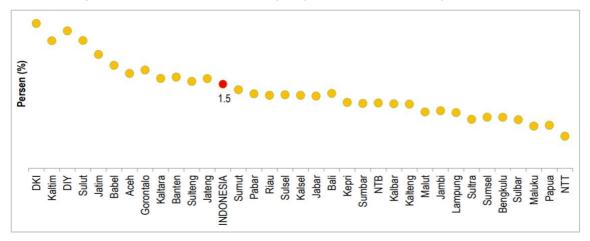
Figure 7. Chronic Respiratory Disease Prevalence by Gender and Age Group (%)

Source: Institute for Health Metrics and Evaluation (IHME), 2017.
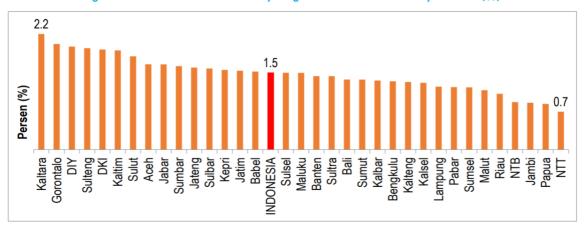Note: Diseases selected are COPD, pneumoconiosis, asthma, interstitial lung disease, and other chronic respiratory diseases.

Figure 8. Diabetes Mellitus Prevalence by Diagnosis of Medical Doctors by Province (%)
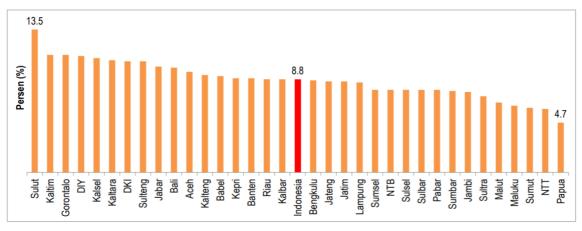

Source: Riskesdas 2018.

Figure 9. Heart Disease Prevalence by Diagnosis of Medical Doctor by Province (%)

Source: Riskesdas 2018.

Figure 10. Hypertension Disease Prevalence by Diagnosis of Medical Doctor and Whether Taking Hypertension Medicine by Province (%)

Source: Riskesdas, 2018.

Table 4. Employment Elasticity Based on 17 Sectors of Employment

Sector of Employment	Elasticity of Employment	# Hardest Hit	Share of GDP (%)	Share of Employment (%)
Wholesale and Retail Trade; Repair of Motor Vehicles and Motorcycles	0.874	1	13.7	18.9
Financial and Insurance Activities	0.863	2	4.2	1.4
Real Estate Activities	0.861	3	3.0	0.3
Accommodation and Food Service Activities	0.859	4	3.2	6.7
Agriculture, Forestry and Fishing	0.852	5	12.9	27.5
Construction	0.786	6	10.6	6.8
Public Administration and Defense; Compulsory Social Security	0.769	7	3.5	3.4
Other Services	0.749	8	2.0	5.0
Health and Social Services Activities	0.669	9	1.2	1.6
Education Services Activities	0.661	10	3.3	5.0
Information and Communication	0.635	11	5.6	0.7
Manufacturing	0.576	12	21.7	15.0
Transportation and Storage	0.551	13	4.4	4.4
Water Supply; Sewerage, Waste Management and Remediation Activities	0.539	14	0.1	0.4
Company Services Activities	0.490	15	2.0	1.5
Electricity, Gas, Steam and air conditioning supply	0.430	16	1.1	0.3
Mining and Quarrying	0.308	17	7.7	1.1

Source: Sakernas 2018 and 2019 (August) and BPS, calculated by authors.

Note: Elasticity of employment means that how many more workers that can be absorbed by a sector when the sector grows by 1%. The higher the elasticity means more workers can be absorbed when the sector grows by 1%. When the sector contracts, the sector with higher elasticity will also lay more workers off.

Table 5. Contribution of Workers and GDP of The Highest Impacted Sectors

Sector	Number of Workers	GDP (IDR Billion)
Wholesale and Retail Trade; Repair of Motor Vehicles and Motorcycles	23,802,189	1,440,523
Accommodation and Food Service Activities	8,829,207	333,358
Financial and Insurance Activities	1,752,704	443,042
Real Estate Activities	400,764	316,837
Total	**34,784,864**	**2,533,760**

Source: Sakernas 2019 (August) and BPS, calculated by authors.

Table 6. Distribution of Status of the Workers of The Hardest Hit Sectors (%)

Status of Work	Wholesale and Retail Trade; Repair of Motor Vehicles and Motorcycles			Accommodation and Food Service Activities			Financial and Insurance Activities			Real Estate Activities		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Row Percentage (%)												
Own Account	47.0	53.0	100	35.9	64.1	100	65.3	34.7	100	69.6	30.4	100
Own Account with Unpaid Worker(s)	45.4	54.6	100	43.0	57.0	100	76.4	23.6	100	74.3	25.7	100
Employer	78.2	21.8	100	53.3	46.7	100	94.8	5.2	100	98.3	1.7	100
Employee	64.8	35.2	100	54.6	45.4	100	64.2	35.8	100	77.4	22.6	100
Casual Worker in Agriculture	79.8	20.2	100	0.0	100.0	100	n.a.	n.a.	n.a.	0.0	100.0	100
Casual Worker in Non-Agriculture	75.4	24.6	100	33.9	66.1	100	44.8	55.2	100	77.9	22.1	100
Unpaid/Family Worker	27.3	72.7	100	26.7	73.3	100	25.0	75.0	100	0.0	100.0	100
Column Percentage (%)												
Own Account	31.2	37.5	34.3	26.5	34.1	30.9	2.2	2.1	2.2	16.7	23.5	18.3
Own Account with Unpaid Worker(s)	15.5	19.9	17.6	20.9	20.0	20.3	0.4	0.2	0.3	1.4	1.6	1.4
Employer	7.8	2.3	5.1	6.0	3.8	4.7	1.1	0.1	0.7	4.2	0.2	3.3
Employee	36.6	21.2	29.2	35.8	21.5	27.5	96.2	97.1	96.5	75.7	71.2	74.6
Casual Worker in Agriculture	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0
Casual Worker in Non-Agriculture	2.4	0.8	1.6	1.2	1.6	1.4	0.1	0.2	0.1	2.0	1.8	2.0
Unpaid/Family Worker	6.4	18.2	12.1	9.6	19.0	15.1	0.1	0.3	0.1	0.0	1.5	0.4

Source: Sakernas 2019 (August), calculated by authors.

Table 7. Distribution of Contract Type of Workers of the Hardest Hit Sectors (%)

Contract Type	Group	Hardest Hit Sectors			
		Wholesale Retail and Trade; Repairs of Motor Vehicles and Motorcycles	Accommodation and Food Service Activities	Financial and Insurance Activities	Real Estate Activities
Perjanjian Kerja Waktu Tanpa Tertentu (PKWTT); Work Contract with Indefinite Time	Total	12.4	10.7	28.6	21.4
	Female	33.3	28.9	37.1	24.6
	Male	66.7	71.1	62.9	75.4
	PwD	8.2	6.8	23.3	7.8
Perjanjian Kerja Waktu Tertentu (PKWT); Work Contract with Definite Time	Total	24.5	26.6	55.6	44.8
	Female	39.3	31.5	36.3	25.7
	Male	60.7	68.5	63.7	74.3
	PwD	14.1	14.2	45.7	29.8
Perjanjian Lisan; Oral Work Contract	Total	26.9	26.0	5.2	12.4
	Female	32.7	54.6	31.6	15.3
	Male	67.3	45.4	68.4	84.7
	PwD	35.6	29.9	15.6	19.4
Tidak Ada Perjanjian; No Contract	Total	34.0	35.0	8.7	19.7
	Female	33.6	57.4	33.2	17.9
	Male	66.4	42.6	66.8	82.1
	PwD	89.9	47.3	7.0	39.9
Tidak Tahu; Do Not Know	Total	2.1	1.6	1.9	1.6
	Female	31.0	38.5	27.5	27.5
	Male	69.0	61.5	72.5	72.5
	PwD	25.7	1.8	8.3	3.0

Source: Sakernas 2019 (August), calculated by authors.

Table 8. Distribution of Sandwich Generation Household by Gender of Household Head and PwD Composition of the Household (%)

Wealth Quantile	Total		Male-Headed HH		Female-Headed HH		HH with PwD		HH without PwD	
	Sandwich HH	Non-Sandwich HH	Sandwich HH	Non-Sandwich HH	Sandwich HH	Non-Sandwich HH	Sandwich HH	Non-Sandwich HH	Sandwich HH	Non-Sandwich HH
Quantile 1	27.3	72.7	25.5	74.5	37.6	62.4	38.9	61.1	21.8	78.2
Quantile 2	20.0	80.0	18.8	81.2	27.3	72.7	30.9	69.1	16.1	83.9
Quantile 3	15.9	84.1	14.7	85.3	22.8	77.2	24.7	75.3	12.9	87.1
Quantile 4	11.7	88.3	10.9	89.1	16.0	84.0	18.9	81.1	9.5	90.5
Quantile 5	7.7	92.3	7.3	92.7	9.7	90.3	14.5	85.5	6.1	93.9
Total	**16.5**	**83.5**	**15.5**	**84.5**	**22.0**	**78.0**	**26.9**	**73.1**	**13.0**	**87.0**

Source: Susenas 2019 (March), calculated by authors.

Table 9. Number of Households by Household Member Composition

Type of Household	Total	Male-Headed HH	Female-Headed HH	HH with PWD	HH without PWD
Have children age 5 or below	23,940,401	21,941,696	1,998,705	4,605,816	19,334,585
Have children age 6-12	27,638,539	25,187,921	2,450,618	5,642,661	21,995,878
Have household member age 60 or older	19,913,911	14,795,012	5,118,899	10,308,848	9,605,063
Have children under 5, children age 6-12, member age 60 or older	1,773,499	1,470,774	302,725	890,905	882,594
Total Household in 2019	**71,437,667**				

Source: Susenas 2019 (March), calculated by authors.

Table 10. Distribution of Person with Disability by Gender and Severity Level

	Male				Female			
	Low	Medium	High	Critical	Low	Medium	High	Critical
Number of People								
Age Group								
Age 0-14	554,237	148,834	53,999	14,089	471,221	118,631	39,369	9,252
Age 15-24	384,844	89,229	29,269	13,339	492,340	57,669	18,502	8,341
Age 25-34	518,037	94,477	15,725	5,923	607,955	84,012	13,291	4,085
Age 35-44	987,853	127,406	18,289	4,267	1,240,833	123,439	16,712	4,628
Age 45-54	1,975,477	231,391	52,439	21,398	2,288,196	337,828	72,851	16,714
Age 55-64	2,161,815	396,624	139,356	41,423	2,494,796	627,375	198,987	69,269
Age 65+	2,099,702	836,689	474,005	226,528	2,312,353	1,262,997	733,310	432,726
Wealth Quantile								
Quantile 1	1,785,705	505,223	215,726	89,812	2,047,850	650,605	312,533	176,856
Quantile 2	1,660,562	385,421	159,849	75,912	1,953,871	523,012	231,545	111,789
Quantile 3	1,688,404	371,628	147,604	65,602	1,956,411	511,341	209,475	96,779
Quantile 4	1,798,998	338,479	136,085	46,105	1,965,394	497,452	182,910	88,183
Quantile 5	1,748,296	323,899	123,818	49,536	1,984,168	429,541	156,559	71,408
Total	**8,681,965**	**1,924,650**	**783,082**	**326,967**	**9,907,694**	**2,611,951**	**1,093,022**	**545,015**
Total PWDs	**25,874,346**							
Row Percentage (%)								
Age Group								
Age 0-14	71.9	19.3	7.0	1.8	73.8	18.6	6.2	1.4
Age 15-24	74.5	17.3	5.7	2.6	85.3	10.0	3.2	1.4
Age 25-34	81.7	14.9	2.5	0.9	85.7	11.8	1.9	0.6
Age 35-44	86.8	11.2	1.6	0.4	89.6	8.9	1.2	0.3
Age 45-54	86.6	10.1	2.3	0.9	84.3	12.4	2.7	0.6
Age 55-64	78.9	14.5	5.1	1.5	73.6	18.5	5.9	2.0
Age 65+	57.7	23.0	13.0	6.2	48.8	26.6	15.5	9.1

	Male				Female			
	Low	Medium	High	Critical	Low	Medium	High	Critical
Wealth Quantile								
Quantile 1	68.8	19.5	8.3	3.5	64.2	20.4	9.8	5.5
Quantile 2	72.8	16.9	7.0	3.3	69.3	18.5	8.2	4.0
Quantile 3	74.3	16.3	6.5	2.9	70.5	18.4	7.6	3.5
Quantile 4	77.6	14.6	5.9	2.0	71.9	18.2	6.7	3.2
Quantile 5	77.9	14.4	5.5	2.2	75.1	16.3	5.9	2.7
Total	**74.1**	**16.4**	**6.7**	**2.8**	**70.0**	**18.4**	**7.7**	**3.8**

Source: Susenas 2019 (March), calculated by authors.

Table 11. Distribution with Any PwD by Gender of Household Head and Household Poverty Status

	Male-Headed		Female-Headed		Total	
	With PWD	Without PWD	With PWD	Without PWD	With PWD	Without PWD
Number of Household						
Poor	1,503,262	3,004,073	432,208	438,259	1,935,470	3,442,332
Vulnerable	3,022,560	7,945,572	818,050	1,007,464	3,840,610	8,953,036
Non-Poor	9,726,054	35,192,513	2,941,902	5,405,750	12,667,956	40,598,263
Total	14,251,876	46,142,158	4,192,160	6,851,473	18,444,036	52,993,631
Row percentage (%)						
Poor	33.4	66.6	49.7	50.3	36.0	64.0
Vulnerable	27.6	72.4	44.8	55.2	30.0	70.0
Non-Poor	21.7	78.3	35.2	64.8	23.8	76.2
Total	23.6	76.4	38.0	62.0	25.8	74.2

Source: Susenas 2019 (March), calculated by authors.

Table 12. Type of Social Assistance Received by Household by Gender of Household Head and Household PwD Composition and Poverty Status

Type of Social Assistance	Total	Male-Headed	Female-Headed	HH with PWD	HH without PWD
Poor (Total HH: 5,377,802)					
Beras Sejahtera (Rastra)	1,271,573	1,065,190	206,383	450,673	820,900
Kartu Keluarga Sejahtera (KKS)	1,321,910	1,113,707	208,203	520,105	801,805
Program Keluarga Harapan (PKH)	1,422,583	1,219,223	203,360	522,640	899,943
Bantuan Pangan Non-Tunai (BPNT)	1,118,687	908,103	210,584	477,081	641,606
Subsidi/Bantuan Sosial Pemerintah Daerah	370,532	308,026	62,506	135,040	235,492
Vulnerable (Total HH: 12,793,646)					
Beras Sejahtera (Rastra)	2,161,821	1,831,625	330,196	701,710	1,460,111
Kartu Keluarga Sejahtera (KKS)	2,501,035	2,178,282	322,753	839,731	1,661,304
Program Keluarga Harapan (PKH)	2,655,793	2,358,156	297,637	797,598	1,858,195
Bantuan Pangan Non-Tunai (BPNT)	2,188,783	1,872,274	316,509	734,540	1,454,243
Subsidi/Bantuan Sosial Pemerintah Daerah	765,015	638,281	126,734	248,152	516,863
Non-Poor (Total HH: 53,266,219)					
Beras Sejahtera (Rastra)	4,279,280	3,492,161	787,119	1,345,187	2,934,093
Kartu Keluarga Sejahtera (KKS)	4,897,031	4,116,921	780,110	1,399,700	3,497,331
Program Keluarga Harapan (PKH)	4,099,417	3,572,885	526,532	1,131,749	2,967,668
Bantuan Pangan Non-Tunai (BPNT)	4,066,221	3,364,637	701,584	1,211,789	2,854,432
Subsidi/Bantuan Sosial Pemerintah Daerah	1,958,902	1,649,360	309,542	550,359	1,408,543

Source: Susenas 2019 (March), calculated by authors.

Table 13. List of 3T Area According to Presidential Decree Number 131 Year 2015

Province Name	District Name	3T Classification
Aceh	Aceh Singkil	Underdeveloped
Aceh	Aceh Besar	Front and Outermost
Aceh	Kota Sabang	Front and Outermost
Sumatera Utara	Nias	Underdeveloped
Sumatera Utara	Nias Selatan	Underdeveloped
Sumatera Utara	Serdang Bedagai	Front and Outermost
Sumatera Utara	Nias Utara	Underdeveloped
Sumatera Utara	Nias Barat	Underdeveloped
Sumatera Barat	Kepulauan Mentawai	Underdeveloped
Sumatera Barat	Solok Selatan	Underdeveloped
Sumatera Barat	Pasaman Barat	Underdeveloped
Riau	Indragiri Hilir	Front and Outermost
Riau	Pelalawan	Front and Outermost
Riau	Bengkalis	Front and Outermost
Riau	Rokan Hilir	Front and Outermost
Riau	Kepulauan Meranti	Front and Outermost
Riau	Kota Dumai	Front and Outermost
Sumatera Selatan	Musi Rawas	Underdeveloped
Sumatera Selatan	Musi Rawas Utara	Underdeveloped
Bengkulu	Seluma	Underdeveloped
Lampung	Lampung Barat	Underdeveloped
Lampung	Pesisir Barat	Underdeveloped
Kepulauan Riau	Karimun	Front and Outermost
Kepulauan Riau	Bintan	Front and Outermost
Kepulauan Riau	Natuna	Front and Outermost
Kepulauan Riau	Kepulauan Anambas	Front and Outermost
Kepulauan Riau	Kota Batam	Front and Outermost
Jawa Timur	Bondowoso	Underdeveloped
Jawa Timur	Situbondo	Underdeveloped
Jawa Timur	Bangkalan	Underdeveloped
Jawa Timur	Sampang	Underdeveloped
Banten	Pandeglang	Underdeveloped
Banten	Lebak	Underdeveloped
Nusa Tenggara Barat	Lombok Barat	Underdeveloped
Nusa Tenggara Barat	Lombok Tengah	Underdeveloped
Nusa Tenggara Barat	Lombok Timur	Underdeveloped
Nusa Tenggara Barat	Sumbawa	Underdeveloped
Nusa Tenggara Barat	Dompu	Underdeveloped
Nusa Tenggara Barat	Bima	Underdeveloped
Nusa Tenggara Barat	Sumbawa Barat	Underdeveloped
Nusa Tenggara Barat	Lombok Utara	Underdeveloped
Nusa Tenggara Timur	Sumba Barat	Underdeveloped

Province Name	District Name	3T Classification
Nusa Tenggara Timur	Sumba Timur	Underdeveloped
Nusa Tenggara Timur	Kupang	Underdeveloped
Nusa Tenggara Timur	Timor Tengah Selatan	Underdeveloped
Nusa Tenggara Timur	Timor Tengah Utara	Underdeveloped, Front and Outermost
Nusa Tenggara Timur	Belu	Underdeveloped, Front and Outermost
Nusa Tenggara Timur	Alor	Underdeveloped, Front and Outermost
Nusa Tenggara Timur	Lembata	Underdeveloped
Nusa Tenggara Timur	Ende	Underdeveloped
Nusa Tenggara Timur	Manggarai	Underdeveloped
Nusa Tenggara Timur	Rote Ndao	Underdeveloped, Front and Outermost
Nusa Tenggara Timur	Manggarai Barat	Underdeveloped
Nusa Tenggara Timur	Sumba Tengah	Underdeveloped
Nusa Tenggara Timur	Sumba Barat Daya	Underdeveloped
Nusa Tenggara Timur	Nagekeo	Underdeveloped
Nusa Tenggara Timur	Manggarai Timur	Underdeveloped
Nusa Tenggara Timur	Sabu Raijua	Underdeveloped, Front and Outermost
Nusa Tenggara Timur	Malaka	Underdeveloped, Front and Outermost
Nusa Tenggara Timur	Kota Kupang	Front and Outermost
Kalimantan Barat	Sambas	Underdeveloped, Front and Outermost
Kalimantan Barat	Bengkayang	Underdeveloped, Front and Outermost
Kalimantan Barat	Landak	Underdeveloped
Kalimantan Barat	Sanggau	Front and Outermost
Kalimantan Barat	Ketapang	Underdeveloped
Kalimantan Barat	Sintang	Underdeveloped, Front and Outermost
Kalimantan Barat	Kapuas Hulu	Underdeveloped, Front and Outermost
Kalimantan Barat	Melawi	Underdeveloped
Kalimantan Barat	Kayong Utara	Underdeveloped
Kalimantan Tengah	Seruyan	Underdeveloped
Kelimantan Selatan	Hulu Sungai Utara	Underdeveloped
Kalimantan Timur	Berau	Front and Outermost
Kalimantan Timur	Mahakam Hulu	Front and Outermost
Kalimantan Timur	Mahakam Ulu	Underdeveloped
Kalimantan Utara	Malinau	Front and Outermost
Kalimantan Utara	Nunukan	Underdeveloped, Front and Outermost
Sulawesi Utara	Kepulauan Sangihe	Front and Outermost
Sulawesi Utara	Kepulauan Talaud	Front and Outermost
Sulawesi Tengah	Banggai Kepulauan	Underdeveloped
Sulawesi Tengah	Donggala	Underdeveloped
Sulawesi Tengah	Toli-Toli	Underdeveloped
Sulawesi Tengah	Buol	Underdeveloped
Sulawesi Tengah	Parigi Moutong	Underdeveloped
Sulawesi Tengah	Tojo Una-Una	Underdeveloped
Sulawesi Tengah	Sigi	Underdeveloped

Province Name	District Name	3T Classification
Sulawesi Tengah	Banggai Laut	Underdeveloped
Sulawesi Tengah	Morowali Utara	Underdeveloped
Sulawesi Selatan	Jeneponto	Underdeveloped
Sulawesi Tenggara	Konawe	Underdeveloped
Sulawesi Tenggara	Bombana	Underdeveloped
Sulawesi Tenggara	Konawe Kepulauan	Underdeveloped
Gorontalo	Boalemo	Underdeveloped
Gorontalo	Pohuwato	Underdeveloped
Gorontalo	Gorontalo Utara	Underdeveloped
Sulawesi Barat	Polewali Mandar	Underdeveloped
Sulawesi Barat	Mamuju Tengah	Underdeveloped
Maluku	Maluku Tenggara Barat	Underdeveloped, Front and Outermost
Maluku	Maluku Tengah	Underdeveloped
Maluku	Buru	Underdeveloped
Maluku	Kepulauan Aru	Underdeveloped, Front and Outermost
Maluku	Seram Bagian Barat	Underdeveloped
Maluku	Seram Bagian Timur	Underdeveloped
Maluku	Maluku Barat Daya	Underdeveloped, Front and Outermost
Maluku	Buru Selatan	Underdeveloped
Maluku Utara	Halmahera Barat	Underdeveloped
Maluku Utara	Kepulauan Sula	Underdeveloped
Maluku Utara	Halmahera Selatan	Underdeveloped
Maluku Utara	Halmahera Timur	Underdeveloped
Maluku Utara	Pulau Morotai	Underdeveloped, Front and Outermost
Maluku Utara	Pulau Taliabu	Underdeveloped
Papua Barat	Teluk Wondama	Underdeveloped
Papua Barat	Teluk Bintuni	Underdeveloped
Papua Barat	Sorong Selatan	Underdeveloped
Papua Barat	Sorong	Underdeveloped
Papua Barat	Raja Ampat	Underdeveloped, Front and Outermost
Papua Barat	Tambrauw	Underdeveloped
Papua Barat	Maybrat	Underdeveloped
Papua	Merauke	Underdeveloped, Front and Outermost
Papua	Jayawijaya	Underdeveloped
Papua	Nabire	Underdeveloped
Papua	Kepulauan Yapen	Underdeveloped
Papua	Biak Numfor	Underdeveloped
Papua	Paniai	Underdeveloped
Papua	Puncak Jaya	Underdeveloped
Papua	Boven Digoel	Underdeveloped, Front and Outermost
Papua	Mappi	Underdeveloped
Papua	Asmat	Underdeveloped
Papua	Yahukimo	Underdeveloped

Province Name	District Name	3T Classification
Papua	Pegunungan Bintang	Underdeveloped, Front and Outermost
Papua	Tolikara	Underdeveloped
Papua	Sarmi	Underdeveloped
Papua	Keerom	Underdeveloped, Front and Outermost
Papua	Waropen	Underdeveloped
Papua	Supiori	Underdeveloped, Front and Outermost
Papua	Mamberamo Raya	Underdeveloped
Papua	Nduga	Underdeveloped
Papua	Lanny Jaya	Underdeveloped
Papua	Mamberamo Tengah	Underdeveloped
Papua	Yalimo	Underdeveloped
Papua	Puncak	Underdeveloped
Papua	Dogiyai	Underdeveloped
Papua	Intan Jaya	Underdeveloped
Papua	Deiyai	Underdeveloped
Papua	Kota Jayapura	Front and Outermost

Source: Presidential Decree Number 131 Year 2015.

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