INDONESIA MULTI-SECTORAL RESPONSE PLAN TO COVID-19

EXTENSION 2020

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Front cover
"A health worker distributes a brochure on COVID-19 to areas around Jakarta" - Credit: Lembaga Penanggulangan Bencana dan Perubahan Iklim Nahdlatul Ulama (LPBI NU)/2020

CONTENTS

LIST OF ABBREVIATIONS

ADB	Asian Development Bank
AHA Centre	ASEAN Coordinating Centre For Humanitarian Assistance AMCF Asia Muslim Charity Foundation
ARV	antiretroviral (treatment)
BASARNAS	Badan SAR Nasional (National Search and Rescue Agency)
BNPB	Badan Nasional Penanggulangan Bencana (National Agency Disaster Management)
CCCM	Camp Coordination and Camp Management Cluster
CSO	civil society organization
FAO	Food and Agriculture Organization of the United Nations
GBV	gender-based Violence
HCT	Humanitarian Country Team
HFI	Humanitarian Forum Indonesia
HI	Human Initiative
HIV	human immunodeficiency virus
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
ICU	intensive care unit
IFRC	International Federation of Red Cross and Red Crescent Societies
ILI	Influenza-like illness
ILO	International Labour Organization
IMF	International Monetary Fund
INGO	international non-governmental organization
IOM	International Organization for Migration
IPC	Infection Prevention and Control
Kemenko PMK	Kementerian Koordinator Bidang Pembangunan Manusia dan Kebudayaan (Coordinating Ministry for Human Development and Culture)
Keppres	Keputusan Presiden (Presidential Decree)
LGBTI	lesbian, gay, bisexual, transgender, and intersex
LPBI NU	Lembaga Penanggulangan Bencana dan Perubahan Iklim, Nahdlatul Ulama MHPSS mental health and psychosocial support services
MoEC	Ministry of Education and Culture
MoH	Ministry of Health
MOSA	Ministry of Social Affairs
MOWE-CP	Ministry of Women's Empowerment and Child Protection MPBI Masyarakat Penanggulangan Bencana Indonesia (Indonesian Society for Disaster Management)
MSF	Médecins Sans Frontières (Doctors Without Borders)
MSMEs	micro, small and medium enterprises

NGO	non-governmental organization
NLC	National Logistics Cluster
OCHA	UN Office for the Coordination of Humanitarian Affairs
PHEIC	public health emergencies of international concern
PLHIV	people living with HIV
PMI	Palang Merah Indonesia (Indonesian Red Cross)
PPEs	personal protective equipment
Pusdokkes POLRI	Pusat Kedokteran dan Kesehatan Polisi Republik Indonesia (Indonesia Police's Centre for Medicine and Health)
PUPR	Ministry of Public Works and People Housing
RC	Resident Coordinator of the United Nations
RCCE	Risk Communications and Community Engagement
SARI	severe acute respiratory infection
SDGs	Sustainable Development Goals
SOP	standard operating procedures
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNCT	United Nations Country Team
UNCTAD	United Nations Conference on Trade and Development UNDSS United Nations Department of Safety and Security
UNESCO	United Nations Educational, Scientific and Cultural Organization UNFPA United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNIDO	United Nations Industrial Development Organization
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNWOMEN	United Nations Entity for Gender Equality and the Empowerment of Women USD United States dollar
WASH	water, sanitation, and hygiene
WHO	World Health Organization
WVI	Wahana Visi Indonesia
YKMI	Yayasan Kemanusiaan Muslim Indonesia

AT GLANCE

Indonesia - Multi Sector Response Plan (MSRP)

A set of monitoring indicators has been agreed at the beginning of the implementation of the Plan. As much as possible, these indicators are aligned with measurements at the regional and global levels. This graph describes how many indicators that have been reported by implementing agencies, in each priority areas of the MSRP.

Priority areas: 7

Indicators: 66

# of Organisation: 28

Health
Total indicator: **18**

Critical Multisectoral Services
Total indicator: **11**

Mitigate the Socioeconomic Impact
Total indicator: **7**

Protection of Vulnerable Groups
Total indicator: **11**

Risk Communications and Community Engagement
Total indicator: **7**

Food Security and Agriculture
Total indicator: **4**

Logistics
Total indicator: **8**

no report report

Funding Status - Indonesia Multi Sector Response Plan (MSRP)

This graph illustrates the size of the funding requirements for implementing MSRP, with the largest allocation for health, which includes reproductive health and psychosocial support, worth US$73.8 million. Food Security and Agriculture received the largest percentage of funding (received 96% of the total requirement).

Funding still needed/ Plan Funding received

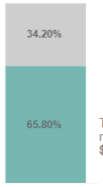
Overall, MSRP has received funding at **68%** of its total requirements.

$144,825,590
Resource requirements (US$)

$93,426,266
Funding received (US$)

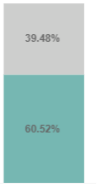
$51,399,324
Funding still needed (US$)

Health



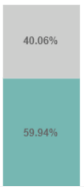
Total requirment: **$73,810,395**

Critical Multisectoral Services



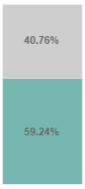
Total requirments: **$27,116,081**

Mitigate the Socioeconomic Impact



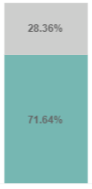
Total requirment: **$16,779,513**

Protection of Vulnerable Groups



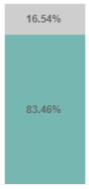
Total requirment: **$12,614,605**

Risk Communications and Community Engagement



Total requirment: **$7,598,868**

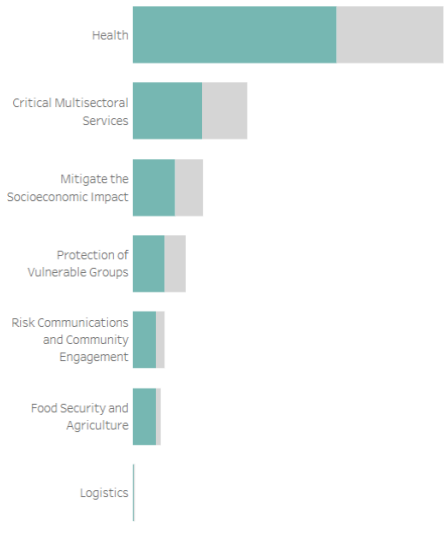
Food Security and Agriculture



Total requirment: **$6,669,173**

Logistics

Total requirment: **$236,954**



The data was collected through agencies report and information from the OCHA FTS (UN Office for the Coordination of Humanitarian Affairs. Financial Tracking Service), the data updated on regular basis and maintain by OCHA.

INTRODUCTION

On January 30, 2020, the International Health Regulations Emergency Committee of the World Health Organization declared the 2019-nCoV outbreak a "Public Health Emergency of International Concern (PHEIC)". The decision aimed at preventing the spread of the virus around the world, and to strengthen countries' preparation for active surveillance, early detection, isolation, and case management, contact tracing and mitigation of the onward spread of COVID-19.

As of 23 September, about 32 million confirmed cases of COVID-19 worldwide, including more than 982,000 associated deaths have been reported in 213 countries and territories.

The COVID-19 pandemic is much more than a health crisis; it is a human crisis in every country in the world claiming many lives and threatening the health, social and economic spheres of society. Invariably, the pandemic will diminish social services, economic activities, financial resources and infrastructure and exacerbate people's existing vulnerabilities including those of low income households with limited or no access to critical healthcare services and lack of safe and nutritious as well as affordable food, those of immunosuppressed people, women, children, the elderly, people with disabilities, refugees without access to cash assistance and with limited livelihoods opportunities to support themselves, and migrant and informal sector workers. Those who will be hit hardest by the COVID-19 crisis are those already at risk of being left furthest behind: particularly the poorest and most marginalized communities where social inequalities may be further exacerbated and the risk of gender-based violence and sexual exploitation and abuse is escalated.

As of 23 September, the Government of Indonesia has confirmed a total of 257,388 cases of COVID-19 throughout all 34 provinces with a total of 9,977 deaths reported. On 13 April 2020, the Government of Indonesia declared COVID-19 as national non-natural disaster. Since 29 May 2020 the Government manages the COVID-19 outbreak emergency response through Presidential Decree No. 11 of 2020 concerning the Establishment of a COVID-19 Public Health Emergency. Large scale social restrictions were implemented in major cities with reference to Government Regulation No. 21 of 2020 concerning Large-Scale Social Restriction in the Context of COVID-19 response. As of 14 September, Jakarta implements again movement restriction measures due to an increase in the number of cases that has taken the health system to its limit.

Indonesia has identified and prioritized its response, including testing, tracing and treatment (3T) to mitigate the further spread of the coronavirus, in eight provinces (Jakarta, East Java, West Java, North Sumatra, South Kalimantan, Central Java, Papua and South Sulawesi) which account for about 70 percent of the total number of confirmed cases in the country.

Indonesia's emergence as one of the world's leading economies with ensuing strong economic growth, a rapid decrease in poverty rates, improvements in education and access to better health services, food, water, sanitation, and electricity is challenged. The COVID-19 pandemic may adversely affect important gains accrued over the past years across a range of SDGs are at risk; including progress in the fight against poverty (SDG1), food security and nutrition (SDG2) and is likely to exacerbate inequalities (SDG10), particularly gender inequality (SDG5). This pandemic has also seen an interruption in routine health services (SDG3).

The economic impact of COVID-19 in Indonesia is fundamentally affecting macro-economic stability and employment. The World Bank and the Ministry of Finance have reassessed 2020 economic growth from 5% to around 2%, and although it is too early to assess with certainty, a worst-case scenario may even foresee minus growth in 2020[1]. It is estimated that an additional 5.9 million to 8.5 million people will become poor due to COVID-19[5]. As of 31 July 2020, 3.5 million workers have been reportedly laid off from their jobs as a result of this crisis, and more layoffs are expected to happen[2]. The ADB estimates that the unemployment loss due to COVID-19 could reach 7.2 million people[3].

In addition, Indonesia is one of the most disaster-prone countries in the world. The coping capacity of the country will likely be reduced in case of major natural disaster occurrence. BNPB (the National Agency for Disaster Management) recorded 1,944 disasters between 1 January and 3 September 2020, which caused 272 deaths and directly affected more than 3,8 million people.

Mindful that current responses may fall short of addressing the global scale and complexity of the pandemic, this document outlines the manner in which organizations of the Indonesia Humanitarian Country Team and other agencies of the United Nations system in the country will come together in a coordinated way to support government-led response efforts to this emergency and alleviate the impact of the pandemic on the most vulnerable segments of the population.

[1] Ministry of Finance, 2020
[2] Ministry of Employment data
[3] ADB, 2020

Given the magnitude of the emergency, this COVID-19 Response Plan is a joint commitment by the Humanitarian Country Team (HCT) and the United Nations Country Team (UNCT) to support the Government of Indonesia, and covers a range of issues through a comprehensive multi-sectoral approach which, during the first six months of the emergency focuses on life-saving and early recovery activities. The multi-sectoral response plan is aligned with the WHO Strategic Preparedness and Response Plan, the Global Humanitarian Response Plan, and the UN Framework for the Immediate Socio-economic Response to COVID-19. The plan will need regular updating to match the unique and evolving nature of this emergency with the most effective and appropriate activities. In September and October, the HCT and UNCT revisited the Plan, following its agreement to extend the implementation duration until 31 December 2020, as the ascending trend of COVID-19 cases continued.

I – NEEDS ANALYSIS

1.1- Public health impact of the COVID-19 epidemic in Indonesia

1.2. - Indirect impact of the COVID-19 epidemic

1.2.1. Macro-economic effects

Services, consumption, and trade

The COVID-19 pandemic has also resulted in an economic crisis, globally, as well as in Indonesia. The pandemic is jeopardizing the macro-stability and trade balance that the country had been able to achieve.

COVID-19 is severely impacting manufacturing production in developing countries because: 1) demand from high-income countries for manufacturing goods and raw materials is decreasing; 2) value chains are being disrupted due to delays in the delivery of necessary components and supplies from more technologically advanced countries; and 3) other factors, including policies (e.g. restriction of movement of goods and people), inability of employees to reach the workplace or financial constraints, which affect the normal production process. The Country's Purchasing Manager's Index (PMI) plummeted from 51.9 in February to 27.5 in April – the deepest among ASEAN countries, due to a steep decline in industrial utility by up to 50 percent. When the industry started to reopen with the ease of Large-Scale Social Restrictions, the Index recovered to 50.8 in August. However, the reopening has led to increasing spread of COVID-19 at factories and industrial areas in big cities, especially in Java Island[6].

[6] https://tirto.id/harga-indeks-manufaktur-naik-merebaknya-klaster-corona-di-pabrik-f23h

The impact of the COVID-19 pandemic is likely to also influence inflation. The Central Statistics Agency (BPS) recorded that the inflation rate during January-August 2020 was 0.93 percent. Meanwhile, the inflation rate from year to year or year on year was 1.32 percent[7]. The inflation could worsen as the overall population purchasing power continues to decline, and more and more people lose their jobs during the crisis.

Impact on food systems

Up to Mid-September, food supplies have remained stable and no shortages were reported in Indonesia. However, there were reports from some provinces on shortages of some basic food supplies, including cooking oil, eggs and chicken. Some households have adapted to the crises for now by eating less than they should.[8] In this prolonged crisis, the Government continues providing food basket assistance to targeted poor population, especially in urban areas.

Under-employment and unemployment

The COVID-19 pandemic has created unprecedented economic challenges globally because large segments of economic activity have come to a sudden stop due to health measures. Economic sectors such as tourism, that account for a large share of the national revenue and employment are highly vulnerable, and likely to create a wave of massive redundancies. The emergency is also likely to have a heavy impact of start-ups and MSMEs, which account for more than 90% of the economic tissue of the country[9]. The Coordinating Ministry for Maritime and Investment Affairs recently informed us that around 180,000 workers in the tourism sector were affected by COVID-19 pandemic[10]. These, in turn, are having a big impact on the livelihoods of millions of Indonesians, particularly as a large segment of the Indonesian labor force includes the informal sector and daily-wage workers. These impacts are felt in particular by women in the tourism sector, whose earnings as a percentage of male earnings in the same sector stood at only 69.93%.[11] These groups are a disadvantage to weather the crisis, and they are being hit the hardest by the

[7] https://www.liputan6.com/bisnis/read/4344848/inflasi-tahunan-agustus-2020-terendah-dalam-20-tahun

[9] The Ministry of Cooperatives and SMEs records over 64 million MSMEs in Indonesia

[10] https://economy.okezone.com/read/2020/07/22/320/2250453/menko-luhut-180-ribu-tenaga-kerja-sektor-pariwasata-terdampak-covid-19

[11] UNWTO (2018). Global Report on Women in Tourism.

pandemic, the loss of jobs, the economic slowdown and public health measures imposed by the government.

According to data from the Ministry of Manpower and BPJS Ketenagakerjaan (Social Security Agency), as of the second week of April 2020, about 2.8 million workers have been reportedly laid off from their jobs as a result of this crisis[12]. On 1 September, the Ministry announced that 3.5 million workers are laid off and the other 6.8 million workers are furlough[13]. The figures are significantly higher than the estimated surge in unemployment due to COVID-19, which ranged between 4.25 and 9.35 million.[14] The rise in unemployment means the loss of valuable productive resources for the economy, and a certain increase of poverty and inequality. Unemployment also creates other problems, such as the increase of mental health issues, crime and conflict. Finally, unemployment affects not just the unemployed, but it has an impact on all family members, which may have a cost to the health and education prospects of the next generation. The current crisis threatens to push back the limited gains made on women's equal participation in the labour force,[15] where the labor participation of women at 54.3% was already nearly 40 percentage points lower than that of men pre-COVID.[16]

1.2.2. Indirect effects on people and systems

Poverty

COVID-19 will impact past progress in poverty reduction in Indonesia. A study by SMERU Research Institute in April estimated that an additional 5.9 million to 8.5 million people will become poor if Indonesia's economic growth drops from 5% to 2.1% and further to 1% in 2020[17]. The Minister of Finance on September 16 announced that during the seven months of the pandemic, poverty has increased from 9.4 percent to 9.78 percent in the country with the population of over 260 million[18]. A spike in poverty rate means that greater social protection programmes are needed not only to address the existing poor but also

[12] Jakarta Post, 13 April 2020
[13] https://kumparan.com/tugujogja/menaker-sebut-3-5-juta-orang-di-indonesia-kena-phk-akibat-pandemi-covid-19-1u7T3SukQwd/full
[14] https://www.coreindonesia.org/view/467/waspada-lonjakan-pengangguran-dampak-pandemi-COVID-19
[15] United Nations, "Shared Responsibility, Global Solidarity: Responding to the Socio-Economic Impact of COVID-19", New York, March 2020. < https://unsdg.un.org/sites/default/files/2020-03/SG-Report-Socio-Economic-Impact-of-COVID-19.pdf >
[16] UN Indonesia (2019). Common Country Analysis.
[17] Suryahadi, A. et al., "The Impact of COVID-19 Outbreak on Poverty: An Estimation for Indonesia", SMERU Research Institute, Indonesia, April 2020 < http://smeru.or.id/sites/default/files/publication/wp_COVID-19impact_draft.pdf >
[18] https://bisnis.tempo.co/read/1386849/akibat-pandemi-covid-sri-mulyani-akui-kemiskinan-dan-pengangguran-meningkat

the newly poor. The resources required to expand the social protection would also need to be increased significantly.

Health

Judging by the evolution of the situation in other countries that are further ahead on the epidemiological curve, it can be safely assumed that COVID-19 will severely challenge the health system capacity of Indonesia; if not country-wide, then certainly in a number of provinces. COVID-19 will have an impact on increasing inadequate infection prevention and control (IPC) measures, poor availability of essential drugs and supplies, reduced availability of hospital beds and a shortage of skilled health workers, especially in underserved areas, disrupting the delivery of essential health services such as antenatal care, safe deliveries, newborn and under-5 treatment and care.

This means that the illness will not only have effects on COVID-19 patients, but also on other citizens requiring hospital care. In particular, pregnant women, newborns and children under the age of 5, people suffering from injuries, and many patients suffering from chronic diseases or patients with diseases that require regular health care and follow up (such as TB or HIV, for example) will be negatively impacted. As negative pressure rooms get used by COVID-19 patients, adverse effects on TB diagnostic and treatment, including MDR-TB, are likely. Adverse effects may also result due to a delay in people seeking healthcare for fear of getting infected with the virus, which may in turn lead to delayed diagnostics and treatment. Patients with chronic diseases who need regular prescriptions and supplies of medicines are less likely to get the care they need.

As the world's largest archipelagic state, with over 17,000 islands, Indonesia faces infrastructure challenges. For example, over 6 per cent of sub-districts do not have a health centre, and many that do exist lack basic services such as electricity, clean water and proper equipment. Some 21 per cent of health centres have limited referral transportation, and 35 per cent have limited 24-hour clean water and electricity. The strain posed by the virus is likely to further hamper the functioning of these centers, including the health of their workers.

The impact on Posyandus (integrated health post), as primary care centers for many Indonesians, is likely to lead to a severe disruption of key routine preventive services such as immunization. Physical distancing measures have led to temporary cessation of village health posts – the backbone child health and nutrition services. Rapid assessments revealed disruptions of immunization programs in 84% of primary care facilities and health posts, with outbreaks of vaccine-preventable disease a serious concern. Safe deliveries and

newborn care are also likely to be compromised. It is also expected that communicable diseases such as malaria, dengue, HIV and TB will rise, as essential services are decreased. This may result in the long-term discontinuity of essential services, and the risk of population losing trust in the health system, leading to a decrease in service utilization. Finally, there is a possible adverse psychological impact of a sustained epidemic on vulnerable groups such as children.

A considerable number of Indonesians live in areas affected by environmental degradation and air pollution, whether major urban centres or areas with annual burning of vegetation for agricultural purposes. Air pollution is one of the top ten health risk factors in Indonesia; post neo-natal and under-5 mortality rates per 100,000 due to lower respiratory infection are 212 and 13, respectively, and children, older people and people with medical conditions are more likely to be affected. Many of the poorer urban settlements within Indonesia's large urban centers are extremely dense, with inadequate WASH facilities, increasing the risk of disease spread. There are also considerable findings that existing medical waste management system will face more pressure with the increase volume of medical waste. There are huge needs of provision of medical equipment and products, yet it should be balanced with adequate provision of medical waste equipment and capacity strengthening inputs because the existing hazardous waste management capacity in country already overwhelmed. The impact of COVID-19 will be greater in these areas, if not addressed adequately.

Sexual and Reproductive Health

Sexual and reproductive health is a significant public health issue that requires high attention during pandemics. Despite unavailability of official reports and statistics on the number of pregnant women who have been infected by COVID-19 up to now, various reports show that pregnant women may be more susceptible to infections, particularly viral respiratory infections. Moreover, respiratory illnesses in pregnant women need to be treated with priority due to the possible increased risk of adverse outcomes.

As health systems become overstretched during an epidemic, the availability and access to reproductive and maternal health care also decreases. Movement restrictions due to quarantines mean that woman and young people may not be able to access sexual and reproductive health services such as contraceptives, and pregnant woman may forego antenatal care and even give birth unattended. This can increase the number of unwanted pregnancies and increases the potential risks of sexual and reproductive health related morbidity and mortality. The provision of family planning and other sexual and reproductive health

commodities, including menstrual health supplies, are central to women's health, empowerment and sustainable development, and may be impacted as supply chains are disrupted by the pandemic.

ARV and HIV prevention and counselling services

HIV control has been particularly challenged by the COVID-19 pandemic. Access to HIV prevention services such as condoms, opioid substitution therapy, and sterile needles and syringes for key population, such as sex workers, people who inject drugs, men who have sex with men and transgender population, have been greatly hampered. Community outreach workers have to be capacitated to be able to deliver services virtually and or door-to-door as closure of hotspots and or sweeping of activities in hotspots have been enforced by civilian police to uphold movement restrictions.

CSO partners also report that many health facilities have either adjusted their HIV related services for testing and treatment (e.g. reduced-hours) or even close them altogether as their infrastructure often gets overwhelmed by efforts to control and respond to COVID-19. However, People Living with HIV (PLHIV) still need to continue their antiretroviral (ARV) treatment without disruption. This is a life-long medication that not only keeps people living with HIV healthy and productive, which also helps prevent transmission of the HIV virus to others.

Access to treatment is also currently challenged by global trade and travel restriction due to the COVID-19 pandemic. Potential stockout of some ARV drugs is looming as drugs procured and or imported from other countries have experienced some delay. PLHIV groups have reported that health facilities have resorted to weekly dose ARV dispensing as opposed to the usual monthly dose ARV dispensing, It is critical for PLHIV to have access to multi-month refills of their HIV medicines especially during the COVID-19 pandemic. There is a need to ensure stable supply chains of essential medicines in Indonesia including antiretrovirals medicines for HIV treatment.

While access to social protection nets has been made available by local government to vulnerable and poor population, certain groups such as migrant and transgender people have difficulties accessing this support due to the requirement of a local identification card.

Nutrition

The recent global evidence has suggested that in the absence of timely action, there could be a 14.3% increase in the prevalence of moderate or severe wasting among children under 5 years of age due to COVID-19 during the first year of the pandemic, leading to an estimated 10,000 additional child deaths per months during this same period. The immediate impact of the pandemic on household income and food security, as well as on food systems by disrupting the production, transportation, and sale of nutritious, fresh, and affordable foods, not only leads to adverse nutritional outcomes, but also to long-term loss of human capital, especially for the most marginalized population.

Notably, the pandemic can cause the disruption of essential nutrition services targeting infants and young children, pregnant and lactating mothers, adolescents and school-age children, as well as women of reproductive age. These include all eight essential nutrition specific interventions supporting the National Stunting Reduction Movement, including the infant and young child feeding counselling, maternal iron folic acid supplementation, prevention of maternal underweight, prevention and treatment of moderate and severe acute malnutrition, growth monitoring, and adolescent weekly iron-folic acid supplementation.

With the current pandemic, the nutritional vulnerabilities of millions of infants, young children and pregnant and lactating mothers in Indonesia are being exacerbated by the devastating impact of the pandemic on household income and food insecurity; reductions in market access and agricultural production; and the disruption of essential nutrition services.

Shelter

The spread of COVID-19 has resulted in increasing levels of tenure insecurity across Indonesia. The initial stage of the pandemic saw tenure insecurity rising primarily amongst the casual urban workforce, many of whom rent on a month by month basis, with rent making up a considerable portion of their monthly income. Loss of employment amongst these workers lead to increasing urban homelessness as well as increased migration back to rural villages, bringing increased spread of disease and adding pressure to communities with already limited health and economic infrastructure. As the pandemic has progressed there has been increasing concerns raised about longer-term renters and mortgagees, particularly in key affected sectors such as hospitality and tourism in urban and tourist centres.

The medical impact of COVID-19 also brings a range of direct shelter impacts with families travelling from urban centres to seek medical assistance for family members and then in need of shelter assistance. In

many circumstances, shelter solutions are also needed for those in need of self-isolation or quarantine. The mandatory closure of hotels and guest houses, while villages and suburbs refuse to accept outsiders is compounding shelter needs across the country.

Dense urban living areas, camps and barracks in areas of ongoing disaster response continue to require rapid decongestion support to reduce the spread of disease amongst vulnerable populations. This is also true for a broad range of residential institutions across the country for students and more vulnerable members of society such as the aged and mentally or physically ill.

Education

The Government of Indonesia responded quickly to the global COVID-19 pandemic: Even before the first local case was detected in March, the Ministry of Education and Culture (MOEC) provided schools with comprehensive guidance on safe operations and COVID-19 prevention. Following confirmation of the first case, the Government closed all 530,000 schools, thus interrupting the education of 60 million school-aged children in the country. To minimize disruption and loss of learning, the government developed a learning from home guidance based on global guidelines and established distance learning alternatives through online, TV and print materials.

Alongside the delivery of these programmes, the MoEC has developed national guidance on flexible use of school operational funds, emergency curriculum and safe reopening of schools. Currently only schools in areas with low and no risks of local transmission of COVID-19 that meet strict requirements are allowed to conduct face-to-face learning sessions. While data collection on the school reopening status is still ongoing, thus far at least 16,600 schools by the end of August had reopened and welcomed around 1.8 million children to face-to-face learning in the classrooms.

The MoEC has facilitated innovative approaches to continued learning during the COVID-19 pandemic, especially through online learning. However, inadequate infrastructure including internet connectivity in many provinces and districts has affected the capacity to provide quality distance learning opportunities.

Many children, particularly those from poor households and in rural, remote areas, do not have access to the internet and/or devices to allow them to engage in online learning at home. In a learning from home rapid survey conducted by MoEC and UNICEF, 35% of students reported no or poor internet connection as a major challenge for their home-based learning. This problem is particularly compounded in rural areas. There are also gendered impacts of the pandemic on education, in particular as the digital gender gap is

sizable, with only 20% of women having access to internet across Indonesia.[19] The school closure has also disproportionally impacted children with disabilities. In another survey conducted by UNICEF, more than 70% of students with disabilities reported they were having difficulties in learning from home activities. The biggest challenges include lack of concentration, learning environment that is not supportive and unavailability of assistive devices and materials.

Gender-based violence

The impact of the COVID-19 pandemic on gender equity will also be significant. Crises compound deep-rooted forms of existing discrimination and inequalities, including gender inequalities, increasing harm and risks for women, girls and gender diverse people both in the home and in the community. Epidemics such as the Ebola outbreak in 2015 saw an increase in violence, sexual exploitation and abuse of women and girls due to increased financial stress on families, increased demands of household chores in caring for the sick, decreased access to livelihoods, more frequent and longer journeys to obtain food or water which increases exposure to sexual assault, and disintegration of social protection structures as resources are diverted towards responding to the outbreak. With restrictions to freedom of movement, combined with fear, tension and stress related to COVID-19, and the negative impacts on household incomes, risks of violence will continue to grow. Particular attention must be paid to women with disabilities, who were already up to two times more likely to experience violence from partners and family members than women without disabilities pre-pandemic.[20]

Women are also more vulnerable to economic fragility during confinement and movement restrictions, for reasons that include their far greater representation in informal sector jobs. In resource-strapped environments, vendors may insist on trading sex with women and girls in exchange for necessary supplies that are scarce. In households where men have fallen ill or died from the epidemic, women and children may be left to fend for themselves, making them vulnerable to violence and sexual exploitation. With schools suspended, young girls and boys can find themselves exposed to a heightened risk of exploitation and abuse. Similarly, the COVID-19 pandemic may also impact the transgender population, as they may experience an increased risk of intimate partner violence and other forms of economic violence.

Within this context, the rollout of social protection packages as part of the COVID-19 response present key opportunities to address the gendered dimensions of the crisis, including through ensuring that targeting

[19] World Wide Web Foundation. Women's Rights Online Report Card: Indonesia.
[20] UN Women (2020), "From Insights to Action: Gender Equality in the Wake of COVID-19."

is based on gender analysis and consultation with women's organizations, removing gendered barriers to accessing social protection schemes, integrating messaging on gender equality as part of 'cash plus' interventions, and ensuring that programming integrates approaches to prevent and respond to GBV[21]. With increasing evidence that cash transfer programs have the potential to decrease intimate partner violence[22], it is also critical that such programmes continuously document and identify the linkages between cash transfers and intimate partner violence to inform the design of shock-responsive social protection programmes in the future.

1.2.3. Effects on livelihoods

Decreased income and increased vulnerabilities

Indonesia has made significant progress in reducing poverty and increasing human development during the last decade. For the first time in Indonesia's history, the poverty rate is below 10%, and Indonesia's standing in the human development index continues to grow. Despite this progress, 40% of Indonesia's population, although above the poverty line, remains vulnerable to socio-economic shocks and dependent on their daily wages and small incomes, with very little or no savings. Based on BPS report, the poverty rate in the second semester of 2019 is 9.22 percent and significantly increased by the first semester 2020 to 9.78 percent[23]. The country efforts to reduced poverty rate for the last 2,5 years[24] is in serious threats only within seven months of the COVID-19 crisis. While the immediate effects of the pandemic on livelihoods are quite clear, it is important to also prepare for secondary and tertiary effects, where many MSMEs (Micro, Small, and Medium Enterprises) may have to be closed, employees laid off in massive numbers, creating the conditions for people to slide back into poverty.

A large number of Indonesians rely on daily wages or tourism to make a living. The loss of income resulting from the current travel restrictions and restrictions of movement will likely have a more compounded effect for these population segments, along with people leaving below or close to the poverty line. The tourism sector, which contributed 6.82 percent of Indonesia GDP and 13 million employment (10.28 percent of the total)[25], is highly vulnerable. Based on the Bureau of Statistic of Indonesia, the contribution is 22.97 percent

[21] UNICEF (2020). Gender-Responsive Social Protection during COVID-19: Technical Note.
[22] The World Bank Research Observer, Volume 33, Issue 2, August 2018, Pages 218–258, https://doi.org/10.1093/wbro/lky002
[23] https://www.bps.go.id/linkTableDinamis/view/id/1219
[24] Comparison with the same poverty rate level in semester 1 2018.
[25] https://lokadata.id/data/penyerapan-tenaga-kerja-sektor-pariwisata-2010-2019-1582009409

lower in Q2 2020 compared with the same quarter last year. Many tourism entrepreneurs have seen a 100% downturn, and not all are able to adapt to the local market. The impact in this segment of the hospitality market is dramatically more severe than the national average of 22% downturn.

Indonesia is a major migrant-sending country, with overseas workers remitting some 1% of total GDP each year. As of September 2020, more than 176,000 migrant workers have officially returned to Indonesia after losing their employment overseas due to the COVID-19 outbreak in destination countries. In response to the crisis, the government suspended formal placement services for returning or aspiring overseas workers in March 2020, a decision aimed at reducing exposure to COVID-19 overseas and limited access to health services. This decision negatively impacted the livelihood options for many Indonesians and resulted in a loss of remittance incomes sent to family and community members. By August 2020, 89,000 migrant workers waiting to migrate for work were unable to move according to the Ministry of Manpower and BP2MI. This temporary blanket ban was lifted in August 2020, with placements to 12 destination countries now open with additional health predeparture provisions. Without formal means of recruitment and placement to prominent destination countries, prospective workers are increasingly vulnerable to economic pressures and will seek alternative means of travel and employment, significantly raising the prospect of human trafficking, and reducing protection measures for some of the most vulnerable segments of Indonesian society. The increased risk of human trafficking through unofficial transport and more dangerous transport routes is also noticed.

A sudden and significant loss of income is expected for some of those employed in the informal sector in geographical areas with reduced formal employment and closed businesses, (street stalls) and the services industry (tourism related, food, entertainment, transportation, retailing at malls). This will also have spillover effects in the value chain of those industries. Sustained increase of prices is less expected, although irregular business practices may produce some price hikes and stocks manipulation. Decreased productivity is expected due to job absence, health-related and caring for children related. And lack of health insurance and overburden of health public facilities may also increase out of pocket health expenditures for families.

Increased food insecurity

Restrictions of movement, as well as basic aversion behaviour by workers, may possibly impede the food production and distribution, which may lead to increased food insecurity. Rice production in January to August 2020 is lower by 23% compared to the same period 2019. Domestic rice production is predicted

to maintain a positive balance nationally and able to meet demands without imports until the end of 2020[26]. Panic buying was noticed in big cities, in early weeks of the pandemic.

1.2.4. Most affected and at-risk population groups

Certain population groups face an increased potential of vulnerability in face of the COVID-19 pandemic.

The urban poor commonly live in crowded conditions, consequently having little change to practice effective social distancing or, in case of symptoms or exposure to the disease, have little opportunity for effective self-isolation. As a rapidly urbanizing country, it is estimated that just under 22 per cent of Indonesia's urban population live in sub-standard housing with deteriorated or incomplete infrastructure. Inhabitants of these areas, including children, are more likely to be excluded from basic services. Within the households those with preexisting increased risk of vulnerability are likely to feel the effects of the COVID-19 outbreak more severely. This includes single headed households, child headed households, households including those living with a disability, the elderly and weak. Increased impact is especially likely in these household if a primary breadwinner falls sick, resulting in significant loss of income.

In times of the COVID-19 pandemic, ***women and girls*** have borne specific impacts, for example, taking on increasing burdens of unpaid care work: while both women and men reported increases in time spent on unpaid care during the pandemic, a higher percentage of women (56%) did so than men (41%) in Indonesia.[27] In addition, fewer women (65%) than men (75%) reported receiving clear, helpful information on COVID-19, indicating also barriers in accessing risk communication materials.[28] Women and girls may be at higher risk of intimate partner violence and other forms of domestic violence due to increased tensions in households. As systems that typically protect women and girls, including community structures, may weaken or break down, specific measures are needed to protect women and girls, such as updated referral pathways to reflect changes in available facilities. Similarly, this may also impact the transgender people, as they may experience an increased risk of intimate partner violence and other forms of economic violence during the COVID-19 pandemic.

[26] WFP's COVID-19: Economic and Food Security Implications (3d Edition), August 2020.
[27] UN Women (2020). Unlocking the Lockdown: The Gendered Effects of COVID-19 on Achieving the SDGs in Asia and the Pacific.
[28] Ibid.

The Elderly, people with pre-existing co-morbidities and people with specific disabilities are particularly vulnerable, given that the case fatality rate for COVID-19 increases with age and a range of pre-existing medical conditions. Persons 60 years or older are considered a high-risk population; other high-risk groups include those with pre-existing conditions such as cardiovascular disease, TB, diabetes, HIV-AIDS, chronic respiratory disease, and immunocompromised persons. In Indonesia, a significant number of older persons have responsibilities for the care of children, with 9 million children living in households headed by older persons; this certainly increased the burden on older persons for care and support resulting from school closures and loss of economic support. Older persons residing at elderly housing or receiving at-home care are particularly vulnerable from COVID-19, due to their lack of independence and limited social networks. Similarly, persons with disabilities are deemed to be especially at risk of COVID-19 infection due to their limited access to information and mobility. They often lack personal protection supplies, vitamins and food intake.

Additionally, ***people with HIV and*** people affected by HIV and those marginalized through stigma and discrimination on the basis of their sexual orientation or sex work have started to experience the impact of COVID-19 to their livelihoods. Most of them rely on daily wages/income to support their livelihoods that have been affected as many local governments have enforced restriction of social mobilization. While access to social protection has been made available by the government to vulnerable and poor people, those who are marginalized have difficulties accessing this support due to the requirement of local identification cards, or not meeting the eligibility requirements applied by the different local governments.

Refugees and IDPs are also face potentially increased risks that may result in increased vulnerability. As of August 2020, Indonesia hosts 13,745 refugees from 48 different countries, 3,819 of which are children[29]; as of January 2020, there are 104,000 IDPs due to natural disasters and 40,000 IDPs due to conflict and violence in Indonesia.[30] Refugees live in different parts of the country, with concentration points in larger cities, particularly the greater Jakarta area (Jabodetabek), where around 7,084 reside. While refugees have access to basic primary health attention in the local health centres (Puskesmas), both IOM and UNHCR run complementary health programmes to ensure, to the extent possible, that refugees receive the health care needed. Between June-September 2020, nearly 400 Rohingya refugees disembarked in Aceh after months at sea which left many in poor health conditions upon arrival. Comprehensive measures are required to ensure newly arrived refugees are integrated into COVID-19 health response measures, and that mitigation

[29] UNHCR – latest statistic update on 31 October 2020
[30] Data from the Internal Displacement Monitoring Center, 28 April 2020.

measures are in place and maintained to reduce transmission risks among the Rohingya refugee post-disembarkation. These include a range of COVID-19 IPC interventions covering all major aspects of the humanitarian response in Aceh, including those related to risk communication and community engagement, health protocols, shelter configuration, WASH facilities and practices and site to vector control. The 2021 planning exercise for the Rohingya refugees' situation in Lhokseumawe, Aceh will be facilitated by UNHCR by end of November 2021 to discuss the activities planned and to be carried out in 2021.

A major and yet under-addressed factor increasing risks for refugees and IDPs is the dense communal living conditions that they are often constrained to. The recently arrived Rohingya refugees in Aceh are confined within a small site, sleeping in large communal rooms, well below the standard of most Indonesian post disaster shelters. Within this high-density environment refugees must share communal cooking, sleeping and WASH facilities. This increases the risk of spread of most transmissible diseases as well as Covid-19. These inadequate communal shelters also increase the risks of domestic violence, stress, and sexual assault.

During the COVID-19 outbreak in Indonesia, official statements of the Indonesian authorities and the established health protocols have highlighted the principle of non-discrimination, thus refugees can in principle access health facilities, albeit the payment will most likely have to borne with external funding. However, the resilience of the extremely vulnerable refugees to deal with the increasing prices of basic commodities and services has critically weakened and increased their exposure to negative copying mechanisms, and therefore their vulnerability has increased.

Health-care workers constitute another high-risk group due to their elevated and prolonged exposure to the COVID-19 virus, increasingly paired with limited number pulmonary doctors in Indonesia, a lack of personal protective equipment and specific psychosocial needs. Currently, Indonesia only has 1,106 pulmonary doctors, which is a very small number when compared with the growing number of COVID-19 cases. According to the Pulmonologist Association, Indonesia ideally needs at least 2,500 pulmonologists to handle the pandemic[31]. Women represent 70% of the health and social sector workforce globally, and special attention should be given to how their work environment may expose them to discrimination. Many female health workers are also primary caregivers for the elderly and children in their own homes.

Returned Indonesian migrant workers – Since the start of the outbreak and as of September, more than 176,000 Indonesian migrant workers have returned to Indonesia from destination countries through official

[31] https://www.klikpdpi.com/index.php?mod=article&sel=9699

channels, according to the National Board for the Protection of Indonesian Migrant Workers (BP2MI). The actual number of returnees is higher due to an unknown number of migrant workers who have returned through irregular channels. Indonesian migrant workers have been significantly impacted economically, with many reporting to have been forced to return without their full salaries being paid by their employers, according to case records taken at government transit shelters, and often burdened by significant levels of debt. Returning migrant workers are not included in estimated statistics of newly unemployed Indonesians affected by the pandemic and encounter increased barriers in accessing government's social benefit schemes. The situation faced by returned migrant workers is compounded with the stigma they face upon return to their home communities. If not mitigated, the deterioration in the economy may potentially drive more Indonesians into desperate attempts to migrate abroad for employment by higher risk irregular channels. This is especially likely as international mobility through regular channels becomes restricted due to measures put in place by destination countries.

Religious or ethnic minorities, who may not fall into one of the six official religions are at a greater risk of harassment and discrimination due to misinformation/infodemic distribution among the society, including, including the lack of access to appropriate health and social and economic support services. Misinformation amongst particular religious groups may also increase risks for a significant proportion of the population through falsely proclaimed cures, pseudo-science theories of protection and ant-vaccination propaganda.

Children, particularly children in remote communities and in the Eastern parts of Indonesia, are exposed to poverty in several dimensions. Illness and death amongst primary caregivers within extended families is likely exacerbate this impact for many poorer households. In addition, children with disabilities, children living in institutions, including within child protection facilities, juvenile detention facilities and residential schools face an increased risk of violence and abuse. Studies have shown that the prevalence of violence against children within institutions rages from 40-60%.

Detainees and prison population are another group with increased vulnerabilities to COVID-19, due to crowded conditions and limited access to health facilities. Institutional residents of old people's homes, nursing homes, boarding houses. Homes for the mentally or physically ill, dense workplace accommodation for factory or migrant workers, are all areas of concern for increased risk of disease spread.

1.2.5. Capacities to cope with the additional pressure from the epidemic

Family and community networks are strong in Indonesia. Collective responses are normally more common than individual responses. On the face of a threat like COVID-19, people may seek family and community support as a key coping mechanism. Government is implementing two key social protection measures: make PKH payments available one month before what was originally planned and reactivate and expand the amount of money given as food subsidy. International assistance may play a role in shaping policy response and monitoring results, but it will be less relevant for financing fiscal policy response.

II. – EXPECTED EVOLUTION OF THE SITUATION AND NEEDS UNTIL DECEMBER 2020

With regard to health, the projection up to December largely depends on the evolvement of the epidemiological curve over the next few weeks. Although more gradual than in many other countries the Indonesian curve continues to rise, with no end in sight. While a flatter curve is beneficial in term of coping capacity of the healthcare systems, it also most likely means a prolongation of the outbreak. Estimates even speak of a duration until 2021.

With regard to food prices, based on WFP's price monitoring and analysis for 10 strategic food commodities, prices for most commodities remain stable with minimal impact on food security. The situation needs be closely monitored throughout the country as the COVID-19 outbreak in Indonesia evolves. Partial disruptions in food production, trade, and distribution due to labour shortages and travel restrictions—if cases continue to rise as predicted - may lead to increases in the price of major food commodities. In the first quarter of 2020, the prices of garlic and sugar—two commodities in which domestic demand is primarily (80-90%) fulfilled from imports—rose throughout the country due to import disruptions. Rising food prices, coupled with lower incomes due to a potential increase in unemployment and underemployment, may lead to rising food insecurity. Hence, to anticipate unwanted consequences related to food security, giving serious attention to health, nutrition and reproductive health care services is paramount. Ensuring the continuation of antenatal, safe delivery, and post-natal care for pregnant women and lactating mothers would help to safeguard the health status of babies and children.

The socio-economic impact of the pandemic in Indonesia will be heavy, multi-sectorial and long lasting. The tourism sector, which contributed 6.82% of Indonesia GDP and 13 million employment (10.28% of total), is highly vulnerable. Based on the Bureau of Statistic of Indonesia, its contribution is 22.97% lower in Q2 2020

compared with the same quarter last year. There has also been a heavy impact on start-ups and SMEs, which account for more than 90% of the economy, big part of which is in informal sector.

High unemployment is impacting housing and tenure security for many, with increasing levels of homelessness, particularly in urban areas, along with increasing migration to seek shelter and or employment. This is placing an additional burden on poorer communities in both rural and urban areas. With increases in unpaid care and domestic workloads, women pay the heavier price: 19% of women have noted an increase in intensity of unpaid domestic work in comparison with 11% of men, and 39% of women compared to 29% of men reported increased time teaching children due to school closures.[32]

As the epidemic spreads throughout the Indonesian archipelago, provincial and local governments, particularly those at high risk will need support to strengthen their capacity to respond in terms of data collection and analysis, coordination, communication, raising awareness and uninterrupted delivery of public services to all citizens, including the poor, vulnerable and those in isolated areas.

Remittances received by Indonesian migrant households, which represented more than 1% of GDP before the pandemic, dropped significantly due to the massive numbers of Indonesian migrant workers pushed to return home due to economic downturns in destination countries. The Bank of Indonesia recorded USD 2.2 billion in remittances received during the 2nd quarter of 2020, which represents a decrease of USD 700 million (or 24%) when compared to the 2nd quarter of 2019. Furthermore, temporary restrictions on the official placement of migrant workers limited critical access to livelihoods for hundreds of thousands of migrant workers lacking gainful employment in Indonesia. Anticipation of an increase in irregular recruitment of workers and potential trafficking and exploitation of Indonesian migrant workers is essential. In recent months, government, international, and local partners have observed an increasing prevalence of trafficking in persons experienced by both Indonesian migrant workers exploited abroad and Indonesians trafficked inside the country, in particular trafficking for the purposes of sexual, including of minors.

In a country with a population of over 260 million, large groups are at risk, particularly the 9.6% of the population or about 25 million people who live below the national poverty live and the 40% of Indonesia's population (~180 million people) living just above that line and being vulnerable to external shocks. It is estimated that between 1.3 to 8.5 million of people may be pushed into poverty[33].

[32] UN Women (2020). Counting the Costs of COVID-19: Assessing the Impact of Gender and the Achievement of the SDGs in Indonesia.
[33] Suryahadi, A., et al (2020). The Impact of COVID-19 Outbreak on Poverty: An Estimation for Indonesia.

The provision of some public services and support services will also be interrupted due to restricted mobility and people to people contact in a large archipelago where online services are not available nationwide. Limited mobility and social distancing will have impact on people's well-being and their human development. Lack of information and awareness together with lack of inter-personal communication may also make rumors and disinformation more widespread and pervasive, misleading citizens in prevention messages and triggering stigma and discrimination. This is particularly true for the marginalised groups and communities in remote areas, where access to public information is limited due to connectivity problem and sometimes language obstacle. Inability to meet physically and travel will have an impact on families and communities pose a risk to reduce social solidarity due to their lower participation in community-based initiatives. In addition, Indonesia is prone to natural disasters. Many of the coping mechanisms for natural disasters are based on community approach and people to people contact. Restrictions imposed due to limiting spread of the virus may weaken preparedness to natural disasters at the community level.

An Immunization perception survey, organized by the Ministry of Health and UNICEF, found that public behaviors and practices of immunization services seeking have been significantly altered. Most parents and caregivers were concerned about the safety of their children during vaccination and demanded immunization services with high quality and adequate safety. Prior to COVID-19, around 90 percent of children in Indonesia were vaccinated in public health facilities, including health posts (posyandu), health centers (puskesmas), and village birth facilities (polindes).

According to the immunization survey, half of responding parents and caregivers brought their children for routine immunization over the past two months, with the other half not attending immunization sessions either due to the conditions created by the COVID-19 pandemic or because their children did not need a vaccine in the given timeframe. However, a majority of respondents – 43 percent – indicated that they are now seeking childhood immunizations in private clinics and hospitals due to closure of government-run or public health facilities, including outreach sites in their area.

While the immunization survey highlights the unavailability of immunization services caused by disruptions to the health system, it also reflects the high demand for vaccines, with parents and caregivers exploring alternative service points that offer immunization services. Respondents reported feeling reluctant to visit health facilities due to fear of contracting COVID-19 and raised concerns about the closure of immunization services, especially at posyandu and community levels. Parents and caregivers also reported high out-of-pocket expenditure for obtaining vaccinations at private health facilities, which are otherwise free of charge at public facilities.

Based on the report 'COVID-19: Community insights from the Asia Pacific Region', a large proportion (65%) of respondents believe COVID-19 is spread by a specific group. The majority believe the spread is because of some people who refuse to follow government regulations such as not wearing masks, going out unnecessarily, and traveling to and from COVID-19 high-risk areas. There is also a small but notable group that believes it is spread because the government did not anticipate the level of spread and effectively implemented lockdown and strict regulations.

The community insights report respondents explain they stay informed mostly through online channels including websites or online news pages, social media, and search engines such as Google. However, these findings are most likely a correlation with the fact that data in Indonesia was exclusively collected through online surveys. Therefore, respondents were more likely to be digital natives with regular internet access.

Interestingly, while online channels such as social media, websites/online news, and search engines are used frequently, they are not as well trusted as other less frequently used channels and sources such as WHO, radio, community health workers, UNICEF, and Red Cross volunteers. This suggests that to have effective communication, it is needed to engage people through well-trusted sources and frequently used channels. For example, MoH or WHO representatives communicating through TV or social media.

Lastly, AC Nielsen's OMNIBUS Study has been conducted to investigate COVID-19 prevention behaviours. This is a survey shared by number of projects each with their own sub-questionnaire. According to the survey in six provincial capitals, people's TOM (Top of Mind) regarding COVID-19 tend to be on the negative aspects rather than aspects related to prevention behaviors. When people heard the term coronavirus or COVID-19, the words that come to most people's mind are dangerous, deadly, scary, etc. (57%). Only around 8% mentioned prevention related words such as hand washing with soap, face mask and etc.

More respondents think transmission is through coughing or sneezing (71%). Fewer see COVID-19 transmit when sick people are speaking or breathing (23% and 25%). Such comprehension theoretically would influence how people practice physical distancing among others. They would not keep safe distance if the person s/he talk to is not coughing or sneezing.

Preliminary analysis shows 47% of respondents are practicing physical distancing and 71% are using face mask. Reasons most people are practicing physical distancing are mostly social norms factors and not about knowledge such as feel bad if go away from other people (40%), other approaches us and not me (36%) and everybody is not keeping safe distance (25%). Whereas not wearing mask is mostly about low perceived threat. More than a half say they forget (54%), which means they are not taking the mask use seriously.

Another 10% said there is no presence of corona in their area and another 6% said PSBB has been lifted (so situation is safe now).

III. – THE GOVERNMENT RESPONSE

3.1. Declaration of National Disaster

On 13 April, through Presidential Decree number 12 of 2020, the President of Indonesia declared the COVID-19 pandemic as a national disaster. After 29 May, the Government manages the COVID-19 outbreak emergency response through Presidential Decree No. 11 of 2020 concerning the Establishment of a COVID-19 Public Health Emergency.

3.2. National Response and Mitigation Plan for COVID-19

The Government of Indonesia, through the Task Force for the Acceleration of the Response to COVID-19, has developed a National Response and Mitigation Plan for COVID-19. The plan has been developed in reference to the 2005 International Health Regulation, that aims at increasing the country's core capacity for the detection, verification, reporting and response to public health emergencies of international concern (PHEIC). Indonesia has adopted the WHO pandemic risk management guidelines by using a whole-community approach and is aligned with the disaster management system. Specifically, the Plan has the following objectives:

a. To limit transmission of the COVID-19 outbreak, reduce subsequent infections in vulnerable communities and health workers, including preventing the wider impact due to comorbidities;
b. Early detection, isolation and early treatment, including carrying out optimal services for COVID-19 patients;
c. Implementation of pharmaceutical and non-pharmaceutical measures for the COVID-19 outbreak;
d. Identification of all resource requirements related to COVID-19 response; and,
e. Maintaining public order and security as well as social and economic stability during the COVID-19 response.

The implementation of the national operations plan is divided into six components, each of which has specific duties and responsibilities:

1. Implementation of command and coordination;
2. Surveillance;
3. Medical and laboratory responses;

4. Pharmaceutical intervention;
5. Non-pharmaceutical interventions;
6. Risk communication and community engagement.

The implementation of the plan is organized in accordance with the disaster management phases:

Response status	Operational definition	Operational focus	Leading Agencies
Preparedness	No case in Indonesia	Strengthening of surveillance, early detection and prevention	National: MoH Regional: heads of region
Disaster readiness/alert	Initial and sporadic cases	Case detection, tracing and isolation	National: MoH Regional: heads of region
Disaster response	Minimum two escalating clusters	Case detection, tracing, pandemic mitigation, physical distancing, business continuity plan	National: BNPB Regional: heads of region
Rehabilitation	No new case after two incubation periods from the last case	Strict surveillance, response de-escalation, rehabilitation of component and functions	Regional leadership

To ensure the collaboration of all resources from multi-stakeholders, the plan utilizes the National Cluster approach that has been regulated by BNPB. The image below provides a graphic representation of the National Clusters in Indonesia:

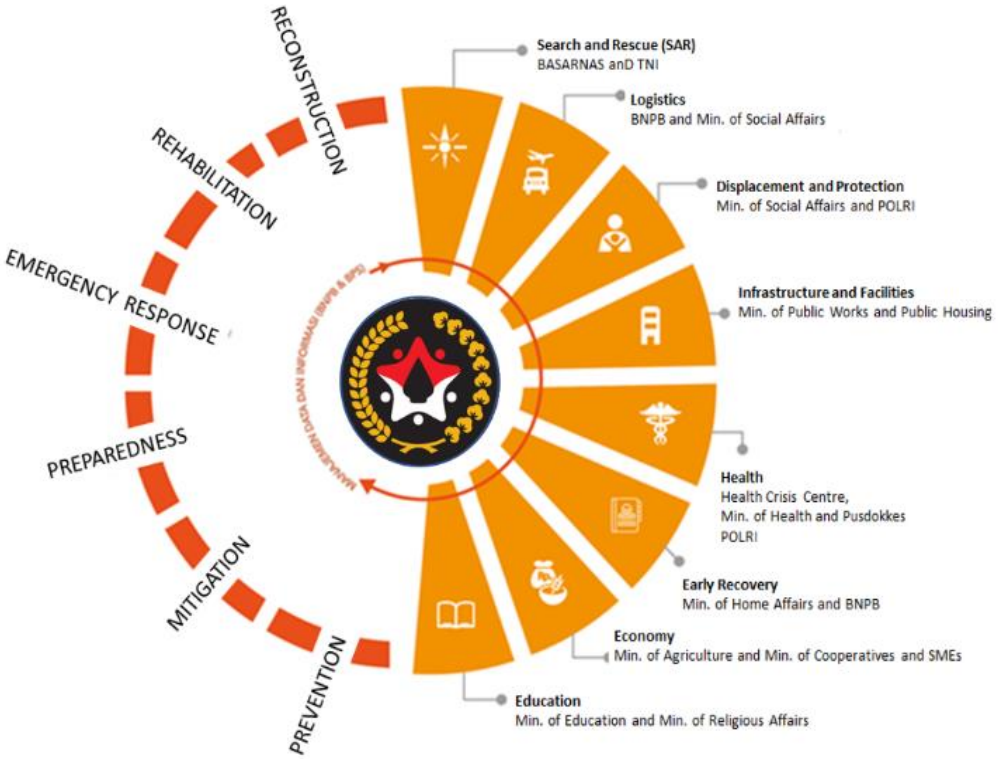


Figure 3: Structure of the Indonesian National Cluster system

Considering the magnitude of the crisis and following the appointment of the Coordinating Ministry for Human Development and Culture as the Steering Lead Agency, and BNPB as the Implementing Lead Agency of the National Task Force for COVID-19, the implementation of the National Cluster will be adjusted within a much broader coordination system.

IV. – COORDINATION MECHANISMS

For the COVID-19 response, the Government of Indonesia has set up a Task Force for the Acceleration of COVID-19 Response through Presidential Decree (Keppres) Number 9 Year 2020, which amended the initial Keppres Number 7 of 2020 concerning the Task Force for the Acceleration of the COVID-19 response. The Coordinating Minister for Human Development and Culture has been appointed as the Chair of the Steering Team, while the Coordinating Minister of Political, Legal and Security and the Minister of Health are the vice-chairpersons. The Task Force Team is led by the Head of National Agency for Disaster Management (BNPB).

In 2014, BNPB and a number of government ministries/institutions agreed to adopt the cluster approach as the mechanism for multi-stakeholder coordination on humanitarian issues in Indonesia; the agreement was formalized through decree number 173/2014 from the Head of BNPB. The national cluster system in Indonesia is envisioned to work before, during and after a disaster. A total of eight national clusters were established, as follows:

No.	National Cluster	Coordinator	Co-Coordinator
1	**Health**, with six sub-cluster and three support teams: • Health Service • Disease control, environmental sanitation, and clean water supply • Reproductive Health • Mental Health • Disaster Victim Identification (DVI) • Nutrition Three support teams: • Health Logistic Team, • Data and Information Team, and • Health Promotion Team	Health Crisis Centre, Ministry of Health	Pusdokkes POLRI
2	**Search and Rescue (SAR)**	BASARNAS	TNI
3	**Logistics**	BNPB	Ministry of Social Affairs
4	**Displacement and Protection** with eight sub-clusters and two working groups:	Ministry of Social Affairs	POLRI

No.	National Cluster	Coordinator	Co-Coordinator
	• Shelter • Water, Sanitation and Hygiene • CCCM • Child Protection • Protection of Elderly, Disability, and other Vulnerable Groups • Prevention and Response to Gender-based Violence and Women Empowerment • Psychosocial Support • Security Two working groups: Cash and Voucher Assistance, and Community Engagement		
5	**Education**	Ministry of Education and Culture	Ministry of Religious Affairs
6	**Infrastructure and Facilities**	Ministry of Public Works and Public Resettlement	
7	**Economy**, with one sub-cluster: Food Security	Ministry of Agriculture	Ministry of Cooperatives and SMEs
8	**Early Recovery**	Ministry of Home Affairs	BNPB

There are 34 ministries in the Task Force for Acceleration of COVID-19 Response, which focuses its activities mostly on health-related issues.

However, as the impact of COVID-19 goes beyond health, the Coordinating Ministry of Human Development and Culture, as the Chair of the Steering Committee to the Task Force for the Acceleration of the COVID-19 Response, has taken the responsibility to coordinate the national cluster system. With that position, the Coordinating Ministry is linking the work of the national clusters with the Government's National Task Force for the COVID-19 Response. Currently, the national clusters and the working groups on Community Engagement, Information Management and Cash and Voucher Assistance are in the process to be embedded into the Task Force coordination efforts.

The Resident Coordinator in Indonesia provides leadership and strategic direction to the United Nations Country Team, consisting of 24 different UN agencies, funds and programmes. The RC also leads the work of the Indonesian Humanitarian Country Team, which brings together UN agencies supporting humanitarian emergencies, as well as the IFRC, the Indonesian Red Cross (PMI), and a representation of national and international NGOs. ICRC, MSF, the AHA Centre and UNDSS participate in the HCT with observer status.

Under this system, the international cluster leads work with their respective national counterparts to support the response in the country. UNOCHA, in its role as the inter-cluster coordinator, liaises with the Coordinating Ministry of Human Development and Culture and the National Disaster Management Agency (BNPB) who leads the operationalization of the National Task Force. The national clusters and working groups are facilitated and technically assisted by HCT members. Currently this is happening at the national level, with the expectation to be expanded to reach the most affected regions, in coordination with the Regional Task Forces for COVID-19.

The Regional Task Forces for COVID-19 are being created on the basis of the Presidential Decree that requested the governors and head districts/municipalities to form a local task force for acceleration of the COVID-19 response. The local Task Force is led by the Head of local government, and administratively it reports to the Head of local government. While the COVID-19 response at the local level is envisioned to be carried out with due regard to the direction of the Chief Executive of the Task Force at the national level, the Task Force at the national level does not have a direct link with the local level ones, except to provide guidance on the objectives, standards and procedures.

Members and partners of the national clusters may have a connection with the local task force through sectoral government offices members of the task force (such as Dinas Sosial of the Ministry of Social Affairs), directly to the local task force in case members/partners of the clusters have offices at the local level, or indirectly through their partners at the local level, who build links with the local task force.

Some partners of the national clusters, such as Humanitarian Forum Indonesia (HFI), Masyarakat Penanggulangan Bencana Indonesia (MPBI), Pujiono Centre and OCHA work to provide its non-government stakeholders and volunteers with coordination, information management and knowledge management services.

Private Sectors and State Own Enterprises collaborations

With regard to WFP's assessment on Private Sector capacity in responding to COVID-19 outbreak that one of the main supports come from the private sector actors, businesses and business associations, who step in and provide logistics services where there are delivery gaps in the capacity of the government includes

1. Customs clearance;
2. Storage, including handling, and warehouse & inventory management;
3. Transportation and distribution.

As the pandemic continues to spread in the country, it is then crucial for the National Logistics Cluster engage strategically with the relevant Private Sector entities and State Own Enterprises in the fulfilment of

the critical gaps whenever additional support is needed by the government COVID-19 Task Force, or the humanitarian communities. The initial structure of national coordination for COVID-19 is as follows:

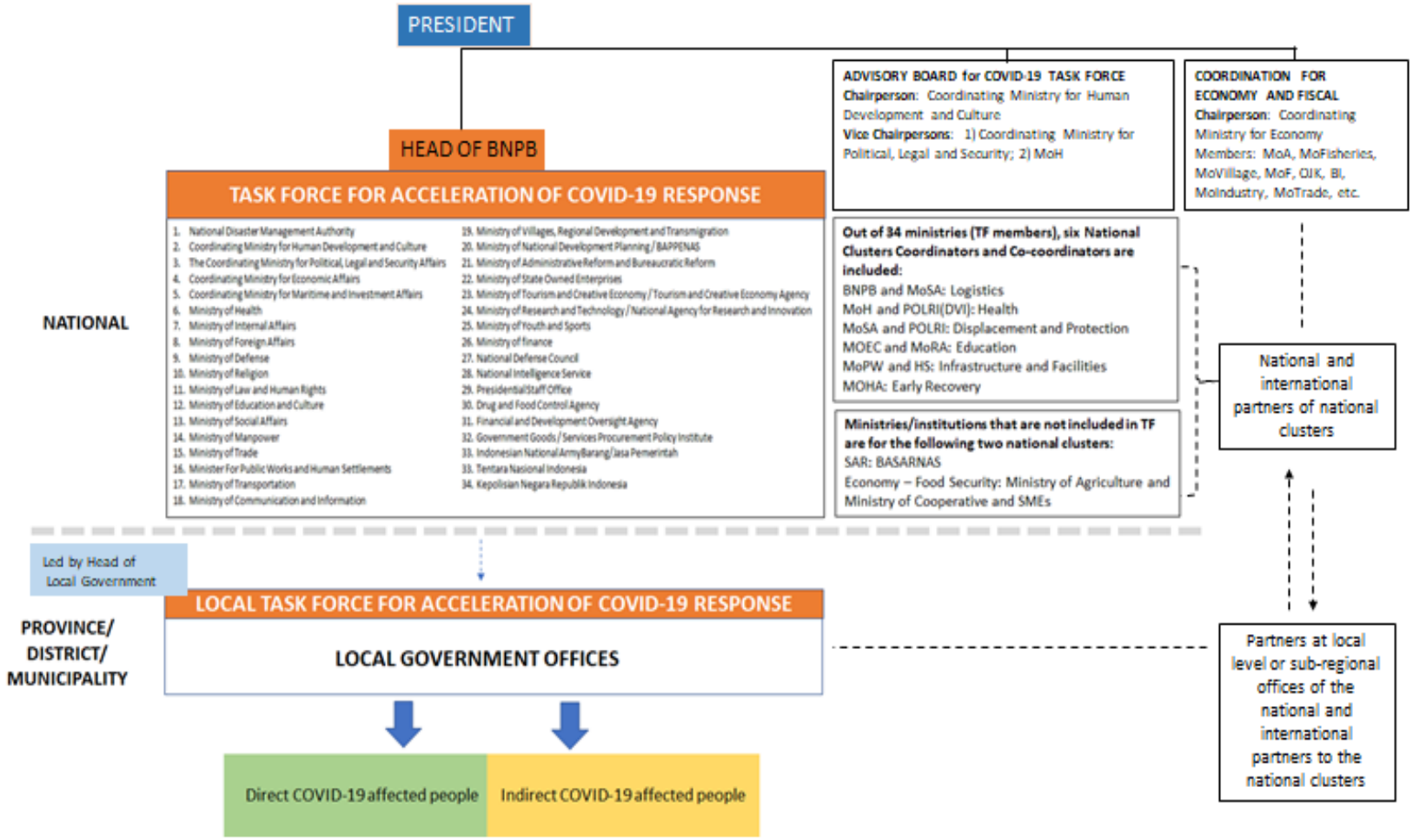


Figure 4: The initial structure of national coordination for COVID-19

The Committee for COVID-19 Response and the National Economic Recovery was created on 20 July through Presidential Regulation No.82 / of 2020, with the aim at integrating the health and economy measures in a balanced and integrated manner. The regulation establishes a committee comprising ministers within the cabinet tasked with developing policies and strategies to speed up the handling of COVID-19 and ensure economic recovery. The structure of the Committee is as follow:

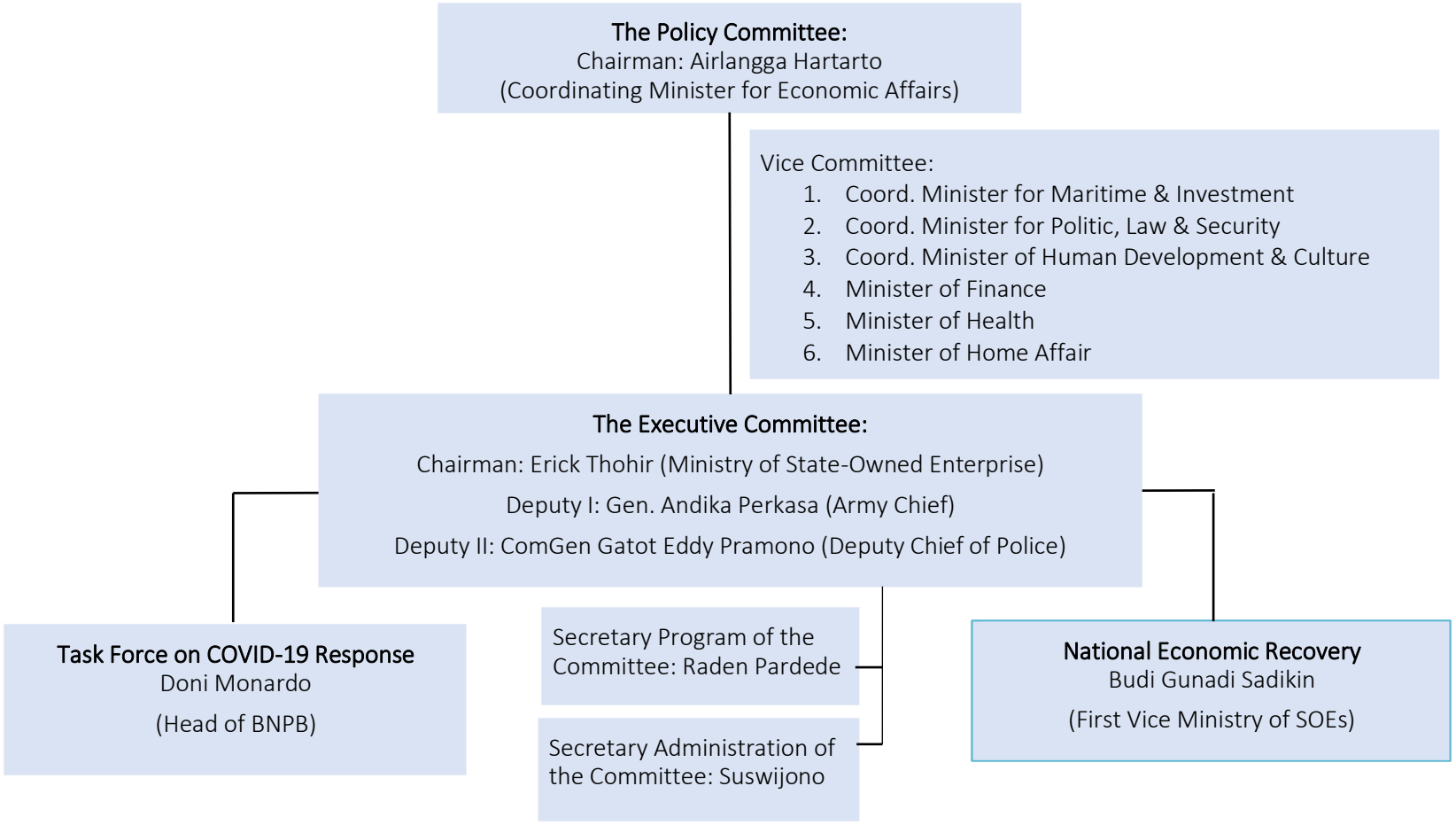


Figure 5: Structure of Committee for COVID-19 Response and the National Economic Recovery

This policy committee is led by the Coordinating Minister for Economic Affairs Airlangga Hartarto. The regulation further stipulates the creation of two task forces:

- The COVID-19 Health Response Task Force chaired by the Head of the National Disaster Management Agency Doni Monardo.
- The national Economic Recovery Task Force chaired by the Deputy Minister of State-Owned Enterprises Budi Gunadi Sadikin.

The regulation further appoints State-Owned Enterprises Minister Erick Thohir as the Chief Executive of the task force to coordinate the efforts of both task forces in ensuring their effectiveness in implementing the government's policies in mitigating the COVID-19 pandemic while maintaining the course for economic recovery. Further, Minister Thohir has established a Project Management Office (PMO) to execute and coordinate the implementation of both taskforces. The Regulation further instructs the dismissal of the COVID-19 (Gugus Tugas) Acceleration Task Force and its sub-national branches with their tasks to be handed over to the new COVID-19 Task Force structure.

In September, the Government of Indonesia also created a National Team for COVID-19 Vaccine Development Acceleration to ensure the advancement of vaccine production in Indonesia, synergy between research agency, national security and independency, and to increase of the capacity and the use of vaccine.

Indonesia does not have a dedicated coordination mechanism that addresses the relations between civilian and military organizations. Both works together and are integrated in a system, which is manifested in the structure of the Task Force for COVID-19 Response. In responding to COVID-19, in February 2020 the TNI started the following operations:

- Medical treatment operations
- Security operations
- Support operations

In these operations, TNI carries out medical assistance, logistics, deployment, and infrastructure building services, with tasks division based on regions: the western, central and eastern parts of the country, under each Joint Regional Defense Command (Kogabwilhan – Komando Gabungan Wilayah Pertahanan).

Under the Kogabwilhan I (western part), TNI created four Integrated Joint Task Command (Kogasgabpad - Komando Tugas Gabungan Terpadu) to manage quarantine/isolation locations and healthcare facilities in:

1. Wisma Atlet makeshift hospital in Jakarta, led by the Commander of Jayakarta Regional Military (Pangdam Jaya),

2. Sebaru Island of Thousand Islands, led by the Commander of the Navy's First Fleet Command (Pangkoarmada I),
3. Natuna Island in Riau Islands, led by the Commander of the First Air Force Operation Command (Pangkoopsau I), and
4. Galang Island in Riau Islands led by the Commander of the First Regional Military (Pangdam 1/BB).

Likewise, Kogabwilhan II in the central part and III in the eastern part are responsible for overseeing the mobilization of capabilities in their respective regions for the COVID-19 response, as a military operation other than war. At the sub-national level, military commands carry out tasks to manage the impact of the corona virus at least through two channels:

1. The developed Regional Task Forces for the Acceleration of COVID-19 response. Although it is not known how many task forces that TNI is engaged, it is not surprising that all of them have local TNI involvement.
2. The standing Regional Leadership Communication Forum (Forkopimda) at each local government, which consists of the head of local government, local chiefs of police, TNI and court.

V. – HCT AND UN COUNTRY TEAM RESPONSE STRATEGY

5.1. Objectives

In line with the Global Humanitarian Response Plan, the Strategic Preparedness and Response Plan and the UN framework for the immediate socio-economic response to COVID-19, the main goal of this HCT/UNCT Multisectoral Response Plan to COVID-19 is to support the Government of Indonesia's efforts in preparing and responding to the pandemic, and will be guided by three objectives:

1. Containing the spread of the COVID-19 pandemic and decreasing morbidity and mortality.
2. Decreasing the deterioration of human assets and rights, social cohesion and livelihoods.
3. Protecting, assisting and advocating for particularly vulnerable groups, such as refugees, pregnant woman, people with disabilities, elderly, internally displaced people, migrants and host communities.

5.2. Duration and Focus

The initial plan, with a focus on life-saving and early recovery activities is envisioned for an initial duration of six months, from April to September 2020, however HCT and UNCT members fully recognize the need for adaptation to the particular challenges of responding to COVID-19, as well as to adjust the plan as needs

may evolve or arise. Regular reviews of the plan based on the evolving situation are envisaged as a minimum after 4 and 6 months whereupon the plan may be extended or otherwise adapted to prevailing needs.
On 4 September, the UNCT and HCT agreed for an extension of MSRP implementation until 31 December 2020.

5.3. Priority areas

Seven priority areas have been established, with key lines of action linked to each priority, detailing the outcomes that the Plan aims to achieve. The seven priority areas are:

a. Health
b. Risk Communications and Community Engagement (RCCE)
c. Logistics
d. Food security
e. Mitigate the socioeconomic impact of the crisis
f. Critical multi-sectoral services
g. Protection of vulnerable groups

The objectives and priority actions for each of these priority areas are described in section VI below.

5.4. Response Principles

The response will be guided by principles advocating protection-focused and gender-appropriate interventions, including:

a. Disaggregate data related to the outbreak by gender, age, disability, ethnic group and geographic spread. Data related to outbreaks and the implementation of the emergency response must be disaggregated by sex, age, and disability and analyzed accordingly in order to understand the gendered differences in exposure and treatment and to design differential preventive measures.
b. Ground the response on strong gender analysis, taking into account gendered roles, responsibilities, and power dynamics. This includes ensuring that containment and mitigation measures also address the burden of unpaid care work and heightened gender-based violence (GBV) risks, particularly those that affect women and girls.
c. Strengthen the leadership and meaningful participation of women and children, adolescents, LGBTI, and persons with disabilities in key decision-making processes in addressing the COVID-19 outbreak. Ensure that all groups get information about how to prevent and respond to the epidemic in ways they can understand.

d. Include internally displaced communities, undocumented persons, mobile communities and indigenous peoples, refugees, asylum seekers and stateless persons, collectively known as persons of concern, in national preparedness and response plans, risk communication and outreach, surveillance and monitoring activities.
e. Ensure human rights are central to the response. Ensure nondiscrimination and equal treatment of individuals seeking assistance. Lockdowns, quarantines and other such measures to contain and combat the spread of COVID-19 should always be carried out in strict accordance with human rights standards and in a way that is necessary and proportionate to the evaluated risk.
f. Measures taken to relieve the burden on primary healthcare structures should prioritize access to sexual and reproductive health services, including pre- and post-natal healthcare, and access to physical rehabilitation.
g. Develop targeted women's and adolescent household head's economic empowerment strategies that are inclusive and age appropriate, or explore cash transfer programming, to mitigate the impact of the outbreak and its containment measures including supporting them to recover and build resilience for future shocks.
h. Follow the guidance to help protect children and schools from transmission of the COVID-19 virus, while ensuring learning continuity of learners and enhancing 21st century skills.
i. All responses must include proactive measures to ensure we do not inadvertently cause harm to people, nor undermine the values, standards and norms that underpin pour work. This includes being conflict sensitive, preventing or reducing the risks of gender-based violence, and upholding humanitarian principles.
j. Take concrete steps not to leave anyone behind in terms of digital connectivity.
k. Consider IASC and Sphere Standards guidance in response to COVID-19.

5.5. Monitoring

This plan will be monitored against a set of key indicators, in order to track progress and review performance to adjust the plan as needed. The indicators will monitor: (1) Achievements per priority area (2) Percentage of funding of the plan. (3) Percentage of utilization of funded activities.

An after-action review (AAR) will be conducted within three months of completion of the plan with the implementation period being subject to ending the status of global endemic and COVID-19 epidemiological situation in Indonesia.

5.6. Financial requirements

The following financial requirements are estimated for the implementation of the plan:

Priority area	Resource requirements (in USD)
Health	66,943,395
Risk Communications and Community Engagement (RCCE)	7,498,868
Logistics	236 954
Food security and agriculture	6,669,173
Mitigate the socioeconomic impact of the crisis	16,779,513
Critical multi-sectoral services	27,116,081
Protection of vulnerable groups	12,614,605
TOTAL	137,858,589

* Total resource requirements of the IFRC and PMI is US$ 6,867,000, which bring the total of US$ 144,725,589

VI – RESPONSE OPERATIONAL DELIVERY PLANS

Priority area 1: Health (including Reproductive Health, Mental Health and Psychosocial Support)

Government lead: MoH

Support lead: WHO

Partners: UNICEF; PMI; IFRC; UNDP; UNFPA; MSF; ICRC; UNAIDS, IOM, UNHCR, Save the Children, Nahdlatul Ulama, Muhammadiyah, Dompet Dhuafa, YAKKUM, WVI, Caritas Indonesia, Human Initiative

Objectives:

To support the Government of Indonesia to:

1. Suppress the human-to-human transmission of COVID-19
2. Provide care and support for patients affected by COVID-10 and their families
3. Ensure the continuity of essential health services during the pandemic
4. Strengthen the resilience of health systems at provincial and district level

Priority Actions:

1. To suppress the human-to-human transmission of COVID-19
    1. **Ensure adequate laboratory capacity**, incl. provision of reagents, supplies, laboratory protocols and SOPs, and supporting the implementation of quality assurance mechanisms and biosafety procedures
    2. **Enhance active case finding, contact tracing and monitoring**, quarantine of contacts and isolation of all cases
    3. **Improve the case-based and aggregate reporting systems and intensify COVID-19 surveillance** using existing respiratory disease surveillance systems, hospital-based SARI and primary care-based ILI surveillance, and community-based surveillance.
    4. **Prevent transmission of COVID-19 to staff, patients and visitors by supporting implementation of appropriate Infection Prevention and control (IPC) practices in health care facilities** including proper segregation of suspected, possible and confirmed cases from ANC, neonatal and maternal health units.
    5. Carry out research about COVID-19, such as **a population-based age-stratified sero-epidemiological survey** or **the global solidarity trial**. (WHO)
    6. Assess and enhance **national capacities at Points of Entry** - including airports, seaports, and land-based border crossing points - for infection prevention and control (IOM, for 2020 and 2021)
    7. **Ensure adequate laboratory capacity**, incl. provision of reagents, supplies, laboratory protocols and SOPs, and supporting the implementation of quality assurance mechanisms and biosafety procedures
    8. **Enhance active case finding, contact tracing and monitoring**, quarantine of contacts and isolation of all cases
    9. **Improve the case-based and aggregate reporting systems and intensify COVID-19 surveillance** using existing respiratory disease surveillance systems, hospital-based SARI and primary care-based ILI surveillance, and community-based surveillance. (UNICEF)

10. **Prevent transmission of COVID-19 to staff, patients and visitors by supporting implementation of appropriate Infection Prevention and control (IPC) practices in health care facilities** including proper segregation of suspected, possible and confirmed cases (UNICEF)

2. To provide care and support for patients affected by COVID-19 and their families
   1. Support the **mapping of public and private health facilities and the assessment of their capacities**, as well as the establishment of **referral mechanisms** from Puskesmas [community health care] to higher level of health facilities.
   2. **Improve capacities** of ICUs, primary and secondary level hospitals, alternative community health facilities, and the referral system, including **the provision of medicines, PPE and health equipment**.
   3. Collaboration with **tele-health service providers for triage and monitoring of health** status of patients with mild symptoms; and facilitation of telemedicine online platforms.
   4. Build the **capacity of health workers** in health facilities, laboratories, pharmacies and transportation)
   5. Integrate **mental health and psychosocial support services** (MHPSS)
   6. Supporting the delivery of **incentives schemes for the health workers**
   7. Support the provision of **health waste management technical assistance**- upgrading, provision, and instalment of autoclaves and incinerators-, to reduce exposure to biological hazards and contaminants.
   8. Support national counterparts in the field of **management of dead bodies**

3. Ensure the continuity of other essential health services during and after the pandemic
   1. **Assessment of ongoing comprehensive and essential health service delivery** to identify gaps in each programme area as well as systemic needs at each level of care;
   2. Development of a **roadmap for the phased reduction of services** from comprehensive to essential health services; and subsequent reversal
   3. Development of **action plans for the delivery of essential health services and availability of adequate medical human resources**;
   4. **Optimization of service delivery** settings and proposition of **alternative models for delivery of care (**telemedicine, web-based, apps etc.) for other essential health services;
   5. **Improvement of data collection, analysis and sharing mechanisms** (digitalization)
   6. Enhancement of **online training options**
   7. Identification of **mechanisms to maintain the availability of essential medications, equipment, and supplies**
   8. Support the **continuation of essential health services such as** the prevention and treatment of communicable and noncommunicable diseases, vaccinations, critical inpatient therapies, emergency health conditions and common acute presentations requiring time-sensitive intervention, auxiliary services, services related to reproductive health, family planning, maternal, newborn and child health, and care for vulnerable populations, such as newborns, children, older adults, refugees, migrants, people with HIV-AIDS, etc.

9. **Protect population seeking care for conditions other than COVID-19** through the establishment of **SOPs, screening and triage** of all patients on arrival at all sites, including through mechanisms in all care sites for isolation of patients meeting the case definition for COVID-19
10. Establish **clear criteria and protocols for transporting patients** from community to hospitals or between services

4. Strengthen the resilience of health systems at provincial and district level
    1. Development of **provincial recovery plans**
    2. **Strengthening of the surveillance and case detection** system
    3. Training and SOPs **for outbreak investigation and appropriate lab referrals**
    4. Strengthening of **IPC** at health facilities
    5. Improvement of **patient flow and quality at infectious disease hospitals** and wards
5. Support vaccine readiness, implementation and monitoring

    With the anticipated introduction of viable COVID-19 vaccines in the country, support will be provided to the Government for vaccine readiness and implementation including political and technical advocacy, strengthening supply side systems, improving demand generation for vaccines, regular data & monitoring and ensuring routine immunization services are not disrupted (UNICEF)

Linkages with other clusters and sectors: Logistics (for the procurement of medical supplies); Multisectoral (for waste management); Risk communications; Protection (access to health care)

Total funding requirements: 67,328,395 USD

WHO: 26,000,000; Save the Children: 300,000; UNDP: 2,400,000; UNFPA: 808,578; UNICEF: 8,052,431; IOM: 4,900,000 USD; UNHCR: 405,270; UNOPS: 12,000,000; Muhammadyah: 7,800,000; Nahdlatul Ulama: 2,787,150; Human Initiative: 300,000; Wahana Visi: 813,366; Dompet Dhuafa: 85,000; Yakkum: 212,000; Caritas Indonesia: 49,600

Priority area 2: Risk Communications and Community Engagement

Government lead: BNPB, KOMINFO

Support lead: UNICEF, IFRC

Partners: : WHO, WVI, MPBI, HFI, CARE, UNFPA, PMI, Nahdlatul Ulama, Muhammadiyah, Caritas Indonesia (KARINA), YAKKUM, Oxfam, UNAIDS, Save the Children, IOM, UNESCO, Planas PRB, Dompet Dhuafa, Human Initiative, Rebana Indonesia, PGI, Rumah Zakat, BAZNAS, FAO

Priority objectives:

1. Build public **trust** in national authorities on public health information and instructions related to COVID-19.
2. Provide a RCCE **guiding framework** and **coordinated** approach to enable an effective country response.

3. Ensure all RCCE **approaches, messages, and materials** shared at all levels and in all phases of the response are based on technically accurate medical and public health science.
4. Promote and facilitate participatory **community engagement** to improve people's knowledge, motivate action, reduce stigma and create an enabling environment for change to contain the spread of virus.
5. Scale up RCCE approaches at national and sub-national levels to promote and sustain critical behaviors during the **various phases** of the response: RESPOND – RECOVER – RESTORE.

Priority Actions

I. Support to national and sub-national authorities

1. Support the development and implementation of national and sub-national **risk-communication and community engagement strategy**.
2. Build the **capacity** of national and subnational authorities, including government officials, programme managers and providers, and community-based organizations on **prevention and response in order to support RCCE plans** at national and sub-national levels. This includes FAO and the Ministry of Agriculture training on cleaning, disinfectant and RCCE implementation to representatives of the slaughterhouses, and markets, and local animal health services in the Greater Jakarta area, Solo, Surabaya, and Medan.

II. Coordination of partners

1. Establish and coordinate a **mechanism to promote collaboration among key stakeholders** and partners including national authorities, UN agencies, NGOs, religious groups and the private sector to ensure a coordinated response through mapping capacities of all partners, consolidation of resources, planning of activities and frequent information sharing to address uncertainty and perceptions and managing misinformation.

III. Communication and community engagement

1. **Public awareness**: Develop and disseminate **messages and content on COVID-19 for key stakeholders and at-risk groups** that are accessible for everyone with different abilities and in local languages, through mass media, including digital media, radio, SMS, and other channels, in order to reduce transmission, minimize mortality, combat stigma, and ensure preventative measures reach the affected populations, especially the most vulnerable.
2. Develop and disseminate **messages related to the 'new normal'** in all settings (health facility, public places: market, public transportation stations, schools, industry/private sectors, etc.) WHO
3. **Community engagement:** Design, implement and amplify **cultural and gender/age appropriate behaviour change and engagement interventions** in collaboration with community-based organizations, faith-based organizations, women led NGOs, youth organizations and other influencer networks, in support of programme interventions at community and facility levels, including with vulnerable groups.
4. **Advocacy**: Advocate for evidence-based **policies and interventions** to mitigate the immediate and secondary, longer-term impact of the pandemic.
5. **Documentation:** Document and disseminate **lessons-learned and case studies to inform future preparedness and response** activities. This includes designing and conducting periodic rapid assessment polls to assess public perceptions, knowledge and understanding about the risk of the disease, concerns, and practices, in order to inform the development of messages and interventions.

Linkages with clusters and sectors: Health, Multisectoral services, Protection of vulnerable groups
Total funding requirements: 7,498,868 USD UNICEF: 2,663,200; WHO: 1,000,000; OXFAM: 200,000; UNAIDS: 50,000; Save the Children: 125,000; UNFPA: 188,615; IOM: 400,000; MPBI: 34,000; CARE: 150,00; UNHCR: 113,520; UNDP: 250,000; Muhammadyah: 750,000, Nahdlatul Ulama: 929,050; Wahana Visi: 406,683; Human Initiative: 100,000; Dompet Dhuafa: 100,000; Caritas Indonesia: 24,800; Yakkum: 20,000; Planas: 34,000; HFI Secretariat: 10,000; FAO: 100,000

Priority area 3: Logistics

Government lead: BNPB, Kemenko PMK
Support lead: WFP
Partners: Indonesian Red Cross (PMI), Relevant private sector entities and State Own Enterprise (ALFI, ALI, ARPI, ASPERINDO and PT POS Indonesia)
Priority objectives: 1. Support the Government-led **National Logistics Cluster's coordination** aiming to minimize duplication of efforts, provide a platform to identify and address common challenges, ensure effective engagement with key inter-agency and/or cross-sector forums, promote sharing of technical expertise, and engage in advocacy to highlight operational challenges; 2. Develop a **Logistics Concept of Operations** based on existing logistics gaps and capacities, aimed to improve efficiency and effectiveness of emergency logistics operations, and ensure alignment with the Government's Operational Plan; 3. Support the Government and humanitarian community in **facilitating the private sector's engagement to ensure the necessary logistics services** can be made available and are accessible to all stakeholders.

Priority Actions:
i. Provide coordination support to the Government-led National Logistics Cluster The following coordination activities are intended to minimize duplication of efforts, provide a platform to identify and address common challenges, ensure effective engagement with key inter-agency and/or cross-sector forums, promote sharing of technical expertise, and engage in advocacy to highlight operational challenges. 1. Establish a dedicated **coordination cell under the NLC**, aiming to strengthen cooperation, synchronize response efforts, and identify shared supply chain challenges; 2. **Coordinate mobilization of technical expertise** within the NLC and the humanitarian logistics community to evaluate the context and identify emerging issues and concerns; 3. **Provide appropriate venues** to discuss sector-specific logistics operations;

4. **Support the ongoing logistics coordination's efforts** undertaken **by local government institutions**, mainly focusing on provinces with pre-established logistics clusters.

i. **Provide a logistics related information management and sharing mechanism to the wider humanitarian community**
   1. **To support operational decision-making, respond to logistics challenges identified and improve the efficiency of the logistics response, the following activities are currently being prepared:**
   2. **Establish a dedicated portal/webpage for information management aimed at collecting and consolidating logistics data. This dedicated webpage will allow the COVID-19 response community to have access to logistics-related information, Government procedures, SOPs, Logistics Capacity Assessment (LCAs) data, logistics related maps, infographics, etc.;**
   3. **Advocate and facilitate the issuance of relevant Standard Operating Procedures (SOPs) in emergency logistics operations;**
   4. **Provide internal support on mapping the Supply Chain capacity for COVID-19.**

III. Facilitate the engagement of private sector in the provision of logistics services. The services facilitated by the NLC are not intended to replace the logistics capacities of any agencies or organizations, but rather to complement through access to the pre-committed logistics services as part of NLC strategy established during the preparedness phase.
   1. **Coordinate the provision of necessary logistics services from NLC members** based on their existing capacities and resources.
   2. **Facilitate the provision of specific services required from the NLC members** and/or wide range supply chain actors in the country, such as cold chain operations, inventory management, commodity tracking, etc.
   3. **Advocate formal activation of alternative international entry points and hubs** in several major cities in the country to facilitate the distribution of critical supplies throughout the country, as stipulated in the Ministry of Health Operational Plan, to which WFP contributed during the development process.

Additional actions (up to December 2020)
Develop IEC materials for information sharing and educational purposes related to COVID-19 response.
Develop a national strategy of commercial supply chain for essential commodities during COVID-19 pandemic.
Cold Chain capacity mapping in anticipating the upcoming needs of COVID-19 vaccines.

Linkages with clusters and sectors: Health, Protection, Multisectoral services. The National Logistics Cluster provides services for other clusters as required.

Total funding requirements: 236,954 USD
WFP: 236,954

Priority area 4: Food security

Government lead: Coordinating Ministry of Economic Affairs (CMEA), BAPPENAS, Ministry of Agriculture (MoA), Ministry of Marine Affairs and Fisheries (MMAF)

Support lead: WFP and FAO

Partners: Dompet Dhuafa, Caritas Indonesia (KARINA), Nahdlatul Ulama, Muhammadiyah, Islamic Relief Worlwide, Sky Volunteer, IBU Foundation, Bina Swadaya, Perkumpulan Scale Up, Prudential Institute for Community Development, Pramuka Peduli Kalimantan Timur.

Support objectives:

1. Support the Government of Indonesia through an updated and **real-time analysis of the impact of COVID-19 on overall food security and food-system livelihoods** in Indonesia.
2. Support Government institutions' efforts to ensure continuous availability and accessibility of food commodities by **identifying the possible actions to mitigate the impacts of the COVID-19 outbreak** in three topics related to food security: (a) institutional responsibilities; (b) continuity of food production; (c) continuity of supply/value chains.

Priority Actions:

i. Support the Government and other stakeholders to develop an updated analyses of the impact of COVID-19 on overall food security and food systems in Indonesia through:

2. **Evidence-based analyses** for improved targeting and **timely response to the impact of COVID-19 on food security** and food system livelihoods among vulnerable elements of the population.
3. **Strengthening of institutional capacities** for the management of data and information, in close coordination with existing provincial monitoring capacities, to **enhance the analytical capacity** of the concerned Ministries and agencies for informed decision-making processes by the 'Food Task Force' (*Satgas Pangan*).

ii. Support Government institutions' efforts to ensure continuous availability and accessibility of food commodities by identifying the possible actions to mitigate the impact of the COVID-19 outbreak in three areas related to food security: (a) institutional responsibilities; (b) continuity of food production; (c) continuity of supply/value chains.

Short-term measures:

1. Support the Government of Indonesia in the area of policy through:
    a. Development of **policies for the removal of impediments to the food production and distribution in supply chain** that has been inadvertently introduced through aspects of the large-scale-social-restriction arrangements;
    b. Development of **policies to ensure the health/safety of agricultural labour force** while having adequate freedom of movement.
2. Strengthen **access to inputs by supporting the following activities**:
    a. Map actual and potential **food needs** across the country;
    b. Target procurement and distribution of essential **agricultural inputs**;

c. Ensure **agricultural inputs remain available for sale** during the large-scale-social-restriction and transport and logistics of these items remains unhindered;
d. Establish mobile units to **support livestock production** (including veterinary services) in poorest areas.

3. Support controlled movements of agricultural labour to fill gaps in labour availability, under clear social distancing guidelines.
4. Contribute to effective **logistic arrangements**:
   a. Ensuring current transportation capacity is maintained and in place, with inter-provincial transport routes fully open to movement of foodstuffs, together with the availability of refrigeration and storage points in main markets, to enable food access and minimize food losses along the supply chain and at selling points;
   b. Consideration is given to **integrating capacities with the private sector**, including the capillary online selling/distribution platforms.
5. **Financial Support**: Consider stimulus packages for more affected groups, such as interest-free agricultural loans or grants.

Medium term measures (should lockdown continue for longer than anticipated):

6. Complete a comprehensive **study of the medium and long term impact of large-scale-social-restriction measures** on Indonesia's food production and distribution system based on primary (if possible) and secondary data and use the results to implement subsequent corrective actions to address barriers and imbalances that have emerged.
7. **Modernise the marketing and buying arrangements for food in the rural areas**, introducing electronic transactions, vertically integrated ordering, pick-up and delivery system, and with the full engagement of the private sector, in order to ensure connectivity and e-banking services penetration, including in remote areas.

Linkages with clusters and sectors: Economy Cluster (under the coordination of Coordinating Ministry on Economic Affairs (CMEA); Logistic cluster

Total funding requirements: 6,669,173 USD

No funding required for WFP; activities will be covered through existing resources.

Immediate funding allocation from FAO on Covid-19 response: 276,073 USD to be allocated to develop a Roadmap and provide targeted technical assistance to the Government.

Muhammadyah: 1,550,000; Nahdlatul Ulama: 3,716,200; Human Initiative: 600,000; Dompet Dhuafa: 170,000; Caritas Indonesia: 49,600; Islamic Relief Worlwide: 156,000, Sky Volunteer: 4,000, IBU Foundation: 67,800, Bina Swadaya: 6,800, Perkumpulan Scale Up: 3,400, Prudential Institute for Community Development: 67,800, Pramuka Peduli Kalimantan Timur: 1,500.

Priority area 5: Mitigate the socioeconomic impact of the crisis

Government lead: Kemenko PMK/KemenkoEk/Bappenas/BNPB

Support lead: UNDP

Partners: Partners: UNICEF, ILO, UNWOMEN, UNFPA, IOM, UNIDO, ADB, CARE, OXFAM, UNAIDS, OCHA, FAO, WFP, Save the Children, IFRC, PMI, MPBI, Planas PRB, HFI, Human Initiative, Nahdlatul Ulama, Muhammadiyah, Dompet Dhuafa, WVI, YAKKUM, ADRA Indonesia, BAZNAS, Caritas Indonesia, Habitat for Humanity Indonesia, Rumah Zakat, Bina Masyarakat Peduli (BMP), Christoffer Blinden Mission (CBM), Catholic Relief Services (CRS), IBU Foundation, Islamic Relief, Kelompok Kerja Sosial/ Perkotaan (KKSP), Lingkar, Sehati, Solider Suisse, Suar, Paluma, Yayasan Baiturrahim Makassar, Yayasan Plan International Indonesia (YPII) Yayasan Sapta Visi Madani (Yasavima).

Support objectives:

1. To provide effective and timely **support to the Government at the national and sub-national levels** in **addressing socio-economic impact of COVID-19**, with particular emphasis of vulnerable groups and households;
2. Provide **advice** to the Government of Indonesia on effective policies and **adjustment of existing as well as new social protection measures** to ensure that vulnerable people are able to better withstand the immediate and secondary effects of the COVID-19 crisis;
3. Provide **support to key stakeholders, especially the business community and small-medium scale enterprises**, particularly those led by women, to implement adequate **measures for immediate response and recovery**, to mitigate the immediate impact and secondary impact of the COVID-19 crisis, and sustain their business and the jobs they create.
4. Provide direct support to **Indonesia's most vulnerable population**, particularly women, children, people with disabilities and marginalized groups to **safeguard them from the socio-economic impact of the COVID-19 crisis**.

Priority Actions:

1. Mezzo-level assessment of the impact of COVID-19 crisis on selected economic sectors with significant impact on employment and incomes, and development of recommendations for overcoming the crisis while adhering to the principle of building back better and enhancing resilience;
2. Assessment of the impact of COVID-19 crisis on micro, small and medium enterprises;
3. Socio-economic impact assessment of the COVID-19 pandemic on households in hardest hit areas, including potential secondary and tertiary impact - with particular focus on vulnerable groups, including women, self-employed, daily workers, migrant households, and people living with disabilities – covering areas of livelihoods, employment, remittances, labour exploitation/human trafficking and access to social services and strengthening their resilience to shocks. The assessment will be followed by recommendations on policy and programmatic measures and actions for implementation to mitigate the impact of the crisis on the most vulnerable and prevent them from sliding back to poverty. Assessment of impacts COVID-19 on international migration from Indonesia, wider impact of decline of remittances, consequences on human trafficking and labour exploitation, and internal migration patterns during pandemic.

4. Support designing of policies and leveraging existing as well as innovative instruments for social protection for mitigating impact of the COVID-19 pandemics on the most vulnerable.
5. Implement support programme to SMEs, with a focus on women entrepreneurs
6. Support to the national and sub-national counterparts in coordination of cash transfers and voucher assistance, ensuring adequate linkages between crisis interventions and existing social protection mechanisms to target the most vulnerable and most affected population in a coordinated and timely manner.
7. Initiate implementation of **initiatives with quick impact to** ease socio-economic challenges of the most vulnerable and disadvantaged groups.
8. Support the government in identifying opportunities and preparing for scaling up response measures toward medium and longer-term recovery support which focuses on green recovery and human development is centered on a multi-sectoral approach. This also support for the development of contingency plans during a pandemic of outbreak of disease. (UNDP)
9. Support the government in development of protection schemes for business sector with focus on MSME by exploring the potential of developing a micro-insurance mechanism to cover business interruption in relation to disaster risks that are not classified as catastrophes. (UNDP)
10. Support vocational training institutions to adopt online delivery of skills development. (ILO)
Linkages with clusters and sectors: Protection, Economy, Food Security, Logistic, Health and others as relevant.
Total funding requirements: 16,779,513 USD OXFAM: 550,000; UNAIDS: 210,000; Save the Children: 150,000; UNICEF: 3,528,000; IOM: 1,000,000; UNFPA: 150,000; MPBI: 34,000; UNIDO 50,000; UNDP 3,350,000; CARE 300,000; UNWOMEN: 320,000; Muhammadyah: 1,550,000; Nahdlatul Ulama: 3,716,200; Human Initiative: 600,000; Dompet Dhuafa: 175,000; Caritas Indonesia: 48,947; Wahana Visi: 813,366: Platform Nasional: 34,000; ILO: 200,000

Priority area 6: Critical multi-sectoral services

Government lead: Coordinating Ministry for Human Development and Culture, MoSA,
Support lead: IOM for CCCM; IFRC for SHELTER: UNICEF for WASH and NUTRITION
Partners: UNICEF, IFRC, WVI, UNDP, ILO, WHO, UNHCR, UNFPA, IOM, ITU, HFI, PMI, MPBI, Planas PRB
Support objectives: 1. Support to ensure **infection-free, continuity, and safety of critical services, including health, water and sanitation, nutrition, food and non-food items, shelter, protection, and education for at-risks population and groups** most exposed and vulnerable to the pandemic. 2. Support the **coordination of government and non- government actors sectoral response** at national and sub-national level in the context of COVID-19, including through the provision of **Information Management (IM)** materials and tools to enable evidence-based humanitarian decision making based on the evolving scale of the pandemic in the country, needs, and support required in ensuring the delivery of critical multi-sectoral services.

3. Support the **delivery of multi-sectoral COVID-19 assistance to vulnerable population** whose conditions are exacerbated due to COVID-19, including internally displaced persons (IDPs), refugees and asylum seekers, migrants, survivors of gender-based violence, children, people with disabilities, older persons, people of concern and host population groups who are particularly vulnerable.
4. **Advocate** for measures to be in place to **address COVID-19 pandemic in camps and camp-like settings and the surrounding host communities**.
5. Support the provision of **information management platforms** and training available for responders to identify and coordinate the multi-sectoral responses.

A. Camp Management

Government lead: Ministry of Social Affairs and PUPR

Support lead: IOM

Partners: UNICEF, IFRC, WVI, UNDP, WHO, UNHCR, UNFPA, Save the Children, Muhammadiyah Disaster Management Centre (MDMC), Dompet Dhuafa, Yakkum Emergency Unit (YEU), Badan Zakat Nasional (BAZNAS), Karina, Humanitarian Forum Indonesia (HFI) Secretariat, Forum Zakat (FOZ), Human Initiative (HI), Lembaga Penanggulangan Bencana dan Iklim Nahdatul Ulama (LPBI-NU)

Priority Actions:

1. Support the **mobilization of the National Cluster on Displacement and Protection**, at national and sub-national levels, to effectively respond to multi-sectoral impacts of COVID-19 through regular coordination meetings with government and non-government stakeholders, needs assessment and development of response plans in outbreak areas
2. Conduct **mapping and tracking of the multi-sectoral needs of quarantine and isolation locations established nationwide** to provide an evidence base for assessment of management arrangement, health and multi-sectoral needs, compliance with minimum standards
3. **Site planning and improvement to ensure effective COVID-19 prevention and mitigation** in displacement sites, points of entry, and transit shelters
4. **Review and plan modalities of service and assistance provision and activities on site** (food, NFI and other types of distribution of assistance, registration/enrolment for assistance, education, protection services etc.) by incorporating COVID-19 sensitive measures.
5. **Capacity building for service providers and frontline responders**, including Ministry of Social Affairs community volunteers (Tagana) and other community groups, to support critical services, including in displacement sites, densely populated areas, in quarantine facilities.
6. **COVID-19 prevention capacity building for the personnel working in collective sites, introduction and information dissemination on self-protection measures, and effective utilization of Personal Protection Equipment (PPE).**

Linkages with clusters and sectors: Protection of vulnerable groups; Risk Communication and Community Engagement; Shelter

B. Shelter

Government lead: Ministry of Social Affairs and PUPR

Support lead: IFRC

Partners: IFRC, WVI, UNDP, PMI, Habitat for Humanity Indonesia, Human Initiative

Priority Actions:

1. Support for coordination of the shelter sector, including:
   a. creation of Coivid-19 specific guidelines for the shelter sector
   b. Covid-19 specific coordination meetings and events
   c. Information and knowledge management support to the Ministry
   d. Training for cluster partners and ministry staff on shelter and covid shelter guidelines
   e. Ongoing analysis and coordination support for emerging shelter needs
2. Shelter Opportunity Surveys in deeply affected areas. Assisting local governments to coordinate with both private and public sector landlords for temporary use of existing facilities for:
   a. Emergency Shelter assistance for migrating and displaced families stuck between provinces
   b. Self-isolation and self-quarantine facilities
   c. Housing for families of those seeking medical assistance
2. Decongestion support programs for heavily congested camps, barracks and urban slums
3. Advocacy with government and private sector for rental support and moratoriums on evictions
4. Sector preparedness and contingency planning for parallel natural disaster response, including:
   a. development and dissemination of suitable guidelines,
   b. contingency stock and response capacity mapping

Linkages with clusters and sectors: Protection of vulnerable groups; Risk Communication and Community Engagement, Mitigating the socioeconomic impact of the Crisis; Camp Management; WASH

C. Education

Government lead: Ministry of Education and Cultural (National Secretariat of School Safety), Ministry of Religious Affairs

Support lead: UNICEF

Partners: Save The Children, HFI, Muhammadiyah, Nahdlatul Ulama, WVI, Caritas Indonesia, PGI, Rumah Zakat, BAZNAS

Priority Actions:

1. Provide technical support to the Ministry of Education and Culture (MoEC) and the Ministry of Religious Affairs to enhance education system-level response to the pandemic

2. Support to MoEC crisis management team including, technical assistance, coordination and communication of activities, including the development and dissemination of school guidance on Preparedness and Response to COVID-19 as well as for safe school reopening including clean-up for schools
3. Strengthening coordination capacity of sub-national governments in their role in responding to the crisis by activation of Education Post
4. Provide support for continued learning during school closure for the most vulnerable population
5. Support the planning and implementation of safe school operations and risk communications
6. Enhanced knowledge sharing and capacity building both for the current response and future pandemics
7. Review and update of Education Cluster COVID-19 response plan
8. Support dissemination of Emergency Curricula
9. Support in the development of Digital learning ecosystem during COVID-19
Linkages with clusters and sectors: Protection of vulnerable groups, MHPSS, RCCE, WASH, Nutrition.

D. WASH
Government lead: BNPB, Ministry of Health, Ministry of Education, Ministry of Public Works, MoSA
Support lead: UNICEF
Partners: Save The Children, Oxfam, PMI, Dompet Dhuafa, WVI, Human Initiative, PGI, Rumah Zakat, Muhammadiyah, Nahdlatul Ulama, BAZNAS
Priority Actions:
1. Provide **technical support and assistance** to BNPB, Ministry of Health, Ministry of Education, Ministry of Public Works, MoSA and other WASH sector leaders to accelerate behaviour change interventions through development and dissemination of **guidance for hygiene promotion, IPC, disinfection and waste management** to ensure sustainability in WASH services and reduce the risk of COVID-19 recurrence.
2. **Facilitation of WASH Cluster** to coordinate WASH sector response plan and COVID-19 related training to WASH Cluster partners.
3. **Engage the private sector to mobilise support** for COVID response in hygiene promotion behaviour change in public places, their workplaces, surrounding communities and as an innovations partner to the Government.
4. **WASH risk assessments for improving access to WASH services and support for long-term advocacy, planning and capacity building/governance** for sub-national government in support of improved WASH services in COVID hotspot areas
5. **Support to new normal COVID protocols** such as safe schools' protocols, rolling out national monitoring system to inform national HWWS interventions, and strengthening post-COVID implementation of the national sanitation and hygiene programme (STBM) through development of a sustainable hygiene behaviour change training programme
Linkages with clusters and sectors: Protection of vulnerable groups, MHPSS, RCCE, Shelter

E. NUTRITION
Government lead: BNPB, Ministry of Health, Ministry of Education, Bappenas, MoSA, MoHA
Support lead: UNICEF
Partners: Save The Children, Caritas Indonesia, Rumah Zakat, BAZNAS, YP2KP, GMIT, Yayasan Jenewa, YADUA
Priority Actions:
Provide technical support to the Ministry of Health and Bappenas in **strengthening their nutrition preparedness and response capacity**, especially in the context of COVID-19 pandemic
Support the **procurement of essential nutrition supplies** to ensure continuity of services
Support the social behavior change **communication on nutrition** in the context of COVID-19 pandemic to raise the awareness on various nutrition issues and generate demand for essential nutrition services
Provide support to strengthen **government coordination on nutrition** in the context of COVID-19 pandemic
Lead **inter-agency coordination** of COVID-19 response efforts being made by UN agencies in the areas of nutrition and food security
Provide technical support in ensuring the continuity of essential nutrition services, and strengthening capacities of national and sub-national government, health workers, and community volunteers, especially in the context of COVID-19 pandemic
Support the design, implementation and dissemination of rapid assessments of nutritional status and continuity of essential nutrition services, especially in the context of COVID-19 pandemic
Linkages with clusters and sectors: Education, WASH, child protection, MHPSS, Social protection, RCCE
Total funding requirements for Critical multi-sectoral services: USD 27,116,081 Save the Children: 300,000; UNICEF: 10,015,968; IOM: 5,000,000; Oxfam: 400,000; CARE: 200,000; UNHCR 600,711; Muhammadyah: 3,200,000; Nahdlatul Ulama: 5,574,300; Human Initiative: 400,000; Wahana Visi: 1,220,049; Dompet Dhuafa: 130,000; Caritas Indonesia: 75,053

Priority area 7: Protection of vulnerable groups

Government lead: MOSA, BNPB, Refugee Task Force, MOWECP, Komnas HAM, Directoratre General of Prisions, Directorate General of Corrections, National Narcotics Board.
Support lead: UNHCR, UNFPA
Partners: Humanity & Inclusion, UNAIDS, UNODC, UNAIDS, UNICEF, IOM, UNDP, UN Women, Save the Children, WVI, HFI, OXFAM, CARE, ICRC, PMI, Nahdlatul Ulama, Muhammadiyah, Caritas Indonesia, YAKKUM, Dompet Dhuafa, Rumah Zakat, ADRA Indonesia
Support objectives:

2. **Ensure and strengthen protection mechanisms** including the provision of **prevention mechanisms, continuation of critical services and referral pathways** to vulnerable populations are in place, including uninterrupted access to health, legal services, social and financial assistance, safe places, alternative care and case management without discrimination or harm. Vulnerable groups include ethnic minorities, marginalised groups, gender-based violence survivors, children without parental care, stateless people, refugees, IDPs, detainees, prisoners, women, older people, persons with disabilities, victims of trafficking, people with HIV and people affected by HIV and those marginalized through stigma and discrimination on the basis of their sexual orientation or sex work, migrant workers, health care providers and their families.
3. Provide **primary basic hygiene materials to the most vulnerable groups** including (non-surgical masks, hand sanitizer, clean water, and soap) and other essential supplies.
4. Ensure all **COVID-19 policies, regulations, guidelines are inclusive and non-discriminatory** through policy advocacy and capacity building/ awareness-raising activities and systemic readjustment with the policy makers.
5. Ensure the most vulnerable groups have **access to critical, practical and accurate information in a language and format they can access and understand** so that they can make informed decisions to protect themselves and their families and to **provide feedback** to the service providers including humanitarian actors.
6. Provide **capacity building to stakeholders**, including national/ regional/ provincial government, midwives and health providers, civil societies societies, and other development/ humanitarian partners in aiding and monitoring services to the vulnerable groups.

Priority Actions:	
1.	Backgrounds and initial rapid assessments
2.	**Protection mechanism and Referral pathway** (access to health, legal services, safe place, advocacy, case management)
3.	Access to primary COVID-19 **prevention and hygiene supplies** (masks, hand sanitizer, clean water and soap) and other logistics for survival. This includes ongoing survey to assess the resilience of refugees during COVID-19 pandemic
4.	Access to **social and financial assistance** (exploring cash for protection modalities and associated risks)
5.	**Risk communication and community engagement** materials (lifesaving information)
6.	**Capacity building and awareness creation**, and support to accountable feedback mechanisms
7.	**Online legal counseling** for PLHIV and Key Affected Populations
8.	Supports community and civil society organisations to **conduct rapid assessments about vulnerable groups** during the pandemic. This includes another batch of COVID-19 cash assistance to refugees
9.	The prison/corrections services implement effective and evidence-based infection, prevention, and control (IPC) measures as part of the overall COVID-19 responses in the community
10.	Support COVID-19 prevention and management in drug treatment centers
11.	Strengthen the front liners capacity on the Mental Health Psychosocial Support and clinical management of rape for survivors.

Linkages with clusters and sectors: Health, Logistics, Risk Communication and Community Engagement, Multisectoral Services
Total funding requirements for 2020: USD 12,614,605 UNFPA: USD 1,270,635; UNHCR: USD 2,333,704; UNDP: 240,000; Oxfam: 150,000; UNAIDS: 50,000; Save the Children: 300,000; IOM: 1,700,000; ITU: 50,000; UNICEF: 2,627,800; UN Women: 330,000; CARE: 150,000; UNWOMEN: 150,000; Muhammadyah: 750,000; Nahdlatul Ulama: 1,858,100; Wahana Visi: 813,366; Dompet Dhuafa: 75,000; Yakkum: 26,000; UNODC: 40,000

Indonesia Multi-Sectoral Response Plan to COVID-19

April-December 2020